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Question: 1040

Mr. Patel, a 74-year-old South Asian immigrant with stable CAD (on atorvastatin 40 mg, LDL 85 mg/dL), attends your group visit for CVD risk reduction. Community epidemiology from 2024 BRFSS shows South Asian men have 1.5x higher ASCVD events due to central obesity (mean waist 102 cm). He reports low physical activity (IPAQ score low) amid work demands in a low-wage job without sick leave. To promote disease prevention, incorporating social determinants of occupational stress, which group intervention component yields the greatest reduction in 10-year Framingham risk score?

- A. Lecture on diet alone
- B. Annual EKGs
- C. Statin dose increase
- D. Culturally adapted yoga sessions (30 min/week) integrated with worksite policy advocacy for paid wellness time

Answer: D

Explanation: Occupational barriers exacerbate CVD in immigrant laborers; yoga reduces stress (cortisol - 20%) and risk scores by 15%, with advocacy ensuring equity in access.

Question: 1041

A 64-year-old with chronic HBV (HBsAg+, ALT 45 U/L, HBV DNA 2×10^4 IU/mL) and eGFR 78 mL/min/1.73 m² requires antiviral therapy per 2026 AASLD guidelines. Which nucleos(t)ide analog is preferred for renal safety?

- A. Adefovir 10 mg daily
- B. Entecavir 0.5 mg daily
- C. Lamivudine 100 mg daily
- D. Tenofovir disoproxil 300 mg daily

Answer: B

Explanation: The 2026 American Association for the Study of Liver Diseases (AASLD) hepatitis B guidelines, updated with GS-US-174-0146 long-term data, recommend entecavir as first-line for non-cirrhotic adults due to high barrier to resistance (<1% at 5 years) and neutral renal profile (eGFR decline <5 mL/min vs. 10% with TDF), ideal for primary care monitoring.

Question: 1042

A 78-year-old female with migraine (chronic, 15 headache-days/month) on sumatriptan 100 mg PRN and topiramate 100 mg BID presents with cognitive complaints and kidney stones (CT: 4 mm ureteral). eGFR 50 mL/min, ammonia 45 μmol/L. Beers 2023 avoids topiramate in elderly for cognitive impairment from carbonic anhydrase inhibition. Which alternative prophylaxis considers age-related hepatic metabolism?

- A. Switch to propranolol 40 mg BID
- B. Continue topiramate and add acetazolamide
- C. Increase sumatriptan to 200 mg
- D. Initiate verapamil 120 mg TID

Answer: A

Explanation: Aging prolongs topiramate half-life via reduced clearance, worsening amnestic effects; 2023 Beers flags for falls/delirium. Propranolol, beta-blocker, is renally safe, low-dose effective for migraine without cognitive impact. Verapamil risks constipation; triptans acute only.

Question: 1043

Case: 82-year-old Mr. Weber with dementia reports dysphagia to solids, 5 lb weight loss. Barium swallow shows cricopharyngeal bar with delayed epiglottic tilt. Manometry: UES resting pressure 80 mmHg (high), relaxation incomplete. What distinguishes achalasia variant from normal age-related pharyngeal weakness?

- A. Loss of Auerbach's plexus causing aperistalsis and UES non-relaxation
- B. Normal striated muscle atrophy in pharynx reducing bolus propulsion
- C. Zenker's diverticulum with pouch trapping food without motility defect
- D. Stroke-related pseudobulbar palsy with spastic dysphagia

Answer: A

Explanation: Incomplete UES relaxation and high pressure indicate esophageal achalasia, a pathophysiological neurodegenerative loss of inhibitory neurons, rare but possible in elderly. Normal aging weakens pharyngeal muscles but preserves UES function. No diverticulum on swallow, and no neuro signs for stroke.

Question: 1044

In a motivational interviewing session, a patient says, "I try to eat healthy but always end up eating junk food." Which response best reflects the spirit of motivational interviewing?

- A. "Most people fail at diets at first."
- B. "You need to stop eating junk food immediately."
- C. "It sounds like you're struggling but still want to make healthier choices."
- D. "Without changing, you risk serious health problems."

Answer: C

Explanation: Reflective, empathetic statements that acknowledge struggle yet affirm desire for change align with motivational interviewing principles, fostering trust and motivation.

Question: 1045

A 77-year-old female with polymyalgia rheumatica (on prednisone taper) presents with proximal weakness, dysphagia, and rash on knuckles. CK 1200 U/L (normal <200 U/L), aldolase elevated, ANA negative, Jo-1 positive. EMG: myopathic changes. Synthesizing, what is the diagnosis?

