



01	A	B	C	D	E
02	A	B	C	D	E
03	A	B	C	D	E
04	A	B	C	D	E
05	A	B	C	D	E
06	A	B	C	D	E
07	A	B	C	D	E
08	A	B	C	D	E
09	A	B	C	D	E
10	A	B	C	D	E
11	A	B	C	D	E
12	A	B	C	D	E
13	A	B	C	D	E

14	A	B	C	D	E
15	A	B	C	D	E
16	A	B	C	D	E
17	A	B	C	D	E
18	A	B	C	D	E
19	A	B	C	D	E
20	A	B	C	D	E
21	A	B	C	D	E
22	A	B	C	D	E
23	A	B	C	D	E
24	A	B	C	D	E
25	A	B	C	D	E
26	A	B	C	D	E

27	A	B	C	D	E
28	A	B	C	D	E
29	A	B	C	D	E
30	A	B	C	D	E
31	A	B	C	D	E
32	A	B	C	D	E
33	A	B	C	D	E
34	A	B	C	D	E
35	A	B	C	D	E
36	A	B	C	D	E
37	A	B	C	D	E
38	A	B	C	D	E
39	A	B	C	D	E

PRACTICE QUESTIONS

Dubai Health Authority (DHA)

PEDS

Specialist Pediatrics

EDITION

Original Demo

QUESTIONS

15

ISSUED

October 14, 2026

Before you begin

What this is

15 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

Original Mometrix demo. This free sample contains fewer questions than the full paid edition.

QUESTION 1

SINGLE CHOICE

A 4-year-old boy is brought for well-child assessment. His weight is 16 kg, height 98 cm, and head circumference 50 cm. Which growth parameter warrants the most urgent evaluation?

- ☐ A Weight for age
- ☐ B Height for age
- ☒ C Head circumference for age
- ☐ D BMI for age

ANSWER C

WHY Head circumference of 50 cm at age 4 years is well above the 97th percentile (normal is approximately 49 cm at birth with only ~6-7 cm growth in the first year and very little thereafter). Macrocephaly at this age requires urgent evaluation for causes such as hydrocephalus, intracranial mass, or genetic syndromes. Weight (16 kg), height (98 cm), and BMI are all within normal limits for age.

QUESTION 2

SINGLE CHOICE

A 5-day-old term, exclusively breastfed infant is brought in with jaundice. Total serum bilirubin is 17 mg/dL on the day of life 5. According to the Bhutani nomogram, this value lies in which risk zone?

- ☐ A Low-risk zone
- ☐ B Low-intermediate risk zone
- ☒ C High-intermediate risk zone
- ☐ D High-risk zone

ANSWER C

WHY On the Bhutani nomogram, a total serum bilirubin of 17 mg/dL at 5 days of life in a term infant falls within the high-intermediate risk zone, indicating that phototherapy is likely indicated and a closer follow-up with intensive phototherapy or exchange transfusion thresholds should be applied depending on the infant's risk factors.

QUESTION 3

MULTIPLE CHOICE

A 3-year-old girl has had 2 febrile urinary tract infections in the past 6 months. Renal and bladder ultrasound is reported as normal. According to current pediatric nephrology guidelines, which of the following are appropriate next steps? (Choose two.)

- ☐ A Proceed directly to surgical management without further imaging
- ☒ B Perform a voiding cystourethrogram (VCUG) or DMSA scan to assess for vesicoureteric reflux and renal scarring
- ☒ C Initiate low-dose prophylactic antibiotics until imaging results are available, if VUR is suspected
- ☐ D No further imaging or follow-up is required because the ultrasound is normal

ANSWER B • C

WHY After recurrent febrile UTIs in young children, a normal ultrasound does not exclude vesicoureteric reflux (VUR) or renal scarring. Current guidelines recommend a VCUG to detect VUR and/or a DMSA scan to detect renal scarring. Low-dose prophylactic antibiotics (e.g., trimethoprim or nitrofurantoin) are considered while awaiting imaging in selected cases, particularly with high-grade reflux or while awaiting VCUG.

QUESTION 4

MULTIPLE CHOICE

During the PALS initial assessment of an unresponsive 4-year-old child with suspected cardiopulmonary arrest, which of the following are key components of the Primary Assessment (the 'evaluate-identify-intervene' sequence)? (Choose two.)

