HIIM134 Medical Terminology
Assignment #3 **165 Points** (point value for each question is located in parentheses by each item)

Assignment Objectives: After completing this assignment you will be able to:

- Apply your new knowledge of terms and abbreviations related to psychiatry, pharmacology, oncology, radiology, and general office visit reports to interpret medical terms in their proper context.
- Perform searches of the internet and other reference materials to answer questions ***(not Wikipedia)***.

Instructions: Read the medical reports in the boxes and answer the questions that follow each of the reports. Use your textbook, Google/Bing, and other reference materials to answer the questions; however, **do not use Wikipedia** for your assignment (points may be deducted). Some of the medical terms are in another chapter of your textbook, so you can use your index in the back of the textbook to help you locate where a particular term might be found. *Appendix II* (Abbreviations) and *Appendix III* (Lab values) in the back of your book are also extremely helpful. This will be similar to what you will find yourself doing on the job. You will understand much of a report, but you may have to check reference materials to understand the remaining information. Many medical reports are written in real life using abbreviations, although the Joint Commission is discouraging their use. However, we would like you to become familiar with them since they may still be found in reports, especially in physician offices. If you cannot locate a particular abbreviation, go to Google (www.Google.com) or Bing (www.bing.com) and enter the abbreviation in the search box. You should then be able find the results in a variety of links that become available. Information about medications can also be found by entering the medication name in Google/Bing if you do not have a drug reference book.

Place your name and answers on the assignment answer sheet. Assume you are a student by the name of James Smith. Save your answer sheet as **Assign3.Answers.HIIM134.Smith.J.doc** (substituting your name). ***Send your assignment answer sheet to the instructor through Canvas. Do not copy and paste your completed worksheet in the homework assignment dialog box. Do not send via email as an attachment.***

Grading Rubric

	Poor	**Fair**	**Good**
Student answered all questions correctly	**Points Range:** 0-111 0%-74% of the answers were correct	**Points Range:** 112-134 75%-89% of the answers were correct	**Points Range:** 135-150 90%-100% of the answers were correct
Proper grammar, spelling and punctuation were present	**Points Range:** 0-2 Answer sheet contains numerous grammatical, punctuation, or spelling errors	**Points Range:** 3-8 Answer sheet contains some grammatical, punctuation, or spelling errors	**Points Range:** 9-10 Answer sheet contains few grammatical, punctuation, or spelling errors
Student placed name on paper and renamed the worksheet digital file according to instructions	**Points Range:** 0 Not present.	**Points Range:** 3 One present, not both.	**Points:** 5 Both are present and done according to instructions

PSYCHIATRY – Consultation

REASON FOR CONSULTATION: Dr. Jane Doe ordered a psychological consultation of this patient, who is currently in the Emergency Department.

CONTACT PERSON: Barbara Green. She identified herself as a friend. There is a *Release of Information* authorization form that was signed by the patient for me and the hospital staff to discuss his situation with Ms. Jones. I do not know how long she has known the patient; however, she identified herself as a friend of the family.

HISTORY OF PRESENT ILLNESS AND REASON FOR ADMISSION: This 48-year-old white male had indicated that he took six Percocet last night. His medical record shows admissions to the Psychiatric Unit of this hospital for a number of different dates during the past ten years. In addition,

this patient had been admitted to several psychiatric facilities in the past with a diagnosis of bipolar affective disorder or manic depressive illness, not otherwise specified. The patient is reportedly on a variety of psychiatric medications, including Depakote. The patient did not indicate a history of outpatient treatment. I am unable to determine how well he followed up on any outpatient care.

There is a history of self-harm behavior. The patient stated that he had had suicidal thoughts, and he said the last time was one year ago; however, he did take a recent overdose. History of violent behavior is unknown. However, the friend reported that there is a history of some kind of violence on this patient's part. This patient made threatening statements of harm to his brother-in-law today, who assaulted him recently. His sister called the police who brought him to the Emergency Room of this hospital. The patient's friend, Barbara Green, is with him in the ER and she reported that the patient has been hallucinating and has been getting progressively worse. She also reported that he took 16 Percocet, and not six, as he said.

