PALS

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Practice Questions

Try all 30 first, then check the answer key at the back.

1. A 3-year-old is brought in by a parent who reports the child has been 'breathing fast' since this morning. You observe the child sitting upright, looking at you, with audible stridor and mild intercostal retractions. His skin is pink and warm. Using the Pediatric Assessment Triangle (PAT), which component is primarily abnormal?

A. Circulation to skin only
B. Appearance and circulation to skin
C. Appearance only
D. Work of breathing only

2. The most common cause of cardiac arrest in pediatric patients is:

A. A blow to the chest
B. Congenital heart disease
C. Respiratory failure
D. Drowning

3. In the PALS systematic approach, after you perform the initial PAT and find an abnormality, your next step is to:

A. Call for advanced airway equipment and prepare for intubation
B. Immediately obtain IV access and draw labs
C. Perform a primary assessment (ABCDE) and identify the problem
D. Obtain a detailed history from the caregiver before touching the child

4. After stabilizing a patient in respiratory failure, the most important clinical goal is:

A. Identify and treat the disease that is causing the respiratory failure
B. Send the patient for a total-body MRI scan
C. Insert bilateral chest tubes to prevent pneumothorax
D. None of the above

5. A 7-year-old presents with rapid breathing, oxygen saturation of 91% on room air, nasal flaring, and subcostal retractions, but responds normally to her name and maintains her airway independently. Blood pressure is 98/62 mmHg. This clinical picture BEST represents:

A. Compensated shock with secondary respiratory compromise
B. Respiratory distress
C. Respiratory failure
D. Decompensated shock

6. Where should you check for a peripheral pulse?

A. Wrist (radial)
B. Foot (pedal)
C. Upper arm (brachial)
D. Neck (carotid)

7. A 5-year-old with a history of asthma is found barely responsive, with agonal breathing at 4 breaths/min, oxygen saturation unmeasurable by pulse oximetry, and cyanotic lips. Which category of respiratory dysfunction does this child demonstrate?

A. Respiratory distress
B. Respiratory failure
C. Upper airway obstruction without failure
D. Compensated respiratory compromise

8. Remembering which of the following acronyms will help you assess a child's mental status?

A. SAMPLE
B. ABCDE
C. BREATH
D. AVPU

9. An 18-month-old is tachycardic at 178 beats/min, has cool mottled extremities with a capillary refill of 4 seconds, and is irritable but responsive to voice. Blood pressure is 86/54 mmHg, which is within the lower-normal range for age. This presentation BEST fits:

A. Distributive shock with normal perfusion
B. Compensated shock
C. Respiratory failure with secondary cardiovascular compromise
D. Decompensated (hypotensive) shock

10. Which of the following drugs should you consider using to treat a child showing supraventricular tachycardia (SVT)?

A. Adenosine
B. Vasopressin
C. Lidocaine
D. Bretylium

11. A 4-year-old involved in a motor vehicle crash arrives with tachycardia of 160 beats/min, blood pressure of 62/40 mmHg, mottled and pale skin, capillary refill of 5 seconds, and a Glasgow Coma Scale score of 10. Which best describes this child's condition?

A. Neurogenic shock with normal blood pressure
B. Distributive shock in a compensated state
C. Compensated hypovolemic shock
D. Decompensated shock

12. After establishing an advanced airway (i.e. endotracheal tube, etc.), there is no need to provide CPR in cycles. CPR should continue at 100 compressions/minute with 8-10 ventilations provided.

A. True
B. False

13. A 6-year-old presents with a heart rate of 170 beats/min and a blood pressure of 84/50 mmHg. He is lethargic but arousable. Capillary refill is 3 seconds centrally. His skin is warm and flushed with bounding peripheral pulses. Lungs are clear. Which type of shock MOST likely explains his findings?

A. Hypovolemic shock — cold and clamped
B. Distributive (septic/vasodilatory) shock — warm and vasodilated
C. Cardiogenic shock — wet and cold
D. Obstructive shock — distended neck veins

14. Which of the following arrhythmias are/or may be life threatening for pediatric patients?

A. Ventricular tachycardia
B. Torsades de pointes
C. Ventricular fibrillation
D. All of the above

15. During the PAT of a 2-year-old, you note she has a weak cry but keeps her eyes fixed on her mother and does not explore her environment. Breathing is quiet with no abnormal sounds. Skin appears pale at the nail beds but pink centrally. How would you classify the PAT findings?

