



# **American Heart Association**

## **Pediatric Advanced Life Support**

### **Written Precourse Self-Assessment**

#### **Questions and Answer Key for Students**

**January 2012**

## PALS Written 2011 Precourse Self-Assessment

### ECG Rhythm Identification

The PALS ECG Rhythm Identification self-assessment test is designed to test your ability to identify rhythms you may encounter as a PALS provider. The rhythms in the list below are the core PALS rhythms that you should be able to identify during the PALS Provider Course teaching and testing stations. If you have difficulty with pediatric ECG rhythm identification, it is strongly suggested that you spend additional time reviewing basic pediatric arrhythmias before the PALS Provider Course. Sources of information about pediatric ECG rhythm identification include the *PALS Provider Manual* and *Learn.® Rhythm Pediatric*, available on OnlineAHA.org.

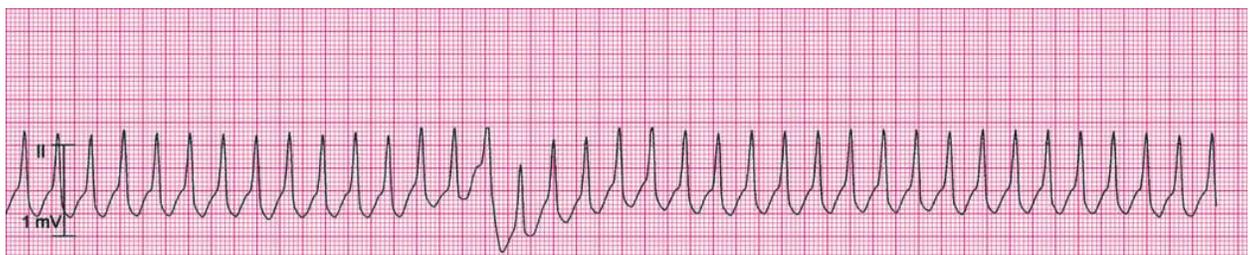
This self-assessment test is composed of 13 multiple-choice questions. For all questions, select the single best answer. An answer may be used more than once. There are 3 self-assessment tests: ECG Rhythm Identification, Pharmacology, and Practical Application.

Pediatric Rhythms:

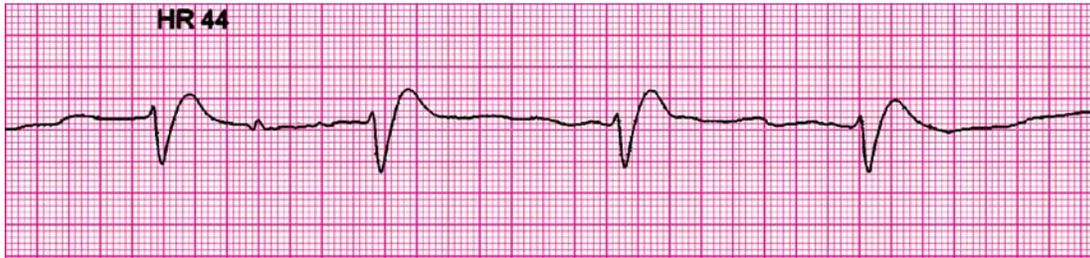
- A. Normal sinus rhythm
  - B. Sinus tachycardia
  - C. Sinus bradycardia
  - D. Supraventricular tachycardia (SVT)
  - E. Wide-complex tachycardia; presumed ventricular tachycardia (monomorphic)
  - F. Ventricular fibrillation (VF)
  - G. Asystole
  - H. Pulseless electrical activity (PEA)
- 

Rhythms 1 to 8: Core PALS Rhythms (select single best answer from rhythms A to H)

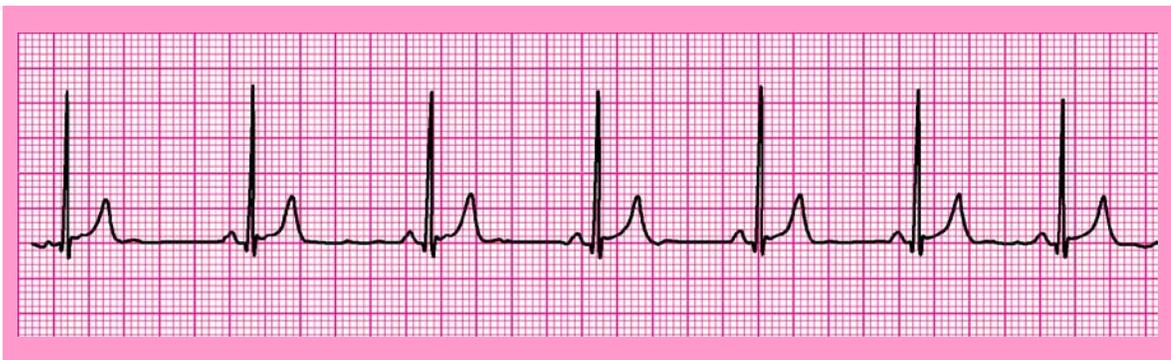
Rhythm 1 (clinical clue: heart rate 214/min)



