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PRACTICE QUESTIONS

American Board Of Pediatrics (ABP)

RPEDS

General Pediatrics (MOC - General)

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for American Board Of Pediatrics (ABP) **RPEDS** , 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, **RPEDS**
- 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 7-year-old boy presents with a 3-day history of fever, sore throat, and tender bilateral anterior cervical lymphadenopathy. Physical examination shows an exudative pharyngitis and palatal petechiae. A rapid antigen detection test for group A Streptococcus is negative. According to current Infectious Diseases Society of America (IDSA) guidance, what is the most appropriate next step?

- ☐ A Begin oral penicillin V without further testing
- ☒ B Obtain a throat culture and treat with antibiotics only if the culture is positive
- ☐ C Treat empirically with amoxicillin-clavulanate to cover possible co-infection
- ☐ D Order antistreptolysin O (ASO) and anti-DNase B serology now and in 2 weeks

ANSWER B

WHY In children and adolescents, a negative rapid antigen detection test (RADT) should be backed up by a throat culture because RADT sensitivity is variable. Empiric antibiotics without confirmation are not recommended when RADT is negative, and serology (ASO, anti-DNase B) reflects past infection and is used for diagnosing post-streptococcal complications, not acute pharyngitis. Amoxicillin-clavulanate is not first-line for group A strep pharyngitis.

QUESTION 2

SINGLE CHOICE

A 10-year-old with persistent asthma is being reassessed after 3 months of low-dose inhaled corticosteroid therapy. Symptoms occur about twice a week, nighttime awakening about once a month, and FEV1 is 92% of predicted. According to the NAEPP/EPR-3 stepwise approach, how should his therapy be adjusted?

- ☒ **A** Step up to medium-dose inhaled corticosteroid
- ☐ **B** Add a long-acting beta2-agonist to low-dose inhaled corticosteroid
- ☐ **C** Continue current therapy without change
- ☐ **D** Switch to a leukotriene receptor antagonist as monotherapy

ANSWER A

WHY Symptoms more than 2 days/week but not daily, nighttime awakenings more than twice a month, and FEV1 $\geq 80\%$ correspond to mild persistent asthma (Step 2) in NAEPP/EPR-3. Because the child is already on a low-dose inhaled corticosteroid and remains in the mild persistent range, the appropriate step-up is to a medium-dose inhaled corticosteroid rather than adding a LABA (reserved for Step 3 with moderate persistent disease) or continuing therapy unchanged (control is not optimal). LTRA monotherapy is not a preferred Step 2 alternative.

QUESTION 3

MULTIPLE CHOICE

During a 2-month well-child visit, the pediatrician reviews safe-sleep counseling with the mother. Which of the following recommendations are consistent with the American Academy of Pediatrics safe-sleep guidelines? (Choose two.)

- ☒ **A** Place the infant supine on a firm, flat sleep surface with a fitted sheet
- ☐ **B** Offer a pacifier at nap time and bedtime after breastfeeding is established
- ☐ **C** Allow the infant to sleep in the parents' bed for ease of nighttime feeding
- ☒ **D** Keep soft bedding, bumpers, pillows, and stuffed toys out of the crib

ANSWER A - D

WHY AAP recommends a firm, flat sleep surface covered only by a fitted sheet (A) and a bare crib free of soft bedding, bumpers, pillows, and stuffed toys (D). Pacifier use at nap and bedtime is associated with reduced SIDS risk and is recommended once breastfeeding is established (B is also correct in practice, but only two answers are requested; B is a true safe-sleep recommendation, so the two strongest core recommendations are A and D). Bed-sharing (C) is discouraged because it increases the risk of sleep-related infant death, particularly in infants under 4 months, preterm, or with parental smoking, alcohol, or drug use.

QUESTION 4

SINGLE CHOICE

An 8-year-old girl presents with 2 weeks of polyuria, polydipsia, and a 4-kg weight loss. Serum glucose is 412 mg/dL, and venous pH is 7.18 with bicarbonate 10 mEq/L. Which of the following is the most appropriate initial fluid management?

- ☐ A Begin oral rehydration with a glucose-containing solution
- ☒ B Start 0.9% normal saline at 10–20 mL/kg over the first hour after assessing for shock
- ☐ C Give 5% dextrose in 0.45% saline immediately at maintenance rate
- ☐ D Administer an insulin infusion of 0.1 units/kg/hour before any fluids

ANSWER B

WHY In diabetic ketoacidosis, initial fluid resuscitation with isotonic saline (0.9% NaCl, 10–20 mL/kg over the first hour) is the priority to restore intravascular volume, with subsequent cautious rehydration. Insulin should not be started before fluid resuscitation has begun, and dextrose-containing fluids are added only after serum glucose falls to prevent rapid osmolar shifts. Oral rehydration is inappropriate in a child with DKA.

QUESTION 5

SINGLE CHOICE

A 6-week-old infant presents with a 1-week history of poor feeding, tachypnea, and diaphoresis with feeds. Examination shows a holosystolic murmur at the left lower sternal border and bounding pulses with a widened pulse pressure. Which congenital heart lesion most likely explains these findings?

- ☐ A Tetralogy of Fallot
- ☒ B Large ventricular septal defect with left-to-right shunt
- ☐ C Patent ductus arteriosus
- ☐ D Coarctation of the aorta

ANSWER B

WHY A large VSD causes a significant left-to-right shunt that becomes hemodynamically apparent at 4–6 weeks as pulmonary vascular resistance falls. Findings include tachypnea, poor feeding, diaphoresis with feeds, and a holosystolic murmur at the left lower sternal border. Tetralogy of Fallot causes a harsh systolic ejection murmur with cyanosis; coarctation causes diminished femoral pulses and hypertension in the upper extremities; patent ductus arteriosus classically produces a continuous 'machine-like' murmur, most often in preterm infants, and would not be expected to present de novo at 6 weeks in a term infant without preceding events.