A. Work of breathing and circulation abnormal; appearance normal
B. Appearance and circulation to skin abnormal; work of breathing normal
C. Appearance abnormal; work of breathing and circulation normal
D. All three PAT components are normal

16. If treating a 10-kg infant with oxygen refractory unstable bradycardia, how much epinephrine should be administered?

A. 1.0 ml of 1:1,000 solution
B. 1.0 ml of 1:10,000 solution
C. 10 ml of 1:1,000 solution
D. 10 ml of 1:10,000 solution

17. Which mnemonic is used in PALS to quickly evaluate the five domains of pediatric appearance during the PAT?

A. SAMPLE
B. AVPU
C. OPQRST
D. TICLS

18. Pediatric patients who develop 'unstable' supraventricular or ventricular tachycardia should immediately receive electrical cardioversion.

A. True
B. False

19. A 10-year-old with known congenital heart disease presents with severe respiratory distress, oxygen saturation of 84% despite 15 L/min non-rebreather mask, frothy pink sputum, and diffuse crackles bilaterally. His heart rate is 140 beats/min and blood pressure is 80/60 mmHg. Which PAT pattern does this child display?

A. Abnormal appearance and work of breathing only — respiratory failure
B. Abnormal circulation to skin only — decompensated shock without respiratory involvement
C. Abnormal work of breathing and circulation to skin — likely cardiopulmonary failure
D. All three PAT components normal — stable patient

20. A young trauma patient is brought into your emergency department, barely responsive, pale, with an 8 second capillary refill. The abdomen is distended and rigid. Stat hemoglobin comes back 5.1 gm. What would be the ideal fluid to treat this patient's hypovolemic shock?

A. 5% dextrose and water
B. 10% dextrose and water
C. Lactated Ringers solution
D. Whole blood or packed cells

21. You are assessing a 9-month-old with bronchiolitis. The PAT reveals: irritable but consolable when held, audible wheezing with subcostal and intercostal retractions, and pink skin with 2-second capillary refill. SpO2 is 93%. After your primary ABCDE assessment confirms patent airway, bilateral wheezing, and no hemodynamic instability, what is the MOST appropriate immediate identification?

A. Distributive shock with secondary work of breathing increase
B. Upper airway obstruction causing respiratory failure
C. Compensated obstructive shock
D. Lower airway obstruction causing respiratory distress

22. Two providers are giving high-quality CPR to an unresponsive, pulseless 2-year-old. Which actions demonstrate high-quality CPR?

A. Chest compressions about 1 inch deep, no recoil, 30:2 ratio
B. 5-second ventilations with compressions 120-140/min
C. Rescue breathing only because two rescuers are present
D. Chest compressions about 2 inches deep with full recoil and a 15:2 ratio, 1-second breaths

23. A 3-year-old presents after a near-drowning event. He is unconscious and apneic, with central cyanosis and no detectable pulse. His skin is cold and mottled diffusely. Applying the PAT rapidly, you identify abnormalities in all three components. What is the IMMEDIATE clinical implication of this three-component PAT failure?

A. The child is in cardiopulmonary arrest requiring CPR and activation of the full arrest algorithm
B. The child is likely in compensated shock requiring a 20 mL/kg fluid bolus
C. The child requires supplemental oxygen and close observation only
D. The child has respiratory distress that may self-resolve with positioning

24. To help manage increased intracranial pressure in a pediatric patient, the head should be:

A. Turned 45 degrees to one side
B. Midline with a 30 degree elevation
C. Flat with neck flexed
D. Trendelenburg position

25. A febrile 8-year-old presents with tachycardia of 155 beats/min and a blood pressure of 78/46 mmHg. A trauma nurse reports capillary refill of 5 seconds and the child mumbles only to painful stimulation. The resident wants to give a 10 mL/kg isotonic fluid bolus and reassess in 30 minutes. What is wrong with this plan according to PALS principles?

A. The child has decompensated shock and requires immediate aggressive intervention, not a delayed reassessment
B. The child should receive a 5 mL/kg colloid bolus instead of isotonic crystalloid
C. Fluid should be withheld until echocardiography rules out cardiogenic etiology
D. The blood pressure is normal for age so no fluid is required

26. A 3-month-old with fever, grunting and a wet 'junky' cough tests RSV-positive. What is the likely diagnosis?

A. Pneumonia
B. Asthma
C. Bronchiolitis
D. Croup

27. When comparing respiratory distress with respiratory failure in a pediatric patient, which finding most reliably indicates the transition from distress to failure?

