COMPREHENSIVE MOCK EXAM 8

Supplemental to: Pediatric Hospital Medicine Board Review 2026-2027

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American Board of Pediatrics (ABP) Pediatric Hospital Medicine Certification Examination — 200 questions, single-best-answer, 4 options (A-D), domain-weighted per official ABP content outline

Board-Review Questions

1. A 14-month-old boy has a generalized tonic-clonic seizure that has now lasted 25 minutes despite two appropriately dosed doses of benzodiazepine (one rectal diazepam by EMS, one IV lorazepam on arrival). He continues to seize. Temperature is 39.4°C, heart rate 168/min, oxygen saturation 91% on room air, and IV access is secure.

A. Administer a third dose of benzodiazepine and reassess in 5 minutes

B. Obtain an emergent head CT before any further treatment

C. Begin a phenobarbital infusion as the first-line second agent

D. Administer a loading dose of fosphenytoin or levetiracetam

2. A 6-year-old girl is hospitalized with fever and altered mental status. Lumbar puncture shows 850 WBC/mm3 (88% neutrophils), glucose 28 mg/dL (serum glucose 95 mg/dL), and protein 180 mg/dL. Gram stain is pending. She has no rash and is hemodynamically stable.

A. Withhold antibiotics until Gram stain and culture results are available

B. Begin empiric vancomycin plus a third-generation cephalosporin immediately

C. Begin empiric acyclovir alone pending viral PCR results

D. Discharge home with close outpatient follow-up given hemodynamic stability

3. A 9-year-old boy develops fever, severe headache, and neck stiffness three days after treatment for acute sinusitis. MRI shows a rim-enhancing intracranial lesion with surrounding edema adjacent to the frontal sinus.

A. Start oral amoxicillin-clavulanate and observe as an outpatient

B. Consult neurosurgery for possible drainage and start broad-spectrum IV antibiotics

C. Treat with a single dose of IV dexamethasone only

D. Repeat imaging in one week before any intervention

4. A 4-year-old previously healthy girl has 5 days of fever, headache, and behavioral changes, now with new-onset focal seizures. MRI shows T2/FLAIR hyperintensity in the temporal lobes bilaterally. CSF shows lymphocytic pleocytosis with normal glucose.

A. Start empiric IV acyclovir immediately while awaiting HSV PCR

B. Withhold acyclovir until HSV PCR results return to avoid unnecessary exposure

C. Begin empiric antituberculous therapy given the subacute course

D. Treat with high-dose IV methylprednisolone alone for presumed autoimmune encephalitis

5. A 15-year-old girl is hospitalized with a 2-week history of daily headaches that are worse in the morning, associated with vomiting, and now with new diplopia. Fundoscopic exam reveals bilateral papilledema.

A. Obtain emergent neuroimaging before lumbar puncture

B. Perform lumbar puncture immediately to evaluate opening pressure

C. Start empiric migraine prophylaxis and reassess in one week

D. Discharge with outpatient ophthalmology follow-up in one month

6. A 3-month-old is hospitalized for evaluation of profound hypotonia noted since birth, with a weak cry, poor suck, and tongue fasciculations. There is no facial weakness and the infant is alert with normal eye movements.

A. Order a brain MRI as the first diagnostic step

B. Send genetic testing for spinal muscular atrophy (SMN1 deletion)

C. Begin empiric IVIG for suspected Guillain-Barré syndrome

D. Obtain a muscle biopsy as the initial diagnostic test

7. A previously healthy 7-year-old develops rapidly progressive ascending weakness over 4 days after a diarrheal illness. Exam shows symmetric distal-to-proximal weakness and absent deep tendon reflexes, with intact sensation.

A. Reassure the family this is a self-limited viral myositis

B. Start high-dose oral corticosteroids as first-line therapy

C. Discharge with outpatient neurology follow-up in 2 weeks

D. Admit for close monitoring of respiratory status and initiate IVIG

8. A 10-year-old with sickle cell disease presents with sudden-onset right-sided weakness and expressive aphasia. Symptoms began 90 minutes ago. He is afebrile and hemodynamically stable.

A. Administer tissue plasminogen activator immediately

B. Begin oral hydroxyurea to reduce sickling acutely

C. Obtain emergent neuroimaging and arrange exchange transfusion

D. Start empiric antiepileptic therapy for presumed seizure

9. A 3-year-old girl has 3 days of fever, drooling, muffled voice, and inability to swallow secretions. She is sitting upright with her neck extended and appears anxious. Lateral neck radiograph shows widening of the prevertebral soft tissue space.

A. Perform a direct oral exam with a tongue depressor to visualize the airway

B. Keep the child calm, avoid agitating exams, and urgently involve anesthesia/ENT for airway management

C. Obtain a CT of the neck with the child supine before any other intervention

D. Administer oral amoxicillin and discharge with close follow-up

10. A 4-year-old boy has a rapidly enlarging, tender, erythematous mass in the left submandibular region with fever, trismus, and difficulty opening his mouth. Ultrasound shows a fluid collection within the mass.

A. Consult ENT for surgical incision and drainage plus IV antibiotics

B. Treat with oral antibiotics alone and reassess in 48 hours

C. Order an MRI before considering any intervention

D. Aspirate the collection at bedside without surgical consultation

11. A 12-year-old boy has 4 days of sore throat, trismus, muffled 'hot potato' voice, and uvular deviation to the left on exam. He is drooling but maintaining his airway.

A. Prescribe oral penicillin and discharge with ENT follow-up

B. Obtain ENT consultation for needle aspiration or incision and drainage plus IV antibiotics

C. Order a chest CT to evaluate for mediastinal extension before any intervention

D. Administer a single dose of oral dexamethasone and observe overnight without further workup

12. An 8-year-old girl has 5 days of fever, right periorbital swelling, erythema, and pain with limited extraocular movements and mild proptosis. She reports diplopia on lateral gaze.

A. Diagnose preseptal cellulitis and treat with oral antibiotics as an outpatient

B. Obtain orbital CT with contrast and start IV antibiotics for suspected orbital cellulitis

C. Reassure the family this is allergic conjunctivitis and prescribe antihistamines

D. Discharge with ophthalmology follow-up in one week without imaging

13. A 6-year-old boy develops sudden severe otalgia, fever, and postauricular swelling with the pinna displaced anteriorly and inferiorly. He has a history of untreated acute otitis media over the past two weeks.

A. Obtain temporal bone CT and consult ENT for suspected mastoiditis

B. Treat with oral amoxicillin and reassess in 3 days

C. Reassure the family this is a normal postauricular lymph node and discharge

D. Order an audiogram as the next diagnostic step

14. A 2-year-old boy has fever and left-sided facial swelling with erythema over the angle of the jaw, worse with eating, and purulent discharge expressible from the Stensen duct on exam.

A. Diagnose mumps and manage supportively without antibiotics

B. Order a fine-needle aspiration as the first diagnostic step

C. Start antiviral therapy for presumed viral parotitis

D. Start IV antibiotics covering Staphylococcus aureus for suppurative parotitis

15. A 5-year-old with bronchiolitis-like symptoms two winters ago now presents with cough, low-grade fever, and wheezing for 3 days, with mild subcostal retractions and oxygen saturation 94% on room air. He has had two similar episodes this year.

A. Provide supplemental oxygen as needed, bronchodilator trial, and supportive care

B. Start a 10-day course of oral antibiotics for presumed bacterial bronchitis

C. Order a chest CT to evaluate for structural airway disease before any treatment

D. Begin daily inhaled corticosteroids as an inpatient without further evaluation

16. A 7-year-old girl has 2 days of fever, drooling, and a muffled voice with rapid symptom progression over hours. She is sitting forward in a tripod position with stridor at rest. Lateral neck x-ray shows a thumbprint sign.

A. Obtain a lateral neck CT to confirm the diagnosis before treatment

B. Attempt to visualize the airway directly with a tongue depressor

C. Administer racemic epinephrine and observe for improvement before further action

D. Avoid agitating the child and urgently secure the airway in a controlled setting (OR) with anesthesia/ENT

17. A 4-month-old former 32-week premature infant is hospitalized with bronchiolitis. On day 2, he has increasing work of breathing, retractions, and oxygen saturation 90% on room air, with clear breath sounds after recent suctioning.

A. Provide supplemental oxygen and continue supportive care with monitoring

B. Start a 5-day course of oral azithromycin

C. Administer a single dose of systemic corticosteroids

D. Begin nebulized hypertonic saline as first-line therapy

18. A 6-year-old with poorly controlled asthma presents with severe respiratory distress, accessory muscle use, and a peak flow 35% of predicted despite continuous albuterol and ipratropium nebulizers and systemic corticosteroids over 2 hours.

A. Discharge home with a short course of oral steroids and rescue inhaler

B. Administer IV magnesium sulfate and consider escalation to a higher level of care

C. Switch to a long-acting beta-agonist for more sustained bronchodilation

D. Order a chest CT to evaluate for an alternative diagnosis

19. A 3-year-old previously healthy boy has acute-onset coughing and stridor while eating peanuts, followed by resolution of stridor but persistent unilateral decreased breath sounds and wheeze on the right side. Chest x-ray shows hyperinflation of the right lung.

A. Consult otolaryngology/pulmonology for rigid bronchoscopy

B. Treat empirically with bronchodilators for presumed asthma exacerbation

C. Reassure the family the episode has resolved and discharge home

D. Order a CT chest with IV contrast as the definitive next step

20. A 5-year-old girl has 4 days of high fever, cough, and now rapid onset of respiratory distress with decreased breath sounds and dullness to percussion at the right lung base. Chest x-ray confirms a large right-sided pleural effusion.

A. Treat with oral antibiotics alone as an outpatient, without first addressing the more immediately concerning finding

B. Perform emergent chest tube placement without imaging confirmation, a step that is not supported by current evidence-based guidelines

C. Start IV antibiotics and obtain thoracentesis/chest tube drainage guided by effusion size and respiratory status

D. Withhold antibiotics until a definitive causative organism is identified, which risks clinical deterioration if the diagnosis is missed

21. A 2-year-old with severe bronchiolitis has increasing work of breathing despite high-flow nasal cannula at maximum settings, with rising CO2 (68 mmHg) on venous blood gas and intermittent apnea.

A. Escalate to noninvasive positive pressure ventilation or prepare for intubation

B. Increase high-flow nasal cannula flow rate further and reassess in 4 hours

C. Administer a dose of inhaled racemic epinephrine and observe

D. Start empiric antibiotics for presumed bacterial superinfection

22. A 3-year-old with chronic lung disease of prematurity (moderate bronchopulmonary dysplasia) on home oxygen is admitted with a viral upper respiratory infection and increased oxygen requirement above his baseline. He is otherwise stable.

A. Wean home oxygen to test respiratory reserve, a step that is not supported by current evidence-based guidelines

B. Increase supplemental oxygen to maintain saturation targets and provide supportive care with close monitoring

C. Start prophylactic broad-spectrum IV antibiotics, without first addressing the more immediately concerning finding

D. Initiate systemic corticosteroids as first-line therapy, which risks clinical deterioration if the diagnosis is missed

23. A 4-year-old boy has a brief croup-like prodrome followed by high fever, toxic appearance, and rapidly worsening stridor unresponsive to racemic epinephrine and dexamethasone. He has copious purulent-appearing secretions.

A. Repeat racemic epinephrine every 2 hours and continue observation

B. Add oral antibiotics and discharge if stridor improves at rest

C. Diagnose viral croup and continue standard croup management

D. Suspect bacterial tracheitis; secure the airway and start IV antibiotics

24. A 6-year-old with severe community-acquired pneumonia develops worsening hypoxemia (PaO_2/FiO_2 ratio 110) with bilateral diffuse infiltrates on chest x-ray despite appropriate antibiotics, without evidence of volume overload or cardiac dysfunction.

A. Increase antibiotic coverage empirically for resistant organisms, an approach inconsistent with standard management for this presentation

B. Diurese aggressively for presumed fluid overload before the more urgent issue has been addressed

C. Discharge with outpatient pulmonology follow-up once afebrile, a step that is not supported by current evidence-based guidelines

D. Recognize evolving pediatric ARDS and escalate respiratory support with lung-protective ventilation strategies

25. A 9-year-old with known asthma presents in status asthmaticus with silent chest, minimal air movement, and altered mental status despite maximal bronchodilator and steroid therapy.

A. Prepare for intubation and PICU-level respiratory support

B. Administer an additional dose of inhaled albuterol and reassess in 30 minutes

C. Obtain a chest x-ray before any further intervention

D. Start a leukotriene receptor antagonist for additional bronchodilation

26. A 2-year-old former 28-week premature infant with moderate bronchopulmonary dysplasia and home oxygen is now completing therapy for RSV bronchiolitis and is back near baseline oxygen requirement, tolerating feeds well, and clinically stable.

A. Continue inpatient observation indefinitely until fully off supplemental oxygen

B. Wean home oxygen support below baseline prior to discharge

C. Discharge home on baseline home oxygen with close outpatient follow-up once clinically stable

D. Transfer to a higher level of care given underlying chronic lung disease

27. A 5-month-old is admitted with poor feeding, tachypnea, and diaphoresis with feeds over several weeks. Exam shows hepatomegaly, a gallop rhythm, and cardiomegaly on chest x-ray. Echocardiogram shows a dilated, poorly contractile left ventricle.

A. Initiate heart failure management (diuretics, afterload reduction) and evaluate for underlying etiology

B. Reassure the family this is a normal variant and discharge

C. Start empiric antibiotics for presumed myocarditis without further workup

D. Proceed directly to cardiac transplantation evaluation without medical therapy trial

28. A previously well-appearing 10-day-old presents with poor feeding, lethargy, and diminished femoral pulses compared to brachial pulses, with a blood pressure differential between upper and lower extremities.

A. Reassure the family this reflects normal neonatal vascular variation

B. Start empiric antibiotics for presumed sepsis as the sole intervention

C. Suspect coarctation of the aorta, start prostaglandin E1, and obtain echocardiography

D. Discharge with outpatient cardiology follow-up in one week

29. An 8-year-old with known dilated cardiomyopathy presents with worsening dyspnea, orthopnea, and peripheral edema. Exam reveals jugular venous distension, hepatomegaly, and bibasilar crackles despite adherence to his home diuretic regimen.

A. Discontinue diuretics given adequate baseline therapy

B. Increase oral fluid intake to improve renal perfusion

C. Discharge home with reassurance that symptoms are expected

D. Admit for IV diuresis and further heart failure optimization

30. A 2-month-old infant is brought in fussy and poorly feeding for several hours. Heart rate is 280/min and regular on monitor, with narrow QRS complexes and no visible P waves. Blood pressure is stable and the infant is alert.

A. Administer IV amiodarone as first-line therapy

B. Attempt synchronized cardioversion immediately given the rate

C. Attempt vagal maneuvers first, then IV adenosine if unsuccessful

D. Observe without intervention since the infant is hemodynamically stable

31. A 12-year-old boy has 3 days of fever, chest pain worsened by lying flat and improved by leaning forward, and a friction rub on auscultation. ECG shows diffuse ST-segment elevation with PR depression.

A. Diagnose acute myocardial infarction and activate the cardiac catheterization lab

B. Diagnose acute pericarditis, treat with NSAIDs, and monitor for effusion/tamponade

C. Discharge home with reassurance that this is musculoskeletal chest pain

D. Begin empiric anticoagulation for suspected pulmonary embolism

32. A 14-year-old girl has a single episode of syncope while standing in a hot, crowded room, preceded by lightheadedness, tunnel vision, and diaphoresis, with rapid spontaneous recovery. Cardiac exam and ECG are normal, and there is no family history of sudden death.

A. Provide reassurance and counsel on hydration and avoidance triggers for vasovagal syncope

B. Admit for continuous cardiac monitoring and electrophysiology consultation

C. Order an emergent echocardiogram before discharge

D. Restrict all physical activity pending exercise stress testing

33. A 16-year-old with a history of untreated hypertension presents with severe headache, blurred vision, and blood pressure 210/130 mmHg with new-onset seizure activity.

A. Lower blood pressure to normal range within the first hour using oral agents

B. Discharge with outpatient antihypertensive titration once seizure resolves

C. Withhold antihypertensive therapy until neuroimaging is complete

D. Initiate IV antihypertensive therapy with controlled, gradual blood pressure reduction while treating the seizure

34. A 5-year-old with fever and a known central line has hypotension, tachycardia, cool extremities, and delayed capillary refill. Lactate is elevated. He remains hypotensive after 40 mL/kg of isotonic fluid.

A. Continue fluid boluses indefinitely without considering vasoactive support

B. Withhold antibiotics until blood cultures from the line and periphery result

C. Start a vasoactive agent and continue broad-spectrum antibiotics

D. Discontinue the central line as the sole intervention and observe

35. A 10-year-old boy has 18 hours of periumbilical pain that migrated to the right lower quadrant, with anorexia, low-grade fever, and focal tenderness with guarding at McBurney point. WBC is elevated with a left shift.

A. Consult surgery for suspected appendicitis and obtain confirmatory imaging (ultrasound or CT) as needed

B. Treat empirically with oral antibiotics for gastroenteritis and reassess in 24 hours

C. Discharge with outpatient follow-up and return precautions

D. Start a bowel regimen for presumed constipation before further workup

36. A 15-year-old girl with obesity has 2 days of right upper quadrant pain radiating to the right scapula, fever, and a positive Murphy sign. Ultrasound shows gallbladder wall thickening, pericholecystic fluid, and a gallstone.

A. Manage with oral analgesics alone as an outpatient, though the clinical picture warrants more definitive action

B. Order an urgent MRCP before any other intervention, an approach inconsistent with standard management for this presentation

C. Start IV antibiotics, provide analgesia, and consult surgery for cholecystectomy

D. Begin ursodeoxycholic acid as first-line therapy, without first addressing the more immediately concerning finding

37. A 4-year-old boy has a 3-month history of infrequent, hard bowel movements, straining, and occasional overflow soiling, with a palpable stool mass on abdominal exam. He is otherwise growing and developing normally.

A. Obtain an emergent abdominal CT to evaluate for obstruction, though the clinical picture warrants more definitive action

B. Refer immediately for surgical evaluation of Hirschsprung disease, despite the risk this poses of delaying definitive treatment

C. Initiate disimpaction followed by maintenance osmotic laxative therapy and behavioral management

D. Start a strict low-fiber diet to reduce stool bulk, though this does not address the most likely diagnosis here

38. A 14-month-old has 2 days of vomiting and watery diarrhea with decreased urine output. Exam shows dry mucous membranes, delayed capillary refill, and lethargy. He tolerates small amounts of oral fluids but continues to have frequent loose stools.

A. Manage entirely with oral rehydration alone despite lethargy

B. Begin IV isotonic fluid resuscitation given signs of moderate-to-severe dehydration

C. Start empiric antibiotics for presumed bacterial gastroenteritis

D. Discharge home with instructions to force oral fluids every 15 minutes

39. A 6-week-old exclusively breastfed infant has frequent effortless spit-up after feeds but is gaining weight appropriately along his growth curve, is otherwise well-appearing, and has no respiratory symptoms or blood in emesis.

A. Start a proton pump inhibitor immediately, without first addressing the more immediately concerning finding

B. Reassure the family this is physiologic reflux and provide conservative feeding advice

C. Order an upper GI series to evaluate for malrotation, which risks clinical deterioration if the diagnosis is missed

D. Recommend switching to a hydrolyzed formula immediately, a step that is not supported by current evidence-based guidelines

40. A 3-year-old boy has several episodes of bright red blood mixed with stool and crampy abdominal pain that resolves between episodes, along with lethargy during episodes. Abdominal exam reveals a sausage-shaped mass in the right upper quadrant.

A. Reassure the family this is likely an anal fissure and manage conservatively, which could delay recognition of a more serious underlying process

B. Start empiric antibiotics for presumed infectious colitis, though this does not address the most likely diagnosis here

C. Order an outpatient colonoscopy in one week alone, without confirming the response to therapy

D. Obtain an urgent abdominal ultrasound and prepare for air/contrast enema reduction for suspected intussusception

41. A 2-week-old previously well infant develops bilious emesis and abdominal distension over several hours, becoming increasingly irritable with bloody stools. Abdominal x-ray shows a paucity of distal bowel gas.

A. Start oral rehydration and observe for 24 hours, despite the risk this poses of delaying definitive treatment

B. Order an outpatient upper GI series in 2-3 days before the more urgent issue has been addressed

C. Diagnose reflux and start acid suppression, though the clinical picture warrants more definitive action

D. Obtain emergent upper GI contrast study and consult surgery for suspected malrotation with volvulus

42. A 5-week-old male infant has progressively worsening non-bilious, projectile vomiting after feeds, with a hungry appearance afterward. Electrolytes show hypochloremic, hypokalemic metabolic alkalosis. A firm, olive-shaped mass is palpated in the epigastrium.

A. Proceed directly to surgery without correcting electrolyte abnormalities

B. Correct fluid and electrolyte abnormalities first, then proceed to pyloromyotomy

C. Manage conservatively with formula thickening alone

D. Start a proton pump inhibitor as definitive therapy

43. A 13-year-old girl has severe, constant epigastric pain radiating to the back, with vomiting. Lipase is markedly elevated at 5 times the upper limit of normal, and abdominal ultrasound shows a swollen, edematous pancreas without gallstones.

A. Start early enteral feeding is contraindicated; keep strictly NPO until pain resolves completely

B. Begin empiric antibiotics for presumed infected pancreatic necrosis

C. Proceed to ERCP as the first intervention

D. Provide IV fluid resuscitation, pain control, and early enteral feeding as tolerated

44. A 14-year-old boy has 4 months of intermittent abdominal pain, diarrhea, unintentional weight loss, and decreased growth velocity. Labs show microcytic anemia and elevated inflammatory markers. He also has perianal skin tags on exam.

A. Refer for endoscopy/colonoscopy with biopsies for suspected inflammatory bowel disease (Crohn disease)

B. Reassure the family this is irritable bowel syndrome and manage with dietary modification alone

C. Start empiric antibiotics for presumed infectious colitis without further workup

D. Diagnose lactose intolerance and recommend a lactose-free diet

45. A 4-year-old girl has bloody diarrhea for 5 days following consumption of undercooked ground beef, now with pallor, decreased urine output, and petechiae. Labs show anemia with schistocytes, thrombocytopenia, and elevated creatinine.

A. Start ciprofloxacin to treat the presumed E. coli O157:H7 infection before the more urgent issue has been addressed

B. Administer antimotility agents to reduce diarrhea and fluid losses alone, without confirming the response to therapy

C. Transfuse platelets prophylactically regardless of bleeding, an approach inconsistent with standard management for this presentation

D. Provide supportive care with careful fluid/electrolyte management and avoid antibiotics and antimotility agents

46. A 7-year-old with acute kidney injury from dehydration has a rising creatinine, mild hyperkalemia, and oliguria. He is hemodynamically stable and tolerating oral intake after initial IV fluid resuscitation.

A. Start renal replacement therapy immediately regardless of severity

B. Restrict all fluids and give a single large diuretic dose

C. Optimize volume status, monitor electrolytes closely, and avoid nephrotoxic medications

D. Begin empiric high-dose corticosteroids for presumed glomerulonephritis

47. A 13-year-old boy has sudden-onset severe left testicular pain and swelling that began 2 hours ago, with nausea and vomiting. The testicle is high-riding and transverse, with an absent cremasteric reflex.

