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Question: 1379

Serial CPSS improvement en route, still positive 1/3. Transport?

A. Aspirin field
B. Reassess NIHSS
C. Continue to stroke center
D. Cancel stroke

Answer: C
Explanation: Any persistent CPSS positivity requires stroke center evaluation.

Question: 1380

In a rural ED, a 58-year-old farmer in anaphylactic arrest (PEA) receives epi 0.3 mg IM, but recurs after 5 minutes. Team of two: nurse compressor (fatigued), physician airway/meds. Family present, allergic

optimizes?

A. Cease epi repeats to avoid family distress over unknown allergy
B. Administer steroids first, deferring compressions
C. Rotate nurse to recorder, physician compresses with liaison support
D. Exclude family for focused anaphylaxis protocol

Answer: C
Explanation: Anaphylaxis ACLS prioritizes epi repeats (0.3-0.5 mg IM q5-15 min) with BLS

minutes). Family presence with liaison (Class 2a) aids history gathering ethically. Steroids/histamines are adjuncts, not first-line; exclusion risks missing details. Closed-loop ("Epi now—dose confirmed?") integrates dynamics, improving perfusion (target ETCO2 >20 mm Hg) and outcomes in reversible arrest.

Question: 1381

A 64-year-old female has a cardiac arrest due to suspected myocardial infarction. After stabilization, what is the most appropriate next step to evaluate her cardiac status?

A. Coronary angiography
B. Echocardiogram
C. Holter monitoring
D. Cardiac MRI

Answer: A
Explanation: Coronary angiography is the most appropriate next step to evaluate the cardiac status of a patient with suspected myocardial infarction. It allows for direct visualization of coronary arteries and helps in determining the need for revascularization.

Question: 1382

A 68-year-old male in witnessed ventricular fibrillation cardiac arrest receives 8 minutes of high-quality CPR with a King LT supraglottic airway placed without interrupting compressions. Waveform capnography shows a persistent square waveform with ETCO2 of 12 mmHg, chest rise is visible bilaterally, but SpO2 remains 78% despite 100% oxygen. What is the most appropriate next management step?

A. Increase ventilation rate to 12 breaths per minute to improve oxygenation
B. Consider termination of resuscitation efforts due to low ETCO2
C. Optimize CPR quality focusing on compression depth and rate
D. Perform immediate endotracheal intubation to secure definitive airway

Answer: C
Explanation: The ETCO2 value of 12 mmHg indicates adequate pulmonary blood flow and confirms correct advanced airway placement during CPR, as values greater than 10 mmHg after advanced airway insertion correlate with sufficient perfusion from high-quality compressions. Low SpO2 in this context reflects ongoing cardiac arrest physiology rather than ventilation failure, and increasing ventilation risks hyperventilation which elevates intrathoracic pressure, reduces venous return, and worsens outcomes. Supraglottic airways like King LT are appropriate for prolonged CPR when placed successfully without compression pauses, with capnography as the gold standard for confirmation over intubation attempts that could interrupt CPR.

Question: 1383

A 70-year-old with dementia arrests in asystole; DNR unclear due to outdated form. Family insists on continuation amid COVID-19 isolation policy waiver. Team rotates poorly, compressor unchanged 8

A. Isolate family, focusing on lab-guided termination

B. Honor presumed DNR, terminating despite family
C. Continue with rotation and ethics consult for directive clarity
D. Withhold rotation to prioritize epi dosing

Answer: C

respecting autonomy. Dynamics mandate rotation every 2 minutes (or fatigue), as poor quality (low depth/ETCO2) predicts futility; labs indicate acidosis but reversible if addressed. Family presence post-waiver supports shared decisions. Epi every 3-5 minutes continues, but rotation is BLS cornerstone. This avoids ethical overreach, enhancing potential ROSC via quality CPR.

Question: 1384

A 78-year-old, HR 50 bpm asymptomatic, BP 140/85 mmHg, sleep apnea history. PSG planned. ACLS?

A. CPAP trial
B. Pace
C. Theophylline
D. Observe

Answer: D
Explanation: Asymptomatic: monitor. Apnea common brady cause; treat underlying.

Question: 1385

In a 68-year-old post-ROSC from PEA with suspected hypovolemia (history of GI bleed, Hgb 7.2 g/dL), fluid resuscitation achieves MAP 70 mm Hg. Echo shows hyperdynamic function, but creatinine rises to 2.1 mg/dL. What ongoing reversible cause treatment balances volume and renal protection?