EMERGENCY DEPARTMENT CHIEF COMPLAINT: The chief complaint was an overdose.

MEDICAL HISTORY: The medical history of this patient is unknown, other than he has various bruises on his body. Allergies are unknown as this patient did not respond to questions concerning that.

SUBSTANCE ABUSE HISTORY: The patient did not respond to questions regarding substance abuse. It should be noted that this patient is a very poor historian and was very confused at the time of the examination.

SOCIAL HISTORY: The patient reported he was born in 19XX. He states that he was raised by his parents and his grandfather. Regarding siblings, he says that he has two sisters. He also made reference to something like six, but was not clear. The family psychiatric history is unknown. The patient reports he has two years of college. He states he is retired, but his prior occupations are unknown. The patient reported he was married two times and is presently divorced. He has three children. The patient reportedly lives alone in a hotel. The only local social support identified was a friend of the family, who is Barbara Green, the contact person.

WEAPONS OR MEDICATIONS FOR OVERDOSE AVAILABLE: This is unknown.

MENTAL STATUS: This patient took a recent overdose of Percocet. The patient has threatened harm to his brother-in-law and had taken 16 Percocet, but only acknowledged having taken six. The patient showed grossly normal development and physique. Grooming and personal hygiene were poor. The patient showed pressured speech and depression. The patient's thought process was somewhat tangential. The patient expressed that he is having auditory hallucinations and expressed paranoid delusions. The patient had severely impaired judgment and poor insight. The patient showed impaired attention and concentration. His thought process was disorganized. His fund of knowledge and orientation were quite poor. The patient's affect was labile. He was alert and agitated. He was pessimistic in his attitude and his mood was irritable. Regarding dangerousness, the patient had expressed homicidal ideation, ideation of harm to others, and he had indicated self-harm behavior. The patient showed impaired physical coordination and some psychomotor agitation.

DIAGNOSTIC IMPRESSION:
Bipolar 1 disorder, most recent episode mixed, with psychotic features.
Bruises to various regions of body.
Recent assault.

RECOMMENDATIONS: This patient should remain admitted, as he is psychotic and is a danger to himself and others. Following inpatient psychiatric stabilization, he will need outpatient psychiatric follow-up.

1. Percocet contains a narcotic pain reliever. This statement is (1)
    A. true
    B. false

2. Define Bipolar 1 disorder. Define Bipolar 2 disorder. (2)

3. Depakote is used to treat what three neurologic or psychiatric disorders? What is its use in this particular patient? (2)

4. What is meant by labile affect? (1)
    A. Little speech and negative or minimal thoughts and behavior.
    B. Sadness, hopelessness, depressive mood.
    C. Exaggerated feeling of well-being.
    D. Variable; undergoing rapid emotional change; emotional instability.

5. The patient indicated that he had paranoid delusions. What is this? (1)
    A. A person experiences a great deal of fear or anxiety, intensified by believing things that are false. Overly suspicious system of thinking; fixed delusion that one is being harassed, persecuted, or unfairly treated.
    B. The fear of situations in which the person is open to public scrutiny.
    C. A breakdown in memory, identity or perception.
    D. A false belief that you are much greater, powerful or influential than you really are.

6. The patient had pressured speech. What does this mean? (1)
    A. He has delayed speech and language skills.
    B. He has a tendency to talk rapidly and frenziedly, is difficult to interrupt, and may be too fast or too unrelated for the listener to understand.
    C. He has uncontrollable repetition of a particular a word, phrase, or gesture, despite the absence or stopping of a stimulus.
    D. He is unable to carry on a normal conversation with another due to a psychosis.