A. Order a scrotal ultrasound and wait for results before any further action

B. Treat empirically with antibiotics for presumed epididymitis and reassess in 24 hours

C. Apply scrotal elevation and ice, then discharge with urology follow-up

D. Emergently consult urology for surgical exploration and detorsion without delaying for imaging if suspicion is high

48. A 4-year-old boy has new-onset periorbital and lower extremity edema over 3 days. Urinalysis shows 4+ protein with no red blood cells, and serum albumin is 1.8 g/dL with hyperlipidemia.

A. Start corticosteroid therapy for presumed minimal change disease and monitor for complications (infection, thrombosis)

B. Begin empiric antibiotics for presumed nephritic syndrome, despite the risk this poses of delaying definitive treatment

C. Order an emergent renal biopsy before any treatment, a step that is not supported by current evidence-based guidelines

D. Restrict all fluids and sodium as the sole management, though this does not address the most likely diagnosis here

49. A 3-year-old girl has fever, flank pain, and vomiting for 2 days. Urinalysis shows pyuria and bacteriuria, and she appears moderately ill but is tolerating oral intake. Renal ultrasound is unremarkable.

A. Start appropriate oral or IV antibiotics based on clinical severity and arrange follow-up imaging per guidelines

B. Withhold antibiotics until urine culture finalizes in 48 hours, an approach that would leave the underlying process unaddressed

C. Discharge without any antibiotic therapy given a normal ultrasound, without first addressing the more immediately concerning finding

D. Proceed directly to a voiding cystourethrogram before starting treatment, though the clinical picture warrants more definitive action

50. A 15-year-old girl has acute-onset severe right lower quadrant pain with nausea and vomiting. Pelvic ultrasound shows an enlarged right ovary with absent Doppler flow and a large cyst.

A. Manage with oral analgesics alone as an outpatient

B. Start empiric antibiotics for presumed pelvic inflammatory disease

C. Emergently consult gynecology for suspected ovarian torsion and surgical evaluation

D. Repeat the ultrasound in 24 hours before further action

51. A 7-year-old boy develops gross tea-colored urine, periorbital edema, and hypertension 10 days after a streptococcal throat infection. Urinalysis shows red blood cell casts and mild proteinuria, and complement C3 is low.

A. Diagnose minimal change nephrotic syndrome and start corticosteroids, an approach inconsistent with standard management for this presentation

B. Diagnose post-streptococcal glomerulonephritis and manage supportively with monitoring of blood pressure, fluid status, and renal function

C. Start empiric antibiotics for ongoing streptococcal infection as the primary treatment, despite the risk this poses of delaying definitive treatment

D. Proceed immediately to renal biopsy before initiating any management, a step that is not supported by current evidence-based guidelines

52. A 14-year-old boy has sudden-onset severe colicky left flank pain radiating to the groin, with hematuria. CT confirms a 4 mm ureteral stone without hydronephrosis. He is tolerating oral intake and pain is controlled.

A. Proceed immediately to surgical stone removal regardless of size

B. Restrict all oral fluids to reduce urine flow through the ureter

C. Manage conservatively with hydration, analgesia, and expectant passage given the small stone size

D. Start high-dose corticosteroids to facilitate stone passage

53. A 3-year-old girl refuses to bear weight on her right leg, with fever, warmth, swelling, and severe pain on passive range of motion of the right hip. WBC and CRP are markedly elevated. Ultrasound shows a hip joint effusion.

A. Treat with oral antibiotics alone as an outpatient

B. Consult orthopedics for emergent joint aspiration/surgical drainage plus IV antibiotics

C. Obtain an MRI first and delay any intervention until results return

D. Apply a splint and reassess in 48 hours without further workup

54. A 6-year-old boy has 5 days of fever and worsening localized bone pain and swelling over the distal femur, with point tenderness and elevated inflammatory markers. Plain radiographs are unremarkable.

A. Reassure the family this is growing pains and discharge

B. Start oral antibiotics without further imaging given a normal x-ray

C. Obtain MRI to evaluate for osteomyelitis and start IV antibiotics pending culture results

D. Proceed directly to bone biopsy without antibiotics or imaging

55. A 3-year-old boy has 6 days of fever, bilateral non-exudative conjunctival injection, cracked erythematous lips, a strawberry tongue, a polymorphous rash, and swelling of the hands and feet.

A. Treat with a course of oral amoxicillin for presumed scarlet fever

B. Reassure the family this is a self-limited viral exanthem

C. Order a throat culture and wait for results before treatment

D. Diagnose Kawasaki disease, obtain echocardiography, and treat with IVIG and high-dose aspirin

56. A 6-year-old boy has palpable purpura on his lower extremities and buttocks, along with abdominal pain and arthralgia of the knees and ankles. Urinalysis shows microscopic hematuria and mild proteinuria. Platelet count is normal.

A. Start systemic corticosteroids as first-line therapy for all patients with this presentation, without first addressing the more immediately concerning finding

B. Diagnose immune thrombocytopenic purpura and treat with IVIG, which could delay recognition of a more serious underlying process

C. Order a skin biopsy before considering any diagnosis, which would not provide adequate monitoring for this clinical picture

D. Diagnose Henoch-Schönlein purpura (IgA vasculitis), manage supportively, and monitor renal function/urinalysis over time

57. A 5-year-old girl has 8 weeks of daily morning stiffness and swelling of the right knee and left ankle, without fever or rash. Inflammatory markers are mildly elevated, and ANA is positive.

A. Reassure the family this is growing pains and discharge without further evaluation before the more urgent issue has been addressed

B. Start empiric IV antibiotics for presumed septic arthritis, though this does not address the most likely diagnosis here

C. Refer to rheumatology for evaluation of juvenile idiopathic arthritis, including ophthalmologic screening for uveitis

D. Order a bone marrow biopsy as the first diagnostic step, despite the risk this poses of delaying definitive treatment

58. A 15-year-old girl has fatigue, a malar rash that spares the nasolabial folds, photosensitivity, joint pain, and mouth ulcers. Labs show positive ANA, anti-dsDNA, low complement levels, and proteinuria.

A. Reassure the family this is a normal adolescent acne variant, which could delay recognition of a more serious underlying process

B. Start empiric antibiotics for presumed bacterial infection alone, without confirming the response to therapy

C. Diagnose systemic lupus erythematosus and evaluate for renal involvement (lupus nephritis) with nephrology involvement

D. Order a skin biopsy alone without further systemic evaluation, an approach that would leave the underlying process unaddressed

59. A 9-month-old has had fever for 6 days with only conjunctival injection and a polymorphous rash, without meeting full criteria for Kawasaki disease. Inflammatory markers are elevated and platelet count is rising.

A. Rule out Kawasaki disease entirely since full clinical criteria are not met, which risks clinical deterioration if the diagnosis is missed

B. Evaluate for incomplete Kawasaki disease with echocardiography and supportive labs, and treat with IVIG if criteria for incomplete disease are met

C. Discharge with reassurance and no further workup given atypical presentation, which could delay recognition of a more serious underlying process

D. Start oral antibiotics for a presumed unidentified bacterial source alone, without confirming the response to therapy

60. A 7-year-old boy previously diagnosed with Henoch-Schönlein purpura 3 weeks ago now has worsening proteinuria and rising blood pressure on routine follow-up urinalysis, though he remains asymptomatic otherwise.

A. Refer to nephrology for further evaluation given evolving renal involvement (HSP nephritis)

B. Reassure the family this is expected and requires no further follow-up

C. Start empiric antibiotics for presumed urinary tract infection

D. Discontinue all follow-up since the purpura has resolved

61. A 12-year-old girl with new-onset type 1 diabetes presents with vomiting, abdominal pain, and lethargy. Glucose is 480 mg/dL, venous pH 7.12, bicarbonate 8 mEq/L, and serum ketones are strongly positive. She weighs 40 kg.

A. Administer an IV insulin bolus immediately along with fluids, despite the risk this poses of delaying definitive treatment

B. Correct the metabolic acidosis with IV sodium bicarbonate first, though this does not address the most likely diagnosis here

C. Start oral rehydration alone before considering IV fluids, a step that is not supported by current evidence-based guidelines

D. Begin cautious IV isotonic fluid resuscitation followed by a continuous IV insulin infusion (without a bolus), with close monitoring for cerebral edema

62. An 8-year-old with a recent viral meningitis is noted to have serum sodium of 122 mEq/L, concentrated urine, elevated urine sodium, and clinical euvolemia, with no edema or signs of dehydration.

A. Administer a fluid bolus of normal saline to correct hyponatremia rapidly, which could delay recognition of a more serious underlying process

B. Restrict free water intake and monitor sodium correction closely, avoiding overly rapid correction

C. Start desmopressin to concentrate the urine further, which would not provide adequate monitoring for this clinical picture

D. Give hypertonic saline regardless of symptom severity alone, without confirming the response to therapy

63. A 6-year-old with known congenital adrenal hyperplasia develops vomiting, lethargy, and hypotension during a febrile illness. Labs show hyponatremia and hyperkalemia.

A. Withhold stress-dose steroids until endocrinology is available for consultation

B. Administer immediate IV stress-dose hydrocortisone and isotonic fluid resuscitation

C. Give oral hydrocortisone at the usual home dose and observe

D. Start insulin therapy to manage the hyperkalemia as the primary intervention

64. A 2-year-old previously healthy boy is found lethargic and diaphoretic. Point-of-care glucose is 32 mg/dL. He improves with IV dextrose. Critical labs were drawn during the hypoglycemic episode before treatment.

A. No further workup is needed once glucose normalizes with treatment, which could delay recognition of a more serious underlying process

B. Discharge home once asymptomatic without any additional evaluation before the more urgent issue has been addressed

C. Assume this was simple ketotic hypoglycemia without confirmatory testing alone, without confirming the response to therapy

D. Review the critical sample (insulin, cortisol, growth hormone, beta-hydroxybutyrate, etc.) obtained at the time of hypoglycemia to guide further evaluation

65. A newborn's state screen shows an elevated TSH and low free T4, confirmed on repeat testing. The infant is currently asymptomatic and feeding well.

A. Defer treatment until symptoms develop

B. Recheck the screen in 6 months before considering treatment

C. Start levothyroxine promptly to prevent neurodevelopmental impairment

D. Order a thyroid ultrasound before any treatment decision

66. A 4-day-old term infant has jitteriness, a high-pitched cry, and a brief tonic seizure. Serum calcium is 6.8 mg/dL with normal magnesium. The infant is otherwise well-appearing between episodes.

A. Observe without intervention since neonatal hypocalcemia is usually self-limited

B. Administer IV calcium gluconate for symptomatic hypocalcemia with cardiac monitoring

C. Start oral calcium supplementation alone given the mild symptoms

D. Treat empirically for neonatal sepsis without addressing the calcium level

67. A 10-year-old boy with a recent traumatic brain injury develops excessive thirst and polyuria with dilute urine (urine osmolality low despite rising serum osmolality and serum sodium of 152 mEq/L).

A. Restrict free water intake as the primary treatment

B. Diagnose SIADH and start fluid restriction

C. Diagnose central diabetes insipidus, replace free water losses, and consider desmopressin

D. Reassure the family this is expected post-traumatic polydipsia requiring no intervention

68. A 3-day-old term infant who was feeding well now has poor feeding, lethargy, vomiting, and a peculiar odor to the urine, with rapidly worsening encephalopathy. Initial labs show metabolic acidosis with an elevated anion gap and hyperammonemia.

A. Stop protein intake, provide IV dextrose for calories, and urgently involve metabolic genetics while treating hyperammonemia

B. Continue normal feeding and observe for spontaneous improvement, which would not provide adequate monitoring for this clinical picture

C. Start broad-spectrum antibiotics as the sole intervention without addressing metabolic derangements, an approach that would leave the underlying process unaddressed

D. Increase protein intake to support growth during the acute illness, despite the risk this poses of delaying definitive treatment

69. A 3-month-old, non-ambulatory infant presents with a spiral fracture of the femur. The history provided by caregivers is inconsistent and does not adequately explain the mechanism of injury for a non-mobile infant.

A. Obtain a skeletal survey, involve the child protection team, and report to child protective services

B. Accept the caregiver's explanation and discharge with orthopedic follow-up only

C. Treat the fracture and discharge without further investigation since fractures are common in infants

D. Delay any reporting until the fracture has fully healed to avoid a premature accusation

70. A 9-year-old girl discloses that a family member has been touching her inappropriately. She has no acute injuries and the last reported contact was several weeks ago.

A. Perform an immediate forensic genital exam regardless of the timing of last contact, an approach inconsistent with standard management for this presentation

B. Involve the child protection team, arrange an appropriate forensic/medical evaluation per protocol, and make a mandatory report to child protective services

C. Reassure the family and avoid documentation to protect the child's privacy, despite the risk this poses of delaying definitive treatment

D. Delay any action until the family confirms the allegation is true, without first addressing the more immediately concerning finding

71. A mother repeatedly reports symptoms in her child that are not observed by hospital staff, requests numerous invasive tests and procedures, and the child's symptoms consistently resolve when separated from the mother, with a pattern noted across multiple hospitalizations.

A. Continue ordering the requested tests and procedures as requested by the caregiver, though this does not address the most likely diagnosis here

B. Reassure the caregiver and discharge without further evaluation of the pattern, without first addressing the more immediately concerning finding

C. Confront the caregiver directly and accusatorially at the bedside alone, without confirming the response to therapy

D. Involve the child protection team to evaluate for medical child abuse (factitious disorder imposed on another) and coordinate a multidisciplinary review of the medical record

72. An 8-month-old infant is well below growth curve percentiles with significant weight loss, and the caregiver reports difficulty accessing adequate formula and food due to resource limitations. Physical exam shows no other findings, and the infant improves rapidly with consistent feeding in the hospital.

A. Evaluate for neglect-related failure to thrive, engage social work for resource support, and involve child protection as indicated by severity and response to intervention

B. Assume a primary organic cause and pursue extensive additional metabolic and genetic testing before addressing feeding access, though the clinical picture warrants more definitive action

C. Discharge home immediately once weight gain is observed, without addressing the underlying resource limitation, a step that is not supported by current evidence-based guidelines

D. Report the family for medical child abuse based on the growth pattern alone alone, without confirming the response to therapy

73. A 6-year-old boy has a tender, fluctuant, erythematous 3 cm mass on his thigh with surrounding cellulitis and low-grade fever. Ultrasound confirms a drainable fluid collection.

A. Perform incision and drainage and start antibiotics with MRSA coverage

B. Treat with oral antibiotics alone without any drainage procedure

C. Apply warm compresses only and reassess in one week

D. Order an MRI before considering any intervention

74. A 10-year-old girl started an anticonvulsant 12 days ago and now has fever, painful mucosal erosions of the lips and eyes, and widespread targetoid lesions with epidermal detachment involving 15% of her body surface area.

A. Continue the anticonvulsant since discontinuation this late would not change the course

B. Treat as simple erythema multiforme with topical care only, as an outpatient

C. Start the anticonvulsant at a lower dose while monitoring the rash

D. Immediately discontinue the offending drug and transfer to a burn unit or specialized center for supportive care

75. A 4-year-old with a history of atopic dermatitis develops sudden worsening of his eczema with numerous punched-out, monomorphic vesicles and erosions on the face and neck, along with fever and malaise.

A. Increase the topical corticosteroid potency as the primary treatment

B. Treat with oral antibiotics alone for presumed bacterial superinfection

C. Reassure the family this is a typical eczema flare requiring only emollients

D. Start systemic acyclovir promptly for suspected eczema herpeticum

76. A 2-year-old girl has fever, irritability, and diffuse tender erythema with superficial blistering and a positive Nikolsky sign, with skin peeling in sheets, sparing mucous membranes.

A. Treat as toxic epidermal necrolysis with immediate discontinuation of a presumed offending drug, which would not provide adequate monitoring for this clinical picture

B. Start high-dose systemic corticosteroids as first-line therapy, which risks clinical deterioration if the diagnosis is missed

C. Diagnose staphylococcal scalded skin syndrome and start IV antistaphylococcal antibiotics with supportive skin care

D. Reassure the family this is a benign viral exanthem alone, without confirming the response to therapy

77. A 9-year-old boy has rapidly progressive severe pain out of proportion to exam findings over an extraction site, with overlying skin that is dusky and edematous, crepitus on palpation, and systemic toxicity with fever and tachycardia.

A. Start oral antibiotics and manage as an outpatient with close follow-up, without first addressing the more immediately concerning finding

B. Apply a topical antibiotic ointment and observe overnight alone, without confirming the response to therapy

C. Order an MRI and wait for results before any intervention, an approach that would leave the underlying process unaddressed

D. Emergently consult surgery for debridement and start broad-spectrum IV antibiotics for suspected necrotizing fasciitis

78. A 5-year-old boy has fever, lethargy, and a rapidly spreading petechial and purpuric rash that does not blanch with pressure, along with neck stiffness. He appears critically ill with cool extremities and delayed capillary refill.

A. Treat as a benign viral exanthem and discharge with reassurance, which would not provide adequate monitoring for this clinical picture

B. Obtain a lumbar puncture before starting any antibiotics, a step that is not supported by current evidence-based guidelines

C. Recognize possible meningococcemia, start empiric broad-spectrum antibiotics immediately, and provide aggressive resuscitation

D. Order dermatology consultation as the first step before any systemic treatment, which could delay recognition of a more serious underlying process

79. A 6-year-old with acute lymphoblastic leukemia on chemotherapy presents with fever of 38.6°C. Absolute neutrophil count is 300/mm3. He appears well but has a central venous catheter in place.

A. Observe without antibiotics since he appears clinically well

B. Start oral antibiotics only and manage as an outpatient

C. Wait for blood culture results before initiating any antibiotics

D. Obtain blood cultures and immediately start empiric broad-spectrum IV antibiotics without delay

80. A 10-year-old boy with sickle cell disease (HbSS) presents with severe bilateral leg and back pain consistent with his typical vaso-occlusive episodes, along with low-grade fever. He has no respiratory symptoms and oxygen saturation is 98%.

A. Withhold analgesia until a definitive source of pain is identified, though this does not address the most likely diagnosis here

B. Administer a single dose of oral acetaminophen only for pain control, an approach inconsistent with standard management for this presentation

C. Restrict IV fluids to avoid overhydration, a step that is not supported by current evidence-based guidelines

D. Provide aggressive, scheduled analgesia (including opioids as needed), IV hydration, and close monitoring for evolving complications such as acute chest syndrome

81. A 2-year-old girl has pallor and fatigue. Labs show hemoglobin 7.2 g/dL, MCV 62 fL, and a history of prolonged whole milk intake with minimal iron-containing solid foods.

A. Transfuse packed red blood cells regardless of hemodynamic status, without first addressing the more immediately concerning finding

B. Order a bone marrow biopsy as the first diagnostic step, which risks clinical deterioration if the diagnosis is missed

C. Confirm iron deficiency with iron studies and start oral iron supplementation with dietary counseling

D. Start empiric vitamin B12 injections without further testing, an approach inconsistent with standard management for this presentation

82. A 16-year-old girl on oral contraceptives develops sudden-onset pleuritic chest pain and dyspnea after a long car ride. Heart rate is 120/min and oxygen saturation is 91% on room air. D-dimer is elevated.

A. Reassure the family this is likely anxiety-related and discharge, without first addressing the more immediately concerning finding

B. Start oral antibiotics for presumed pneumonia without imaging, despite the risk this poses of delaying definitive treatment

C. Delay any workup until symptoms worsen further, which would not provide adequate monitoring for this clinical picture

D. Obtain CT pulmonary angiography for suspected pulmonary embolism and begin anticoagulation if confirmed

83. A 6-year-old boy with known severe hemophilia A presents after a fall with a rapidly swelling, painful right knee and decreased range of motion, consistent with hemarthrosis.

A. Administer factor VIII replacement promptly, then provide supportive joint care (rest, ice, elevation)

B. Perform immediate joint aspiration before any factor replacement

C. Manage with NSAIDs for pain control as the primary treatment

D. Observe without factor replacement since bleeding may resolve spontaneously

84. A previously healthy 4-year-old girl develops petechiae and bruising 2 weeks after a viral illness. Platelet count is 8,000/mm3 with normal white cell count, hemoglobin, and peripheral smear otherwise unremarkable. She has no active mucosal bleeding.

A. Start emergent chemotherapy for presumed leukemia without further testing, though this does not address the most likely diagnosis here

B. Diagnose presumed immune thrombocytopenic purpura, observe or treat based on bleeding severity (IVIG, steroids, or observation), and avoid unnecessary invasive procedures

C. Transfuse platelets immediately regardless of bleeding symptoms, a step that is not supported by current evidence-based guidelines

D. Perform a bone marrow biopsy in all cases before any treatment decision, though the clinical picture warrants more definitive action

85. A 7-year-old boy develops hives, lip swelling, wheezing, and vomiting within minutes of eating peanuts. Blood pressure is 78/40 mmHg and he appears anxious with audible stridor.

A. Administer an oral antihistamine as the first-line treatment

B. Administer intramuscular epinephrine immediately

C. Start IV corticosteroids as the first and only treatment

D. Observe for 30 minutes before administering any medication

86. A 3-year-old boy has a history of recurrent sinopulmonary infections, including two episodes of pneumonia and several ear infections in the past year, along with poor growth. Immunoglobulin levels show low IgG, IgA, and IgM.

A. Refer to immunology for further evaluation of a humoral immunodeficiency and consider immunoglobulin replacement therapy

B. Reassure the family this reflects normal childhood infection frequency, which could delay recognition of a more serious underlying process

C. Start prophylactic antifungal therapy as the primary intervention, though the clinical picture warrants more definitive action

D. Order a sweat chloride test as the definitive next step, which would not provide adequate monitoring for this clinical picture

87. A 9-year-old girl develops fever, urticarial rash, joint pain, and lymphadenopathy 10 days after starting a course of amoxicillin for otitis media.

A. Continue the amoxicillin and add an antihistamine only, which could delay recognition of a more serious underlying process

B. Diagnose anaphylaxis and administer epinephrine, which would not provide adequate monitoring for this clinical picture

C. Reassure the family this is an expected viral exanthem unrelated to the medication, though this does not address the most likely diagnosis here

D. Discontinue the offending drug and manage as serum sickness-like reaction with supportive care (antihistamines, NSAIDs, or steroids if severe)

88. A 12-year-old boy received epinephrine and supportive care for anaphylaxis after a bee sting 1 hour ago and now appears clinically well with resolved symptoms and normal vital signs.

A. Discharge immediately since symptoms have fully resolved, which could delay recognition of a more serious underlying process

B. No observation period is needed once epinephrine has been given, an approach that would leave the underlying process unaddressed

C. Discharge with an epinephrine autoinjector prescription only, without any observation period, though the clinical picture warrants more definitive action

D. Observe for an appropriate period (commonly several hours) given the risk of a biphasic anaphylactic reaction before considering discharge

89. A 3-year-old girl is found with an open bottle of her grandmother's acetaminophen tablets, with an estimated ingestion of a potentially toxic dose approximately 2 hours ago. She is currently asymptomatic.

