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| 25. | A | 50. | B |

1. A

Objective: Chapter 10, Objective 2

Page: 193

Rationale: “Pulling traction” is not a prehospital option, and the term traction is not an appropriate description for motion restriction of the spine. Traction usually results in further instability of any spinal-column injury.

2. C

Objective: Chapter 8, Objective 8

Page: 165

Rationale: Pulsus paradoxus, or paradoxical pulse, may be noted. This is where the radial pulse is not felt with inspiration.

3. D

Objective: Chapter 16, Objective 6

Page: 311

Rationale: Partial-thickness burns cause damage through the epidermis and into a variable depth of the dermis. Emergency care of partial-thickness burns involves cooling the burn and covering it with a clean, dry dressing.

4. B

Objective: Chapter 17, Objective 6

Page: 324

Rationale: Patients in traumatic cardiopulmonary arrest after electrical or lightning injury have a higher rate of survival than arrest from other causes, and full resuscitation should always be attempted when they are encountered. Be sure the patient is no longer in contact with the electricity source. Do not become a victim yourself!

5. D

Objective: Chapter 13, Objective 1

Page: 251

Rationale: The retroperitoneal abdomen is the part of the abdomen behind the thoracic and true portions of the abdomen, separated from the other abdominal regions by a thin retroperitoneal membrane; it includes the kidneys, ureters, pancreas, posterior duodenum, ascending and descending colon, abdominal aorta, and inferior vena cava.

6. A

Objective: Chapter 17, Objective 6

Page: 314

Rationale: Limit burn wound progression as much as possible. Rapid cooling early in the course of a surface burn injury can help limit this progression. Following removal from the source of the burn, the skin and clothing are still hot, and this heat continues to injure the tissues, causing an increase in burn depth and seriousness of the injury. Cooling halts this process and is beneficial if done appropriately. Cooling should be done with tap water or any source of clean room-temperature water, but it should be undertaken for no more than 5 to 10 minutes. Cooling for longer periods of time can induce hypothermia and subsequent shock. Do not use ice or ice water because this may induce hypothermia.

7. C

Objective: Chapter 2, Objective 2

Page: 24

Rationale: The purpose of the ITLS Primary Survey is to prioritize the patient and to identify immediately life-threatening conditions in less than 2 minutes.

8. D

Objective: Chapter 14, Objective 5

Page: 264

Rationale: Proper management of fractures and dislocations will decrease the incidence of pain, disability, and serious complications. Treatment in the prehospital setting is directed at proper immobilization of the injured part by the use of an appropriate splint and padding. Pain control with appropriate analgesics is another major component of the care of injured extremities.

9. C

Objective: Chapter 20, Objective 2

Page: 373

Rationale: In supine hypotension syndrome, the hypotension is caused by the weight of the pregnant uterus pressing on the inferior vena cava and decreasing the return of blood to the heart by up to 30%.

10. D

Objective: Chapter 12, Objective 2

Page: 234

Rationale: When the ICP increases, the systemic blood pressure increases to try to preserve blood flow to the brain. The body senses the rise in systemic blood pressure, and this triggers a drop in the pulse rate as the body tries to lower the systemic blood pressure.

11. D

Objective: Chapter 6, Objective 6

Page: 110

Rationale: Try to maintain a pulse oximeter reading of 95% or higher. However, do not withhold oxygen from a patient with a pulse oximeter reading above 95% who also shows signs and symptoms of hypoxia or difficulty breathing.

12. A

Objective: Chapter 16, Objective 1

Page: 296

Rationale: Hypoxemia is the most common cause of traumatic cardiopulmonary arrest. Acute airway obstruction or ineffective breathing will be clinically manifested as hypoxemia.

13. D

Objective: Chapter 8, Objective 7

Page: 162

Rationale: If you are not authorized to decompress the chest, the patient must be transported rapidly to the hospital so decompression can be performed.

14. A

Objective: Chapter 19, Objective 2

Page: 362

Rationale: Care providers must distinguish between signs and symptoms of a chronic disease and an acute problem. For example: A geriatric patient may have non-pathologic rales, or the loss of skin elasticity and the presence of mouth breathing may not necessarily represent dehydration or dependent edema.

15. B

Objective: Chapter 14, Objective 5

Page: 271

Rationale: Use a splint that will immobilize one joint above and one joint below the injury site.

16. B

Objective: Chapter 2, Objective 1

Page: 28

Rationale: When immediate interventions are needed, delegate them to your team members while you continue the assessment. This is an important concept that immediately addresses problems encountered and yet does not interrupt the assessment sequence and does not increase scene time. Teamwork is essential to good patient outcomes.

