Excerpt from the Nurse Practitioner Certification Examination and Practice Preparation
Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP

The following is an excerpt from Dr. Fitzgerald’s book, The Nurse Practitioner Certification Examination and Practice Preparation. Based on the second edition which was an AJN Book of the Year award winner, the third edition features even more questions and content.

How would you answer these sample questions from the section on iron deficiency anemia?

1. Which of the following is most consistent with iron-deficiency anemia?
   A. Low mean corpuscular volume (MCV), normal mean corpuscular hemoglobin (MCH)
   B. Low MCV, low MCH
   C. Low MCV elevated MCH
   D. Normal MCV, normal MCH

2. One of the earliest laboratory markers in iron-deficiency anemia is:
   A. An increase in RBC distribution width (RDW)
   B. A reduced hemoglobin level.
   C. A low MCH level.
   D. An increased platelet count.

(Answers and rationals on page 6)

Gerontological Nurse Practitioner Alternative Eligibility Ends December 31, 2010

Nurse practitioners who wish to apply for ANCC Gerontological Nurse Practitioner certification using alternate eligibility must submit an application by December 31, 2010. Applications seeking certification through alternate eligibility that are received after December 31, 2010 will not be processed.

Fitzgerald Health offers a gerontology package which provides 77.3 contact hours to meet the ANCC requirements. In addition, certified gerontologic nurse practitioners can use these as CE for recertification (see details on next page).
The ANCC has announced a certification test to enable licensed Adult, Family, and Acute Care Nurse Practitioners who treat older adults to use alternative eligibility criteria to qualify to sit for ANCC’s Gerontological Nurse Practitioner certification exam. Visit www.nursecredentialing.org for details. FHEA provides 77.3 contact hours to meet the ANCC requirements in the following three programs:

**GNP Certification Alternative Criteria per ANCC**

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- Pharmacologic Issues in Older Adults (including Polypharmacy)
- Geriatric Syndromes: Constipation, Dementia/Delirium, Anxiety/Depression, Falls, Failure to Thrive, Functional Loss, Incontinence, Sensory Loss, Sleep Disorders, Pain Management
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- Scope and Standards of Advanced Gerontological Nursing Practice
- Wellness Assessment of the Gerontological Patient
- Age-related Physiologic Changes
- Illness Assessment of the Gerontological Patient
- Pharmacology Considerations in the Gerontological Patient
- Blepharitis, Macular Degeneration, Cataracts
- Hypertension, Coronary Artery Disease, Peripheral Arterial Disease
- Pneumonia, Asthma, Pulmonary Embolus
- Constipation, Diarrhea, GERD, Diverticulitis, Abdominal Pain
- UTI, BPH, Atrophic Vaginitis
- Arthritis, Gout, Osteoporosis
- Dementia, Delirium, Depression, Movement Disorders, TIA
- Diabetes, Thyroid Disorders, Anemias
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* Post-tests included in fee for these programs.

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Breastfed Infants are less likely to Experience Fever after Immunizations
by Marie L. Bosco, BSN, RNC, IBCLC

The American Academy of Pediatrics (AAP) has identified breastfeeding as the first immunization for newborns. It not only provides antibodies to protect against infection, but also helps immunizations to work better (AAP). Breastmilk boosts the newborns immune system allowing for a stronger response to the immunizations. New research published in Pediatrics in June 2010 showed that breastfeeding reduced the risk for fever after immunizations. Fever is one of the most common side-effects of infant immunizations. Of 460 infants included in this study, 25% of the infants who were exclusively breastfed developed a fever, 31% of partially breastfed infants developed fever, and 53% of exclusively formula fed infants developed fever after receiving their first or second dose of hexavalent combination vaccine (diphtheria, tetanus, acellular pertussis, hepatitis B, inactive polio virus, and Haemophilus influenzae type b). Mothers were taught how to measure and record their infant’s temperature the evening of the immunization along with the next 3 days. The information was recalled by phone on the third day after the vaccine.

