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# CNN-NP

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**Question: 609**

A 57-year-old male on hemodialysis presents with a phosphorus level of 8.2 mg/dL despite taking lanthanum carbonate 1000 mg three times daily. His calcium is 9.0 mg/dL, and iPTH is 600 pg/mL. What is the most appropriate next step?

A. Increase lanthanum carbonate to 1500 mg three times daily
B. Add cinacalcet 30 mg daily
C. Initiate paricalcitol 2 mcg three times weekly
D. Switch to calcium acetate 667 mg three times daily

Answer: B

Explanation: Persistent hyperphosphatemia and elevated iPTH suggest uncontrolled secondary hyperparathyroidism. Cinacalcet lowers iPTH and may indirectly improve phosphate control by reducing bone turnover. Increasing lanthanum carbonate may help but does not address iPTH. Paricalcitol risks hypercalcemia. Calcium acetate is contraindicated due to potential hypercalcemia.

**Question: 610**

A 57-year-old male with ESRD on hemodialysis presents with a hemoglobin of 8.5 g/dL and transferrin saturation (TSAT) of 15%. His ferritin is 100 ng/mL. He is on erythropoietin 6000 units weekly. What is the most appropriate next step?

A. Continue current erythropoietin dose
B. Start IV iron sucrose 200 mg weekly
C. Increase erythropoietin to 8000 units weekly
D. Switch to darbepoetin alfa 60 mcg weekly

Answer: B

Explanation: Low TSAT (15%) and ferritin (100 ng/mL) indicate iron deficiency anemia in this hemodialysis patient. IV iron sucrose 200 mg weekly is the most appropriate step to correct iron stores and improve erythropoietin response, per KDIGO guidelines. Continuing or increasing erythropoietin without addressing iron deficiency is ineffective. Switching to darbepoetin is not indicated without optimizing iron.

**Question: 611**

A 71-year-old male with ESRD on hemodialysis presents with a serum albumin of 2.8 g/dL and a normalized protein catabolic rate (nPCR) of 0.6 g/kg/day. His dry weight is 65 kg. The NP suspects protein-energy wasting. What is the most appropriate intervention?

A. Administer IV albumin 25 g post-dialysis
B. Start enteral tube feeding with 2,000 kcal/day

C. Increase dietary protein intake to 1.2 g/kg/day
D. Initiate testosterone 100 mg IM weekly

Answer: C

Explanation: Protein-energy wasting is indicated by low serum albumin and nPCR (<0.8 g/kg/day). Increasing dietary protein intake to 1.2 g/kg/day, per KDOQI guidelines, is the first-line intervention to improve nutritional status in hemodialysis patients. Enteral feeding is reserved for severe malnutrition. IV albumin does not address underlying nutritional deficits. Testosterone is not standard for protein-energy wasting in ESRD.

**Question: 612**

A 57-year-old male with CKD Stage 5 has a serum iPTH of 800 pg/mL, calcium 9.5 mg/dL, and phosphorus 6.8 mg/dL. He is on calcitriol 0.5 µg daily. What is the most appropriate next step?

A. Increase calcitriol to 1 µg daily
B. Switch to sevelamer 1600 mg three times daily
C. Add paricalcitol 5 µg three times weekly
D. Start cinacalcet 30 mg daily

Answer: D

Explanation: Severe secondary hyperparathyroidism (iPTH 800 pg/mL) with elevated phosphorus requires cinacalcet to lower PTH by reducing parathyroid gland activity. Increasing calcitriol or adding paricalcitol risks hypercalcemia, and sevelamer addresses phosphorus but not PTH directly.

**Question: 613**

A 59-year-old male with ESRD on hemodialysis presents with a serum calcium of 10.8 mg/dL, phosphorus 5.5 mg/dL, and PTH 450 pg/mL. He is on sevelamer 800 mg TID and calcitriol 0.5 mcg IV thrice weekly. The NP calculates his calcium-phosphorus product as 59.4 $mg^2/dL^2$. What is the most appropriate management?

A. Increase calcitriol to 1 mcg IV thrice weekly
B. Start cinacalcet 30 mg daily and stop calcitriol
C. Switch sevelamer to calcium acetate 667 mg TID
D. Continue current regimen and monitor labs

Answer: B

Explanation: The patient has hypercalcemia (calcium 10.8 mg/dL) and an elevated calcium-phosphorus product (>55 $mg^2/dL^2$), increasing the risk of vascular calcification. Stopping calcitriol (which increases calcium) and starting cinacalcet (to lower PTH and calcium) is appropriate. Increasing calcitriol worsens hypercalcemia. Switching to calcium acetate risks further calcium elevation. Continuing the current regimen does not address the hypercalcemia.