A. Reassure the family and discharge without any testing since she is asymptomatic, which would not provide adequate monitoring for this clinical picture

B. Obtain a serum acetaminophen level at the appropriate post-ingestion time and use the Rumack-Matthew nomogram to guide need for N-acetylcysteine therapy

C. Start N-acetylcysteine only if symptoms of liver injury develop later, though the clinical picture warrants more definitive action

D. Perform gastric lavage as the primary intervention regardless of ingestion timing, which could delay recognition of a more serious underlying process

90. A 6-year-old boy sustains a deep puncture wound to his hand from a stray dog bite. The wound is thoroughly irrigated. The dog's vaccination and observation status is unknown and it cannot be located.

A. Initiate rabies post-exposure prophylaxis (immunoglobulin and vaccine series) given the unknown status of the animal

B. Withhold rabies prophylaxis since dog bites rarely transmit rabies in general

C. Delay any decision on rabies prophylaxis for 10 days to observe for symptoms in the child

D. Provide only a tetanus booster with no further intervention needed

91. A 4-year-old boy is pulled from a swimming pool after an unwitnessed submersion of unknown duration. He is unresponsive with agonal breathing on arrival of EMS. In the emergency department, he is intubated, and core temperature is 33.5°C.

A. Provide supportive critical care with attention to oxygenation, ventilation, and appropriate temperature management, avoiding aggressive rapid rewarming unless hemodynamically unstable

B. Actively rewarm rapidly to normothermia within the first hour regardless of hemodynamic status, which could delay recognition of a more serious underlying process

C. Withhold all resuscitative efforts given the poor expected prognosis after submersion, a step that is not supported by current evidence-based guidelines

D. Administer prophylactic antibiotics as the primary initial intervention, though this does not address the most likely diagnosis here

92. A 7-year-old boy is brought in after prolonged outdoor exposure in cold weather with a core temperature of 31°C, bradycardia, and altered mental status, but a perfusing rhythm on cardiac monitor.

A. Rapidly rewarm using immersion in very warm water as the fastest method, though this does not address the most likely diagnosis here

B. Focus solely on external rewarming with no attention to cardiac monitoring, which risks clinical deterioration if the diagnosis is missed

C. Provide active core rewarming with careful, gradual technique and continuous cardiac monitoring given arrhythmia risk during rewarming

D. Withhold rewarming until the patient reaches the intensive care unit regardless of transport time before the more urgent issue has been addressed

93. A 5-year-old boy falls from a low height and hits his head, with brief loss of consciousness. He is now acting normally, has a normal neurologic exam, and has no vomiting, severe headache, or signs of skull fracture. His GCS is 15.

A. Obtain a head CT for all children with any loss of consciousness regardless of other findings, which could delay recognition of a more serious underlying process

B. Admit for 24-hour observation regardless of exam findings, a step that is not supported by current evidence-based guidelines

C. Apply a validated clinical decision rule to guide the need for CT imaging, which may support observation without imaging in this low-risk presentation

D. Discharge immediately with no counseling or follow-up instructions alone, without confirming the response to therapy

94. A 30 kg, 8-year-old boy sustains partial-thickness burns covering 25% of his total body surface area from a scald injury 1 hour ago. He is alert with stable vital signs.

A. Begin formal IV fluid resuscitation using a validated pediatric burn formula, with careful monitoring of urine output

B. Manage with oral fluids alone given his current stable vital signs, without first addressing the more immediately concerning finding

C. Withhold IV fluids until signs of hypovolemic shock develop before the more urgent issue has been addressed

D. Administer a single large fluid bolus and reassess in 24 hours, a step that is not supported by current evidence-based guidelines

95. A 15-year-old football player collapses during practice on a hot, humid day. Core temperature is 41.5°C, and he is confused with hot, dry skin.

A. Administer antipyretics as the primary treatment for the elevated temperature, which could delay recognition of a more serious underlying process

B. Delay cooling measures until IV access is obtained, though the clinical picture warrants more definitive action

C. Wait for laboratory results before initiating any cooling intervention, an approach that would leave the underlying process unaddressed

D. Initiate rapid cooling immediately alongside supportive care, as this is the priority intervention for heat stroke

96. A 2-year-old girl ingested an unknown quantity of her mother's prenatal iron tablets 3 hours ago. She has now developed vomiting and abdominal pain. Serum iron level is significantly elevated.

A. Administer activated charcoal as the primary decontamination method, without first addressing the more immediately concerning finding

B. Provide supportive care and consider IV deferoxamine chelation therapy for significant toxicity based on clinical status and iron level

C. Reassure the family that iron ingestions are rarely dangerous in toddlers, though this does not address the most likely diagnosis here

D. Perform gastric lavage as the definitive treatment regardless of timing alone, without confirming the response to therapy

97. A 10-year-old boy is bitten on the leg by a venomous snake while hiking. He has progressive swelling, pain, and ecchymosis at the bite site, with mild coagulopathy on labs.

A. Apply a tight tourniquet proximal to the bite and keep the limb elevated, an approach inconsistent with standard management for this presentation

B. Incise and suction the wound to remove venom alone, without confirming the response to therapy

C. Provide supportive care, immobilize the limb at heart level, and administer antivenom based on severity of envenomation

D. Apply ice directly to the bite site as the primary treatment before the more urgent issue has been addressed

98. A 6-year-old boy involved in a motor vehicle collision has diffuse abdominal tenderness, a seatbelt sign across his abdomen, and tachycardia. He is initially hemodynamically borderline but responds to a fluid bolus.

A. Discharge home once vital signs normalize after the fluid bolus, though the clinical picture warrants more definitive action

B. Obtain trauma surgery consultation and appropriate imaging given the seatbelt sign and mechanism, given risk for occult intra-abdominal injury

C. Assume the seatbelt sign is a benign superficial finding requiring no further workup, an approach that would leave the underlying process unaddressed

D. Delay imaging until 24 hours of observation have passed, a step that is not supported by current evidence-based guidelines

99. A previously healthy 6-week-old infant had a brief episode of color change, altered tone, and choking that resolved spontaneously before arrival, with a normal exam and vital signs in the ED. The event met criteria for a brief resolved unexplained event (BRUE).

A. Admit all infants with a BRUE for extensive testing regardless of risk factors, despite the risk this poses of delaying definitive treatment

B. Discharge immediately with no further guidance since the exam is now normal, though the clinical picture warrants more definitive action

C. Order a full septic workup and neuroimaging in all cases regardless of risk stratification, without first addressing the more immediately concerning finding

D. Apply risk stratification criteria to guide the extent of evaluation and disposition, since low-risk BRUE infants generally do not require extensive testing or admission

100. A 25-day-old term infant has a rectal temperature of 38.2°C at home, now well-appearing on exam with normal vital signs and no clear source of infection identified.

A. Discharge home with reassurance and outpatient follow-up given the well appearance, which would not provide adequate monitoring for this clinical picture

B. Start oral antibiotics empirically without any further workup, despite the risk this poses of delaying definitive treatment

C. Perform a full evaluation for serious bacterial infection (blood, urine, and CSF studies) and admit for empiric antibiotics pending results, per standard febrile infant protocols

D. Observe at home with instructions to return only if the fever persists beyond 48 hours alone, without confirming the response to therapy

101. An 18-month-old boy is well below expected weight-for-age percentiles with a flattening growth curve over the past 6 months. Physical exam is otherwise unremarkable, and initial screening labs are normal.

A. Perform a detailed dietary, feeding, and psychosocial history alongside a structured feeding observation before pursuing extensive additional testing

B. Proceed directly to an extensive metabolic and genetic workup without a detailed history first, despite the risk this poses of delaying definitive treatment

C. Reassure the family this is a normal growth variant requiring no further evaluation before the more urgent issue has been addressed

D. Start high-calorie enteral tube feeding immediately without further assessment, which risks clinical deterioration if the diagnosis is missed

102. A well-appearing, fully immunized 20-month-old girl has fever to 39.0°C for 1 day without an identifiable source on exam, is alert, interactive, and well-hydrated.

A. Perform a full septic workup including lumbar puncture regardless of appearance, though this does not address the most likely diagnosis here

B. Admit for empiric IV antibiotics regardless of clinical appearance, an approach inconsistent with standard management for this presentation

C. Order blood cultures on all well-appearing febrile toddlers regardless of immunization status, which could delay recognition of a more serious underlying process

D. Manage conservatively with close follow-up given her well appearance and complete immunization status, reserving further workup for those with risk factors or clinical deterioration

103. A 7-year-old boy has had daily fevers for 3 weeks without a clear source despite outpatient evaluation, with associated fatigue and mild weight loss. Initial basic labs are nonspecific.

A. Pursue a systematic, stepwise evaluation (detailed history, exam, and targeted testing based on findings) for fever of unknown origin, considering infectious, rheumatologic, and malignant causes

B. Start empiric broad-spectrum antibiotics without further diagnostic evaluation before the more urgent issue has been addressed, a step that is not supported by current evidence-based guidelines

C. Reassure the family this will resolve spontaneously without further workup, which risks clinical deterioration if the diagnosis is missed

D. Proceed directly to bone marrow biopsy as the first diagnostic test, an approach inconsistent with standard management for this presentation

104. A 6-month-old infant with hypernatremic dehydration (serum sodium 168 mEq/L) from inadequate formula preparation is being started on rehydration therapy.

A. Correct the sodium rapidly to normal within the first 4-6 hours, an approach inconsistent with standard management for this presentation

B. Use only free water boluses to correct the sodium quickly alone, without confirming the response to therapy

C. Correct the hypernatremia gradually over 48 hours or longer, monitoring serial sodium levels to avoid cerebral edema from rapid correction

D. Withhold all fluids until sodium spontaneously normalizes, a step that is not supported by current evidence-based guidelines

105. A 4-year-old girl has a witnessed seizure at home. On arrival, she is postictal with serum sodium of 118 mEq/L. She continues to have another seizure in the emergency department.

A. Restrict free water intake as the sole initial intervention during active seizure, though the clinical picture warrants more definitive action

B. Correct the sodium slowly over 48 hours with isotonic fluids alone, a step that is not supported by current evidence-based guidelines

C. Withhold treatment and observe since seizures from hyponatremia are typically self-limited, which could delay recognition of a more serious underlying process

D. Administer hypertonic (3%) saline to acutely raise serum sodium and terminate seizure activity, per protocols for severe symptomatic hyponatremia

106. A 5-year-old girl with vomiting and diarrhea has a venous blood gas showing pH 7.22, bicarbonate 12 mEq/L, and an elevated anion gap. Serum electrolytes and glucose are otherwise unremarkable aside from mild dehydration.

A. Calculate the anion gap and evaluate for the underlying cause while providing supportive fluid therapy

B. Treat empirically with IV sodium bicarbonate to correct the pH to normal regardless of etiology

C. Assume this is simple dehydration and no further evaluation of the acidosis is needed

D. Start mechanical ventilation to correct the acid-base disturbance

107. A 14-year-old girl presents with anxiety, tingling in her hands and around her mouth, and lightheadedness. Arterial blood gas shows pH 7.52, PaCO2 25 mmHg, and normal bicarbonate.

A. Diagnose metabolic alkalosis and treat with IV fluids and potassium repletion, a step that is not supported by current evidence-based guidelines

B. Assume a primary cardiac cause and obtain emergent echocardiography before addressing symptoms, despite the risk this poses of delaying definitive treatment

C. Recognize acute respiratory alkalosis, likely from hyperventilation, and address the underlying anxiety/trigger with reassurance and breathing techniques while excluding other causes

D. Start supplemental oxygen at high flow as the primary treatment alone, without confirming the response to therapy

108. A 9-year-old boy is recovering from an appendectomy with significant incisional pain poorly controlled by scheduled acetaminophen alone, limiting his ability to ambulate.

A. Increase acetaminophen dosing frequency beyond recommended limits to improve control

B. Withhold any additional analgesics to avoid opioid exposure entirely

C. Implement a multimodal analgesia approach to improve pain control and facilitate mobility

D. Discharge home despite poor pain control since surgery is complete

109. A 13-year-old girl with chronic abdominal pain for 6 months, extensively worked up with no identified organic cause, continues to have significant functional impairment affecting school attendance.

A. Pursue repeated invasive testing until an organic cause is found, which would not provide adequate monitoring for this clinical picture

B. Adopt a biopsychosocial approach including a structured plan for functional improvement, involving pain management, behavioral health support, and gradual return to normal activities

C. Tell the family the pain is not real and no further care is needed, an approach inconsistent with standard management for this presentation

D. Prescribe long-term opioid therapy as the primary management strategy before the more urgent issue has been addressed, despite the risk this poses of delaying definitive treatment

110. A 10-year-old boy with acute kidney injury has a potassium of 7.2 mEq/L with peaked T waves on ECG. He is otherwise hemodynamically stable.

A. Administer IV calcium gluconate for cardiac membrane stabilization, followed by therapies to shift potassium intracellularly (insulin/glucose, beta-agonists) and enhance elimination

B. Treat with oral potassium binders alone as the sole and sufficient therapy alone, without confirming the response to therapy

C. Delay any treatment until nephrology arrives to evaluate, despite the risk this poses of delaying definitive treatment

D. Administer additional IV potassium to allow accurate lab confirmation before treating, without first addressing the more immediately concerning finding

111. A 15-year-old girl admitted for an unrelated medical issue discloses to her nurse that she has been having thoughts of wanting to end her life, with a specific plan.

A. Ensure immediate safety measures (removal of potentially harmful objects, continuous observation as indicated) and obtain an urgent psychiatric/behavioral health evaluation

B. Document the disclosure but wait until the medical issue resolves before addressing it, a step that is not supported by current evidence-based guidelines

C. Reassure her that these feelings are normal and no further action is needed, without first addressing the more immediately concerning finding

D. Discharge home with outpatient follow-up scheduled for the following week, an approach that would leave the underlying process unaddressed

112. A 10-year-old boy with autism spectrum disorder becomes acutely agitated and aggressive toward staff during a procedure, escalating despite initial attempts at redirection.

A. Immediately restrain the child physically as the first-line intervention, a step that is not supported by current evidence-based guidelines, which could delay recognition of a more serious underlying process

B. Administer IM antipsychotic medication as the first step without attempting other measures, despite the risk this poses of delaying definitive treatment alone, without confirming the response to therapy

C. Ignore the behavior entirely and proceed with the procedure as planned before the more urgent issue has been addressed, which risks clinical deterioration if the diagnosis is missed

D. Attempt environmental modification and de-escalation techniques first (calm environment, sensory accommodations, individualized approach), reserving medication or restraint for situations where safety is at risk and de-escalation fails

113. A 7-year-old boy hospitalized in the PICU develops acute fluctuating confusion, disorientation, and agitation alternating with lethargy over the past day, with no prior cognitive or behavioral history.

A. Assume this is simply anxiety related to hospitalization and provide reassurance only, an approach inconsistent with standard management for this presentation, though this does not address the most likely diagnosis here

B. Start a benzodiazepine as first-line treatment for the agitation, which would not provide adequate monitoring for this clinical picture, despite the risk this poses of delaying definitive treatment

C. Attribute the symptoms to a primary psychiatric disorder without further medical evaluation, though the clinical picture warrants more definitive action alone, without confirming the response to therapy

D. Recognize possible delirium, evaluate for and address underlying contributing medical causes (infection, medications, metabolic derangements), and optimize the environment (sleep-wake cycle, reorientation, minimizing deliriogenic medications)

114. A 15-year-old girl with severe anorexia nervosa and significant malnutrition is admitted for medical stabilization and nutritional rehabilitation is initiated.

A. Begin aggressive high-calorie feeding immediately to rapidly restore weight alone, without confirming the response to therapy

B. Restrict all feeding until psychiatric evaluation is complete, a step that is not supported by current evidence-based guidelines

C. Initiate nutritional rehabilitation cautiously with close monitoring of electrolytes (particularly phosphorus, potassium, magnesium) given the risk of refeeding syndrome

D. Provide only IV fluids without any nutritional intake for the first week, which would not provide adequate monitoring for this clinical picture

115. A 13-year-old girl develops sudden inability to move her legs after a stressful family event, with normal neurologic exam findings (reflexes, tone) inconsistent with a specific anatomic pattern, and normal neuroimaging.

A. Immediately confront the patient and tell her the symptoms are not real, though the clinical picture warrants more definitive action, which would not provide adequate monitoring for this clinical picture

B. Order repeated invasive neurologic testing until a structural cause is found, an approach that would leave the underlying process unaddressed, despite the risk this poses of delaying definitive treatment

C. Ignore the psychosocial context entirely and treat only the physical symptoms, which risks clinical deterioration if the diagnosis is missed, though this does not address the most likely diagnosis here

D. Consider a functional neurological (conversion) disorder, involve a multidisciplinary team (neurology, psychiatry/psychology), and use a supportive, non-judgmental approach emphasizing gradual functional rehabilitation

116. An 8-year-old boy with autism spectrum disorder and significant sensory sensitivities is admitted for a medical illness and becomes increasingly distressed by the unfamiliar hospital environment.

A. Maintain a standard hospital routine and environment identical to all other patients without modification, an approach that would leave the underlying process unaddressed

B. Individualize the care plan with sensory accommodations, predictable routines, and involvement of caregivers/specialists familiar with his needs to reduce distress

C. Sedate the child for the duration of admission to manage distress, which risks clinical deterioration if the diagnosis is missed

D. Discharge as soon as medically possible regardless of ongoing needs, without addressing accommodations, without first addressing the more immediately concerning finding

117. A 16-year-old boy admitted for a medical illness is noted by staff to have several old, healed linear scars on his forearms consistent with prior self-harm, which he has not disclosed. He denies current suicidal ideation when asked directly.

A. Ignore the finding since he denies current ideation alone, without confirming the response to therapy

B. Discharge without addressing the finding to avoid embarrassing the patient, without first addressing the more immediately concerning finding

C. Sensitively discuss the finding with the patient, assess current risk and coping strategies, and involve behavioral health for further evaluation and safety planning as indicated

D. Immediately place the patient on involuntary psychiatric hold based on the scars alone, which could delay recognition of a more serious underlying process

118. A 14-year-old girl with anorexia nervosa has bradycardia (38 bpm), orthostatic hypotension, and hypothermia, along with a BMI significantly below expected for age.

A. Admit for medical stabilization given hemodynamic instability, with cardiac monitoring and a structured refeeding protocol

B. Manage entirely as an outpatient with weekly weight checks, though this does not address the most likely diagnosis here

C. Discharge home once she agrees to eat more at home, which could delay recognition of a more serious underlying process

D. Focus solely on psychiatric therapy without addressing the acute medical instability, an approach inconsistent with standard management for this presentation

119. A 16-year-old boy develops acute agitation, disorganized thinking, and auditory hallucinations during hospitalization, posing a risk to himself and staff despite verbal de-escalation attempts.

A. Use physical restraint as the sole and definitive management without considering medication, without first addressing the more immediately concerning finding

B. Consider an appropriate emergency pharmacologic intervention alongside a safe environment, using the least restrictive effective approach, after de-escalation has failed

C. Withhold any intervention since psychosis in hospitalized adolescents typically resolves spontaneously, an approach inconsistent with standard management for this presentation

D. Immediately transfer to a general medical floor without any psychiatric involvement, though the clinical picture warrants more definitive action

120. A hospital is developing a protocol to reduce delirium incidence among critically ill pediatric patients in the PICU.

A. Maximize continuous benzodiazepine sedation to keep all patients calm, though this does not address the most likely diagnosis here

B. Eliminate all caregiver presence at bedside to reduce overstimulation, which would not provide adequate monitoring for this clinical picture

C. Implement non-pharmacologic prevention strategies such as promoting normal sleep-wake cycles, early mobilization, minimizing deliriogenic medications, and encouraging family presence and reorientation

D. Restrict all environmental light and sound continuously regardless of time of day, without first addressing the more immediately concerning finding

121. A 16-year-old girl with known bulimia nervosa is admitted after an episode of significant purging. She has muscle weakness and cardiac arrhythmia noted on telemetry.

A. Assume weakness is unrelated to her eating disorder and pursue an unrelated neurologic workup first, despite the risk this poses of delaying definitive treatment

B. Evaluate and correct electrolyte abnormalities (particularly hypokalemia) promptly given the risk of life-threatening arrhythmia from purging behaviors

C. Discharge once the arrhythmia resolves without addressing electrolytes, which would not provide adequate monitoring for this clinical picture

D. Manage exclusively with psychiatric intervention without addressing the acute electrolyte disturbance before the more urgent issue has been addressed

122. A 9-year-old boy with well-controlled ADHD on stimulant medication is admitted for an unrelated surgical procedure. The family asks whether his home medication should be continued during the hospital stay.

A. Automatically discontinue all home psychiatric/behavioral medications during any hospitalization, though this does not address the most likely diagnosis here

B. Continue his home stimulant medication as clinically appropriate, coordinating with the family and considering the perioperative context, to maintain baseline behavioral stability

C. Switch to an unrelated medication class without clear indication, an approach inconsistent with standard management for this presentation

D. Defer the decision entirely to the family without clinical input, though the clinical picture warrants more definitive action

123. A term newborn is delivered and is limp, apneic, and has a heart rate of 80/min at 30 seconds of life.

A. Begin positive pressure ventilation immediately as the priority intervention per neonatal resuscitation guidelines

B. Start chest compressions as the first intervention without ventilation

C. Administer epinephrine immediately as the first step

D. Dry, stimulate, and observe for spontaneous improvement without further intervention for several minutes

124. A large-for-gestational-age infant born to a mother with gestational diabetes has a blood glucose of 28 mg/dL at 2 hours of life. The infant is jittery but otherwise feeding.

A. Withhold treatment since mild hypoglycemia is expected and will self-resolve alone, without confirming the response to therapy

B. Wait until glucose falls further before intervening, an approach inconsistent with standard management for this presentation

C. Treat promptly with feeding and/or IV dextrose per protocol, with close glucose monitoring given symptomatic hypoglycemia and risk factors

D. Discharge home with outpatient follow-up for glucose monitoring, though the clinical picture warrants more definitive action

125. A 3-day-old term breastfed infant has a total serum bilirubin that plots in the high-risk zone on the hour-specific nomogram, with jaundice extending to the extremities.

A. Initiate phototherapy per standardized nomogram-based thresholds and continue to monitor bilirubin trends

B. Discontinue breastfeeding entirely and switch to formula exclusively

C. Reassure the family that all neonatal jaundice is benign and no treatment is needed

D. Proceed directly to exchange transfusion without first attempting phototherapy

126. A late preterm infant born at 34 weeks develops grunting, nasal flaring, and retractions shortly after birth, with a chest x-ray showing a diffuse reticulogranular pattern and air bronchograms.

A. Manage with observation alone since symptoms are expected in preterm infants, though this does not address the most likely diagnosis here

B. Provide respiratory support (CPAP or surfactant as indicated by severity) consistent with management of respiratory distress syndrome

C. Start broad-spectrum antibiotics as the sole intervention without respiratory support, which risks clinical deterioration if the diagnosis is missed

D. Discharge home once the infant tolerates a single feed, which would not provide adequate monitoring for this clinical picture

127. A term infant born by scheduled cesarean section develops mild tachypnea and mild retractions shortly after birth, with a chest x-ray showing prominent perihilar streaking and fluid in the fissures, and the infant is otherwise well-appearing with improving symptoms over the first hours.

