Canadian
GNC
Canadian Gerontological Nursing Examination (GNC)

Latest Version: 6.0

Question: 1

You are counseling a patient with Type II diabetes. The GNP understands that the macronutrient with the most influence on postprandial glucose levels is:

A. fat
B. carbohydrate
C. fiber
D. protein

Answer: B

Explanation:
The macronutrient that has the greatest impact on postprandial glucose levels is carbohydrates. Protein and fiber have little effect on plasma glucose response and fat is associated with increased risk of cardiovascular disease.

Question: 2

A 65-year-old patient that has transferred into your care from another provider presents with a history of migraine headaches. She is on Tylenol with codeine for treatment of these headaches but nothing for abortive therapy. The GNP understands that a good agent to prescribe for her for abortive therapy is:

A. ketorolac (toradol) 100 mg IM
B. amitriptyline (Elavil) 100 mg PO
C. sumatriptan (Imitrex) 6 mg IM
D. ergotamine (Ergostat) 2 mg SL

Answer: D

Explanation:
Ergotamine sublinginal at 2 mg is the correct dose of abortive therapy for migraine headaches. Ketorolac is give 30-60mg IM for pain, but does not help with abortive therapy. Sumatriptan is given subcutaneously (SC) or PO, not IM and is a good medication for abortive migraine therapy. Amitriptyline is not used in abortive therapy.

Question: 3

When treating a 70-year-old frail Caucasian female, the lab results reveal that she has a microcytic, hypochromic anemi
a. What is the diagnosis and dietary treatment of choice?

A. folic acid deficiency anemia eat more beans, rice, leafy green vegetables
B. iron deficiency anemia eat more red meats, organ meats, and raisins
C. vitamin B12 deficiency anemia eat more apples, oranges, and bananas
D. sickle cell anemia eat more fried foods and carbohydrates

Answer: B

Explanation:
The lab results for a 70-year-old frail Caucasian female showing microcytic, hypochromic anemia indicate that her red blood cells are smaller than usual (microcytic) and have reduced hemoglobin content (hypochromic). The most likely diagnosis for this type of anemia is iron deficiency anemia.
Iron deficiency anemia is one of the most common types of anemia, especially in older adults. It occurs when the body's iron stores are depleted. In a frail elderly patient, this could be due to a number of factors including inadequate dietary intake, chronic blood loss (possibly from gastrointestinal sources), or malabsorption disorders.
The dietary treatment of choice for iron deficiency anemia focuses on increasing the intake of iron-rich foods. Key dietary recommendations include: 1. **Red meats:** These are rich in heme iron, which is more easily absorbed by the body than the non-heme iron found in plant foods. 2. **Organ meats:** Like liver and kidney, these are also high in heme iron. 3. **Raisins and other dried fruits:** These provide non-heme iron and are a good option for adding to cereals or as snacks.
In addition to these foods, it may be beneficial to include foods that enhance iron absorption. Vitamin C, for example, can enhance the absorption of non-heme iron when eaten in conjunction with iron-rich foods. Good sources of Vitamin C include citrus fruits, tomatoes, and bell peppers.
It's also important to note what to avoid. Certain foods and substances can inhibit iron absorption, such as calcium-rich foods and beverages, coffee, tea, and some medications. These should not be consumed simultaneously with iron-rich meals.
In severe cases, or where dietary intake isn't sufficient to replete iron stores, iron supplements might be necessary. However, these should only be taken under medical supervision, as excessive iron supplementation can lead to complications, particularly in older adults.
Monitoring and follow-up are crucial to evaluate the effectiveness of dietary changes and to ensure that hemoglobin levels return to normal. Periodic blood tests will be necessary to monitor the progress in managing the anemia. This comprehensive approach ensures that not only is the iron deficiency addressed through diet, but that other aspects of health and nutrition are considered, providing a holistic treatment to the patient.

Question: 4

Which of the following is NOT true in regard to aging?

A. Older persons are still interested in sex.
B. Aging means illness and disability.
C. All older persons are unique.
D. Mental function does not necessarily decline with old age.

Answer: B

Explanation:
Older persons are at risk for health problems and disabilities; however, most are healthy. In fact some lifestyle changes can even reverse or slow many changes blamed on aging.

Question: 5

An older adult was screened for colorectal cancer and had a "positive" screen. She went on to have a colonoscopy that was normal with no findings of cancer present. The screen was a :

A. false positive
B. false negative
C. true positive
D. true negative

Answer: A

Explanation:
The correct term for this scenario is "false positive." This term is used when a screening test indicates the presence of a condition—such as colorectal cancer—when in fact, the condition is not present. In this case, the older adult had a positive screening result for colorectal cancer, but a subsequent, more definitive test (colonoscopy) showed no evidence of cancer.
A false positive can cause unnecessary anxiety and stress for the patient, as well as lead to further invasive testing, which can be costly and carry its own risks. Additionally, the unnecessary procedures following a false positive result can lead to an increase in healthcare costs, not only for the individual but also for the healthcare system as a whole.
Screening tests are generally designed to be sensitive and are used widely to ensure that conditions are not missed. However, the trade-off for this sensitivity is often a lack of specificity, meaning that these tests can sometimes produce false positive results. This lack of specificity is why confirmatory tests, like colonoscopy in the case of colorectal cancer screening, are crucial for verifying the presence of a condition.
The implications of false positive results emphasize the importance of careful consideration in the use of screening tests, particularly in populations where the prevalence of the condition is low. Medical professionals must balance the benefits of early detection with the potential psychological and physical consequences of false positive results, along with the economic impacts on the healthcare system.

