

ACLS CARDIAC ARREST PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. What energy level is typically used for the initial defibrillation shock with biphasic devices?**
 - A. Typically 200 J (range 120-200 J)
 - B. 120 J
 - C. 360 J
 - D. 100 J
- 2. For patients with STEMI after ROSC, what is the immediate recommended reperfusion strategy?**
 - A. Reperfusion is contraindicated after ROSC
 - B. PCI alone is sufficient; fibrinolysis is not used
 - C. Fibrinolytic therapy alone is recommended
 - D. Immediate reperfusion therapy with PCI, fibrinolytic therapy, or both
- 3. If amiodarone is not available, which lidocaine dosing regimen is recommended?**
 - A. 0.5 mg/kg IV/IO initial dose, max 2 mg/kg
 - B. 2 mg/kg IV/IO initial dose
 - C. 1 to 1.5 mg/kg IV/IO initial dose, followed by 0.5 to 0.75 mg/kg IV/IO every 5-10 minutes, up to 3 mg/kg
 - D. 0.3 mg/kg IV/IO initial dose, max 2 mg/kg
- 4. Which electrolyte abnormality is associated with prominent U waves on ECG?**
 - A. Hyperkalemia
 - B. Hypokalemia
 - C. Hyponatremia
 - D. Hypercalcemia
- 5. In evaluating a patient in cardiac arrest, one of the key questions is whether the rhythm is shockable or nonshockable.**
 - A. Is there a palpable pulse
 - B. Is the patient conscious
 - C. Is the rhythm shockable (ventricular fibrillation and pulseless ventricular tachycardia) or nonshockable (PEA and asystole)
 - D. Is the blood pressure elevated

- 6. Which signs indicate cardiac arrest in an unresponsive patient with no normal breathing, prompting immediate CPR?**
- A. Unresponsiveness, absence of normal breathing, and no pulse
 - B. Unresponsiveness with normal breathing
 - C. Normal pulse with irregular breathing
 - D. Alert and oriented, with normal respiration
- 7. In modern ACLS guidelines, which statement about vasopressor use is accurate?**
- A. Vasopressin is not routinely recommended; epinephrine remains vasopressor of choice
 - B. Epinephrine has been removed from standard guidelines
 - C. Norepinephrine is now the first-line vasopressor in all arrests
 - D. Dopamine is preferred for unstable arrests
- 8. Which rhythms are considered shockable in adult ACLS?**
- A. Atrial fibrillation with rapid ventricular response
 - B. Asystole and pulseless electrical activity (PEA)
 - C. Normal sinus rhythm
 - D. Ventricular fibrillation and pulseless ventricular tachycardia
- 9. Which of the following is a known cause of ventricular fibrillation?**
- A. Hypoglycemia
 - B. Myocardial ischemia or infarction
 - C. Hyperglycemia
 - D. Hypertension
- 10. Which biomarker may be evaluated within 72 hours of ROSC as part of neuroprognostication?**
- A. Neuron-specific enolase (NSE)
 - B. Troponin I
 - C. C-reactive protein
 - D. D-dimer

Answers

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1. A
2. D
3. C
4. B
5. C
6. A
7. A
8. D
9. B
10. A

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Explanations

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1. What energy level is typically used for the initial defibrillation shock with biphasic devices?

A. Typically 200 J (range 120-200 J)

B. 120 J

C. 360 J

D. 100 J

Biphasic defibrillators deliver energy more efficiently, using two current directions, which allows successful defibrillation with lower energy while reducing myocardial injury. Because of this, the typical starting energy for a first shock on modern biphasic devices is around 200 J. The range of 120–200 J accounts for differences between specific devices and manufacturer presets. Higher energies like 360 J were common with older monophasic shocks, whereas 100–120 J would be considered too low for a standard initial biphasic shock. So, 200 J is the best starting point because it balances effectiveness with safety across most devices.

2. For patients with STEMI after ROSC, what is the immediate recommended reperfusion strategy?

A. Reperfusion is contraindicated after ROSC

B. PCI alone is sufficient; fibrinolysis is not used

C. Fibrinolytic therapy alone is recommended

D. Immediate reperfusion therapy with PCI, fibrinolytic therapy, or both

The key idea is that after return of spontaneous circulation in a STEMI, restoring blood flow quickly is essential to save heart muscle and improve survival. The best approach is immediate reperfusion using PCI if it can be done promptly. If PCI isn't available within an acceptable time frame, fibrinolytic therapy is a standard alternative to start reperfusion. In some cases, a pharmacoinvasive strategy is used—giving fibrinolysis first and then proceeding to PCI as soon as feasible. Because the situation depends on what is available locally and how fast PCI can be delivered, the immediate recommended reperfusion strategy is to pursue PCI, fibrinolytic therapy, or both, as appropriate. Reperfusion is not contraindicated after ROSC; timely reperfusion is the goal.

