Nursing

AMET

Advanced Emergency Medical Technician (AMET)

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Product Version

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2. **Questions and Answers in PDF Format.**

Latest Version: 6.0

Question: 1

You are assessing a 58-year-old male complaining of sudden onset "tearing" back pain radiating to his abdomen. He appears pale and diaphoretic. Initial BP is 200/110 mmHg in the right arm. Radial pulses are strong and equal bilaterally. Lung sounds are clear. As you prepare for transport, you reassess BP and find it is now 170/100 mmHg in the right arm and 140/90 mmHg in the left arm. What Complication does this finding *most strongly* suggest?

A. Developing tension pneumothorax.
B. Aortic dissection-
C. Acute heart failure.
D. Worsening hypertensive urgency.

Answer: B

Explanation:
The scenario presents classic signs of aortic dissection: sudden tearing bacWabdominal pain, diaphoresis, pallor, and hypertension- The critical discriminating cue is the newly identified significant inter-arm systolic BP difference (>20 mmHg — 170 vs 140 mmHg). This asymmetry strongly suggests dissection involving the aortic arch vessels, compromising blood flow to one subclavian artery. Tension pneumothorax (A) typically causes unilateral absent breath sounds, tracheal deviation, and hypotension, not BP asymmetry Acute heart failure (C) usually presents with respiratory distress and crackles. Hypertensive urgency (D) wouldn't cause an inter-arm BP difference- The combination of pain description and BP asymmetry makes aortic dissection (B) the most likely and critical complication requiring immediate recognition and rapid transport.

Question: 2

You find an unresponsive 22-year-old male in a park with shallow respirations (R 6), pinpoint pupils, and cyanotic lips. Bystanders state he was "snorting pills." A used needle is nearby. Vital signs: BP 86/50, P 52, Sp02 84%. After initiating BVM ventilation, which medication is critical?

A. Administer 15 g oral glucose gel
B. Administer 325 mg chewable aspirin
C. Administer 4 mg naloxone intranasally
D. Administer 0.5 mg intramuscular epinephrine

Answer: C

Explanation:
Naloxone is the opioid antagonist indicated for respiratory depression, pinpoint pupils, and overdose history Glucose (A) risks aspiration in unresponsive patients and ignores opioid toxidrome. Aspirin (B) is

for cardiac ischemia, not overdose. Epinephrine (D) may be needed for shock but doesn't reverse opioid CNS depression; naloxone addresses the primary life threat

Question: 3

A patient presents with bilateral pitting pedal edema extending to the mid-shin. Which associated assessment finding would *most specifically* indicate this edema is likely due to acute decompensated heart failure (ADHF) rather than chronic venous insufficiency?

A. Presence of varicose veins
B. Warmth and erythema over the edematous area
C. Sudden onset of dyspnea and orthopnea
D. Unilateral swelling and calf tenderness

Answer: C

Explanation:
Bilateral pitting pedal edema is common in both chronic venous insufficiency and ADHE However, the acute onset of dyspnea (difficulty breathing) and orthopnea (difficulty breathing lying fiat) are hallmark signs of pulmonary congestion resulting from left ventricular failure in ADHF, directly linking the edema to cardiac decompensation. Option A (Varicose veins) is characteristic of chronic venous insufficiency, not a new indicator of ADHE Option B (Warmth and erythema) suggests cellulitis or DVT, not typical for isolated ADHF-related edema. Option D (Unilateral swelling and tenderness) strongly indicates deep vein thrombosis (DVT), not the bilateral presentation typical of ADHF. The respiratory symptoms provide the critical cardiac link.

Question: 4

You are treating a 32-year-old male found unresponsive in his bedroom by his roommate. The roommate states the patient has a history of heroin use. On assessment, the patient is unresponsive to painful stimuli. His respiratory rate is 6 breaths per minute, shallow, and you note paradoxical abdominal movement. His Sp02 is 89% on room air. His skin is cool, pale, and cyanotic around the lips. What is the most immediate* intervention required?