Why are breastfed infants less likely to be febrile? It may be the proinflammatory cytokines produced in response to the vaccine acting as pyrogens and the antimicrobial and anti-inflammatory components of breastmilk help to minimize febrile response by causing a decrease in the production of interleukin or of Toll-like receptor; this in turn affects thermoregulation in the hypothalamus. In addition, breastfeeding likely provides comfort and emotional support to the infant. Breastfed infants also have higher caloric intake after the proinflammatory interleukin 1B leading to fever. Although further research is needed to replicate these results, healthcare providers should support and encourage mothers to continue to breastfeed. Breastfeeding is best for both mothers and their infants. Breastfeeding after immunization can be therapeutic and comforting to young infant.

References:

Weight Loss Supplement Recalled
by Emily Paquin

The obesity drug sibutramine (Meridia), manufactured by Abbott Laboratories, was recently recalled by the US Food and Drug Administration (FDA). Sibutramine is a prescription-only product and is not intended for use in over-the-counter diet pills. In a recent study, sibutramine was found to increase the risk for stroke, myocardial infarction risks, and caused a 16% increase in nonfatal heart attacks. Sibutramine can be found in other products including an over-the-counter drug called Slimming Beauty Bitter Orange Slimming Capsules. The FDA has advised healthcare professionals to discontinue the prescription of these drugs until further notice. In place of sibutramine, healthcare providers are being encouraged to prescribe other FDA approved weight loss supplements such as an over-the-counter supplement called Alli, or Xenical which is available by prescription. Orlistat (the generic form of Alli and Xenical) is also recommended.

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If you are interested in having Dr. Fitzgerald or one of our other talented associates speak at your school, local, regional or national conference, please e-mail: services@fhea.com for more information. Conference administrative services are also available.

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Fitzgerald Health Education Associates Conference Center
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March 3–4, 2011
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If you have ever wanted to share your practice expertise by speaking to other providers, or if you just want to improve your “platform skills,” this is the seminar for you! This two-day intensive workshop will be led by Dr. Margaret Fitzgerald, one of the most experienced, well-known, and skilled NP speakers in the country. With more than one thousand presentations to her credit, she has been recognized by the NP community for her dynamic speaking abilities. Dr. Margaret Fitzgerald also earned the coveted Certified Speaking Professional (CSP) designation from the National Speakers Association.

Dr. Margaret A. Fitzgerald’s Speaker School will make extensive use of recorded practice presentations prepared by participants, recorded in the FHEA studio, and critiqued by instructors and peers. Hands-on presentation preparation and slide development techniques will be covered. Also learn how to improve your “speaking voice.” The workshop is limited to twenty participants. A personal laptop equipped with Microsoft PowerPoint will be required.

Click here for more information
Administering Influenza Vaccine in Egg Allergy Persons: Are We Needlessly Avoiding Vaccinations?
by Christy Yates, MSN, FNP-BC, NP-C, AE-C
Family Allergy & Asthma, Family Health Centers, Inc.,
Louisville, KY
Senior Lecturer, Fitzgerald Health Education Associates, Inc.

Editor’s Note: Christy Yates would like to thank Stephen Pollard, MD, for his input and support with this article.

The 2010-2011 Influenza recommendations by the Center for Disease Control’s Advisory Committee on Immunization Practices (ACIP) include routine vaccination of all persons aged 6 months and older. The universal recommendation emphasizes the importance of preventing influenza among all age groups and is supported by evidence that the vaccine is safe and effective. In addition, removing the age and risk indications reduces barriers to vaccination.

In general, anaphylactic reactions to vaccines are rare. There are approximately 235 million doses of vaccines administered in the United States each year, and anaphylactic reactions are estimated to occur at a rate of approximately one per million doses. The 2010-2011 CDC guidelines recommend avoidance in persons with an anaphylactic hypersensitivity to eggs or to other components of the influenza vaccine unless they have been desensitized. A review of reports to the Vaccine Event Reporting System (VAERS) over a 15-year period from 1990 to 2005, during which 747 million doses of influenza vaccine were administered in the US, revealed four reports of death shortly after influenza vaccination that identified anaphylaxis as the cause. No information on egg allergy was provided nor was any evaluation performed to determine whether these were allergic reactions.