7. Define the following terms: (5)
    Tangential thought process
    Auditory hallucination
    Homicidal ideation (Include the meaning of both terms in your definition)
    Impaired physical coordination
    Psychomotor agitation

PSYCHIATRY and PHARMACOLOGY – History and Physical

HISTORY OF PRESENT ILLNESS: The patient is a 69-year-old single Caucasian female with a past medical history of schizoaffective disorder, diabetes, osteoarthritis, hypothyroidism, GERD, and dyslipidemia who presents to the emergency room with the complaint of "manic" symptoms due to recent medication adjustments. The patient had been admitted to General Hospital on March 21, 20xx for altered mental status and at that time, the medical team discontinued Zyprexa and lithium.

In the Emergency Room, the patient reported euphoria, pressured speech, irritability, decreased appetite, and impulsivity. She also added that over the past three days, she felt more confused and reported having blackouts as well as hallucinations about white lines and dots on her arms and face from the medication changes. She was admitted voluntarily to the inpatient unit and medications were not restarted for her.

On the unit this morning, the patient is loud and non-redirectable, she is singing loudly and speaking in a very pressured manner. She reports that she would like to speak with Dr. Philip Anders, the psychiatrist, who saw her at General Hospital, because she "trusts him." The patient is somewhat reluctant to answer questions stating that she has answered enough of people's questions; however, she is talkative and reports that she feels as though she needs a sedative. The patient reports that she is originally from Minneapolis, and she moved to Seattle about a year ago to be with her daughter. She also expressed frustration over the fact that her daughter wanted her removed from the apartment she was in initially and had her placed in a nursing home due to inability to care for herself. The patient also complains that her daughter is "trying to tell me what medications to take." The patient sees her internist, Dr. Jonathan Baker, for outpatient care of her general medical problems.

PAST PSYCHIATRIC HISTORY: According to her medical records, the patient has been mentally ill for over 30 years with past diagnoses of bipolar disorder, schizoaffective disorder, and schizophrenia. She has been stable on lithium and Zyprexa according to her daughter and was recently taken off

those medications, changed to Seroquel, and the daughter reports that she has decompensated since then. It is not known whether the patient has had prior psychiatric inpatient admissions; however, she denies that she has.

MEDICATIONS:
1. Seroquel 100 mg, 1 p.o. b.i.d.
2. Risperdal 1 mg tab, 1 p.o. t.i.d.
3. Actos 30 mg, 1 p.o. daily.
4. Lipitor 10 mg, 1 p.o., h.s.
5. Gabapentin 100 mg, 1 p.o. b.i.d.
6. Glimepiride 2 mg, 1 p.o. b.i.d.
7. Levothyroxine 25 mcg, 1 p.o. q.a.m.
8. Protonix 40 mg, 1 p.o. daily.

ALLERGIES: No known drug allergies.

FAMILY HISTORY: According to her medical records, her mother died of stroke, father died of alcohol abuse and diabetes, one sister is alive with diabetes, and one uncle died of leukemia.

SOCIAL HISTORY: The patient is from Minneapolis and moved to Seattle approximately one year ago. She lived independently in an apartment until about one month ago when her daughter moved her into a nursing home. She has been married once, but her spouse left her when her three children were young. Her children are ages 47, 49, and 51. She had one year of college, and she currently is retired after working in the Minneapolis public school system for 20 or more years. She reports that her spouse was physically abusive to her. She reports occasional alcohol use and quit smoking 11 years ago.

MENTAL STATUS EXAM:
GENERAL: The patient is an obese, white female who appears older than stated age, seated in a chair wearing large dark glasses.
BEHAVIOR: The patient is singing loudly and joking with interviewers. She is pleasant, but non-cooperative with interviewers.
SPEECH: Increased volume, rate, and tone. Normal in flexion and articulation.
MOTOR: Agitated.
AFFECT: Mood is elevated and congruent.
THOUGHT PROCESSES: Tangential and logical at times.
THOUGHT CONTENTS: Denies suicidal or homicidal ideation. Denies auditory or visual hallucination. Has both positive grandiose delusions and positive paranoid delusions.
INSIGHT: Poor to fair.
JUDGMENT: Impaired. The patient is alert and oriented to person, place, date, year, but not day of the week.

