PEDIATRIC CARDIAC ARREST PRACTICE TEST (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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

1. During pediatric CPR, rhythm checks are performed at what interval?

A. Every 2 minutes and after defibrillation

B. Every 30 seconds

C. Every 5 minutes

D. Only when chest compressions pause

2. What atropine dosing is suggested for pediatric symptomatic bradycardia with poor perfusion?

A. 0.01 mg/kg IV, max 0.1 mg

B. 0.04 mg/kg IV, max 2 mg

C. 0.02 mg/kg IV/IO, min 0.1 mg, max per dose 0.5 mg

D. No atropine recommended

3. What is the primary objective of post-cardiac arrest care?

A. Restore circulation only

B. Manage pain

C. Prevent arrhythmias

D. Reduce morbidity and mortality by assessment and management of respiratory, cardiovascular, and neurologic systems

4. What is the recommended atropine dose for symptomatic bradycardia in pediatric patients?

A. 0.04 mg/kg IV/IO

B. 0.02 mg/kg IV/IO, minimum 0.1 mg; maximum per dose 0.5 mg

C. 0.1 mg/kg IV/IO

D. 0.5 mg/kg IV/IO

5. During pediatric CPR, the chest compression depth is approximately proportional to which measurement?

A. About one-third of the chest's AP diameter

B. About half the chest's AP diameter

C. About one-quarter of the AP diameter

D. Full chest recoil

6. Which infant CPR technique is used when there are two rescuers?

A. Two-finger chest compressions.

B. One-handed chest compressions.

C. Two-thumb-encircling hands on the infant chest.

D. Two-handed chest compressions on the infant chest.

7. What is the recommended immediate treatment for tension pneumothorax?

A. Defibrillation

B. IV antibiotic therapy

C. Chest tube insertion only after imaging

D. Needle decompression

8. In pediatric chest trauma with shock, which emergent condition should be considered?

A. Tension pneumothorax

B. Myocardial infarction

C. Pulmonary embolism

D. Aortic dissection

9. In pediatric CPR, what is the upper end of the recommended chest compression rate (per minute)?

A. 100 compressions per minute

B. 80 compressions per minute

C. 60 compressions per minute

D. 120 compressions per minute

10. Which option best describes ECMO/ECPR prerequisites for pediatric arrest?

A. In cases where there is no ECMO center available.

B. Refractory arrest with reversible cause and a suitable center.

C. Only in neonates.

D. Any arrest regardless of reversibility.

Answers

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

Explanations

1. During pediatric CPR, rhythm checks are performed at what interval?

A. Every 2 minutes and after defibrillation

B. Every 30 seconds

C. Every 5 minutes

D. Only when chest compressions pause

Rhythm checks in pediatric CPR are done in a two-minute cycle, with an immediate check after a defibrillation shock. This cadence lets you continuously provide high-quality chest compressions while still re-evaluating the heart rhythm to decide if another shock is needed or if return of spontaneous circulation has occurred. Why this interval works: a 2-minute cycle fits with the CPR rhythm that balances movement of blood with timely rhythm assessment, and checking right after a shock ensures you respond promptly to the post-defibrillation state (whether another shock is indicated or you should continue CPR). Checking more frequently (every 30 seconds) would cause unnecessary pauses in compressions, while waiting five minutes would delay crucial reassessment. Checks are not limited to moments when compressions pause; they're performed at the defined interval and right after defibrillation to guide the next steps.

2. What atropine dosing is suggested for pediatric symptomatic bradycardia with poor perfusion?

A. 0.01 mg/kg IV, max 0.1 mg

B. 0.04 mg/kg IV, max 2 mg

C. 0.02 mg/kg IV/IO, min 0.1 mg, max per dose 0.5 mg

D. No atropine recommended

In pediatric symptomatic bradycardia with poor perfusion, atropine is used to counteract excessive vagal (parasympathetic) influence on the heart, helping the heart rate rise quickly to improve perfusion. The recommended approach is a dose of 0.02 mg/kg given IV or IO, with a minimum dose of 0.1 mg to ensure a detectable amount in smaller children and a maximum of 0.5 mg per dose to prevent excessive anticholinergic effects. If perfusion remains compromised and the rhythm persists, repeating the same dose every 3–5 minutes is acceptable, up to the per-dose maximum. This dosing targets rapid vagal relief and is specific to pediatric bradycardia where atropine is indicated; smaller or larger per-dose amounts are not aligned with the guideline, and there are scenarios where atropine may not be effective, requiring other interventions.