Since influenza vaccines are grown in chick extraembryonic fluid and contain micrograms of egg protein, there has been a concern for the potential risk of an allergic reaction when administering the influenza vaccine to an egg allergic person. To provide a comparison, the measles, mumps, and rubella (MMR) vaccine contains picograms to nanograms of egg protein, which are clinically insignificant amounts. In the past, influenza manufacturers did not state the egg protein content of the vaccines; independent research laboratories found some egg protein levels to be as high as 42 mcg/ml. Currently, most manufacturers provide this information in the package insert. The protein content also varies in any given years’ vaccine and between manufacturers. The 2009-2010 seasonal and H1N1 influenza vaccines manufactured by CSL Biotherapeutics, Inc., GlaxoSmithKline, MedImmune, LLC, and Novartis Vaccines and Diagnostics, Inc. all were reported to contain <1 mcg per dose. The lowest reported threshold for anaphylaxis during oral egg challenges is 130 mcg of egg protein (Taylor, S. et. al.). The safe administration of influenza vaccine containing up to 1.2 mcg of egg protein/ml has been reported in multicenter trials in egg allergic persons.

A report in The Journal of Allergy and Clinical Immunology (Gagnon, et al., 2010) revealed the safe vaccination of 830 confirmed egg-allergic patients (approximately 90% less than 12 years of age) with a monovalent adjuvanted A/H1N1 pandemic vaccine manufactured in Canada by Glaxo-Smith-Kline. Among the 830 confirmed egg-allergic patients, 9% required two divided doses due to a history of respiratory or cardiovascular reactions after egg ingestion and 91% were vaccinated in a single dose since they had other egg-induced allergic reactions that were lower risk. No patient receiving the vaccine had an anaphylactic reaction. Further vaccination of more than 3,600 other children with egg allergy caused no anaphylaxis. The authors concluded that vaccination of patients with egg allergy with an adjuvanted monovalent A/H1N1 influenza vaccine resulted in no anaphylaxis and on that basis appears to be safe. However, these results cannot be generalized to all seasonal influenza vaccines, since the content of ovalbumin in the delivered vaccine was <0.015 mcg/ml, lower than in some seasonal influenza vaccines.

Until recently, there were no parameters to guide healthcare providers according to the egg protein level in the influenza vaccines and the patients’ risk for allergic reaction. Therefore, many healthcare providers withheld influenza immunizations for any reported egg allergy. This unfortunately left many individuals susceptible to influenza and the associated morbidity and mortality. The recent worldwide concern about H1N1 influenza and the known substantial benefit from H1N1 and seasonal influenza vaccination has accelerated efforts over the last few years to reduce another barrier to receiving influenza vaccines: possible needless avoidance of immunization due to egg allergy.

(Continued on page 8)
FHEA News

**What our Customers Say…**

I took the certification exam yesterday and passed! I just wanted to express my gratitude to you for your FNP certification exam prep course. I haven’t taken the exam in 10 years. I stalled on applying for the exam because I couldn’t imagine how I’d study. I took the FNP/ANP review course in Oak Brook, IL in early January. The class, on-line materials and study guides and other items I purchased made all the difference. Thanks for your instruction and for the very professional way it was delivered. The on-line modules were represented on the exam (cultural sensitivity, cultural competence, and prenatal care). I feel more knowledgeable and mindful of the importance of keeping current with primary care to do my job better.

—Patricia K. Musto DNP

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**FHEA Announces New Team Member**

Fitzgerald Health Education Associates, Inc. is pleased to announce that Kimberly Dempster-Gonzalez, MAOM, has joined their staff in the newly created position of Director of Academic, Corporate and Government Marketing. Mrs. Dempster-Gonzalez will lead FHEA’s marketing and sales efforts as they expand their business presence in the academic (university), corporate and government sectors both nationally and internationally.