PHYSICAL EXAMINATION:
GENERAL: Alert and oriented, in no acute distress.
VITAL SIGNS: Blood pressure 152/92, heart rate 81, and temperature 97.2.
HEENT: Normocephalic and atraumatic. PERRLA. EOMI. Moist mucous membranes.
NECK: Supple. No lymphadenopathy, no JVD, and no bruits.
CHEST: Clear to auscultation bilaterally.
CARDIOVASCULAR: RRR. S1 and S2 heard. No murmurs, rubs, or gallops.
ABDOMEN: Obese, soft, nontender, and nondistended. Positive bowel sounds.
EXTREMITIES: No cyanosis, clubbing, or edema.

ASSESSMENT: This is a 69-year-old Caucasian female with a past medical history of schizoaffective disorder, diabetes, hypothyroidism, osteoarthritis, dyslipidemia, and GERD who presents to the emergency room with complaints of inability to sleep, irritability, elevated mood, and impulsivity over the past three days, which she attributes to a recent change in medication after an admission to General Hospital during which time the patient was taken off her usual medications of lithium and Zyprexa. The patient is manic and disinhibited and is unable to give a sufficient interview at this time.

DIAGNOSES: 1. Schizoaffective disorder. 2. Diabetes, hypothyroidism, osteoarthritis, GERD, and dyslipidemia. 3. Family strife and recent relocation.

PLAN: The patient was admitted voluntarily to General Hospital Inpatient Psychiatric Unit under Dr. Anders's care. Medications resumed include Zyprexa, Actos, levothyroxine, Lipitor, Protonix, glimepiride, and folate. We will order an EKG, and we will monitor the patient and make further adjustments to her medications as necessary.

1. The patient was diagnosed with schizoaffective disorder. What is meant by that condition? (1)

2. Lithium is used for what type of condition in a mentally ill patient? (1)
    A. Hypochondriasis
    B. Dissociative disorder
    C. Delirium tremens
    D. Mania

3. In the Emergency Room the patient reported euphoria. What is this condition?(1)
    A. An involuntary persistent idea or emotion
    B. Exaggerated feeling of well-being or feeling "high"
    C. Sadness, hopelessness, depressive mood, or feeling "low."
    D. Emotionally cold and aloof; indifferent to the feelings of others

4. Human behavior without adequate thought, the tendency to act with less forethought than do most individuals of equal ability and knowledge, or a predisposition toward rapid, unplanned reactions to internal or external stimuli without regard to the negative consequences of these reactions. This describes (1)
    A. impulsivity
    B. dysthymia
    C. fugue
    D. histrionic disorder

5. In the Past Psychiatric History section of the report, it states that the patient's medication was changed to Seroquel. What did the daughter report happened as a result of the change? (1)
    A. The patient got better and her mood improved.
    B. The patient had worsening of symptoms to the state of a serious mental disorder.
    C. The patient's hallucinations disappeared.
    D. The patient had increased preoccupation with body aches and pains.

6. What <u>one</u> word in the Past Psychiatric History means the same as your answer in question #5? (1)

7. What do the letters stand for in the following abbreviations ***<u>in the context of this medical report</u>***? Do NOT define. If you are unsure, check the back of your textbook, or go to Google and enter "medical abbreviations". To be considered correct you must only use the meaning that applies to the medical report of this patient. (5)
    GERD
    PERRLA
    JVD
    RRR
    S1, S2 (as it relates to the heart)

8. Describe the hallucinations that she had when she discontinued her medications? What did the patient see? (1)

9. Define the following terms – be specific: (3)
    Clubbing (related to the hands/fingers)
    Bruits
    Dyslipidemia

10. The patient was started on Zyprexa. What are the two purposes of this drug that apply to this patient's condition? (1)
    a. Schizophrenia and delirium tremens
    b. Bipolar disorder and generalized anxiety disorder
    c. Bipolar disorder and schizophrenia
    d. Antisocial personality disorder and delirium tremens

