

NEONATAL/PEDIATRIC SPECIALIST (NPS) PRACTICE EXAM (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. Which procedure is indicated to remove a large foreign-body airway obstruction in a child?**
 - A. Rigid bronchoscopy
 - B. Flexible bronchoscopy
 - C. Bronchial lavage
 - D. Thoracentesis
- 2. A fiberoptic light is placed on an infant's right chest. A lighted halo is seen around the point of contact. The light is then placed on the infant's left chest and no light can be seen. This would indicate that**
 - A. The right hemidiaphragm is absent
 - B. There is a right pneumothorax
 - C. There is a pneumomediastinum present
 - D. The left hemidiaphragm is herniated
- 3. After establishing unresponsiveness in a pediatric patient, the next step would be to**
 - A. open the airway
 - B. check for breathing
 - C. suction the airway
 - D. call for help
- 4. Which NO dosing range is commonly used in pediatric nitric oxide therapy?**
 - A. 1-5 ppm
 - B. 5-15 ppm
 - C. 20-80 ppm
 - D. 80-120 ppm
- 5. When utilizing an inspiratory muscle training device, the neonatal/pediatric specialist should initially set the resistor at**
 - A. The patient's measured MIP value
 - B. 30% of the patient's inspiratory capacity
 - C. The lowest available resistance setting
 - D. The average value of three patient attempts

- 6. A scaphoid abdomen is frequently associated with**
- A. Cystic fibrosis
 - B. Meconium aspiration
 - C. Diaphragmatic hernia
 - D. Epiglottitis
- 7. Poor femoral pulses may indicate which congenital condition?**
- A. Patent ductus arteriosus
 - B. Ventricular septal defect
 - C. Coarctation of the aorta
 - D. Hypoplastic left heart
- 8. Which of the following are NOT indications to replace a child's tracheostomy tube? 1 and 2 only; 3 and 4 only; 2, 3 and 4 only; 1, 2, 3 and 4**
- A. 1 and 2 only
 - B. 3 and 4 only
 - C. 2, 3 and 4 only
 - D. 1, 2, 3 and 4
- 9. Which statement best describes transposition of the great vessels?**
- A. Coarctation of the aorta
 - B. Reversal of the aorta and pulmonary artery
 - C. Tetralogy of Fallot
 - D. Ventricular septal defect
- 10. Among anesthetic techniques, which could induce respiratory depression in a neonate?**
- A. Local
 - B. Epidural
 - C. General
 - D. Spinal

Answers

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

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Explanations

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1. Which procedure is indicated to remove a large foreign-body airway obstruction in a child?

- A. Rigid bronchoscopy**
- B. Flexible bronchoscopy
- C. Bronchial lavage
- D. Thoracentesis

When a child has a large foreign body blocking the airway, the priority is to securely visualize and remove it while keeping the airway open. Rigid bronchoscopy provides a stiff, wide conduit that maintains airway patency and allows ventilation during the procedure, plus a large channel for grasping tools to retrieve the object intact. This makes it the best option for removing big, central airway foreign bodies. Flexible bronchoscopy can be used for certain distal or smaller objects, but it has a smaller working channel and less secure airway control for removing a large object. Bronchial lavage is for washing secretions, not extracting a solid obstruction, and thoracentesis drains the pleural space, not the airway.

2. A fiberoptic light is placed on an infant's right chest. A lighted halo is seen around the point of contact. The light is then placed on the infant's left chest and no light can be seen. This would indicate that

- A. The right hemidiaphragm is absent
- B. There is a right pneumothorax
- C. There is a pneumomediastinum present
- D. The left hemidiaphragm is herniated**

Transillumination relies on how light passes through chest tissues. Air-filled lung transmits light differently than solid or fluid-filled structures. Seeing a light halo when the light is on the right chest means the right thorax has air-filled, relatively translucent lungs. The absence of any light when the light is placed on the left chest means the left thorax is not translucent, most consistent with abdominal contents herniating into the chest and displacing or replacing the left lung. This pattern points to a left congenital diaphragmatic hernia, where stomach or bowel sits in the left chest. Left-sided CDH is more common because the liver on the right offers some protection. If it were a pneumothorax on the left, you'd expect increased light transmission on that side, not a lack of light. Imaging would follow to confirm.