A. Restrict fluids and start furosemide for emerging acute kidney injury
B. Continue balanced crystalloid boluses targeting CVP 8-12 mm Hg
C. Switch to albumin 5% infusion for colloid oncotic support
D. Initiate norepinephrine despite euvolemia to maintain MAP >65 mm Hg

Answer: D

guidelines recommend vasopressors like norepinephrine to sustain MAP ≥65 mm Hg for cerebral/coronary autoregulation, even if euvolemic, while monitoring for overload in renal compromise. Fluid restriction risks under-resuscitation, colloids lack superiority, and diuretics are for confirmed overload.

Question: 1386

A 79-year-old female with Paget's arrests; ECG Mobitz I progressing to PEA, bone scan active, Ca 10.8 mg/dL. What?

A. Zolendronic acid 4 mg IV stat
B. Hydration and monitor, no acute
C. CPR with calcium avoidance
D. Bisphosphonate pamidronate 90 mg IV over 2 hours

Answer: B

onset.

Question: 1387

A 66-year-old female post-dinner develops crushing chest pain radiating to back, dyspnea, diaphoresis, nausea. Home BP 178/102 mmHg, SpO2 90% R
A. ED 12-lead ECG (7 min post-arrival): 2.5 mm ST elevation in III, aVF, V1-R (reciprocal changes in I, aVL). Troponin pending. No recent trauma/head injury. What contraindicates nitroglycerin administration?
A. Nausea and diaphoresis
B. Elevated blood pressure
C. Shortness of breath alone
D. Chest pain severity

Answer: B
Explanation: Nitroglycerin is contraindicated if systolic BP <90 mmHg or >180-200 mmHg in some hypertensive crises to avoid reflex tachycardia or cerebral hypoperfusion; here, 178 systolic warrants caution or avoidance pending control. Inferior STEMI (III, aVF contiguous, right ventricular involvement suggested by V1-R) still receives aspirin/oxygen, with morphine alternative for pain. Symptoms confirm ACS urgency.

Question: 1388

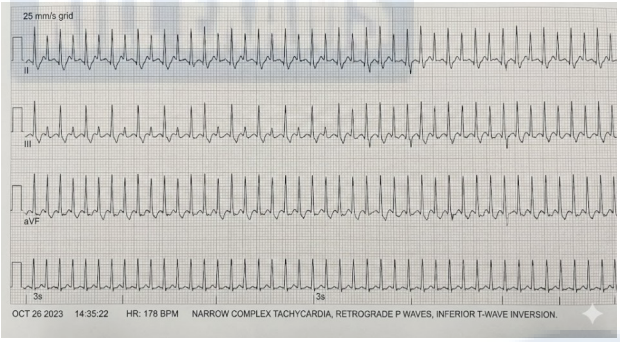
Non-shockable PEA to asystole cycles, epi q3min x3, EtCO2 11 mmHg persistent low despite optimization, no H's/T's obvious.

A. Intubate immediately
B. Switch to amio
C. Double epi dose
D. Consider TOR if criteria

Answer:
Explanation: Prolonged non-shockable poor EtCO2 (<10-20 mmHg after 20 min) part of multimodal TOR (ALS rule: no shockable, no ROSC 10 min, etc.); EMS/hospital protocols. Airway defer if interrupting.

Question: 1389

A 55-year-old female post-coronary artery bypass graft surgery 3 days prior develops acute onset chest discomfort and diaphoresis while ambulating in the hospital ward. Her blood pressure is 102/68 mmHg, heart rate 178 bpm, and she reports a Glasgow Coma Scale score of 14 due to mild confusion. Arterial blood gas analysis reveals pH 7.32, pCO2 48 mmHg, pO2 82 mmHg on 4 L nasal cannula, bicarbonate 22 mEq/L, and base excess -4. A bedside ECG monitor shows the rhythm in the image placeholder. The patient's ejection fraction from preoperative echocardiogram was 45%, and she has no contraindications to antiarrhythmic therapy. Assuming stability is borderline but leaning toward unstable due to ischemic



A. Seek immediate cardiology consultation and withhold all interventions pending 12-lead ECG
B. Proceed directly to synchronized cardioversion at 50 J biphasic with midazolam 2 mg IV sedation
C. Attempt vagal maneuvers followed by adenosine 6 mg IV rapid push if unsuccessful
D. Administer procainamide 20-50 mg/min IV infusion until rhythm conversion or maximum dose reached

