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Question: 942

A 5-year-old with a history of a corrected congenital heart defect is being transported for septic shock. The clinician decides to use an alpha-1 adrenergic agonist to increase systemic vascular resistance. Which medication is a pure alpha-1 agonist?

- A. Isoproterenol
- B. Dobutamine
- C. Phenylephrine

Answer: C

Explanation: Phenylephrine is a selective alpha-1 adrenergic receptor agonist. It causes potent vasoconstriction of the peripheral blood vessels, which increases systemic vascular resistance and raises blood pressure. Unlike epinephrine or dopamine, it has virtually no beta-adrenergic activity, meaning it does not directly increase heart rate or myocardial contractility.

Question: 943

A neonate is being transported for management of Hyperammonemia suspected to be caused by a Urea Cycle Disorder. What is the most important initial management goal for this infant?

- A. Administering high-protein feeds
- B. Restricting all fluid intake
- C. High-rate glucose IV infusion

Answer: C

Explanation: The primary goal in managing a urea cycle disorder is to reverse the catabolic state that leads to protein breakdown and ammonia production. Providing a high rate of intravenous glucose (with or without intralipids) provides non-protein calories to suppress catabolism while protein intake is temporarily halted.

Question: 944

During the transport of a 14-year-old with a massive hemothorax, the patient suddenly develops worsening respiratory distress and obstructive shock symptoms. The chest tube, which was draining bright red blood, has stopped draining. What is the most likely cause of this acute clinical deterioration?

- A. Development of a tension pneumothorax
- B. Kinking or occlusion of the chest tube
- C. Rupture of the diaphragm from blunt force

Answer: B

Explanation: In a patient with a known hemothorax, a sudden cessation of drainage accompanied by hemodynamic collapse and respiratory distress suggests that the tube has become occluded (often by a blood clot). This allows blood or air to accumulate in the pleural space, leading to a tension physiology where the mediastinum is shifted, venous return is impaired, and the patient enters obstructive shock.

Question: 945

A pediatric patient with a ruptured arteriovenous malformation (AVM) is being transported. The transport nurse must ensure the patient's head is maintained in a specific position to optimize venous drainage and minimize ICP. What is the recommended position?

- A. Midline and flat at 0 degrees
- B. Midline at 30 degrees elevation
- C. Turned to the side at 45 degrees

Answer: B

Explanation: Maintaining the head in a midline position at 30 degrees of elevation is the standard of care for neurological transport. This position utilizes gravity to facilitate venous outflow through the jugular veins while preventing kinking of the vessels that occurs when the head is turned, thereby helping to keep intracranial pressure lower.

Question: 946

When assessing a neonate for transport who was born to a mother with poorly controlled gestational diabetes, the clinician anticipates which specific electrolyte imbalance within the first 24 hours of life?

- A. Hypocalcemia related to delayed functional hypoparathyroidism in the newborn infant
- B. Hypomagnesemia caused by excessive maternal renal excretion of magnesium in utero
- C. Hypercalcemia due to increased parathyroid hormone sensitivity in the neonatal period

Answer: A

Explanation: Infants of diabetic mothers are at increased risk for hypocalcemia. The mechanism involves maternal hypermagnesemia (due to renal losses) causing fetal hypermagnesemia, which suppresses the fetal parathyroid glands. After birth, the infant experiences a functional hypoparathyroidism, leading to a delayed rise in parathyroid hormone and subsequent low serum calcium levels.

Question: 947

A 10-year-old child with a suspected spinal cord injury after a diving accident is being transported. The patient is bradycardic and hypotensive, with warm, flushed skin below the level of the injury. What is the most likely cause of this hemodynamic profile?

- A. Hypovolemic shock from an undiagnosed internal hemorrhage
- B. Neurogenic shock resulting from a loss of sympathetic vascular tone
- C. Obstructive shock caused by an undiagnosed tension pneumothorax

Answer: B

Explanation: Neurogenic shock occurs after a high-level spinal cord injury (typically above T6) due to the disruption of the autonomic nervous system. This leads to a loss of sympathetic tone, resulting in massive vasodilation (causing warm, flushed skin) and a lack of compensatory tachycardia (leading to bradycardia). This is distinct from hypovolemic shock, where the skin is typically cool and pale and the heart rate is elevated.