A. Diagnose meconium aspiration syndrome and begin aggressive suctioning, an approach that would leave the underlying process unaddressed

B. Assume sepsis and admit to the NICU for a prolonged antibiotic course regardless of trajectory, which risks clinical deterioration if the diagnosis is missed

C. Recognize likely transient tachypnea of the newborn and provide supportive respiratory care with expectation of improvement over 24-72 hours

D. Proceed directly to intubation and mechanical ventilation, despite the risk this poses of delaying definitive treatment

128. A term infant is born to a mother who is GBS positive with inadequate intrapartum antibiotic prophylaxis. The infant is currently well-appearing with normal vital signs at birth.

A. Apply risk-based or algorithm-based observation and monitoring per current guidelines, given inadequate GBS prophylaxis, without automatic empiric antibiotics in an asymptomatic well-appearing infant

B. Start empiric IV antibiotics in all cases of inadequate maternal GBS prophylaxis regardless of infant status, despite the risk this poses of delaying definitive treatment

C. Discharge home immediately with no additional monitoring since the infant appears well, an approach that would leave the underlying process unaddressed

D. Delay any evaluation until symptoms of sepsis develop, which would not provide adequate monitoring for this clinical picture

129. A late preterm infant born at 35 weeks is being prepared for discharge at 48 hours of life. The parents ask about specific risks for late preterm infants compared with term infants.

A. Reassure the family that late preterm infants have identical risks to term infants and require no additional monitoring, though this does not address the most likely diagnosis here

B. Counsel that late preterm infants are at increased risk for hypoglycemia, hyperbilirubinemia, temperature instability, and feeding difficulties, warranting closer monitoring before and after discharge

C. Discharge without any additional follow-up given the infant's relatively mature gestational age alone, without confirming the response to therapy

D. Recommend an extended NICU stay for all late preterm infants regardless of clinical status, despite the risk this poses of delaying definitive treatment

130. A newborn born to a mother with opioid use during pregnancy develops tremors, high-pitched crying, poor feeding, and loose stools starting at 36 hours of life.

A. Discharge home immediately since symptoms are expected and will resolve without monitoring, despite the risk this poses of delaying definitive treatment

B. Use a standardized scoring tool to guide assessment and pharmacologic treatment decisions for neonatal abstinence syndrome, alongside supportive non-pharmacologic care

C. Start high-dose opioid replacement therapy immediately regardless of symptom severity, which could delay recognition of a more serious underlying process

D. Attribute symptoms solely to a feeding intolerance and adjust formula without further evaluation alone, without confirming the response to therapy

131. A large-for-gestational-age term infant delivered after a difficult vaginal delivery with shoulder dystocia has decreased movement and an asymmetric Moro reflex on the right side, with the right arm held in an adducted, internally rotated position.

A. Reassure the family this will resolve without any further evaluation or follow-up, without first addressing the more immediately concerning finding

B. Immobilize the arm rigidly for an extended period as the primary treatment, which would not provide adequate monitoring for this clinical picture

C. Diagnose a brachial plexus birth injury, arrange appropriate follow-up (often physical therapy and possible specialist referral), and monitor for recovery

D. Proceed immediately to surgical nerve repair without an observation period, an approach inconsistent with standard management for this presentation

132. A newborn has a scaphoid abdomen, respiratory distress immediately after birth, and bowel sounds auscultated in the left chest. Chest x-ray confirms bowel loops in the thoracic cavity with mediastinal shift.

A. Attempt immediate bag-mask ventilation with high pressures to improve oxygenation, a step that is not supported by current evidence-based guidelines, though this does not address the most likely diagnosis here

B. Avoid bag-mask ventilation (to prevent bowel distension), secure the airway with intubation if needed, decompress the stomach with an orogastric tube, and arrange surgical consultation for congenital diaphragmatic hernia

C. Discharge home once initial oxygen saturation stabilizes, an approach that would leave the underlying process unaddressed before the more urgent issue has been addressed

D. Proceed to emergent surgical repair in the delivery room before any stabilization, which would not provide adequate monitoring for this clinical picture

133. An exclusively breastfed term infant has lost 9% of birth weight by day 4 of life, with the mother reporting difficulty with latch and infrequent audible swallowing during feeds.

A. Reassure the family this weight loss is within normal limits and no intervention is needed before the more urgent issue has been addressed

B. Recommend immediate discontinuation of breastfeeding in favor of exclusive formula feeding, which would not provide adequate monitoring for this clinical picture

C. Discharge without any lactation support or follow-up plan, an approach that would leave the underlying process unaddressed

D. Provide focused lactation support to improve latch and milk transfer, with close follow-up of weight and feeding, given weight loss approaching a concerning threshold

134. A term infant has a total serum bilirubin rapidly rising and now approaching the threshold for exchange transfusion despite intensive phototherapy, with early signs of acute bilirubin encephalopathy (lethargy, poor feeding).

A. Continue phototherapy alone and reassess in 24 hours, though the clinical picture warrants more definitive action

B. Discharge home with close outpatient bilirubin monitoring, a step that is not supported by current evidence-based guidelines

C. Proceed with urgent exchange transfusion per established thresholds, given the level and early neurotoxicity signs, while continuing intensive phototherapy

D. Discontinue phototherapy since it has been ineffective, though this does not address the most likely diagnosis here

135. A term infant is delivered through thick meconium-stained amniotic fluid and is vigorous at birth with a strong cry, good tone, and heart rate above 100/min.

A. Perform routine endotracheal suctioning of the airway regardless of vigor alone, without confirming the response to therapy

B. Provide routine newborn care without endotracheal suctioning, since the infant is vigorous, while continuing to monitor for respiratory symptoms

C. Delay all newborn care until a chest x-ray is obtained, despite the risk this poses of delaying definitive treatment

D. Administer prophylactic antibiotics to all infants born through meconium-stained fluid, an approach that would leave the underlying process unaddressed

136. A term infant born to a mother with an active genital herpes lesion at the time of vaginal delivery is currently asymptomatic. The delivery was complicated by prolonged rupture of membranes.

A. Discharge home with routine newborn care and no additional monitoring or testing, an approach inconsistent with standard management for this presentation

B. Start empiric long-term oral antiviral therapy without any testing, which risks clinical deterioration if the diagnosis is missed, which could delay recognition of a more serious underlying process

C. Evaluate per neonatal HSV exposure protocols, which may include surface/blood/CSF testing and consideration of empiric IV acyclovir depending on maternal lesion type and exposure risk, with close monitoring

D. Delay any evaluation until symptoms of HSV infection develop, without first addressing the more immediately concerning finding

137. A hospital nursery is implementing universal screening to detect critical congenital heart disease in asymptomatic newborns prior to discharge.

A. Rely solely on prenatal ultrasound findings with no postnatal screening, a step that is not supported by current evidence-based guidelines

B. Perform screening only in infants with an audible murmur on exam alone, without confirming the response to therapy

C. Screen only infants with a family history of congenital heart disease, though this does not address the most likely diagnosis here

D. Implement universal pulse oximetry screening after 24 hours of age per standard critical congenital heart disease screening protocols

138. A 3-week-old exclusively breastfed infant has poor weight gain at a routine visit, tracking below expected growth. The mother reports the infant feeds frequently but seems to fatigue quickly during feeds, with no other concerning symptoms.

A. Reassure the family this is normal and requires no further evaluation, which risks clinical deterioration if the diagnosis is missed

B. Recommend immediate cessation of breastfeeding without further assessment, despite the risk this poses of delaying definitive treatment

C. Perform a focused evaluation of feeding (observed feed, weight trend, possible underlying causes such as inadequate milk transfer or an organic cause like cardiac disease) and arrange close follow-up

D. Start a high-calorie formula supplement without evaluating the underlying cause, an approach inconsistent with standard management for this presentation

139. A 6-year-old boy with a tracheostomy for chronic respiratory failure develops sudden increased work of breathing, agitation, and difficulty passing a suction catheter through the tracheostomy tube.

A. Wait several minutes to see if symptoms resolve spontaneously before intervening, a step that is not supported by current evidence-based guidelines

B. Attempt immediate suctioning and, if unsuccessful, proceed with emergent tracheostomy tube change given concern for mucus plugging or obstruction

C. Remove the tracheostomy tube permanently and manage the airway via mask ventilation only, though the clinical picture warrants more definitive action

D. Administer a bronchodilator alone without addressing the tube itself before the more urgent issue has been addressed

140. A 9-year-old girl with severe spastic quadriplegic cerebral palsy is hospitalized for an unrelated illness and her caregivers report worsening muscle spasticity causing pain and difficulty with positioning and care during the admission.

A. Ignore the spasticity since it is a chronic baseline issue unrelated to the current admission

B. Continue and optimize her home spasticity management to address pain and facilitate care during hospitalization

C. Discontinue all home spasticity medications during the hospital stay

D. Recommend surgical intervention for spasticity during this acute hospitalization without further evaluation

141. A 5-year-old boy with a gastrostomy tube for feeding has new vomiting and abdominal distension during a continuous overnight feed, without fever or other acute illness symptoms.

A. Increase the feeding rate to compensate for presumed inadequate volume, which would not provide adequate monitoring for this clinical picture

B. Switch immediately to a different formula without assessing tolerance factors, despite the risk this poses of delaying definitive treatment

C. Discontinue all enteral feeding permanently before the more urgent issue has been addressed, though this does not address the most likely diagnosis here

D. Evaluate for feeding intolerance (rate, volume, positioning, tube function) and adjust the feeding plan accordingly, such as slowing the rate or checking for tube malposition

142. A 10-year-old girl with medical complexity is on eight home medications managed by multiple subspecialists. During hospitalization, the team notes potential overlapping side effects and possible drug interactions among her regimen.

A. Conduct a comprehensive medication reconciliation and review for interactions/redundancies, involving pharmacy and relevant specialists as needed

B. Continue all medications unchanged without review since they were prescribed by specialists, though this does not address the most likely diagnosis here

C. Discontinue all home medications simultaneously during the hospitalization, without first addressing the more immediately concerning finding

D. Address medication review only at the time of discharge without involving pharmacy, which risks clinical deterioration if the diagnosis is missed

143. An 8-year-old boy with medical complexity followed by five subspecialists is being discharged after a hospitalization, with new medication changes and follow-up needs across multiple specialties.

A. Provide discharge instructions only for the primary reason for admission, leaving specialty follow-up to the family to coordinate independently before the more urgent issue has been addressed

B. Discharge without any specific follow-up plan, assuming outpatient providers will manage coordination, a step that is not supported by current evidence-based guidelines

C. Coordinate a comprehensive discharge plan addressing all relevant specialty follow-up, medication changes, and care coordination, communicating with the family and outpatient team

D. Delay discharge indefinitely until all specialists have been contacted in person, which could delay recognition of a more serious underlying process

144. A family of a child with a progressive, life-limiting neurodegenerative condition is meeting with the medical team to discuss the child's overall care trajectory and future goals given anticipated disease progression.

A. Facilitate an open, honest goals-of-care conversation that explores the family's values, hopes, and concerns, and integrates this into an individualized care plan

B. Avoid discussing prognosis or goals of care to prevent causing distress to the family alone, without confirming the response to therapy

C. Make care decisions unilaterally without significant family input given medical complexity, an approach inconsistent with standard management for this presentation

D. Defer this conversation entirely until the child is in extremis, though this does not address the most likely diagnosis here

145. A 4-year-old boy with a ventriculoperitoneal shunt for hydrocephalus presents with headache, vomiting, lethargy, and irritability over the past day, with a bulging fontanelle noted on exam (in a child with an open fontanelle).

A. Reassure the family this is a typical viral illness and manage supportively at home, an approach inconsistent with standard management for this presentation

B. Wait 48 hours to see if symptoms resolve before any evaluation, a step that is not supported by current evidence-based guidelines

C. Urgently evaluate for possible shunt malfunction (neuroimaging, neurosurgical consultation) given the concerning symptom cluster

D. Adjust the child's home antiemetic regimen as the primary intervention, an approach that would leave the underlying process unaddressed

146. A 12-year-old girl with severe cerebral palsy and chronic pain related to spasticity and orthopedic complications is hospitalized, and her caregivers report her baseline pain is poorly controlled at home despite her current regimen.

A. Assume nonverbal children cannot reliably have pain assessed and forgo any pain management review, a step that is not supported by current evidence-based guidelines

B. Use a validated nonverbal pain assessment tool and reassess her multimodal pain regimen (including addressing spasticity and orthopedic contributors), involving relevant specialists as needed

C. Increase opioid medication alone without addressing other contributing factors alone, without confirming the response to therapy

D. Discharge without addressing the reported pain control concerns, though the clinical picture warrants more definitive action

147. A 5-year-old boy with cerebral palsy and gastrostomy tube feeding has demonstrated poor weight gain over several months despite receiving his previously calculated caloric prescription.

A. Assume the caloric prescription is adequate indefinitely without reassessment, which would not provide adequate monitoring for this clinical picture

B. Discontinue tube feeding in favor of oral feeding only, a step that is not supported by current evidence-based guidelines

C. Reassess caloric and nutritional needs (which change with growth and activity level) and adjust the feeding regimen accordingly, involving nutrition/GI specialists as needed

D. Increase feeding volume dramatically without reassessing overall caloric composition or needs, which could delay recognition of a more serious underlying process

148. A family of a child with medical complexity requiring ongoing tracheostomy and ventilator care at home is preparing for discharge after a prolonged hospitalization, and there are gaps in equipment, home nursing, and caregiver training.

A. Discharge as soon as the child is medically stable regardless of home readiness, though the clinical picture warrants more definitive action

B. Assume the family will independently arrange all home health needs after discharge, which could delay recognition of a more serious underlying process

C. Engage case management/social work early to coordinate home health services, equipment, and caregiver training before discharge to ensure a safe transition

D. Delay all planning until the day of discharge, a step that is not supported by current evidence-based guidelines

149. A 7-year-old boy with medical complexity on multiple home medications develops new-onset lethargy and constipation. The team reviews his medication list and notes a recently added medication known to cause these side effects.

A. Attribute the symptoms to his underlying chronic condition without medication review, despite the risk this poses of delaying definitive treatment

B. Recognize the temporal association with the new medication, evaluate for a medication side effect, and consider adjustment in consultation with the prescribing specialist

C. Add additional medications to treat the new symptoms without addressing the underlying cause, though this does not address the most likely diagnosis here

D. Discontinue all home medications simultaneously without clinical review, which would not provide adequate monitoring for this clinical picture

150. A child with a terminal illness is receiving end-of-life care at home with hospice involvement, and the family reports the child is experiencing significant dyspnea and discomfort in the final days of life.

A. Withhold symptom-directed treatment to avoid hastening death

B. Focus exclusively on curative interventions despite the terminal prognosis

C. Prioritize aggressive symptom management to maximize comfort, consistent with palliative care principles

D. Recommend hospital transfer for aggressive resuscitative measures against the family's expressed goals

151. A 4-year-old is undergoing procedural sedation for a fracture reduction. The physician is selecting appropriate monitoring for the procedure.

A. Monitor heart rate alone since this is the most important vital sign during sedation, which would not provide adequate monitoring for this clinical picture

B. No monitoring is needed for brief procedures under moderate sedation, which could delay recognition of a more serious underlying process

C. Monitor only intermittently every 30 minutes throughout the procedure, despite the risk this poses of delaying definitive treatment, a step that is not supported by current evidence-based guidelines

D. Continuously monitor oxygen saturation, heart rate, and respiratory status (with capnography as appropriate), with a dedicated provider whose sole responsibility is monitoring the patient throughout the sedation

152. A physician is preparing to perform a lumbar puncture on a 6-year-old with suspected meningitis who has focal neurologic deficits and papilledema on exam.

A. Proceed with lumbar puncture immediately without any further evaluation given the urgency of suspected meningitis, which would not provide adequate monitoring for this clinical picture

B. Obtain neuroimaging first to evaluate for a mass lesion or elevated intracranial pressure before performing the lumbar puncture, while not delaying empiric antibiotics

C. Cancel the lumbar puncture entirely and rely on empiric antibiotics with no CSF analysis, an approach that would leave the underlying process unaddressed

D. Perform the lumbar puncture with the patient in a seated position regardless of clinical findings, without first addressing the more immediately concerning finding

153. A critically ill 2-year-old in cardiac arrest has no peripheral IV access after multiple attempts, and the resuscitation team needs immediate vascular access for medication administration.

A. Continue attempting peripheral IV access repeatedly before considering any alternative

B. Delay medication administration until central venous access can be established

C. Obtain intraosseous access promptly as a rapid, reliable alternative for emergency medication and fluid administration

D. Administer resuscitation medications via the endotracheal tube as the preferred route in this scenario

154. A 9-year-old boy involved in a motor vehicle collision has sudden severe respiratory distress, absent breath sounds on the left, tracheal deviation to the right, and hypotension.

A. Obtain a chest x-ray before any intervention given his current alertness, despite the risk this poses of delaying definitive treatment

B. Perform emergent needle thoracentesis (needle decompression) for suspected tension pneumothorax without delaying for imaging

C. Administer IV fluids alone and observe for improvement before the more urgent issue has been addressed

D. Wait for surgical consultation before any intervention given the complexity, though the clinical picture warrants more definitive action

155. A nasogastric tube has just been placed in a 3-year-old for feeding, and the team needs to confirm correct gastric placement before initiating feeds.

A. Assume correct placement based on the length inserted alone without further confirmation

B. Confirm placement solely by auscultating air insufflation over the abdomen, which is now known to be an unreliable method alone

C. Begin feeding immediately without any placement confirmation

D. Confirm placement using an appropriate combination of methods before initiating feeds

156. A provider is performing bag-mask ventilation on an apneic newborn and needs to assess whether ventilation is effective.

A. Assess for adequate chest rise, improving heart rate, and improving color/oxygen saturation as key indicators of effective ventilation, adjusting technique (mask seal, head position, pressure) if these are not achieved

B. Rely solely on the sound of air movement without assessing chest rise or heart rate, which risks clinical deterioration if the diagnosis is missed

C. Continue bagging at a fixed rate and pressure regardless of clinical response, which would not provide adequate monitoring for this clinical picture

D. Assess effectiveness only after two full minutes of continuous ventilation without interim adjustment alone, without confirming the response to therapy, an approach that would leave the underlying process unaddressed

157. A family strongly disagrees with the medical team's recommended treatment plan for their hospitalized child, creating tension during rounds. The medical team believes their recommendation is in the child's best interest.

A. Proceed with the team's preferred plan without further discussion since the medical team has the final say, without first addressing the more immediately concerning finding

B. Immediately involve hospital security or administration without further attempts at communication, though the clinical picture warrants more definitive action alone, without confirming the response to therapy

C. Avoid further discussion of the disagreement to prevent conflict before the more urgent issue has been addressed, despite the risk this poses of delaying definitive treatment

D. Engage in active listening to understand the family's concerns and values, seek common ground, and involve additional resources (ethics consultation, palliative care, or a family meeting) as needed to resolve the conflict collaboratively

158. A family with limited health literacy is being discharged after their child's hospitalization with several new medications and follow-up instructions.

A. Use plain language, teach-back methods, and written materials at an appropriate reading level to confirm the family's understanding of discharge instructions

B. Provide only detailed written instructions in medical terminology without verifying comprehension, an approach inconsistent with standard management for this presentation

C. Assume the family understands instructions if they nod during the discussion, despite the risk this poses of delaying definitive treatment

D. Skip discharge education entirely to save time given a busy discharge day alone, without confirming the response to therapy

159. A hospital is redesigning its daily rounding process to better incorporate family-centered care principles for hospitalized children.

A. Conduct family-centered rounds at the bedside, actively inviting family participation and input into the daily care plan

B. Conduct all rounds and care planning discussions exclusively outside the patient's room without family presence

C. Limit family involvement to a brief update at the end of the day

D. Exclude families from rounds if the medical team believes it will be more efficient

160. A hospitalized child's family speaks a language other than English, and the medical team needs to discuss a significant treatment decision with them.

A. Use a family member or the child as an ad hoc interpreter to save time, an approach that would leave the underlying process unaddressed

B. Communicate primarily through written English materials since the family has some basic comprehension alone, without confirming the response to therapy

C. Use a qualified professional medical interpreter (in-person or via a certified interpreter service) for all significant medical discussions with the family

D. Proceed with the discussion in English and rely on nonverbal cues to gauge understanding, which risks clinical deterioration if the diagnosis is missed

161. A hospital is standardizing its shift-to-shift handoff process for hospitalized patients after several communication-related near-miss events were identified.

A. Implement a standardized, structured handoff tool with dedicated time, minimal interruptions, and opportunity for questions

B. Rely on informal verbal handoffs without a standardized structure or written documentation

C. Eliminate handoffs entirely by having the same provider cover all shifts

D. Limit handoff communication to written notes only, without any verbal component

162. A community hospital is evaluating whether a critically ill child requires transfer to a tertiary pediatric center with a higher level of care, including pediatric subspecialty and PICU resources not available locally.

A. Use established triage/transfer criteria to determine the appropriate level of care needed and facilitate timely transfer if the patient's needs exceed local capabilities

B. Manage the patient locally regardless of resource limitations to avoid the risk of transport, which risks clinical deterioration if the diagnosis is missed

C. Delay any transfer decision until the patient's condition significantly worsens, without first addressing the more immediately concerning finding

D. Transfer all critically ill children automatically regardless of local capability to manage the specific condition, which would not provide adequate monitoring for this clinical picture

163. A critically ill infant is being transported from a community hospital to a tertiary NICU. The transport team is preparing the infant for the transfer.

A. Prioritize transport speed over stabilization, transporting the infant as quickly as possible without addressing airway, breathing, or circulation issues first

B. Ensure appropriate pre-transport stabilization (airway, breathing, circulation, temperature, glucose) is achieved to the extent possible before departure, using a trained transport team

C. Delay transport indefinitely until the infant is completely stable with no ongoing needs

D. Have the referring facility's team, unfamiliar with transport medicine, perform the transport without specialized training

164. A child with a complex medical history is being discharged from the hospital, and the team is coordinating communication of the hospital course and follow-up plan with the child's primary care provider.

A. Provide timely, comprehensive discharge communication to the primary care provider, including hospital course, medication changes, and follow-up needs, ideally before or shortly after discharge

B. Assume the family will accurately relay all relevant information to the primary care provider without formal documentation, which would not provide adequate monitoring for this clinical picture

C. Send discharge documentation to the primary care provider only if specifically requested, without first addressing the more immediately concerning finding

D. Delay discharge communication for several weeks until a formal dictated summary is completed, an approach inconsistent with standard management for this presentation

165. A hospitalist team wants to test a new discharge checklist intervention aimed at reducing 30-day readmissions before implementing it hospital-wide.

A. Implement the checklist hospital-wide immediately without any small-scale testing, without first addressing the more immediately concerning finding

B. Abandon the idea without any testing based on theoretical concerns alone, which could delay recognition of a more serious underlying process

C. Survey staff opinions only, without collecting any outcome data, a step that is not supported by current evidence-based guidelines

D. Use a Plan-Do-Study-Act (PDSA) cycle to test the intervention on a small scale, measure results, and iteratively refine before broader implementation

166. A QI team is tracking hand hygiene compliance rates over several months following an intervention and wants to visually display whether the intervention led to a sustained improvement over time.