A. Respiratory rate increasing from 24 to 32 breaths/min
B. Oxygen saturation dropping from 98% to 95%
C. Decreased level of consciousness with poor muscle tone and inadequate respiratory effort
D. Appearance of mild nasal flaring in a previously quiet child

28. In any type of shock, the primary goal is to balance tissue perfusion with metabolic demand by focusing on:

A. Blood glucose control
B. Electrolyte replacement
C. Temperature regulation
D. Oxygen delivery versus oxygen demand

29. A 5-year-old with severe sepsis has a heart rate of 165 beats/min, a systolic blood pressure of 75 mmHg, and capillary refill of 6 seconds. The team initiates the evaluate-identify-intervene loop. After identifying decompensated septic shock, what is the CORRECT next action according to PALS?

A. Complete the secondary assessment with a full SAMPLE history before any treatment
B. Intervene with fluid resuscitation and vascular access, then reassess (re-enter the evaluation loop)
C. Transfer to the ICU and defer treatment to the intensivist
D. Await blood culture results before starting antibiotics or fluids to avoid masking the source

30. A PALS team is preparing to defibrillate a child in cardiac arrest. For which rhythm(s) is defibrillation appropriate?

A. Asystole
B. Sinus bradycardia
C. Ventricular fibrillation and pulseless ventricular tachycardia
D. Pulseless electrical activity

Answer Key & Explanations

1. D — Work of breathing only
The PAT assesses Appearance, Work of Breathing, and Circulation to skin; stridor and intercostal retractions indicate abnormal work of breathing, while the child's alertness and pink skin indicate normal appearance and circulation.

2. C — Respiratory failure
Respiratory failure is the most common cause of cardiac arrest in children. If intervention is not done early and aggressively, the outcome is usually very poor.

3. C — Perform a primary assessment (ABCDE) and identify the problem
The PALS evaluate-identify-intervene loop directs the provider to follow the initial PAT with a hands-on primary (ABCDE) assessment to identify the type and severity of physiologic derangement before choosing an intervention.

4. A — Identify and treat the disease that is causing the respiratory failure
Determining the underlying cause and beginning aggressive treatment is essential, as mechanical ventilation alone won't address conditions like bacterial pneumonia.

5. B — Respiratory distress
Respiratory distress is characterized by increased work of breathing (flaring, retractions), mild hypoxia, and preserved mental status and airway control; respiratory failure requires signs of inadequate gas exchange such as markedly altered mentation, apnea, or severe hypoxia that exceeds the child's compensatory effort.

6. C — Upper arm (brachial)
The brachial artery is a major blood vessel located in the upper arm and is the recommended site for pulse check in infants per PALS guidelines.

7. B — Respiratory failure
Respiratory failure is identified when the child's breathing effort is insufficient to maintain adequate oxygenation and ventilation, evidenced here by near-apneic rate, unmeasurable SpO2, cyanosis, and markedly decreased level of consciousness.

8. D — AVPU
AVPU (Alert, Voice, Pain, Unresponsive) is used to assess a child's mental status.

9. B — Compensated shock
Compensated shock describes a state in which compensatory mechanisms (tachycardia, vasoconstriction) maintain blood pressure within an acceptable range despite signs of poor peripheral perfusion such as cool extremities, prolonged capillary refill, and tachycardia.

10. A — Adenosine
Pediatric patients should be given adenosine for the treatment of SVT. The first recommended dose is 0.1

mg/kg up to a maximum of 6 mg; the second is 0.2 mg/kg up to a maximum of 12 mg.

11. D — Decompensated shock
Decompensated shock is present when compensatory mechanisms fail and blood pressure falls below the fifth percentile for age, accompanied by signs of severely impaired perfusion; a systolic BP of 62 mmHg is clearly hypotensive for a 4-year-old (normal lower limit approximately 70 + 2× age = 78 mmHg).

12. A — True
After an advanced airway is in place, CPR should continue continuously (no cycles) with ventilations provided independently of compressions at approximately 10 breaths per minute.

13. B — Distributive (septic/vasodilatory) shock — warm and vasodilated
Distributive shock (early septic shock is the classic pediatric example) produces warm, flushed skin with bounding pulses and widened pulse pressure due to pathologic vasodilation, distinguishing it from the cold, clamped extremities seen in hypovolemic or cardiogenic shock.