11. Complete the table below to include the dose, frequency and purpose or use of the drugs for each of the eight medications that the doctor has listed for this patient ***(for the purpose of the drug, be brief: one to four word phrases are enough).*** Use the dose and frequency the doctor has listed in the MEDICATIONS section of the patient's History and Physical Report. Use ***NO*** abbreviations when completing the table. ***Convert all abbreviations to complete words*** including the dose, frequency and purpose. One point will be taken off for each abbreviation that you enter. You may use regular numbers rather than English for the numbers – for example, you can write 2 instead of two. For example if Brofutin (a drug) is listed as 3 mm 1 PO q4h and its use is to relieve pain, tenderness, swelling, and stiffness caused by osteoarthritis and rheumatoid arthritis, you would enter for Brofutin in the appropriate boxes: 3 millimeters, every 4 hours, osteoarthritis and rheumatoid arthritis. ***Note: he patient had 1 of each drug, so that has already been included in its own column for you. Do not repeat it in the dose or frequency columns*** (24)

USE NO ABBREVIATIONS

Drug Name	Amount/Route	Dose	Frequency	Purpose or use of drug
Brofutin	***1 orally***	***3 millimeters***	***Every 4 hours***	***Osteoarthritis and rheumatoid arthritis***
Seroquel	1 orally			
Risperdal	1 tablet orally			
Actos	1 orally			
Lipitor	1 orally			
Gabapentin	1 orally			
Glimepiride	1 orally			
Levothyroxine	1 orally			
Protonix	1 orally			

ONCOLOGY – Consultation Report

REASON FOR CONSULTATION: Newly diagnosed head and neck cancer.

HISTORY OF PRESENT ILLNESS:
The patient is a very pleasant 61-year-old gentleman who was recently diagnosed with squamous cell carcinoma of the base of the tongue bilaterally with downward extension into the right tonsillar fossa. He was also noted to have palpable enlarged level 2 cervical lymph nodes. His staging is T3 N2c M0 Stage IV invasive squamous cell carcinoma of the head and neck. The patient comes in to the clinic today after radiation oncology consultation. His otolaryngologist performed a direct laryngoscopy with biopsy on July 29, 20xx. The patient reports that in the previous December-January timeframe, he had noted some difficulty swallowing and ear pain. He had a work up by his local internist that was relatively negative, and he was treated for gastroesophageal reflux disease. His symptoms continued to progress, and he developed difficulty with his speech, dysphagia, otalgia and odynophagia. He was then referred to Dr. Stone and examination revealed a mass at the right base of the tongue that extended across the midline to include the left base of the tongue as well as posterior extension involved in the right tonsillar fossa. He was noted to have enlarged neck nodes bilaterally. His biopsy was positive for squamous cell carcinoma.

PAST MEDICAL HISTORY: Significant for mild hypertension. He has had cataract surgery, gastroesophageal reflux disease and a history of biceps tendon tear.

ALLERGIES: Penicillin.

CURRENT MEDICATIONS: Lisinopril/hydrochlorothiazide 20/25 mg q.d., alprazolam 0.5 mg q.d., omeprazole 20 mg b.i.d., Lortab 7.5/500 mg q 4h p.r.n.

FAMILY HISTORY: Significant for father who has stroke and grandfather with lung cancer.
SOCIAL HISTORY: The patient is married but has been separated from his wife for many years; they remain close. They have two adult sons. He is retired from the Air Force and currently works as an engineer for Boeing. He was born and raised in New York. He has about a pack a day 20-year smoking history and he reports quitting on July 27. He drinks alcohol socially. No use of illicit drugs.

REVIEW OF SYSTEMS: The patient's chief complaint is fatigue. He has difficulty swallowing and dysphagia. He is responding well to acetaminophen and hydrocodone for pain control. He denies any chest pain, shortness of breath, fevers, chills and night sweats. The rest of his review of systems is negative.