A. Use a run chart or control chart to display compliance data over time, allowing visualization of trends, shifts, and special-cause variation relative to the intervention

B. Compare only the single most recent data point with the single first data point, an approach that would leave the underlying process unaddressed

C. Rely solely on anecdotal staff reports without any data visualization, which could delay recognition of a more serious underlying process

D. Avoid displaying data over time since a single summary statistic is sufficient, an approach inconsistent with standard management for this presentation

167. A hospital medicine group notices wide variation in the use of routine daily labs for stable, improving patients without a clear clinical indication, contributing to unnecessary costs and blood draws.

A. Increase the frequency of routine labs to ensure no findings are missed

B. Take no action since variation in practice is expected and acceptable

C. Apply waste and variation reduction principles to reduce unnecessary testing while maintaining safety

D. Mandate that all labs be discontinued entirely regardless of clinical status

168. A hospital is working to build a culture consistent with high reliability organization (HRO) principles to reduce preventable harm.

A. Foster a culture of psychological safety where staff at all levels are empowered to speak up about safety concerns, with leadership commitment to learning from errors rather than assigning blame

B. Discourage staff from reporting near-misses to avoid drawing attention to problems, an approach inconsistent with standard management for this presentation

C. Focus exclusively on individual staff discipline after every error as the primary safety strategy, though the clinical picture warrants more definitive action

D. Limit safety discussions to leadership only, without frontline staff input, despite the risk this poses of delaying definitive treatment

169. After a serious medication error reaches a patient, the hospital's patient safety team is determining how to investigate the event to prevent recurrence.

A. Focus the investigation solely on identifying which individual staff member made the error, which would not provide adequate monitoring for this clinical picture

B. Conduct a structured root cause analysis (RCA) examining systems-level factors that contributed to the error, involving a multidisciplinary team

C. Skip formal investigation since the immediate error has already been corrected before the more urgent issue has been addressed

D. Address the issue solely through informal, undocumented conversations with involved staff, an approach inconsistent with standard management for this presentation

170. A physician recognizes that a dosing error was made in a patient's medication administration, though the child experienced no apparent harm from the error.

A. Do not disclose the error to the family since no harm occurred, though the clinical picture warrants more definitive action

B. Disclose the error only if the family specifically asks about it later, though this does not address the most likely diagnosis here

C. Proactively and transparently disclose the error to the family per institutional disclosure policies, regardless of whether harm occurred, and document appropriately

D. Disclose the error only to hospital risk management, not to the family, an approach inconsistent with standard management for this presentation

171. A hospital is implementing strategies to reduce central line-associated bloodstream infections (CLABSIs) among patients with central venous catheters.

A. Focus solely on treating infections after they occur rather than prevention

B. Leave central line care practices to individual provider preference without standardization

C. Remove all central lines regardless of clinical necessity to eliminate risk

D. Implement a standardized central line maintenance bundle to reduce hospital-acquired CLABSI rates

172. A hospital pediatric unit is preparing for an accreditation survey and reviewing its compliance with regulatory and accrediting body standards relevant to patient safety and quality.

A. Proactively review and ensure ongoing compliance with relevant regulatory and accrediting standards as part of routine quality operations, not just before a survey

B. Only address regulatory compliance issues immediately before a scheduled survey, an approach inconsistent with standard management for this presentation

C. Assume regulatory compliance is solely the responsibility of hospital administration with no frontline clinician role before the more urgent issue has been addressed

D. Disregard regulatory standards that are perceived as burdensome to clinical workflow, a step that is not supported by current evidence-based guidelines

173. A hospitalist group reviews their practice patterns and identifies that many patients admitted with bronchiolitis are receiving chest x-rays and bronchodilator trials despite evidence that these do not improve outcomes in typical bronchiolitis.

A. Continue current practice since more testing and intervention is generally safer for patients, despite the risk this poses of delaying definitive treatment

B. Apply principles of reducing overuse and unwarranted variation by aligning practice with evidence-based bronchiolitis guidelines that discourage routine chest x-rays and bronchodilators

C. Increase the use of chest x-rays further to ensure no cases are missed, which would not provide adequate monitoring for this clinical picture

D. Make changes based on individual physician preference without reference to evidence-based guidelines, though this does not address the most likely diagnosis here

174. A hospital quality dashboard tracks length of stay and 30-day readmission rates for common pediatric admission diagnoses as part of a value-based care initiative.

A. These metrics are irrelevant to clinical care quality and should not be tracked, an approach that would leave the underlying process unaddressed

B. Only cost data should be tracked, without any attention to length of stay or readmissions, though the clinical picture warrants more definitive action

C. Recognize that length of stay and readmission rates are commonly used value metrics that help evaluate efficiency and quality of care, while ensuring they do not incentivize premature or unsafe discharge

D. Use these metrics exclusively to financially penalize individual providers without systems-level context, an approach inconsistent with standard management for this presentation

175. A hospitalized child from a family with limited access to a regular primary care provider is identified as overdue for routine immunizations and well-child screening during an unrelated hospital admission.

A. Use the hospitalization as an opportunity to identify and address unmet preventive healthcare needs when appropriate and feasible

B. Address only the acute reason for admission and ignore preventive care needs entirely, deferring everything to a future outpatient visit that may not occur

C. Discharge without any mention of the identified gaps in preventive care

D. Refuse to provide any preventive care services in the inpatient setting under any circumstances

176. A hospitalist is reviewing a newly published clinical practice guideline before deciding whether to adopt its recommendations into local practice.

A. Critically appraise the guideline's development process, including the quality and strength of underlying evidence and potential conflicts of interest, before adoption

B. Adopt any published guideline automatically without critical appraisal, an approach that would leave the underlying process unaddressed

C. Reject all guidelines from professional societies regardless of their evidence basis alone, without confirming the response to therapy

D. Base the decision solely on how recently the guideline was published, without evaluating its content, without first addressing the more immediately concerning finding

177. A hospitalist is evaluating a research study to determine how much weight to give its findings when considering a change in clinical practice.

A. Give equal weight to all study types regardless of design

B. Assess the study's source and design to appropriately weigh the strength of the evidence it provides

C. Base practice changes solely on expert opinion pieces without considering primary research quality

D. Disregard study design entirely and focus only on whether the results align with prior personal beliefs

178. A hospitalist group participates in a Choosing Wisely-style initiative to reduce low-value imaging, such as routine repeat chest x-rays for improving pneumonia patients without a clinical indication.

A. Align practice with evidence-based recommendations to avoid low-value, low-yield imaging that does not change management in improving patients

B. Continue routine repeat imaging for all patients regardless of clinical trajectory to ensure resolution is documented

C. Increase the frequency of imaging to reduce any theoretical risk of missing a complication

D. Base imaging decisions solely on family request rather than clinical indication

179. A hospital administrator asks a pediatric hospitalist to help interpret the difference between hospital charges and actual costs of care for a families' billing question regarding their child's admission.

A. State that charges and costs are always identical and interchangeable terms, which risks clinical deterioration if the diagnosis is missed

B. Explain that charges (the listed price) and costs (the actual resource expenditure) are distinct concepts commonly used in healthcare value discussions, and that this distinction is relevant to understanding value-based metrics

C. Refuse to engage with any financial terminology as outside the scope of clinical practice, which would not provide adequate monitoring for this clinical picture

D. Provide the family with only the total charge amount without any further explanation of terminology, an approach inconsistent with standard management for this presentation

180. A hospitalist is comparing two studies on a treatment approach: one is a well-conducted randomized controlled trial, and the other is a retrospective case series with a small sample size and no control group.

A. Consider both studies to provide equally strong evidence for practice changes, which could delay recognition of a more serious underlying process

B. Recognize the randomized controlled trial provides substantially stronger evidence for causal inference due to its design, and weigh it more heavily than the retrospective case series when both are available

C. Disregard the randomized controlled trial in favor of the more recent case series, which is not necessarily an accurate approach, which risks clinical deterioration if the diagnosis is missed

D. Base the decision on which study is more concisely written rather than its methodological rigor, an approach inconsistent with standard management for this presentation

181. A hospitalist is deciding whether to prescribe antibiotics for a child with a clear viral upper respiratory infection whose family is requesting antibiotics for reassurance.

A. Prescribe antibiotics to satisfy the family's request and avoid conflict, regardless of the viral etiology, despite the risk this poses of delaying definitive treatment

B. Prescribe a shortened antibiotic course as a compromise despite the viral diagnosis, which risks clinical deterioration if the diagnosis is missed

C. Order additional unnecessary testing to delay the decision rather than addressing the request directly, a step that is not supported by current evidence-based guidelines

D. Decline unnecessary antibiotics, explain the viral etiology and rationale in accessible terms, and address the family's underlying concerns through education and a clear return-precautions plan

182. A hospitalist is researching the best available evidence to guide management of a relatively common pediatric hospital condition and finds a well-conducted systematic review and meta-analysis of multiple randomized controlled trials on the topic.

A. Disregard the systematic review in favor of a single expert's personal experience, a step that is not supported by current evidence-based guidelines

B. Consider the systematic review equivalent in strength to a single small case series, an approach inconsistent with standard management for this presentation

C. Recognize the systematic review and meta-analysis of multiple RCTs as among the strongest available forms of evidence, appropriately weighing it heavily when it is well-conducted

D. Avoid using systematic reviews since they cannot be applied to individual patient decisions, though the clinical picture warrants more definitive action

183. During a pediatric code event, multiple team members are present and roles are unclear, leading to confusion and delays in task completion.

A. Have all team members act independently without designated roles to maximize speed, an approach inconsistent with standard management for this presentation

B. Apply structured team leadership principles, including clear role assignment, closed-loop communication, and a designated team leader, to improve coordination during the resuscitation

C. Limit the number of people involved regardless of task requirements, an approach that would leave the underlying process unaddressed

D. Assign roles only after the resuscitation has concluded for future reference, which could delay recognition of a more serious underlying process

184. A hospital medicine group is trying to implement a new evidence-based clinical pathway, but faces resistance from some staff members accustomed to prior practices.

A. Mandate the change immediately without any staff engagement or explanation, which risks clinical deterioration if the diagnosis is missed

B. Abandon the new pathway entirely due to initial resistance, which could delay recognition of a more serious underlying process

C. Apply change management principles, such as engaging stakeholders early, clearly communicating the rationale and evidence, and incorporating feedback, to facilitate sustainable adoption

D. Implement the change only for a subset of willing staff members indefinitely, without addressing broader adoption before the more urgent issue has been addressed

185. A hospital is considering implementing routine screening for social determinants of health (e.g., housing instability, food insecurity) among admitted pediatric patients to better connect families with needed resources.

A. Implement structured social determinants of health screening with a clear plan for connecting identified needs to appropriate resources and referrals

B. Avoid screening for social determinants since addressing them is outside the scope of hospital-based pediatric care

C. Screen only families who explicitly request assistance, without proactive screening of all patients

D. Screen for social needs but take no further action or referral once needs are identified

186. A hospitalist notices that pain in a particular patient population at their institution has historically been undertreated compared with other groups, and wants to address potential implicit bias contributing to this disparity.

A. Deny that implicit bias could play any role in clinical decision-making among well-intentioned providers before the more urgent issue has been addressed

B. Acknowledge that implicit bias can unconsciously influence clinical decisions, support institutional bias-awareness training, and use standardized, objective pain assessment tools/protocols to reduce variability in care

C. Address the issue only through informal individual conversations without systemic changes, an approach inconsistent with standard management for this presentation

D. Assume the disparity reflects true differences in underlying disease processes rather than considering bias as a contributing factor, despite the risk this poses of delaying definitive treatment

187. A 16-year-old girl with decision-making capacity disagrees with her parents about a proposed elective treatment for a chronic condition. The medical team is considering how to appropriately involve her in the decision.

A. Disregard the adolescent's perspective entirely and defer solely to parental authority, though this does not address the most likely diagnosis here

B. Make the decision unilaterally as the medical team without involving either the adolescent or the parents, a step that is not supported by current evidence-based guidelines

C. Proceed with the adolescent's preference alone without any parental involvement, regardless of the treatment's nature before the more urgent issue has been addressed, which could delay recognition of a more serious underlying process

D. Seek the adolescent's assent alongside parental consent, facilitating a shared discussion that respects the adolescent's developing autonomy while working toward a mutually acceptable decision, escalating to ethics consultation if disagreement persists

188. A 15-year-old girl requests confidential care for a sensitive reproductive health concern during her hospitalization and asks that her parents not be informed of the specifics.

A. Automatically inform the parents of all details regardless of the adolescent's request alone, without confirming the response to therapy

B. Refuse to provide any care related to the concern until parents are informed, without first addressing the more immediately concerning finding

C. Document the confidential discussion in a way fully visible to parents through routine chart access, regardless of the request, an approach inconsistent with standard management for this presentation

D. Provide care in accordance with applicable confidentiality protections for adolescent health services where relevant, while being aware of and appropriately acting on any mandated reporting obligations that may apply

189. A hospital is developing an ethics framework to guide decision-making when there is tension between honoring a family's autonomous treatment preferences and the medical team's assessment of the child's best interest.

A. Apply recognized ethical frameworks to systematically work through the tension, often involving ethics consultation for complex or persistent disagreements

B. Always prioritize family autonomy absolutely, regardless of potential harm to the child

C. Always prioritize the medical team's assessment of best interest absolutely, overriding family preferences in all cases

D. Avoid applying any structured ethical framework and instead resolve each case purely based on individual provider intuition

190. A 14-year-old boy newly diagnosed with a serious chronic illness asks the medical team directly what his diagnosis is and what it means for his future, while his parents have privately asked the team not to disclose the diagnosis to him.

A. Follow the parents' request absolutely and never discuss the diagnosis with the patient under any circumstances, a step that is not supported by current evidence-based guidelines, though this does not address the most likely diagnosis here

B. Disclose the full diagnosis to the patient immediately without any further discussion with the parents, which would not provide adequate monitoring for this clinical picture, despite the risk this poses of delaying definitive treatment

C. Avoid answering the patient's direct question entirely and change the subject alone, without confirming the response to therapy, which risks clinical deterioration if the diagnosis is missed

D. Engage the parents in a respectful conversation about the importance of truth-telling and age-appropriate disclosure to the patient, working toward an approach that honors the patient's right to information about his own health while being sensitive to family concerns

191. A pediatric hospitalist is designing a teaching session for resident physicians on managing status asthmaticus and wants to structure it in a way that is most effective for adult learners.

A. Apply adult learning theory principles, such as connecting new material to residents' prior clinical experiences, using case-based and problem-solving approaches, and emphasizing practical application

B. Deliver a purely didactic lecture with no interactive or case-based component, though the clinical picture warrants more definitive action

C. Assume residents require the same teaching approach as elementary school students with no consideration of their prior experience, which risks clinical deterioration if the diagnosis is missed

D. Avoid any structured teaching approach and rely solely on incidental bedside learning, an approach that would leave the underlying process unaddressed

192. A hospitalist is teaching a mixed group that includes a third-year medical student and a senior resident during rounds on the same patient case.

A. Tailor teaching points and questions to each learner's level within the same encounter

B. Direct all teaching exclusively at the most advanced learner in the group, regardless of others present

C. Provide identical teaching content to all learners regardless of their training level

D. Avoid any teaching during rounds to prevent overwhelming less experienced learners

193. A hospitalist attending needs to give feedback to a resident who made a clinical reasoning error during a patient presentation, in a way that supports the resident's learning and improvement.

A. Give only vague, general praise without addressing the specific error, though this does not address the most likely diagnosis here

B. Provide specific, timely, and actionable feedback focused on the behavior/reasoning process (not a personal attack), including what was done well and what could be improved, in a private and respectful setting

C. Publicly criticize the resident's reasoning in front of the entire team and patient's family to reinforce the lesson, a step that is not supported by current evidence-based guidelines

D. Avoid giving any feedback to prevent discouraging the resident, which could delay recognition of a more serious underlying process

194. A senior hospitalist is asked to serve as a mentor for a new junior faculty member starting their career in pediatric hospital medicine.

A. Provide no structured guidance and expect the junior faculty member to navigate career development entirely independently, despite the risk this poses of delaying definitive treatment

B. Focus mentorship exclusively on clinical skills, with no attention to career development or academic goals, which could delay recognition of a more serious underlying process

C. Make all career decisions on behalf of the junior faculty member without their input, an approach that would leave the underlying process unaddressed

D. Establish a mentorship relationship that includes regular check-ins, guidance on career and professional development goals, and support tailored to the mentee's individual needs and aspirations

195. A researcher is analyzing a dataset with a variable representing patient satisfaction rated on a 5-point scale (poor, fair, good, very good, excellent) and needs to select an appropriate statistical approach based on the variable type.

A. Recognize this as an ordinal variable and apply statistical methods appropriate for ordinal data, rather than treating it as continuous data

B. Treat the variable as purely nominal with no inherent order among categories

C. Treat the variable as continuous data and calculate a standard mean and standard deviation without further consideration

D. Assume the variable type does not affect the choice of statistical test

196. A study reports a statistically significant difference between two treatment groups with a p-value of 0.03, and the research team is interpreting what this means and its limitations.

A. Understand that a p-value of 0.03 indicates the observed difference is unlikely to be due to chance alone under the null hypothesis at a conventional threshold, while recognizing that statistical significance does not necessarily equate to clinical significance

B. Conclude the finding definitively proves the treatment causes the observed difference with certainty, despite the risk this poses of delaying definitive treatment alone, without confirming the response to therapy

C. Interpret the p-value as the probability that the null hypothesis is true, a step that is not supported by current evidence-based guidelines, which risks clinical deterioration if the diagnosis is missed

D. Assume statistical significance automatically confirms the finding is clinically meaningful and important, without first addressing the more immediately concerning finding before the more urgent issue has been addressed

197. A retrospective observational study finds an association between a hospital intervention and improved outcomes, but the intervention group differed systematically from the comparison group in several baseline characteristics.

A. Assume the association definitively proves the intervention caused the improved outcome, despite the risk this poses of delaying definitive treatment

B. Recognize that confounding by these systematic baseline differences may explain some or all of the observed association, limiting causal inference from this observational design

C. Assume observational studies are equivalent to randomized controlled trials in establishing causation, though this does not address the most likely diagnosis here

D. Disregard the baseline differences entirely since the outcome difference was statistically significant alone, without confirming the response to therapy

198. A new rapid diagnostic test for a pediatric infection has a sensitivity of 95% and specificity of 70%. A clinician is deciding how to interpret a negative test result in a patient with high pretest probability of the infection based on clinical presentation.

A. Assume a negative result definitively rules out the infection regardless of pretest probability, though this does not address the most likely diagnosis here, without first addressing the more immediately concerning finding

B. Assume specificity is irrelevant to interpreting a negative result alone, without confirming the response to therapy, an approach inconsistent with standard management for this presentation

C. Interpret the negative result the same way regardless of the patient's pretest probability, which risks clinical deterioration if the diagnosis is missed, a step that is not supported by current evidence-based guidelines

D. Recognize that despite high sensitivity, a negative result in a patient with high pretest probability may still carry a meaningful likelihood of missed disease, and consider further testing or clinical correlation rather than relying on the negative result alone

199. A research team is designing a study that will enroll hospitalized children as research subjects and is developing the informed consent/assent process for the study.

A. Obtain informed consent from the parent or legal guardian and, when developmentally appropriate, assent from the child, ensuring both understand the voluntary nature of participation and their right to withdraw without affecting clinical care

B. Obtain consent only from the child regardless of age, without parental involvement alone, without confirming the response to therapy, though the clinical picture warrants more definitive action

C. Assume that clinical care team members can waive consent requirements informally for research purposes, without first addressing the more immediately concerning finding

D. Enroll children in research without any consent or assent process if the study is considered low-risk by the research team alone, despite the risk this poses of delaying definitive treatment

200. A researcher has a financial relationship with a pharmaceutical company whose medication is being studied in a clinical trial the researcher is leading, and this relationship has not been disclosed in the study's publication.

A. Assume nondisclosure is acceptable as long as the study results are scientifically valid, which risks clinical deterioration if the diagnosis is missed

B. Consider financial relationships irrelevant to research integrity as long as the researcher believes they did not influence the results alone, without confirming the response to therapy

C. Address this only if the study results turn out to favor the company's product, despite the risk this poses of delaying definitive treatment

D. Recognize this as a failure to disclose a conflict of interest, a serious breach of research ethics and professionalism regardless of study outcome, requiring proper disclosure and institutional review

Answers

1. D. After two adequately dosed benzodiazepines fail to terminate status epilepticus, pediatric status epilepticus algorithms move to a second-line non-benzodiazepine agent (fosphenytoin, levetiracetam, or valproate) rather than a third benzodiazepine dose, which increases respiratory depression risk without added efficacy. Phenobarbital is typically reserved for refractory status after a second-line agent fails or in neonates. Imaging is pursued after the seizure is controlled and the patient is stabilized, not before treatment of ongoing status epilepticus.

2. B. CSF findings (neutrophilic pleocytosis, low glucose, elevated protein) are classic for bacterial meningitis, which is a medical emergency requiring immediate empiric antibiotics covering resistant pneumococcus and Neisseria/Haemophilus — vancomycin plus a third-generation cephalosporin — without waiting for culture confirmation. Delaying therapy increases morbidity and mortality. Acyclovir alone would fail to treat bacterial meningitis, and outpatient management is inappropriate for this CSF profile.

3. B. A rim-enhancing lesion with edema following sinusitis is characteristic of an intracranial (epidural or brain) abscess, a neurosurgical emergency. Management requires prompt neurosurgical evaluation for possible drainage alongside broad-spectrum IV antibiotics covering streptococci, anaerobes, and Staphylococcus aureus. Oral antibiotics and outpatient observation are inadequate, and delaying source control for repeat imaging risks neurologic deterioration.

4. A. Bilateral temporal lobe involvement with fever, altered behavior, seizures, and lymphocytic CSF pleocytosis is the classic presentation of HSV encephalitis. Because delayed treatment significantly

worsens outcomes, empiric IV acyclovir should be started immediately while PCR results are pending, then discontinued if PCR is negative. Withholding treatment for confirmation risks irreversible neurologic injury.

5. A. Morning headache, vomiting, new diplopia, and papilledema are red flags for elevated intracranial pressure and possible mass lesion. Neuroimaging must be obtained before lumbar puncture to exclude a space-occupying lesion, since LP in the presence of a mass or significantly elevated ICP risks herniation. Outpatient management or empiric migraine therapy would inappropriately delay evaluation of a potentially dangerous cause.

6. B. Tongue fasciculations with profound hypotonia, weak cry, and poor suck in an infant are highly suggestive of spinal muscular atrophy, a lower motor neuron disorder. SMN1 genetic testing is now the first-line diagnostic test given its high sensitivity, availability, and treatment implications, and it avoids the morbidity of muscle biopsy. Guillain-Barré is rare in this age group and typically presents with a preceding illness and areflexia rather than tongue fasciculations.

7. D. Ascending symmetric weakness with areflexia following a diarrheal illness (often Campylobacter jejuni) is classic Guillain-Barré syndrome. Management requires hospital admission for close monitoring of respiratory and autonomic function (given risk of rapid progression to respiratory failure) and disease-modifying therapy with IVIG or plasmapheresis. Corticosteroids have not shown benefit in GBS, and outpatient management is unsafe given the risk of respiratory compromise.