Answer: B

wide QRS and stable versus unstable status, with unstable defined by hypotension (<90 mmHg systolic, here 102/68 mmHg is borderline but compounded by symptoms), altered mental status (GCS 14), and ischemic chest pain. This rhythm represents atrioventricular nodal reentrant tachycardia, a regular narrow-complex supraventricular tachycardia, confirmed by retrograde P waves post-QRS. For unstable patients, synchronized cardioversion is the definitive intervention, initiating at 50 J biphasic for narrow regular rhythms to minimize risk of degeneration to ventricular fibrillation, with sedation like midazolam to ensure patient comfort without delaying treatment. Vagal maneuvers and adenosine are first-line for stable narrow regular tachycardia but contraindicated in instability due to potential transient asystole exacerbating hypoperfusion. Procainamide is reserved for stable wide-complex monomorphic ventricular tachycardia, and while expert consultation is valuable, it does not supersede immediate cardioversion in unstable

scenarios. Post-procedure, obtain full 12-lead ECG to rule out ischemia (T-wave changes noted), optimize oxygenation (current pO2 82 mmHg inadequate), and consider anticoagulation if atrial involvement suspected, while addressing postoperative factors like fluid status or anemia.

Question: 1390

A 65-year-old with AFib history in casino collapses with narrow-complex regular tachycardia 195 bpm, BP 80/50 mmHg, GCS 14 with agitation, clutching chest, lactate 3.8 mmol/L, recent K+ 3.1 mEq/L on labs. Monitor confirms no flutter waves. Priority action?

A. Amiodarone 150 mg IV bolus
B. Expert consult for ablation
C. Immediate synchronized cardioversion 50-100 J
D. Carotid massage if no bruits

Answer: C
Explanation: Unstable criteria met: systolic hypotension, altered mental status (GCS 14/agitation), shock (elevated lactate), ischemic chest pain—all tachycardia-induced. ACLS mandates synchronized cardioversion without delay for such patients; narrow regular rhythm starts at 50-100 J. Adenosine considered only if stable narrow-complex; history of AFib does not preclude this if currently regular SVT.

Question: 1391

During ED resuscitation of a 62-year-old pregnant (32 weeks) female in perimortem C-section candidate with amniotic fluid embolism arrest (PEA), LMA placement yields ETCO2 17 mmHg. After manual left uterine displacement, 15 minutes in, ETCO2 drops to 5 mmHg, fetal monitor shows bradycardia 80 bpm, maternal ABG pH 7.08, PaCO2 68 mmHg, PaO2 52 mmHg. What ventilation priority enhances maternal-fetal perfusion?

A. 15 breaths/min to rapidly correct maternal hypercapnia before delivery
B. 8 breaths/min with 6 mL/kg and immediate perimortem cesarean delivery
C. Apply 10 cmH2O PEEP post-delivery to improve fetal oxygenation
D. 10 breaths/min asynchronous, delaying delivery until ETCO2 >15 mmHg

Answer: B
Explanation: In pregnant arrest, aortocaval compression worsens preload, and embolism adds dead space;

weeks gestation to relieve compression and improve maternal CPR, with conservative ventilation (8-10 breaths/min, 6 mL/kg) to minimize pressure on gravid uterus, targeting ETCO2 >10 mmHg for dual perfusion, as studies show delivery boosts maternal ROSC by 50% via hemodynamic relief. Rate increase risks aspiration/barotrauma; delaying contravenes timelines; PEEP post-delivery only if needed. Reassess

capnography for waveform post-delivery.

Question: 1392

A 50-year-old marathon runner collapses mid-race with chest pain, gasping shortness of breath, nausea, heavy sweating. Bystanders note pallor; EMS 12-lead ECG shows subtle 1.1 mm ST elevation in II, III, aVF plus new RBB**B.** Vitals: BP 148/88, HR 55 bpm junctional, SpO2 88%, lactate 4.1. What lab/ECG parameter drives reperfusion urgency?

A. SpO2 below 94%
B. Junctional bradycardia
C. ST elevation in contiguous leads
D. Elevated lactate alone

Answer: C
Explanation: STEMI diagnosis mandates reperfusion (PCI <90 min) when ST elevation ≥1 mm in two contiguous leads (II, III, aVF inferior group); new RBBB suggests right coronary occlusion extending to conduction. Oxygen addresses SpO2 88%, aspirin precedes, bradycardia monitored but reperfusion primary. Symptoms/labs support ACS.