Question: 948

A 9-year-old male with a history of a large mediastinal mass is experiencing increased respiratory distress and facial swelling during transport. He is currently in a supine position. What is the most appropriate immediate positioning intervention?

- A. Placing the patient in a sitting or semi-Fowler's position
- B. Placing the patient in a prone position to improve V/Q matching
- C. Placing the patient in Trendelenburg to improve venous return

Answer: A

Explanation: Superior Vena Cava (SVC) Syndrome or mediastinal mass compression can cause critical airway and vascular obstruction. Placing the patient in a sitting or semi-Fowler's position uses gravity to reduce the pressure of the mass on the airway and the superior vena cava, potentially improving both ventilation and cardiac output.

Question: 949

The "Time of Useful Consciousness" (TUC) is a concept primarily used in aviation. In the context of a neonatal transport team, how does a rapid decompression event affect the team's ability to care for the infant?

- A. Slower respiratory rate in staff
- B. Reduced time to perform tasks
- C. Increased ability to concentrate

Answer: B

Explanation: Rapid decompression at high altitudes leads to a sudden drop in the partial pressure of oxygen, causing hypoxia. The Time of Useful Consciousness is the period during which an individual can still perform purposeful activities. If this time expires, the team cannot provide life-saving care to the neonate.

Question: 950

A 15-year-old adolescent is being transported for heatstroke after a long-distance race in high humidity. The core temperature is 41°C (105.8°F), and the patient is experiencing altered mental status and hypotension. Which cooling method is most effective and recommended for rapid reduction of core temperature during the stabilization phase?

- A. Evaporative cooling using lukewarm water mist and large fans
- B. Gastric lavage with iced saline via a large-bore nasogastric tube
- C. Application of cold packs to the axilla and groin regions

Answer: A

Explanation: Evaporative cooling is considered highly effective for heatstroke because it utilizes the high latent heat of vaporization to remove heat from the body surface. While immersion in cold water is the gold standard in some settings, it is often impractical during transport. Evaporative cooling, combined with convection, provides a safe and rapid rate of cooling while allowing the transport team to maintain access to the patient for monitoring and other necessary medical interventions.

Question: 951

What is the primary electrolyte concern in an ELBW infant during the first 24 hours of life if they have high insensible water losses?

- A. Hypernatremia
- B. Hypercalcemia
- C. Hypokalemia

Answer: A

Explanation: High insensible water loss (IWL) leads to the loss of free water. In the ELBW infant, the loss of water exceeds the loss of solutes, leading to an increase in the concentration of sodium in the blood. This hypernatremia can cause intracellular dehydration and increase the risk of brain injury.

Question: 952

A 2-year-old with severe croup has received dexamethasone. How long does this medication typically take to show a clinical effect in reducing airway edema?

- A. 4 to 6 hours
- B. 10 to 15 minutes
- C. 1 to 2 hours

Answer: C

Explanation: While racemic epinephrine works almost instantly, corticosteroids like dexamethasone have a delayed onset. It generally takes about 1 to 2 hours for the anti-inflammatory effects to begin reducing the subglottic edema in croup. Transport teams must be aware of this delay and not rely on steroids for immediate airway stabilization during short transports.

Question: 953

During the transport of a neonate with a core temperature of 34.5°C (94.1°F), the nurse notes a decrease in the infant's oxygen saturation (SpO_2) and an increase in respiratory effort. This clinical deterioration is most likely linked to:

- A. Reduction in the surfactant production due to metabolic alkalosis
- B. Pulmonary hypertension and increased pulmonary vascular resistance
- C. Increased affinity of hemoglobin for oxygen (left shift)

Answer: B

Explanation: Cold stress leads to a cascade of physiological events, including the release of norepinephrine. This results in peripheral vasoconstriction and can lead to increased pulmonary vascular resistance (PVR). Increased PVR can cause right-to-left shunting and exacerbate respiratory distress or lead to persistent pulmonary hypertension of the newborn (PPHN).

Question: 954

A 12-hour-old infant has a pre-ductal saturation of 95% and a post-ductal saturation of 82%. A chest X-ray shows clear lung fields and a "string of pearls" appearance of the pulmonary vasculature. Which medication must be initiated immediately during transport?