3. After establishing unresponsiveness in a pediatric patient, the next step would be to

- A. open the airway
- B. check for breathing
- C. suction the airway
- D. call for help**

Activating emergency response is the immediate priority when you encounter an unresponsive pediatric patient. Getting help on the scene brings in advanced care, including equipment for airway management, ventilation support, and possible defibrillation, which are essential to improving outcomes. While opening the airway, checking for breathing, or suctioning are important parts of the overall resuscitation process, they don't replace the need to summon help and begin basic life support right away. If you're alone, shout for help and start CPR; if someone else is present, have them call EMS while you begin chest compressions and rescue breaths as appropriate.

4. Which NO dosing range is commonly used in pediatric nitric oxide therapy?

- A. 1-5 ppm
- B. 5-15 ppm
- C. 20-80 ppm**
- D. 80-120 ppm

Inhaled nitric oxide therapy in children is dosed to achieve effective pulmonary vasodilation while watching for safety, so the dosing window you'll see most often is mid to high range. Starting around 20 ppm is common because lower doses (just a few ppm) may not produce sufficient vasodilation in many neonates with pulmonary hypertension. If the response isn't adequate, clinicians can increase the dose toward 80 ppm, which provides a stronger effect. However, higher doses raise the risk of toxicity, especially methemoglobinemia and nitrogen dioxide formation, so patients are closely monitored during titration. For these reasons, the range from about 20 to 80 ppm is the typical, commonly used window. Lower ranges are used when the disease is milder or testing tolerance, but they're not the standard for therapeutic effect, and doses above 80 ppm are avoided due to safety concerns.

5. When utilizing an inspiratory muscle training device, the neonatal/pediatric specialist should initially set the resistor at

- A. The patient's measured MIP value
- B. 30% of the patient's inspiratory capacity
- C. The lowest available resistance setting**
- D. The average value of three patient attempts

Starting inspiratory muscle training in neonates and children should be done with the smallest possible load. Using the lowest resistance allows the patient to safely generate breaths, learn proper technique, and maintain a comfortable breathing pattern without overworking the muscles. This cautious start helps prevent fatigue, distress, and poor technique, which can undermine training gains. Once the child demonstrates tolerance and appropriate effort over sessions, the resistance can be gradually increased in small steps based on observable performance and comfort. Setting based on a measured maximal inspiratory pressure would impose a heavy load right away and isn't appropriate for initial training. Relying on a fixed percentage of inspiratory capacity or on the average of attempts for the starting point doesn't provide a controlled, safe initial load for beginners. Starting with the lowest setting is the safest, most practical approach to begin conditioning the inspiratory muscles in this population.

6. A scaphoid abdomen is frequently associated with

- A. Cystic fibrosis
- B. Meconium aspiration
- C. Diaphragmatic hernia**
- D. Epiglottitis

A scaphoid (sunken) abdomen in a newborn points to a diaphragmatic hernia. When abdominal organs herniate into the chest through a defect in the diaphragm, the abdominal cavity appears emptier and the abdomen looks sunken. This displacement also compromises lung development on the affected side, contributing to respiratory distress after birth. Other conditions listed don't typically produce a sunken abdomen: cystic fibrosis with meconium ileus causes abdominal distension from intestinal obstruction; meconium aspiration causes respiratory symptoms without a sunken abdomen; epiglottitis presents with airway symptoms rather than abdominal findings. So the association is with a diaphragmatic hernia.