3. If amiodarone is not available, which lidocaine dosing regimen is recommended?

A. 0.5 mg/kg IV/IO initial dose, max 2 mg/kg

B. 2 mg/kg IV/IO initial dose

C. 1 to 1.5 mg/kg IV/IO initial dose, followed by 0.5 to 0.75 mg/kg IV/IO every 5-10 minutes, up to 3 mg/kg

D. 0.3 mg/kg IV/IO initial dose, max 2 mg/kg

When amiodarone isn't available, lidocaine is used as the alternative antiarrhythmic for shockable ventricular arrhythmias in ACLS. The best dosing approach is to give an initial bolus of 1 to 1.5 mg/kg IV/IO. If arrhythmias persist, repeat with 0.5 to 0.75 mg/kg IV/IO every 5–10 minutes, up to a total cumulative dose of 3 mg/kg. This titrated bolus strategy quickly achieves effective plasma levels while keeping the total amount limited to reduce toxicity. If ongoing suppression is needed after the boluses, an infusion of lidocaine (e.g., 1–4 mg/min) can be considered. Monitor for signs of toxicity, especially in patients with liver impairment or possible conduction disturbances.

4. Which electrolyte abnormality is associated with prominent U waves on ECG?

- A. Hyperkalemia
- B. Hypokalemia**
- C. Hyponatremia
- D. Hypercalcemia

Prominent U waves on ECG are most characteristic of low potassium. When potassium levels fall, the outward K⁺ current during repolarization decreases, prolonging the late phase of ventricular repolarization. This creates a small, extra deflection after the T wave—the U wave—best seen in the precordial leads (often V2–V4). Along with U waves, hypokalemia commonly shows flattened or inverted T waves and ST-segment depression, and can predispose to arrhythmias. In contrast, hyperkalemia tends to produce tall, peaked T waves with widened QRS and eventually a sine-wave pattern, not prominent U waves. Hyponatremia and hypercalcemia have different ECG patterns that do not feature prominent U waves as a classic finding.

5. In evaluating a patient in cardiac arrest, one of the key questions is whether the rhythm is shockable or nonshockable.

- A. Is there a palpable pulse
- B. Is the patient conscious
- C. Is the rhythm shockable (ventricular fibrillation and pulseless ventricular tachycardia) or nonshockable (PEA and asystole)**
- D. Is the blood pressure elevated

The main idea being tested is how to decide whether a cardiac-arrest rhythm should be shocked. The best choice names the two categories that guide defibrillation: shockable rhythms are ventricular fibrillation and pulseless ventricular tachycardia, while nonshockable rhythms are pulseless electrical activity and asystole. This distinction tells you what action to take next: if the rhythm is shockable, deliver defibrillation as promptly as possible; if it is nonshockable, continue high-quality CPR and treat reversible causes rather than shocking. The other options don't directly indicate whether defibrillation is appropriate—palpating a pulse, the patient's consciousness, or blood pressure don't define the rhythm's shockability and don't determine whether a shock is indicated.

6. Which signs indicate cardiac arrest in an unresponsive patient with no normal breathing, prompting immediate CPR?

- A. Unresponsiveness, absence of normal breathing, and no pulse**
- B. Unresponsiveness with normal breathing
- C. Normal pulse with irregular breathing
- D. Alert and oriented, with normal respiration

The main idea is recognizing cardiac arrest by a combination of signs that mean the heart isn't circulating blood. If a person is unresponsive and not breathing normally, you next check for a pulse. When there is no pulse, along with the unresponsiveness and absent normal breathing, it indicates cardiac arrest and immediate CPR is required. This is why the best answer includes all three elements: unresponsiveness, no normal breathing, and no pulse. If someone is unresponsive but breathing normally, you don't start CPR; you'd monitor and call for help. If there's a pulse but not normal breathing, you provide rescue breaths rather than chest compressions. If the person is alert and oriented with normal respiration, CPR isn't indicated.

