Import Settings:

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Information Field: Complexity

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Information Field: Objective

Highest Answer Letter: D

Multiple Keywords in Same Paragraph: No

**Chapter: Pediatric Emergencies - Pediatric Emergencies - TBNK**

**Multiple Choice**

1. In contrast to adults, children:

A) land on their feet when they fall.

B) have proportionately larger heads.

C) experience head injury less frequently.

D) lose most body heat through the chest.

Ans: B

Complexity: Easy

Ahead: Pediatric Anatomy, Physiology, and Pathophysiology

Subject: Pediatric Emergencies

Page: 2121

Feedback: Pediatric Anatomy, Physiology, and Pathophysiology, page 2121

2. Compared to adults, the smaller diameter of a child's airway makes it more vulnerable to:

A) laryngospasm.

B) inhalation injury.

C) oropharyngeal secretions.

D) obstruction by the tongue.

Ans: D

Complexity: Easy

Ahead: Pediatric Anatomy, Physiology, and Pathophysiology

Subject: Pediatric Emergencies

Page: 2121

Feedback: Pediatric Anatomy, Physiology, and Pathophysiology, page 2121

3. A child's vocal cords can be difficult to visualize during intubation because:

A) the epiglottis is floppy and U-shaped.

B) the cords themselves are more posterior.

C) a sniffing position is difficult to achieve.

D) the area of the cricoid cartilage is narrow.

Ans: A

Complexity: Moderate

Ahead: Pediatric Anatomy, Physiology, and Pathophysiology

Subject: Pediatric Emergencies

Page: 2121

Feedback: Pediatric Anatomy, Physiology, and Pathophysiology, page 2121

4. Which of the following statements regarding a child's chest wall is correct?

A) Lung sounds are difficult to hear because of the thick intercostal muscles.

B) Children are belly breathers because they rely heavily on their diaphragms.

C) A child's chest wall has proportionately more subcutaneous fat on the chest.

D) Retractions are less obvious in children owing to their noncompliant rib cages.

Ans: B

Complexity: Moderate

Ahead: Pediatric Anatomy, Physiology, and Pathophysiology

Subject: Pediatric Emergencies

Page: 2121

Feedback: Pediatric Anatomy, Physiology, and Pathophysiology, page 2121

5. When a child experiences a low cardiac output state, he or she relies MOST on:

A) increased tidal volume.

B) central vasoconstriction.

C) an increase in heart rate.

D) increased stroke volume.

Ans: C

Complexity: Moderate

Ahead: Pediatric Anatomy, Physiology, and Pathophysiology

Subject: Pediatric Emergencies

Page: 2122

Feedback: Pediatric Anatomy, Physiology, and Pathophysiology, page 2122

6. Most children begin to develop stranger anxiety between \_\_\_ and \_\_\_ months of age.

A) 3, 6

B) 6, 12

C) 12, 18

D) 18, 24

Ans: B

Complexity: Moderate

Ahead: Developmental Stages

Subject: Pediatric Emergencies

Page: 2118

Feedback: Developmental Stages, page 2118

7. Children between 1 and 2 years of age:

A) are capable of basic reasoning.

B) have a well-developed sense of cause and effect.

C) generally explore the world exclusively by crawling.

D) may have negative associations with health care providers.

Ans: D

Complexity: Moderate

Ahead: Developmental Stages

Subject: Pediatric Emergencies

Page: 2119

Feedback: Developmental Stages, page 2119

8. The FIRST step in examining a toddler in stable condition is to:

A) let the child sit on a parent's lap.

B) place yourself at the child's level.

C) quickly examine any painful areas.

D) allow the child to hold a favorite toy.

Ans: A

Complexity: Moderate

Ahead: Developmental Stages

Subject: Pediatric Emergencies

Page: 2119

Feedback: Developmental Stages, page 2119

9. When assessing a 5-year-old child, you should:

A) be able to conduct a head-to-toe exam.

B) ask simple yes or no questions if possible.

C) generally use a toe-to-head exam approach.

D) first ask a parent where the child is hurting.

Ans: A

Complexity: Moderate

Ahead: Developmental Stages

Subject: Pediatric Emergencies

Pages: 2119–2120

Feedback: Developmental Stages, pages 2119–2120

10. An 8-year-old child:

A) is analytic but is not capable of abstract thought.

B) should not be the initial historian regarding an illness.

C) is anatomically and physiologically similar to an adult.

D) generally requires little reassurance and encouragement.

Ans: C

Complexity: Moderate

Ahead: Developmental Stages

Subject: Pediatric Emergencies

Page: 2120

Feedback: Developmental Stages, page 2120

11. With respect to CPR and foreign body airway obstruction procedures, the child should be treated as an adult once:

A) he or she reaches the age of 8 to 10 years.

B) resting vital signs are consistent with an adult.

C) his or her body weight is estimated at 55 pounds.

D) secondary sexual characteristics have developed.

Ans: D

Complexity: Moderate

Ahead: Developmental Stages

Subject: Pediatric Emergencies

Page: 2120

Feedback: Developmental Stages, page 2120

12. A 15-year-old child can be difficult to treat for all of the following reasons, EXCEPT:

A) peer pressure.

B) stranger anxiety.

C) independence issues.

D) cognizance of body image.

Ans: B

Complexity: Moderate

Ahead: Developmental Stages

Subject: Pediatric Emergencies

Page: 2120

Feedback: Developmental Stages, page 2120

13. Establishing good rapport with the caregiver of a sick or injured child at the scene is vital because:

A) caregivers often take their anger out on prehospital professionals.

B) he or she will be a source of important information and assistance.

C) doing so will quickly deescalate any hostility that he or she may have.

D) the caregiver generally will not accompany the child in the ambulance.

Ans: B

Complexity: Moderate

Ahead: Parents of Ill or Injured Children

Subject: Pediatric Emergencies

Page: 2125

Feedback: Parents of Ill or Injured Children, page 2125

14. If the parent or caregiver of a sick or injured child is emotionally distraught:

A) provide support, but remember that your first priority is the child.

B) you should firmly tell him or her that the situation is under control.

C) he or she should follow the ambulance in his or her personal vehicle.

D) the parent or caregiver should be removed from the scene immediately.

Ans: A

Complexity: Moderate

Ahead: Parents of Ill or Injured Children

Subject: Pediatric Emergencies

Page: 2125

Feedback: Parents of Ill or Injured Children, page 2125

15. The Pediatric Assessment Triangle was designed to:

A) formulate a working field diagnosis upon first sight of an ill child.

B) identify immediate life threats through a rapid hands-on assessment.

C) help EMS providers form a hands-off general impression of an ill child.

D) provide a means for performing a rapid head-to-toe physical assessment.

Ans: C

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Pages: 2125–2126

Feedback: Pediatric Patient Assessment, pages 2125–2126

16. The Pediatric Assessment Triangle will help answer all of the following questions, EXCEPT:

A) “Is the child sick or not sick?”

B) “Will the child cooperate during my exam?”

C) “Does the child require emergency treatment?”

D) “What is the most likely physiologic abnormality?”

Ans: B

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2126

Feedback: Pediatric Patient Assessment, page 2126

17. A sick or injured child's general appearance is MOST reflective of:

A) the etiology of the problem.

B) his or her cardiovascular status.

C) his or her central nervous system function.

D) his or her ability to be consoled.

Ans: C

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2126

Feedback: Pediatric Patient Assessment, page 2126

18. A child who is disinterested in your presence and has a blank stare and poor muscle tone:

A) is likely hypoglycemic or in septic shock.

B) should be ventilated with a bag-mask device.

C) will most likely require pharmacologic support.

D) requires immediate intervention and transport.

Ans: D

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Pages: 2126–2127

Feedback: Pediatric Patient Assessment, pages 2126–2127

19. The work-of-breathing component of the Pediatric Assessment Triangle includes all of the following, EXCEPT:

A) listening for grunting or audible wheezing.

B) noting the child's position during breathing.

C) auscultating the lungs for adventitious sounds.

D) looking for substernal or intercostal retractions.

Ans: C

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Pages: 2127–2128

Feedback: Pediatric Patient Assessment, pages 2127–2128

20. A conscious child who is in the sniffing position:

A) is trying to align the axes of the airway to improve ventilation.

B) is clearly experiencing an obstruction of the lower airway.

C) will refuse to lie down and leans forward on outstretched arms.

D) assumes a physical position that optimizes accessory muscle use.

Ans: A

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2128

Feedback: Pediatric Patient Assessment, page 2128

21. In contrast to adults, retractions in children are:

A) more evident in the intercostal area.

B) less commonly seen below the sternum.

C) usually less prominent above the clavicles.

D) evident in the sternocleidomastoid muscles.

Ans: A

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2128

Feedback: Pediatric Patient Assessment, page 2128

22. When assessing a child's circulation by looking at his or her skin, pallor is MOST indicative of:

A) vasomotor instability and decompensated shock.