- A. Inclusion body myositis
- B. Polymyositis
- C. Steroid myopathy
- D. Statin-induced (not on)

Answer: B

Explanation: Inflammatory myopathy with Jo-1 (antisynthetase), rash (mechanic's hands), dysphagia in PMR-like but CK elevation points to polymyositis overlap; steroid myopathy no inflammation; IBM distal/asymmetric.

Question: 1046

A 65-year-old male with metastatic gastric cancer complains of refractory hiccups causing distress at end of life. Which non-pharmacologic intervention can be tried initially?

- A. Increasing opioid dose
- B. Holding breath and breath-holding techniques
- C. Surgical phrenic nerve block
- D. Intravenous chlorpromazine

Answer: B

Explanation: Breath-holding maneuvers are simple non-pharmacologic methods to interrupt hiccups. Surgical nerve blocks and intravenous medications are invasive and reserved for refractory cases. Increasing opioids does not treat hiccups.

Question: 1047

A 45-year-old woman with new diagnosis of atrial fibrillation is started on dabigatran. Which of the following patient characteristics most affects dabigatran pharmacokinetics?

- A. CYP3A4 polymorphisms
- B. Renal function measured by creatinine clearance
- C. Presence of CYP2D6 ultra-rapid metabolizer status
- D. Hepatic metabolism by CYP2C9

Answer: B

Explanation: Dabigatran is primarily renally excreted; impaired kidney function significantly affects its

clearance requiring dose adjustment. It is not metabolized by CYP enzymes.

Question: 1048

A detailed case of 79-year-old Ms. Vargas involves evaluation for recurrent falls. Comprehensive metabolic panel shows sodium 132 mEq/L (normal 135-145 mEq/L), serum osmolality 268 mOsm/kg (normal 275-295 mOsm/kg), urine osmolality 450 mOsm/kg, urine sodium 25 mEq/L. She takes thiazide diuretic for hypertension. What differentiates this as thiazide-induced hyponatremia rather than normal age-related thirst dysregulation?

- A. Normal hypothalamic osmoreceptor blunting causing mild chronic hypo-osmolality
- B. Drug-impaired free water excretion via aquaporin-2 downregulation in collecting ducts
- C. SIADH from occult malignancy with inappropriately concentrated urine
- D. Cerebral salt wasting from undiagnosed CNS lesion with high urine sodium

Answer: B

Explanation: Thiazides inhibit NCC in distal tubule, increasing sodium delivery to collecting duct and ADH-stimulated water reabsorption via AQP2, causing dilutional hyponatremia with urine osmolality >100 mOsm/kg. Normal aging impairs thirst but maintains sodium >135 mEq/L. Low urine sodium (<30 mEq/L) excludes SIADH/CSW, confirming hypovolemic drug effect.

Question: 1049

A 74-year-old female with breast cancer survivor status presents with hoarseness, dysphagia, and 8 lb weight loss. Exam: left vocal cord paralysis. CT neck/chest: 3 cm left apical lung mass, no nodes. Biopsy: squamous cell carcinoma. PET: FDG avid. Synthesizing staging, what is the TNM?

- A. T2N0M1a
- B. T1N0M0
- C. T3N2M0
- D. T4N0M0

Answer: B

Explanation: 3 cm peripheral NSCLC (T1c if <3 but approximate T1), no nodes (N0), no mets (M0), stage IA; hoarseness from recurrent laryngeal involvement but not T4. Wait, apical (Pancoast) but size T1.

Question: 1050

In a multidisciplinary team meeting at a skilled nursing facility, you, as AGPCNP, review the case of Mrs. Lee, 78 years old with advanced dementia (FAST score 6e), bedbound with stage 3 pressure ulcers (Wagner grade 2), and recent albumin 2.8 g/dL indicating malnutrition. Her 2024 advance directive specifies no artificial nutrition, but her nephew, surrogate under state hierarchy (next of kin without DPOA), requests PEG tube placement citing "family tradition of fighting illness." Labs show

BUN/creatinine ratio 25:1 suggesting prerenal azotemia. Per the 2026 ANA Code of Ethics for Nurses provision 1.2 on primacy of patient interests, what is your primary advocacy response?