Question: 6

A patient is diagnosed with restless leg syndrome. What should the GNP order as part of the laboratory workup for this condition?

A. ALT and AST
B. urinalysis
C. BUN and creatinine
D. serum ferritin

Answer: D

Explanation:
Restless leg syndrome (RLS) is the unrelenting urge to move the legs and it does not affect the upper extremities. Iron deficiency has been considered as a cause of RLS with the exact mechanism of this unknown at this time. Even in patients with normal serum ferritin levels, a month long trial of oral iron has been shown to be helpful.

Question: 7

Presbycusis is the age-related decrease in hearing in all but which of the following?

A. size of the eardrum
B. auditory threshold
C. pitch and tone discrimination
D. speech intelligibility

Answer: A

Explanation:
Presbycusis, commonly known as age-related hearing loss, primarily affects the inner ear but can also involve the middle and outer ear. It typically manifests as a gradual reduction in hearing sensitivity, particularly to high-frequency sounds, and affects various auditory functions. These include hearing acuity, auditory threshold, pitch and tone discrimination, and speech intelligibility.
Hearing acuity refers to the clarity or sharpness of hearing, which tends to decline with age. The auditory threshold is the minimum volume at which a sound is perceived, and this threshold increases (i.e., worsens) in individuals with presbycusis. Pitch and tone discrimination involves the ability to differentiate between different frequencies and sound patterns, which also deteriorates with age. Speech intelligibility is the ability to comprehend spoken words and sentences, which becomes more challenging as presbycusis progresses.
However, presbycusis does not directly affect the size of the eardrum. The eardrum, or tympanic membrane, is a thin membrane that separates the outer ear from the middle ear and vibrates in response to sound waves. While its function is crucial for hearing, its size does not change significantly due to aging alone. Factors that might alter the eardrum's size or shape include injuries, infections, or surgeries, but these are not related to the natural aging process described in presbycusis.
Thus, in the context of the question regarding which aspect is not affected by presbycusis, the correct answer is the size of the eardrum. All other options listed—auditory threshold, pitch and tone discrimination, and speech intelligibility—are indeed impacted by the age-related changes of presbycusis.

Question: 8

In giving a person end-of-life care, pain management is crucial. Which of the following is NOT true of untreated or undertreated pain?

A. It affects the quality of life and social interactions.
B. It consumes energy.

C. It contributes to sleep disturbances.
D. It is an invasive intervention.

Answer: D

Explanation:
In the context of providing end-of-life care, effective pain management is essential for ensuring the patient's comfort and dignity. However, there are several misconceptions and truths about the nature of pain and its management. Below, we'll explore why one of the given statements is not true about untreated or undertreated pain.
The statement that "It is an invasive intervention" is not true regarding untreated or undertreated pain. In medical terminology, an "invasive intervention" refers to medical procedures that involve entry into the body through incision or insertion of an instrument. Examples include surgical procedures, injections, and the insertion of devices like catheters or scopes. In contrast, untreated or undertreated pain is the absence of sufficient intervention—it reflects a lack of adequate medical management rather than an intervention itself.
On the other hand, the other statements listed are indeed true about untreated or undertreated pain: 1. "It affects the quality of life and social interactions." Pain can be debilitating, affecting not only the physical state of the individual but also their emotional and social well-being. Chronic pain can lead to withdrawal from social activities, strained relationships, and isolation. 2. "It consumes energy." Managing chronic or acute pain requires significant physical and mental resources. Persistent pain can lead to constant discomfort, which exhausts the body's energy stores, making it difficult for individuals to engage in daily activities or maintain their normal routine. 3. "It contributes to sleep disturbances." Pain often interferes with sleep patterns by making it difficult to fall asleep or stay asleep. This can lead to a cycle of sleep deprivation and increased pain perception, further exacerbating the individual's overall condition.
Pain management in end-of-life care is considered a supportive intervention that primarily focuses on symptom control rather than curing a disease. It aims to improve the quality of life for patients by reducing pain and other distressing symptoms. Effective pain management strategies can involve pharmacological treatments, such as the administration of painkillers, and non-pharmacological methods, including physical therapy, psychological support, and complementary therapies like acupuncture or massage.
In conclusion, while untreated or undertreated pain has several adverse effects on a person's energy levels, quality of life, social interactions, and sleep, it is incorrect to describe it as an invasive intervention. Understanding the true nature of pain and its proper management is crucial in providing compassionate and effective end-of-life care.

