ACCS GENERAL CRITICAL CARE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Table of Contents

Copyright 1

Table of Contents 2

Introduction 3

How to Use This Guide 4

Questions 5

Answers 8

Explanations 10

Next Steps 16

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. What is the first-line agent in the initial management of status epilepticus?

A. Phenytoin

B. Valproate

C. Lorazepam

D. Midazolam

2. A chest tube must be clamped for how long to be discontinued?

A. 12 hours

B. 24 hours

C. 48 hours

D. 72 hours

3. Which sign indicates that wall suction is adequately set for suction control in a chest drainage system?

A. Continuous bubbling in the suction control bottle

B. Bubbling in the water-seal chamber

C. No bubbling anywhere

D. Visible bubbling in both chambers

4. During an acute coronary event, what intervention is identified as most beneficial for protecting heart tissue?

A. Therapeutic hypothermia protocol

B. Prolonged bed rest

C. Sleep medication

D. Liver-strengthening regimen

5. Which statement best characterizes septic shock pathophysiology and its initial management?

A. Septic shock is hypovolemic; management focuses on plasma expansion with blood products.

B. Septic shock is distributive shock due to infection causing systemic vasodilation, capillary leak, and myocardial dysfunction with tissue hypoperfusion. Initial management includes early broad-spectrum antibiotics, source control, 30 mL/kg crystalloid resuscitation, norepinephrine to maintain MAP ≥65 mmHg, and ongoing lactate/perfusion monitoring.

C. Septic shock is cardiogenic shock from myocardial infarction; treat with inotropes only.

D. Septic shock is obstructive; relieve obstruction before antibiotics.

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6. Which approach is cited as the most helpful in preserving cardiac tissue when a patient has had a recent heart attack or is currently having one?

A. Therapeutic hypothermia protocol

B. Conventional antibiotic therapy for unrelated infections

C. Sun exposure

D. Taking a multivitamin only

7. If the end-tidal CO2 (PetCO2) is more than 10 mmHg below the arterial PaCO2, what condition is most likely?

A. Deadspace ventilation/pulmonary embolism

B. Hyperventilation syndrome

C. Pulmonary edema

D. Hypoventilation

8. Which combination of treatments is described as part of the management for fulminating pulmonary edema?

A. Diuretic, 100% Oxygen, and Positive Pressure Ventilation

B. Atropine, Epinephrine, and Digoxin

C. Diuretic only

D. Digitalis, Diuretic, and Beta-blocker

9. Which drug is used to treat anti-cholinergic crisis according to the material?

A. Atropine

B. Physostigmine

C. Naloxone

D. Diphenhydramine

10. Which parameter is most directly associated with risk of volutrauma during mechanical ventilation?

A. Peak inspiratory pressure

B. Plateau pressure

C. PEEP

D. Tidal volume

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Answers

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1. C
2. B
3. A
4. A
5. B
6. A
7. A
8. A
9. A
10. B

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Explanations

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1. What is the first-line agent in the initial management of status epilepticus?

A. Phenytoin

B. Valproate

C. Lorazepam

D. Midazolam

In status epilepticus, the priority is rapid seizure termination, and benzodiazepines provide the quickest, most reliable way to achieve this by enhancing GABA-A receptor–mediated inhibition. Among benzodiazepines, lorazepam given IV is preferred as the first-line option because it has a rapid onset and a relatively longer anticonvulsant effect, which helps prevent early recurrence while arranging subsequent therapy. If IV access isn't immediately available, alternatives like intramuscular midazolam can be used, but lorazepam remains the standard initial choice when IV administration is possible. Phenytoin and valproate are important later-line agents to prevent recurrence after the initial stop, not the immediate first-step.

2. A chest tube must be clamped for how long to be discontinued?

A. 12 hours

B. 24 hours

C. 48 hours

D. 72 hours

Testing whether the pleural space remains stable after removal is the key idea. When a chest tube is clamped before discontinuation, you temporarily halt drainage to see if air or fluid will reaccumulate once the tube is out. The typical clamping duration is about 24 hours because this window allows detection of delayed recurrence of pneumothorax or fluid collection. During this period, monitor the patient for signs of breathing trouble, check the drainage system for ongoing air leaks, and obtain imaging (often a chest X-ray) to confirm the lung remains expanded and there is no reaccumulation. If the patient stays stable, the lung stays inflated, and imaging shows no issue, the chest tube can be removed. If an air leak or reaccumulation occurs, or the patient becomes symptomatic, the tube should not be removed and further assessment or intervention is needed.

