

01	☐ A	☐ B	☐ C	☐ D	☐ E
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37	☒ A	☐ B	☐ C	☐ D	☐ E
38	☐ A	☐ B	☐ C	☒ D	☐ E
39	☒ A	☐ B	☐ C	☐ D	☐ E

PRACTICE QUESTIONS

American Board Of Pediatrics (ABP)

REMER

Pediatric Emergency Medicine (MOC - Subspecialty)

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for American Board Of Pediatrics (ABP) **REMER**, each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, **REMER**
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

QUESTION 1

SINGLE CHOICE

A 4-month-old infant presents with fever, vomiting, and a diffuse petechial rash. Heart rate is 190/min, blood pressure is 60/40 mmHg, and capillary refill is 4 seconds. After two 20 mL/kg boluses of isotonic crystalloid, blood pressure and perfusion have not improved. Which is the most appropriate next step?

- ☐ A Begin a third 20 mL/kg crystalloid bolus
- ☒ B Initiate peripheral inotropic support, such as a dopamine infusion, while securing central access
- ☐ C Perform immediate lumbar puncture to confirm meningitis
- ☐ D Administer 25% dextrose 2 mL/kg IV
- ☐ E Switch to a 10 mL/kg albumin bolus

ANSWER B

WHY After two fluid boluses with persistent signs of shock (fluid-refractory shock), pediatric septic shock guidelines recommend initiating vasoactive/inotropic support early, with peripheral access used to begin dopamine (or epinephrine) while central access is obtained. Continued crystalloid bolusing without inotropy risks fluid overload and delays definitive therapy. Lumbar puncture is contraindicated in an unstable, shocked infant, hypoglycemia has not been demonstrated, and albumin is not a first-line resuscitation fluid.

QUESTION 2

SINGLE CHOICE

Which is the correct pediatric drug dose and concentration for the first dose of intravenous epinephrine in a child with cardiac arrest?

- ☐ A 0.01 mg/kg of 1:1,000 (1 mg/mL) solution, IV/IO
- ☐ B 0.1 mg/kg of 1:1,000 (1 mg/mL) solution, IV/IO
- ☒ C 0.01 mg/kg of 1:10,000 (0.1 mg/mL) solution, IV/IO
- ☐ D 1 mg/kg of 1:10,000 (0.1 mg/mL) solution, IV/IO

ANSWER C

WHY Per PALS guidelines, the IV/IO dose of epinephrine in pediatric cardiac arrest is 0.01 mg/kg (0.1 mL/kg) using the 1:10,000 (0.1 mg/mL) solution. The 1:1,000 concentration is reserved for intramuscular use in anaphylaxis (0.01 mg/kg, max 0.3 mg), not for IV/IO arrest management.

QUESTION 3

SINGLE CHOICE

A 3-year-old child with known congenital heart disease is found unresponsive and pulseless on the monitor showing a narrow-complex tachycardia at 280/min with no palpable output. Cardiopulmonary resuscitation is in progress. What is the first pharmacologic intervention indicated?

- ☐ A Adenosine 0.1 mg/kg rapid IV push
- ☒ B Synchronized cardioversion at 0.5–1 J/kg
- ☐ C Amiodarone 5 mg/kg IV bolus
- ☐ D Epinephrine 0.01 mg/kg (1:10,000) IV/IO
- ☐ E Synchronized cardioversion at 2 J/kg

ANSWER B

WHY An unstable supraventricular tachycardia (SVT) in an infant or child—defined by poor perfusion, altered mental status, or pulselessness—is treated with immediate synchronized cardioversion beginning at 0.5–1 J/kg, escalating to 2 J/kg if unsuccessful. Adenosine is used for hemodynamically stable SVT. Amiodarone is reserved for refractory arrhythmias. Epinephrine is appropriate for asystole/PEA, not for SVT with a pulse (or pseudo-pulseless SVT) where cardioversion is definitive.

QUESTION 4

SINGLE CHOICE

A 6-month-old with bronchiolitis presents with worsening respiratory distress over the past 12 hours. Examination reveals marked intercostal and subcostal retractions, head bobbing, a respiratory rate of 80/min, and SpO₂ of 88% on room air. The infant is intermittently apneic and not consistently arousable. Which is the most appropriate next step in management?

- ☐ A Trial of high-flow nasal cannula in the emergency department with continuous monitoring
- ☒ B Immediate tracheal intubation and mechanical ventilation
- ☐ C Administer racemic epinephrine and observe for 30 minutes
- ☐ D Discharge home with instructions for nasal suctioning
- ☐ E Obtain a chest radiograph and viral respiratory panel before any intervention

ANSWER B

WHY Apnea, severe hypoxemia, and depressed mental status in an infant with bronchiolitis indicate impending respiratory failure and require immediate airway control with tracheal intubation and mechanical ventilation. High-flow nasal cannula is not appropriate for an infant with apnea and altered mental status. Racemic epinephrine is for croup, not bronchiolitis. Discharging such an infant would be dangerous. While imaging may eventually be obtained, securing the airway takes priority.