Question: 9

Your 75-year-old male patient presents with a lump on his breast. How would you proceed with this?

A. Tell him that since he is male there is no risk of cancer.
B. Evaluate the lump and proceed with a mammogram and ultrasound.
C. Tell him that this is common in men his age and that he should not worry that it is cancer.
D. Palpate the lump and do an ultrasound.

Answer: B

Explanation:
When a 75-year-old male patient presents with a lump on his breast, it is crucial to approach the situation with the same level of concern as one would for a female presenting similar symptoms. Although male breast cancer is less common than female breast cancer, it can still occur, and the risk increases with age. Therefore, dismissing the possibility of cancer based on gender alone, as suggested in the option "Tell him that since he is male there is no risk of cancer," would be inappropriate and potentially dangerous.
The appropriate course of action would involve a thorough clinical evaluation of the lump. This evaluation should start with a detailed medical history and physical examination, focusing on the size, location, consistency, and mobility of the lump. It is also important to inquire about any additional symptoms such as nipple discharge, changes in the skin over the lump, or any recent changes in the breast tissue.
Following the physical examination, diagnostic imaging should be utilized to further evaluate the lump. A mammogram is recommended as it is the standard imaging technique for detecting breast abnormalities, though it is less commonly performed in males due to the smaller volume of breast tissue. An ultrasound may also be particularly useful as it can help differentiate between solid masses, which may be more indicative of cancer, and cystic (fluid-filled) masses, which are often benign.
In some cases, if the imaging results are inconclusive or if there is a strong suspicion of cancer, a biopsy may be necessary. A biopsy involves taking a sample of tissue from the lump which is then examined under a microscope to determine if cancer cells are present.
The options suggesting that the lump should be evaluated with both a mammogram and ultrasound reflect the best practice. Notably, the approach to managing breast lumps in males should mirror that in females, given the potential for malignancy. Misleading the patient by stating that such findings are common and non-cancerous without proper evaluation, as suggested in another response option, could delay diagnosis and treatment of a potentially serious condition.
In summary, any new breast lump in a male patient, regardless of age, warrants careful evaluation to rule out breast cancer. This includes a combination of physical exams, imaging studies such as mammograms and ultrasounds, and possibly a biopsy. It is essential to treat these cases with the seriousness they deserve to ensure that any potential malignancy is detected and treated promptly.

Question: 10

An 82-year old man who is independent has hypertension, BPH, and hyperlipidemia. He is otherwise healthy. What should he be advised about regarding having a colonoscopy done to screen for colorectal cancer?

A. Screening stops at age 80 years.
B. Screening with colonoscopy is not advised in the elderly.
C. Colonoscopy is the preferred screening method for the elderly at risk for colorectal cancer.
D. He should be offered an alternative screening method.

Answer: D

Explanation:

The question involves making an appropriate decision regarding colorectal cancer screening for an 82-year-old man who is also managing multiple chronic conditions such as hypertension, BPH (benign prostatic hyperplasia), and hyperlipidemia. In general, screening for colorectal cancer is a preventive health measure aimed at detecting early, treatable stages of cancer or precancerous conditions. However, the appropriateness of screening, especially using colonoscopy, varies based on the patient's age, overall health condition, life expectancy, and personal preferences.

For individuals over the age of 75, the decision to screen for colorectal cancer should be individualized, taking into account the patient's overall health and estimated life expectancy. The U.S. Preventive Services Task Force (USPSTF) guidelines suggest that routine screening should not be initiated or continued after the age of 85 years. Between the ages of 76 and 85, the decision to screen should be based on the patient's overall health, prior screening history, and preferences. Importantly, the benefit of screening in this age group may be limited, particularly if life expectancy is less than 10 years, as the risks associated with screening procedures may outweigh the potential benefits.

In the case of an 82-year-old man who is relatively healthy but has a life expectancy potentially impacted by his age and existing conditions, the potential benefits of a colonoscopy should be carefully weighed against the risks. Colonoscopy is an invasive procedure that carries risks such as bleeding, perforation of the colon, and complications from anesthesia. These risks tend to increase with age and the presence of other health conditions.

Additionally, the effectiveness of screening in this age group is also a consideration. The progression from a detectable polyp to colorectal cancer can take several years, and the slower progression in elderly patients may mean that the cancer might not pose a significant threat during their expected lifetime. Therefore, performing a colonoscopy might not necessarily improve outcomes if the patient's life expectancy is shorter than the time it would take for a polyp to turn into cancer.

Given these considerations, alternative methods of screening that are less invasive and carry fewer risks might be more appropriate for this individual. Methods such as fecal immunochemical test (FIT) or stool DNA test could be considered as they are less invasive and pose minimal risk to the patient. These methods can also be effective in indicating the need for a colonoscopy only if results suggest abnormal findings.

Ultimately, the decision to proceed with any form of screening should involve a detailed discussion between the patient and his healthcare provider. This discussion should cover the potential benefits and risks of screening, the patient's values and preferences, and the overall goal of care considering his age and health status.

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