- ☒ **A** Assessing airway patency and breathing effectiveness
- ☐ **B** Measuring serum lactate
- ☐ **C** Evaluating circulation, including heart rate, blood pressure, and perfusion
- ☐ **D** Performing a focused abdominal ultrasound (FAST scan)
- ☒ **E** Assessing disability using AVPU and pupillary response
- ☐ **F** Calculating a Glasgow Coma Scale every 15 minutes throughout resuscitation

ANSWER A • E

WHY The PALS Primary Assessment follows the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) sequence. Airway patency/breathing effectiveness and disability (AVPU and pupils) are core components. Serum lactate, FAST scan, and scheduled GCS scoring every 15 minutes are not part of the PALS primary assessment framework - GCS is only one element of the 'D' assessment and is not repeated on a fixed schedule during active resuscitation.

QUESTION 5

SINGLE CHOICE

A 4-year-old child presents with chronic non-bloody diarrhea, abdominal distension, and poor weight gain over the past 6 months. Laboratory evaluation shows a positive anti-tissue transglutaminase IgA (anti-tTG IgA) at 10 times the upper limit of normal, with normal total IgA. Which of the following is the most appropriate next step in management?

- ☐ A Start a trial of lactose-free diet and reassess in 4 weeks
- ☒ B Refer for upper gastrointestinal endoscopy with duodenal biopsy to confirm the diagnosis
- ☐ C Initiate a gluten-free diet without further testing
- ☐ D Repeat the serology in 6 months to confirm persistence before acting
- ☐ E Order HLA-DQ2/DQ8 typing to confirm genetic susceptibility

ANSWER B

WHY According to current pediatric gastroenterology guidance (ESPGHAN 2012 and subsequent updates), a diagnosis of celiac disease can be made without biopsy in symptomatic children who have anti-tTG IgA levels >10 times the upper limit of normal AND a positive endomysial antibody (EMA) on a separate sample, performed on a gluten-containing diet. Because only anti-tTG has been obtained here, the next step to confirm the diagnosis before committing the child to lifelong gluten exclusion is referral for upper GI endoscopy with duodenal biopsies. Starting a gluten-free diet without histologic confirmation risks misdiagnosis and lifelong unnecessary dietary restriction. Lactose-free diet does not address the suspected underlying cause. HLA typing is reserved for selected equivocal cases, not as a confirmatory next step.

QUESTION 6

SINGLE CHOICE

A 14-month-old previously healthy child has pallor. CBC: Hb 8.2 g/dL, MCV 58 fL, MCH 19 pg, RBC $4.5 \times 10^{12}/L$, RDW 18%, ferritin 8 ng/mL, and normal hemoglobin electrophoresis. Which is the most appropriate oral iron therapy?

- ☒ **A** Ferrous sulfate 3-6 mg/kg/day of elemental iron in divided doses
- ☐ **B** Iron polymaltose complex 1 mg/kg/day once daily
- ☐ **C** Iron sucrose infusion 5 mg/kg single dose
- ☐ **D** Ferrous sulfate 1 mg/kg/day elemental iron once weekly

ANSWER A

WHY The lab profile is diagnostic of iron deficiency anemia. Standard treatment is 3-6 mg/kg/day of elemental iron in 2-3 divided doses. Intermittent dosing is less effective. Parenteral iron is reserved for intolerance to oral iron or malabsorption. The reticulocyte count should rise within 1 week, and Hb should normalize within 1-2 months; therapy continues for 2-3 months after Hb normalizes to replete stores.

QUESTION 7

SINGLE CHOICE

During PALS management of an infant with severe symptomatic bradycardia (HR 50/min) and poor perfusion despite adequate oxygenation and ventilation, the next pharmacologic intervention is:

- ☐ **A** Atropine 0.02 mg/kg IV
- ☒ **B** Adrenaline (epinephrine) 0.01 mg/kg IV (1:10,000)
- ☐ **C** Adenosine 0.1 mg/kg IV rapid push
- ☐ **D** Synchronized cardioversion at 1 J/kg

ANSWER B

WHY In PALS, if symptomatic bradycardia persists despite effective oxygenation and ventilation, the first-line drug is epinephrine 0.01 mg/kg IV (1:10,000). Atropine is recommended only for bradycardia due to vagal stimulation or cholinergic toxicity, and cardioversion is not used for bradycardia.

QUESTION 8

SINGLE CHOICE

A 14-month-old has 4 days of vomiting and watery diarrhea. He is alert, eyes are not sunken, mouth is moist, skin pinch goes back quickly, and he is drinking well. According to WHO/IMCI dehydration classification, his dehydration status is:

- ☐ A Severe dehydration
- ☐ B Some dehydration (moderate)
- ☒ C No dehydration
- ☐ D Hypernatremic dehydration

ANSWER C

WHY IMCI classification requires ≥ 2 signs in a category. With alert mental status, eyes not sunken, moist mouth, normal skin pinch, and good drinking, this child has NO signs of dehydration and is therefore classified as 'no dehydration.' Management is treatment Plan A: continued feeding plus ORS at home.