PHYSICAL EXAM:
VITALS: BP: 115/70. HEART RATE: 62. TEMP: 97.4. Weight: 93.6 kg.
GEN: He is very pleasant and in no acute distress. He has noticeable mass on his left neck.
HEENT: Pupils are equal, round, and reactive to light. Sclerae anicteric. His oropharynx is notable for scalloped tongue and he has no oral ulcers. Upon protrusion of his tongue, he has deviation to the right.
NECK: Noticeable for bilateral palpable adenopathy with a large palpable mass in the left neck.
LUNGS: Clear to auscultation on the right. He has some mild vesicular breath sounds in the left.
CV: Regular rate; normal S1, S2, no murmurs.
ABDOMEN: Soft. He has positive bowel sounds. No hepatosplenomegaly. No axillary inguinal adenopathy.
EXT: No lower extremity edema.

LABORATORY STUDIES:
1. A PET/CT scan shows a large hypermetabolic mass involved in the posterior aspect of the tongue, which is predominantly right-sided but extends across the midline to involve the right posterior aspect of the tongue as well.
2. Extensive bulky hypermetabolic cervical lymphadenopathy bilaterally.
3. No evidence of distant hypermetabolic metastatic disease.
4. His biopsy of the right base of the tongue shows invasive squamous cell carcinoma. Biopsy of the left base of the tongue shows invasive squamous cell carcinoma, moderately differentiated.

ASSESSMENT/PLAN: This is a pleasant but unfortunate 61-year-old gentleman who was diagnosed with stage IV, a squamous cell carcinoma of the oropharynx. He has met with radiation oncology to discuss the plan and he has also been in close contact with his dentist. He has a known abscess and is in need of some bridge work. I discussed issues with his dentist; the patient will be seeing her this Friday for cleaning. One of the things that we will need to coordinate is evaluation of the involvement of his salivary glands. There needs to be a discussion as to whether or not he would be better off with the tooth extraction prior to radiation. We will coordinate this between myself, radiation oncology, and his dentist.

As far as his chemotherapy treatment, the plan at this point is to proceed with two cycles of induction chemotherapy. The first cycle will include docetaxel, cisplatin and 5-fluorouracil plus Erbitux. Typical administration is docetaxel, cisplatin and 5-fluorouracil on day 1 with continuous infusion of 5-fluorouracil through day 4. Erbitux will be administered on day 1 and day 8 of the first cycle. We will plan to proceed with the second cycle to include docetaxel, cisplatin and continuous infusion of 5-fluorouracil without the Erbitux. Following induction chemotherapy, we plan to obtain a PET/CT scan. Again, this will be closely coordinated with radiation onset if they can do with planning CT at that time of the PET. Radiation will be planned with concurrent Erbitux. This will be given, the first dose will be one week prior to starting the radiation and then given weekly throughout radiation. I briefly discussed with the patient the possibility of admission for the induction chemotherapy. The patient was not very excited at this particular discussion. I feel with him living in the Everett area that a hospital inpatient admission to the Oncology unit may be our best bet and would also be a way of being able to closely monitor his kidney function and administer the necessary hydration. He is scheduled for chemo education on August 16. He received prescription refill for Lortab, and I will see him in clinic when he comes in for chemotherapy education so that we can talk further about treatment administration. I appreciate the consultation.

1. The patient had squamous cell carcinoma which is derived from what type of tissue? (1)
    A. Connective tissue
    B. Mesenchymal tissue
    C. Immune cells of the lymphatic system
    D. Epithelial tissue

2. His staging is T3 N2c M0, Stage IV invasive carcinoma of the head and neck. What do the following letters refer to in staging? ***One word*** answers for each is satisfactory. (3)
   T
   N
   M

3. Which doctor did the direct laryngoscopy with biopsy? (1)
   A. Dentist
   B. Otolaryngologist
   C. Oncologist
   D. Internist

4. Dysphagia and odynophagia have similar meanings which refer to difficulty in (1)
   A. speaking
   B. hearing
   C. swallowing
   D. chewing

5. What areas showed the tumor when Dr. Stone did his examination (refer to the History of Present Illness in the report? Be very complete. (1)