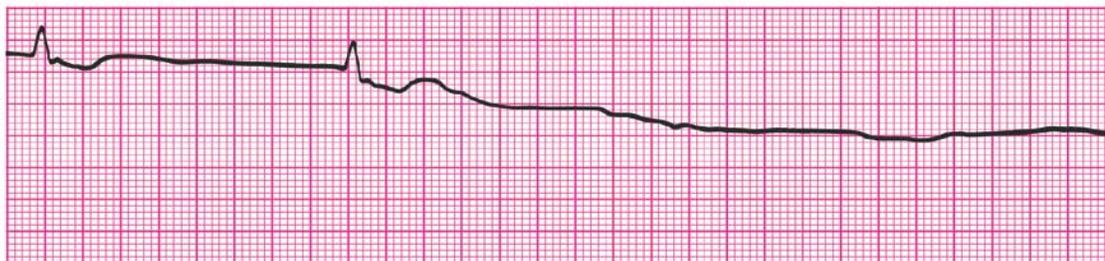
**Rhythm 2 (clinical clues: heart rate 44/min; no detectable pulses)**



**Rhythm 3 (clinical clues: age 8 years; heart rate 50/min)**



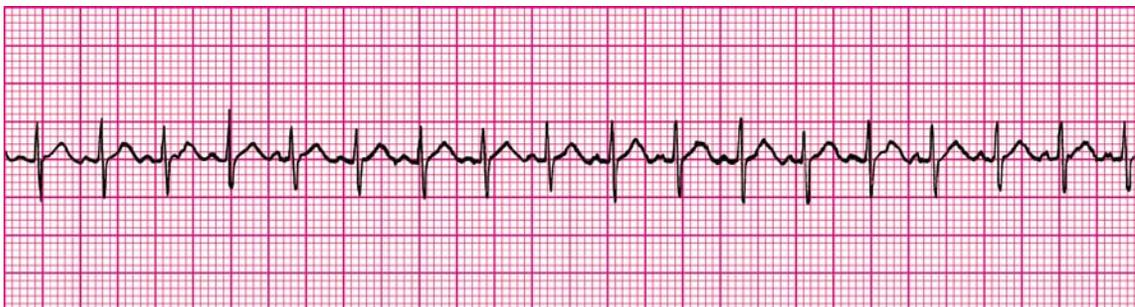
**Rhythm 4 (clinical clue: no detectable pulses)**



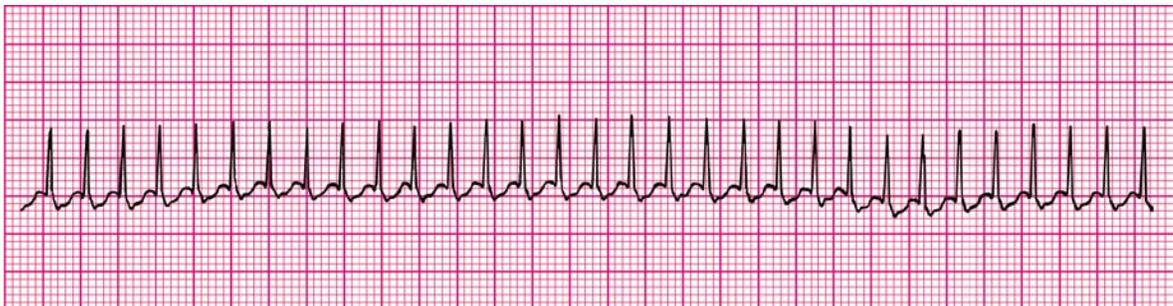
**Rhythm 5 (clinical clue: no consistent heart rate detected; no detectable pulses)**



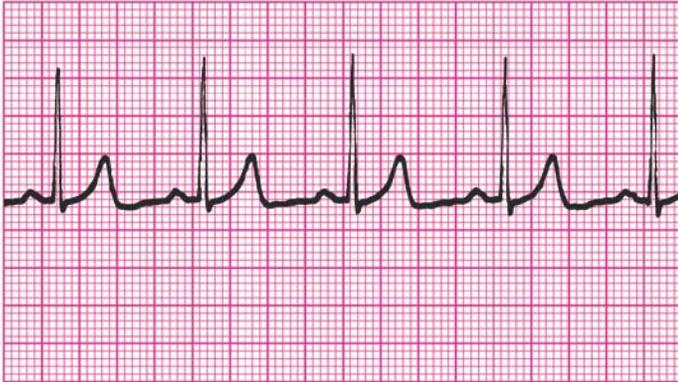
**Rhythm 6 (clinical clues: age 3 years; heart rate 188/min)**



**Rhythm 7 (clinical clue: heart rate 300/min)**



**Rhythm 8 (clinical clues: age 8 years; heart rate 75/min)**



## PALS Written 2011 Precourse Self-Assessment

### Pharmacology

The PALS Pharmacology self-assessment test is designed to test your knowledge of core drugs that will be used in the PALS Provider Course.

If this self-assessment shows that your knowledge of the pharmacology and indications for these drugs is deficient, it is strongly suggested that you spend additional time reviewing basic resuscitation drug pharmacology before taking a PALS course. Sources of PALS drug information include the *PALS Provider Manual* and the *2010 Handbook of Emergency Cardiovascular Care for Healthcare Providers* (ECC Handbook).

The Pharmacology self-assessment consists of 11 multiple-choice questions. Select the single best answer. There are 3 self-assessment tests: ECG Rhythm Identification, Pharmacology, and Practical Application.

