Self-Assessment Quiz

The questions in this self-assessment quiz are based on the articles in this issue of the journal. Each of the questions or statements is followed by five possible answers or completions. Select all of the correct answers to each of the questions and circle the corresponding letters. The answers appear on the inside front cover of this issue.

As an organization accredited for continuing medical education, the American Academy of Pediatrics certifies that this continuing medical education activity, when used and completed as directed, meets the criteria for two hours of credit in Category I of the Physician’s Recognition Award of the American Medical Association and two hours of PREP elective credit.

To earn two hours of Category I credit and two hours of PREP elective credit, you must be registered for PREP or subscribing to PEDIATRICS IN REVIEW. You have received a three-ring binder which contains a set of IBM computer cards and return envelopes. There are no monthly deadlines for the return of the computer cards, except that all cards must be returned by June 30, 1982 to ensure proper credit. Be sure that the date on the computer card corresponds with the date on each issue. Please do not write over the date or the ID number on the card.

We invite you to write specific comments about the relevance of each of the articles and any other comments you wish to make about the Journal on the back of each card.

1. A 2-week-old infant is reevaluated because of mild tachypnea and a grade II systolic murmur found at birth. Which of the following are important in evaluating this infant’s cardiac status?
   A. Sleeping patterns.
   B. Length.
   C. Feeding history.
   D. Weight.
   E. Stool character.

2. During a routine school examination, the pediatrician should search for silent cardiac problems. The most likely abnormalities to be found for the first time at this age include:
   A. Ventricular septal defect.
   B. Atrial septal defect secundum.
   C. Arrhythmia.
   D. Hypertension.
   E. Coarctation of the aorta.

3. A 3-year-old child with severe bilateral pneumonia is being treated with IV penicillin. CBC reveals hemoglobin 11 gm/100 ml, WBC 3,000/cu mm, 40% polymorphonuclear leukocytes, 60% lymphocytes, and adequate platelets. The most likely etiologies for her neutropenia include:
   A. Overwhelming sepsis.
   B. Laboratory error.
   C. Penicillin induced.
   D. Cyclic neutropenia.
   E. Bone marrow aplasia.

4. The initial management should include:
   A. Obtain a hematology consultation.
   B. Repeat the blood count serially.
   C. Perform a bone marrow examination.
   D. Revise antibiotic therapy.
   E. Determine immunoglobulins.

5. Cyclic neutropenia is a familial condition characterized by:
   A. Occurrence after 10 years of age.
   B. Gingivitis.
   C. Low neutrophil and high monocyte counts.
   D. Malabsorption.
   E. Treatment with monthly transfusions.

6. An 8-month-old infant has a two-day history of diarrhea now complicated by vomiting, with temperature 39 C (102 F), heart rate 125 beats per minute, blood pressure 55/25. The infant is lethargic but irritable on stimulation, with skin velvety, reflexes brisk, mucous membranes dry, and fontanel sunken. He voids 40 ml of urine while being examined. Which of the following are TRUE statements regarding this patient?
   A. The deficit approximates 100 ml/kg.
   B. Blood volume should be immediately expanded with 10% glucose.
   C. Potassium should be given in the initial fluid, as this ion along with intracellular water loss is the major deficit.
   D. Fluid requirements include the deficit, ongoing losses, and maintenance needs and should be repaired over a 48-hour period.
   E. The most likely complication of giving fluids too rapidly is congestive heart failure.

7. A 4-month-old infant with severe diarrhea has moderately severe hyponatremic dehydration. Blood pressure is 40/20 and there is no recent history of voiding. You should:
   A. Give 20 ml/kg of plasma followed by 20 ml/kg of 10% glucose in the first hour.
   B. Order blood gases to determine hydrogen ion disturbance.
   C. Anticipate significant hyperglycemia eight hours later and reduce IV solution to 5% glucose.
   D. Plan on restoring the calculated deficit in the first 24 hours.
   E. Give hypertonic saline if the hyponatremia is severe.

8. A 10-kg infant has an injury to the mouth and is unable to take oral fluids though he is active in his crib. The treatment would include:
   A. Estimate calorie requirement as 30 calories/kg and give 1 ml/calorie of fluid.
   B. Weigh daily to determine adequate hydration.
   C. Give a maintenance fluid volume of 75 to 100 ml/kg/day.
   D. Calculate sodium and potassium requirements as approximately 2 to 3 mEq/kg/day.
   E. Order urinary specific gravity and serum osmolality as they are important adjuncts of this infant’s fluid management.

9. An 8-day-old premature infant recently recovered from RDS and now on formula feedings, passed a blood-tinged stool. The infant is listless and jaundiced with abdominal distension. Your management should include:
   A. Obtain an abdominal x-ray.
   B. Stop all feedings and start IV alimentation.
   C. Obtain blood cultures.
   D. Order platelet transfusions if platelet count is low.
   E. Evaluate the stool for reducing substances.

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