1. A client was diagnosed with major neurocognitive disorder due to Alzheimer's disease. What pharmacologic therapy would be anticipated? A. Carbidopa-Levodopa B. Amitriptyline **C. Memantine** D. Quetiapine

2. An 89-year-old presents with symptoms of Dementia. Which diagnostic test should be performed initially to rule out treatable causes of symptoms? A- Arterial Blood Gas, B- Magnetic Resonance Imaging, C-Electrocardiogram. **D-Cobalamin level**

In the case of an 89-year-old patient presenting with symptoms of dementia, the initial diagnostic test to rule out treatable causes of symptoms should be **D - Cobalamin level.**

Cobalamin (Vitamin B12) deficiency can lead to cognitive impairments and dementia-like symptoms, making it a treatable cause of such symptoms. Other tests, such as MRI, can provide more information on brain structure and an electrocardiogram might help identify cardiovascular issues, but checking cobalamin levels is more directly related to reversible causes of dementia.

The most appropriate initial diagnostic test to rule out treatable causes of dementia symptoms is:

D. Cobalamin level

A cobalamin (vitamin B12) deficiency can cause reversible cognitive impairment and symptoms that mimic dementia, especially in older adults. It's important to check for this deficiency early in the diagnostic process, as treatment can improve or reverse symptoms if identified.

- **Arterial Blood Gas (A)** is used to assess oxygen and carbon dioxide levels in the blood, which is not typically relevant for diagnosing dementia.
- **Magnetic Resonance Imaging (MRI) (B)** can be helpful to assess structural brain changes, but it's not usually the first step when ruling out reversible causes of

dementia.

- **Electrocardiogram (C)** assesses heart rhythm and function but is not directly relevant to diagnosing cognitive impairment.

Starting with a cobalamin level helps identify a common and easily treatable cause of cognitive decline.

In evaluating patients who appear demented, the role of the physical examination is to elucidate possible causative factors such as the cogwheel rigidity and tremor associated with Parkinson disease or neurologic deficits suggestive of prior strokes. Standard laboratory studies commonly assessed in dementia patients include a complete blood count (CBC), serum electrolytes, liver function tests (LFTs), blood urea nitrogen (BUN), creatinine (Cr), thyroid function tests, serum B_{12}, and folate levels, Venereal Disease Research Laboratory (VDRL) test, and a urinalysis. Currently, there is no clear clinical indication for testing for the apolipoprotein E epsilon 4 allele. Often, a CT scan is performed if there are focal neurologic findings, and an electroencephalogram (EEG) may be performed if there is delirium. When patients are delirious, the neurologic examination may be complicated by inattention due to altered levels of consciousness. Delirium workup often includes the same laboratory workup described above for dementia. Urine or blood cultures, chest radiograph, neuroimaging studies, or EEG also may be appropriate.

3. What information can assist the clinician in differentiating Dementia from Depression?

A patient with dementia has symptoms for a long time before seeking medical help. B- clients with the diagnosis typically have a slow progression of symptoms after onset. C- A client with depression typically presents with an insidious onset of symptoms. D- client with dementia typically provide detailed complaints of specific cognitive dysfunction.

From Kaplan pg 237

Table 3-25
Major Clinical Features Differentiating Depression-Related Cognitive Dysfunction from Dementia

Depression	Dementia
Clinical Course and History	
Family always aware of dysfunction and its severity	Family often unaware of dysfunction and its severity
Onset can be dated with some precision	Onset can be dated only within broad limits
Symptoms of short duration before medical help is sought	Symptoms usually of long duration before medical help is sought
Rapid progression of symptoms after onset	Slow progression of symptoms throughout course
History of previous psychiatric dysfunction common	History of previous psychiatric dysfunction unusual
Complaints and Clinical Behavior	
Patients usually complain much of cognitive loss	Patients usually complain little of cognitive loss
Patients' complaints of cognitive dysfunction usually detailed	Patients' complaints of cognitive dysfunction usually vague
Patients emphasize disability	Patients conceal disability
Patients highlight failures	Patients delight in accomplishments, however trivial
Patients make little effort to perform even simple tasks	Patients struggle to perform tasks

The correct answer is:

A. A patient with dementia has symptoms for a long time before seeking medical help.

This statement reflects a common difference between dementia and depression. Clients with dementia often experience a gradual decline in cognitive function over time and may not recognize or report the problem themselves, often seeking medical help later when symptoms are more pronounced.

Here's why the other options are less accurate:

- **B. Clients with dementia typically have a slow progression of symptoms after onset**: While this is true, it doesn't directly help distinguish dementia from depression, as depression can also present with cognitive difficulties over time.
- **C. A client with depression typically presents with an insidious onset of symptoms**: Depression usually has a more **acute onset** and clients often report a clear timeline of when they started feeling depressed or cognitively impaired, unlike dementia's gradual progression.
- **D. Clients with dementia typically provide detailed complaints of specific cognitive dysfunction**: In fact, clients with dementia often have **poor insight** into their cognitive deficits and may not be able to provide detailed complaints. In contrast, clients with depression may focus on specific cognitive complaints like memory difficulties, even though objective testing may show minimal impairment.

