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PRACTICE QUESTIONS

Ministry of Health Kuwait Medical Licensing Department

PEDS

Pediatrics For Registrar

EDITION

Original Demo

QUESTIONS

15

ISSUED

October 14, 2026

Before you begin

What this is

15 practice questions for Ministry of Health Kuwait Medical Licensing Department **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 5-year-old child develops pallor, oliguria, and edema 1 week after an episode of bloody diarrhea. Laboratory findings include hemoglobin 7.2 g/dL, platelet count 45,000/ μ L, blood urea nitrogen 65 mg/dL, and serum creatinine 3.8 mg/dL. Peripheral smear shows fragmented red blood cells. Which is the most appropriate first-line treatment for the renal complications?

- ☐ A High-dose intravenous methylprednisolone
- ☐ B Plasma exchange (plasmapheresis)
- ☒ C Supportive care with meticulous fluid, electrolyte, and blood pressure management, including dialysis if needed
- ☐ D Eculizumab (anti-C5 monoclonal antibody) as first-line therapy

ANSWER C

WHY This child has typical (diarrhea-associated, Shiga toxin-producing *E. coli*) hemolytic uremic syndrome (HUS). The cornerstone of management is supportive care: careful fluid and electrolyte management, antihypertensive therapy when needed, red cell transfusions for severe anemia, and dialysis for severe AKI, electrolyte derangement, or fluid overload. Antibiotics in STEC infection, antiplatelet agents, and steroids are not beneficial. Plasma exchange is not routinely indicated in typical HUS. Eculizumab is reserved for atypical (complement-mediated) HUS, not typical post-diarrheal HUS.

QUESTION 2

SINGLE CHOICE

According to current GINA-based pediatric asthma guidelines, for a child aged 6-11 years with moderate persistent asthma who remains uncontrolled on low-dose inhaled corticosteroid (ICS) plus as-needed SABA, what is the preferred step-up therapy?

- ☐ A Switch to a leukotriene receptor antagonist alone
- ☒ B Add a long-acting β_2 -agonist (LABA) to the low-dose ICS (low-dose ICS-formoterol as maintenance and reliever)
- ☐ C Double the dose of the low-dose ICS only
- ☐ D Add oral theophylline to the low-dose ICS

ANSWER B

WHY Current GINA-based guidance for children 6-11 years old who are uncontrolled on low-dose ICS recommends either increasing the ICS dose (preferred over LABA in some age groups) or adding a long-acting β_2 -agonist (LABA). For step 3, the preferred controller is low-dose ICS plus LABA, with low-dose ICS-formoterol as the maintenance and reliever regimen, which is now the preferred GINA approach to reduce severe exacerbations. Leukotriene receptor antagonists and oral theophylline are alternative, not preferred, add-on options.

QUESTION 3

SINGLE CHOICE

A 9-year-old boy with known asthma is brought to the emergency department with acute shortness of breath. He is unable to complete sentences, has marked intercostal and subcostal retractions, and oxygen saturation is 88% on room air. Which is the most appropriate immediate therapy?

- ☐ A Oral montelukast and oral prednisolone
- ☒ B Inhaled short-acting beta-2 agonist (salbutamol) via nebulizer with ipratropium bromide and systemic corticosteroids
- ☐ C Inhaled corticosteroids only
- ☐ D Intramuscular adrenaline (epinephrine)

ANSWER B

WHY This child has a severe acute asthma exacerbation. The first-line treatment is repeated doses of nebulized short-acting beta-2 agonists (salbutamol) combined with ipratropium bromide (anticholinergic) in severe cases, plus systemic corticosteroids (oral or IV). Oxygen supplementation should be given to maintain SpO₂ ≥ 92-94%. IM adrenaline is reserved for anaphylaxis, not asthma. Inhaled corticosteroids alone are inadequate in an acute severe exacerbation, and oral montelukast has no role in acute treatment.

QUESTION 4

SINGLE CHOICE

A 4-year-old child has a positive tuberculin skin test (TST) with 16 mm of induration. He is asymptomatic with a normal chest radiograph and no exposure to a known active TB case. Which is the most appropriate next step?