3. Which sign indicates that wall suction is adequately set for suction control in a chest drainage system?

A. Continuous bubbling in the suction control bottle

B. Bubbling in the water-seal chamber

C. No bubbling anywhere

D. Visible bubbling in both chambers

The sign being tested is the presence of continuous bubbling in the suction control bottle. In a chest drainage system with a water-filled suction control chamber, wall suction pulls air through that water column. Steady, continuous bubbling shows that suction is being transmitted to the drainage system and that the set negative pressure is being achieved. If there is no bubbling in the suction control chamber, suction may not be reaching the system due to a kink, block, or misconnection, so the suction control isn't adequately set. Bubbling in the water-seal chamber reflects air movement from the patient or a leak and is not used to verify the suction control setting. Intermittent bubbling with breathing is expected in the seal chamber, but not a reliable indicator of suction control. Visible bubbling in both chambers would suggest an abnormal situation or fault, not the correct sign of proper suction control.

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4. During an acute coronary event, what intervention is identified as most beneficial for protecting heart tissue?

A. Therapeutic hypothermia protocol

B. Prolonged bed rest

C. Sleep medication

D. Liver-strengthening regimen

Protecting heart tissue during ischemia hinges on ways to blunt the injury that occurs when blood flow is limited. Therapeutic cooling lowers the heart's metabolic demands and slows many injury pathways at the cellular level. By reducing metabolic rate, it decreases calcium overload, inflammation, and the production of harmful free radicals, which can all contribute to evolving damage when blood supply is restored or limited. When used as part of a controlled protocol, humidity and temperature management can help preserve viable myocardium by limiting how aggressively cells burn through their energy stores during the ischemic period. In this set of options, cooling stands out as a direct method to shield tissue, whereas other choices do not address the ischemic-protection goal. Prolonged bed rest doesn't provide a mechanism to protect myocardial tissue during an acute event and can lead to deconditioning and other risks. Sleep medications don't specifically protect the heart from ischemic injury, and a liver-strengthening regimen isn't relevant to the acute protection of cardiac tissue.

5. Which statement best characterizes septic shock pathophysiology and its initial management?

A. Septic shock is hypovolemic; management focuses on plasma expansion with blood products.

B. Septic shock is distributive shock due to infection causing systemic vasodilation, capillary leak, and myocardial dysfunction with tissue hypoperfusion. Initial management includes early broad-spectrum antibiotics, source control, 30 mL/kg crystalloid resuscitation, norepinephrine to maintain MAP ≥65 mmHg, and ongoing lactate/perfusion monitoring.

C. Septic shock is cardiogenic shock from myocardial infarction; treat with inotropes only.

D. Septic shock is obstructive; relieve obstruction before antibiotics.

Septic shock is a distributive form of shock from infection, causing systemic vasodilation, capillary leak, and often some myocardial dysfunction that leads to tissue hypoperfusion despite circulating volume. The best initial management aims to rapidly restore perfusion and control the infection. Start broad-spectrum antibiotics early and identify and control the source. Aggressive fluid resuscitation with crystalloid solutions is given promptly, about 30 mL/kg in the initial resuscitation window, to support intravascular volume and perfusion. If the patient remains hypotensive after adequate fluids, initiate a vasopressor—norepinephrine is the recommended first choice—to keep mean arterial pressure at least 65 mmHg. Throughout this process, monitor lactate and other perfusion indicators to assess response and adjust therapy accordingly. This integrated approach—antibiotics, source control, timely crystalloid resuscitation, vasopressor support, and ongoing perfusion monitoring—fits septic shock best. Other options misclassify the problem or misstate management. Thinking septic shock as purely hypovolemic and treating with plasma products isn't accurate; septic shock commonly requires crystalloids first and antibiotics, with blood products reserved for specific hemorrhagic cases. Treating it as cardiogenic and relying on inotropes alone ignores the infection-driven vasodilation and the need for source control. Labeling it as obstructive and focusing solely on relieving an obstruction also doesn't reflect the typical initial priorities, which center on rapid infection control and hemodynamic stabilization.

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6. Which approach is cited as the most helpful in preserving cardiac tissue when a patient has had a recent heart attack or is currently having one?

A. Therapeutic hypothermia protocol

B. Conventional antibiotic therapy for unrelated infections

C. Sun exposure

D. Taking a multivitamin only

When heart tissue is starved of oxygen during a heart attack, saving as much muscle as possible depends on lowering the heart's oxygen demand and blunting the injury that occurs when blood flow returns. Therapeutic hypothermia, or targeted temperature management, cools the body to a level that slows cellular metabolism. This reduced metabolic rate means the heart muscle requires less oxygen, which helps limit cell death during ongoing ischemia and diminishes the damage that can happen when blood supply is restored. Cooling also dampens inflammatory responses and reduces the formation of damaging free radicals that contribute to reperfusion injury. Because of these protective effects on myocardial viability, this approach is cited as the most helpful in preserving cardiac tissue in the setting of a recent heart attack or active ischemia. The other options don't address the acute ischemic injury: antibiotics help infections unrelated to the heart attack, sun exposure offers no protective mechanism, and a multivitamin provides no immediate tissue-preserving effect in this context.