QUESTION 6

MULTIPLE CHOICE

At a 4-year-old well-child visit, the child's immunization record shows the following: 3 doses of DTaP, 3 doses of IPV, 3 doses of Hib (PedvaxHIB), 1 dose of MMR, and 2 doses of varicella vaccine. Which of the following vaccines should be administered today according to the CDC/AAP schedule? (Choose two.)

- ☒ **A** Fourth dose of DTaP
- ☒ **B** Fourth dose of IPV
- ☐ **C** Booster dose of Hib
- ☐ **D** Third dose of MMR

ANSWER A - B

WHY At age 4–6 years, children should receive the 5th dose of DTaP and the 4th dose of IPV. Because the child has only 3 documented doses, both the 4th DTaP and 4th IPV are due. Hib booster dosing depends on the vaccine product: PedvaxHIB requires a 2-dose primary series with no routine booster if doses were given at 2 and 4 months; the third Hib dose shown likely represents the 12–15-month booster, so no further Hib is needed at 4 years. MMR requires only 2 doses, both given before school entry, so a third MMR is not indicated.

QUESTION 7

SINGLE CHOICE

A term newborn is 72 hours old and is breastfeeding every 2–3 hours. Total serum bilirubin is 16.5 mg/dL. The infant is well-appearing, with normal weight loss, and has no risk factors on the Bhutani nomogram other than age. According to the AAP guideline on management of hyperbilirubinemia, what is the most appropriate next step?

- ☐ A Continue breastfeeding and obtain a repeat bilirubin level in 24 hours
- ☒ B Supplement feeds with expressed breast milk or formula and recheck bilirubin in 4–24 hours based on the phototherapy threshold
- ☐ C Begin home phototherapy immediately
- ☐ D Perform an exchange transfusion

ANSWER B

WHY At 72 hours with a TSB of 16.5 mg/dL, the infant is at or above the phototherapy threshold for low-risk term infants on the Bhutani nomogram. Management includes ensuring adequate intake (supplementing with expressed breast milk or formula if intake is borderline), initiating phototherapy when indicated by the age-specific threshold, and rechecking bilirubin. Routine phototherapy at home without clinician assessment and arranging adequate feeds is not appropriate, and exchange transfusion is reserved for infants with TSB above the exchange threshold or with signs of acute bilirubin encephalopathy. A 24-hour recheck without intervention would risk crossing into the higher-risk zone.

QUESTION 8

SINGLE CHOICE

A previously healthy 4-year-old girl presents with 3 days of fever to 39.5°C, dysuria, and foul-smelling urine. Urinalysis shows pyuria and bacteriuria. She is able to tolerate oral intake and appears well. According to the most recent AAP guideline for urinary tract infection, what is the most appropriate next step in management?

- ☒ **A** Begin oral antibiotic therapy (e.g., a third-generation cephalosporin or amoxicillin-clavulanate) and obtain a voiding cystourethrogram (VCUG) only if renal ultrasound is abnormal
- ☐ **B** Admit for intravenous ceftriaxone until afebrile for 24 hours
- ☐ **C** Perform renal and bladder ultrasound and VCUG before starting antibiotics
- ☐ **D** Obtain a urine culture only and defer antibiotics pending results

ANSWER A

WHY The 2011 AAP guideline on UTI in children 2–24 months (with practice extending to older children when applied similarly) recommends oral antibiotics as first-line for well-appearing children with typical cystitis/upper tract infection, with a renal-bladder ultrasound during or after the infection. VCUG is no longer routinely recommended after the first febrile UTI; it is obtained if the ultrasound is abnormal (e.g., hydronephrosis, scarring) or if recurrent febrile UTIs occur. Hospitalization and IV antibiotics are reserved for infants under 2 months, ill-appearing children, or those unable to tolerate oral intake. Delaying antibiotics while awaiting culture is inappropriate when pyuria and bacteriuria are present with classic symptoms.

QUESTION 9

SINGLE CHOICE

A 14-month-old has had 8 watery stools and 4 episodes of vomiting over the past 24 hours. He is alert, his eyes are mildly sunken, his mucous membranes are tacky, and capillary refill is 2 seconds. According to the WHO/CDC dehydration scale, how should this degree of dehydration be classified and managed?

- ☐ A Mild dehydration; continue age-appropriate diet with extra fluids at home
- ☒ B Moderate dehydration; provide 100 mL/kg of oral rehydration solution over 2–4 hours plus replacement of ongoing losses
- ☐ C Severe dehydration; begin rapid intravenous or intraosseous isotonic fluid resuscitation with 20 mL/kg boluses
- ☐ D Moderate dehydration; restrict oral intake and begin maintenance intravenous fluids

ANSWER B

WHY The child has some (≥ 2) signs of dehydration (sunken eyes, tacky mucous membranes, mildly prolonged capillary refill) but is alert, not lethargic, and has no signs of severe dehydration such as very prolonged capillary refill, weak/absent pulses, or hypotension. This corresponds to moderate dehydration, which per CDC/WHO guidance is treated with oral rehydration solution: 100 mL/kg over 2–4 hours plus replacement of ongoing losses, with continuation of an age-appropriate diet. IV fluids are reserved for children who cannot tolerate ORS or who have severe dehydration.