Mrs. Dempster-Gonzalez has a master’s degree in organizational management and brings to FHEA extensive professional experience working with corporate, pharmaceutical, academic and association relations, communications and development. For the last 12 years, Mrs. Dempster-Gonzalez held the position of Director of Development and Operations for the American Academy of Nurse Practitioners Foundation (AANP Foundation), the first national foundation working to support and benefit nurse practitioners of all specialties which began operations in 1998. This previous experience makes her uniquely qualified to undertake new FHEA business endeavors and activities. The daughter of a nurse practitioner, Mrs. Dempster-Gonzalez has been advocating for NPs both personally and professionally for almost four decades.

“We are very excited to have Kimberly join our team,” states FHEA Founder, President and Principal Lecturer Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP. “She has a rich professional background and innovative ideas that we know will compliment and facilitate FHEA’s growth and continued national and international leadership in NP education and development.”

**FHEA Weddings in the Dominican Republic**

FHEA employee Jeff Turner married Rosana Padilla on October 3, 2010 in Cotui, Dominican Republic.

FHEA employee Johanna Cabrera married Joseph Walker on October 9, 2010 at the Barcelo Resort in Puerto Plata, Dominican Republic.

Best wishes to the newlyweds!

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**Notice of System Maintenance for Testing and Learning Site**

Routine maintenance is scheduled for November 20, 2010. FHEA is committed to providing our customers maximum uptime, reliability, and security for our On-line Testing and Learning Site. Regular system maintenance is critical to achieving this goal. System maintenance is normally performed the third Saturday of each month.

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Worldwide, iron deficiency is the most common reason for anemia. Because an estimated 8 years of poor iron intake is needed in adults before iron-deficiency anemia occurs, diet is rarely its origin. Rather, chronic blood loss causing a wasting of the RBCs' recyclable iron, the body's most important iron source, is the most common cause. Occult gastrointestinal blood loss, such as from an oozing gastritis or gastrointestinal malignancy, is a common reason, as is excessive menstrual flow.

Men and postmenopausal women require 1 mg of iron each day. During reproductive years, women require 1.5 to 3 mg/day of iron, in part because of the monthly loss of RBCs with the menses. In all these circumstances, these iron requirements are achievable with a well-balanced diet. One milliliter of packed RBCs contains 1 mg of iron, so even losses of 2 to 3 mL of blood per day through chronic, low gastrointestinal bleeding or repeated phlebotomy can lead to iron deficiency.

The laboratory diagnosis of iron-deficiency anemia is supported by the following findings (Table 11-3 Identifying Commons Anemias).

- Early disease: low to normal hgb, low hct, and low total RBC count; normocytic, possible hypochromic; RDW > 15%
- Later disease: microcytic, hypochromic anemia with low RBC count and elevated RDW > 15%
- Low serum iron level: reflecting iron concentration in circulation. Serum iron is reflective of iron intake during the past 24-48 hours and can be falsely elevated because of recent high levels of dietary iron ingestion or self-prescribed oral iron supplementation.
- Elevated total iron-binding capacity (TIBC): a measure of transferrin, a plasma protein that easily combines with iron; when more of transferrin is available for binding, the TIBC level increases, reflecting iron deficiency.
- Iron saturation less than 15%: calculated by dividing the serum iron level by the TIBC.
- Low serum ferritin level: the body’s major iron storage protein
- Absence of iron from bone marrow, if aspiration is done

Therefore, a decrease in hemoglobin or RBC indices is a late rather than an early marker of disease. Therapy for patients with iron-deficiency anemia involves not only iron replacement but also treatment of the underlying cause.
The NP is In
by Jaclyn Fitzgerald

With the need for primary care increasing in the United States, many healthcare professionals and patients have noticed that nurse practitioners are at the forefront of their industry.

With more than 8,000 NPs graduating annually, a noticeable trend in the healthcare field is that the NP is nearly always “in” when patients are in need of care. According to a 2002 British Medical Journal report, many patients feel that they receive the same quality of care from NPs as they do from physicians. Patients also feel that they receive more individualized care when seeing an NP, because NPs often have greater availability and can often devote more time to patients.