6. Define: (3)
   Sclerae anicteric
   Vesicular breath sounds
   Moderately differentiated (referring to a characteristic of tumors)

7. What do the letters PET/CT stand for ***in the context of this medical report***? Do NOT define. (1)

8. Match the patient's drug with its corresponding medical use in the body. Place the letter of the correct use found in Column B on the box in front of Column A (5)

Letter of Answer	COLUMN A - DRUG	COLUMN B - USE IN BODY/DRUG TYPE
	Alprazolam	A. Moderate to severe pain
	5-Fluorouracil	B. Hypertension
	Lisinopril	C. Chemotherapy
	Lortab	D. Anxiety
	Omeprazole	E. GERD

General – Visit Note

CC: 37 y.o. ♂ w/ diabetes c/o swelling of the Ⓡ foot and calf x 3d.
S: There is no Hx of trauma, pain, SOB, or cardiac Sx. Smoker x 12 years ½ pkg q.d. Denies ETOH
consumption.
Meds: parenteral insulin q.d. NKDA.
O: Pt. is afebrile, BP 140/84, P 72, R 16, lungs are clear; abdomen is benign w/o organomegaly; muscle tone and strength are WNL. There is swelling of the Ⓡ calf but w/o erythema or tenderness.
A: Edema of Ⓡ calf of unknown etiology.
P: Schedule STAT vascular sonogram of lower extremities; pt is to keep the leg elevated x 2d then
RTC for follow-up and test results on Thursday (or sooner if ↑ edema, SOB, or CP).

1. What is the sex of the patient? (1)
   A. Male
   B. Female

2. Where is the patient to be seen for follow-up on Thursday? (1)
    A. Emergency room
    B. Outpatient clinic
    C. Inpatient hospital

3. What was the condition of the patient's abdomen? (1)
    A. Shows signs of cancer
    B. Internal organs are enlarged
    C. Internal organs are not enlarged
    D. Muscle tone and strength are weak

4. How is the patient's insulin administered? (1)
    A. Orally
    B. Sublingually
    C. By injection
    D. Rectally

5. What ***one*** word in the patient's chart note gives you the answer to #4? (1)

6. What is the cause of the patient's complaint? (1)
    A. Unknown
    B. Fever
    C. Shortness of breath
    D. Trauma

7. When should the sonogram be performed? (1)
    A. Immediately
    B. Within two days
    C. At the time of follow-up
    D. Only if symptoms persist

8. How long should the patient's leg be kept elevated? (1)
    A. One week
    B. Two weeks
    C. One day
    D. Two days

9. In the context of this report, what would the abbreviation CP mean? (1)
    A. Cerebral palsy
    B. Cardiopulmonary
    C. Chickenpox
    D. Chest pain

10. The patient states he does not drink alcohol. This statement is (1)
    A. true
    B. false

11. What abbreviation in this report indicates that the patient is not allergic to medications? (1)

RADIOLOGY REPORT

HISTORY: Lower extremity pain
PROCEDURE: X-ray examination of the right lower extremity was performed:
FINDINGS: Correlation is made with ^{99m}Tc nuclear medicine bone scan. Expansile, well-defined cystic lesion with sclerotic margin is evident throughout the distal aspect of the right tibia which may relate to enchondroma or non-ossifying fibroma. Similar smaller lesions are projected in the proximal right tibia and possible right talus and distal fibula. There is no fracture or dislocation. Remainder of the examination is unremarkable.
IMPRESSION: Lesions as described involving the right leg may relate to multiple enchondromas or non-ossifying fibromas. Paget's disease is also a diagnostic consideration. Recommend MRI scan of the right leg with Gd contrast for further evaluation.