4. A client presents with concerns about difficulties at work. He states that he has trouble speaking up when things aren't going well because he is afraid that others won't like him or will think he is stupid. He is not in a relationship because he can't imagine anyone wanting to be with him. The clients symptoms are consistent with which disorder? **Avoidant Personality disorder**, Paranoid Personality disorder, antisocial personality disorder, or dependent personality disorder

From Week 7 Module

Avoidant

Avoidant personality disorder is characterized by extreme sensitivity to criticism or rejection. Individuals with an avoidant personality disorder may feel inadequate, inferior, or unattractive and are often socially inhibited, withdrawn, or shy, though they greatly desire companionship. They typically avoid activities that require interpersonal contact.

Avoidant personality disorder

This disorder is characterized by feelings of inadequacy, hypersensitivity to negative evaluation, and social inhibition. The client describes **fear of rejection** and **avoidance of situations** where he may be criticized or judged (e.g., speaking up at work), which are hallmark features of avoidant personality disorder. He also mentions feeling unworthy of relationships, a common symptom in individuals with this condition.

Here's why the other options are less appropriate:

- **Paranoid personality disorder (PPD)** involves pervasive distrust and suspicion of others, which doesn't align with the client's concern about being disliked or rejected.
- **Antisocial personality disorder** is characterized by disregard for others' rights, impulsivity, and deceit, which doesn't fit this client's presentation of social anxiety and fear of rejection.
- **Dependent personality disorder** involves excessive reliance on others and difficulty making decisions without reassurance, but the client's primary issue is **fear of rejection**, not dependence on others.

Avoidant Personality Disorder
Persons with avoidant personality disorder show extreme sensitivity to rejection and may lead socially withdrawn lives. Although shy, they are not asocial and show a great desire for companionship, but they need unusually strong guarantees of uncritical acceptance. We often describe this group as having an inferiority complex.

5. A client presents with ataxia, short-term memory loss, and nystagmus. The client has a history of prolonged, heavy alcohol use. What is the most likely diagnosis? A. Unspecified alcohol-related disorder, **B. Wernicke Encephalopathy,** C. Delirium tremens, D. Alcohol-induced persisting dementia

6. A client who has been diagnosed with mild neurocognitive disorder asks what he can do to improve his prognosis. What is the best response? Begin taking Memantine, Begin taking Vitamin D daily, **Begin a regular exercise program**, and Request assistance from a family with managing finances.

from Week 6 Module

Nonpharmacological Interventions

- physical activity
- consistent surroundings and routines
- diet (Mediterranean)
- memory aids (calendar)
- cognitive stimulation (puzzles, word games)
- cognitive behavioral therapy
- support groups
- alternative therapies (aromatherapy, music, dance, animal)

7. A 50-year-old client presents with fatigue and poor motivation to the point that she is avoiding work. She reports that for the past several weeks she has a poor appetite and sleeps over 14 hours per day. She notes that last month, she felt "much better" had lots of energy and didn't need much sleep. She went on several shopping sprees that caused her checking account to be overdrawn. Which diagnosis is most consistent with the client's symptoms? Histrionic, personality disorder, **Bipolar II disorder**, Borderline personality disorder, D. Bipolar I disorder

8. Inattention and a variable level of consciousness are the hallmark symptoms of which condition? A. Neurocognitive disorder due to prion disease. B. Neurocognitive disorder with Lewy bodies, C. Neurocognitive disorder due to Alzheimer's disease, **D. Delirium**

9. What statement describes clients with personality disorders? **They are resistant to behavioral change**, they often need help to change maladaptive behaviors, they have the ability to tolerate frustration and pain, they typically form satisfying and intimate relationships with significant others

From Kaplan pg 560

Persons with personality disorders are far more likely to refuse psychiatric help and to deny their problems than persons with anxiety disorders, depressive disorders, or obsessive-compulsive disorder. In general, personality disorder symptoms are ego-syntonic (i.e., acceptable to the ego, as opposed to ego-dystonic) and alloplastic (i.e., adapt by trying to alter the external environment rather than themselves). Persons with personality disorders do not feel anxiety about their maladaptive behavior. Because they do not routinely acknowledge pain from what others perceive as their symptoms, they often seem disinterested in treatment and impervious to recovery.

10. When conducting a cognitive assessment, what does the question "what did you have for dinner last night" assess? Attention span, Remote Memory, **Recent Memory**, General Knowledge

11. A 25-year-old presents with irritability, insomnia, and excessive energy. She states that she has felt this way for about a week. Last month she reports that she felt really down and slept most of the time. She endorses a pattern of ups and downs in her mood at least half the time over the past few years. Which diagnosis is most consistent with this clients' symptoms? Dysthymia, Bipolar 2 disorder, **Cyclothymia,** Premenstrual Dysphoric disorder.

12. A 17-year-old who presents with symptoms of decreased energy and loss of interest in activities reports that a few weeks ago she went through an episode in which she experienced racing thoughts, easy distractibility, and decreased need for sleep. Which screening tool is most appropriate for the PMHNP to use? A. Children's Depression Inventory (CDI), B. Hamilton Depression Rating Scale (HAM-D), **C. Mood disorder questionnaire**, D. Positive and Negative Syndrome Scale (PANSS)

13. A client presents to the emergency department following a nonfatal suicide attempt. She