

AACN

CMC
Cardiac Medicine Certification

Questions And Answers PDF Format:

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Question: 1

A 47-year-old woman presents to the hospital with a blood pressure of 220/130 mmHg. She is confused and restless on arrival and is unable to answer questions. Her family reports that she complained of a bad headache and nausea earlier in the day. Her husband notes that she stopped taking her blood pressure medications over the past few days because she did not feel like she needed them anymore. What is the most appropriate treatment approach?

- A. Slowly lower the patient's systolic blood pressure to 120 mmHg with intravenous (IV) antihypertensive medication, and then switch to oral antihypertensive medication for maintenance.
- B. Slowly lower the patient's diastolic blood pressure to 85 mmHg with oral antihypertensive medication, and then adjust the dose of antihypertensive medication to maintain blood pressure.
- C. Rapidly lower the patient's systolic blood pressure to 120 mmHg with oral antihypertensive medication, and then adjust the dose of antihypertensive medication to maintain blood pressure.
- D. Rapidly lower the patient's diastolic blood pressure to 100 mmHg with IV antihypertensive medication, and then gradually reduce the diastolic pressure to 85 mmHg with oral antihypertensive medication.

Answer: D

Explanation:

The patient described in the question is experiencing a hypertensive emergency with associated hypertensive encephalopathy. In this situation, a patient's diastolic blood pressure should be rapidly lowered to around 100 mmHg with intravenous antihypertensive medication (with the maximum initial decrease 25% or less of the presenting value). This initial decrease in blood pressure should take place over 2–6 hours. Once the blood pressure is controlled, the patient should be switched to oral therapy, and the diastolic blood pressure should gradually be reduced to about 85 mmHg over the next 2-3 months. While the severity of the symptoms calls for rapid lowering of the blood pressure, if the blood pressure is lowered too much over a short period of time, other complications, such as renal failure, could occur.

Question: 2

A routine x-ray shows that a patient has an asymptomatic descending thoracic aortic aneurysm. The aneurysm has a diameter of 4 cm. What is the recommended initial management?

- A. Beta-blockers for aggressive blood pressure control and surveillance
- B. Surveillance only
- C. Surgical correction
- D. Aspirin, aggressive blood pressure control with a beta-blocker, an angiotensin-converting enzyme inhibitor, and surveillance

Answer: A

Explanation:

In an asymptomatic patient with a descending thoracic aortic aneurysm with a diameter of less than 6 cm, medical management is generally recommended, though some evidence is showing that the individual's height should also be taken into account when considering surgery. Medical management includes aggressive blood pressure control with beta-blockers as part of the regimen, surveillance for signs and symptoms, and serial imaging to evaluate growth and structure. Surgery is indicated if the patient is symptomatic, if the descending aortic aneurysm is 6 cm or greater, if the aneurysm has an accelerated growth rate, or if there is evidence of dissection.

Question: 3

A patient complains of right-sided calf pain. The nurse decides to evaluate the patient for a possible deep venous thrombosis (DVT). All of the following signs or symptoms are typical of a DVT EXCEPT

- A. unilateral swelling of the calf.
- B. warmth.
- C. skin breakdown.
- D. superficial venous dilation.

Answer: C

Explanation:

There are no physical examination findings that can definitively diagnose a deep venous thrombosis (DVT), but certain findings may help guide further action. Findings that may be associated with a DVT include a palpable cord, unilateral calf or thigh pain, unilateral edema, warmth, tenderness, erythema, and superficial venous dilation. Skin breakdown is not a typical sign of DVT.

Question: 4

What is the most serious acute complication associated with coronary artery stenting?

- A. Stent fracture
- B. Stroke
- C. Myocardial infarction

D. Renal failure

Answer: B

Explanation:

Stroke is the most serious acute complication associated with coronary artery stenting in patients with carotid stenosis. Stroke may result from thromboembolism, hypoperfusion, intracerebral hemorrhage, or cerebral hyperperfusion. Stent fractures, myocardial infarctions, and renal dysfunction are other complications of coronary artery stenting. but stroke is considered the most serious.

Question: 5

The nurse is caring for a 72-year-old man who was admitted to the hospital to rule out acute coronary syndrome. While the nurse is in the room talking to the patient, he suddenly clutches his chest and then falls back on his bed unresponsive. The nurse calls for help and begins cardiopulmonary resuscitation. A team arrives with the crash cart and attaches a monitor/defibrillator to the patient's chest. The monitor reveals asystole. What should the next immediate action be?

- A. Shock the patient.
- B. Resume chest compressions.
- C. Insert an advanced airway.
- D. Give 1 mg of epinephrine intravenously.

Answer: B

Explanation:

Asystole is not a rhythm that can be shocked (defibrillated) into regularity. One of the most important parts of advanced cardiac life support is to minimize interruptions in chest compressions. In this case, chest compressions should be resumed immediately while the rest of the team prepares for next steps. A team member should ensure that the patient has good intravenous access and 1 mg of epinephrine can be given every 3-5 minutes, but chest compressions should continue while this is taking place. The patient may need to have an advanced airway placed, but once again, chest compressions should be continued while preparations are made.

Question: 6

Major mechanical complications of acute myocardial infarction include all of the following EXCEPT

- A. rupture of the left ventricular free wall.
- B. rupture of the interventricular septum.
- C. the development of mitral regurgitation.
- D. the development of aortic regurgitation.

Answer: D

Explanation:

The three major medical complications of acute myocardial infarction include rupture of the left ventricular free wall, rupture of the interventricular septum, and the development of mitral regurgitation (often due to papillary muscle rupture). If a new murmur develops, if there is evidence of hypoperfusion, or if severe decompensated heart failure occurs, suspicion of a mechanical complication is warranted. The diagnosis is often made with echocardiography. Each of these complications can lead to cardiogenic shock and death if not treated emergently.

Question: 7

A 68-year-old woman presents with acute substernal chest pain and dyspnea

a. An electrocardiogram reveals deep T-wave inversion with QT-interval prolongation. Laboratory analysis reveals very mild elevation of troponin and cardiac enzymes. The patient had no history of cardiac disease. Shortly before her symptoms developed, she had been told that her daughter and grandchild had been killed in a car accident. Echocardiography showed left ventricular (LV) apical ballooning with dyskinesis of the apical one-half of the LV. Coronary angiography demonstrated only mild coronary atherosclerosis. When the patient was reevaluated weeks later, it was shown that she had recovered normal LV function. What did this patient most likely experience?

- A. Psychosomatic chest pain
- B. Takotsubo cardiomyopathy
- C. A myocardial infarction
- D. Hypertrophic cardiomyopathy

Answer: B

Explanation:

Stress-induced (takotsubo) cardiomyopathy is characterized by transient systolic dysfunction of the apical segment of the left ventricle (LV), LV apical ballooning, electrocardiographic changes, mild elevation of troponin and cardiac enzymes, and absence of obstructive coronary artery disease. Symptoms may be similar to a myocardial infarction, but the fact that there is only very mild elevation in troponin and the patient's quick recovery should initiate the consideration of other options. The combination of characteristic findings described here and the preceding stressor indicate stress-induced cardiomyopathy. It is frequently triggered by an acute medical illness or an intense emotional or physical stress.

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