7. In modern ACLS guidelines, which statement about vasopressor use is accurate?

- A. Vasopressin is not routinely recommended; epinephrine remains vasopressor of choice**
- B. Epinephrine has been removed from standard guidelines
- C. Norepinephrine is now the first-line vasopressor in all arrests
- D. Dopamine is preferred for unstable arrests

During CPR the goal of vasopressors is to boost coronary and cerebral perfusion by raising diastolic aortic pressure. Epinephrine achieves this effectively through alpha-adrenergic vasoconstriction and improves the chances of return of spontaneous circulation. The modern ACLS guidance continues to designate epinephrine as the vasopressor of choice for cardiac arrest. Vasopressin was studied as an alternative, but evidence has not shown a clear outcome benefit when used routinely, so it is not recommended as a standard addition to the epinephrine protocol. That is why the statement that vasopressin is not routinely recommended while epinephrine remains the vasopressor of choice is the best answer. The other options don't fit because norepinephrine has not replaced epinephrine as first-line in all arrests, and dopamine is not the preferred agent for unstable arrests.

8. Which rhythms are considered shockable in adult ACLS?

- A. Atrial fibrillation with rapid ventricular response
- B. Asystole and pulseless electrical activity (PEA)
- C. Normal sinus rhythm
- D. Ventricular fibrillation and pulseless ventricular tachycardia**

In adult ACLS, defibrillation is used for rhythms that are nonperfusing due to chaotic or rapid electrical activity. Ventricular fibrillation and pulseless ventricular tachycardia fit this because there's no effective cardiac output; a high-energy shock can interrupt the disordered electrical activity and allow a new perfusing rhythm to emerge when CPR continues and underlying causes are addressed. Atrial fibrillation with rapid ventricular response isn't treated with defibrillation in this context since it usually has an organized rhythm and a pulse. If the patient were unstable with a pulse, synchronized cardioversion might be considered, but not unsynchronized defibrillation during a non-arrest situation. Normal sinus rhythm is already normal and doesn't require shock. Asystole and pulseless electrical activity lack a meaningful, effective electrical rhythm to reset with a shock; the approach is CPR plus medications and addressing reversible causes rather than defibrillation.

9. Which of the following is a known cause of ventricular fibrillation?

- A. Hypoglycemia
- B. Myocardial ischemia or infarction**
- C. Hyperglycemia
- D. Hypertension

Ventricular fibrillation is driven by rapid, disorganized electrical activity in the ventricles due to acute electrical instability of the heart muscle. The most well-established trigger for this chaos is acute myocardial ischemia or infarction. When heart tissue becomes ischemic, its cells lose ATP, ion pumps fail, and potassium and calcium handling becomes deranged. This creates multiple ectopic electrical foci and promotes reentry circuits, so the ventricles fire in a chaotic, uncoordinated way rather than contracting effectively. The result is no meaningful cardiac output and sudden deterioration unless defibrillation rapidly restores organized rhythm. Other conditions listed do not typically precipitate VF in the same direct, immediate way. Metabolic derangements like hypoglycemia or hyperglycemia affect overall physiology and can influence arrhythmia risk in certain contexts, but they are not classic, direct triggers of ventricular fibrillation. Hypertension over time can contribute to structural heart changes that raise arrhythmia risk, but it is not the immediate precipitant of VF as seen with acute ischemia or infarction.

10. Which biomarker may be evaluated within 72 hours of ROSC as part of neuroprognostication?

- A. Neuron-specific enolase (NSE)**
- B. Troponin I
- C. C-reactive protein
- D. D-dimer

After return of spontaneous circulation, predicting neurological outcome relies on markers of brain injury as well as clinical and imaging data. Neuron-specific enolase (NSE) is released into the blood when neurons are damaged from the hypoxic-ischemic injury that occurs during cardiac arrest. Measuring NSE within the first 72 hours after ROSC provides prognostic information because higher levels correlate with more severe brain injury and a poorer neurological outcome, especially when interpreted alongside exam findings, imaging, and electrophysiology. Other biomarkers listed reflect injury or processes outside the brain—Troponin I tracks heart muscle injury, C-reactive protein indicates inflammation, and D-dimer relates to coagulation and clot breakdown—so they are not used to gauge neuroprognosis after cardiac arrest.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://aclscardiacarrest.examzify.com>

We wish you the very best on your exam journey. You've got this!

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