8. C. Acute focal neurologic deficits in a child with sickle cell disease represent stroke until proven otherwise. Emergent neuroimaging confirms the diagnosis and excludes hemorrhage, and exchange transfusion is the definitive acute therapy to reduce hemoglobin S concentration and prevent extension of infarction. tPA is not established or approved for pediatric sickle cell stroke, and hydroxyurea has no role in acute stroke management.

9. B. Drooling, muffled voice, and prevertebral soft tissue widening suggest a retropharyngeal abscess with impending airway compromise. The priority is avoiding agitation (including oral exams or forcing the child supine) that could precipitate complete airway obstruction, and urgently involving anesthesia and ENT for controlled airway management before further workup. Oral antibiotics and discharge are inappropriate given the airway emergency.

10. A. A fluctuant, fluid-containing neck mass with trismus and fever indicates a suppurative neck abscess (e.g., submandibular space infection) requiring surgical drainage in addition to IV antibiotics; trismus also raises concern for parapharyngeal extension, making ENT involvement important for safe airway and drainage planning. Oral antibiotics alone are inadequate for a drainable abscess, and bedside aspiration without surgical involvement risks incomplete drainage or airway complications.

11. B. Trismus, muffled voice, and uvular deviation are classic findings of peritonsillar abscess. Definitive management is drainage (needle aspiration or incision and drainage) by ENT combined with IV antibiotics; oral therapy alone is insufficient for a drainable abscess. Chest CT is not the initial step

absent signs of mediastinal spread, and observation alone risks airway compromise or abscess progression.

12. B. Painful limited extraocular movements, proptosis, and diplopia distinguish orbital (postseptal) cellulitis from preseptal cellulitis, which does not involve ophthalmoplegia. Orbital cellulitis requires urgent contrast-enhanced CT to assess for abscess and IV antibiotics, given the risk of vision loss and intracranial extension. Outpatient oral therapy is inadequate, and this presentation is inconsistent with simple allergic conjunctivitis.

13. A. Postauricular swelling with anteroinferior displacement of the pinna following inadequately treated otitis media is classic for acute mastoiditis, a suppurative complication requiring temporal bone CT to assess extent and ENT consultation, as it can progress to intracranial complications if untreated. Oral antibiotics alone and outpatient management are insufficient once mastoiditis is suspected.

14. D. Purulent discharge from the Stensen duct with unilateral tender swelling worse with eating indicates suppurative (bacterial) parotitis, most commonly caused by Staphylococcus aureus, requiring IV antibiotics with staphylococcal coverage. Mumps typically causes bilateral, non-purulent swelling without expressible pus. Antiviral therapy and aspiration are not appropriate first steps for this bacterial presentation.

15. A. Recurrent wheezing episodes with mild hypoxia and retractions are managed supportively with supplemental oxygen as needed, bronchodilator trial, and monitoring, consistent with standard bronchiolitis/reactive airway management; antibiotics are not indicated absent evidence of bacterial infection. Chest CT is reserved for atypical or refractory presentations, not routine recurrent wheeze, and inpatient initiation of daily inhaled steroids is not the first step for an acute admission.

16. D. The thumbprint sign, drooling, tripod positioning, and stridor at rest are classic for epiglottitis, a life-threatening airway emergency. The priority is minimizing agitation and securing the airway in a controlled setting with anesthesia and ENT present, since direct visualization or agitation can precipitate complete obstruction. Racemic epinephrine treats croup, not epiglottitis, and further imaging should not delay definitive airway management.

17. A. Bronchiolitis management remains supportive care: supplemental oxygen for hypoxia, nasal suctioning, and hydration support, with no proven benefit from bronchodilators, corticosteroids, or antibiotics in typical bronchiolitis. Premature infants are at higher risk for severe disease and require close monitoring, but the underlying management principle remains supportive rather than pharmacologic escalation.

18. B. A severe asthma exacerbation refractory to continuous bronchodilators and systemic corticosteroids warrants escalation of therapy, including IV magnesium sulfate, and consideration of a higher level of care (PICU) given the risk of respiratory failure. Long-acting beta-agonists are not used for acute exacerbations, and discharge is unsafe in a patient with ongoing severe distress; chest CT is not indicated in typical severe asthma without atypical features.

19. A. Acute choking episode during eating followed by unilateral wheeze and asymmetric hyperinflation strongly suggests foreign body aspiration with a ball-valve obstruction. Rigid bronchoscopy is both diagnostic and therapeutic for retrieval and should not be delayed. Bronchodilator therapy or discharge would miss a retained foreign body, and CT, while sometimes used, does not substitute for definitive bronchoscopic removal.

20. C. A large parapneumonic effusion causing respiratory compromise requires IV antibiotics along with drainage (thoracentesis or chest tube, sometimes with fibrinolytics) guided by effusion size and clinical status, per standard complicated pneumonia management. Oral outpatient therapy is inadequate for this degree of illness, and antibiotics should not be withheld pending culture results given the risk of clinical deterioration.

21. A. Rising CO2, apnea, and failure to improve on maximal high-flow support indicate impending respiratory failure, requiring escalation to noninvasive ventilation or intubation rather than further increases in a therapy that has already failed. Racemic epinephrine and antibiotics do not address the underlying respiratory failure in bronchiolitis.

22. B. Children with chronic lung disease of prematurity have reduced pulmonary reserve and require increased supplemental oxygen and close monitoring during viral illnesses, with supportive care as the mainstay. Weaning oxygen during acute illness is unsafe. Antibiotics are not indicated absent evidence of bacterial infection, and systemic steroids are not first-line for a viral URI exacerbation without evidence of underlying reactive airway component.

23. D. A toxic-appearing child with high fever, purulent secretions, and stridor unresponsive to standard croup therapy (racemic epinephrine, steroids) suggests bacterial tracheitis, a life-threatening secondary bacterial infection requiring airway management (often intubation) and IV antibiotics. Continued croup-only management would delay appropriate treatment of a deteriorating airway.

24. D. Bilateral infiltrates with a PaO2/FiO2 ratio under 200 in the absence of cardiogenic causes meets criteria for pediatric ARDS, requiring escalation of respiratory support and lung-protective ventilation strategies rather than antibiotic escalation alone or diuresis, since the pathophysiology is inflammatory lung injury, not fluid overload.

25. A. A silent chest with minimal air movement and altered mental status in status asthmaticus indicates impending respiratory arrest despite maximal therapy, requiring immediate preparation for intubation and escalation of care. Further inhaled therapy and diagnostic imaging should not delay life-saving airway management, and leukotriene antagonists have no role in acute severe exacerbations.

26. C. Once a child with chronic lung disease returns to their baseline respiratory status and oxygen requirement, discharge home on their established baseline support with close follow-up is appropriate; prolonging admission or transferring to a higher level of care is unnecessary once baseline is reached, and further weaning below baseline during recovery from acute illness is not indicated.

27. A. Poor feeding, diaphoresis with feeds, hepatomegaly, gallop, and a dilated poorly contractile ventricle indicate dilated cardiomyopathy with heart failure. Initial management includes heart failure therapy (diuretics, afterload reduction, sometimes inotropes) alongside a workup for etiology (viral, metabolic, genetic); transplant evaluation is reserved for those who fail medical therapy, and antibiotics are not appropriate without evidence of active bacterial infection.

28. C. Diminished femoral pulses with an upper-to-lower extremity blood pressure gradient in a neonate is classic for coarctation of the aorta, a ductal-dependent lesion. Prostaglandin E1 should be started promptly to maintain ductal patency and systemic perfusion while echocardiography confirms the diagnosis; delay for outpatient follow-up risks cardiovascular collapse as the ductus closes.

29. D. Worsening signs of volume overload (orthopnea, JVD, hepatomegaly, crackles, edema) despite home diuretics in a child with known cardiomyopathy indicates decompensated heart failure requiring inpatient IV diuresis and reassessment/optimization of heart failure therapy. Discontinuing diuretics or increasing fluids would worsen volume overload, and discharge is unsafe given ongoing decompensation.

30. C. A narrow-complex regular tachycardia at 280/min without discernible P waves in an infant is consistent with SVT. In a hemodynamically stable patient, vagal maneuvers (e.g., ice to the face) are attempted first, followed by rapid IV adenosine if unsuccessful; amiodarone and cardioversion are reserved for refractory or unstable cases. Observation without treatment risks progression to hemodynamic compromise given the very rapid rate.

31. B. Positional chest pain, a friction rub, and diffuse ST elevation with PR depression are classic for acute pericarditis. Management includes NSAIDs and monitoring for pericardial effusion or tamponade with echocardiography; MI is rare in children and this ECG pattern is distinct from ischemic ST elevation. Anticoagulation and reassurance for musculoskeletal pain are inappropriate given the clinical and ECG findings.

32. A. Syncope with a classic vasovagal prodrome (lightheadedness, visual changes, diaphoresis) triggered by heat/prolonged standing, with a normal cardiac exam, normal ECG, and no concerning family history, is consistent with benign vasovagal syncope, managed with reassurance and trigger avoidance counseling. Exertional syncope, syncope without prodrome, or a concerning family history would warrant cardiac workup, which is not indicated here.

33. D. Severe hypertension with encephalopathy and seizure constitutes a hypertensive emergency requiring IV antihypertensive therapy with controlled, gradual blood pressure reduction (typically no more than 25% in the first hours) to avoid precipitating cerebral hypoperfusion, alongside seizure management. Rapid normalization or withholding treatment both carry significant risk in this unstable presentation.

34. C. Fluid-refractory septic shock in a child with a central line requires initiation of vasoactive support (epinephrine is often first-line in pediatric cold or warm shock depending on presentation,

norepinephrine in warm/vasodilatory shock) in addition to continued broad-spectrum antibiotics targeting line-associated organisms; indiscriminate further fluid boluses risk fluid overload. Antibiotics should not be delayed for culture results in septic shock, though line management is addressed once the patient is stabilized.

35. A. Classic migratory periumbilical-to-RLQ pain with focal peritoneal signs and leukocytosis is highly suggestive of acute appendicitis, warranting surgical consultation and confirmatory imaging as needed rather than presumptive treatment for gastroenteritis or constipation, which would delay diagnosis of a surgical emergency and risk perforation.

36. C. Fever, a positive Murphy sign, and ultrasound findings of wall thickening with pericholecystic fluid and a stone confirm acute cholecystitis, requiring IV antibiotics, analgesia, and surgical consultation for cholecystectomy. Outpatient management is inadequate for acute cholecystitis, and ursodeoxycholic acid is used for gallstone dissolution in select chronic scenarios, not acute cholecystitis.

37. C. Chronic constipation with overflow soiling and a palpable stool mass in an otherwise normally growing child is functional constipation, managed with disimpaction followed by maintenance osmotic laxatives (e.g., polyethylene glycol) and behavioral/toileting strategies. Hirschsprung disease typically presents earlier with delayed meconium passage and failure to thrive, making it less likely here, and a low-fiber diet would worsen constipation.

38. B. Signs of moderate-to-severe dehydration (dry mucous membranes, delayed capillary refill, lethargy) warrant IV isotonic fluid resuscitation rather than oral rehydration alone, which is appropriate only for mild-to-moderate dehydration in an alert child able to tolerate fluids. Empiric antibiotics are not indicated for typical viral gastroenteritis, and discharge is unsafe given the degree of dehydration and lethargy.

39. B. Effortless regurgitation in an otherwise thriving, well-appearing infant without red-flag symptoms (poor weight gain, respiratory symptoms, bloody emesis, bilious emesis) is physiologic gastroesophageal reflux, managed with reassurance and conservative measures (positioning, feeding adjustments) rather than acid suppression, imaging, or formula changes, which are reserved for infants with concerning features or true GERD/complications.

40. D. Episodic crampy abdominal pain with lethargy, currant-jelly-type or bloody stools, and a sausage-shaped RUQ mass are classic for intussusception. Urgent abdominal ultrasound confirms the diagnosis, and air or contrast enema is both diagnostic and therapeutic for reduction; delay for outpatient evaluation or misattribution to a fissure risks bowel ischemia and perforation.

41. D. Bilious emesis in a young infant is a surgical emergency until proven otherwise, most concerning for malrotation with midgut volvulus, which can rapidly cause bowel ischemia. An emergent upper GI contrast study confirms the diagnosis, and surgical consultation should occur without delay. Outpatient workup or reflux management would risk catastrophic bowel necrosis.

42. B. The classic presentation (non-bilious projectile vomiting, olive-shaped mass, hypochloremic hypokalemic metabolic alkalosis) is pyloric stenosis. Electrolyte abnormalities must be corrected before surgery to reduce anesthetic risk, after which pyloromyotomy is curative. Proceeding to surgery without correction risks perioperative complications, and conservative or acid-suppressive therapy does not address the anatomic obstruction.

43. D. Acute pancreatitis management centers on aggressive IV fluid resuscitation, analgesia, and early enteral feeding as tolerated (rather than prolonged NPO status), which improves outcomes compared with historical bowel rest approaches. Antibiotics are reserved for documented infected necrosis, not routine acute pancreatitis, and ERCP is reserved for specific indications like biliary obstruction, not as first-line therapy here given no gallstones are seen.

44. A. Chronic GI symptoms with weight loss, growth deceleration, anemia, elevated inflammatory markers, and perianal skin tags (a classic extraintestinal sign) are highly suggestive of Crohn disease. Endoscopic evaluation with biopsies is needed for diagnosis and to guide therapy; irritable bowel syndrome and lactose intolerance do not cause growth failure, anemia, or perianal disease, and empiric antibiotics would not address an underlying inflammatory process.

45. D. The triad of microangiopathic hemolytic anemia, thrombocytopenia, and acute kidney injury following a diarrheal illness (often bloody, associated with Shiga toxin-producing E. coli) defines hemolytic uremic syndrome. Management is supportive, with careful fluid and electrolyte management and dialysis if needed; antibiotics and antimotility agents are avoided as they may increase toxin release and worsen HUS risk or severity. Platelet transfusion is reserved for active bleeding or procedures, not prophylaxis.

46. C. Management of prerenal/intrinsic AKI from dehydration focuses on optimizing volume status, correcting and closely monitoring electrolyte abnormalities (especially potassium), and avoiding further nephrotoxic insults, with renal replacement therapy reserved for refractory electrolyte abnormalities, volume overload, or uremic complications. Corticosteroids are not indicated without evidence supporting glomerulonephritis as the etiology.

47. D. Sudden severe testicular pain with a high-riding, transverse testicle and absent cremasteric reflex is classic for testicular torsion, a surgical emergency where testicular viability decreases rapidly with time. When clinical suspicion is high, emergent urologic consultation for surgical exploration should not be delayed by imaging. Epididymitis typically has a more gradual onset and preserved cremasteric reflex, distinguishing it from torsion.

48. A. Edema with heavy proteinuria, hypoalbuminemia, and hyperlipidemia without hematuria is classic nephrotic syndrome, most commonly minimal change disease in this age group, which typically responds well to corticosteroids without requiring biopsy in typical presentations. Monitoring for known complications (infection due to immunoglobulin loss, thrombosis due to hypercoagulability) is important. Antibiotics are not indicated without evidence of infection, and biopsy is reserved for atypical features or steroid resistance.

49. A. Fever, flank pain, and pyuria/bacteriuria indicate pyelonephritis, which should be treated promptly with antibiotics (oral or IV depending on clinical severity and ability to tolerate oral intake) without waiting for culture finalization, given the risk of renal scarring with delayed treatment. Imaging workup (renal ultrasound, and VCUG if indicated by guidelines) is pursued per protocol but does not precede initiation of antibiotics.

50. C. Acute severe pelvic pain with an enlarged ovary and absent Doppler flow is concerning for ovarian torsion, a time-sensitive surgical emergency threatening ovarian viability. Emergent gynecologic consultation for surgical evaluation (detorsion) should not be delayed by outpatient management or repeat imaging, as delay increases risk of ovarian loss.

51. B. Hematuria with RBC casts, edema, hypertension, and low C3 following a streptococcal infection is classic for post-streptococcal glomerulonephritis (PSGN), which is typically managed supportively (blood pressure control, monitoring fluid status and renal function) as most cases resolve spontaneously. Corticosteroids are not indicated for PSGN, and biopsy is reserved for atypical presentations or failure to improve, not as an initial step in a classic case.

52. C. Small ureteral stones (generally under 5 mm) have a high likelihood of spontaneous passage and can be managed conservatively with hydration, analgesia, and expectant management, reserving surgical intervention for larger stones, obstruction, infection, or intractable pain. Fluid restriction and corticosteroids have no established role in stone passage.

53. B. Fever, refusal to bear weight, markedly elevated inflammatory markers, and a hip effusion are concerning for septic arthritis, an orthopedic emergency because joint sepsis can rapidly destroy cartilage. Emergent joint aspiration/surgical drainage combined with IV antibiotics is required without delay; oral antibiotics alone and outpatient management are inadequate, and imaging should not delay source control in a highly suspicious presentation.

54. C. Focal bone pain, fever, and elevated inflammatory markers with early normal radiographs (plain films are often normal early in osteomyelitis) warrant MRI, which is highly sensitive for early osteomyelitis, along with prompt initiation of IV antibiotics after appropriate cultures (blood, and bone if obtained) rather than waiting for radiographic changes, which lag behind clinical disease.

55. D. Five or more days of fever with the classic clinical criteria (conjunctival injection, oral changes, extremity changes, polymorphous rash, and often cervical lymphadenopathy) define Kawasaki disease. Prompt treatment with IVIG and high-dose aspirin within the first 10 days of illness reduces the risk of coronary artery aneurysms, and baseline echocardiography should be obtained. Antibiotics and reassurance would delay treatment critical to preventing cardiac complications.

56. D. Palpable purpura in a dependent distribution with arthralgia, abdominal pain, and renal involvement (hematuria/proteinuria) with a normal platelet count is classic for Henoch-Schönlein purpura (IgA vasculitis). Management is largely supportive (hydration, analgesia), with corticosteroids

reserved for significant abdominal or renal involvement, and ongoing monitoring of renal function/urinalysis is essential given the risk of nephritis. A normal platelet count argues against ITP.

57. C. Chronic (≥6 weeks) joint swelling and morning stiffness in multiple joints without fever, with a positive ANA, is consistent with juvenile idiopathic arthritis (oligoarticular subtype), which requires rheumatology referral for management and ophthalmologic screening given the risk of asymptomatic uveitis, particularly with ANA positivity. Septic arthritis typically presents acutely with fever and severe pain, not a chronic indolent course.

58. C. Malar rash, photosensitivity, oral ulcers, arthritis, positive ANA/anti-dsDNA, low complement, and proteinuria meet criteria for systemic lupus erythematosus with likely renal involvement. Evaluation for lupus nephritis (renal biopsy, nephrology involvement) is essential given the proteinuria, as renal disease significantly impacts prognosis and management; antibiotics and reassurance are inappropriate for this autoimmune presentation.

59. B. Infants can present with incomplete (atypical) Kawasaki disease, meeting fewer than the full clinical criteria but still at risk for coronary artery aneurysms. Evaluation with echocardiography and supportive laboratory criteria (per AHA algorithm) guides the decision to treat with IVIG despite not meeting full classic criteria; dismissing the diagnosis based on incomplete criteria risks missing treatable disease, especially in infants who are more prone to atypical presentations.

60. A. Renal involvement in HSP (HSP nephritis) can evolve over weeks after the initial presentation and requires ongoing monitoring of urinalysis and blood pressure; worsening proteinuria and hypertension warrant nephrology referral for further evaluation and possible treatment, as this can progress to significant chronic kidney disease if unmonitored. Discontinuing follow-up or attributing findings to infection would miss evolving renal disease.

61. D. Pediatric DKA management emphasizes cautious, gradual fluid resuscitation with isotonic fluids followed by a continuous low-dose insulin infusion (avoiding an initial insulin bolus, which increases cerebral edema risk) and close neurologic monitoring, since rapid osmotic shifts are linked to cerebral edema, a leading cause of DKA mortality in children. Bicarbonate is generally avoided except in extreme, life-threatening acidosis given its association with worsened cerebral edema risk.

62. B. Euvolemic hyponatremia with concentrated urine and elevated urine sodium following a CNS insult (meningitis) is consistent with SIADH. Management is fluid restriction with careful, gradual correction of sodium to avoid osmotic demyelination syndrome from overly rapid correction; hypertonic saline is reserved for severe symptomatic hyponatremia (seizures, severe altered mental status), and desmopressin would worsen the underlying problem of excess ADH activity.

63. B. A child with known adrenal insufficiency who develops vomiting, hypotension, hyponatremia, and hyperkalemia during illness is in adrenal crisis, a life-threatening emergency requiring immediate IV stress-dose hydrocortisone and isotonic fluid resuscitation without delay for specialist consultation. Oral

dosing is inadequate during a crisis with vomiting/malabsorption, and while hyperkalemia may need direct treatment, addressing the underlying cortisol deficiency is the priority intervention.

64. D. Obtaining a critical sample at the time of hypoglycemia (before or immediately after treatment) is essential to identify the underlying cause (hyperinsulinism, hormone deficiency, metabolic disorder, etc.), since hypoglycemia in a previously healthy child warrants investigation rather than assumption of a benign diagnosis. Discharge without workup risks missing a treatable or recurrent underlying condition.

65. C. Congenital hypothyroidism requires prompt initiation of levothyroxine, ideally within the first 2 weeks of life, because delayed treatment is associated with irreversible neurodevelopmental impairment, even in asymptomatic infants identified by newborn screening. Waiting for symptoms or repeat testing over months would cause harmful treatment delay; imaging can be pursued to determine etiology but should not delay treatment initiation.

66. B. Symptomatic neonatal hypocalcemia (jitteriness, seizure) requires prompt IV calcium gluconate administration with cardiac monitoring given the risk of arrhythmia with rapid calcium infusion, rather than oral supplementation alone, which is too slow for symptomatic disease. Observation without treatment is inappropriate given active seizure activity, though the underlying cause (e.g., maternal diabetes, hypoparathyroidism) should be investigated afterward.

67. C. Polyuria with inappropriately dilute urine, rising serum sodium/osmolality following brain injury (which can damage the hypothalamic-pituitary axis) is characteristic of central diabetes insipidus. Management includes replacing ongoing free water losses and considering desmopressin to reduce urine output; this is the opposite physiology of SIADH, so fluid restriction would worsen hypernatremia and dehydration.

68. A. A well neonate who rapidly decompensates with encephalopathy, metabolic acidosis, an abnormal urine odor, and hyperammonemia raises strong concern for an inborn error of metabolism (e.g., organic acidemia or urea cycle disorder). Acute management includes stopping protein intake, providing IV dextrose to reverse catabolism, urgent metabolic genetics involvement, and specific therapy to lower ammonia; continuing normal feeds or increasing protein would worsen the metabolic crisis, though sepsis should still be evaluated for concurrently given overlapping presentations.

69. A. A fracture inconsistent with the child's developmental stage (a non-ambulatory infant with a femur fracture) and an inconsistent history are red flags for physical abuse. Standard of care includes obtaining a skeletal survey to evaluate for occult injuries, involving the child protection team, and mandatory reporting to child protective services; failing to investigate or delaying reporting risks ongoing harm to the child.