Question: 1393

PEA in 38-year-old pregnant (28 weeks) with leg swelling post-long flight. Epinephrine given, fetal heart tones present. D-dimer elevated, ABG normal. What reversible cause and specific modification?

A. Pulmonary embolism; consider perimortem C-section if no ROSC in 4 min
B. Hypovolemia; left uterine displacement during CPR
C. Amniotic fluid embolism; magnesium 4 g IV
D. Aortic dissection; beta-blocker labetalol IV

Answer: A
Explanation: Leg swelling/D-dimer suggest pulmonary thrombosis (T from T's) causing obstructive PEA. In pregnancy >20 weeks, manual left uterine displacement for CPR, and if no ROSC within 4 minutes, perimortem C-section improves maternal perfusion/ROSC. Thrombolysis risky in pregnancy; amniotic

rapid delivery for maternal benefit.

Question: 1394

A 72-year-old female presents with sudden onset of left-sided weakness and difficulty speaking. Her CT

scan shows no hemorrhage, and she is within the treatment window for tP

A. What is the maximum allowable blood pressure before administering tPA?

A. 185/110 mmHg

B. 190/120 mmHg

C. 180/110 mmHg

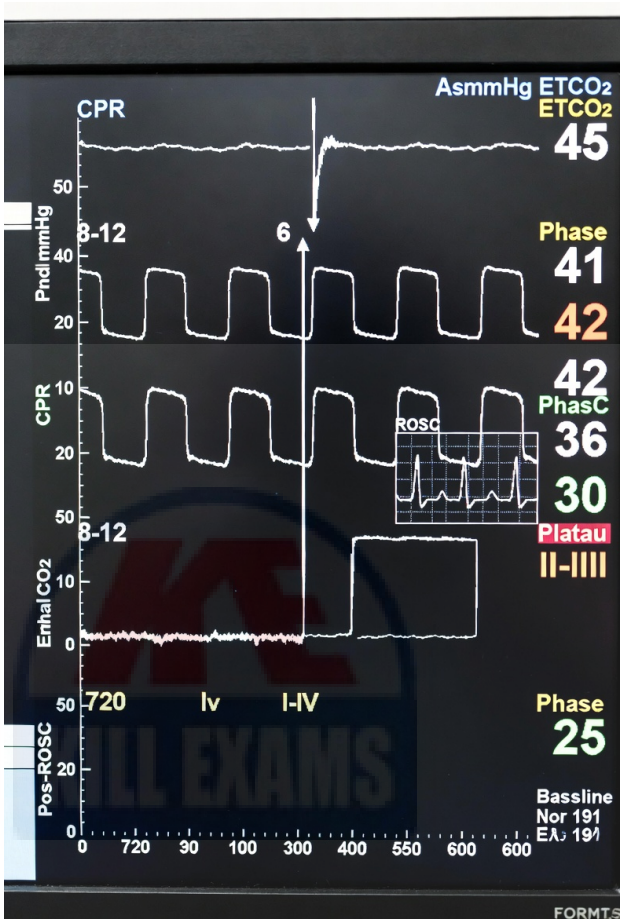
D. 160/90 mmHg

Answer: A

Explanation: The maximum allowable blood pressure before administering tPA is 185/110 mmHg. If the patient's blood pressure exceeds this value, it must be managed to ensure safe administration of fibrinolytics.

Question: 1395

During a prolonged in-hospital cardiac arrest rhythm of asystole in a 72-year-old diabetic patient with sepsis, the ACLS team places an endotracheal tube after failed bag-mask attempts, confirming placement with initial waveform capnography showing ETCO2 of 8 mmHg and a rectangular waveform. After 12 minutes of CPR at 100-120 compressions/min and asynchronous ventilations at 10 breaths/min, the ETCO2 suddenly rises to 42 mmHg with a sustained plateau phase on the waveform, coinciding with organized sinus rhythm on the monitor. No pulse is immediately palpable, but the team notes improved SpO2 to 98% on 100% oxygen. What is the most reliable confirmatory action to verify ROSC in this scenario, integrating quantitative capnography data?