B) peripheral vasoconstriction and compensated shock.

C) poor oxygenation and a state of circulatory collapse.

D) systemic vasodilation with resulting low blood pressure.

Ans: B

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2128

Feedback: Pediatric Patient Assessment, page 2128

23. Which of the following statements regarding acrocyanosis is correct?

A) Acrocyanosis is seen in the skin and mucous membranes and is a late finding if respiratory failure or shock is present.

B) Acrocyanosis is only considered to be a normal finding in newborns and usually resolves within 12 hours following birth.

C) Acrocyanosis is a bluish discoloration of the chest, abdomen, and face and is the most extreme visual indicator of poor perfusion.

D) Acrocyanosis is cyanosis of the hands and feet, and is a normal finding in infants younger than 2 months of age who are cold.

Ans: D

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2129

Feedback: Pediatric Patient Assessment, page 2129

24. The length-based resuscitation tape:

A) is only reliable in children who weigh less than 20 kg.

B) should not be relied upon for determining pediatric drug doses.

C) is used to estimate a child's weight based on his or her height.

D) is generally more accurate than the weight given by a caregiver.

Ans: C

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Pages: 2129–2130

Feedback: Pediatric Patient Assessment, pages 2129–2130

25. Counting an infant's respiratory rate for 15 seconds and then quadrupling that number:

A) is recommended because it is the quickest way to determine if the infant's baseline respiratory rate is abnormally slow or abnormally fast.

B) may yield a falsely low respiratory rate because infants may have periodic breathing or variable respiratory rates with short periods of apnea.

C) is impractical because the inherent respiratory rate of an infant is usually rapid and counting for such a short period of time leaves room for error.

D) is appropriate only if you are auscultating the child's respirations with a stethoscope while simultaneously listening to lung sounds.

Ans: B

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2130

Feedback: Pediatric Patient Assessment, page 2130

26. A normal respiratory rate in a child:

A) may be observed if the child has been breathing rapidly with increased work of breathing and is becoming fatigued.

B) generally ranges between 15 and 20 breaths per minute and is influenced easily by factors such as excitement, fear, or fever.

C) cannot be established accurately because a toddler's respirations generally are grossly irregular and extremely difficult to count.

D) is a sign of impending respiratory failure if it is observed in conjunction with a room air oxygen saturation reading of less than 96%.

Ans: A

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2130

Feedback: Pediatric Patient Assessment, page 2130

27. When evaluating a child's oxygen saturation level with a pulse oximeter:

A) you should recall that peripheral vasodilation from a warm environment will typically yield a false reading.

B) it should be evaluated in the context of the Pediatric Assessment Triangle and remainder of the primary assessment.

C) you should provide ventilatory assistance with a bag-mask device if the reading is below 94% and not increasing rapidly.

D) a reading of less than 96% on room air indicates respiratory distress and necessitates the administration of supplemental oxygen.

Ans: B

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2130

Feedback: Pediatric Patient Assessment, page 2130

28. Early hypoxia in a child would MOST likely present with:

A) tachycardia.

B) bradypnea.

C) mottled skin.

D) bradycardia.

Ans: A

Complexity: Easy

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2131

Feedback: Pediatric Patient Assessment, page 2131

29. If you cannot palpate the femoral pulse in an unresponsive infant, you should:

A) apply an AED at once.

B) palpate the brachial pulse.

C) initiate CPR immediately.

D) assess for adequate breathing.

Ans: C

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2131

Feedback: Pediatric Patient Assessment, page 2131

30. Assessment of a child in a cold environment would MOST likely yield:

A) a rapid, weak pulse.

B) flushing of the skin.

C) delayed capillary refill.

D) a slow, irregular pulse.

Ans: C

Complexity: Easy

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2131

Feedback: Pediatric Patient Assessment, page 2131

31. It is important to remember that blood pressure is only one component in the overall assessment of a child because:

A) it is an unreliable measurement of perfusion in all children.

B) hypotension is seen much earlier in children than in adults.

C) blood pressure may remain adequate in compensated shock.

D) it generally yields a falsely low reading in agitated children.

Ans: C

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Pages: 2134–2135

Feedback: Pediatric Patient Assessment, pages 2134–2135

32. To evaluate function of an infant's or child's cerebral cortex, you should:

A) assess pupil reaction.

B) use the AVPU scale.

C) assess for posturing.

D) evaluate motor activity.

Ans: B

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2132

Feedback: Pediatric Patient Assessment, page 2132

33. When a child who is too young to verbalize is in significant pain:

A) your ability to assess accurately for physiologic abnormalities is impaired.

B) narcotic analgesic drugs should be avoided unless transport will be delayed.

C) benzodiazepine drugs are preferred over opiates to minimize central nervous system depression.

D) pain scales using facial expressions are a valuable tool to assess pain severity.

Ans: A

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2135

Feedback: Pediatric Patient Assessment, page 2135

34. The decision to transport an acutely ill child immediately or remain at the scene to perform additional interventions is LEAST dependent on:

A) the child's age and fear level.

B) transport time to the hospital.

C) expected benefits of treatment.

D) your EMS system's regulations.

Ans: A

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Pages: 2132–2133

Feedback: Pediatric Patient Assessment, pages 2132–2133

35. Which of the following is often not acquired during the SAMPLE history of an adult, but should be routinely acquired in an infant or child?

A) Prescribed medications

B) Nature of symptoms

C) Preceding events

D) Immunizations

Ans: D

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2133

Feedback: Pediatric Patient Assessment, page 2133

36. In contrast to adults, cardiac arrest in children is usually caused by:

A) a dysrhythmia.

B) a toxic ingestion.

C) respiratory failure.

D) congenital anomalies.

Ans: C

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2136

Feedback: Pediatric Patient Assessment, page 2136

37. Respiratory distress in children:

A) represents the end result of prolonged hypoxia and indicates impending cardiopulmonary failure.

B) is a compensated state in which increased work of breathing results in adequate pulmonary gas exchange.

C) is associated with a decreased level of consciousness, abnormally slow respirations, and weak muscle retractions.

D) is characterized by prominent use of the sternocleidomastoid muscles in infants and children younger than 2 years of age.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2137

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2137

38. When an infant or child is in respiratory failure:

A) tachypnea is usually present despite a marked decrease in heart rate.

B) decreased cerebral perfusion leads to restlessness and a weak, rapid pulse.

C) he or she can no longer compensate, which causes hypoxia and hypercarbia.

D) oxygen via nonrebreathing mask should be given if tidal volume is reduced.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2137

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2137

39. Common signs of impending respiratory failure in infants and children include:

A) a falling oxygen saturation despite high-flow oxygen administration.

B) abdominal breathing and a pulse rate less than 120 beats per minute.

C) marked agitation and tachycardia with ectopic ventricular complexes.

D) tachypnea and hyperpnea with nasal flaring and prominent retractions.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2137

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2137

40. Treatment for a child with respiratory distress should include:

A) a semisitting position and bag-mask ventilation.

B) a position of comfort and supplemental oxygen.

C) a supine position and drug-assisted intubation.

D) a sniffing position and bag-mask ventilation.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Pages: 2137–2138

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, pages 2137–2138

41. A young child with marked respiratory distress who is agitated and thrashing about should receive oxygen via:

A) nonrebreathing mask because agitation indicates cerebral ischemia.

B) the blow-by technique while he or she sits on the lap of a caregiver.

C) positive pressure ventilation after he or she has been properly sedated.

D) a method that minimizes metabolic demand and oxygen consumption.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Pages: 2137–2138

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, pages 2137–2138

42. If an infant or small child swallowed a rigid foreign body, he or she would MOST likely experience respiratory distress because:

A) a foreign body in the esophagus would cause reflux and aspiration.

B) when an infant or child is stressed, he or she tends to swallow a lot of air.

C) the feeling of a foreign body in the throat would cause severe anxiety.

D) the esophageal foreign body can compress the relatively pliable trachea.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2138

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2138

43. A typical finding for a foreign body aspiration is:

A) a child with recent flu-like symptoms who presents with acute stridor.

B) an otherwise healthy child with a progressive increase in work of breathing.

C) an afebrile child with a sudden onset of coughing or gagging while playing.

D) a temperature less than 102°F with sudden drooling, crowing, and dyspnea.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2138

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2138

44. If you have reason to believe that an unresponsive child has a foreign body airway obstruction, you should:

A) assess for a pulse and then begin chest compressions.

B) perform 30 chest compressions and then look in the mouth.

C) administer abdominal thrusts until the object is expelled.

D) try to remove it by performing a finger sweep of the mouth.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2139

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2139

45. If a 2-year-old child with a foreign body airway obstruction becomes unresponsive, you should position him or her supine and then:

A) visualize the upper airway.