- A. Furosemide
- B. Alprostadil
- C. Hydrocortisone

Answer: B

Explanation: A significant difference between pre-ductal and post-ductal oxygen saturations (greater than 10%) indicates right-to-left shunting at the ductal level. This is often seen in ductal-dependent cyanotic heart disease or severe Persistent Pulmonary Hypertension of the Newborn (PPHN). Administering Alprostadil (prostaglandin E1) is essential to maintain patency of the ductus arteriosus, ensuring either systemic or pulmonary blood flow depending on the underlying lesion, and is a standard of care in neonatal transport for suspected cardiac lesions.

Question: 955

A 620-gram neonate born at 24 weeks gestation is being stabilized for transport. The team is utilizing a chemical thermal mattress and a polyethylene wrap. Despite these measures, the infant's temperature is 35.8°C. What is the most appropriate physiological rationale for maintaining a neutral thermal environment in this specific patient population?

- A. Minimizing oxygen consumption and metabolic rate
- B. Reducing the risk of intraventricular hemorrhage
- C. Maximizing glucose stores for organogenesis

Answer: A

Explanation: Maintaining a neutral thermal environment is critical for the extremely low birth weight neonate because it allows the infant to maintain a normal core temperature with minimum oxygen consumption and caloric expenditure. When an infant is outside this range, they must increase their metabolic rate to produce heat, which can lead to metabolic acidosis, hypoxia, and rapid depletion of limited glycogen stores.

Question: 956

A 6-month-old infant with chronic lung disease (CLD) is being transported at an altitude of 5,000 feet in an unpressurized aircraft. The infant has a baseline oxygen requirement of 0.5 L/min at sea level. According to Dalton's Law and the alveolar gas equation, what adjustment is required?

- A. Maintain the sea-level flow rate and monitor with pulse oximetry
- B. Increase the inspired oxygen concentration to maintain PaO₂ levels
- C. Decrease the flow of oxygen to prevent oxygen toxicity at altitude

Answer: B

Explanation: As barometric pressure decreases with altitude, the partial pressure of inspired oxygen also decreases. For a patient with CLD and limited reserve, this change will lead to hypoxia. To maintain the

same partial pressure of arterial oxygen (PaO₂) as at sea level, the fraction of inspired oxygen (FiO₂) or the flow rate must be increased during flight.

Question: 957

A 1,200-gram infant is being transported on a pressure-controlled ventilator. The transport therapist notes that the exhaled tidal volume has suddenly dropped from 6 mL to 2 mL, and the breath sounds are diminished bilaterally. The ventilator circuit and endotracheal tube position are verified as intact. What is the most likely cause of this acute change?

- A. Occlusion of the endotracheal tube by a mucus plug
- B. Development of a unilateral tension pneumothorax
- C. Improvement in the infant's lung compliance

Answer: A

Explanation: A sudden, significant drop in exhaled tidal volume while on pressure-controlled ventilation suggests a total or near-total obstruction of the airway. In neonates, especially those with small-diameter endotracheal tubes, mucus plugging is a common and critical cause of acute ventilation failure that requires immediate suctioning or tube replacement.

Question: 958

A transport team is caring for a 12-year-old in neurogenic shock following a diving accident. The patient is hypotensive and bradycardic. Which medication is the most appropriate first-line pressor to address both the loss of vascular tone and the low heart rate?

- A. Atropine
- B. Phenylephrine
- C. Dopamine

Answer: C

Explanation: Neurogenic shock results in a loss of sympathetic tone, leading to vasodilation (hypotension) and a lack of compensatory tachycardia (bradycardia). Dopamine provides both alpha-adrenergic stimulation for vasoconstriction and beta-adrenergic stimulation to increase the heart rate, making it more suitable than a pure alpha-agonist like phenylephrine.

Question: 959

A neonate is being transported for evaluation of a midline scalp defect and a small, hair-covered lump over

the spine. The transport team should prioritize which position to prevent further neurological injury?

- A. Supine position with head elevated
- B. Prone position with head to side
- C. Lateral decubitus with hip flexion

Answer: B

Explanation: In the presence of a neural tube defect or an open myelomeningocele, the infant must be kept in the prone position. This prevents direct pressure on the exposed neural elements and the delicate sac, reducing the risk of trauma and cerebrospinal fluid leakage. This position is maintained throughout the transport process until surgical intervention can occur.



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