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- 1. You are called to help resuscitate an infant with severe symptomatic bradycardia associated with respiratory distress. The bradycardia persists despite establishment of an effective airway, oxygenation, and ventilation. There is no heart block present. Which of the following is the *first drug* you should administer?**
    - A. Atropine
    - B. Dopamine
    - C. Adenosine
    - D. Epinephrine
- 
- 2. Which of the following statements about the effects of epinephrine during attempted resuscitation is true?**
    - A. Epinephrine decreases peripheral vascular resistance and reduces myocardial afterload so that ventricular contractions are more effective
    - B. Epinephrine improves coronary artery perfusion pressure and stimulates spontaneous contractions when asystole is present
    - C. Epinephrine is contraindicated in ventricular fibrillation because it increases myocardial irritability
    - D. Epinephrine decreases myocardial oxygen consumption
-

3. **Initial impression of a 2-year-old female reveals her to be alert with mild breathing difficulty during inspiration and pale skin color. On primary assessment, she makes high-pitched inspiratory sounds (mild stridor) when agitated; otherwise her breathing is quiet. Her SpO<sub>2</sub> is 92% in room air, and she has mild inspiratory intercostal retractions. Lung auscultation reveals transmitted upper airway sounds with adequate distal breath sounds bilaterally. Which of the following is the most appropriate initial therapeutic intervention for this child?**

- A. Perform immediate endotracheal intubation
  - B. Administer an IV dose of dexamethasone
  - C. Nebulize 2.5 mg of albuterol
  - D. Administer humidified supplementary oxygen as tolerated and continue evaluation
- 

4. **Which of the following most reliably delivers a high (90% or greater) concentration of inspired oxygen in a toddler or older child?**

- A. Nasal cannula with 4 L/min oxygen flow
  - B. Simple oxygen mask with 15 L/min oxygen flow
  - C. Nonbreathing face mask with 12 L/min oxygen flow
  - D. Face tent with 15 L/min oxygen flow
- 

5. **Which of the following statements about endotracheal drug administration is true?**

- A. Endotracheal drug administration is the preferred route of drug administration during resuscitation because it results in predictable drug levels and drug effects
  - B. Endotracheal doses of resuscitation drugs in children have been well established and are supported by evidence from clinical trials
  - C. Intravenous drug doses for resuscitation drugs should be used whether you give the drugs by the IV, the intraosseous (IO), or the endotracheal route
  - D. Endotracheal drug administration is the least desirable route of administration because this route results in unpredictable drug levels and effects
- 

6. **Which of the following statements most accurately reflects the PALS recommendations for the use of magnesium sulfate in the treatment of cardiac arrest?**

- A. Magnesium sulfate is indicated for VF refractory to repeated shocks and amiodarone or lidocaine
  - B. Routine use of magnesium sulfate is indicated for shock-refractory monomorphic VT
  - C. Magnesium sulfate is indicated for torsades de pointes and VF/pulseless VT associated with suspected hypomagnesemia
  - D. Magnesium sulfate is contraindicated in VT associated with an abnormal QT interval during the preceding sinus rhythm
-

7. You enter a room to perform an initial impression of a previously stable 10-year-old male and find him unresponsive and apneic. A code is called and bag-mask ventilation is performed with 100% oxygen. The cardiac monitor shows a wide-complex tachycardia. The boy has no detectable pulses, so compressions and ventilations are provided. As soon as the defibrillator arrives you deliver an unsynchronized shock with 2 J/kg. The rhythm check after 2 minutes of CPR reveals VF. You then deliver a shock of 4 J/kg and resume immediate CPR beginning with compressions. A team member had established IO access, so you give a dose of epinephrine, 0.01 mg/kg (0.1 mL/kg of 1:10,000 dilution) IO, when CPR is restarted after the second shock. At the next rhythm check, persistent VF is present. You administer a 4 J/kg shock and resume CPR. Based on the PALS Pediatric Cardiac Arrest Algorithm, what are the next drug and dose to administer when CPR is restarted?

- A. Epinephrine 0.1 mg/kg (0.1 mL/kg of 1:1,000 dilution) IO
  - B. Atropine 0.02 mg/kg IO
  - C. Amiodarone 5 mg/kg IO
  - D. Magnesium sulfate 25 to 50 mg/kg IO
- 

8. Parents of a 1-year-old female phoned the Emergency Response System when they picked up their daughter from the babysitter. Paramedics perform an initial impression revealing an obtunded infant with irregular breathing, bruises over the abdomen, abdominal distention, and cyanosis. Assisted bag-mask ventilation with 100% oxygen is initiated. On primary assessment heart rate is 36/min, peripheral pulses cannot be palpated, and central pulses are barely palpable. Cardiac monitor shows sinus bradycardia. Two-rescuer CPR is started with a 15:2 compression-to-ventilation ratio. In the emergency department the infant is intubated and ventilated with 100% oxygen, and IV access is established. The heart rate is now up to 150/min but there are weak central pulses and no distal pulses. Systolic blood pressure is 74 mm Hg. Of the following, which would be most useful in management of this infant?