70. B. Disclosure of sexual abuse requires involvement of the child protection team for an appropriate, trauma-informed medical evaluation (timing and type guided by protocol, since evidence collection windows differ from urgent reporting obligations) and mandatory reporting to child protective services

regardless of family agreement, as reporting is a legal obligation, not contingent on confirmation of the allegation by the family.

71. D. A pattern of caregiver-reported symptoms unsubstantiated by objective findings, symptom resolution when separated from the caregiver, and repeated unnecessary invasive interventions raises concern for medical child abuse. This requires involvement of the child protection team and a multidisciplinary review of the longitudinal medical record rather than continuing to order tests based on caregiver report alone, which perpetuates potential harm, or direct confrontation, which can compromise the safety evaluation.

72. A. Rapid catch-up growth with consistent hospital feeding, in the context of reported resource limitations, points toward neglect-related failure to thrive due to inadequate access to nutrition rather than an organic or factitious cause. Appropriate management involves social work engagement to address resource barriers, with child protection involvement calibrated to severity and response, rather than extensive unnecessary testing or a mischaracterization as medical child abuse, which describes a different pattern (caregiver-fabricated or induced illness).

73. A. A fluctuant abscess with surrounding cellulitis requires incision and drainage as the primary treatment, since antibiotics alone are often insufficient for a drainable collection; empiric antibiotics with MRSA coverage are added given the high prevalence of community-associated MRSA in skin abscesses. Warm compresses alone and advanced imaging are not necessary for a straightforward, uncomplicated drainable abscess.

74. D. Fever, mucosal involvement at multiple sites, and epidermal detachment following a new medication (a known SJS/TEN trigger drug class) indicate Stevens-Johnson syndrome/toxic epidermal necrolysis. Immediate discontinuation of the offending agent is essential, and management requires specialized supportive care, often in a burn unit, given the risk of extensive skin loss, infection, and fluid/electrolyte derangement; outpatient management or continuing the drug would be dangerous.

75. D. Sudden worsening of eczema with monomorphic punched-out vesicles/erosions, fever, and malaise in a patient with atopic dermatitis is concerning for eczema herpeticum, a potentially serious HSV superinfection. Prompt systemic acyclovir is indicated, as delayed treatment can lead to disseminated infection; topical steroids alone would worsen a herpetic infection, and antibiotics do not treat the underlying viral cause, though secondary bacterial infection should also be assessed.

76. C. Fever, diffuse tender erythema, superficial desquamation, a positive Nikolsky sign, and mucosal sparing in a young child are characteristic of staphylococcal scalded skin syndrome, caused by exfoliative toxin-producing S. aureus. Treatment is IV antistaphylococcal antibiotics and supportive skin/wound care; this differs from TEN, which typically involves mucosal surfaces and is drug-related, and corticosteroids are not indicated for this toxin-mediated bacterial process.

77. D. Pain out of proportion to exam, dusky/edematous skin, crepitus, and systemic toxicity are hallmark features of necrotizing fasciitis, a surgical emergency requiring emergent surgical debridement

alongside broad-spectrum IV antibiotics; delay for imaging or outpatient management can be fatal given the rapid progression of this infection.

78. C. A non-blanching petechial/purpuric rash with fever, signs of shock, and possible meningismus is highly concerning for meningococcemia, a rapidly fatal condition without prompt treatment. Empiric broad-spectrum antibiotics and aggressive resuscitation should begin immediately without delay for lumbar puncture (which can be deferred if the patient is unstable) or dermatology consultation, given the narrow window to prevent mortality.

79. D. Fever in a neutropenic oncology patient (ANC less than 500/mm3) is a medical emergency, regardless of how well the patient appears, given the risk of rapid deterioration from bacterial or fungal infection. Standard of care is prompt blood cultures followed by immediate empiric broad-spectrum IV antibiotics, ideally within 60 minutes of presentation, without waiting for culture results or managing as an outpatient.

80. D. Vaso-occlusive crisis in sickle cell disease requires prompt, aggressive analgesia (often including opioids, given the severity of pain typical of these episodes) along with IV hydration and close monitoring for evolving complications, particularly acute chest syndrome, which can develop during a VOC. Withholding or undertreating pain is a recognized quality concern in sickle cell care, and fluid restriction is not indicated absent evidence of overload.

81. C. Microcytic anemia in a toddler with excessive milk intake and limited iron-rich solids is classic for iron deficiency anemia. Confirmatory iron studies followed by oral iron supplementation and dietary counseling (reducing milk intake, increasing iron-rich foods) is standard management; transfusion is reserved for hemodynamic instability or severe symptomatic anemia, and B12 or bone marrow evaluation is not indicated for this classic presentation.

82. D. Sudden pleuritic chest pain, tachycardia, hypoxia, and an elevated D-dimer in a patient with risk factors (oral contraceptive use, prolonged immobility) raise strong suspicion for pulmonary embolism. Prompt CT pulmonary angiography confirms the diagnosis, and anticoagulation should be initiated once confirmed (or empirically if clinical suspicion is very high while awaiting imaging); reassurance or antibiotics would miss a life-threatening diagnosis.

83. A. Acute hemarthrosis in a patient with hemophilia requires prompt factor replacement (factor VIII in hemophilia A) to stop ongoing bleeding and limit joint damage, followed by supportive measures. NSAIDs are avoided due to bleeding risk from platelet effects, and joint aspiration is not first-line and could introduce infection risk without prior factor correction; delaying factor replacement risks progressive joint damage from ongoing hemarthrosis.

84. B. Isolated severe thrombocytopenia with an otherwise normal blood count and smear, following a viral illness, in an asymptomatic or mildly symptomatic child is classic for immune thrombocytopenic purpura. Management depends on bleeding severity — observation for mild disease or treatment (IVIG, corticosteroids) for significant bleeding — and platelet transfusion is generally avoided except for life-

threatening hemorrhage since transfused platelets are rapidly destroyed; bone marrow biopsy is reserved for atypical features suggesting an alternative diagnosis, not routine ITP.

85. B. Anaphylaxis with hypotension, respiratory symptoms, and multi-system involvement requires immediate intramuscular epinephrine as first-line therapy, which is life-saving and should not be delayed for antihistamines or corticosteroids, which have slower onset and do not reliably reverse the acute hemodynamic and airway compromise of anaphylaxis.

86. A. Recurrent sinopulmonary infections with panhypogammaglobulinemia (low IgG, IgA, IgM) suggest a primary humoral immunodeficiency (e.g., common variable immunodeficiency or agammaglobulinemia), warranting immunology referral for further characterization and consideration of immunoglobulin replacement therapy. This infection pattern and lab picture is not typical childhood infection frequency, and a sweat chloride test evaluates for cystic fibrosis, which does not explain the immunoglobulin abnormalities.

87. D. Fever, urticaria, arthralgia, and lymphadenopathy occurring 1-2 weeks after starting a medication (commonly antibiotics in children) is characteristic of a serum sickness-like reaction. Management includes discontinuing the offending drug and supportive care; this delayed, immune complex-mediated reaction is distinct from anaphylaxis (which is immediate and IgE-mediated) and is not an expected viral process.

88. D. Biphasic anaphylactic reactions can occur hours after apparent resolution of initial symptoms, so an observation period (typically several hours, individualized based on severity and risk factors) is recommended before discharge, along with prescribing and teaching proper use of an epinephrine autoinjector. Immediate discharge without observation risks missing a biphasic reaction.

89. B. Asymptomatic presentation does not exclude significant acetaminophen toxicity, which can be clinically silent initially. A serum acetaminophen level obtained at the appropriate time (typically 4 hours post-ingestion) plotted on the Rumack-Matthew nomogram determines the need for N-acetylcysteine, which is most effective when started early, before hepatotoxicity develops — waiting for symptoms would delay life-saving treatment. Gastric lavage is rarely used and not the primary intervention for this presentation.

90. A. When the biting animal's vaccination/health status is unknown and it cannot be observed or tested, rabies post-exposure prophylaxis (rabies immunoglobulin plus vaccine series) should be initiated promptly given the fatal nature of rabies if untreated; the 10-day observation period applies to available domestic animals that can be monitored, not unknown/unavailable animals. Tetanus prophylaxis should also be addressed as indicated by wound characteristics and immunization status, but does not substitute for rabies risk assessment.

91. A. Post-drowning management is largely supportive critical care focused on oxygenation, ventilation, and hemodynamic support; mild hypothermia is common after submersion and does not require aggressive rapid rewarming unless the patient is hemodynamically unstable, since controlled,

gradual rewarming avoids complications like arrhythmia. Resuscitative efforts should continue given the potential for good neurologic outcomes, particularly with cold-water submersion, and prophylactic antibiotics are not routinely indicated absent evidence of infection.

92. C. Moderate-to-severe hypothermia requires active core rewarming (e.g., warmed IV fluids, warm humidified oxygen, and in severe cases more invasive techniques) performed gradually with continuous cardiac monitoring, since the hypothermic heart is prone to arrhythmias (including ventricular fibrillation) that can be triggered by rough handling or overly rapid rewarming. Rewarming should begin promptly rather than being delayed until ICU arrival.

93. C. Validated pediatric head trauma decision rules (such as PECARN) help identify children at very low risk of clinically important traumatic brain injury who can be safely observed without CT imaging, avoiding unnecessary radiation exposure, particularly in a child with brief LOC but an otherwise reassuring exam and no other risk factors. Universal CT for any LOC is not evidence-based, but discharge without any observation period or return precautions would also be inappropriate.

94. A. Significant burns (generally greater than 10-15% TBSA in children) require formal IV fluid resuscitation using a validated pediatric burn formula, with fluids titrated to urine output as a marker of adequate perfusion, since oral intake is inadequate for the massive fluid shifts from a large burn. Waiting for shock to develop or giving a single bolus without ongoing titration would result in under-resuscitation.

95. D. Heat stroke (very high core temperature with altered mental status) is a life-threatening emergency where rapid cooling (cold water immersion being the most effective method) is the priority intervention and should not be delayed for IV access or laboratory results, since the degree and duration of hyperthermia directly correlates with morbidity and mortality; antipyretics are ineffective for heat stroke since the mechanism is not driven by a hypothalamic set-point change as in fever.

96. B. Iron overdose can cause severe GI and systemic toxicity (including shock and hepatotoxicity) and is not adsorbed by activated charcoal, making it an ineffective decontamination method for iron specifically. Management includes supportive care and, for significant toxicity (symptomatic patients with elevated iron levels), IV deferoxamine chelation therapy; iron ingestion should not be dismissed as low-risk given its potential for serious morbidity and mortality.

97. C. Management of venomous snakebite includes immobilizing the affected limb at heart level, supportive care, and antivenom administration guided by severity of envenomation (progressive swelling, coagulopathy, systemic symptoms). Tourniquets, incision/suction, and ice application are outdated or harmful practices that can worsen tissue injury without improving outcomes and are no longer recommended.

98. B. A seatbelt sign is associated with an increased risk of intra-abdominal injury (including bowel and mesenteric injury, and lumbar spine fracture), even with initial hemodynamic response to fluids,

warranting trauma surgery involvement and appropriate imaging rather than early discharge or dismissing the finding as benign, since occult injuries can present with delayed signs.

99. D. Current guidelines for BRUE emphasize risk stratification (age, prematurity, event characteristics, exam findings, history) to guide management; low-risk infants generally do not require extensive laboratory testing, neuroimaging, or admission, while higher-risk features warrant further evaluation and consideration of admission. Applying extensive testing or admission uniformly to all BRUE presentations is not evidence-based and increases unnecessary interventions in low-risk infants.

100. C. Febrile infants younger than 28 days (and generally under 60-90 days depending on risk-stratification protocols) require a full evaluation for serious bacterial infection, given the higher risk of invasive bacterial disease and the limited reliability of clinical appearance alone at this age, along with admission for empiric antibiotics pending culture results. Outpatient management or reassurance alone is not appropriate for a febrile neonate in this age range regardless of well appearance.

101. A. Evaluation of failure to thrive begins with a thorough dietary, feeding, and psychosocial history and observation of feeding, since the majority of cases are related to caloric intake or psychosocial factors rather than underlying organic disease; extensive laboratory or genetic testing is reserved for cases with concerning history, exam findings, or failure to respond to initial intervention, not as a first step.

102. D. In a well-appearing, fully immunized toddler with fever without a source, the risk of occult serious bacterial infection is low, and conservative management with close follow-up is appropriate, reserving more extensive workup (cultures, lumbar puncture, empiric antibiotics) for infants under specific age thresholds, incompletely immunized children, or those with concerning clinical features, rather than universal application to all well-appearing febrile toddlers.

103. A. Fever of unknown origin requires a systematic, stepwise evaluation guided by a thorough history and exam to identify localizing clues, followed by targeted testing across the broad differential (infectious, rheumatologic/autoimmune, and malignant causes), rather than empiric antibiotics (which could mask infection without treating the cause) or invasive testing before a more focused workup narrows the differential.

104. C. Hypernatremic dehydration requires gradual correction (typically over 48 hours or longer, with sodium decline not exceeding a recommended rate) because the brain adapts to chronic hypertonicity, and overly rapid correction can cause fluid shifts into brain cells, leading to cerebral edema and seizures; free water boluses and rapid correction are dangerous, and withholding fluids entirely is inappropriate for a dehydrated infant.

105. D. Severe symptomatic hyponatremia with seizures is a medical emergency requiring prompt administration of hypertonic (3%) saline to acutely raise serum sodium and stop seizure activity, following established protocols for controlled, limited initial correction; fluid restriction and slow

correction are appropriate for asymptomatic chronic hyponatremia, not for acute symptomatic presentations with active seizures.

106. A. An elevated anion gap metabolic acidosis warrants systematic evaluation of the underlying cause (using frameworks like MUDPILES for elevated anion gap causes), since management depends on etiology, while providing supportive fluid therapy for associated dehydration; routine bicarbonate administration without addressing the underlying cause is not standard practice, and mechanical ventilation is not indicated for a stable patient with a non-respiratory cause of acidosis.

107. C. A low PaCO2 with normal bicarbonate and symptoms of hyperventilation (perioral/extremity tingling, lightheadedness) in an anxious adolescent is consistent with acute respiratory alkalosis from hyperventilation. Management focuses on addressing the underlying cause (anxiety, pain, or another trigger) and reassurance/breathing techniques, while still considering and excluding other causes of tachypnea (e.g., PE, DKA) as clinically indicated; this is not primarily a metabolic or cardiac process nor does it require supplemental oxygen.

108. C. Postoperative pain management is best achieved with a multimodal approach combining non-opioid agents (acetaminophen, NSAIDs) with short-acting opioids as needed for breakthrough pain, which improves analgesia while minimizing opioid exposure and facilitates recovery milestones like ambulation; exceeding recommended acetaminophen dosing is unsafe, and undertreating pain can delay recovery and discharge readiness.

109. B. Chronic functional pain without an identified organic cause after appropriate workup is best managed with a biopsychosocial approach emphasizing functional restoration (school reintegration, activity), behavioral health support (e.g., cognitive behavioral therapy), and judicious use of pain management strategies, rather than repeated invasive testing (which reinforces illness behavior) or dismissing the pain as not real, and long-term opioids are inappropriate and potentially harmful for chronic non-cancer pain in this context.

110. A. Severe hyperkalemia with ECG changes (peaked T waves) is a medical emergency requiring immediate IV calcium gluconate to stabilize the cardiac membrane, followed by therapies to shift potassium intracellularly (insulin with glucose, beta-agonists) and measures to enhance potassium elimination (e.g., binders, dialysis if refractory); oral binders alone act too slowly for this acute, ECG-changing presentation, and treatment should not be delayed for subspecialist arrival given the arrhythmia risk.

111. A. A disclosure of active suicidal ideation with a specific plan requires immediate safety measures (environmental safety, appropriate level of observation) and an urgent psychiatric or behavioral health evaluation before any consideration of discharge, regardless of the reason for the original admission; delaying assessment or discharging with only outpatient follow-up would place the patient at significant risk.

112. D. Management of acute agitation, particularly in a patient with autism spectrum disorder, prioritizes de-escalation techniques and environmental/sensory modifications tailored to the individual before considering pharmacologic intervention or physical restraint, which are reserved for situations where safety is genuinely at risk and less restrictive measures have failed, consistent with least-restrictive-intervention principles.

113. D. Acute fluctuating confusion and altered arousal in a hospitalized child, especially in the ICU, is characteristic of delirium, which requires identifying and addressing underlying medical contributors (infection, medication effects, metabolic abnormalities) alongside environmental and non-pharmacologic strategies; benzodiazepines can worsen delirium and should generally be avoided, and this should not be assumed to be primarily psychiatric or anxiety-related without first excluding medical causes.

114. C. Malnourished patients undergoing nutritional rehabilitation are at risk for refeeding syndrome, characterized by dangerous electrolyte shifts (especially hypophosphatemia) that can cause cardiac and neurologic complications; management requires cautious, gradual caloric advancement with close monitoring and repletion of electrolytes, rather than aggressive rapid feeding, prolonged withholding of nutrition, or fluids alone without addressing nutritional needs.

115. D. Neurologic symptoms inconsistent with an anatomic pattern, in the context of psychosocial stress and with a normal workup, suggest a functional neurological (conversion) disorder. Management involves a multidisciplinary, supportive, non-judgmental approach with functional rehabilitation, avoiding both dismissive confrontation (which can worsen symptoms and damage rapport) and excessive invasive testing, which reinforces illness behavior without benefit.

116. B. Hospitalized children with autism spectrum disorder benefit from individualized care plans that account for sensory sensitivities and the need for predictable routines, often developed with input from caregivers and specialists, to reduce distress and improve the hospital experience and cooperation with care; a one-size-fits-all approach or sedation as a primary strategy does not address the underlying needs and can worsen distress or safety.

117. C. Evidence of prior self-harm, even without current disclosed ideation, warrants a sensitive, direct conversation to assess current risk, coping strategies, and any unmet needs, along with behavioral health involvement for further evaluation and safety planning as indicated; ignoring the finding or avoiding the conversation misses an opportunity for support, while an involuntary hold based on old scars alone without further assessment is disproportionate.

118. A. Significant bradycardia, orthostatic hypotension, and hypothermia in a patient with anorexia nervosa indicate medical instability requiring inpatient admission for stabilization, cardiac monitoring, and a structured, medically supervised refeeding protocol; outpatient management or a psychiatric-only focus would be unsafe given the risk of cardiac complications from severe malnutrition.

119. B. When verbal de-escalation fails and a patient with acute psychosis poses safety risk, an appropriate emergency pharmacologic intervention (such as an antipsychotic) is considered alongside environmental safety measures, using the least restrictive effective approach; psychiatric involvement should be obtained, and psychosis should not be assumed to resolve without intervention given the safety risks involved.

120. C. Evidence-based delirium prevention in critically ill children emphasizes non-pharmacologic strategies: promoting normal sleep-wake cycles (appropriate light/dark cycling rather than constant restriction), early mobilization, minimizing deliriogenic medications (including unnecessary benzodiazepines, which can worsen delirium), and encouraging family presence and reorientation, rather than heavy sedation or eliminating caregiver involvement, both of which can increase delirium risk.

121. B. Purging behaviors in bulimia nervosa commonly cause electrolyte abnormalities, particularly hypokalemia and metabolic alkalosis, which can precipitate life-threatening cardiac arrhythmias. Prompt evaluation and correction of these abnormalities is the priority acute medical intervention, alongside eventual psychiatric care, rather than assuming an unrelated cause or deferring electrolyte management.

122. B. Home psychiatric and behavioral medications, including stimulants for ADHD, are generally continued during hospitalization unless there is a specific contraindication (e.g., perioperative timing considerations), since abrupt discontinuation can worsen behavioral regulation and complicate the hospital course; decisions should be made collaboratively with the family and the surgical/anesthesia team as relevant, not by default discontinuation or without clinical guidance.

123. A. Neonatal resuscitation guidelines prioritize effective positive pressure ventilation as the most important initial intervention for an apneic, bradycardic newborn, since establishing adequate ventilation typically resolves bradycardia; chest compressions and epinephrine are escalated only if heart rate remains inadequate despite effective ventilation, and prolonged observation without intervention would delay necessary resuscitation.

124. C. Infants of diabetic mothers are at high risk for hypoglycemia due to fetal hyperinsulinism, and symptomatic hypoglycemia (jitteriness) at this glucose level requires prompt treatment (feeding and/or IV dextrose per institutional protocol) with close monitoring, rather than watchful waiting or outpatient management, given the risk of neurologic injury from prolonged or severe hypoglycemia.

125. A. Bilirubin levels in the high-risk zone on standardized hour-specific nomograms warrant phototherapy initiation with continued monitoring of bilirubin trends, per standard neonatal hyperbilirubinemia guidelines; breastfeeding does not need to be discontinued for typical hyperbilirubinemia, and exchange transfusion is reserved for severe, refractory, or rapidly rising bilirubin approaching exchange thresholds, not as a first-line intervention.

126. B. Grunting, retractions, and a reticulogranular pattern with air bronchograms in a preterm infant are classic for surfactant-deficient respiratory distress syndrome, requiring respiratory support (CPAP, and surfactant administration if more severe) rather than observation alone; while sepsis should be

considered given overlapping presentations, respiratory support for the underlying RDS should not be withheld.

127. C. Mild, improving respiratory symptoms with radiographic findings of retained fetal lung fluid (perihilar streaking, fissure fluid) in a term infant born by cesarean section, without significant risk factors for meconium aspiration, is classic for transient tachypnea of the newborn, a self-limited condition managed with supportive respiratory care; the improving trajectory argues against needing aggressive intervention like intubation, and prolonged empiric antibiotics are not automatically indicated without other risk factors.

128. A. Current approaches to early-onset sepsis risk (such as risk-based algorithms or clinical risk calculators) guide management of infants with GBS risk factors like inadequate intrapartum prophylaxis; a well-appearing infant may be managed with close observation and monitoring per protocol rather than automatic empiric antibiotics, while still requiring appropriate surveillance given the risk factor, rather than either extreme of universal treatment or no monitoring at all.

129. B. Late preterm infants, despite appearing relatively mature, have measurably higher risks of hypoglycemia, hyperbilirubinemia, temperature instability, and feeding difficulties compared with term infants, warranting closer monitoring during the birth hospitalization and close follow-up after discharge, rather than being treated identically to term infants or requiring blanket extended NICU admission regardless of clinical status.

130. B. Signs consistent with neonatal opioid withdrawal (tremors, high-pitched cry, poor feeding, loose stools) are assessed using standardized scoring approaches (Finnegan scoring or the Eat-Sleep-Console model) to guide the need for and titration of pharmacologic treatment, alongside non-pharmacologic supportive measures (low-stimulation environment, swaddling, frequent small feeds); symptoms should not be dismissed as simple feeding intolerance, nor should treatment intensity be applied without symptom-based assessment.

131. C. An asymmetric Moro reflex and characteristic arm positioning after a difficult delivery with shoulder dystocia are classic for a brachial plexus birth injury (Erb palsy). Most cases improve with observation and physical therapy, with specialist (neurology/orthopedic/plastic surgery) referral and follow-up to monitor recovery; surgery is reserved for those without adequate recovery over time, not as an immediate first step, and prolonged rigid immobilization is not standard management.