3. What is the primary objective of post-cardiac arrest care?

A. Restore circulation only

B. Manage pain

C. Prevent arrhythmias

D. Reduce morbidity and mortality by assessment and management of respiratory, cardiovascular, and neurologic systems

After resuscitation, the goal is to minimize brain injury and other organ damage by supporting all critical body systems affected by the arrest. This means ensuring good oxygenation and ventilation to optimize respiratory function, maintaining stable cardiovascular status to preserve cerebral perfusion, and actively protecting the brain through neurologic assessment and targeted therapies. It also involves treating underlying causes, controlling temperature, glucose, and hemodynamics, and preventing secondary complications. Because post-cardiac arrest care is a coordinated, multi-system effort, the objective described—reducing morbidity and mortality by assessing and managing the respiratory, cardiovascular, and neurologic systems—best captures the overall aim. The other options focus on only one aspect (circulation, pain, or arrhythmia prevention) and miss the comprehensive, multi-system approach essential to improving outcomes.

4. What is the recommended atropine dose for symptomatic bradycardia in pediatric patients?

A. 0.04 mg/kg IV/IO

B. 0.02 mg/kg IV/IO, minimum 0.1 mg; maximum per dose 0.5 mg

C. 0.1 mg/kg IV/IO

D. 0.5 mg/kg IV/IO

In pediatric symptomatic bradycardia, atropine is dosed by weight and given IV or IO to quickly counteract excessive vagal tone on the heart. The standard approach is 0.02 mg/kg per dose, with a minimum of 0.1 mg and a maximum of 0.5 mg per dose. This keeps the dose effective across different child sizes while limiting the risk of anticholinergic toxicity. The 0.02 mg/kg amount is the amount most likely to raise the heart rate when bradycardia is due to vagal stimulation, which is a common reversible cause in children. The minimum ensures even very small patients receive a measurable dose, while the maximum prevents too much atropine, which can cause overheating, delirium, tachyarrhythmias, or paradoxical bradycardia at high levels. If atropine doesn't improve the rhythm, other interventions such as pacing or an epinephrine infusion are considered.

5. During pediatric CPR, the chest compression depth is approximately proportional to which measurement?

A. About one-third of the chest's AP diameter

B. About half the chest's AP diameter

C. About one-quarter of the AP diameter

D. Full chest recoil

In pediatric CPR, how deep you push down should scale with the size of the chest. The guideline is to depress the chest about one-third of the chest's anterior-posterior (front-to-back) diameter. This proportion keeps the heart compressed enough to generate blood flow without causing excessive injury, and it naturally accommodates the wide range of chest sizes from infants to larger children. For example, a small infant's chest AP diameter is narrower, so about a 1.5–4 cm depth corresponds to one-third of that diameter. In an older child, the same fraction translates to a larger actual depth, around 5 cm or so. It's also important to allow full chest recoil between compressions to maximize venous return, but that recoil is separate from the depth guideline.

6. Which infant CPR technique is used when there are two rescuers?

A. Two-finger chest compressions.

B. One-handed chest compressions.

C. Two-thumb-encircling hands on the infant chest.

D. Two-handed chest compressions on the infant chest.

When two rescuers are performing CPR on an infant, the two-thumb-encircling hands technique is used. Placing both thumbs on the sternum while the fingers wrap around the chest behind the infant creates stable, deep, and consistent compressions, which is crucial for this small chest. This method also allows the second rescuer to provide breaths without interrupting the chest compressions, helping maintain perfusion. The other techniques are more suited to single-rescuer scenarios or larger bodies, where achieving reliable depth and coordination is harder; in two-rescuer infant CPR, the encircling two-thumb approach gives the best combination of depth, consistency, and teamwork.