B) perform chest compressions.

C) assess for a carotid pulse.

D) perform abdominal thrusts.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2139

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2139

46. Immediate treatment for a conscious child with anaphylaxis includes:

A) epinephrine IM.

B) diphenhydramine IV.

C) a dopamine infusion.

D) normal saline boluses.

Ans: B

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2140

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2140

47. Which of the following statements regarding croup is correct?

A) Croup is also referred to as acute bacterial subglottic stenosis.

B) Hallmark signs of croup include high fever and a sore throat.

C) Most cases of croup result in severe hypoxia and hypercarbia.

D) Croup is a viral upper airway infection that may cause stridor.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Pages: 2140–2141

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, pages 2140–2141

48. The MOST important initial treatment for a child in respiratory failure due to suspected croup is:

A) prompt intubation before the airway closes.

B) a 2.25% concentration of racemic epinephrine.

C) ventilatory assistance with a bag-mask device.

D) continuous administration of a beta-2 agonist.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2141

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2141

49. Epiglottitis in children:

A) presents with a sudden onset of low-grade fever and dyspnea.

B) should be suspected if the child presents with diffuse wheezing.

C) is uncommon because children are vaccinated against *Haemophilus influenza* type b.

D) should be confirmed by visualizing the larynx and epiglottis with a laryngoscope.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2141

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2141

50. The goal in treating a child with epiglottitis is to:

A) transport him or her to the hospital with a maintainable airway.

B) administer corticosteroids to reduce edema in the upper airway.

C) intubate him or her before the epiglottis blocks the upper airway.

D) administer oxygen by nonrebreathing mask and transport at once.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2141

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2141

51. In contrast to upper airway emergencies, lower airway emergencies:

A) often present with more prominent retractions.

B) are generally associated with high-grade fever.

C) include laryngotracheobronchitis and diphtheria.

D) involve restriction of airflow during exhalation.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2142

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2142

52. A child who is experiencing a moderate asthma attack would MOST likely present with:

A) a markedly prolonged expiratory phase.

B) wheezing during inspiration and expiration.

C) an inability to speak in complete sentences.

D) an oxygen saturation between 80% and 90%.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2142

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2142

53. Medications used to prevent an asthma attack include:

A) inhaled steroids.

B) beta-2 agonists.

C) inhaled albuterol.

D) oral ibuprofen.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2142

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2142

54. Which of the following represents the correct drug, dose, and delivery route for an 18-kg child experiencing severe respiratory distress due to bronchospasm?

A) Albuterol, 1 mg nebulized

B) Ipratropium, 0.5 mg nebulized

C) Albuterol, 0.25 mg nebulized

D) Epinephrine, 0.1 mg/kg IM

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Pages: 2142–2143

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, pages 2142–2143

55. Which of the following statements regarding bronchiolitis is correct?

A) Infants who were born past 42 weeks are at highest risk for respiratory failure and arrest secondary to bronchiolitis.

B) The pathophysiology of bronchiolitis is acute bronchospasm secondary to a bacterium that enters the lower respiratory tract.

C) Bronchiolitis is usually caused by the metapneumovirus and occurs with greatest frequency during late spring and early summer.

D) Bronchiolitis is a viral infection of the lower airway that commonly affects infants and children younger than 2 years of age.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2143

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2143

56. To maintain a neutral airway position in an unresponsive infant, you should:

A) slightly extend the infant's head.

B) pad underneath the infant's occiput.

C) place a towel roll under the shoulders.

D) insert an appropriate-sized oral airway.

Ans: C

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2145

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2145

57. An oral or nasal airway in an unresponsive infant or child may serve all of the following purposes, EXCEPT:

A) facilitating oral suctioning.

B) averting the need for intubation.

C) replacing manual head positioning.

D) helping to maintain an open airway.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Pages: 2145–2146

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, pages 2145–2146

58. When inserting an oropharyngeal airway in a child, you should:

A) use a tongue blade to depress the tongue.

B) open the mouth with the tongue-jaw lift.

C) hyperextend the head to facilitate insertion.

D) suction the oropharynx for 15 seconds first.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

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Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2146

59. Nasopharyngeal airways are rarely used in children younger than 1 year of age because:

A) the diameter of their nares is small and easily obstructed by secretions.

B) most nasopharyngeal airways are too large and result in an obstruction.

C) nasopharyngeal stimulation commonly results in a tachycardic response.

D) unlike older children, small children often have a more active gag reflex.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2147

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2147

60. Proficiency in ventilating apneic infants or children with a bag-mask device:

A) cannot be achieved by practicing on a manikin.

B) may avert the need for endotracheal intubation.

C) is more important for paramedics than EMTs.

D) is difficult because their faces are much smaller.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2148

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2148

61. Appropriate bag-mask ventilation for an apneic 3-year-old child involves:

A) ensuring a consistently delivered tidal volume of 400 mL.

B) providing hyperventilation to ensure carbon dioxide elimination.

C) hyperextending the head to ensure an adequate mask-to-face seal.

D) delivering each breath over 1 second until the chest rises visibly.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Pages: 2148–2149

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, pages 2148–2149

62. Ventilating a child too fast with a bag-mask device may cause:

A) reflex hypertension.

B) severe hypercarbia.

C) decreased preload.

D) cerebral vasodilation.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2149

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2149

63. When preparing to intubate a small child, it is important to remember that:

A) the small child's epiglottis is very rigid.

B) prolonged attempts often cause tachycardia.

C) you should hyperventilate before intubating.

D) small children have a relatively large occiput.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2151

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2151

64. The use of a straight blade during pediatric intubation:

A) is generally reserved for neonates only.

B) makes it easier to manipulate the epiglottis.

C) is associated with a higher risk of bradycardia.

D) facilitates laryngoscopy by lifting the vallecula.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2150

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2150

65. The MOST appropriate ET tube for a 6-year-old child is:

A) 4.0 mm, cuffed.

B) 4.5 mm, cuffed.

C) 5.0 mm, uncuffed.

D) 5.5 mm, uncuffed.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2151

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2151

66. Because stimulation of the parasympathetic nervous system can occur during intubation of a child, you should:

A) closely monitor the child's cardiac rhythm.

B) premedicate with 0.04 mg/kg of atropine.

C) limit your intubation attempt to 10 seconds.

D) use a curved blade instead of a straight blade.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2151

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2151

67. A(n) \_\_\_ orogastric or nasogastric tube would the MOST appropriate size for a 4-year-old child.

A) 4-F

B) 6-F

C) 8-F

D) 10-F

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2154

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2154

68. Which of the following statements regarding nasogastric (NG) and orogastric (OG) insertion in children is correct?

A) Gastric decompression with an NG or OG tube is only appropriate for children older than 10 years of age.

B) The correct size NG or OG tube for a child should be half the ET tube size that he or she would need.

C) Prior to inserting an NG or OG tube in an unresponsive child without a gag reflex, you should intubate his or her trachea.

D) Insertion of an orogastric tube is contraindicated in children with severe head trauma or injury to the midface.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2154

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2154

69. In contrast to a child with pulmonary edema secondary to congestive heart failure, the respirations of a hypercarbic child without pulmonary edema would MOST likely be:

A) rapid with audible rhonchi.

B) tachypneic and without retractions.

C) slow with increased work of breathing.

D) bradypneic with periods of marked apnea.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Pages: 2164–2165

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, pages 2164–2165

70. Signs of compensated shock in the infant or child include all of the following, EXCEPT:

A) abnormal mentation.

B) tachycardia and pallor.

C) prolonged capillary refill.

D) decreased peripheral perfusion.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2156

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2156

71. Infants and children in shock:

A) typically become hypotensive sooner than adults because of a relative decrease in total blood volume.

B) generally remain alert for longer periods than adults despite a significant decrease in cerebral perfusion.

C) compensate more efficiently than adults by increasing heart rate and peripheral vascular resistance.

D) maintain end-organ perfusion longer than adults, making capillary refill time a less reliable perfusion indicator.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2156

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2156

72. The approximate total blood volume of a 60-pound child is:

A) 1.9 L.

B) 2.4 L.

C) 3.1 L.

D) 3.8 L.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2156

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2156

73. When caring for an infant or child who is in compensated shock, you should:

A) intubate at the earliest sign of altered mentation.

B) administer a 10-mL/kg normal saline fluid bolus.

C) assist ventilations to improve tissue oxygenation.

D) establish IV or IO access en route to the hospital.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2156

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2156

74. A child in decompensated shock with hypotension should:

A) be intubated to protect his or her airway.

B) receive initial fluid resuscitation at the scene.

C) be given 25% dextrose to prevent hypoglycemia.

D) receive volume expansion with 5% dextrose in water.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2157

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2157

75. Distributive shock in children is MOST often the result of:

A) sepsis.

B) spinal injury.

C) heart failure.