A. Administer high-flow oxygen via non-rebreather mask at 15 LPM_
B. Insert a nasopharyngeal airway and begin bag-valve-mask (BVM) ventilation with supplemental oxygen.
C. Administer 2 mg intranasal naloxone.
D. Position the patient supine and apply a cervical collar

Answer: B

Explanation:
The patient exhibits inadequate ventilation (RR 6/min, shallow, paradoxical breathing) leading to hypoxia (Sp02 89%, cyanosis) and unresponsiveness, strongly suggesting opioid-induced respiratory depression. The immediate threat is inadequate ventilation, not just oxygenation_ While naloxone (C) is

indicated for reversal, correcting hypoxia via positive pressure ventilation (B) takes absolute priority to prevent cardiac arrest. High-flow oxygen alone (A) is insufficient as the patient cannot move air effectively. Cervical immobilization (D) is unnecessary without trauma mechanism and delays essential ventilatory support. BVM addresses the core problem of hypoventilation immediately.

Question: 5

During the initial management of a conscious adult patient reporting acute sexual assault, what is the Advanced EMT's *primary* responsibility regarding potential evidence?

A. Instruct the patient not to bathe, urinate, or change clothes.
B. Collect any visible foreign materials from the patient's clothing or skin.
C. Cut around (not through) any defects in the patient's clothing for preservation.
D. Place all patient belongings in a single paper bag for law enforcement.

Answer: A

Explanation:
Preserving potential biological evidence (semen, saliva, hair) is paramount Instructing the patient to avoid bathing, urinating, or changing clothes minimizes contamination or loss of critical forensic material before a specialized Sexual Assault Forensic Exam (SAFE). Option B risks contamination; evidence collection requires trained personnel with specific kits. Option C is incorrect; clothing should be removed intact without cutting through existing holes/tears, ideally by the patient. Option D risks cross-contamination; items must be packaged separately in paper (not plastic) bags- The correct answer focuses on non-invasive actions within the AEMT scope that maximally preserve evidence integrity without compromising the forensic chain of custody, unlike actions involving handling evidence (B, C, D).

Question: 6

You are assisting with the delivery of a newborn in the emergency department. The amniotic fluid is meconium-stained, and the infant is apneic and floppy. The mother is known to be HIV-positive and her viral load status is unknown. As you prepare to perform neonatal resuscitation, what is the *critical* Standard Precautions-related action regarding airway management?

A. Immediately perform endotracheal intubation without suctioning to minimize aerosol generation near the infant's face.
B. Suction the hypopharynx under direct visualization *before* any positive pressure ventilation is initiated, using a meconium aspirator attached to wall suction.
C. Avoid any airway suctioning and initiate bag-mask ventilation with a HEPA filter immediately due to the HIV risk.
D. Defer airway management to a physician due to the high infectious risk and complexity-

Answer: B

Explanation:

Standard Precautions require barrier protection (gloves, gown, eye protection) for all contact with bodily fluids, including meconium. The immediate priority for a non- vigorous, meconium-stained infant is to suction the airway *before* positive pressure ventilation (PPV) to prevent meconium aspiration. Using a meconium aspirator attached to wall suction effectively contains the contaminated material, protecting both the provider and the environment. Option A risks forcing meconium deeper into the lungs by initiating PPV first. Option C neglects the critical need to clear the meconium-obstructed airway for effective resuscitation. Option D is incorrect; airway management, including suctioning, is within the AEMT scope, and delaying care for this life-threatening condition is unacceptable. HIV status necessitates strict Standard Precautions but doesn't alter the fundamental airway management sequence.

Question: 7

68-year-old male with severe COPD is in respiratory distress. His Sp02 is 82% on room air, respiratory rate is 28/min with shallow effort, and he is lethargic. A family member states he ran out of his home oxygen. Applying high-flow oxygen via non-rebreather mask apidly improves his Sp02 to 98%, but his respiratory rate decreases to 8/min. What is the *most appropriate* next action?

A. Reduce oxygen to a nasal cannula at 2 LPM to avoid suppressing his respiratory drive.
B. Continue high-flow oxygen and prepare for assisted ventilation.
C. Administer naloxone in case of accidental opioid overdose.
D. Switch to a simple face mask at 10 LPM for improved comfort.