QUESTION 5

SINGLE CHOICE

For an 8-year-old child undergoing rapid sequence intubation for suspected meningococcal sepsis with severe shock, which induction agent is most appropriate?

- ☐ A Etomidate 0.3 mg/kg IV
- ☒ B Ketamine 1–2 mg/kg IV
- ☐ C Propofol 2 mg/kg IV
- ☐ D Thiopental 4 mg/kg IV
- ☐ E Midazolam 0.3 mg/kg IV as the sole induction agent

ANSWER B

WHY Ketamine is the induction agent of choice for the hemodynamically unstable child because of its sympathomimetic effects that support heart rate and blood pressure, and its preservation of airway reflexes. Etomidate, although hemodynamically neutral, suppresses adrenal steroidogenesis and is generally avoided in pediatric sepsis. Propofol and thiopental cause significant hypotension in shock. Midazolam alone is not adequate as an induction agent.

QUESTION 6

SINGLE CHOICE

A 5-year-old presents with 25 minutes of continuous generalized seizure activity. She has received two doses of IV lorazepam (0.1 mg/kg each) without response. Blood glucose is normal. What is the most appropriate next-line agent?

- ☐ A Repeat IV lorazepam for a third dose
- ☒ B IV fosphenytoin 20 mg phenytoin equivalents/kg
- ☐ C IV phenobarbital 30 mg/kg
- ☐ D IV levetiracetam 60 mg/kg
- ☐ E IV sodium bicarbonate 1 mEq/kg

ANSWER B

WHY After two doses of a benzodiazepine in established status epilepticus, the next-line treatment is a second-line antiepileptic such as fosphenytoin (20 mg PE/kg), levetiracetam (60 mg/kg), or valproate. Fosphenytoin is a well-established second-line agent for convulsive status epilepticus. Repeating lorazepam beyond two doses is generally not recommended because of respiratory depression risk. Phenobarbital is used after fosphenytoin fails. Sodium bicarbonate is not an anticonvulsant.

QUESTION 7

SINGLE CHOICE

A previously healthy 10-year-old struck by a car is brought to the ED. Primary survey reveals a patent airway, decreased breath sounds on the right, and a soft abdomen. A chest radiograph demonstrates a large right-sided pneumothorax with mediastinal shift. What is the most appropriate immediate intervention?

- ☐ A Observe with 100% oxygen and repeat chest film in 1 hour
- ☒ B Needle thoracostomy followed by tube thoracostomy on the right
- ☐ C Bilateral needle thoracostomy as a diagnostic procedure
- ☐ D Pericardiocentesis
- ☐ E Endotracheal intubation alone

ANSWER B

WHY A large pneumothorax with mediastinal shift in a trauma patient represents a tension pneumothorax until proven otherwise and requires immediate needle decompression followed by definitive tube thoracostomy. Observation is inappropriate; pericardiocentesis is for cardiac tamponade; bilateral needle thoracostomy is not indicated for unilateral findings; intubation without chest decompression will worsen the tension physiology.

QUESTION 8

SINGLE CHOICE

A 22-day-old male infant presents with fever to 38.7°C, irritability, and poor feeding. Examination is otherwise unremarkable. Which is the most appropriate management?

- ☐ A Discharge home with close follow-up after a normal complete blood count
- ☐ B Obtain a urinalysis and urine culture only and discharge with oral antibiotics if positive
- ☒ C Obtain blood, urine, and cerebrospinal fluid cultures and begin empiric parenteral antibiotics, admitting to hospital
- ☐ D Observe without antibiotics and recheck in 24 hours
- ☐ E Obtain only a blood culture and begin oral cephalexin

ANSWER C

WHY Neonates ≤ 28 days of age with fever are at significant risk for serious bacterial infection, including bacteremia, urinary tract infection, and meningitis, and commonly have subtle presentations. Standard management includes a full septic workup (blood, urine, and cerebrospinal fluid cultures) and empiric parenteral antimicrobial therapy with hospital admission.

QUESTION 9

SINGLE CHOICE

A 4-year-old is brought to the ED after ingesting an unknown quantity of acetaminophen 4 hours ago. He is asymptomatic. An acetaminophen level is drawn and falls above the Rumack–Matthew nomogram line indicating probable hepatotoxicity at the 4-hour time point. What is the most appropriate next step?

- ☒ **A** Initiate N-acetylcysteine according to a standard treatment nomogram (such as the 21-hour IV protocol)
- ☐ **B** Discharge with activated charcoal and outpatient follow-up
- ☐ **C** Perform gastric lavage and observe
- ☐ **D** Administer vitamin K
- ☐ **E** Initiate hemodialysis immediately

ANSWER A

WHY When the 4-hour acetaminophen concentration is above the treatment line on the Rumack–Matthew nomogram, N-acetylcysteine is indicated to prevent or mitigate hepatic injury. NAC is most effective when started within 8 hours of ingestion and can be given using the Prescott 21-hour IV protocol or the 72-hour oral protocol. Activated charcoal alone is insufficient in this case, lavage is rarely useful at 4 hours, vitamin K is for warfarin, and hemodialysis is not indicated for acetaminophen poisoning unless very severe.