D) anaphylaxis.

Ans: A

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2160

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2160

76. Early distributive shock in children is characterized by:

A) warm, flushed skin.

B) weak peripheral pulses.

C) pallor and diaphoresis.

D) gross neurologic deficits.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2160

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2160

77. Vasopressor support to improve vascular tone in a child in septic shock should be considered:

A) as soon as sepsis is suspected as the underlying problem.

B) only if other causes of distributive shock are ruled out.

C) if hypotension persists despite 60 mL/kg of isotonic fluid.

D) if the child’s sustained heart rate is greater than 130 beats/min.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2160

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2160

78. Unlike other types of shock, a child in cardiogenic shock would MOST likely present with:

A) an enlarged spleen.

B) unlabored tachypnea.

C) increased work of breathing.

D) a primary cardiac dysrhythmia.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2160

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2160

79. Failure of a child's SpO2 to increase despite high-flow oxygen is MOST indicative of:

A) relative hypovolemia.

B) congenital heart disease.

C) right-sided heart failure.

D) decreased vascular tone.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2160

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2160

80. The first-line treatment of pediatric patients in distributive shock is:

A) a vasopressor infusion.

B) volume resuscitation.

C) drug-assisted intubation.

D) continuous positive airway pressure.

Ans: B

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2160

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2160

81. You should be MOST suspicious for cardiogenic shock in an infant or child if:

A) he or she appears listless or lethargic.

B) his or her heart rate varies with activity.

C) his or her heart rate is greater than 150 beats/min.

D) perfusion decreases following a fluid bolus.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2160

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2160

82. Bradydysrhythmias in children MOST often occur secondary to:

A) severe hypoxia.

B) drug ingestion.

C) AV heart block.

D) cardiac irritability.

Ans: A

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2160

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2160

83. The preferred initial pharmacologic agent for pediatric bradycardia is:

A) atropine.

B) epinephrine.

C) dobutamine.

D) amiodarone.

Ans: B

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2162

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2162

84. First-degree heart block in children:

A) is typically asymptomatic and does not require special treatment.

B) should be suspected when a randomly dropped QRS is observed.

C) should be treated with cardiac pacing, even if the child is stable.

D) does not respond to atropine and should be treated with dopamine.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2161

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2161

85. Which of the following is the first-line treatment for a hemodynamically unstable child with bradycardia?

A) Epinephrine IV or IO

B) Chest compressions

C) Ventilatory support

D) Transcutaneous pacing

Ans: C

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2161

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2161

86. The presence of tachycardia in children:

A) commonly reflects an underlying cardiac pathology that requires emergent intervention.

B) often causes hypotension and is usually associated with a QRS complex greater than 0.08 seconds.

C) should be interpreted in the context of the child’s history and physical examination findings.

D) necessitates a 20-mL/kg bolus of an isotonic crystalloid solution until the cardiac rhythm is assessed.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2162

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2162

87. Which of the following components is NOT used to distinguish sinus tachycardia from supraventricular tachycardia?

A) Pulse rate

B) P wave presence

C) Systolic blood pressure

D) QRS complex width

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2162

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2162

88. Unlike sinus tachycardia, supraventricular tachycardia in infants is characterized by:

A) a presence of P waves.

B) an unvarying pulse rate.

C) a history of fever or dehydration.

D) a pulse rate greater than 180 beats/min.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2162

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2162

89. The MOST appropriate vagal maneuver for an infant involves:

A) blowing into an occluded straw.

B) holding ice packs firmly to the face.

C) firmly massaging the carotid artery.

D) applying a heat stimulus to the body.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2162

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2162

90. If an initial cardioversion attempt is unsuccessful in a 33-pound child, you should repeat the procedure using \_\_\_ joules:

A) 10

B) 15

C) 30

D) 50

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2162

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2162

91. Hemodynamically stable children with a wide QRS complex tachycardia that persists despite initial treatment:

A) should receive amiodarone.

B) respond well to adenosine.

C) are likely experiencing supraventricular tachycardia.

D) will respond to vagal maneuvers.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2163

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2163

92. Adenosine may be considered for a hemodynamically stable child with a wide complex tachycardia if:

A) the heart rate is over 180 beats/min.

B) the QRS complex is less than 0.12 seconds.

C) the child has a history of congenital heart disease.

D) the ventricular rhythm is regular and monomorphic.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Pages: 2162–2163

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, pages 2162–2163

93. Treatment for pediatric asystole includes:

A) atropine.

B) epinephrine.

C) cardiac pacing.

D) hyperventilation.

Ans: B

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2164

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2164

94. When attempting resuscitation of a child with pulseless electrical activity, you should:

A) administer epinephrine via the ET tube if possible.

B) attempt to identify an underlying cause of the arrest.

C) perform synchronized cardioversion if the rate is fast.

D) give atropine if the heart rate is less than 60 beats/min.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2164

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2164

95. Prior to administering pharmacologic therapy to an infant or child with pulseless ventricular tachycardia, the paramedic should perform:

A) intubation.

B) cardioversion.

C) defibrillation.

D) CPR for 5 minutes.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2164

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2164

96. Which of the following clinical findings is the MOST consistent with hypertrophic cardiomyopathy?

A) Unexplained syncope

B) Chest pain with fever

C) Sustained hypertension

D) Unresolving bradycardia

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2166

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2166

97. Dilated cardiomyopathy is a condition in which the heart is:

A) deprived of oxygen due to sudden coronary vasospasm.

B) unusually thick and must pump harder to eject blood.

C) temporarily impaired by an isolated bacterial infection.

D) weakened and enlarged, making it a less efficient pump.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2166

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2166

98. Etomidate should be avoided as an induction agent in pediatric intubation in the presence of:

A) hypovolemia.

B) tachycardia.

C) hypotension.

D) septic shock.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Page: 2168

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, page 2168

99. Common signs and symptoms of meningitis in young children include all of the following, EXCEPT:

A) poor feeding.

B) nuchal rigidity.

C) bulging fontanelle.

D) irritability and fever.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Page: 2169

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, page 2169

100. Meningococcal meningitis with sepsis is typically characterized by a(n):

A) purpuric rash.

B) insidious onset.

C) low-grade fever.

D) persistent cough.

Ans: A

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Page: 2170

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, page 2170

101. Which of the following is the MOST easily correctable problem in a child with an altered mental status?

A) Ingestion of aspirin 2 hours ago

B) High fever with a widespread rash

C) Blood glucose reading of 40 mg/dL

D) Dehydration associated with hypokalemia

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Page: 2167

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, page 2167

102. In the newborn, hypoglycemia is defined as a blood glucose level less than \_\_\_ mg/dL.

A) 40

B) 50

C) 60

D) 70

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Page: 2167

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, page 2167

103. In children, complex partial seizures would MOST likely manifest with:

A) focal motor jerking with loss of consciousness.

B) generalized tonic-clonic movement of all extremities.

C) focal motor jerking without loss of consciousness.

D) a brief loss of attention without abnormal body movement.

Ans: A

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Page: 2168

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, page 2168

104. In contrast to a complex febrile seizure, a simple febrile seizure:

A) lasts less than 15 minutes and occurs in children without underlying neurologic abnormalities.

B) is focal in nature and tends to occur in children with a baseline developmental abnormality.

C) is not associated with tonic-clonic body movement and occurs in children older than 6 years of age.

D) is of short duration and occurs when the child's body temperature gradually rises above 102.5°F.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Page: 2168

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, page 2168

105. Which of the following statements regarding simple febrile seizures is correct?

A) The overall prognosis for a child with simple febrile seizures worsens with each seizure episode.

B) They are unique to children, are common, and typically do not cause any type of permanent deficit.

C) More than one simple febrile seizure in a child is highly suggestive of an underlying neurologic problem.

D) Any child who experiences a simple febrile seizure is at significant risk for developing epilepsy.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Page: 2168

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, page 2168

106. The MOST appropriate airway management for an actively seizing child whose airway is not maintainable with positioning involves:

A) immediate endotracheal intubation.

B) insertion of an oropharyngeal airway adjunct.

C) nasal airway insertion and suctioning as needed.

D) 100% oxygen and a left lateral recumbent position.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Page: 2169

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, page 2169

107. Common medications used to treat pediatric seizures in the prehospital setting include all of the following, EXCEPT:

A) Ativan.

B) Dilantin.

C) diazepam.

D) midazolam.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Page: 2169

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, page 2169

108. When treating a child who is seizing with diazepam, the paramedic should remember that:

A) it is a long-acting drug and has the greatest potential for respiratory compromise.

B) a single dose of diazepam usually terminates all seizures, without the need to redose.

C) naloxone should be administered if signs of respiratory depression develop.

D) the half-life is short and breakthrough seizures may occur during long transports.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Page: 2169

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, page 2169

109. In contrast to toxic ingestions in toddlers, toxic ingestions in adolescents:

A) are usually unintentional.