It’s not just the demand for NPs that has grown recently; it’s their salaries as well. A report released by the Medical Group Management Association (MGMA) last month indicated that in the past five years NPs have seen a 21.9% increase in their pay. In contrast, primary care physicians have seen an average increase of 13.9% whereas compensation for specialty physicians rose 2.9%. These pay increases are indicative of how vital the role of the NP is in an industry where physicians are few and far between.

The MGMA report recommended that all states should re-evaluate the regulations in their Nurse Practice Act. Many healthcare professionals believe that the scope of practice for NPs in all states needs to be expanded so that they can practice more independently and continue to increase the quality of healthcare that they provide. With the number of people in need of primary care projected to rise exponentially over the next few years, now is the time to make these changes. The healthcare reform bill enacted by the Obama administration will result in 32 million newly insured young people and 15 million new Medicare applicants by 2014, according to a study released this year by the Association of American Medical Colleges (AAMC). In accordance with the Affordable Care Act, the U.S. Department of Health and Human Services announced in September that $320 million in grants would be used to aid primary care clinics and expand nursing programs at colleges and universities in an attempt to offset the anticipated demand for healthcare. NPs will continue to serve a vital role in the healthcare industry now and when the full impact of the reform is witnessed.

References:


Contact Hour Tracker

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Upcoming Suturing Conference
The Art of Wound Repair—Suturing for NPs and PAs
Instructor: Robert M. Blumm, MA, PA-C
Location: New York, NY
Date: February 2, 2011
Class hours: 8:30AM - 4:30PM

Wound repair is a necessary skill for all NPs and PAs. It is usually placed into their academic curriculum with the knowledge that there will be an extensive period of practical application as they continue their studies and move forward into rotations. However, many NPs and PAs graduate from their programs and pass their boards without acquiring this useful and billable skill.

This workshop will be a full-day course with the utilization of a pig’s foot, anesthesia tips, 4-0 nylon suture, and a disposable stapler. Dermabond and other newer products about to come on the market will be covered, as an introduction to the use of a bio-adhesive in the care of lacerations.

Click here for more information
The publication of Adverse Reactions to Vaccines provides an evidence-based approach to the evaluation of the person at risk for allergic reactions to vaccines, including the influenza vaccines. It was developed by the Joint Task Force on Practice Parameters (JTF), representing the American Academy of Allergy, Asthma and Immunology (AAAAI), the American College of Allergy, Asthma and Immunology (ACAII) and the Joint Council of Allergy, Asthma and Immunology (Ann Allergy Asthma Immunol. 2009 Oct;103 [4 Suppl 2]:S1-14; www.allergyparameters.org). There are two key points of the practice parameter; first, the evidence shows that most people with a history of egg allergy or a history of previous reaction to an influenza vaccine can be immunized safely after allergy testing. Second, patients with suspected allergy to vaccines or vaccine components should be evaluated by an allergist/immunologist. The summary of the practice parameter in the table below will primarily focus on influenza vaccines and egg allergy.

