# Flex Therapist CEUs

## HIV/AIDS: Prevention, Treatment, and Patient Care

**1. Which statement best distinguishes HIV infection from AIDS in clinical practice?**

A. A person is considered to have AIDS as soon as HIV antibodies are detectable, regardless of immune function or symptoms.
B. HIV and AIDS are two entirely different viruses that require completely different classes of antiretroviral medications.
C. AIDS refers to the brief acute stage immediately after HIV acquisition, before the body has produced antibodies to the virus.
D. HIV is the underlying viral infection, whereas AIDS is the most advanced stage of untreated or inadequately treated HIV marked by severe immune damage or specific opportunistic illnesses.

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**2. A patient newly diagnosed with HIV asks what their CD4 count and viral load mean. Which explanation reflects current evidence?**

A. The CD4 count is useful only during acute infection, while viral load is meaningful only after HIV has progressed to AIDS.
B. The CD4 count shows how much virus is in the blood, whereas the viral load primarily measures liver function and medication side effects.
C. Both CD4 count and viral load measure antibody levels against HIV and are interchangeable for monitoring treatment effectiveness.
D. The CD4 count reflects the strength of the immune system, while the viral load measures how much HIV is present in the blood and how well treatment is controlling the virus.

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**3. Why do current clinical recommendations emphasize starting antiretroviral therapy (ART) as soon as possible after an HIV diagnosis?**

A. Early ART rapidly eliminates latent HIV reservoirs and typically cures the infection within the first year of treatment.
B. Early and consistent ART suppresses HIV replication, protects immune function, greatly reduces the risk of progression to AIDS, and lowers HIV-related illness and death.
C. Starting ART early prevents HIV antibodies from forming, which makes later laboratory monitoring unnecessary.
D. Immediate ART is recommended mainly to reduce short-term flu-like symptoms, with minimal effect on long-term disease progression.

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**4. A patient on antiretroviral therapy has maintained an undetectable viral load and asks about transmitting HIV to a regular sexual partner. Based on the U=U principle, how should the healthcare professional respond?**

A. When HIV is durably suppressed to an undetectable level with effective treatment, the virus is not sexually transmitted to partners.
B. An undetectable viral load slightly reduces transmission risk, but the partner is still highly likely to acquire HIV during sexual contact.
C. Undetectable viral load eliminates all forms of transmission, including through shared needles and childbirth, without any additional precautions.
D. Viral load measurements do not relate to transmission risk, so the partner's risk is unchanged regardless of treatment effectiveness.

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**5. Front desk staff in a physical therapy clinic express fear after learning a patient has HIV and worry about transmission from handshakes and shared waiting room chairs. Which evidence-based explanation should the PT provide?**

A. HIV can survive for long periods on surfaces, so handshakes and shared chairs are common transmission routes in outpatient settings.
B. HIV can be transmitted through any type of close physical proximity, so patients with HIV should be isolated in separate waiting areas whenever possible.
C. HIV is transmitted through specific body fluids such as blood, semen, vaginal fluids, rectal fluids, and breast milk contacting mucous membranes or the bloodstream; it is not spread by hugging, shaking hands, sharing chairs, or using the same toilet.
D. HIV is easily transmitted in air droplets from coughing or talking, making open waiting rooms particularly high risk.

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**6. A 32-year-old with HIV-negative status reports condomless sex with men and intermittent injection drug use. Which prevention plan best reflects current CDC-aligned strategies?**

A. Offer HIV testing and discuss a combination approach including consistent condom use, initiation of PrEP, and referral to syringe services or substance use treatment to avoid sharing injection equipment.
B. Reassure the patient that avoiding anal sex alone is sufficient and that neither PrEP nor changes in injection practices are necessary if partners appear healthy.
C. Advise the patient to take a short, self-directed course of leftover antibiotics after high-risk encounters instead of using condoms or PrEP.
D. Recommend double-gloving during sexual activity and routine vitamin supplementation as the primary HIV prevention measures.

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**7. A healthcare worker presents 60 hours after a significant needle-stick exposure to blood from a patient known to have HIV. Which management approach is most appropriate?**

A. Reassure the worker that PEP is unnecessary since infection would already be established by 60 hours after exposure.
B. Delay any intervention until at least six months after the exposure because PEP is effective only if started more than 90 days after contact.
C. Initiate post-exposure prophylaxis (PEP) as an emergency intervention as soon as possible because the exposure occurred within the recommended 72-hour window, and prescribe a 28-day course if indicated.