Answer: B

Explanation:
Hypoxemia is the primary threat in COPD exacerbations; the myth of "hypoxic drive suppression" is outdated and dangerous. The decreased respiratory rate after oxygen administration indicates fatigue and CO2 retention, not oxygen-induced hwyventilation. Reducing oxygen (A) risks profound hypoxia Naloxone (C) is inappropriate without opioid exposure evidence. A simple face mask (D) delivers lower FiO2 than a non-rebreather. The correct action is to maintain adequate oxygenation while preparing for ventilatory support (B) due to signs of respiratory failure (lethargy, shallow breaths, decreased RR post-oxygen)- Cues: lethargy, shallow respirations, and decreased RR after O2 signal inadequate ventilation.

Question: 8

You respond to a known opioid user found unresponsive with snoring respirations. His respiratory rate is 6/min and shallow, pulse oximetry is 85% on room air, and he has pinpoint pupils. A naloxone auto-injector is available per protocol. After positioning the patient supine, what is the next most appropriate airway management step?

A. Insert an oropharyngeal airway (OPA) and begin bag-mask ventilation (BMV)
B. Administer intramuscular naloxone immediately.
C. Apply high-flow oxygen via non-rebreather mask.
D. Suction the oropharynx thoroughly-

Answer: A

Explanation:
The patient has clear signs of respiratory failure (RR 6/min, Sp02 85%, snoring) due to suspected opioid overdose. The immediate threat is hypoxia. While naloxone (B) is indicated, securing the airway and supporting ventilation takes precedence over medication administration to reverse the cause. An OPA is essential to relieve the soft tissue obstruction causing snoring and facilitate effective BMV (A). Oxygen alone (C) is insufficient for inadequate respiratory effort. Suctioning (D) is only indicated if secretions or vomitus are present, which isn't descriEEd here. BMV with an adjunct (A) directly addresses the inadequate ventilation and hypoxia, buying time for naloxone to take effect.

Question: 9

Which situation most clearly triggers a *mandatory* reporting obligation for an Advanced EMT under standard EMS protocols and legal statutes?

A. Suspected misuse of prescription medication by a competent adult patient.
B. An injury pattern consistent with intimate partner violence disclosed by an alert adult.
C. Observable signs of suspected child abuse or neglect during a home response.
D. A patient's refusal of care against medical advice for a non-life-threatening condition.

Answer: C

Explanation:
Mandatory reporting laws universally require healthcare providers, including AEMTs, to report *suspected* child abuse or neglect to designated authorities (e.g., child protective services). Option C directly aligns with this obligation- Option A involves potential illegal activity but typically lacks a specific mandatory reporting duty for EMS outside specific contexts (e.g., controlled substance diversion programs, not general patient care). Option B (intimate partner violence) often involves complex consent and safety considerations; reporting mandates for adults vary significantly by jurisdiction and usually aren't absolute without patient consent or court orders, unlike child abuse. Option D involves patient autonomy; refusal of care by a competent adult is generally legally binding and does not trigger mandatory reporting.

Question: 10

ECG tracing shows irregular, low-amplitude waveforms mimicking atrial fibrillation, but only during patient movement. The baseline shifts slowly between these episodes. Which artifact type *best* explains this finding?

A. 60-cycle interference
B. Loose electrode contact
C. Somatic tremor
D. Wandering baseline

Answer: C

Explanation:
Somatic tremor artifact presents as irregular, low-amplitude waveforms resembling atrial fibrillation, triggered specifically by muscle movement (e.g., shivering or Parkinsonism). The slow baseline shifts between episodes further indicate intermittent muscle activity. Option A (60-cycle) shows uniform, high-frequency spikes unaffected by movement. Option B (loose electrode) causes abrupt, erratic signal loss without rhythmic waveforms. Option D (wandering baseline) involves slow, undulating baseline drift due to respiration or poor adhesion but lacks the fine fibrillation-like waveforms. Distinguishing somatic tremor prevents misdiagnosis of arrhythmias and unnecessary interventions.

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