- ☐ **A** Full anti-tubercular therapy with 4 drugs (HRZE) for 2 months followed by HR for 4 months
- ☒ **B** Isoniazid monotherapy for 9 months (or isoniazid plus rifampin for 3 months) as treatment of latent TB infection
- ☐ **C** No treatment is required; repeat TST in 6 months
- ☐ **D** Start isoniazid, rifampin, pyrazinamide, and ethambutol and isolate the child until sputum cultures are negative

ANSWER B

WHY This child has latent tuberculosis infection (LTBI) - positive TST, asymptomatic, normal chest X-ray, and no evidence of active disease. The standard treatment for LTBI in children is isoniazid monotherapy for 9 months (preferred) or 6 months, or alternatively rifampin alone for 4 months, or isoniazid plus rifampin for 3 months. The 4-drug regimen (HRZE) is reserved for active TB disease, which has not been demonstrated here. Withholding treatment risks progression to active disease.

QUESTION 5

MULTIPLE CHOICE

A 2-month-old previously healthy infant is admitted with bronchiolitis due to respiratory syncytial virus (RSV). He has mild intercostal retractions, RR 55/min, SpO₂ 93% on room air, and is feeding 60% of usual volume by bottle. Which of the following are appropriate components of supportive care? (Choose two.)

- ☒ **A** Supplemental oxygen to maintain SpO₂ ≥ 90%
- ☐ **B** Routine nebulized hypertonic saline every 4 hours
- ☒ **C** Nasal suctioning to clear secretions before feeds
- ☐ **D** Empirical broad-spectrum intravenous antibiotics

ANSWER A - C

WHY Supportive care for hospitalized infants with bronchiolitis includes supplemental oxygen to maintain SpO₂ ≥ 90% and nasal suctioning to clear secretions that can obstruct breathing and feeding. Routine nebulized hypertonic saline in hospitalized infants with bronchiolitis has not consistently shortened length of stay and is not a universally recommended supportive measure in current guidance. Empirical broad-spectrum antibiotics are not indicated unless there is evidence of a secondary bacterial infection (e.g., concurrent acute otitis media or pneumonia).

QUESTION 6

SINGLE CHOICE

A 7-year-old is brought to the ER with generalized tonic-clonic seizure ongoing for 25 minutes. What is the first-line parenteral benzodiazepine according to standard pediatric emergency protocols?

- ☐ **A** Phenytoin
- ☒ **B** Diazepam (IV/rectal)
- ☐ **C** Phenobarbital
- ☐ **D** Levetiracetam

ANSWER B

WHY The first-line treatment for status epilepticus is a benzodiazepine (IV lorazepam or IV/rectal diazepam) given within the first 5-10 minutes. Phenytoin, phenobarbital, and levetiracetam are second-line agents used if seizures persist.

QUESTION 7

SINGLE CHOICE

A 14-month-old child with acute watery diarrhea has SOME dehydration (WHO Plan B). According to WHO/IMCI recommendations, what is the correct volume of ORS to be given over the first 4 hours?

- ☐ A 200 ml
- ☐ B 400 ml
- ☒ C 600 ml
- ☐ D 1000 ml

ANSWER C

WHY According to WHO/IMCI guidelines for children with some dehydration (Plan B), the recommended volume of ORS over the first 4 hours is approximately 75 ml/kg. For a 14-month-old child weighing about 8 kg, this equates to roughly 600 ml. The correct answer is 600 ml.

QUESTION 8

MULTIPLE CHOICE

A 5-day-old term, exclusively breastfed infant is brought because of jaundice. The infant is feeding well, has normal stooling, and the examination is unremarkable. Total serum bilirubin is 14 mg/dL. Which of the following are appropriate components of management? (Choose two.)

- ☒ **A** Continue breastfeeding and monitor
- ☐ **B** Stop breastfeeding permanently and switch to formula
- ☒ **C** Perform a direct (conjugated) bilirubin measurement
- ☐ **D** Initiate triple-exchange transfusion
- ☐ **E** Recommend phototherapy only if conjugated bilirubin exceeds 2 mg/dL

ANSWER A - C

WHY In a well-appearing, well-feeding term breastfed infant at day 5, a total bilirubin of 14 mg/dL is in the low-intermediate risk zone on the Bhutani nomogram and generally requires continuation of breastfeeding with close monitoring rather than cessation. Measuring the direct (conjugated) fraction is appropriate to rule out cholestasis/conjugated hyperbilirubinemia, which would prompt a different workup. Stopping breastfeeding permanently is not indicated, exchange transfusion thresholds are far higher (typically >25 mg/dL in term infants without risk factors), and the decision to start phototherapy is based on the total serum bilirubin plotted against age in hours on the Bhutani/AAP nomogram, not on the conjugated fraction alone.