QUESTION 9

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 10

SINGLE CHOICE

A 14-month-old child presents with 4 days of vomiting and diarrhea. He is lethargic, has very sunken eyes, a very dry mouth, and a capillary refill of 4 seconds. According to WHO/IMCI classification, what is the severity of dehydration and the recommended rehydration approach?

- ☐ A Some dehydration; give oral rehydration solution over 4 hours
- ☒ B Severe dehydration; begin rapid intravenous rehydration with isotonic fluid
- ☐ C Severe dehydration; give oral rehydration solution by nasogastric tube
- ☐ D No dehydration; continue oral fluids at home

ANSWER B

WHY Lethargy, very sunken eyes, very dry mouth, and delayed capillary refill (>3 seconds) meet IMCI criteria for severe dehydration. The recommended treatment is urgent rapid intravenous rehydration with isotonic crystalloid, starting with 30 ml/kg in the first hour for infants, followed by 70 ml/kg over the next 5 hours. ORS (oral or NG) is reserved for patients who can drink and do not require urgent IV access.

QUESTION 11

MULTIPLE CHOICE

Which of the following are recognized concerning features ('red flags') that should raise suspicion of non-accidental injury in a child presenting with trauma? (Choose two.)

- ☐ A A history of the injury that is inconsistent with the child's developmental stage
- ☒ B Pattern bruises (such as loop marks or fingertip bruising) on protected areas of the body
- ☒ C A spiral femur fracture in a 9-month-old who reportedly 'rolled off the bed'
- ☐ D A single supracondylar fracture of the humerus after a fall onto an outstretched hand in a 7-year-old

ANSWER B - C

WHY Pattern bruises on protected areas (buttocks, back, ears) and a spiral femoral fracture in a pre-walking infant with an inconsistent history are classic red flags for non-accidental injury. A history inconsistent with developmental stage is a red flag, but a single supracondylar fracture from a fall on an outstretched hand in a 7-year-old is a typical accidental injury.

QUESTION 12

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.

QUESTION 13

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 $\text{SpO}_2 < 90\%$. 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 14

SINGLE CHOICE

A 10-year-old presents with new-onset polyuria, polydipsia, weight loss, Kussmaul breathing, and dehydration. pH 7.10, bicarbonate 7 mmol/L, blood glucose 28 mmol/L. According to current pediatric DKA guidelines, which is the most appropriate initial fluid management?

- ☒ **A** Bolus 20 mL/kg of 0.9% saline rapidly over the first hour, then continue isotonic fluids with deficit replacement over 24-48 hours, avoiding rapid falls in serum osmolality to reduce cerebral edema risk
- ☐ **B** Give 5% dextrose immediately as the first fluid
- ☐ **C** Give 3% hypertonic saline as the initial bolus
- ☐ **D** No fluids until blood glucose normalizes

ANSWER A

WHY Current pediatric DKA guidelines (ISPAD and PALS-aligned) recommend cautious isotonic fluid resuscitation—typically 10-20 mL/kg isotonic saline bolus over 1 hour—followed by gradual replacement of deficit over 24-48 hours to avoid rapid osmolar shifts that precipitate cerebral edema. Dextrose is added once blood glucose falls to ~250-300 mg/dL (~14-17 mmol/L). Hypertonic saline is reserved for established cerebral edema.

QUESTION 15

SINGLE CHOICE

A previously healthy 6-year-old boy is brought in following a first generalized tonic-clonic seizure that lasted 3 minutes. He has fully recovered and neurological examination is normal. His parents are very anxious. According to standard pediatric practice, the most appropriate next step is:

- ☐ A Start maintenance phenytoin immediately
- ☐ B Start maintenance valproic acid immediately
- ☒ C Counsel the family, arrange EEG and neuroimaging, and start an antipyretic regimen if febrile; do not start daily anticonvulsants after a first unprovoked seizure without risk factors
- ☐ D Perform an emergency craniotomy

ANSWER C

WHY After a first unprovoked afebrile seizure in a developmentally normal child with normal examination, daily anticonvulsants are generally not started; the recurrence risk is ~40-50% and benefits of treatment are small. Standard practice is parental counseling, EEG, MRI brain, and follow-up. Anticonvulsants are reserved for recurrent seizures, status epilepticus, or specific syndromes. Craniotomy has no role without a mass lesion.