- A. Epinephrine 0.01 mg/kg (0.1 mL/kg of 1:10,000 dilution) IV
  - B. Rapid bolus of 20 mL/kg of isotonic fluid
  - C. Atropine 0.02 mg/kg IV
  - D. Synchronized cardioversion
- 

9. Which of the following statements about calcium is true?

- A. Routine administration of calcium is not indicated during cardiac arrest
- B. The recommended dose is 1 to 2 mg/kg of calcium chloride
- C. Calcium chloride 10% has the same bioavailability of elemental calcium as calcium gluconate in critically ill children
- D. Indications for administration of calcium include hypercalcemia, hypokalemia, and hypomagnesemia

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**10. An infant with a history of vomiting and diarrhea arrives by ambulance. During your primary assessment the infant responds only to painful stimulation. The upper airway is patent, the respiratory rate is 40/min with good bilateral breath sounds, and 100% oxygen is being administered. The infant has cool extremities, weak pulses, and a capillary refill time of more than 5 seconds. The infant's blood pressure is 85/65 mm Hg, and glucose concentration (measured by bedside test) is 30 mg/dL (1.65 mmol/L). Which of the following is the most appropriate treatment to provide for this infant?**

- A. Establish IV or IO access and administer 20 mL/kg D<sub>5</sub>0.45% sodium chloride bolus over 15 minutes
- B. Establish IV or IO access and administer 20 mL/kg Lactated Ringer's solution over 60 minutes
- C. Perform endotracheal intubation and administer epinephrine 0.1 mg/kg 1:1,000 via the endotracheal tube
- D. Establish IV or IO access, administer 20 mL/kg isotonic crystalloid over 10 to 20 minutes, and simultaneously administer D<sub>25</sub>W 2 to 4 mL/kg in a separate infusion

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**11. Initial impression of a 9-year-old male with increased work of breathing reveals the boy to be agitated and leaning forward on the bed with obvious respiratory distress. You administer 100% oxygen by nonbreathing mask. The patient is speaking in short phrases and tells you that he has asthma but does not carry an inhaler. He has nasal flaring, severe suprasternal and intercostal retractions, and decreased air movement with prolonged expiratory time and wheezing. His SpO<sub>2</sub> is 92% (on nonbreathing mask). What is the next medical therapy to provide to this patient?**

- A. Adenosine 0.1 mg/kg
- B. Amiodarone 5 mg/kg IV/IO
- C. Albuterol by nebulization
- D. Procainamide 15 mg/kg IV/IO

## PALS Written 2011 Precourse Self-Assessment

### Practical Application

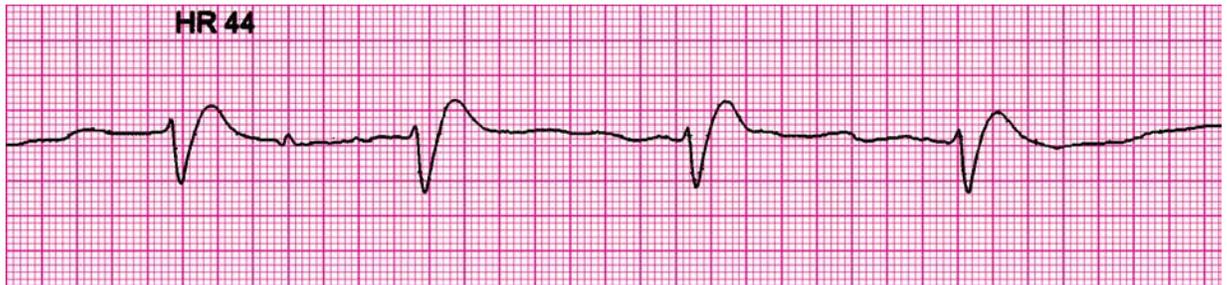
The PALS Practical Application self-assessment test is designed to test your knowledge of appropriate treatment selections based on pediatric assessment information provided in case scenarios. This exercise specifically evaluates your ability to identify core PALS rhythms (if presented), knowledge of core drugs, knowledge of the PALS flowcharts and algorithms for respiratory distress/respiratory failure and shock, and knowledge of the PALS algorithms for rhythm disturbances.

If you have difficulty with the practical application questions, it is strongly suggested that you review the core PALS rhythms, core drug information, the PALS flowcharts and algorithms for respiratory distress/failure and shock, and the PALS rhythm disturbances algorithms. Sources of this information include the *PALS Provider Manual* and the *2010 Handbook of Emergency Cardiovascular Care for Healthcare Providers* (ECC Handbook).

This self-assessment consists of 19 multiple-choice questions. Select the single best answer. There are 3 self-assessment tests: ECG Rhythm Identification, Pharmacology, and Practical Application.

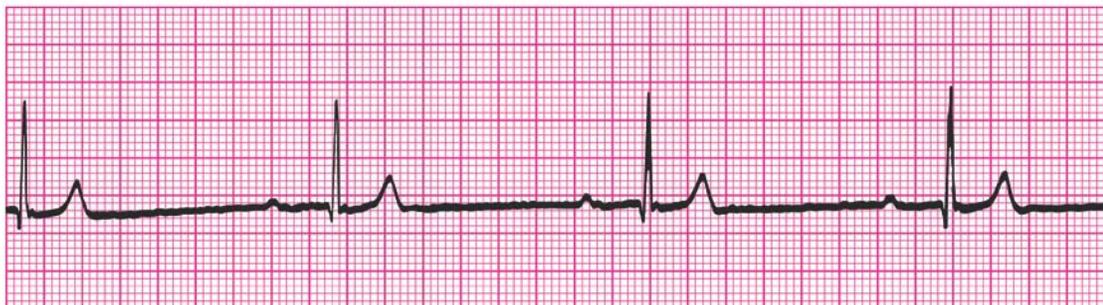
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1. An 8-month-old male is brought to the emergency department (ED) for evaluation of severe diarrhea and dehydration. In the ED the child becomes unresponsive and pulseless. You shout for help and start CPR at a compression rate of at least 100/min and a compression-to-ventilation ratio of 30:2. Another provider arrives, at which point you switch to 2-rescuer CPR with a compression-to-ventilation ratio of 15:2. The cardiac monitor shows the following rhythm:



The infant is intubated and ventilated with 100% oxygen. An IO line is rapidly established and a dose of epinephrine is given. Of the following choices for management, which would be most appropriate to give next?

