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PRACTICE QUESTIONS

Dubai Health Authority (DHA)

PEDS

Specialist Pediatrics

Uploaded by Community B

EDITION

Original Demo

QUESTIONS

8

ISSUED

October 14, 2026

Before you begin

What this is

8 practice questions for Dubai Health Authority (DHA) PEDS , 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, PEDS
- the question number
- the email address on your order

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

Licence

Free Mometrix practice demo. The complete question bank is available through a paid account.

QUESTION 1

MULTIPLE CHOICE

Which of the following are evidence-supported components of routine management for an otherwise healthy 4-month-old with mild-to-moderate acute viral bronchiolitis? (Choose two.)

- ☒ **A Nasal suctioning with saline drops**
- ☐ **B Nebulized hypertonic (3%) saline**
- ☐ **C Routine systemic corticosteroids**
- ☒ **D Maintaining adequate hydration and small frequent feeds**

ANSWER A - D

WHY Supportive care is the cornerstone: nasal saline drops and suctioning, adequate hydration, and oxygen supplementation when SpO₂ <90%. Routine systemic corticosteroids are NOT recommended. Nebulized hypertonic saline is reserved for hospitalized infants, not for routine outpatient management of mild-to-moderate disease.

QUESTION 2

MULTIPLE CHOICE

Which of the following are recommended routine screening components at a 4-year-old well-child visit according to standard pediatric preventive care guidelines? (Choose two.)

- ☒ **A Vision and hearing screening**
- ☐ **B Annual fasting lipid profile in all children regardless of risk**
- ☒ **C Developmental and behavioral screening (e.g., using a standardized tool such as ASQ or PEDS)**
- ☐ **D Universal screening for celiac disease in the general population**

ANSWER A - C

WHY Vision and hearing screening are recommended at multiple well-child visits including age 4, and standardized developmental/behavioral screening (e.g., ASQ, PEDS) is recommended. Universal fasting lipid screening is not recommended at age 4; selective screening based on risk factors is performed once between ages 9-11 and again at 17-21. Universal screening for celiac disease is not recommended in low-risk children in most guidelines.

QUESTION 3 SINGLE CHOICE

An 8-year-old with persistent asthma is currently using a low-dose inhaled corticosteroid (ICS) plus a SABA as needed, but continues to have daytime symptoms more than twice weekly and one nighttime awakening per week. According to GINA stepwise management, what is the next appropriate step?

- ☐ A Discontinue the inhaled corticosteroid and continue SABA only
- ☒ B Increase to low-dose ICS-formoterol as MART (maintenance and reliever therapy)
- ☐ C Add a leukotriene receptor antagonist only
- ☐ D Refer immediately for oral corticosteroid burst without controller adjustment

ANSWER B

WHY When symptoms are not controlled on low-dose ICS plus as-needed SABA (Step 2), GINA recommends stepping up to low-dose ICS-formoterol as MART (Step 3) as the preferred controller/reliever approach. Discontinuing ICS is contraindicated in persistent asthma. Leukotriene antagonists are an alternative but not the preferred next step, and oral steroid bursts are reserved for acute exacerbations, not routine step-up therapy.

QUESTION 4 SINGLE CHOICE

An 18-month-old presents with a generalized tonic-clonic seizure lasting 4 minutes during a febrile illness (temperature 39.5°C). There is no history of afebrile seizures, and neurological examination is normal. Which is the most appropriate management?

- ☐ A Start phenobarbital maintenance therapy
- ☐ B Start valproic acid maintenance therapy
- ☒ C Reassure; provide anticipatory guidance on febrile seizure recurrence
- ☐ D Start oral phenytoin and arrange EEG

ANSWER C

WHY This is a simple febrile seizure (generalized, <15 minutes, single episode in 24 hours, no focal features, in a child 6 months-5 years with fever). Simple febrile seizures do NOT require daily anticonvulsant therapy. The risk of developing epilepsy is only slightly higher than the baseline population (~1-2%). Parents should be counseled on seizure first aid and recurrence (~30%).