**Question: 614**

A 53-year-old female with CKD Stage 4 has a serum bicarbonate of 16 mEq/L, eGFR 25 mL/min/1.73 m², and normal anion gap. What is the most appropriate treatment?

A. Start sodium bicarbonate 1300 mg twice daily
B. Initiate furosemide 80 mg daily
C. Administer IV sodium bicarbonate 50 mEq
D. Begin ammonium chloride 500 mg daily

Answer: A

Explanation: Metabolic acidosis (bicarbonate 16 mEq/L) in CKD is treated with oral sodium bicarbonate to maintain levels ≥22 mEq/L, slowing CKD progression. IV bicarbonate is for acute severe acidosis, furosemide does not correct acidosis, and ammonium chloride worsens acidosis.

**Question: 615**

A 60-year-old male on hemodialysis presents with a pre-dialysis plasma osmolality of 320 mOsm/kg (normal: 275–295 mOsm/kg) and a serum sodium of 145 mEq/L. The NP suspects hyperosmolar state. What is the most likely cause?

A. Dehydration
B. Excessive dialysate sodium
C. Uremia
D. Hyperglycemia

Answer: D

Explanation: Hyperosmolarity with elevated sodium in hemodialysis patients is often due to hyperglycemia, which increases plasma osmolality (calculated as 2 × Na + glucose/18 + BUN/2.8). Dehydration is less likely with controlled dialysis. Excessive dialysate sodium affects post-dialysis sodium, not pre-dialysis. Uremia is chronic in ESRD.

**Question: 616**

A 38-year-old female with CKD Stage 4 presents with a serum creatinine of 3.8 mg/dL, eGFR 18 mL/min/1.73 m², and hemoglobin of 9.2 g/dL. Her iron studies show: ferritin 150 ng/mL, TSAT 18%. What is the next step in managing her anemia?

A. Initiate darbepoetin alfa 60 µg weekly
B. Transfuse 2 units of packed red blood cells
C. Start oral iron sulfate 325 mg three times daily
D. Administer IV iron sucrose 200 mg weekly

Answer: D

Explanation: The patient has anemia of CKD with low TSAT (18%), indicating iron deficiency, despite adequate ferritin. IV iron sucrose is preferred to replete iron stores and improve erythropoiesis before starting erythropoiesis-stimulating agents (ESAs) like darbepoetin alfa. Oral iron is poorly absorbed in CKD, and transfusion is reserved for severe symptomatic anemia or acute blood loss, not indicated here.

**Question: 617**

A 46-year-old male with CKD stage 4 has an eGFR of 20 mL/min/1.73 m² and a serum uric acid of 9.5 mg/dL. He has no history of gout. What is the most appropriate management?

A. Initiate allopurinol 100 mg daily
B. Start febuxostat 40 mg daily
C. No intervention
D. Increase fluid intake to 3 L/day

Answer: C

Explanation: Asymptomatic hyperuricemia (uric acid 9.5 mg/dL) in CKD stage 4 does not require treatment in the absence of gout or urate nephropathy. No intervention is the most appropriate management. Allopurinol and febuxostat are indicated for symptomatic hyperuricemia or specific complications, not routinely in CKD. Increasing fluid intake is not targeted for hyperuricemia management.

**Question: 618**

A 69-year-old female with CKD stage 5 on hemodialysis presents with a phosphorus level of 7.8 mg/dL. She is non-compliant with her phosphate binder. Which binder is most appropriate to improve compliance?

A. Calcium acetate 667 mg with meals
B. Sucroferric oxyhydroxide 500 mg daily
C. Sevelamer carbonate 800 mg three times daily
D. Lanthanum carbonate 1,000 mg with meals

Answer: B

Explanation: Sucroferric oxyhydroxide 500 mg daily is the most appropriate phosphate binder to improve compliance, as it requires fewer pills and has a lower pill burden. Calcium acetate risks hypercalcemia. Lanthanum and sevelamer require multiple daily doses, which may reduce adherence in a non-compliant patient.

**Question: 619**

A 67-year-old male with CKD stage 4 (eGFR 22 mL/min/1.73 $m^2$) presents with metabolic acidosis (serum bicarbonate 16 mEq/L). His medications include lisinopril 20 mg daily and furosemide 40 mg daily. His arterial blood gas shows pH 7.30, $pCO_2$ 32 mmHg, and $HCO_3^-$ 15 mEq/L. What is the most appropriate initial treatment?