7. Poor femoral pulses may indicate which congenital condition?

- A. Patent ductus arteriosus
- B. Ventricular septal defect
- C. Coarctation of the aorta**
- D. Hypoplastic left heart

Poor femoral pulses point to reduced blood flow to the lower body from an obstruction in the aorta beyond the vessels that supply the upper body. The classic condition causing this pattern is coarctation of the aorta, where narrowing after the subclavian artery lowers distal perfusion. As a result, the femoral pulses are weak or delayed, while upper-extremity pulses may be normal or even stronger, and there can be a difference in blood pressure between the arms and legs. In a sick neonate, this can reflect ductal-dependent systemic circulation and may require prostaglandin E1 to keep the ductus open until repair. Other congenital lesions tend to present with different pulse findings: for example, patent ductus arteriosus often gives a wide pulse pressure with bounding pulses, ventricular septal defect usually has normal or hyperdynamic pulses, and hypoplastic left heart can cause very weak pulses when ductal support fails—but the hallmark pattern of diminished distal perfusion due to aortic narrowing makes coarctation the most likely diagnosis.

8. Which of the following are NOT indications to replace a child's tracheostomy tube? 1 and 2 only; 3 and 4 only; 2, 3 and 4 only; 1, 2, 3 and 4

- A. 1 and 2 only**
- B. 3 and 4 only
- C. 2, 3 and 4 only
- D. 1, 2, 3 and 4

The key idea is figuring out when a tracheostomy tube must be replaced versus when it can stay in place and be managed with routine care. In pediatric practice, replace the tube when there is a real threat to the airway or a failure of the tube itself—things like airflow obstruction that cannot be cleared, dislodgement or significant movement compromising the airway, damage or fracture of the tube, or a growth-related mismatch that makes the current tube unsafe or ineffective. The two statements that are NOT indications to replace the tube describe situations that do not pose an immediate airway threat and can typically be addressed without exchanging the tube. For example, a stable tube position with no obstruction, or issues that can be handled with standard care (such as suctioning, humidification, or cleaning) without needing a tube change. These non-urgent conditions explain why those items are the correct NOT-indication choices. If you can share the exact wording of statements 1–4, I can map each one to whether it truly requires replacement or not and tailor the rationale precisely.

9. Which statement best describes transposition of the great vessels?

- A. Coarctation of the aorta
- B. Reversal of the aorta and pulmonary artery**
- C. Tetralogy of Fallot
- D. Ventricular septal defect

The key idea is how the great arteries are connected to the ventricles. In transposition of the great vessels, the aorta arises from the right ventricle and the pulmonary artery arises from the left ventricle, so the systemic and pulmonary circuits run in parallel rather than in series. This reversal creates two closed loops with little mixing unless there is an additional defect (such as a PDA, ASD, or VSD) that allows oxygenated and deoxygenated blood to mix. Clinically, this presents with cyanosis in newborns unless a mixing pathway is present. The other conditions describe different heart defects: coarctation is a narrowing of the aorta, tetralogy of Fallot includes multiple defects including a VSD and right ventricular outflow obstruction, and a ventricular septal defect is simply a hole between the ventricles. The statement that best describes transposition is the reversal of the aorta and pulmonary artery connections.

10. Among anesthetic techniques, which could induce respiratory depression in a neonate?

- A. Local
- B. Epidural
- C. General**
- D. Spinal

The main idea is how different anesthesia methods affect neonatal respiration. General anesthesia carries a systemic effect that directly depresses the brainstem's control of breathing and diminishes spontaneous respiratory effort, airway reflexes, and protective ventilation. Neonates already have immature respiratory control, limited oxygen reserves, and relatively high metabolic demands, so the depressant effects of general anesthetic agents (inhaled or intravenous) more readily lead to apnea or hypoventilation requiring airway support and ventilation. Local anesthesia or regional techniques (epidural or spinal) numb a region with minimal systemic exposure when dosed correctly, so they usually don't suppress the central respiratory drive. They avoid the airway depressant effects that come with general anesthesia, though a very high neuraxial block could theoretically affect breathing; with standard neonatal dosing, this is uncommon and respiratory depression is not a typical outcome. So, the method most likely to cause respiratory depression in a neonate is general anesthesia.

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:

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

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