17. C

Objective: Chapter 17, Objective 6

Page: 315

Rationale: Intravenous (IV) line insertion is rarely needed on scene during initial care unless delay in transport to a hospital is unavoidable. It takes hours for burn shock to develop. Therefore, the only reason to initiate IV therapy on scene is if other factors indicate a need for fluid volume or medication administration.

18. D

Objective: Chapter 10, Objective 4

Page: 193

Rationale: Emergency Rescue is reserved for those situations in which there is immediate (within seconds) environmental threat to the life of the victim and/or emergency care responder. Patients should be moved to a safe area in a manner that places the emergency care responder at the least risk. Rapid extrication should be considered for patients whose medical conditions or situations require fast intervention (1 or 2 minutes— but not seconds) to prevent death.

19. B

Objective: Chapter 4, Objective 2

Page: 60

Rationale: Early shock is the loss of approximately 15% to 25% of blood volume. That is enough to stimulate slight to moderate tachycardia, pallor, narrowed pulse pressure, thirst, weakness, and possibly delayed capillary refill.

20. A

Objective: Chapter 16, Objective 3

Page: 295

Rationale: In a review of trauma patients who presented unconscious without palpable pulse or spontaneous respiration, patients with sinus rhythm and non-dilated (< 4 mm) reactive pupils had a good chance of survival.

21. C

Objective: Chapter 18, Objective 4

Page: 340

Rationale: Note whether the child is “working” to breathe, demonstrated by subcostal or suprasternal retractions, nasal flaring, or grunting. Look at the chest rise, listen for air going in and out, and feel the air coming out of the nose. If there is no movement, reposition the jaw to remove any anatomical obstruction. If you still do not sense any air exchange, you must breathe for the child. If you have any doubt that the child is breathing adequately on his or her own, immediately assist the child’s breathing.

22. B

Objective: Chapter 6, Objective 3

Page: 108

Rationale: A carbon dioxide level below 35 mmHg indicates hyperventilation.

23. B

Objective: Chapter 12, Objective 7

Page: 234

Rationale: Cerebral herniation syndrome is the only situation in which hyperventilation is still indicated. (You must ventilate every 3 seconds [20/minute] for adults, every 2.5 seconds [25/minute] for children older than one year, and every 2 seconds [30/minute] for infants younger than one year.) If you have waveform capnography, attempt to keep the ETCO₂ at about 30 to 35 mmHg.

24. B

Objective: Chapter 10, Objective 3

Page: 196

Rationale: Immobilization onto a long backboard is not indicated in penetrating wounds of the torso, neck, or head unless there is clinical evidence of a spine injury.

25. A

Objective: Chapter 2, Objective 5

Page: 24

Rationale: When you have completed the initial assessment and rapid trauma survey or focused exam, enough information is available to decide if a critical situation is present. Patients with critical trauma situations are transported immediately. Most treatment interventions will be done during transport.

26. C

Objective: Appendix A, Objective 3

Page: A-7

Rationale: Write a report of the incident as soon as possible. Blood tests (if any) to be done on the exposed emergency care provider depend on reports of testing of the source patient.

27. C

Objective: Chapter 2, Objective 2

Page: 33

Rationale: If the patient has an altered mental status, do a brief neurologic exam to identify possible increased intracranial pressure (ICP). This exam should include the pupils and Glasgow Coma Scale (GCS) score. All patients with altered mental status should have a finger-stick glucose test performed.

28. A

Objective: Chapter 4, Objective 4

Page: 62

Rationale: Hypovolemic shock victims usually have tachycardia, pallor, and flat neck veins. If you encounter a trauma patient with a fast heart rate, who is pale, with weak radial pulses and flat neck veins, this patient is probably bleeding from some injury, either internally or externally (or possibly both).

29. C

Objective: Chapter 6, Objective 2

Page: 103

Rationale: Always immediately clear blood and secretions. You also must be alert for sounds that indicate trouble. Remember: Noisy breathing is obstructed breathing.

30. B

Objective: Chapter 4, Objective 2

Page: 61

Rationale: During compensated shock, the body is still able to maintain perfusion by compensatory mechanisms and will present with weakness, pallor, tachycardia, diaphoresis, and tachypnea.

31. D

Objective: Chapter 19, Objective 3

Page: 365

Rationale: All elderly patients should have cardiac monitoring, pulse oximetry, and capnography, if available.

32. A

Objective: Chapter 18, Objective 4

Page: 349

Rationale: Changing level of consciousness is the best indicator of traumatic brain injury.

33. C

Objective: Chapter 12, Objective 2

Page: 245

Rationale: When the ICP increases, the systemic blood pressure increases to try to preserve blood flow to the brain. The body senses the rise in systemic blood pressure, and this triggers a drop in the pulse rate as the body tries to lower the systemic blood pressure.

34. A

Objective: Chapter 2, Objective 9

Page: 36

Rationale: If the ITLS Primary Survey does not reveal a critical condition, the ITLS Secondary Survey may be performed on scene.