A. Administer 1 mg epinephrine push and resume full compressions, as the waveform rise may indicate transient perfusion artifact

B. Pause compressions for 10 seconds to perform pulse check and auscultate for bilateral breath sounds while observing the capnography for sustained ETCO2 >40 mmHg

C. Inflate the ET tube cuff to 30 cmH2O and reassess tidal volumes to rule out leak as the cause of the ETCO2 increase

D. Obtain a 12-lead ECG to assess for STEMI as the cause of arrest and guide thrombolysis

Answer: B

Explanation: This intricate sepsis-related asystolic arrest scenario highlights capnography's prognostic role in prolonged CPR (>10 minutes), where low ETCO2 (8 mmHg) reflects poor pulmonary perfusion from inadequate cardiac output during compressions, correlating with <25% survival odds per ACLS data. The sudden ETCO2 surge to 42 mmHg with a sustained plateau indicates restored systemic circulation, as increased venous return delivers buffered CO2 to alveoli, elevating end-tidal levels >35-40 mmHg—a hallmark of ROSC often preceding palpable pulse by 5-10 seconds due to capnography's sensitivity to microcirculatory changes. The rectangular waveform confirms adequate ventilation without hyperventilation (avoiding intrathoracic pressure spikes >20 mmHg that reduce output by 30%). Immediate confirmation requires pausing compressions briefly (<10 seconds to limit coronary perfusion drop) for carotid/femoral pulse assessment and bilateral auscultation, while monitoring capnography for persistence of the rise—sustained >40 mmHg post-pause validates ROSC with 95% specificity. Resume compressions if no pulse, but this waveform shift mandates halt to prevent over-resuscitation risks like rib

fractures. ECG for STEMI delays airway/ROSC focus in sepsis etiology, epinephrine ignores the perfusion signal, and cuff inflation risks barotrauma without addressing circulation. Post-ROSC, target ETCO2 35-45 mmHg, titrate vasopressors for MAP >65 mmHg, and initiate post-arrest care including targeted temperature management.

Question: 1396

A 74-year-old female achieves ROSC after 35-minute OHCA in asystole, with initial labs showing pH 6.98, lactate 10.5 mmol/L, and base excess -18 mEq/L, pointing to severe acidosis as a reversible

stance on its use for ongoing treatment?

A. Combine with tromethamine for synergistic buffering in prolonged arrest aftermath
B. Routine administration of 1 mEq/kg every 10 minutes to buffer metabolic acidosis
C. Use only if pH <7.2 despite ventilation and vasopressors, targeting normalization
D. Avoid entirely, as it risks intracellular acidosis worsening in hypoperfusion states

Answer: C
Explanation: Metabolic acidosis (hydrogen ion excess, an "H") as a reversible cause in post-arrest care warrants bicarbonate if severe (pH <7.2) and refractory to primary corrections like ventilation (to reduce

use risks hypernatremia or paradoxic intracellular acidosis, and alternatives like tromethamine lack evidence.

Question: 1397

During a 44-year-old male's near-drowning arrest on beach, sand debris noted, no trauma; team uses two-rescuer bag-mask post-ROS**C.** SpO2 92%. What optimizes post-arrest ventilation?

A. Head-tilt/chin-lift with suction, 500-600 mL target
B. Nasopharyngeal for semi-conscious recovery phase
C. Low O2 21% to prevent absorption atelectasis
D. Jaw-thrust for water aspiration neck caution

Answer: A
Explanation: Head-tilt/chin-lift (no trauma) with oropharyngeal/suction clears debris for effective two-rescuer bag-mask, delivering 500-600 mL tidal volumes at 10/min with 100% oxygen transitioning to titrated for SpO2 >94%, preventing re-arrest in aspiration; jaw-thrust unneeded, gag guides adjunct, high O2 initial standard.

Question: 1398

A 66-year-old in PE arrest (D-dimer 5 µg/mL, echo RV strain): BLS CPR, team: compressor good, but defibrillator "Thrombolytics?" unlooped amid hypoxia (SpO2 84% ET), leader no rotation cue (fatigue subtle, ETCO2 13 mmHg), recorder misses time. ROSC tP

A. What flaw?

A. D-dimer high; anticoag only

B. Echo wait; empiric heparin

C. Unlooped query; affirm high-risk decisions

D. Subtle fatigue; monitor vital signs

Answer: C

Explanation: PE (H's/T's) PEA BLS to ACLS requires looped high-risk calls ("tPA 100 mg—indication confirmed? Risks?"), especially hypoxia-impacted. Subtle fatigue needs proactive rotation (every 2 min, ETCO2 13 mmHg low). Empiric tPA per guidelines if suspected.

Question: 1399

A patient presents with chest pain and an ECG showing a wide-complex tachycardia. The QRS duration is 0.16 seconds. The patient is stable. What is the best next step in management?