7. What is the recommended immediate treatment for tension pneumothorax?

A. Defibrillation

B. IV antibiotic therapy

C. Chest tube insertion only after imaging

D. Needle decompression

When a tension pneumothorax occurs, air builds up under pressure in the chest, compressing the affected lung and shifting the mediastinal structures. This rapidly impairs ventilation and, more critically, reduces venous return to the heart, leading to a dangerous drop in cardiac output and blood pressure. Because the danger progresses in minutes, the treatment must relieve the pressure immediately, without waiting for imaging or more definitive procedures. The quickest, most effective way to achieve that relief is needle decompression. By inserting a large-bore needle into the chest (commonly in the second intercostal space at the midclavicular line or a safe alternative site) air is allowed to escape, which immediately decompresses the chest and restores venous return and oxygenation. This life-saving step is followed by chest tube placement to provide continuous drainage and re-expand the lung. Defibrillation is used for certain abnormal heart rhythms, not for a trapped air situation like tension pneumothorax. IV antibiotics do not address the mechanical problem causing instability. Chest tube insertion is essential for ongoing management but should not delay relief of the pressure, which is accomplished with needle decompression.

8. In pediatric chest trauma with shock, which emergent condition should be considered?

A. Tension pneumothorax

B. Myocardial infarction

C. Pulmonary embolism

D. Aortic dissection

The key idea is that in a child with chest trauma who is now in shock, the most immediate threat is a tension pneumothorax. When air enters the pleural space and cannot escape, pressure builds rapidly, collapsing the affected lung and pushing the mediastinum toward the opposite side. This compresses the great veins and reduces venous return to the heart, causing a sudden drop in cardiac output and blood pressure—the shock you're seeing. Because this condition can deteriorate in minutes, you treat it right away by relieving the pressure. In practice, that means rapid decompression with a large-bore needle into the chest (often at the second intercostal space midclavicular line) or, once stabilized, placement of a chest tube. You would look for signs like sudden deterioration after chest trauma, reduced or absent breath sounds on one side, hyperresonance on that side, and signs of poor perfusion. Other potential causes of chest trauma–related shock, such as myocardial injury, pulmonary embolism, or aortic injury, are far less likely to present as an acutely life-threatening, pressure-driven crisis in the moment of trauma. They are important to consider later or in different clinical contexts, but the emergency condition that must be addressed first is tension pneumothorax.

9. In pediatric CPR, what is the upper end of the recommended chest compression rate (per minute)?

A. 100 compressions per minute

B. 80 compressions per minute

C. 60 compressions per minute

D. 120 compressions per minute

In pediatric CPR, the chest compression rate should be about 100–120 compressions per minute. The upper end is 120 per minute. Keeping a pace around two compressions per second helps maintain adequate blood flow to the heart and brain. If you go slower, perfusion drops; if you go faster, you risk shallower compressions and incomplete chest recoil, which also reduces effectiveness. The other options are slower than the guideline upper limit, so they would not maximize perfusion as well as the top end.

10. Which option best describes ECMO/ECPR prerequisites for pediatric arrest?

A. In cases where there is no ECMO center available.

B. Refractory arrest with reversible cause and a suitable center.

C. Only in neonates.

D. Any arrest regardless of reversibility.

The key idea is that ECMO/ECPR is considered only when there is a reversible cause for the arrest and a capable center is available to initiate ECMO. This means you've got a child in cardiac arrest that does not respond to high-quality CPR (refractory arrest) and there is a plausible, reversible reason for the collapse—such as myocarditis, pulmonary embolism, severe hypoxia, toxin ingestion, or a surgically correctable problem—and you can quickly get to a center with ECMO capability and a trained team to cannulate and support the patient. If there is no ECMO-capable center nearby, initiating ECMO isn't feasible, because effective ECMO support requires specialized resources and rapid cannulation that typical resuscitation teams don't possess. It's also not limited to neonates; pediatric ECMO/ECPR includes infants and older children who meet the criteria, so restricting to neonates would miss many appropriate cases. And it isn't used for arrests with nonreversible causes, where bridging to recovery isn't possible—even if ECMO could temporarily support circulation, without a reversible problem to fix, the overall outcome would remain poor. So the best-fit description is a refractory arrest with a reversible cause and access to a suitable ECMO-capable center.

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://pediacardiacarrest.examzify.com

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