B) typically involve multiple agents.

C) are associated with lower mortality.

D) involve small quantities of a single agent.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Toxicologic Emergencies

Subject: Pediatric Emergencies

Page: 2179

Feedback: Pathophysiology, Assessment, and Management of Toxicologic Emergencies, page 2179

110. Beta-blocker ingestion in small children would MOST likely cause:

A) acute hypoglycemia.

B) agitation or irritability.

C) marked hypertension.

D) ventricular fibrillation.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Toxicologic Emergencies

Subject: Pediatric Emergencies

Page: 2180

Feedback: Pathophysiology, Assessment, and Management of Toxicologic Emergencies, page 2180

111. The management for any potentially toxic exposure in children begins by:

A) identifying the toxin.

B) providing an antidote.

C) ensuring a patent airway.

D) assessing respiratory effort.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Toxicologic Emergencies

Subject: Pediatric Emergencies

Page: 2180

Feedback: Pathophysiology, Assessment, and Management of Toxicologic Emergencies, page 2180

112. Which of the following is the MOST appropriate dose of activated charcoal for a 45-pound child?

A) 5 g

B) 10 g

C) 15 g

D) 20 g

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Toxicologic Emergencies

Subject: Pediatric Emergencies

Page: 2181

Feedback: Pathophysiology, Assessment, and Management of Toxicologic Emergencies, page 2181

113. Sorbitol is not recommended for use in young children because it:

A) induces vomiting, which increases the risk for pulmonary aspiration.

B) can cause severe diarrhea and life-threatening electrolyte abnormalities.

C) has been linked to sudden cardiac death due to ventricular dysrhythmias.

D) prolongs the QT interval and is associated with ventricular fibrillation.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Toxicologic Emergencies

Subject: Pediatric Emergencies

Page: 2181

Feedback: Pathophysiology, Assessment, and Management of Toxicologic Emergencies, page 2181

114. Any child with unexplained hyperpnea should be suspected of having \_\_\_\_\_\_\_\_\_ toxicity.

A) opiate

B) salicylate

C) beta blocker

D) organophosphate

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Toxicologic Emergencies

Subject: Pediatric Emergencies

Page: 2180

Feedback: Pathophysiology, Assessment, and Management of Toxicologic Emergencies, page 2180

115. Sudden infant death syndrome (SIDS) is a term used when the unexpected death of an infant under 1 year of age:

A) cannot be explained after a complete autopsy.

B) when signs of physical abuse are not present.

C) occurs in the absence of any obvious trauma.

D) occurs between the months of January and March.

Ans: A

Complexity: Moderate

Ahead: Sudden Infant Death Syndrome

Subject: Pediatric Emergencies

Page: 2186

Feedback: Sudden Infant Death Syndrome, page 2186

116. Fever in infants younger than 2 months of age is defined as a body temperature that is \_\_\_\_°F or greater.

A) 99.2

B) 100.4

C) 101.2

D) 102.0

Ans: B

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Fever Emergencies

Subject: Pediatric Emergencies

Page: 2183

Feedback: Pathophysiology, Assessment, and Management of Fever Emergencies, page 2183

117. Which of the following is LEAST characteristic of a brief resolved unexplained event (BRUE) in an infant?

A) Pallor or cyanosis

B) A period of apnea

C) Brief loss of a pulse

D) Loss of muscle tone

Ans: C

Complexity: Moderate

Ahead: Brief Resolved Unexplained Event

Subject: Pediatric Emergencies

Page: 2187

Feedback: Brief Resolved Unexplained Event, page 2187

118. What forms of child maltreatment are often difficult to identify and may go unreported?

A) Sexual and emotional abuse

B) Emotional abuse and neglect

C) Neglect and physical abuse

D) Physical and emotional abuse

Ans: B

Complexity: Moderate

Ahead: Child Abuse and Neglect

Subject: Pediatric Emergencies

Page: 2183

Feedback: Child Abuse and Neglect, page 2183

119. You should be MOST suspicious for child abuse when caring for an injured 4-year-old child if:

A) there was an unusual delay in calling 9-1-1.

B) the child presents with bruises to both shins.

C) the caregiver demands that you treat the child.

D) you can smell alcohol on the caregiver's breath.

Ans: A

Complexity: Moderate

Ahead: Child Abuse and Neglect

Subject: Pediatric Emergencies

Page: 2184

Feedback: Child Abuse and Neglect, page 2184

120. Once you suspect that a child may have been abused, you should:

A) apprise the caregiver of your suspicions.

B) transport the child to the hospital at once.

C) question the child in front of the caregiver.

D) carefully document what you see and hear.

Ans: D

Complexity: Moderate

Ahead: Child Abuse and Neglect

Subject: Pediatric Emergencies

Page: 2184

Feedback: Child Abuse and Neglect, page 2184

121. Bruises that occur \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ are rarely incurred accidentally.

A) in a toddler

B) to both shins

C) to the forehead

D) in a straight line

Ans: D

Complexity: Moderate

Ahead: Child Abuse and Neglect

Subject: Pediatric Emergencies

Page: 2185

Feedback: Child Abuse and Neglect, page 2185

122. An infant or small child who falls from a significant height would MOST likely experience:

A) lumbar spine fractures.

B) lateral thoracic trauma.

C) a traumatic brain injury.

D) bilateral femur fractures.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies

Subject: Pediatric Emergencies

Page: 2187

Feedback: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies, page 2187

123. When assessing an otherwise healthy child who is injured, you notice that his general appearance is abnormal. This should make you MOST suspicious for:

A) child abuse.

B) a head injury.

C) hypoglycemia.

D) internal bleeding.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies

Subject: Pediatric Emergencies

Page: 2188

Feedback: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies, page 2188

124. Which of the following statements regarding chest trauma in children is correct?

A) The pliability of children's rib cages predisposes them to sternal fractures.

B) Signs of a pneumothorax are often more obvious in children than in adults.

C) Children are more prone to intrathoracic trauma due to compression forces.

D) Most cases of fatal chest trauma occur in children who fall more than 10 feet.

Ans: C

Complexity: Moderate

Ahead: Pediatric Anatomy, Physiology, and Pathophysiology

Subject: Pediatric Emergencies

Page: 2124

Feedback: Pediatric Anatomy, Physiology, and Pathophysiology, page 2124

125. In contrast to adults, young children are more prone to liver and spleen injuries because the organs:

A) extend well below the rib cage.

B) are both highly vascular.

C) are more mobile and less supported.

D) are relatively smaller and less protected.

Ans: A

Complexity: Moderate

Ahead: Pediatric Anatomy, Physiology, and Pathophysiology

Subject: Pediatric Emergencies

Page: 2123

Feedback: Pediatric Anatomy, Physiology, and Pathophysiology, page 2123

126. If a child who is wearing a helmet strikes a fixed object on his or her bicycle and flies over the handlebars, you would MOST likely encounter:

A) facial fractures with associated brain injury.

B) stretching or tearing injuries to the kidneys.

C) open or closed fractures of the lower extremities.

D) compression injuries to the intra-abdominal organs.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies

Subject: Pediatric Emergencies

Page: 2187

Feedback: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies, page 2187

127. The general area of a child's body that sustains initial trauma after being struck by an automobile depends MAINLY on:

A) the child's height and the height of the bumper upon impact.

B) the travel speed of the vehicle and the weight of the child.

C) whether the child turns away from or toward the vehicle.

D) whether the vehicle ran over the child following impact.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies

Subject: Pediatric Emergencies

Page: 2187

Feedback: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies, page 2187

128. In young children, air bags pose a particular threat for injuries to the:

A) thoracic organs.

B) abdominal organs.

C) head and neck.

D) soft tissues of the face.

Ans: C

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies

Subject: Pediatric Emergencies

Page: 2187

Feedback: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies, page 2187

129. When mechanically securing an injured child's head and neck to a backboard, you should:

A) place padding underneath the occiput.

B) place tape or a strap or tape over the chin.

C) use towel rolls instead of a cervical collar.

D) manually stabilize the child's torso first.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies

Subject: Pediatric Emergencies

Page: 2189

Feedback: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies, page 2189

130. To ensure that an infant's head is in a neutral position during spinal immobilization, you should:

A) provide slight extension of his or her head.

B) place padding under the infant's shoulders.

C) place a towel roll behind the infant's neck.

D) use towel rolls for lateral head stabilization.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies

Subject: Pediatric Emergencies

Page: 2189

Feedback: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies, page 2189

131. In contrast to the SAMPLE history of a child with an illness, the SAMPLE history of an injured child should include a specific inquiry regarding:

A) routine medication use.

B) any known drug allergies.

C) any prior hospitalizations.

