ACLS PROMED PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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 dosing for lidocaine when used as an alternative antiarrhythmic during VF/pVT refractory?**

   A. 0.5 mg/kg

   B. 2-3 mg/kg

   C. 1-1.5 mg/kg

   D. 3-4 mg/kg

2. **Which item is NOT part of the H's and T's mnemonic in ACLS?**

   A. Tamponade

   B. Tension pneumothorax

   C. Thrombosis

   D. Trauma

3. **What is the MAP target after ROSC if hypotension persists?**

   A. ≥60 mmHg

   B. ≥65 mmHg

   C. ≥70 mmHg

   D. ≥75 mmHg

4. **Why is minimizing hyperventilation important during CPR?**

   A. Hyperventilation reduces venous return and coronary perfusion, decreasing ROSC.

   B. Hyperventilation increases cerebral perfusion and ROSC.

   C. Ventilation rate has no impact on ROSC.

   D. Hyperventilation improves defibrillation success.

5. **In a PEA arrest associated with tension pneumothorax, what is the immediate management?**

   A. Antibiotics

   B. Epinephrine

   C. Needle decompression or chest tube insertion

   D. Defibrillation

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6. What is a primary post-arrest objective regarding temperature?

A. Maintain fever above 38°C for 24 hours

B. Maintain normothermia without active cooling

C. Maintain targeted temperature management in the 32-36°C range for 24 hours with careful rewarming

D. Do not alter body temperature

7. Which of the following is not used to treat acute stroke?

A. Tissue plasminogen activator

B. Aspirin

C. Clopidogrel

D. Naloxone

8. Which strategy helps minimize interruptions in chest compressions?

A. Minimize interruptions by extending compression pauses for rhythm checks

B. Increase the frequency of rhythm analyses during CPR

C. Avoid prolonged rhythm analysis

D. Pause briefly for every potential rhythm change

9. How should you assess a pulse during CPR?

A. Pulse checks should be brief and infrequent; if in doubt, continue chest compressions and reassess rhythm.

B. Pulse checks should last 60 seconds before continuing compressions.

C. If no pulse is felt, stop CPR and call for help.

D. Pulse check is not needed during CPR.

10. Regarding NSAIDs in ACS, which statement is true?

A. They have no impact on mortality.

B. They eliminate reinfarction risk.

C. They are associated with increased risk of mortality and reinfarction.

D. They are standard therapy in STEMI.

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Answers

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

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Explanations

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1. What is the dosing for lidocaine when used as an alternative antiarrhythmic during VF/pVT refractory?

A. 0.5 mg/kg

B. 2-3 mg/kg

C. 1-1.5 mg/kg

D. 3-4 mg/kg

Dosing for lidocaine as an alternative antiarrhythmic during refractory VF/pVT. In ACLS, lidocaine is used when amiodarone isn't available or hasn't controlled the rhythm. The recommended initial intravenous bolus is 1 to 1.5 mg/kg. If the rhythm persists, you can give additional boluses of 0.5 to 0.75 mg/kg every 5 to 10 minutes, with a cumulative maximum of 3 mg/kg. Some protocols also use a continuous infusion after the bolus (1–4 mg/min), but the crucial dose during the emergency is the 1–1.5 mg/kg bolus. This matches the standard initial dosing. The other options are either too low for an initial bolus or exceed the maximum total dose.

2. Which item is NOT part of the H's and T's mnemonic in ACLS?

A. Tamponade

B. Tension pneumothorax

C. Thrombosis

D. Trauma

In ACLS, the Hs and Ts list reversible causes of cardiac arrest that you should rapidly evaluate and treat during resuscitation. The Hs cover problems like hypovolemia, hypoxia, acidosis (Hydrogen ion), and electrolyte or temperature issues, while the Ts include Toxins, Tamponade, Tension pneumothorax, and Thrombosis. Trauma is not part of this standard mnemonic. That's why Trauma is the item that doesn't belong. In practice, you'd still consider trauma as a separate scenario in traumatic arrest, but it isn't one of the Hs and Ts.

3. What is the MAP target after ROSC if hypotension persists?

A. ≥60 mmHg

B. ≥65 mmHg

C. ≥70 mmHg

D. ≥75 mmHg

After ROSC, keeping blood flow to the brain adequate is essential. The standard target is a mean arterial pressure of at least 65 mmHg to help ensure cerebral perfusion, especially since autoregulation can be impaired after cardiac arrest and intracranial pressure may rise. If hypotension persists, use fluids and vasopressors to achieve this MAP goal, adjusting as needed based on perfusion and cardiac status. Targets higher than 65 are not routinely needed and can increase cardiac workload unless there's a specific reason (like markedly elevated ICP) to push higher.

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4. Why is minimizing hyperventilation important during CPR?

A. Hyperventilation reduces venous return and coronary perfusion, decreasing ROSC.

B. Hyperventilation increases cerebral perfusion and ROSC.

C. Ventilation rate has no impact on ROSC.

D. Hyperventilation improves defibrillation success.

During CPR, how you ventilate matters because each rapid breath increases intrathoracic pressure and reduces the amount of blood returning to the heart. This drop in venous return lowers preload and, more importantly, decreases coronary perfusion pressure—the pressure driving blood to the heart muscle between compressions. When coronary perfusion pressure falls, the chance of returning to a sustainable heartbeat (ROSC) goes down. That's why minimizing hyperventilation is important: you want enough ventilation to oxygenate without pushing in air so forcefully or so rapidly that it impedes blood flow to the heart and brain. Hyperventilation can also cause hypocapnia and cerebral vasoconstriction, further reducing brain perfusion. The other statements aren't correct because overly rapid ventilation doesn't improve perfusion or ROSC, and it doesn't inherently boost defibrillation success.