### Adverse Reactions to Vaccines Practice Parameter 10/09: Influenza Vaccines and Egg Allergy

<table>
<thead>
<tr>
<th>Practice Parameter Summary Statement</th>
<th>Comment</th>
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<tr>
<td>Mild local reactions and constitutional symptoms after vaccinations are common and do not contraindicate future doses.</td>
<td>Local, injection site reactions (swelling, redness, and/or soreness) are common and do not warrant withholding future vaccinations. Delayed hypersensitivity contact dermatitis reactions at the injection site are also not contraindications to future vaccinations.</td>
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<td>All serious events occurring after vaccine administration should be reported to the Vaccine Adverse Event Reporting System (VAERS), even if it is not certain that the vaccine was causal.</td>
<td>The Vaccine Adverse Event Reporting System (VAERS) relies on reporting from healthcare professionals, parents, and patients so all events can be evaluated for strength of potential causality.</td>
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<tr>
<td>All suspected anaphylactic reactions to vaccines should ideally be evaluated by an allergist in an attempt to determine the culprit allergen.</td>
<td>Before labeling the patient “allergic” to the vaccine and leaving the patient inadequately immunized, refer to an allergist to determine if the patient is allergic and if it is to the immunizing agent itself or to a constituent in the vaccine. Not knowing this may pose a risk with future vaccinations that contain the same ingredient and/or prevent the patient from receiving needed immunizations. The recommended protocol for skin testing (i.e. egg and influenza vaccine) in the parameter is being utilized by allergists across the country. The office visit takes approximately 2 hours, which includes the history, exam and skin testing. If the skin test is negative, the patient is given the full dose of the influenza vaccine. If the skin test is positive, the influenza vaccine may still be administered, if necessary, in graded doses under close observation.</td>
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<td>IgE-mediated reactions to vaccines are more often caused by vaccine components rather than the immunizing agent itself (i.e. egg protein in influenza vaccines).</td>
<td>Measles and mumps vaccines are grown in chick embryo fibroblast cultures and contain negligible or no protein. They can be administered safely to egg allergic persons. Egg protein is present, however, in higher amounts in influenza vaccines and may cause reactions in egg allergic patients. Administration of influenza vaccine containing 1.2 mcg/ml of egg protein or less has been safely administered to egg allergic patients. The vaccine is newly made each year and there are variable amounts of egg protein present in any given years’ vaccine (as high as 42 ug/ml of egg protein). Whether this is sufficient to cause a reaction in an egg allergic person is not known but may pose a risk. The trigger point for reactions above 1.2 mcg/ml egg protein is not known and varies among individuals.</td>
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<td>In patients with histories and skin test results consistent with an IgE-mediated reaction to the influenza vaccine, consideration can be given to administering the vaccine in graded doses under observation by an allergist.</td>
<td>Patients needing influenza vaccination who are at higher risk for systemic reactions, with either a strong positive history or a positive skin test, should receive graded dosing of the influenza vaccination under close medical observation by an allergist. Emergency treatment should be readily available should an anaphylactic reaction occur. The procedure lasts approximately 2 hours.</td>
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### References


(Administering the Influenza Vaccine: Continued from page 4)
5 ¾ Day Advanced Pathophysiology for NPs and Advanced Practice Clinicians
Manhattan, NY
July 18-23, 2011

Presented by:
Sally K. Miller, PhD, ACNP-BC, ANP-BC, FNP-BC, GNP-BC, CNE, FAANP
Margaret A. Fitzgerald, DNP, FNP-BC, NP-C, FAANP, CSP

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Topics Presented by Sally K. Miller

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II. Mechanisms of cellular transport.
III. Membrane and action potentials.

Unit III Mechanisms of Cell Trauma
I. Reversible injury.
II. Irreversible injury.
III. Hypoxia.
IV. Physical trauma.
V. Infectious trauma.
VI. Chemical trauma.

Unit IV Cellular Response to Injury
I. Adaptation.
II. Inflammation.

Unit V Pathophysiology of the Hematologic System
I. Hematopoiesis.
II. Microcytic anemias.
III. Macrocytic anemias.
IV. Hemoglobinopathies.
V. Primary hemostasis.
VI. Secondary hemostasis.

Unit VI Pathophysiology of the Nervous System
I. Synaptic transmission.
II. Neurotransmitter.
III. Post-synaptic processes.
IV. Selected disorders.

Unit VII Pathophysiology of the Cardiovascular System
I. Cardiac action potential.
II. Contractile tissue.
III. Non-contractile tissue.
IV. Cardiac conduction.
V. Contractile fibers and the sarcomere.
VI. Electromechanical coupling.
VII. Cardiac muscle tasks.
VIII. Selected disorders.
IX. Lipid synthesis and transport.
X. Selected dyslipidemias.

Unit IX Pathophysiology of Endocrine Disease
I. Types of hormones.
II. Hormone receptors.
III. Feedback mechanisms of secretion.
IV. Maintenance of plasma glucose concentration.
V. Maintenance of thyroid hormone concentration.
VI. Maintenance of adrenal cortex/medullary hormone concentration.
VII. Selected disorders.