A. Sodium bicarbonate 650 mg orally twice daily
B. Increase furosemide to 80 mg daily
C. Discontinue lisinopril
D. Administer acetazolamide 250 mg daily

Answer: A

Explanation: The patient has metabolic acidosis (pH <7.35, low $HCO_3^-$) with partial respiratory compensation (low $pCO_2$). In CKD, alkali therapy with sodium bicarbonate is indicated for serum bicarbonate <22 mEq/L to prevent bone loss and muscle wasting. Starting sodium bicarbonate 650 mg twice daily is appropriate to correct acidosis gradually. Increasing furosemide may worsen acidosis by increasing bicarbonate loss. Discontinuing lisinopril is not indicated, as it helps slow CKD progression. Acetazolamide causes acidosis and is contraindicated.

**Question: 620**

A 59-year-old male with CKD stage 3 and a lipid profile of LDL-C 115 mg/dL, HDL-C 30 mg/dL, triglycerides 450 mg/dL is on atorvastatin 20 mg daily. His eGFR is 45 mL/min/1.73 $m^2$. What is the most appropriate additional therapy?

A. Fenofibrate 145 mg daily
B. Niacin 1.5 g daily
C. Ezetimibe 10 mg daily
D. Omega-3 fatty acids 4 g daily

Answer: A

Explanation: For elevated triglycerides (450 mg/dL) in CKD stage 3, fenofibrate at 145 mg daily is appropriate to reduce triglycerides and cardiovascular risk. Niacin is less preferred due to its side effects. Ezetimibe has minimal effect on triglycerides. Omega-3 fatty acids are indicated for triglycerides ≥500 mg/dL. Fenofibrate is the best choice for this scenario.

**Question: 621**

A 58-year-old male with CKD stage 4 (eGFR 18 mL/min/1.73 $m^2$) presents with metabolic acidosis (serum bicarbonate 16 mEq/L, pH 7.28). His serum potassium is 5.8 mEq/L, and he takes lisinopril 20 mg daily. What is the most appropriate treatment for his acidosis?

A. Discontinue lisinopril
B. Furosemide 40 mg orally daily
C. Sodium polystyrene sulfonate 15 g orally

D. Sodium bicarbonate 650 mg orally twice daily

Answer: D

Explanation: Metabolic acidosis in CKD (bicarbonate 16 mEq/L, pH 7.28) requires correction to prevent bone loss and muscle wasting. Sodium bicarbonate 650 mg twice daily is the standard treatment to raise serum bicarbonate to 22–24 mEq/L. Furosemide may worsen dehydration and acidosis. Sodium polystyrene sulfonate addresses hyperkalemia but not acidosis. Discontinuing lisinopril may help hyperkalemia but does not correct acidosis directly.

**Question: 622**

A 55-year-old male on PD presents with ultrafiltration failure. His 4-hour PET shows a D/P creatinine ratio of 0.9, indicating high transporter status. Which PD prescription adjustment is most appropriate?

A. Increase dwell time to 6 hours
B. Switch to icodextrin for long dwell
C. Use higher dextrose concentration (4.25%)
D. Increase fill volume to 2.5 L

Answer: B

Explanation: A high transporter (D/P creatinine 0.9) indicates rapid solute transport but poor ultrafiltration due to rapid glucose absorption. Icodextrin, a glucose polymer, provides sustained ultrafiltration for long dwells, ideal for high transporters. Increasing dwell time worsens ultrafiltration in high transporters. Higher dextrose concentrations are less effective due to rapid absorption. Increasing fill volume may cause discomfort without improving ultrafiltration.

**Question: 623**

A 58-year-old male on hemodialysis presents with a serum albumin of 2.8 g/dL and a 5% weight loss over 3 months. His dietary protein intake is 0.8 g/kg/day. What is the most appropriate intervention?

A. Initiate anabolic steroids
B. Administer IV albumin 25 g weekly
C. Start oral nutritional supplements
D. Increase dietary protein to 1.2 g/kg/day

Answer: D

Explanation: Hypoalbuminemia (2.8 g/dL) and weight loss suggest protein-energy wasting, common in dialysis patients. Increasing dietary protein to 1.2 g/kg/day (KDOQI recommendation) addresses nutritional deficiency. IV albumin is not indicated for chronic hypoalbuminemia. Oral supplements may help but are less specific than increasing protein intake. Anabolic steroids are not first-line for malnutrition.