D. Administer a single high-dose antiretroviral injection and consider the exposure adequately treated without further follow-up.

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**8. A pregnant patient living with HIV is anxious about transmitting the virus to her infant. What should the clinician emphasize about perinatal HIV transmission?**

A. The only meaningful way to prevent perinatal transmission is to avoid all prenatal care and hospital-based deliveries.
B. Transmission to the infant is virtually guaranteed once the mother has HIV, regardless of treatment or obstetric management.
C. Perinatal transmission occurs primarily through casual proximity during pregnancy, so antiretroviral therapy offers little benefit.
D. With appropriate medical care and effective antiretroviral therapy during pregnancy, childbirth, and postpartum, the risk of transmission to the infant can be greatly reduced.

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**9. Current U.S. surveillance data show that Black or African American individuals represent about 12% of the population but 39% of HIV diagnoses. How should healthcare professionals interpret this disparity?**

A. It reflects a disproportionate burden of HIV influenced by social, economic, healthcare, and structural factors that affect access to prevention, testing, and treatment.
B. It proves that biological susceptibility among Black or African American individuals is the primary driver of HIV risk, independent of social conditions.
C. It indicates that current prevention strategies are unnecessary in other racial and ethnic groups because HIV is now confined to a single group.
D. It suggests that HIV testing should be restricted to Black or African American communities to conserve public health resources.

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**10. In 2024, approximately 1.16 million people were living with diagnosed HIV in the United States and related jurisdictions, and 69% had viral suppression. What does this pattern most strongly suggest?**

A. The total number of people living with HIV must have risen solely because HIV incidence has dramatically increased in recent years.
B. Effective antiretroviral therapy has improved survival so more people are living with HIV over longer periods, but a substantial proportion still need better access to and engagement in treatment.
C. Viral suppression in 69% of patients indicates that ongoing HIV care is no longer necessary for the majority of people with HIV.
D. High prevalence of diagnosed HIV means that current treatments have failed to extend life expectancy for most individuals.

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**11. More than half (about 51%) of U.S. HIV diagnoses in 2024 occurred in the Southern region. Which factor is most consistent with the content as a contributor to this geographic pattern?**

A. Greater efficiency of casual-contact transmission in the South due to cultural norms around shared public spaces.
B. Enhanced survival of HIV in warm, humid climates, making the virus more transmissible in Southern states than in other regions.
C. Differences in healthcare access, poverty, stigma, and availability of prevention services that influence who can obtain testing, PrEP, and ongoing HIV care.
D. Reduced effectiveness of antiretroviral medications among residents of Southern states because of regional viral strains.

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**12. In 2024, 83% of people newly diagnosed with HIV were linked to care within one month, yet about 22% already met criteria for AIDS at diagnosis. What is the most appropriate interpretation of these data?**

A. While linkage to care after diagnosis is relatively strong, many people are still being diagnosed late in the disease course, underscoring the need for more routine and earlier HIV testing.
B. The high proportion with AIDS at diagnosis suggests that current antiretroviral medications are ineffective once a person has received an HIV test.
C. Because most people are linked to care promptly, further investment in HIV testing and public awareness campaigns is unlikely to change outcomes.
D. These numbers show that early testing is now universal and that advanced HIV disease is no longer a concern in clinical practice.

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**13. A patient presents 12 days after a high-risk exposure and is very concerned about acute HIV infection. Which testing strategy is most consistent with the described window periods?**

A. Perform an oral-fluid antibody test now, because antibody tests reliably detect HIV within the first week after exposure.
B. Arrange a nucleic acid test (NAT) now, since it can usually detect HIV 10 to 33 days after infection, and plan follow-up antigen/antibody testing later to confirm results.
C. Wait at least 90 days before offering any HIV test, since no available test can detect infection earlier than three months.
D. Order a finger-stick antigen/antibody test now and consider any negative result definitive, making further follow-up unnecessary.