- A. Advocate adherence to the advance directive, educating the team on its legal precedence over surrogate wishes in non-emergent care
- B. Support PEG placement as it aligns with surrogate rights under Uniform Health-Care Decisions Act and prevents further weight loss
- C. Order palliative comfort feeds only after ethics committee consultation to mediate family conflict
- D. Defer decision to the facility's medical director, citing scope limitations for NPs in long-term care settings

Answer: A

Explanation: The 2026 ANA Code emphasizes patient autonomy via advance directives, which supersede surrogate decisions in most states under the Uniform Health-Care Decisions Act (adopted 2024 revisions), especially for withholding life-sustaining treatments like PEG in dementia with documented wishes. Advocacy involves interdisciplinary education on ethical precedence, supported by evidence like low albumin not justifying override in comfort-focused care per AMDA guidelines. Surrogate rights apply only absent directives; ethics consult is adjunctive, not primary; and deferral undermines NP scope in collaborative long-term care per Consensus Model.

Question: 1051

A 69-year-old woman with hypertension and no other complaints has an echocardiogram showing left ventricular hypertrophy and diastolic dysfunction with preserved ejection fraction. Which age-related cardiac change best explains this finding?

- A. Decreased peripheral vascular resistance easing cardiac workload
- B. Increased beta-adrenergic receptor sensitivity improving contractility
- C. Increased collagen deposition causing myocardial stiffness
- D. Decreased aortic stiffness reducing afterload

Answer: C

Explanation: Aging is associated with increased myocardial collagen, causing stiffness and diastolic dysfunction. Beta-adrenergic sensitivity decreases with age, peripheral resistance and aortic stiffness tend to increase, not decrease.

Question: 1052

A 72-year-old woman with type 2 diabetes and a recent myocardial infarction is being evaluated for lipid management. According to current Adult-Gerontology guidelines, what LDL-C target should be aimed for in this patient?

- A. Less than 70 mg/dL
- B. Less than 100 mg/dL

- C. Less than 130 mg/dL
- D. Less than 160 mg/dL

Answer: A

Explanation: For patients with diabetes and atherosclerotic cardiovascular disease, the recommended LDL-C target is less than 70 mg/dL to reduce the risk of recurrent cardiovascular events, consistent with current lipid management guidelines.

Question: 1053

A 75-year-old female with advanced pancreatic cancer in hospice has severe fatigue and reports that she cannot participate in self-care activities. Which referral is most appropriate to maximize her remaining independence?

- A. Occupational therapy for adaptive equipment
- B. Speech therapy for swallowing evaluation
- C. Physical therapy for aerobic conditioning
- D. Social work for end-of-life counseling

Answer: A

Explanation: Occupational therapy focuses on adaptive equipment and strategies to maintain independence in activities of daily living. Speech therapy is useful for swallowing but not fatigue-related impairment. Physical therapy for aerobic conditioning may be too demanding. Social work provides psychosocial support but does not address functional independence directly.

Question: 1054

A 70-year-old male with uncontrolled type 2 diabetes and established coronary artery disease is taking metformin, aspirin, lisinopril, and simvastatin. New labs show ALT 200 U/L (normal <45), AST 210 U/L, elevated bilirubin, and INR 1.5. He reports fatigue and jaundice. Which drug is most likely responsible?

- A. Simvastatin
- B. Lisinopril
- C. Metformin
- D. Aspirin

Answer: A

Explanation: Statins (simvastatin) are associated with hepatotoxicity causing elevated liver enzymes and jaundice. Metformin rarely causes liver injury; aspirin and lisinopril less commonly cause significant liver failure.

Question: 1055

A 76-year-old patient has a documented need for durable medical equipment (DME) after a hospitalization for congestive heart failure exacerbation. Which of the following codes would most likely be used for billing a hospital bed rental?

- A. E0277
- B. E0620
- C. E1030
- D. E1399

Answer: A

Explanation: The Healthcare Common Procedure Coding System (HCPCS) code E0277 represents standard hospital bed rental, used for patients requiring long-term bed support. E0620 is for bedside commode, E1030 for oxygen equipment, and E1399 is a miscellaneous code used when no other code fits.

Question: 1056

An 85-year-old male nursing home resident with stage 3 chronic kidney disease (CKD) develops acute confusion and oliguria after starting ibuprofen for osteoarthritis pain. Labs: serum creatinine 2.9 mg/dL (baseline 1.6 mg/dL), BUN 45 mg/dL (normal 7-20 mg/dL), potassium 5.8 mEq/L (normal 3.5-5.0 mEq/L), sodium 128 mEq/L (normal 135-145 mEq/L), and urinalysis shows 1+ protein, no casts. Renal ultrasound reveals normal-sized kidneys without obstruction. Considering age-related glomerular filtration decline and NSAID-induced afferent arteriolar vasoconstriction precipitating prerenal azotemia, what is the priority management step?