7. If the end-tidal CO2 (PetCO2) is more than 10 mmHg below the arterial PaCO2, what condition is most likely?

A. Deadspace ventilation/pulmonary embolism

B. Hyperventilation syndrome

C. Pulmonary edema

D. Hypoventilation

The important idea is the relationship between end-tidal CO2 and arterial CO2 as a window into ventilation–perfusion balance. In a healthy lung, the end-tidal CO2 (PetCO2) closely reflects the arterial CO2 (PaCO2), so the difference is small. When PetCO2 is markedly lower than PaCO2—more than about 10 mmHg—the system has a large amount of dead space ventilation, meaning ventilated areas of the lung are not being perfused and thus not contributing CO2 back to the blood. Pulmonary embolism best fits this pattern. A clot blocks blood flow to portions of the lung that are ventilated, creating alveolar dead space. CO2-rich blood from these regions doesn't return to the lungs to be exhaled, so PetCO2 drops while PaCO2 can stay elevated or rise, producing a large gradient. Other scenarios don't create such a pronounced PetCO2–PaCO2 disparity. Hyperventilation lowers both gases and keeps the gradient small; pulmonary edema causes shunt (perfused but poorly ventilated units) with a different pattern of gas exchange, and hypoventilation raises both gases similarly, again keeping the gradient relatively small.

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8. Which combination of treatments is described as part of the management for fulminating pulmonary edema?

A. Diuretic, 100% Oxygen, and Positive Pressure Ventilation

B. Atropine, Epinephrine, and Digoxin

C. Diuretic only

D. Digitalis, Diuretic, and Beta-blocker

The key idea is rapid stabilization of a patient with massive fluid in the lungs by prioritizing oxygenation, ventilation support, and quick removal of excess fluid. In fulminant pulmonary edema, alveoli are flooded, causing severe hypoxemia. Providing high-concentration oxygen helps maximize the amount of oxygen that can reach the blood despite shunting. Positive pressure ventilation, whether noninvasive or invasive with PEEP, keeps airways open, recruits collapsed lung units, improves gas exchange, and lowers both preload and pulmonary capillary pressures, which reduces further fluid leakage into the lungs. A diuretic acts quickly to mobilize the excess fluid, decreasing circulating volume and the filling pressures that drive edema. So, combining diuretic therapy with 100% oxygen and positive pressure ventilation addresses both the oxygenation and the fluid overload driving the crisis, which is why this trio is the most appropriate management in fulminant pulmonary edema. Other approaches that omit urgent oxygenation/ventilatory support or fail to remove fluid promptly do not tackle the immediate life-threatening physiology as effectively.

9. Which drug is used to treat anti-cholinergic crisis according to the material?

A. Atropine

B. Physostigmine

C. Naloxone

D. Diphenhydramine

Anticholinergic crisis happens when muscarinic receptors are blocked, so the treatment goal is to restore acetylcholine activity at those receptors. Physostigmine fits best here because it's a reversible acetylcholinesterase inhibitor that crosses the blood–brain barrier. By inhibiting acetylcholinesterase, it increases acetylcholine levels in both the central nervous system and the periphery, reversing the delirium and the peripheral symptoms caused by anticholinergic toxicity. Atropine, while also affecting muscarinic receptors, would not counteract the underlying deficiency of cholinergic signaling and can actually worsen the picture if given as the antidote. Naloxone targets opioid overdose, and diphenhydramine, being itself anticholinergic, would not treat the crisis.

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10. Which parameter is most directly associated with risk of volutrauma during mechanical ventilation?

A. Peak inspiratory pressure

B. Plateau pressure

C. PEEP

D. Tidal volume

Volutrauma risk from mechanical ventilation is driven by the actual distending pressure applied to the alveoli. The plateau pressure represents the pressure in the alveoli during an inspiratory hold when flow is zero, so it directly reflects the distending pressure the lung tissue experiences for the given tidal volume and compliance. Because plateau pressure quantifies alveolar distension, it is the best single indicator of the risk of volutrauma. Peak inspiratory pressure, while it can be high, also includes pressure needed to overcome airway resistance and may not correspond to alveolar overdistension. PEEP influences baseline pressure and recruitment but isn't a direct measure of distending pressure during inspiration, and tidal volume's impact depends on the resulting plateau pressure within the lung's compliance. Therefore, plateau pressure is the most direct predictor of volutrauma risk, with the clinical aim of keeping it under roughly 30 cm H2O.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

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We wish you the very best on your exam journey. You've got this!

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