14. D — All of the above
All three arrhythmias listed are/can be life threatening if left untreated.

15. B — Appearance and circulation to skin abnormal; work of breathing normal
A weak cry and failure to interact with the environment indicate abnormal appearance (tone/interactivity), and peripheral pallor reflects abnormal circulation to skin; absent increased work of breathing means that component is normal, pointing toward a circulatory or neurological rather than respiratory etiology.

16. B — 1.0 ml of 1:10,000 solution
The recommended dose of epinephrine is 0.1 ml/kg of the 1:10,000 solution (0.01 mg/kg). For a 10-kg infant: 0.1 ml/kg × 10 kg = 1.0 ml of the 1:10,000 solution.

17. D — TICLS
TICLS (Tone, Interactivity, Consolability, Look/gaze, Speech/cry) is the AHA-endorsed mnemonic for assessing the Appearance component of the Pediatric Assessment Triangle.

18. A — True
When arrhythmia reduces cardiac output with signs of shock, immediate cardioversion prevents progression to cardiac arrest.

19. C — Abnormal work of breathing and circulation to skin — likely cardiopulmonary failure
The simultaneous presence of severe increased work of breathing (frothy sputum, crackles, refractory hypoxia) and signs of poor perfusion (low BP, pale or mottled skin) indicates abnormality in both work of breathing and circulation to skin, reflecting combined cardiopulmonary failure — a finding that mandates the most aggressive intervention.

20. D — Whole blood or packed cells
Red blood cells carrying oxygen to tissues are essential for hemorrhage replenishment. In hemorrhagic shock with severe anemia, blood products are the preferred resuscitation fluid.

21. D — Lower airway obstruction causing respiratory distress
Bronchiolitis produces lower airway obstruction; the clinical picture — wheezing, retractions, mild hypoxia with preserved mentation and normal perfusion — classifies this as lower airway obstruction in the respiratory distress category, not failure, because compensatory effort is still maintaining adequate (though mildly

reduced) oxygenation.

22. D — Chest compressions about 2 inches deep with full recoil and a 15:2 ratio, 1-second breaths
For 2-rescuer child CPR, PALS recommends 15:2 compression-to-ventilation ratio, approximately 2 inches compression depth, full chest recoil, and 1-second rescue breaths.

23. A — The child is in cardiopulmonary arrest requiring CPR and activation of the full arrest algorithm
When all three PAT components are simultaneously abnormal — appearance (unconscious), work of breathing (apneic), and circulation (cyanotic, pulseless, cold) — the child is in cardiopulmonary arrest, mandating immediate CPR initiation and activation of the pediatric cardiac arrest algorithm.

24. B — Midline with a 30 degree elevation
Head positioning midline with 30-degree head-of-bed elevation helps promote venous drainage and reduce intracranial pressure.

25. A — The child has decompensated shock and requires immediate aggressive intervention, not a delayed reassessment
A blood pressure of 78 mmHg systolic is below the fifth-percentile threshold for an 8-year-old (approximately 86 mmHg), altered mental status indicates end-organ dysfunction, and this constellation defines decompensated shock requiring immediate escalating intervention — not a 30-minute observation window.

26. C — Bronchiolitis
RSV-positive with a wet cough and grunting in a young infant is classic for bronchiolitis, the most common lower respiratory tract infection in infants.

27. C — Decreased level of consciousness with poor muscle tone and inadequate respiratory effort
The hallmark that distinguishes respiratory failure from distress is decompensation of the central nervous system and/or respiratory mechanics — manifested as declining consciousness, hypotonia, and inadequate effort — because it signals the child can no longer maintain compensatory drive to sustain oxygenation and ventilation.

28. D — Oxygen delivery versus oxygen demand
The primary goal in all types of shock is to optimize oxygen delivery to meet metabolic demand and prevent end-organ injury.

29. B — Intervene with fluid resuscitation and vascular access, then reassess (re-enter the evaluation loop)
The PALS evaluate-identify-intervene loop is iterative: once decompensated shock is identified the provider intervenes immediately (vascular access, fluid bolus, antibiotics) and then re-enters the evaluation loop to assess response, not waits for secondary data before acting.

30. C — Ventricular fibrillation and pulseless ventricular tachycardia
Defibrillation is indicated only for shockable rhythms: ventricular fibrillation (VF) and pulseless ventricular tachycardia (pVT). Asystole and PEA are non-shockable rhythms.

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