D) his or her last tetanus shot.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies

Subject: Pediatric Emergencies

Page: 2191

Feedback: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies, page 2191

132. Signs of pain in an infant would MOST likely include:

A) tachycardia and inconsolability.

B) a heart rate that is not variable.

C) diaphoresis and dilated pupils.

D) labored tachypnea and pallor.

Ans: A

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies

Subject: Pediatric Emergencies

Page: 2192

Feedback: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies, page 2192

133. Which of the following statements regarding burns in the pediatric patient is correct?

A) A child's larger skin surface-to-body mass ratio increases his or her susceptibility to heat and fluid loss.

B) A burn that is characterized by clear demarcation lines is generally suggestive of an unintentional burn.

C) Unlike adults, the rule of palm is an inaccurate tool to determine the extent of burns in pediatric patients.

D) A child with burns to both lower extremities has burns to approximately 36% of his or her body surface area.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Burns

Subject: Pediatric Emergencies

Page: 2192

Feedback: Pathophysiology, Assessment, and Management of Burns, page 2192

134. You would MOST likely encounter a child with a tracheostomy tube breathing spontaneously on room air if:

A) he or she has a brainstem abnormality that affects the respiratory drive.

B) the tracheostomy tube was placed because of a congenital airway anomaly.

C) the purpose of the tube is to bypass a mechanical upper airway obstruction.

D) a self-limiting condition necessitated placement of the tracheostomy tube.

Ans: C

Complexity: Moderate

Ahead: Children With Special Health Care Needs

Subject: Pediatric Emergencies

Page: 2193

Feedback: Children With Special Health Care Needs, page 2193

135. If a child with a functioning central venous line requires emergency drug therapy, you should:

A) administer the drug through the central line, but only give half the usual dose of the drug.

B) avoid using the central line if possible and attempt to establish peripheral IV access elsewhere.

C) carefully cleanse the injection port on the central line and administer the drug in the usual fashion.

D) flush the central line with at least 30 mL of normal saline first and then administer the emergency drug.

Ans: B

Complexity: Moderate

Ahead: Children With Special Health Care Needs

Subject: Pediatric Emergencies

Page: 2194

Feedback: Children With Special Health Care Needs, page 2194

136. Ventricular shunts are typically placed in children who:

A) are born with a congenital condition in which the ventricles of the brain produce excessive amounts of cerebrospinal fluid.

B) have experienced a severe traumatic brain injury that results in chronic cerebral edema and increased intracranial pressure.

C) are born with an abnormally small brain, which results in a relative increase in the amount of circulating cerebrospinal fluid.

D) have impaired circulation and absorption of cerebrospinal fluid, leading to increased size of the ventricles of the brain and increased intracranial pressure.

Ans: D

Complexity: Moderate

Ahead: Children With Special Health Care Needs

Subject: Pediatric Emergencies

Page: 2194

Feedback: Children With Special Health Care Needs, page 2194

137. When caring for a child with a ventricular shunt or gastrostomy tube, it is important to:

A) provide supportive care only and then rapidly transport the child to the most appropriate medical facility.

B) recognize that the caregiver is a key resource and that his or her expertise should be utilized to assist in the care of the child.

C) assure the caregiver that you can care for the child effectively and recommend that he or she follow the ambulance in his or her own vehicle.

D) obtain a complete medical history from the caregiver and then develop a treatment plan based on your knowledge of special health care devices.

Ans: B

Complexity: Moderate

Ahead: Children With Special Health Care Needs

Subject: Pediatric Emergencies

Page: 2195

Feedback: Children With Special Health Care Needs, page 2195

138. Most injuries in pediatric patients:

A) can be totally eliminated with training.

B) involve trauma to the chest and spine.

C) are predictable and preventable events.

D) occur due to gross caregiver negligence.

Ans: C

Complexity: Moderate

Ahead: An Ounce of Prevention

Subject: Pediatric Emergencies

Page: 2195

Feedback: An Ounce of Prevention, page 2195

139. You are dispatched to a residence for a 17-year-old woman with acute abdominal pain. When you arrive and begin your assessment, it is clear that the patient is uncomfortable with the presence of her parents because she is reluctant to answer your questions. You should:

A) recognize that the parents are an invaluable resource for information.

B) diplomatically ask the parents if their daughter can have some privacy.

C) tell the patient that her parents must legally be present during the exam.

D) reassure the patient and tell her that her candor is vital to your treatment.

Ans: B

Complexity: Moderate

Ahead: Developmental Stages

Subject: Pediatric Emergencies

Page: 2120

Feedback: Developmental Stages, page 2120

140. Upon arriving at the scene of a 4-year-old boy with respiratory distress, you enter the residence and see the child, who is conscious, sitting on his father's lap. The father is aware of your presence, but the child is not. Your initial action should be to:

A) make physical contact with the child as soon as possible in order to identify any life threats.

B) allow the father to carry his son to the ambulance, where you can perform an initial assessment.

C) quickly build good rapport with the child by picking him up and asking him what his name is.

D) visually assess the child from across the room for any signs of increased work of breathing.

Ans: D

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Pages: 2125–2126

Feedback: Pediatric Patient Assessment, pages 2125–2126

141. While assessing the airway of a 3-year-old girl who is unresponsive, you hear a snoring sound during each of her slow, shallow breaths. You should:

A) insert an oropharyngeal airway and apply high-flow oxygen.

B) begin bag-mask ventilations to improve her low tidal volume.

C) provide free-flow oxygen as you nasotracheally intubate her.

D) manually maneuver her head and reassess her breathing status.

Ans: D

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Pages: 2127–2128

Feedback: Pediatric Patient Assessment, pages 2127–2128

142. A 7-year-old conscious boy presents with marked respiratory distress. Your assessment reveals the presence of intercostal and supraclavicular retractions and nasal flaring. His oxygen saturation is 93% on room air, and his heart rate is rapid. The MOST appropriate initial treatment for this child involves:

A) administering oxygen as tolerated, auscultating his lung sounds, and being prepared to assist his ventilations.

B) conducting a focused history and physical exam and allowing him to breathe room air to see if his oxygen saturation falls.

C) recognizing that the child is in respiratory failure and making immediate preparations to perform endotracheal intubation.

D) assisting his ventilations with a bag-mask device and determining if his tachycardia is ventricular or supraventricular in origin.

Ans: A

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2130

Feedback: Pediatric Patient Assessment, page 2130

143. Upon arriving at the scene of a 4-year-old girl who is ill, you note that she is tachypneic and tachycardic. Her skin is warm and moist, and there are no signs of increased work of breathing. The child's mother denies any vomiting or diarrhea. This child's tachycardia and tachypnea are MOST likely the result of:

A) fever and anxiety.

B) early hypoxemia.

C) a cardiac problem.

D) moderate dehydration.

Ans: A

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2131

Feedback: Pediatric Patient Assessment, page 2131

144. A 9-year-old who fell off his bike has an isolated deformity to his forearm and is in significant pain. The child is conscious and alert, his vital signs are stable, and his mother is present. Your initial effort to relieve this child's pain should involve:

A) encouraging the child to breathe high-flow oxygen.

B) not allowing the child to visualize his deformed arm.

C) providing calm reassurance to both mother and child.

D) administering morphine or fentanyl via slow IV push.

Ans: C

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Page: 2135

Feedback: Pediatric Patient Assessment, page 2135

145. A 10-year-old child fell approximately 15 feet from a balcony, landing on a sidewalk. He is conscious and alert, and complains of pain to the right side of his body. After completing your primary survey, you should:

A) apply spinal precautions, begin transport, and perform a rapid assessment while en route to the hospital.

B) provide any immediately needed care, perform a rapid assessment, apply spinal precautions, and transport.

C) perform a focused physical exam, obtain baseline vital signs, apply spinal precautions, and transport.

D) correct immediate life threats, perform a detailed head-to-toe exam, apply spinal precautions, and transport.

Ans: B

Complexity: Moderate

Ahead: Pediatric Patient Assessment

Subject: Pediatric Emergencies

Pages: 2135–2136

Feedback: Pediatric Patient Assessment, pages 2135–2136

146. You are dispatched to a daycare center for a 5-year-old girl with trouble breathing. Upon arriving at the scene, you assess the child and note that she is responsive to pain only, has weak intercostal retractions, and is breathing at a slow rate with shallow depth. You should:

A) apply oxygen via pediatric nonrebreathing mask and attach a pulse oximeter.

B) deliver two effective rescue breaths and assess her pulse for at least 5 seconds.

C) administer high-flow oxygen, assess her cardiac rhythm, and establish IO access.

D) begin assisting her ventilations with a bag-mask device and assess her pulse rate.

Ans: D

Complexity: Difficult

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2137

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2137

147. A 10-month-old infant presents with an acute onset of increased work of breathing. According to the infant's mother, the child was crawling around in the living room prior to the event and was fine 10 minutes earlier. Your assessment reveals that the infant appears alert to his surroundings, has loud inspiratory stridor, and pink skin. You should:

A) look inside the infant's mouth using a tongue blade and penlight.