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**14. Why are nucleic acid tests (NATs) not routinely used for general population HIV screening despite their short window period?**

A. They are relatively expensive and specialized, so they are typically reserved for suspected recent infection or when other test results require further evaluation.
B. They cannot detect HIV until at least six months after exposure, making them unsuitable for most clinical situations.
C. They detect only HIV antibodies and therefore miss acute infections before seroconversion.
D. They are recommended exclusively for self-testing at home rather than use in healthcare settings.

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**15. A patient had a possible sexual exposure to HIV three weeks ago and undergoes a rapid finger-stick antigen/antibody test, which is negative. According to the window-period information, what is the best next step?**

A. Advise the patient that all HIV tests provide identical window periods, so timing of repeat testing is unnecessary.
B. Assure the patient that the negative rapid test conclusively rules out HIV infection from this exposure and that no further testing is indicated.
C. Explain that the negative result is encouraging but may still fall within the window period for this test type and arrange follow-up testing about three months after the exposure.
D. Skip further HIV testing and focus solely on screening for other sexually transmitted infections because HIV infection can be excluded.

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**16. Which recommendation about routine HIV testing is most consistent with current CDC guidance described in the course?**

A. Routine HIV testing should be limited to people older than 50 years because younger individuals have minimal risk for infection.
B. Everyone between ages 13 and 64 should have at least one HIV test as part of routine healthcare, with more frequent testing for individuals with ongoing risk factors such as multiple sex partners or injection drug use.
C. HIV testing should be performed only when a patient presents with advanced symptoms strongly suggestive of AIDS.
D. Once a person has a single negative HIV test as an adult, additional testing is unnecessary regardless of future behaviors or exposures.

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**17. A PT is treating a patient living with HIV who has no open wounds and is performing standard therapeutic exercises. Staff request special isolation procedures because of fear of infection. Which response best reflects evidence-based infection control?**

A. Institute contact isolation for all therapy sessions with this patient and require double-gloving for any physical assistance, regardless of exposure risk.
B. Reinforce that HIV is not transmitted through casual contact and that standard precautions—such as hand hygiene and appropriate use of personal protective equipment when blood or body fluids might be encountered—are sufficient for all patients, including those with HIV.
C. Cancel in-person therapy and switch to remote visits to avoid any possibility of provider exposure to HIV.
D. Treat the patient only at the end of the day so surfaces can be disinfected overnight due to high risk of environmental HIV transmission.

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**18. A 54-year-old person with well-controlled HIV, peripheral neuropathy, and significant fatigue is referred to outpatient PT for lower-extremity weakness and balance issues. Which rehabilitation approach is most appropriate?**

A. Develop an individualized program that includes progressive strengthening, balance and gait training, and graded aerobic activity with attention to pacing, energy conservation, and the patient’s symptoms and medical status.
B. Avoid strengthening and aerobic exercise because exertion is contraindicated in individuals living with HIV, focusing instead on passive range of motion only.
C. Use a standardized high-intensity exercise protocol without modification, assuming all individuals with HIV tolerate exercise in the same way.
D. Restrict therapy to education about HIV transmission and defer any physical interventions until neuropathic symptoms completely resolve.

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**19. To reduce HIV-related stigma in clinical practice, which communication strategy aligns best with the course content?**

A. Ask detailed questions about the patient’s sexual history in front of family members to motivate lifestyle changes through social pressure.
B. Document the patient as an "HIV patient" and openly discuss their diagnosis in common areas to encourage other patients to be more cautious.
C. Use person-first, nonjudgmental language such as "person living with HIV," maintain confidentiality, and avoid assumptions about how the individual acquired HIV or their behaviors.
D. Emphasize that HIV is primarily the result of personal irresponsibility so the patient understands the seriousness of their condition.

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**20. A patient with well-controlled HIV is in PT after total knee replacement. Midway through the episode of care, the PT notices new unexplained weight loss, increased fatigue, and worsening balance. What is the most appropriate action?**

A. Attribute the symptoms to normal postsurgical recovery and continue progressing exercise intensity without informing other providers.
B. Communicate these functional changes to the patient’s medical team and recommend further medical evaluation while adjusting the rehab plan as needed for safety.
C. Discharge the patient immediately from physical therapy because any new symptom in a person with HIV indicates treatment failure.
D. Independently alter the patient’s antiretroviral regimen to reduce fatigue before contacting the prescribing provider.

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