QUESTION 5

SINGLE CHOICE

A 7-year-old girl is evaluated for short stature. Height is 110 cm (-2.5 SDS), weight 20 kg (-1 SDS), and she is at the 25th centile for her mid-parental target height. Examination is normal, including no dysmorphic features and normal upper-to-lower segment ratio. Bone age is delayed by 2 years. Which is the most likely diagnosis?

- ☒ **A** Constitutional growth delay
- ☐ **B** Familial short stature
- ☐ **C** Growth hormone deficiency
- ☐ **D** Turner syndrome
- ☐ **E** Hypothyroidism

ANSWER A

WHY Constitutional growth delay classically presents with normal birth weight, normal growth velocity in childhood but delayed bone age, normal final adult height, and often a family history of 'late bloomers'. The child's height is close to mid-parental target centile, growth velocity is preserved, examination is normal, and bone age is delayed - fitting constitutional growth delay. Familial short stature would have bone age equal to chronological age. Turner syndrome would show features such as webbed neck and would not have bone age significantly delayed without other signs.

QUESTION 6

SINGLE CHOICE

An 8-year-old with known asthma presents with acute severe wheeze, oxygen saturation 88% in room air, and inability to complete sentences. After high-flow oxygen and nebulized salbutamol (which is the most appropriate next systemic medication to give?

- ☐ A Oral montelukast 4 mg
- ☒ B Intravenous magnesium sulfate 25-50 mg/kg over 20 minutes
- ☐ C Oral theophylline 5 mg/kg loading dose
- ☐ D Nebulized sodium cromoglycate

ANSWER B

WHY In acute severe asthma unresponsive to initial inhaled bronchodilators and systemic corticosteroids, intravenous magnesium sulfate (25-50 mg/kg over 20 minutes) is recommended as next-line therapy. Montelukast, theophylline, and cromoglycate are not indicated in acute severe asthma.

QUESTION 7

SINGLE CHOICE

A 9-year-old presents with 2 days of polyuria, polydipsia, and abdominal pain. He is lethargic, Kussmaul breathing is noted, and capillary glucose reads 'HI'. Initial labs: pH 7.08, HCO₃ 7 mmol/L, Na 132 mmol/L, K 5.8 mmol/L. After fluid resuscitation with isotonic saline and starting an insulin infusion at 0.05-0.1 units/kg/hour, which is the next essential step?

- ☒ **A** Add 40 mEq/L of potassium chloride to the maintenance fluids once urine output is documented
- ☐ **B** Begin insulin only after the serum potassium is confirmed >5.5 mmol/L
- ☐ **C** Give intravenous sodium bicarbonate bolus to correct the pH to >7.20
- ☐ **D** Switch immediately to subcutaneous insulin and discontinue the infusion
- ☐ **E** Give an intravenous calcium gluconate bolus

ANSWER A

WHY In pediatric DKA, total body potassium is depleted despite an initially elevated serum potassium, and insulin will drive K⁺ intracellularly, risking dangerous hypokalemia. Once urine output is documented and serum K⁺ is <5.5 mmol/L (or in the low-normal range with adequate urine output), potassium should be added to IV fluids (typically 20-40 mEq/L KCl). Insulin should not be started until potassium is ≥3.3 mmol/L to avoid precipitating hypokalemia. Bicarbonate is generally reserved for severe acidosis (pH <6.9) and is not routine.

QUESTION 8

SINGLE CHOICE

According to GINA 2024 stepwise management, an 8-year-old child with mild persistent asthma (symptoms >2 days/week but not daily, night cough once or twice a month, normal lung function) should be started on which of the following controller therapies?

- ☒ **A** Low-dose inhaled corticosteroid (ICS) taken whenever SABA is needed (ICS-formoterol as needed)
- ☐ **B** High-dose inhaled corticosteroid plus LABA
- ☐ **C** Leukotriene receptor antagonist alone
- ☐ **D** Oral theophylline

ANSWER A

WHY For children ≥ 6 years with mild persistent asthma, GINA 2024 recommends low-dose ICS-formoterol as needed as the preferred controller (Track 1), with low-dose daily ICS plus as-needed SABA as the alternative (Track 2). High-dose ICS/LABA and leukotriene-only regimens are not first-line for mild persistent asthma.