QUESTION 9

SINGLE CHOICE

According to current GINA-based pediatric asthma guidelines, for a child aged 6-11 years with moderate persistent asthma (Step 3), the preferred maintenance treatment is:

- ☐ A Low-dose inhaled corticosteroid (ICS) taken as needed with a SABA
- ☐ B Low-dose inhaled corticosteroid-formoterol combination taken as needed (MART)
- ☐ C Low-dose inhaled corticosteroid plus leukotriene receptor antagonist daily
- ☒ D **Medium-dose inhaled corticosteroid-formoterol combination as maintenance and reliever therapy (MART)**
- ☐ E High-dose inhaled corticosteroid with a long-acting beta-agonist and oral steroids

ANSWER D

WHY GINA Step 3 for children 6-11 years with moderate persistent asthma prefers either low-dose ICS-formoterol as MART OR medium-dose ICS-formoterol as MART as the preferred controller/reliever strategy, with medium-dose MART being the widely endorsed preferred regimen at this severity. Step 1 (low-dose ICS-formoterol PRN) is for mild intermittent disease, and high-dose ICS+LABA plus oral steroids is reserved for severe asthma (Steps 4-5).

QUESTION 10

SINGLE CHOICE

An 11-year-old girl with new-onset type 1 diabetes mellitus presents with Kussmaul respirations, abdominal pain, and dehydration. Initial labs: glucose 480 mg/dL, pH 7.10, HCO₃ 8 mEq/L, Na 130 mEq/L, K 5.5 mEq/L. What is the most appropriate initial fluid and insulin management?

- ☒ **A** Begin 0.9% saline bolus (10-20 mL/kg), then start insulin infusion at 0.1 U/kg/hour
- ☐ **B** Begin 5% dextrose in 0.45% saline immediately, then start insulin infusion
- ☐ **C** Give insulin bolus of 0.1 U/kg IV, then start 5% dextrose
- ☐ **D** Start insulin infusion at 0.1 U/kg/hour with no initial fluid bolus

ANSWER A

WHY Pediatric DKA management emphasizes cautious fluid resuscitation and insulin infusion WITHOUT an initial bolus. Initial step is isotonic saline (10-20 mL/kg bolus) to restore circulation, followed by continued fluid replacement. Insulin infusion is started at 0.05-0.1 U/kg/hour AFTER initial fluids have begun (typically 1 hour after starting fluids). Bolus insulin is NOT recommended in children due to risk of cerebral edema. Dextrose is added when blood glucose falls to ~250-300 mg/dL.

QUESTION 11

MULTIPLE CHOICE

A 10-month-old infant has acute watery diarrhea without blood. He is alert, has good skin turgor, normal eyes, and drinks eagerly when offered ORS. Which of the following are appropriate components of management? (Choose two.)

- ☒ **A** Administer oral rehydration solution (ORS) over 4 hours according to the WHO deficit plan for mild dehydration
- ☐ **B** Prescribe loperamide to shorten the duration of diarrhea
- ☒ **C** Continue age-appropriate feeding including breastfeeding throughout rehydration
- ☐ **D** Admit for intravenous fluids regardless of clinical status
- ☐ **E** Routine prescription of a 7-day course of oral ciprofloxacin

ANSWER A - C

WHY For an infant with mild dehydration due to acute gastroenteritis, WHO/UNICEF guidelines recommend oral rehydration using ORS over 4 hours, with resumption of normal feeding (including continued breastfeeding) immediately. Antimotility agents like loperamide are contraindicated in young children because of the risk of ileus and bacterial sepsis. Empirical antibiotics (including ciprofloxacin) are not indicated for routine acute watery diarrhea. IV fluids are reserved for infants with severe dehydration, persistent vomiting, or shock.