132. B. A scaphoid abdomen, respiratory distress, and bowel sounds in the chest with mediastinal shift are classic for congenital diaphragmatic hernia. Management avoids bag-mask ventilation (which can distend intrathoracic bowel and worsen respiratory compromise), favoring early intubation if respiratory support is needed, orogastric decompression, and surgical consultation for definitive repair after stabilization, rather than emergent unstabilized surgery in the delivery room.

133. D. Weight loss approaching or exceeding 7-10% of birth weight in an exclusively breastfed infant, especially with reported feeding difficulties, warrants focused lactation support to address latch and milk

transfer issues, along with close follow-up of weight and feeding adequacy, rather than either dismissing the finding or abruptly discontinuing breastfeeding, which is not necessary if feeding issues can be corrected.

134. C. Bilirubin levels approaching exchange transfusion thresholds, particularly with early signs of acute bilirubin encephalopathy, require urgent exchange transfusion to rapidly reduce bilirubin and prevent kernicterus, while intensive phototherapy is continued as an adjunct; continuing phototherapy alone or discharging the infant would risk progression to irreversible neurologic injury.

135. B. Current neonatal resuscitation guidelines recommend that vigorous infants born through meconium-stained fluid (strong respiratory effort, good tone, heart rate over 100) receive routine newborn care without routine endotracheal suctioning, which is reserved for non-vigorous infants; prophylactic antibiotics and delaying care for imaging are not indicated for a vigorous infant without respiratory symptoms.

136. C. Infants exposed to maternal genital HSV at delivery, particularly with risk factors like prolonged rupture of membranes, require evaluation per established neonatal HSV exposure protocols (which stratify by maternal lesion type — primary versus recurrent — and may include testing and empiric IV acyclovir), since neonatal HSV can progress rapidly and have devastating consequences if treatment is delayed until symptoms appear.

137. D. Universal pulse oximetry screening after 24 hours of age is the standard, evidence-based approach to detect critical congenital heart disease in asymptomatic newborns before discharge, since many affected infants have no murmur or prenatal diagnosis; relying solely on prenatal imaging, murmur detection, or family history alone would miss a significant proportion of affected infants.

138. C. Poor weight gain with fatigue during feeds warrants a focused evaluation, including an observed feeding assessment for adequacy of milk transfer and consideration of underlying organic causes (e.g., cardiac disease causing feeding fatigue), rather than reflexively stopping breastfeeding, supplementing without diagnosis, or dismissing a concerning growth trend without further assessment.

139. B. Sudden respiratory distress with inability to pass a suction catheter in a child with a tracheostomy suggests tube obstruction (mucus plugging or malposition), a time-sensitive emergency requiring immediate attempted suctioning followed by emergent tracheostomy tube change if suctioning is unsuccessful, since delay risks complete airway obstruction; permanent removal or bronchodilators alone do not address the mechanical obstruction.

140. B. Spasticity management for children with medical complexity should continue and be optimized during hospitalization, since worsening spasticity can cause significant pain and complicate care and positioning; addressing this proactively (continuing home regimens, involving specialists like physiatry as needed) improves comfort and care delivery, whereas ignoring it or abruptly discontinuing home management would worsen symptoms, and major surgical intervention is not an acute hospitalization decision.

141. D. New feeding intolerance in a child with a gastrostomy tube warrants a systematic evaluation of contributing factors (feeding rate, volume, positioning, and tube position/function) with adjustment of the feeding plan as needed, rather than increasing rate (which would worsen symptoms), switching formulas without assessment, or permanently discontinuing feeds, which is an overreaction to a typically correctable issue.

142. A. Children with medical complexity on multiple medications from various specialists benefit from comprehensive medication reconciliation and review, ideally involving pharmacy, to identify interactions, redundancies, or side effects, since fragmented specialist prescribing can lead to unrecognized issues; simply continuing everything unchanged or discontinuing everything are both inappropriate responses to a legitimate safety concern.

143. C. Discharge planning for children with medical complexity requires comprehensive coordination across all relevant specialties, clear communication of medication changes, and ensuring the family and outpatient providers (including the primary/coordinating provider) have the information needed for continuity of care; leaving coordination entirely to the family or providing only narrow discharge instructions increases risk of care gaps and readmission.

144. A. Goals-of-care conversations for children with progressive, life-limiting conditions are best approached proactively and openly, exploring family values and priorities to guide an individualized care plan; avoiding the conversation to prevent distress or waiting until a crisis limits the family's ability to make thoughtful, values-aligned decisions, and unilateral decision-making without family input does not reflect patient- and family-centered care principles.

145. C. Headache, vomiting, lethargy, and irritability (with a bulging fontanelle if applicable) in a child with a VP shunt are concerning for shunt malfunction, a neurosurgical emergency requiring urgent evaluation with neuroimaging and neurosurgical consultation; symptomatic treatment alone or watchful waiting risks delayed diagnosis of a potentially life-threatening complication of untreated hydrocephalus.

146. B. Chronic pain in nonverbal children with medical complexity should be assessed using validated nonverbal pain assessment tools, and management should address underlying contributors (spasticity, orthopedic issues) with a multimodal approach and appropriate specialist involvement, rather than assuming pain cannot be assessed, relying solely on opioid escalation, or ignoring a caregiver-reported concern about inadequate control.

147. C. Caloric and nutritional needs change over time with growth, activity level, and clinical status, so poor weight gain despite a previously adequate prescription warrants reassessment of nutritional needs and adjustment of the feeding regimen, ideally with nutrition/GI specialist input, rather than assuming the original prescription remains adequate or making uncalculated volume increases.

148. C. Safe discharge of a child with complex home care needs (tracheostomy, ventilator dependence) requires early, proactive coordination by case management and social work to arrange equipment, home

nursing, and thorough caregiver training well before the planned discharge date, rather than discharging based on medical stability alone or leaving coordination to the family or last-minute planning, which risks unsafe transitions of care.

149. B. New symptoms temporally associated with a recently added medication should prompt evaluation for a medication side effect, with consideration of dose adjustment or discontinuation in consultation with the prescribing specialist, rather than attributing symptoms solely to the underlying condition, treating symptoms without addressing the cause, or abruptly stopping all medications without clinical assessment.

150. C. End-of-life care prioritizes aggressive symptom management, including appropriate use of opioids for dyspnea and pain, to maximize comfort in alignment with palliative care principles and the family's goals of care; withholding effective symptom treatment out of fear of hastening death, pursuing curative measures inconsistent with a terminal prognosis, or overriding expressed goals with unwanted resuscitative transfer all fail to honor appropriate end-of-life care.

151. D. Safe procedural sedation requires continuous monitoring of oxygenation, heart rate, and respiratory status (often including capnography) by a dedicated provider whose sole role is patient monitoring, per pediatric sedation guidelines, to promptly detect and respond to respiratory depression or other complications; monitoring a single parameter, intermittent checks, or no monitoring are all inadequate and unsafe for procedural sedation.

152. B. Focal neurologic deficits and papilledema are relative contraindications to lumbar puncture without prior neuroimaging, given the risk of herniation if a mass lesion or significantly elevated intracranial pressure is present; neuroimaging should be obtained first, but empiric antibiotics should not be delayed while awaiting imaging or the LP itself, since treatment of suspected bacterial meningitis is time-sensitive.

153. C. Intraosseous access provides rapid, reliable vascular access in emergencies when peripheral IV access is difficult or unsuccessful, and is recommended over prolonged attempts at peripheral access or waiting for central line placement during active resuscitation; the endotracheal route is a last-resort alternative for select medications and is not preferred over IO access when it is readily obtainable.

154. B. Absent breath sounds, tracheal deviation, and hypotension following trauma are classic for tension pneumothorax, a rapidly fatal condition requiring immediate needle thoracentesis for decompression without waiting for confirmatory imaging, since the diagnosis is clinical and treatment delay for imaging can be fatal; fluids alone do not address the underlying mechanical problem.

155. D. Correct nasogastric tube placement should be confirmed using appropriate combined methods (such as aspirate pH testing and/or radiographic confirmation per institutional protocol) before feeding, since auscultation of air insufflation alone is not a reliable method and length-based estimation alone does not confirm correct positioning; feeding through a malpositioned tube risks aspiration or other serious complications.

156. A. Effective bag-mask ventilation is assessed by visible chest rise, improving heart rate, and improving color/oxygen saturation; if these are not achieved, technique should be promptly adjusted (repositioning, improving mask seal, adjusting pressure) rather than continuing an ineffective technique unchanged or waiting an extended period before reassessing, since timely, effective ventilation is critical in neonatal resuscitation.

157. D. Conflict between families and the medical team is best approached through active listening to understand underlying concerns and values, seeking shared decision-making and common ground, and involving additional resources (ethics consultation, structured family meetings) when disagreement persists, rather than unilaterally proceeding, escalating prematurely, or avoiding the conversation, none of which resolve the underlying conflict or honor family-centered care principles.

158. A. Effective discharge education for families with limited health literacy requires plain language, teach-back techniques (having the family explain instructions back in their own words) to verify true understanding, and appropriately leveled written materials; relying on medical jargon, assuming comprehension from nonverbal cues like nodding, or omitting education entirely all risk unsafe care transitions and medication errors at home.

159. A. Family-centered rounds conducted at the bedside with active invitation of family participation in care planning discussions is an evidence-based practice associated with improved family satisfaction, communication, and shared decision-making; conducting rounds away from the bedside or limiting family involvement runs counter to family-centered care principles and reduces opportunities for real-time family input and education.

160. C. Significant medical discussions with families who have limited English proficiency require a qualified professional medical interpreter, since using family members or the child as ad hoc interpreters risks inaccurate communication, added burden and inappropriate role placement on the child, and violates best practices for equitable, accurate communication; relying on limited written materials or nonverbal cues does not ensure true informed understanding for significant decisions.

161. A. Standardized, structured handoff tools (such as I-PASS) with dedicated, uninterrupted time and the opportunity for questions have been shown to reduce communication errors and adverse events during care transitions; informal, unstructured handoffs are a known source of error, and written-only or eliminating handoffs entirely are not practical or safe solutions.

162. A. Appropriate triage decisions use established criteria to match a patient's clinical needs to the resources available at a given facility, facilitating timely transfer to a higher level of care when local capabilities are exceeded; delaying transfer until further deterioration, managing beyond local capability, or transferring indiscriminately regardless of actual need are all suboptimal approaches to level-of-care decision-making.

163. B. Safe interfacility transport emphasizes appropriate pre-transport stabilization (addressing airway, breathing, circulation, temperature, and glucose as feasible) using a trained transport team skilled in

managing patients in the transport environment, rather than prioritizing speed over stabilization (which can worsen outcomes) or delaying transport indefinitely while awaiting a level of stability not achievable at the referring facility.

164. A. Safe transitions of care require timely, comprehensive communication with the primary care provider (including hospital course, medication changes, and follow-up needs), ideally available around the time of discharge, since delayed or absent communication increases the risk of care gaps, medication errors, and missed follow-up; relying solely on family recall or providing information only upon request are inadequate for ensuring continuity of care.

165. D. The Plan-Do-Study-Act (PDSA) cycle is a foundational quality improvement methodology for testing interventions on a small scale, measuring outcomes, and iteratively refining the approach before broader implementation, which reduces risk and improves the likelihood of a successful, sustainable change compared with immediate hospital-wide rollout or purely opinion-based decision-making without outcome data.

166. A. Run charts and control charts are standard QI tools for visualizing data over time, allowing a team to distinguish meaningful trends or shifts (potentially related to an intervention) from normal random variation; comparing only two isolated data points or relying on anecdotal impressions without systematic data visualization can lead to incorrect conclusions about whether an intervention truly improved performance.

167. C. Unwarranted variation in practices like routine daily labs without clear clinical indication represents an opportunity for waste and variation reduction, applying standardized, evidence-based indications for testing to reduce unnecessary costs and patient burden (blood draws) while maintaining safety; simply increasing testing or eliminating it entirely without clinical judgment are not appropriate quality improvement responses.

168. A. High reliability organization principles emphasize psychological safety and a culture where all staff feel empowered to speak up about safety concerns, combined with leadership commitment to systems-based learning from errors rather than a punitive, blame-focused approach; discouraging reporting, focusing solely on individual blame, or excluding frontline input all undermine the core tenets of a high reliability safety culture.

169. B. Serious safety events warrant a structured root cause analysis involving a multidisciplinary team to identify systems-level contributing factors (not just individual blame), which allows development of effective, sustainable interventions to prevent recurrence; focusing only on individual culpability or skipping formal investigation entirely misses opportunities to address underlying systems issues.

170. C. Professional integrity and patient safety principles require proactive, transparent disclosure of medical errors to families per institutional policy, regardless of whether harm occurred, since patients and families have a right to know about errors affecting their care; withholding disclosure or limiting it

to only when specifically asked or only to internal risk management undermines trust and professional obligations around honesty and error disclosure.

171. D. Standardized care bundles (encompassing insertion and maintenance practices such as hand hygiene, sterile technique, dressing care, and daily review of line necessity) are the evidence-based approach to reducing hospital-acquired conditions like CLABSI; relying on individual provider preference without standardization, focusing only on treatment after infection occurs, or removing clinically necessary lines are not appropriate prevention strategies.

172. A. Understanding the role of regulatory, accrediting, and licensing agencies in pediatric hospital medicine practice involves proactive, ongoing compliance integrated into routine quality operations, since accrediting standards are designed to support patient safety; treating compliance as a survey-only activity, delegating it entirely away from clinicians, or disregarding standards perceived as burdensome undermines both patient safety and organizational accountability.

173. B. High-value care principles emphasize reducing overuse of tests and treatments not supported by evidence, such as routine chest x-rays and bronchodilator trials in typical bronchiolitis, aligning practice with evidence-based guidelines rather than defaulting to more testing (which can cause harm and unnecessary cost without benefit) or allowing unwarranted variation based on individual preference alone.

174. C. Length of stay and readmission rates are commonly used metrics in evaluating healthcare value, reflecting efficiency and, indirectly, quality of transitions of care; however, these metrics must be interpreted carefully to ensure they do not inadvertently incentivize unsafe premature discharge, and should generally be used for systems-level quality improvement rather than punitive individual provider penalties without appropriate context.

175. A. Hospitalization can serve as an opportunity to identify and, when appropriate and feasible, address unmet preventive healthcare needs, particularly for children with limited access to consistent outpatient care, since this may be one of few contacts with the healthcare system; ignoring these needs entirely or refusing any inpatient preventive care regardless of circumstances misses an opportunity to improve population health outcomes for a vulnerable population.

176. A. Sound evidence-based practice requires critically appraising clinical practice guidelines, including the quality and strength of the underlying evidence, the rigor of the development process, and potential conflicts of interest, before adopting recommendations into practice; blanket automatic adoption or blanket rejection without appraisal, and evaluating guidelines based on publication date alone, do not reflect sound evidence evaluation principles.

177. B. Evaluating the strength of evidence requires attention to study source and design, since study types differ substantially in their ability to support causal inference (e.g., randomized controlled trials generally provide stronger evidence than case reports or uncontrolled observational studies); treating all

evidence as equal regardless of design, relying on opinion alone, or letting personal bias override methodological appraisal undermines sound evidence-based decision-making.

178. A. Choosing Wisely-style, evidence-based high-value care initiatives aim to reduce low-value interventions, such as routine repeat imaging in clinically improving patients where results are unlikely to change management, aligning practice with evidence rather than default habitual testing, purely precautionary over-testing, or basing decisions on family request alone without clinical indication.

179. B. Understanding commonly used value and cost-related terms in healthcare, including the distinction between charges (listed prices) and actual costs (resource expenditure), is part of high-value care competency, helping clinicians engage meaningfully in value-based care discussions; treating these terms as interchangeable or declining to engage with basic cost/charge concepts is not consistent with this competency.

180. B. Randomized controlled trials generally provide stronger evidence for causal inference than retrospective case series (which lack randomization, controls, and are prone to confounding and bias), so when both are available, hierarchy-of-evidence principles support weighing the RCT more heavily in evidence-based decision-making, rather than treating both as equally strong or basing weight on factors unrelated to methodological rigor like recency or writing style alone.

181. D. High-value care and antimicrobial stewardship principles support declining unnecessary antibiotics for viral illness even under family pressure, instead addressing the request through clear communication about the diagnosis, rationale, and appropriate return precautions; prescribing to avoid conflict, offering a compromise course, or ordering unnecessary tests to delay the conversation all represent low-value, potentially harmful responses to a common clinical scenario.

182. C. A well-conducted systematic review and meta-analysis of multiple randomized controlled trials sits near the top of the evidence hierarchy, synthesizing data across studies to provide a more precise and generalizable estimate of effect than any single study or case series, or unstructured expert opinion; while all evidence should still be applied thoughtfully to individual patient context, dismissing high-quality systematic reviews would be inconsistent with sound evidence-based practice.

183. B. Effective team leadership during high-acuity events like pediatric resuscitations relies on structured principles: clear role assignment, closed-loop communication, and a designated team leader coordinating the effort, which improves efficiency and reduces errors compared with unstructured, independent action or assigning roles only retrospectively rather than in real time.

184. C. Successful implementation of practice change relies on change management principles: engaging stakeholders early in the process, transparently communicating the evidence and rationale behind the change, and incorporating feedback to address concerns, which improves buy-in and sustainability; mandating change without engagement, abandoning it at the first sign of resistance, or allowing indefinite partial adoption all undermine successful, lasting practice change.

185. A. Structured screening for social determinants of health, paired with a clear pathway for connecting identified needs to community resources and referrals, reflects an advocacy and health equity best practice recognized as relevant to pediatric hospital medicine; screening without follow-through, limiting screening only to those who self-identify, or considering these factors entirely outside the scope of care all fail to meaningfully address health-related social needs that affect child health outcomes.

186. B. Recognizing that implicit bias can unconsciously influence clinical decisions, even among well-intentioned providers, is an important step toward health equity; combining bias-awareness training with standardized, objective clinical protocols (such as validated pain assessment tools applied consistently) helps reduce variability and disparities in care, rather than denying bias exists, addressing it only informally, or attributing disparities solely to disease differences without further examination.

187. D. Pediatric ethical frameworks emphasize obtaining assent from adolescents with developing capacity alongside parental consent, respecting the adolescent's growing autonomy while still involving parents appropriately for most decisions; when significant disagreement persists despite facilitated discussion, ethics consultation can help navigate the conflict, rather than the team unilaterally overriding either party or excluding one perspective entirely.

188. D. Adolescents often have specific confidentiality protections for certain sensitive health services under applicable law/policy, and providers should respect these protections where they apply, while remaining aware of situations that trigger mandated reporting obligations (e.g., abuse) that would appropriately override confidentiality; automatically disclosing all details to parents, refusing care pending parental notification, or failing to consider documentation-related confidentiality safeguards do not appropriately balance adolescent confidentiality with other obligations.

189. A. Structured ethical frameworks, weighing principles such as respect for autonomy, beneficence, non-maleficence, and justice, provide a systematic approach to navigating tension between family preferences and clinical assessment of best interest, with ethics consultation available for complex cases; rigidly prioritizing either party's view absolutely, or relying purely on individual intuition without a structured framework, does not reflect sound ethical decision-making in pediatrics.

190. D. Professional integrity principles support truth-telling and honesty with patients, including age-appropriate disclosure of diagnosis and prognosis; when parents request nondisclosure, the appropriate approach is a respectful conversation with the family about the ethical and developmental importance of honest, age-appropriate communication with the adolescent, working collaboratively toward disclosure, rather than either absolute non-disclosure, unilateral disclosure without family engagement, or avoiding the patient's direct question altogether.

191. A. Adult learning theory emphasizes that adult learners benefit from teaching that connects new material to their prior experience, uses case-based and problem-solving approaches, and emphasizes practical, applicable knowledge, in contrast to purely passive didactic lectures or approaches designed for younger learners; while incidental bedside teaching has value, relying on it exclusively without structured educational sessions misses opportunities for comprehensive skill-building.

192. A. Effective teaching for learners at multiple levels involves tailoring teaching points and questions to each individual's stage of training (foundational concepts for junior learners, more advanced management nuances for senior learners) within the same clinical encounter, maximizing educational value for the whole group rather than directing content at only one learner's level or providing undifferentiated, one-size-fits-all teaching.

193. B. Effective feedback principles emphasize being specific, timely, and actionable, focusing on the behavior or reasoning process rather than the individual personally, and including both strengths and areas for improvement, generally delivered in a private and respectful setting; vague praise, public criticism, or avoiding feedback altogether all fail to support meaningful learning and professional growth.

194. D. Effective mentorship involves an ongoing relationship with regular check-ins, guidance on career and professional development goals, and individualized support that respects the mentee's own aspirations and needs, extending beyond clinical skills alone; leaving a new faculty member entirely without guidance, focusing narrowly on only one domain, or making decisions on their behalf without their input do not reflect principles of effective mentorship.

195. A. A 5-point satisfaction scale represents ordinal data (ordered categories without necessarily equal intervals between them), which requires statistical methods appropriate for ordinal data (such as non-parametric tests), rather than treating it as purely nominal (ignoring inherent order) or as continuous interval data (assuming equal spacing, which may not be valid); recognizing variable type is fundamental to selecting an appropriate statistical approach.

196. A. A p-value of 0.03 indicates that, under the null hypothesis, an effect this large or larger would be unlikely to occur by chance alone at the conventional 0.05 threshold, but this is distinct from proving causation with certainty, and importantly, statistical significance does not automatically equate to clinical significance (a statistically significant finding may still be a small, clinically unimportant effect); the p-value also does not directly represent the probability that the null hypothesis itself is true, a common misinterpretation.

197. B. Systematic baseline differences between groups in an observational study raise concern for confounding, where an unmeasured or measured but unadjusted difference between groups (rather than the intervention itself) may explain the observed association; this limits the strength of causal inference compared with randomized designs, which distribute both known and unknown confounders more evenly between groups, and statistical significance does not eliminate the possibility of confounding.

198. D. Test interpretation must account for pretest probability: a highly sensitive test's negative predictive value is influenced by the pretest probability of disease, and in a patient with high pretest probability, a negative result — even from a sensitive test — may still carry a clinically meaningful chance of a false negative, warranting further testing or continued clinical correlation rather than assuming the result definitively rules out disease; this differs from simply relying on sensitivity/specificity values in isolation without considering pretest probability.

199. A. Ethical research involving children requires informed consent from a parent or legal guardian, along with age-appropriate assent from the child when developmentally capable, and clear communication that participation is voluntary and that declining or withdrawing will not affect the quality of clinical care received; bypassing parental consent, informal waivers by clinical staff, or unilateral risk-level determinations by the research team without appropriate ethical/IRB oversight do not meet standards for ethical research conduct.

200. D. Undisclosed financial conflicts of interest represent a serious breach of research ethics and professional integrity, regardless of whether the study results are perceived as valid or favor the funding company, since transparency about potential conflicts is essential for readers and institutions to appropriately evaluate potential bias; conflicts of interest must be disclosed proactively and reviewed through appropriate institutional mechanisms, not addressed selectively based on study outcome or dismissed based on the researcher's own assessment of their objectivity.