- A. Defibrillation 2 J/kg
  - B. Normal saline 20 mL/kg IV rapidly
  - C. High-dose epinephrine, 0.1 mg/kg (0.1 mL/kg of 1:1,000 dilution), IO
  - D. Amiodarone 5 mg/kg IO
- 
2. Initial impression of a 10-month-old male in the emergency department reveals a lethargic pale infant with slow respirations. You begin assisted ventilation with a bag-mask device using 100% oxygen. On primary assessment heart rate is 38/min, central pulses are weak but distal pulses cannot be palpated, blood pressure is 60/40 mm Hg, and capillary refill is 4 seconds. During your assessment a colleague places the child on a cardiac monitor and you observe the following rhythm:



The rhythm remains unchanged despite ventilation with 100% oxygen. What are your next management steps?

- A. Administer adenosine 0.1 mg/kg rapid IV/IO and prepare for synchronized cardioversion
  - B. Start chest compressions and give epinephrine 0.1 mg/kg (0.1 mL/kg of 1:1,000 dilution) IV/IO
  - C. Start chest compressions and give epinephrine 0.01 mg/kg (0.1 mL/kg of 1:10,000 dilution) IV/IO
  - D. Administer 20 mL/kg isotonic crystalloid and epinephrine 0.01 mg/kg (0.1 mL/kg of 1:10,000 dilution) IV/IO
- 

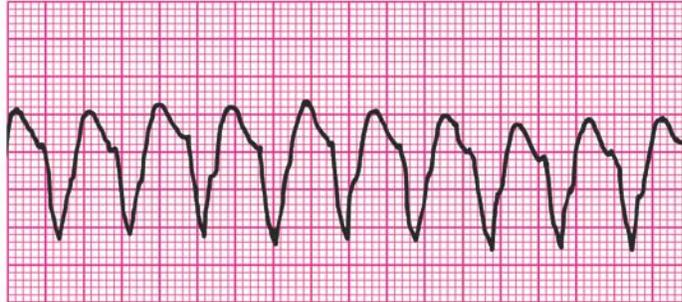
3. **A 3-year-old unresponsive, apneic child is brought to the emergency department. EMS personnel report that the child became unresponsive as they arrived at the hospital. The child is receiving CPR, including bag-mask ventilation with 100% oxygen and chest compressions at a rate of at least 100/min. Compressions and ventilations are being coordinated at a ratio of 15:2. You confirm that apnea is present and that ventilation is producing bilateral breath sounds and chest expansion while a colleague confirms absent pulses. Cardiac monitor shows the following rhythm:**



**A biphasic manual defibrillator is present. You quickly use the crown-heel length of the child on a length-based, color-coded resuscitation tape to estimate the approximate weight as 15 kg. Which of the following therapies is most appropriate for this child at this time?**

- A. Establish IV/IO access and administer amiodarone 5 mg/kg IV/IO
  - B. Establish IV/IO access and administer lidocaine 1 mg/kg IV/IO
  - C. Attempt defibrillation at 30 J, then resume CPR beginning with compressions
  - D. Establish IV/IO access and administer epinephrine 0.01 mg/kg (0.1 mL/kg of 1:10,000 dilution) IV/IO
-

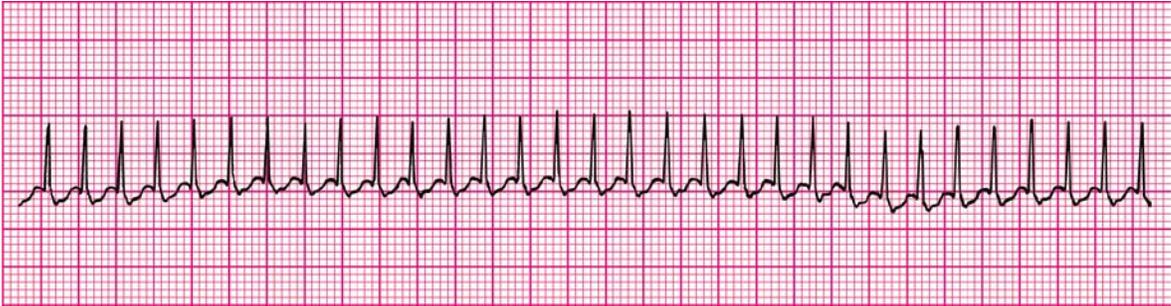
4. Initial impression of a 10-year-old male shows him to be unresponsive. You shout for help and check for breathing or only gasping. After finding that he is pulseless, you begin cycles of compressions and ventilations with a compression rate of at least 100/min and compression-to-ventilation ratio of 30:2. A colleague arrives and places the child on a cardiac monitor, revealing the following rhythm:



The two of you attempt defibrillation at 2 J/kg and give 2 minutes of CPR. The rhythm persists at the second rhythm check, at which point you attempt defibrillation using 4 J/kg. A third colleague establishes IO access and administers one dose of epinephrine 0.01 mg/kg (0.1 mL/kg of 1:10,000 dilution) during the compressions following the second shock. If VF or pulseless VT persists after 2 minutes of CPR, what is the *next* drug/dose to administer?