Unit X Pathophysiology of Pulmonary Disease
I. Anatomy and physiology of airways.
II. Vascular and lymphatic anatomy.
III. Autonomic nervous system regulation.
IV. Compliance and recoil.
V. Airflow and resistance.
VI. Ventilation and perfusion.
VII. Selected obstructive/restrictive diseases.

Unit XI - Pathophysiology of Renal Disease
I. Anatomy and physiology of the nephron.
II. Regulation of blood pressure, calcium, and erythropoietin.
III. Regulation of renal function; tubuloglomerular feedback.
IV. Cortical and medullary flow.
V. Acute renal failure.
VI. Chronic kidney disease.
VII. Electrolyte imbalance.
VIII. Regulation of acid/base balance.

Unit XII - Pathophysiology of Digestive System Disease
I. Anatomy and musculature of the gastrointestinal tract.
II. Neural control systems.
III. Chemical control systems.
IV. Myogenic control systems.
V. Oropharyngeal/esophageal motility.
VI. Gastric motility and control.
VII. Gastric acid secretion.
VIII. Selected disease states.

Topics Presented by Margaret A. Fitzgerald

Unit VII - Pathophysiology in Reproduction
I. Factors influencing impaired female fertility.
II. Factors influencing impaired male infertility.
III. Pathophysiologic problems encountered in pregnancy: Recurrent pregnancy loss, pregnancy induced hypertension, placental disorders, others.

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**Note 1:** Registrations received or postmarked between two months and two weeks prior to the start of the course qualify for this rate.
**Note 2:** Registrations received or postmarked more than two months prior to the start date of the course qualify for this rate.

Upon receipt of your enrollment and full payment, you will receive a confirmation of registration and directions to the course. A fee of $50.00 will be charged for cancellation. No refunds will be granted within two weeks of the starting date. All cancellations and changes must be received in writing.

¹ Contact hours differ from the live course. See www.fhea.biz for details.
² Because states’ requirements vary, it is important that you contact your Board for details regarding educational requirements for prescriptive authority.

For more information visit: www.fhea.biz
Question and Answer
with Margaret A. Fitzgerald
DNP, FNP-BC, NP-C, FAANP, CSP

Question: I will be graduating in 26 days and I'm terrified at the thought of going from an "expert" nurse with 20 years of experience to a "novice." I realize that I am so green, I probably glow in the dark. Do you have any advice?

Response: Please remember, you know much more than you realize! Your years of nursing practice, bolstered by successful completion of graduate study, have clearly provided you with the ability to provide thoughtful evaluations. This is a mark of a highly skilled clinician. How about thinking of yourself as a person who has provided healthcare for more than two decades and has successfully completed graduate school and is ready to embark on a new career challenge?

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Contents:

Dermatology DDxDeck, Book

These cards are linked together at one corner, much like a collection of color samples, allowing you to compare potential diagnoses visually, side by side, without the need to flip back and forth between different pages. Each card includes a full color image and information about a particular diagnosis, as well as cross references (DDx-ref) to other potential diagnoses. Small enough to fit in your pocket, this is the perfect reference for those on the front line of dermatological diagnosis.

Dermatology Across the Lifespan, Audio CD Set

This package contains 4 CDs and includes on-line access to all images associated with the lectures.

Topics covered:
- A Primer in Dermatology: Increasing skills to enhance clinical competence
- Is this Skin Cancer? Identifying and treating malignant cutaneous neoplasms
- The Golden Years: Understanding and treating skin in the older adult
- Help My Child: Topics, diagnosis and treatment of common pediatric dermatologic conditions

Common Dermatologic Procedures, DVD

Learn to identify and treat a variety of skin lesions and strategies for lesion management including shave and punch biopsies, cryotherapy, elliptical excision biopsy.

Click here for more information
### Dr. Margaret Fitzgerald’s Upcoming Speaking Engagements

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