1. Define the following terms: (4)
   Expansile
   Enchondroma
   Non-ossifying fibroma
   Paget's disease of bone *(Make sure your answer is complete enough to distinguish it from other diseases of the bone.)*

2. What do the letters stand for in the following abbreviations ***in the context of this medical report***? Do NOT define. (3)
   ^{99m}Tc
   MRI
   Gd *(make sure it relates to the Radiology Report – refer to your chapter on Radiology in your textbook for help)*

QUESTIONS FROM MATERIAL IN THE ELSEVIER/EVOLVE ONLINE COURSE

MODULE 17 *Question #1: From Section III, Lesson 2, Activity 2.10*

Review all the online module lectures for Section III, Lesson 2, *Therapeutic Interventions for the Eye* and then indicate the name of the surgery for the following patients in Section III, Lesson 2, Activity 2.8. ***Use no abbreviations***. Some of these terms are not found in the textbook but are discussed in the online module lecture. (10 points)

Horace
Helena
Audrey
Charlie
Dave
Deborah
Jonah
Howard
Gerard
Tracy

MODULE 17 *Question #2: From Section VII, Lesson 1, Activity 1.10*

Several patients are discussed. For each of the patients below, indicate their diagnoses ***(write these out, do not provide the abbreviation)***. (5 Points)

1. Janet
2. Albert
3. Herve
4. Jasper
5. Perry

MODULE 18 ***Question #3: From Section II, Lesson 4, Activity 4.9***

Read the description in the activity and select the correct medical term. To receive credit, provide the exact medical term listed in the module activity. (4 points)

1.
2.
3.
4.

MODULE 18 ***Question #4: From Section II, Lesson 4, Activity 4.10***

List each definition found in the left hand column (write the exact words) and then enter the correct medical term that matches that definition from the right hand column. (4 points)

Definition	Medical Term

MODULE 18 ***Question #5: From Section IV, Listen and Spell (First listen and spell activity).***

Enter the names of the 8 words that are pronounced aloud. ***To get full credit, the word must be spelled correctly.*** (8 points)

1.
2.
3.
4.
5.
6.
7.
8.

MODULE 19 ***Question #6: From Section II, Lesson 1, Activity 1.11***

List each definition found in the left hand column (write the exact words) and then enter the correct medical term that matches that definition from the right hand column. (4 points)

Definition	Medical Term

MODULE 19 ***Question #7: From Section IV Applications. Medical Report.***

Review the medical report on Anthony Brazzali (the patient who was discussed as the threaded case study throughout the online module) and answer the questions in each of the three activities. (8 points)

Activity 1
1.
2.
Activity 2
1.
2.
3.
4.

Activity 3
1.
2.

MODULE 20 ***Question #8: From Section I, Lesson 2, Activity 2.9***

Read the case scenario and then answer the questions about the scenario. Enter the complete answers, not just the letters because the order of the answers can change depending on when it is opened and how often it is reviewed. ***If only a letter is included it will be counted as incorrect.*** (6 points)

1.
2.
3.
4.
5.
6.

MODULE 20 ***Question #9: From Section IV Applications. Medical Report Case Study 2***

Review Case Study 2 and answer the questions in both activities. In the second activity (listen and spell) the ***answers must be spelled correctly in order to be considered correct.*** (8 points)

Activity 1
1.
2.
3.
Activity 2
1.
2.
3.
4.
5.

MODULE 21 ***Question #10: From Section IV Medical Report Follow-up: Listen and Spell***

Enter the names of the 4 words that are pronounced aloud. T***o get full credit, the word must be spelled correctly.*** (4 points)
1.
2.
3.
4.

MODULE 21 ***Question #11: From Section IV Case Study***

Review the case study and answer the questions in each of the two activities. (8 points)

Activity 1
1.
2.
3.
4.

Activity 2
1.
2.
3.
4.

MODULE 22 ***Question 12: From Section I, Lesson 2, Activity 2.10***

List each definition found in the left hand column (write the exact words) and then enter the correct medical term that matches that definition from the right hand column. You will need to use the slide bar to the right of the right hand column to see all the choices. Not all items in the right hand column will be used. (5 points)

Definition	Medical Term

MODULE 22 Question #13: From Section V, Case Study 2, Activity #1

Review the case study and answer the questions the first activity. (4 points)

Activity 1
1.
2.
3.
4.