- A. Epinephrine 0.1 mg/kg (0.1 mL/kg of 1:1,000 dilution) IV
  - B. Adenosine 0.1 mg/kg IV
  - C. Amiodarone 5 mg/kg IV
  - D. Atropine 0.02 mg/kg IV
-

5. A 1-year-old male is brought to the emergency department for evaluation of poor feeding, fussiness, and sweating. On initial impression he is lethargic but arousable and has labored breathing and a dusky color. Primary assessment reveals a respiratory rate of 68/min, heart rate 300/min that does not vary with activity or sleep, blood pressure 70/45 mm Hg, weak brachial pulses and absent radial pulses, capillary refill 6 seconds, SpO<sub>2</sub> 85% in room air, and good bilateral breath sounds. You administer high-flow oxygen and place the child on a cardiac monitor. You see the following rhythm with little beat-to-beat variability of the heart rate:



Secondary assessment reveals no history of congenital heart disease. IV access has been established. Which of the following therapies is most appropriate for this infant?

- A. Make an appointment with a pediatric cardiologist for later in the week
  - B. Adenosine 0.1 mg/kg IV rapidly; if adenosine is not immediately available, perform synchronized cardioversion
  - C. Perform immediate defibrillation without waiting for IV access
  - D. Establish IV access and administer a fluid bolus of 20 mL/kg isotonic crystalloid
- 
6. A child becomes unresponsive in the emergency department and is not breathing. You provide ventilation with 100% oxygen. You are uncertain if a faint pulse is present with the following rhythm:



What is your *next* action?

- A. Start high-quality CPR beginning with chest compressions
  - B. Order transcutaneous pacing
  - C. Start an IV and give atropine 0.01 mg/kg IV
  - D. Start an IV and give epinephrine 0.01 mg/kg IV (0.1 mL/kg of 1:10,000 dilution)
- 

**7. You are preparing to use a manual defibrillator and paddles in the pediatric setting. When would it be most appropriate to use the smaller “pediatric” sized paddles for shock delivery?**

- A. To attempt synchronized cardioversion but not defibrillation
  - B. If the patient weighs less than approximately 25 kg or is less than 8 years of age
  - C. If the patient weighs less than approximately 10 kg or is less than 1 year of age
  - D. Whenever you can compress the victim's chest using only the heel of one hand
- 

**8. A 7-year-old boy is found unresponsive, apneic, and pulseless. CPR is ongoing. The child is intubated and vascular access is established. The ECG monitor reveals an organized rhythm, but a pulse check reveals no palpable pulses. Effective ventilations and compressions are resumed, and an initial IV dose of epinephrine is administered. Which of the following therapies should you perform next?**

- A. Attempt to identify and treat reversible causes (using the H's and T's as a memory aid)
  - B. Attempt defibrillation at 4 J/kg
  - C. Administer epinephrine 0.1 mg/kg IV (0.1 mL/kg of 1:1,000 dilution)
  - D. Administer synchronized cardioversion at 1 J/kg
- 

**9. You are evaluating an irritable 6-year-old girl with mottled color. On primary assessment she is febrile (temperature 40°C [104°F]), and her extremities are cold (despite a warm ambient temperature in the room) with capillary refill of 5 seconds. Distal pulses are absent and central pulses are weak. Heart rate is 180/min, respiratory rate is 45/min, and blood pressure is 98/56 mm Hg. Which of the following most accurately describes the categorization of this child's condition using the terminology taught in the PALS Provider Course?**

- A. Hypotensive shock associated with inadequate tissue perfusion
  - B. Hypotensive shock associated with inadequate tissue perfusion and significant hypotension
  - C. Compensated shock requiring no intervention
  - D. Compensated shock associated with tachycardia and inadequate tissue perfusion
-

10. **An 8-year-old child was struck by a car. He arrives in the emergency department alert, anxious, and in respiratory distress. His cervical spine is immobilized, and he is receiving a 10 L/min flow of 100% oxygen by nonrebreathing face mask. Primary assessment reveals respiratory rate 60/min, heart rate 150/min, systolic blood pressure 70 mm Hg, and SpO<sub>2</sub> 84% on supplementary oxygen. Breath sounds are absent over the right chest, and the trachea is deviated to the left. He has weak central pulses and absent distal pulses. Which of the following is the most appropriate immediate intervention for this child?**

- A. Perform endotracheal intubation and call for a STAT chest x-ray
  - B. Provide bag-mask ventilation and call for a STAT chest x-ray
  - C. Establish IV access and administer a 20 mL/kg normal saline fluid bolus
  - D. Perform needle decompression of the right chest and assist ventilation with a bag and mask if necessary
- 

11. **An 18-month-old child presents with a 1-week history of cough and runny nose. You perform an initial impression, which reveals a toddler responsive only to painful stimulation with slow respirations and diffuse cyanosis. You begin a primary assessment and find that the child's respiratory rate has fallen from 65/min to 10/min, severe inspiratory intercostal retractions are present, heart rate is 160/min, SpO<sub>2</sub> is 65% in room air, and capillary refill is less than 2 seconds. Which of the following is the most appropriate immediate treatment for this toddler?**