B) avoid agitating the infant, offer supplemental oxygen, and transport.

C) deliver five sharp back slaps between the infant's shoulder blades.

D) apply a pediatric nonrebreathing mask and transport expeditiously.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2149

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2149

148. You are providing high-flow oxygen to a 3-year-old boy with severe respiratory distress. When you reassess him, you note that he is pale and his respiratory rate has decreased from 30 breaths/min to 12 breaths/min. You should:

A) assist his ventilations with a bag-mask device.

B) secure his airway with an endotracheal tube.

C) begin treatment with a beta-2 agonist medication.

D) auscultate his lung sounds and reassess his SpO2.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Pages: 2137–2138

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, pages 2137–2138

149. Several cycles of chest compressions have failed to remove a foreign body airway obstruction in an unresponsive infant. Your next action should be to:

A) perform laryngoscopy and try to visualize the foreign body.

B) continue chest compressions and perform a cricothyrotomy.

C) open the infant's airway and sweep the infant's mouth with your finger.

D) perform back slaps and chest thrusts and then look in the mouth.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2140

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2140

150. A 9-year-old, 55-pound girl presents with generalized hives, marked facial swelling, and loud inspiratory stridor. She is conscious but appears sleepy. You can MOST rapidly improve this child's condition by:

A) starting an epinephrine infusion.

B) administering diphendydramine.

C) administering epinephrine IM.

D) administering a nebulized bronchodilator.

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2140

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2140

151. You receive a call at 11:50 PM for a 3-year-old boy with respiratory distress. As soon as you enter the child's residence, you can hear a loud, barking cough. You find the child sitting on his mother's lap. He is conscious and appears alert to his surroundings. According to the child's mother, he has been sick for the past few days with a low-grade fever, but then began experiencing a high-pitched cough. His skin is warm and dry, his heart rate is 120 beats/min, and his oxygen saturation is 99% on room air. There are no signs of increased work of breathing. You should:

A) administer high-flow oxygen via pediatric nonrebreathing mask, keep him calm, and transport.

B) establish vascular access, give an appropriate dose of methylprednisolone, and transport.

C) administer 0.5 mL of racemic epinephrine via nebulizer, apply the cardiac monitor, and transport.

D) allow the child to assume a position of comfort, avoid agitating him, and transport him to the hospital.

Ans: D

Complexity: Difficult

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Pages: 2140–2141

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, pages 2140–2141

152. A 12-year-old boy presents with marked respiratory distress; hot, moist skin; and anxiety. He is sitting with his chin thrust forward and has inspiratory stridor. According to the child's grandmother, his symptoms began suddenly about 30 minutes ago. You should be MOST suspicious for:

A) acute viral croup.

B) bacterial epiglottitis.

C) subglottic narrowing.

D) laryngotracheobronchitis.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2141

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2141

153. A 13-year-old, 40-pound girl is experiencing an acute asthma attack that has been unresponsive to three puffs of her albuterol inhaler. She is conscious and alert, but is notably dyspneic and has diffuse wheezing. In addition to administering supplemental oxygen, you should:

A) give epinephrine 1:1,000 SQ.

B) give nebulized ipratropium.

C) administer dose of albuterol.

D) ventilate her with a bag-mask device.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Page: 2142

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, page 2142

154. You are transporting an unresponsive intubated 4-year-old child. An IO catheter is in place, and you are ventilating the child at an age-appropriate rate. Suddenly, the child becomes cyanotic and experiences a significant drop in her heart rate and oxygen saturation, and loss of a capnographic waveform. You attempt to auscultate her lung sounds but are unable to hear over the drone of the engine. You should:

A) extubate immediately and ventilate with a bag-mask device.

B) increase your ventilation rate and reassess the child's condition.

C) administer 0.02 mg/kg of atropine via rapid IO push and reassess.

D) look for vapor mist in the ET tube and attach a colorimetric device.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Respiratory Emergencies

Subject: Pediatric Emergencies

Pages: 2152–2153

Feedback: Pathophysiology, Assessment, and Management of Respiratory Emergencies, pages 2152–2153

155. You receive a call for a “sick child.” When you arrive at the scene, the child's mother tells you that her 5-year-old son has had vomiting and diarrhea for the past day and will not eat or drink anything. On exam, the child's level of consciousness appears consistent with his age. His skin is cool and pale, he is tachypneic, his capillary refill time is 4 seconds, and his heart rate is 150 beats/min. The MOST appropriate treatment for this child involves:

A) applying high-flow oxygen via pediatric nonrebreathing mask, assessing his blood glucose level, elevating his legs 12 inches, and transporting at once.

B) establishing IV access and administering a 20-mL/kg normal saline bolus, applying high-flow oxygen, administering 25% dextrose, and transporting.

C) administering supplemental oxygen, keeping the child warm, assessing his blood glucose level, transporting, and establishing vascular access en route.

D) administering supplemental oxygen, starting an IV line, assessing his blood glucose level, delivering at least two 20-mL/kg normal saline boluses, and transporting.

Ans: C

Complexity: Difficult

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Page: 2156

Feedback: Pathophysiology, Assessment, and Management of Shock, page 2156

156. You are assessing a 7-month-old infant who presents with listlessness, pallor, and increased work of breathing. The infant's mother tells you that the child was born 2 months premature and was in the neonatal intensive care unit for 3 weeks. She denies any recent vomiting, diarrhea, or fever. The infant's oxygen saturation is 89% and does not improve with supplemental oxygen. Her heart rate is rapid and weak and does not vary with activity. When you apply the cardiac monitor, you will MOST likely encounter a:

A) wide QRS complex rhythm with occasional P waves and a rate greater than 150 beats/min.

B) rhythm with QRS complexes greater than 0.08 seconds in duration and a heart rate greater than 180 beats/min.

C) narrow QRS complex rhythm with absent P waves and a heart rate greater than 220 beats/min.

D) rhythm with QRS complexes less than 0.08 seconds in duration and a heart rate less than 220 beats/min.

Ans: C

Complexity: Difficult

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2162

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2162

157. A 4-year-old boy is found unresponsive by his mother. When you begin your assessment, the child's mother tells you that her son apparently ingested some of her antihypertensive medication. The child has poor perfusion and is breathing poorly. As you are assisting the child's ventilations with high-flow oxygen, your partner informs you that the child's heart rate is 50 beats/min and weak and that the cardiac monitor reveals sinus bradycardia. You should:

A) ask your partner to insert an IO catheter and administer epinephrine 1:10,000.

B) attempt immediate transcutaneous pacing while continuing ventilation assistance.

C) establish immediate vascular access and administer 0.02 mg/kg of atropine sulfate.

D) initiate one-rescuer CPR while your partner attempts to establish vascular access.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Pages: 2160–2162

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, pages 2160–2162

158. A 6-year-old girl who has been running a fever for the past 2 days presents with lethargy and tachycardia. Her heart rate is 170 beats/min and varies with activity. Her skin is cool and clammy, and her capillary refill time is 4 seconds. The cardiac monitor reveals a narrow complex tachycardia with a rate that varies between 150 and 170 beats/min. You should:

A) apply chemical ice packs to the child's face to try to slow her heart rate.

B) establish vascular access and administer a 20-mL/kg normal saline bolus.

C) start an IV line and give adenosine while monitoring her cardiac rhythm.

D) transport immediately and establish vascular access en route to the hospital.

Ans: B

Complexity: Difficult

Ahead: Pathophysiology, Assessment, and Management of Shock

Subject: Pediatric Emergencies

Pages: 2156–2157

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, pages 2156–2157

159. You and your partner are caring for a child with stable supraventricular tachycardia that was refractory to initial treatment. As your partner is preparing to establish vascular access, the child's level of consciousness decreases markedly. You reassess the child and note that her femoral pulse is rapid and weak. You should:

A) perform immediate synchronized cardioversion and reassess.

B) begin chest compressions as your partner establishes the IV line.

C) preoxygenate the child and then perform endotracheal intubation.

D) establish vascular access and administer 0.1 mg/kg of adenosine.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2162

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2162

160. You are assessing a 10-year-old child with a wide-complex tachycardia, but cannot decide whether electrical or pharmacologic therapy is the most appropriate initial treatment approach. Which of the following interventions would pose the GREATEST potential for harm?

A) Administering high-flow oxygen and obtaining a 12-lead ECG tracing

B) Establishing IO access, administering a sedative, and cardioverting at 15 joules

C) Starting an IV line and administering amiodarone followed by procainamide

D) Establishing vascular access and rapidly administering 3 mg of adenosine

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Page: 2163

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, page 2163

161. Your primary survey of an unresponsive 5-year-old, 40-pound child reveals that he is apneic and pulseless. CPR is initiated and the cardiac monitor is applied, which reveals ventricular fibrillation. You should:

A) continue high-quality CPR and reassess in 2 minutes.