**Question: 624**

A 65-year-old male with ESRD on hemodialysis develops a fever of 38.7°C and erythema around his tunneled catheter exit site. Blood cultures are positive for methicillin-resistant Staphylococcus aureus (MRSA). What is the most appropriate management?

A. Administer oral clindamycin 600 mg three times daily
B. Use vancomycin lock therapy
C. Start topical mupirocin and monitor
D. Initiate IV vancomycin and remove catheter

Answer: D

Explanation: Catheter-related bloodstream infection with MRSA requires IV vancomycin and catheter removal (option B) to eliminate the infection source. Oral clindamycin (option A) is inadequate for bloodstream infections. Topical mupirocin (option C) is for localized infections, not bacteremia. Vancomycin lock (option D) is adjunctive, not primary treatment.

**Question: 625**

A 63-year-old male on peritoneal dialysis presents with a dialysate leak at the catheter exit site and reduced ultrafiltration. His 24-hour ultrafiltration volume is 500 mL with 2.5% dextrose. What is the most appropriate management?

A. Initiate intraperitoneal antibiotics
B. Reduce dwell volumes temporarily
C. Remove the peritoneal catheter
D. Switch to hemodialysis permanently

Answer: B

Explanation: A dialysate leak at the catheter exit site can reduce ultrafiltration by allowing fluid to escape into subcutaneous tissues. Reducing dwell volumes temporarily allows the leak to heal while maintaining peritoneal dialysis. Intraperitoneal antibiotics are not indicated without infection, catheter removal is premature, and switching to hemodialysis is unnecessary unless the leak persists.

**Question: 626**

A 65-year-old male patient with a kidney transplant (6 months post-transplant) presents with fever, dysuria, and a urine culture positive for Escherichia coli (sensitive to ciprofloxacin). His serum creatinine is 1.8 mg/dL (baseline 1.3 mg/dL). The NP must adjust the antibiotic dose. What is the MOST appropriate ciprofloxacin dose, assuming an eGFR of 40 mL/min/1.73 $m^2$?

A. Ciprofloxacin 250 mg orally every 12 hours
B. Ciprofloxacin 500 mg orally every 12 hours
C. Ciprofloxacin 750 mg orally every 12 hours

D. Ciprofloxacin 500 mg orally every 24 hours

Answer: D

Explanation: Ciprofloxacin is renally cleared, requiring dose adjustment in reduced eGFR (40 mL/min/1.73 m²). For an eGFR of 30–50 mL/min/1.73 m², the recommended dose for uncomplicated UTI is ciprofloxacin 500 mg orally every 24 hours to prevent accumulation and toxicity. Ciprofloxacin 250 mg every 12 hours is insufficient for systemic infection. Ciprofloxacin 500 mg or 750 mg every 12 hours exceeds the safe dose for this eGFR, risking toxicity (e.g., seizures, tendon rupture).

**Question: 627**

A 54-year-old female with a kidney transplant has a BK virus PCR of 50,000 copies/mL and a creatinine of 2.8 mg/dL (baseline 1.4 mg/dL). She takes tacrolimus and mycophenolate. What is the most appropriate management?

A. Start leflunomide 20 mg daily
B. Increase tacrolimus trough to 10 ng/mL
C. Administer cidofovir 1 mg/kg weekly
D. Reduce mycophenolate dose by 50%

Answer: D

Explanation: BK virus nephropathy requires reducing immunosuppression, typically by lowering mycophenolate dose by 50%, to allow immune clearance of the virus. Leflunomide or cidofovir is considered for refractory cases. Increasing tacrolimus worsens BK viremia.

**Question: 628**

A 61-year-old male with a kidney transplant presents with a CMV viral load of 10,000 copies/mL. He is asymptomatic but has a leukocyte count of 3,000/µL. His immunosuppression includes tacrolimus, mycophenolate, and prednisone. What is the most appropriate management?

A. Reduce mycophenolate dose by 50%
B. Discontinue tacrolimus
C. Start valganciclovir 900 mg twice daily
D. Administer CMV immunoglobulin

Answer: C

Explanation: Asymptomatic CMV viremia (10,000 copies/mL) with leukopenia requires preemptive treatment with valganciclovir 900 mg twice daily, adjusted for renal function, to prevent progression to CMV disease. Reducing mycophenolate may help leukopenia but doesn’t address viremia. Discontinuing tacrolimus risks rejection. CMV immunoglobulin is used for prophylaxis or severe disease, not preemptive therapy.

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