- A. Establish vascular access and administer a 20 mL/kg bolus of isotonic crystalloid
  - B. Open the airway and provide positive-pressure ventilation using 100% oxygen and a bag-mask device
  - C. Administer 100% oxygen by face mask, establish vascular access, and obtain a STAT chest x-ray
  - D. Administer 100% oxygen by face mask, obtain an arterial blood gas, and establish vascular access
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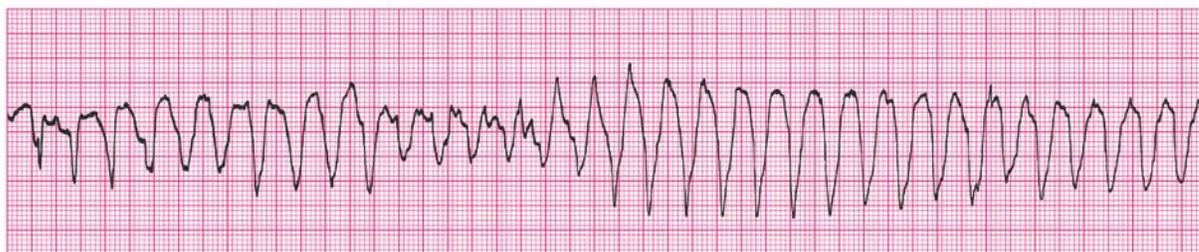
12. **You are supervising another healthcare provider who is inserting an intraosseous (IO) needle into an infant's tibia. Which of the following signs should you tell the provider is the best indication of successful insertion of a needle into the bone marrow cavity?**

- A. Pulsatile blood flow will be present in the needle hub
  - B. Fluids can be administered freely without local soft tissue swelling
  - C. You are unable to aspirate any blood through the needle
  - D. Once inserted, the needle shaft of the needle moves easily in all directions within the bone
-

13. A pale and obtunded 3-year-old child with a history of diarrhea is brought to the hospital. Primary assessment reveals respiratory rate of 45/min with good breath sounds bilaterally. Heart rate is 150/min, blood pressure is 90/64 mm Hg, and SpO<sub>2</sub> is 92% in room air. Capillary refill is 5 seconds and peripheral pulses are weak. After placing the child on a nonrebreathing face mask (10 L/min flow) with 100% oxygen and obtaining vascular access, which of the following is the most appropriate immediate treatment for this child?
- A. Obtain a chest x-ray
  - B. Begin a maintenance crystalloid infusion
  - C. Administer a bolus of 20 mL/kg isotonic crystalloid
  - D. Administer a dopamine infusion at 2 to 5 mcg/kg per minute
- 

14. You have just assisted with the elective endotracheal intubation of a child with respiratory failure and a perfusing rhythm. Which of the following provides the most reliable, prompt assessment of correct endotracheal tube placement in this child?
- A. Absence of audible breath sounds over the abdomen during positive-pressure ventilation
  - B. Auscultation of breath sounds over the lateral chest bilaterally plus presence of mist in the endotracheal tube
  - C. Confirmation of appropriate oxygen and carbon dioxide tensions on arterial blood gas analysis
  - D. Clinical assessment of adequate bilateral breath sounds and chest expansion plus presence of exhaled CO<sub>2</sub> in a colorimetric detection device after delivery of 6 positive-pressure ventilations
- 

15. A 4-year-old male is in pulseless arrest in the pediatric intensive care unit. A code is in progress. As the on-call physician you quickly review his chart and find that his baseline corrected QT interval on a 12-lead ECG is prolonged. A glance at the monitor shows recurrent episodes of the following rhythm:



The boy has received one dose of epinephrine 0.01 mg/kg (0.1 mL/kg of 1:10,000 dilution) but continues to demonstrate the rhythm illustrated above. If this rhythm persists at the next rhythm check, which medication would be *most* appropriate to administer at this time?

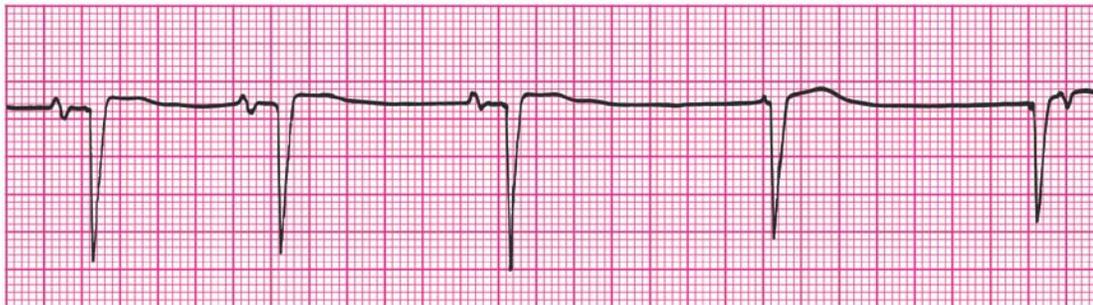
- A. Adenosine 0.1 mg/kg IV
  - B. Epinephrine 0.1 mg/kg (0.1 mL/kg of 1:1,000 dilution) IV
  - C. Lidocaine 1 mg/kg IV
  - D. Magnesium sulfate 25 to 50 mg/kg IV
- 

16. You are participating in the elective intubation of a 4-year-old child with respiratory failure. You must select the appropriate sized uncuffed endotracheal tube. You do not have a color-coded, length-based tape to use to estimate correct endotracheal tube size. Which of the following is the most appropriate estimated size uncuffed endotracheal tube for an average 4-year-old?