B) defibrillate with 40 joules and immediately resume CPR.

C) start an IV and administer 0.2 mg of epinephrine 1:10,000.

D) charge the defibrillator to 80 joules while CPR is ongoing.

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies

Subject: Pediatric Emergencies

Pages: 2163–2165

Feedback: Pathophysiology, Assessment, and Management of Cardiovascular Emergencies, pages 2163–2165

162. A 4-year-old girl presents with a fever of 103.2°F. The child's mother states that the fever came on suddenly and was not preceded by any symptoms. The child is conscious and alert with unlabored tachypnea, tachycardia, and a blood pressure that is consistent with her age. Prehospital treatment for this child includes all of the following, EXCEPT:

A) 81 mg of aspirin.

B) free-flow oxygen.

C) 250 mg of acetaminophen.

D) simple cooling measures.

Ans: A

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Fever Emergencies

Subject: Pediatric Emergencies

Page: 2183

Feedback: Pathophysiology, Assessment, and Management of Fever Emergencies, page 2183

163. You and your partner arrive at the scene shortly after a 2-year-old child experienced an apparent seizure. The child's father tells you that his son's entire body began shaking and that the episode lasted less than 5 minutes. Your assessment of the child reveals that he is conscious, is crying, and has hot, moist skin. His heart rate is 160 beats/min, and his respirations are 40 breaths/min. You should:

A) advise the father to take his son to see a pediatrician the following day.

B) cool the child with tepid water, administer high-flow oxygen, and transport.

C) establish vascular access, give a 20-mL/kg saline bolus, and transport him.

D) keep the child cool and transport him to the hospital for physician evaluation.

Ans: D

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Neurologic Emergencies

Subject: Pediatric Emergencies

Pages: 2168–2169

Feedback: Pathophysiology, Assessment, and Management of Neurologic Emergencies, pages 2168–2169

164. You are dispatched to a residence at 6:15 AM for an unconscious 3-month-old infant who is not breathing. Upon arrival at the scene, you find the father performing CPR on the infant. The infant's mother is sitting on the couch, crying. Your assessment reveals that the child is apneic and pulseless. Her skin is pale and cold, and there is gross lividity to her chest. You should:

A) continue CPR and assess the infant's cardiac rhythm to confirm asystole.

B) recognize that the infant has been deceased for an extended period of time.

C) pronounce the infant dead if he does not respond to 5 minutes of full ACLS.

D) tell the parents that the child likely suffocated because she slept on her stomach.

Ans: B

Complexity: Moderate

Ahead: Sudden Infant Death Syndrome

Subject: Pediatric Emergencies

Pages: 2186–2187

Feedback: Sudden Infant Death Syndrome, pages 2186–2187

165. A 2-year-old girl fell approximately 12 feet from a second-story window, landing on her head. Your primary survey reveals that she is unresponsive; has slow, irregular respirations; and has blood draining from her mouth and nose. A rapid exam of her body does not reveal any gross injuries or bleeding. You should:

A) manually stabilize her head and neck in a neutral position, insert a nasal airway, and hyperventilate her at a rate of 35 breaths/min.

B) suction her mouth and nose for no longer than 15 seconds, insert an oral airway, and apply high-flow oxygen with a pediatric nonrebreathing mask.

C) open her airway with the jaw-thrust maneuver, suction her mouth and nose, insert an oral airway, and assist her ventilations with a bag-mask device.

D) insert an oral airway, apply a cervical collar, preoxygenate her with a bag-mask device and 100% oxygen for 30 seconds, and intubate her trachea.

Ans: C

Complexity: Difficult

Ahead: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies

Subject: Pediatric Emergencies

Pages: 2187–2188

Feedback: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies, pages 2187–2188

166. Following significant blunt trauma to the abdomen, a 9-year-old boy presents with diaphoresis and pallor. He is conscious and alert, with a blood pressure of 90/58 mm Hg, a heart rate of 130 beats/min, and a respiratory rate of 28 breaths/min with adequate depth. With an estimated ground transport time of 30 minutes, you should:

A) assist his ventilations to increase tidal volume, cover him with a blanket, establish at least one large-bore IV line, administer a 20-mL/kg normal saline bolus, and transport to a trauma center.

B) administer high-flow oxygen, apply spinal precautions if indicated, provide warmth, begin transport, establish vascular access en route, and administer enough crystalloid solution to maintain adequate perfusion.

C) apply supplemental oxygen, start two large-bore IV lines with normal saline, administer several crystalloid boluses of 20 mL/kg, apply spinal precautions if indicated, and transport to an appropriate medical facility.

D) apply warm blankets, elevate his lower extremities 12 inches, administer high-flow oxygen, insert an IO catheter, administer a 250-mL normal saline bolus, and transport expeditiously to an appropriate trauma center.

Ans: B

Complexity: Difficult

Ahead: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies

Subject: Pediatric Emergencies

Pages: 2187–2188

Feedback: Pathophysiology, Assessment, and Management of Pediatric Trauma Emergencies, pages 2187–2188

167. You are called to a residence for a ventilator-dependent child with respiratory distress. Upon your arrival, the child's mother tells you that the child was doing fine, but then suddenly began experiencing labored breathing. She further tells you that the child's home ventilator was recently replaced with a newer one. Assessment of the child reveals that she is in marked respiratory distress and has intercostal retractions. Your FIRST action should be to:

A) suction the child's tracheostomy tube to rule out secretions as the problem.

B) assess the patency of the tracheostomy tube to determine if it is dislodged.

C) remove the tracheostomy tube and replace it with a similar-sized ET tube.

D) disconnect the child from the ventilator and begin bag-mask ventilations.

Ans: D

Complexity: Moderate

Ahead: Children With Special Health Care Needs

Subject: Pediatric Emergencies

Pages: 2193–2194

Feedback: Children With Special Health Care Needs, pages 2193–2194

168. You receive a call to a residence for a 6-year-old girl with a decreased level of consciousness. The child has hydrocephalus following surgery to remove a brain tumor and has a ventricular shunt in place. The child's level of consciousness is markedly decreased from its baseline, and the child's caregiver tells you that she thinks the shunt is obstructed. Which of the following sets of vital signs is MOST indicative of shunt obstruction and increased intracranial pressure?

A) Blood pressure 140/92 mm Hg; pulse 58 beats/min; respirations 8 breaths/min

B) Blood pressure 106/66 mm Hg; pulse 80 beats/min; respirations 14 breaths/min

C) Blood pressure 90/50 mm Hg; pulse 110 beats/min; respirations 10 breaths/min

D) Blood pressure 130/68 mm Hg; pulse 70 beats/min; respirations 28 breaths/min

Ans: A

Complexity: Difficult

Ahead: Children With Special Health Care Needs

Subject: Pediatric Emergencies

Pages: 2194–2195

Feedback: Children With Special Health Care Needs, pages 2194–2195

169. A 6-month-old child has burns to his head, face, neck, and anterior chest. What percentage of his body surface area has been burned?

A) 21%

B) 27%

C) 36%

D) 45%

Ans: C

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Burns

Subject: Pediatric Emergencies

Page: 2192

Feedback: Pathophysiology, Assessment, and Management of Burns, page 2192

170. A 12-year-old child with a history of hemophilia presents with a headache and slurred speech. What should you suspect?

A) Cerebral thrombus

B) Intracranial bleeding

C) Bacterial meningitis

D) Hemorrhagic shock

Ans: B

Complexity: Moderate

Ahead: Pathophysiology, Assessment, and Management of Hematologic, Oncologic, and Immunologic Emergencies

Subject: Pediatric Emergencies

Page: 2178

Feedback: Pathophysiology, Assessment, and Management of Hematologic, Oncologic, and Immunologic Emergencies, page 2178

171. After administering glucagon to a child with hypoglycemia, you should:

A) position the child on his or her side.

B) administer a 100 mL fluid bolus.

C) insert a nasopharyngeal airway.

D) obtain a 12-lead electrocardiogram.

Ans: A

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Endocrine Emergencies

Subject: Pediatric Emergencies

Page: 2175

Feedback: Pathophysiology, Assessment, and Management of Endocrine Emergencies, page 2175

172. Rapid IV fluid administration in a child with diabetic ketoacidosis increases the risk of:

A) hemodilution.

B) cerebral edema.

C) hypokalemia.

D) hyperkalemia.

Ans: B

Complexity: Easy

Ahead: Pathophysiology, Assessment, and Management of Endocrine Emergencies

Subject: Pediatric Emergencies

Page: 2175

Feedback: Pathophysiology, Assessment, and Management of Endocrine Emergencies, page 2175