35. A

Objective: Chapter 1, Objective 1

Page: 4

Rationale: It is a critical part of the trauma assessment and begins before you approach the patient. If you fail to perform the preliminary steps of scene size-up, you may jeopardize your safety as well as that of your partner and patient.

36. B

Objective: Chapter 12, Objective 7

Page: 234

Rationale: Cerebral herniation syndrome is the only situation in which hyperventilation is still indicated. (You must ventilate every 3 seconds [20/minute] for adults, every 2.5 seconds [25/minute] for children older than one year, and every 2 seconds [30/minute] for infants younger than one year.) If you have waveform capnography, attempt to keep the ETCO₂ at about 30 to 35 mmHg.

37. D

Objective: Chapter 12, Objective 5

Page: 239

Rationale: An altered mental status can be seen in every form of substance abuse. However, remember that an altered level of consciousness is always due to a head injury, shock, or hypoglycemia until proven otherwise. Also remember that all patients have an emergency medical condition until proven otherwise.

38. B

Objective: Chapter 8, Objective 8

Page: 165

Rationale: Identification of cardiac tamponade classically relies on the presence of hypotension with narrow pulse pressure and Beck’s triad, a combination of distended neck veins, muffled heart sounds, and hypotension.

39. D

Objective: Chapter 8, Objective 9

Page: 166

Rationale: The mechanism is blunt trauma to the anterior chest, as in a deceleration motor vehicle collision or a fall from a height. Bruising of the heart is basically the same injury as an acute myocardial infarction and likewise presents with chest pain, dysrhythmias, or cardiogenic shock (rare).

40. B

Objective: Chapter 4, Objective 5

Page: 63

Rationale: When direct pressure is unsuccessful, the recommendation is to immediately apply a tourniquet if control of bleeding is in a location where the tourniquet may be applied. If a tourniquet cannot be applied, a hemostatic dressing along with direct pressure should be utilized immediately. Pressure points are not effective in controlling hemorrhage.

41. A

Objective: Chapter 4, Objective 1

Page: 60

Rationale: It is important to remember that blood pressure requires a “steady state” activity of all the preceding factors. The heart must be pumping, the blood volume must be adequate, the blood vessels must be intact, and the lungs must be oxygenating the blood.

42. B

Objective: Chapter 6, Objective 4

Page: 104

Rationale: Oropharyngeal airways (OPAs) are designed to keep the tongue off the posterior pharyngeal wall and thereby help maintain a patent airway.

43. C

Objective: Chapter 2, Objective 5

Page: 34

Rationale: When you have completed the initial assessment and rapid trauma survey or focused exam, enough information is available to decide if a critical situation is present. Patients with critical trauma situations are transported immediately. Most treatment interventions will be done during transport.

44. A

Objective: Chapter 4, Objective 4

Page: 66

Rationale: The condition causing the vascular space to be too large for a normal amount of blood is called “shock,” or relative hypovolemia. Neurogenic shock, commonly called spinal shock, is a form of relative hypovolemia. The clinical presentation of neurogenic shock differs from hemorrhagic shock in that there is no catecholamine release and thus no pallor (vasoconstriction), tachycardia, or sweating. The patient will have a decreased blood pressure, but the heart rate will be normal or slow, and the skin is usually warm, dry, and pink.

45. D

Objective: Chapter 13, Objective 2

Page: 251

Rationale: Blunt trauma is the most common mechanism of abdominal injury and has relatively high mortality rates of 10% to 30%. The reason is likely related to the frequency of accompanying injuries to the head, chest, pelvis, and/or an extremity in as many as 70% of motor vehicle collision victims.

46. D

Objective: Chapter 8, Objective 8

Page: 165

Rationale: The major differential diagnosis in the field is tension pneumothorax. With cardiac tamponade, the patient will be in shock with equal breath sounds and a midline trachea, unless there is an associated pneumothorax or hemothorax.

47. C

Objective: Chapter 8, Objective 3

Page: 131

Rationale: A large flail segment is best managed through positive pressure intervention. Although oxygen administration is indicated it should be administered at 12-15 lpm.

48. A

Objective: Chapter 1, Objective 4

Page: 15

Rationale: The secondary blast injury is the result of the patient being struck by material (shrapnel) propelled by the blast force.

49. C

Objective: Chapter 18, Objective 4

Page: 340

Rationale: Note whether the child is “working” to breathe, demonstrated by subcostal or suprasternal retractions, nasal flaring, or grunting. If you have any doubt that the child is breathing adequately on his or her own, immediately assist the child’s breathing.

50. B

Objective: Chapter 4, Objective 4

Page: 68

Rationale: If cardiac output falls (either due to a slow or very fast heart rate, or lowered stroke volume), blood pressure will fall.