- A. 3-mm tube
  - B. 4-mm tube
  - C. 5-mm tube
  - D. 6-mm tube
- 

17. You are caring for a 3-year-old with vomiting and diarrhea. You have established IV access. When you place an orogastric tube, the child begins gagging and continues to gag after the tube is placed. The child's color has deteriorated; pulses are palpable but faint and the child is now lethargic. The heart rate is variable (range 44/min to 62/min). You begin bag-mask ventilation with 100% oxygen. When the heart rate does not improve, you begin chest compressions.

The cardiac monitor shows



Which of the following would be the *most* appropriate therapy to consider next?

- A. Epinephrine 0.1 mg/kg (0.1 mL/kg of 1:1,000 dilution) IV
  - B. Atropine 0.02 mg/kg IV
  - C. Attempt synchronized cardioversion at 0.5 J/kg
  - D. Cardiology consult for transcutaneous pacing
-

18. You are transporting a 6-year-old endotracheally intubated patient who is receiving positive-pressure mechanical ventilation. The child begins to move his head and suddenly becomes cyanotic and bradycardic. SpO<sub>2</sub> is 65% with good pulse signal. You remove the child from the mechanical ventilator circuit and provide manual ventilation with a bag via the endotracheal tube. During manual ventilation with 100% oxygen, the child's color and heart rate improve slightly and his blood pressure remains adequate. Breath sounds and chest expansion are present and adequate on the right side, but they are consistently diminished on the left side. The trachea is not deviated, and the neck veins are not distended. A suction catheter passes easily beyond the tip of the endotracheal tube. Which of the following is the most likely cause of this child's acute deterioration?
- A. Tracheal tube displacement into the right main bronchus
  - B. Tracheal tube obstruction
  - C. Tension pneumothorax on the right side
  - D. Equipment failure
- 

19. A 3-year-old boy presents with multiple system trauma. The child was an unrestrained passenger in a motor vehicle crash. On primary assessment he is unresponsive to voice or painful stimulation. His respiratory rate is <6/min, heart rate is 170/min, systolic blood pressure is 60 mm Hg, capillary refill is 5 seconds, and SpO<sub>2</sub> is 75% in room air. Which of the following most accurately summarizes the first actions you should take to support this child?
- A. Provide 100% oxygen by simple mask, stabilize the cervical spine, establish vascular access, and provide maintenance IV fluids
  - B. Provide 100% oxygen by simple mask and perform a head-to-toe survey to identify the extent of all injuries; begin an epinephrine infusion and titrate to maintain a systolic blood pressure of at least 76 mm Hg
  - C. Establish immediate vascular access, administer 20 mL/kg isotonic crystalloid, and reassess the patient; if the child's systemic perfusion does not improve, administer 10 to 20 mL/kg packed red blood cells
  - D. Open the airway (jaw-thrust technique) while stabilizing the cervical spine, administer positive-pressure ventilation with 100% oxygen, and establish immediate IV/IO access

## PALS Written 2011 Precourse Self-Assessment

### ECG Rhythm Identification Answer Sheet

Pediatric Rhythms (core PALS rhythms A to H)

- A. Normal sinus rhythm
- B. Sinus tachycardia
- C. Sinus bradycardia
- D. Supraventricular tachycardia (SVT)
- E. Wide-complex tachycardia; presumed ventricular tachycardia (monomorphic)
- F. Ventricular fibrillation (VF)
- G. Asystole
- H. Pulseless electrical activity (PEA)

Question	Answer									Page in <i>PALS Provider Manual</i>
1.	A	B	C	D	●	F	G	H		125
2.	A	B	C	D	E	F	G	●	H	146
3.	A	B	●	D	E	F	G	H		114
4.	A	B	C	D	E	F	●	H		145
5.	A	B	C	D	E	●	G	H		146
6.	A	●	C	D	E	F	G	H		122
7.	A	B	C	●	E	F	G	H		122
8.	●	B	C	D	E	F	G	H		241

### Pharmacology Answer Sheet

Question	Answer					Page in <i>PALS Provider Manual</i>
1.	A	B	C	●		119
2.	A	●	C	D		213-214
3.	A	B	C	●		51
4.	A	B	●	D		239
5.	A	B	C	●		151
6.	A	B	●	D		153
7.	A	B	●	D		161
8.	A	●	C	D		163
9.	●	B	C	D		153
10.	A	B	C	●		95
11.	A	B	●	D		53

## Practical Application Answer Sheet

Question	Answer				Page in <i>PALS Provider Manual</i>
1.	A	●	C	D	162
2.	A	B	●	D	119
3.	A	B	●	D	156-157
4.	A	B	●	D	161
5.	A	●	C	D	135-136
6.	●	B	C	D	161
7.	A	B	●	D	157
8.	●	B	C	D	162
9.	A	B	C	●	73
10.	A	B	C	●	105
11.	A	●	C	D	50
12.	A	●	C	D	110
13.	A	B	C	●	96-97
14.	A	B	C	●	239
15.	A	B	●	D	153
16.	A	●	C	D	111
17.	A	●	C	D	119
18.	●	B	C	D	176
19.	A	B	C	●	163