QUESTION 12

SINGLE CHOICE

A 6-week-old infant presents with poor feeding, tachypnea, and failure to thrive. Examination reveals a holosystolic murmur at the left lower sternal border and a bounding pulse with a wide pulse pressure. The most likely diagnosis is:

- ☐ A Tetralogy of Fallot
- ☒ B Ventricular septal defect with significant left-to-right shunt
- ☐ C Coarctation of the aorta
- ☐ D Total anomalous pulmonary venous return

ANSWER B

WHY Presentation at 6 weeks (when pulmonary vascular resistance has fallen) with tachypnea, poor feeding, failure to thrive, a holosystolic murmur at the left lower sternal border, and bounding pulses with wide pulse pressure is classic for a moderate-to-large VSD with significant left-to-right shunt causing increased pulmonary blood flow. Tetralogy typically has a systolic ejection murmur; coarctation shows differential pulses and BP; TAPVR presents with cyanosis in the neonatal period.

QUESTION 13

SINGLE CHOICE

A 4-year-old child born in a high TB-prevalence country has a positive tuberculin skin test (TST) with 14 mm of induration. He is asymptomatic with a normal chest radiograph and no risk factors for progression other than age. What is the most appropriate management?

- ☐ A Observe and repeat the TST in 6 months
- ☐ B Treat for active TB with 4-drug therapy (HRZE) for 2 months followed by HR for 4 months
- ☒ C Treat for latent TB infection (LTBI) with isoniazid and rifampin for 3 months
- ☐ D No treatment required because the TST induration is below the 15 mm threshold

ANSWER C

WHY A 4-year-old with a TST induration of 10 mm or more (in a child who is otherwise well, BCG-vaccinated, or from a high-prevalence country) is considered positive and, with a normal chest radiograph and no symptoms, is diagnosed with latent TB infection. The preferred LTBI regimen in children is 3 months of isoniazid plus rifampin (3HR). Treating active TB with 4 drugs is reserved for confirmed/suspected active disease. Observation alone risks progression to active TB, particularly in young children. The 15 mm threshold applies to children with no risk factors; 10 mm applies to children with risk factors including age < 5 years or recent immigration from a high-prevalence area.

QUESTION 14

SINGLE CHOICE

A 2-year-old previously healthy child presents with pallor. Hemoglobin is 8.5 g/dL, MCV is 64 fL, MCH is low, and the red cell distribution width (RDW) is elevated. Ferritin is low. The first-line treatment is:

- ☐ A Packed red blood cell transfusion
- ☒ B Oral ferrous sulfate 3-6 mg/kg/day of elemental iron in divided doses
- ☐ C Intramuscular iron dextran injection weekly
- ☐ D Folic acid 1 mg daily
- ☐ E Vitamin B12 injections monthly

ANSWER B

WHY The laboratory picture (microcytic, hypochromic anemia with elevated RDW and low ferritin) is classic for iron-deficiency anemia in a toddler, typically due to excessive cow's milk intake. First-line therapy is oral elemental iron 3-6 mg/kg/day divided in 2-3 doses. Reticulocytosis is expected within 5-7 days. Transfusion is reserved for severe symptomatic anemia or hemoglobin <4-5 g/dL. IM iron carries the risk of anaphylaxis and is rarely indicated. Folate and B12 deficiency produce macrocytic, not microcytic, anemia.

QUESTION 15

MULTIPLE CHOICE

A 10-month-old infant presents with 3 days of acute watery diarrhea without blood. He is alert, has good skin turgor, normal eyes, drinks eagerly, and has no sunken fontanelle. Per WHO/IMCI, which of the following are appropriate components of management? (Choose two.)

- ☒ **A** Oral rehydration solution (ORS) 75 mL/kg over 4 hours
- ☐ **B** Routine empirical antibiotics such as ciprofloxacin
- ☐ **C** Zinc supplementation 20 mg/day for 10 days
- ☒ **D** Continued feeding with age-appropriate diet including breast milk

ANSWER A - D

WHY Per WHO/IMCI, an infant with some dehydration is classified as 'some dehydration' (Plan B) and is treated with ORS 75 mL/kg over 4 hours (in infants) along with continued age-appropriate feeding, including breastfeeding. Zinc 20 mg/day for 10-14 days is recommended for children with acute diarrhea in countries with high prevalence of zinc deficiency, though it is particularly emphasized in children under 5 with diarrhea in low-resource settings. Empirical antibiotics are not indicated for non-bloody acute watery diarrhea without cholera or dysentery features.