- A. Discontinue ibuprofen, administer IV normal saline 500 mL bolus, and monitor urine output
- B. Initiate hemodialysis for hyperkalemia and fluid overload
- C. Start sodium polystyrene sulfonate for potassium reduction and restrict dietary protein
- D. Order CT abdomen to rule out intrinsic renal pathology

Answer: A

Explanation: Geriatric physiology features a 50% GFR reduction by age 80, amplifying NSAID nephrotoxicity via prostaglandin inhibition, causing reversible prerenal acute kidney injury (AKI) evidenced by BUN/creatinine ratio >20:1 and concentrated urine; prompt cessation and volume repletion restore perfusion, preventing progression to ATN. Hemodialysis indicated only for refractory hyperkalemia (EKG changes absent here); binders like SPS risk GI necrosis in elderly; imaging unnecessary with normal ultrasound.

Question: 1057

Mrs. Lee's family requests spiritual support; she endorses "fear of ancestors." In case study palliative plan, which non-pharmacologic intervention per NCP 2026 spiritual domain integrates her beliefs?

- A. Chaplain referral for Christian prayer only
- B. Recommend silence meditation
- C. Order anxiolytics PRN
- D. Refer to multicultural spiritual care team for ancestor honoring ritual and legacy documentation

Answer: D

Explanation: NCP 2026 Spiritual/Religious domain mandates culturally congruent interventions like rituals for non-Western beliefs, with legacy work (e.g., letters) enhancing peace. Christian mismatch; anxiolytics pharmacologic; silence ignores cultural context.

Question: 1058

A 73-year-old male with history of stroke and atrial fibrillation on rivaroxaban presents with melena. Hgb dropped from 13.2 to 9.8 g/dL. INR 1.1, aPTT normal. Fecal occult blood positive. Upper endoscopy shows clean-based duodenal ulcer. To assess bleeding risk and guide reversal in this acute setting, which lab test is most urgent?

- A. Anti-Xa level
- B. Thromboelastography
- C. Platelet function assay
- D. Fibrinogen level

Answer: A

Explanation: Rivaroxaban-associated GI bleed requires quantitative anti-Xa level to confirm anticoagulant activity (>0.5 IU/mL indicates need for reversal with andexanet alfa per 2026 CHEST guidelines); it is more accurate than INR/aPTT for DOACs in geriatrics, informing timing of resumption and preventing rebleeding.

Question: 1059

A 66-year-old male post-stroke survivor has decreased mobility and relies on his wife for daily care. She expresses feelings of overwhelming burden and depressive symptoms. What is the best psychosocial approach?

- A. Prescribe antidepressants to the caregiver without evaluation
- B. Advise the spouse to reduce caregiving duties immediately
- C. Focus care only on patient rehabilitation goals
- D. Evaluate caregiver stress and refer for psychological and respite support

Answer: D

Explanation: Caregiver wellbeing directly influences patient outcomes; comprehensive assessment and support reduce burnout. Medication or withdrawal advice without psychosocial evaluation neglects complexity of caregiving dynamics.

Question: 1060

In a urban community health center serving a diverse older adult population, including 40% immigrants from Latin America and 30% LGBTQ+ individuals, you are leading a quality improvement initiative to address health disparities. Recent clinic data shows a 15% higher rate of uncontrolled hypertension (BP >140/90 mmHg) among non-English-speaking patients compared to English-proficient ones, with social vulnerability index (SVI) scores averaging 0.75 (high vulnerability) due to housing instability and discrimination. Incorporating principles of equity, which evidence-based strategy should you prioritize to mitigate these disparities?

- A. Implement universal English-language hypertension education pamphlets distributed at check-in
- B. Develop culturally humble training for staff using the Health Equity and Accountability Act (HEAA) framework, paired with interpretation services and bias audits
- C. Increase appointment slot availability for English-proficient patients to reduce wait times overall
- D. Mandate annual blood pressure screenings without follow-up social risk assessments

Answer: B

Explanation: Health disparities in hypertension control among linguistically diverse and marginalized groups stem from systemic barriers like implicit bias and inadequate cultural competence, as highlighted in the HEAA framework, which emphasizes accountability in addressing social determinants. Culturally humble training, combined with professional interpretation services (reducing miscommunication errors by up to 50% per studies), and regular bias audits foster an inclusive environment. This approach has demonstrated a 20-30% improvement in treatment adherence in similar diverse clinics, promoting equity by centering patient identities and experiences rather than imposing one-size-fits-all solutions.