5. In a PEA arrest associated with tension pneumothorax, what is the immediate management?

A. Antibiotics

B. Epinephrine

C. Needle decompression or chest tube insertion

D. Defibrillation

Relieving the pressure from a tension pneumothorax is the immediate priority in a pulseless electrical activity arrest caused by this condition. The trapped air under tension compresses the heart and great vessels, drastically reducing venous return and cardiac output. Rapid decompression—via needle thoracostomy followed by chest tube placement—unloads that pressure, restores venous return, and can reestablish circulation. Antibiotics, broad ACLS medications like epinephrine, or attempting defibrillation won't fix the underlying mechanical problem and thus aren't the immediate steps here. After decompression, continue CPR and follow ACLS protocol, with definitive chest tube care as available.

6. What is a primary post-arrest objective regarding temperature?

A. Maintain fever above 38°C for 24 hours

B. Maintain normothermia without active cooling

C. Maintain targeted temperature management in the 32-36°C range for 24 hours with careful rewarming

D. Do not alter body temperature

After resuscitation, the brain is highly vulnerable to further injury from reperfusion and inflammation. The main goal is to protect neural tissue by actively controlling temperature rather than letting it drift toward fever or remain untreated. Maintaining targeted temperature management in the 32-36°C range for about 24 hours provides a neuroprotective effect: it lowers cerebral metabolic demand, stabilizes cellular processes, and dampens inflammatory injury, all of which can improve neurological outcome. Rewarming must be gradual to avoid destabilizing hemodynamics and electrolyte shifts. Fever worsens brain injury, so avoiding fever is also a key part of this approach. Simply keeping the patient normothermic without cooling doesn't guarantee against fever or the benefits of controlled temperature management, whereas the described plan offers a structured, evidence-supported protection window.

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7. Which of the following is not used to treat acute stroke?

A. Tissue plasminogen activator

B. Aspirin

C. Clopidogrel

D. Naloxone

In acute stroke, the focus is on restoring blood flow or preventing further clotting to minimize brain injury. Tissue plasminogen activator is used for eligible patients with acute ischemic stroke within a defined time window to dissolve the clot and reopen the blocked vessel. Antiplatelet agents like aspirin are given early to reduce the risk of early recurrence and additional events, and clopidogrel serves as another antiplatelet option in certain stroke scenarios or after initial therapy depending on guidelines. Naloxone, on the other hand, is an opioid receptor antagonist used to reverse opioid overdose and has no role in treating stroke or improving cerebral perfusion, so it is not used in acute stroke management.

8. Which strategy helps minimize interruptions in chest compressions?

A. Minimize interruptions by extending compression pauses for rhythm checks

B. Increase the frequency of rhythm analyses during CPR

C. Avoid prolonged rhythm analysis

D. Pause briefly for every potential rhythm change

The main idea is that keeping chest compressions going as much as possible during CPR is essential because interruptions reduce perfusion to the heart and brain. Rhythm analysis should be quick and done only when necessary, with compressions resumed immediately after the check. This is why avoiding prolonged rhythm analysis is the best strategy to minimize interruptions. Spreading out rhythm checks, increasing how often analyses occur, or pausing for every potential rhythm change all create longer hands-off times, which diminish perfusion and worsen outcomes.

9. How should you assess a pulse during CPR?

A. Pulse checks should be brief and infrequent; if in doubt, continue chest compressions and reassess rhythm.

B. Pulse checks should last 60 seconds before continuing compressions.

C. If no pulse is felt, stop CPR and call for help.

D. Pulse check is not needed during CPR.

During CPR, keeping blood flowing to the heart and brain is the priority, so pauses for checks must be as short as possible. Pulse assessment should be quick and infrequent, and if you're unsure whether a pulse exists, you should continue chest compressions and reassess using the rhythm on the monitor or defibrillator rather than spending a long time palpating. This approach minimizes interruptions and preserves perfusion pressure, which improves chances of return of spontaneous circulation and neurologic outcome. The other ideas don't fit because checking the pulse for a full minute causes dangerous pauses in compressions, stopping CPR when no pulse is felt delays essential treatment, and pulse checks aren't ignored during CPR—guidelines emphasize rapid, brief checks and using objective rhythm data to guide actions.

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10. Regarding NSAIDs in ACS, which statement is true?

A. They have no impact on mortality.

B. They eliminate reinfarction risk.

C. They are associated with increased risk of mortality and reinfarction.

D. They are standard therapy in STEMI.

In ACS, NSAIDs are linked to worse outcomes, so they are not recommended. They do not reduce mortality or reinfarction; in fact, they're associated with higher risk of death and recurrent ischemic events. This harm is thought to come from interference with antiplatelet therapy, adverse renal effects, fluid retention, and blood pressure increases, all of which can worsen myocardial injury. Therefore the statement reflecting increased risk of mortality and reinfarction is the true one. NSAIDs are not standard therapy for STEMI, and when pain relief is needed, alternatives like acetaminophen or cautious use of opioids are preferred.

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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:

https://aclspromed.examzify.com

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

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