A. Procainamide

B. Synchronized cardioversion

C. Amiodarone

D. Observation

Answer: A

Explanation: In stable patients with wide-complex tachycardia, procainamide is a suitable option for pharmacological management. It can help to convert the rhythm to normal sinus and manage the tachycardia effectively.

Question: 1400

A 65-year-old male with sepsis-induced arrest achieves ROSC after 30 min of CPR. Comatose, BP 78/48 mmHg, HR 110 bpm, SpO2 91% on NRB, ETCO2 35 mmHg via BVM. ABG: PaCO2 48 mmHg, PaO2 82 mmHg, lactate 6.5 mmol/L. Cultures pending; antibiotics started. TTM contraindicated due to infection. To achieve hemodynamic goals, what is the initial vasopressor strategy?

A. Dobutamine 2.5 mcg/kg/min added to fluids for septic cardiomyopathy

B. Phenylephrine infusion for pure vasopressor effect avoiding tachycardia

C. Norepinephrine monotherapy titrated to systolic BP >90 mmHg

D. Start vasopressin 0.04 units/min plus norepinephrine to target MAP 65 mmHg

Answer: C

for hypotension (systolic BP >90 mmHg or MAP ≥65 mmHg) due to its beta-1 inotropic and alpha-1 vasopressive effects, balancing shock without excess tachycardia. Vasopressin combo is for refractory cases; dobutamine follows echo confirmation of low output; phenylephrine reflexively slows HR, worsening asystole risk. Address hypercapnia (PaCO2 48 mmHg) with ventilation once intubated, targeting 35-45 mmHg.

Question: 1401

Seizure arrest King LT ETCO2 18 mmHg; 14/min ventilation, ICP concerns. Priority?

A. Mannitol
B. Continue
C. Reduce rate
D. Intubate

Answer: C
Explanation: Hyperventilation risks ICP.

Question: 1402

A 67-year-old male smoker with COPD exacerbation presents with 2-hour wheezing and chest tightness; ECG subtle anterior ST-elevation 1 mm, troponin 0.4 ng/mL, ABG pH 7.32, pCO2 55 mmHg, FEV1 45% predicted. PCI 95 minutes. What adjunct contraindicates fibrinolysis if delay occurs?

A. Hypercapnic respiratory acidosis, risking arrhythmia post-thrombolysis
B. Subtle ST changes, better suited to conservative monitoring
C. COPD alone, proceed with half-dose if needed for age
D. Smoking history, increasing clot burden but not contraindication

Answer: A
Explanation: If PCI delay >120 minutes, fibrinolysis considered; however, severe acidosis (pH <7.2 often cutoff) and hypercapnia contraindicate due to reperfusion arrhythmia/VF risk (hypoxia potentiates). ACLS prioritizes PCI; upstream ticagrelor. Optimize ventilation (BiPAP if SpO2 <90%); smoking irrelevant.

Question: 1403

Cath lab RCA occlusion stented, 71-year-old develops HR 38 bpm 2:1 AV block, BP 76/46 mmHg, new right bundle branch block on 12-lead, troponin 2.1 ng/mL rising, SpO2 90% on NR**B.** Atropine 1 mg x2 ineffective. Pacing pad placement?

A. Apical-anterior and sternal positions
B. Anterior-lateral and posterior-torso positions
C. Repeat atropine to total 3 mg first
D. Dopamine 5 mcg/kg/min prior to pads

Answer: B
Explanation: Inferior ischemia-induced high-degree AV block with wide QRS (RBBB) limits atropine; TCP uses anterior-posterior pad placement (anterior precordium to left posterior scapular) for optimal current vector in adults, demand mode 70 bpm titrate mA to capture (often higher threshold post-MI). Poor perfusion (hypotension, hypoxia) mandates no further atropine delay. Dopamine chemical option if pads unavailable.

Question: 1404

Code metrics: compressions 115/min, 5.7 cm, 88% recoil, fraction 76%, EtCO2 13 mmHg, pauses rhythm/meds total 22 sec/cycle. Primary quality fix?

A. Slow rate to 105/min
B. Rotate compressors q1 min
C. Team training debrief
D. Recruit CPR coach feedback

Answer: D
Explanation: Compression fraction <80% from pauses demands real-time feedback/coaching optimizing pauses <10 sec total, boosting EtCO2. Rotation standard q2 min; rate/debrief secondary.

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