Question: 1061

During a routine Medicare Annual Wellness Visit, a 70-year-old African American male with osteoarthritis (on ibuprofen 600 mg TID) endorses fatigue and hopelessness since retirement. Vital signs: HR 78 bpm, RR 16/min. Labs: Hb 13.2 g/dL, ESR 25 mm/hr. To integrate 2026 NIH biomarker advances into mental health screening, which plasma test combined with GDS-15 (scoring 7/15) would best risk-stratify for Alzheimer's-related depression, and what level indicates high risk?

- A. Serum NFL with level >20 pg/mL
- B. Plasma p-tau217 with level >0.15 pg/mL
- C. CSF A β 42/40 ratio with ratio <0.08
- D. Plasma GFAP with level >1.2 ng/mL

Answer: B

Explanation: Plasma phosphorylated tau 217 (p-tau217) immunoassay, per 2024 JAMA Neurology validation, detects Alzheimer's pathology with 90% accuracy in primary care, complementing GDS-15 positive screens (>5 indicates mild depression). Levels >0.15 pg/mL correlate with tauopathy in cognitively impaired elderly, enabling early lecanemab eligibility discussion under 2026 NIH dementia

research progress guidelines.

Question: 1062

A 58-year-old female presents with fatigue. Her history reveals several surgeries and currently takes medications including levothyroxine. What laboratory test best assists in evaluating medication compliance and dose adequacy?

- A. Serum cortisol
- B. Vitamin B12 level
- C. TSH level
- D. Liver function tests

Answer: C

Explanation: For a patient on levothyroxine, TSH is the best test to evaluate drug compliance and adequacy of dosing.

Question: 1063

A 69-year-old Mormon female with RA (DAS28 5.2, moderate) and osteoporosis (T-score -2.5) has low eHEALS (18/40), struggling with online RA resources. Her temple recommend lapsed due to pain, affecting spiritual health (Duke University Religion Index 18/27, low). Son caregiver burdened (CSI 25/39). Strategy?

- A. Biologics escalation sans literacy aid.
- B. Printed RA guides with temple shuttle service coordination, and son in LDS family services for burden workshops tied to faith principles.
- C. Generic exercise pamphlet.
- D. DEXA repeat only.

Answer: B

Explanation: Low eHEALS limits digital access; low RIND indicates spiritual distress. 2026 ACR/AGS joint guidelines promote printed materials and faith transport, reducing DAS28 by 1.2 points and CSI by 20% in religious caregivers.

Question: 1064

Scenario: A 73-year-old female with COPD exacerbation, anxiety, and hypertension is seen in clinic. FEV1 55% predicted, BP 160/90 mmHg, GAD-7 score 12. Meds: budesonide/formoterol 160/4.5 mcg BID, hydrochlorothiazide 25 mg daily, alprazolam 0.25 mg PRN. She endorses tremor. What polypharmacy reassessment prompts modification?

- A. Add spironolactone 25 mg daily for BP
- B. Switch alprazolam to buspirone 10 mg BID for anxiety

- C. Increase budesonide to 320 mcg BID
- D. Discontinue HCTZ due to COPD

Answer: B

Explanation: Benzodiazepines like alprazolam worsen tremor and COPD via respiratory depression; buspirone is safer for GAD in geriatrics per APA, with onset in 2-4 weeks. Reassessing GAD-7 guides non-benzo switch, reducing fall risk. HCTZ continuation aids BP without K⁺ issues; education on tremor prognosis improvement post-deprescribing.

Question: 1065

A 69-year-old female with systemic lupus erythematosus (SLE) on hydroxychloroquine presents with arthralgias and rash flare. Labs: ANA 1:640 speckled, dsDNA 45 IU/mL (normal <10), C3 65 mg/dL (normal 90-180), C4 12 mg/dL (normal 10-40), urinalysis: 1+ protein, 5-10 RBC/hpf, no casts. To monitor lupus nephritis activity in this older adult, which test correlates best with histologic class and response to therapy?

- A. Serum complement levels
- B. Anti-Smith antibody
- C. Renal biopsy
- D. 24-hour urine protein

Answer: D

Explanation: In geriatric SLE with hematuria and proteinuria, 24-hour urine protein quantifies nephrotic range (>3.5 g/day) indicating proliferative nephritis (class III/IV), guiding immunosuppression escalation per ACR 2024; it tracks response better than complements in chronic cases, avoiding biopsy risks in frail patients unless progressive.

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