PLAB PEDIATRICS PRACTICE EXAM (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 developmental aspect is typically delayed in children with Prader-Willi Syndrome?

A. Motor skills

B. Speech

C. Cognitive abilities

D. All of the above

2. In a child less than 2 years old, which type of mass is described as soft, non-tender, and not translucent?

A. Lymphangioma

B. Teratoma

C. Branchial cyst

D. Thyroglossal duct cyst

3. What is a key developmental feature of Rett syndrome?

A. Developmental regression after normal development for 2-3 years

B. Delayed speech and language development

C. Persistent developmental delays from birth

D. Normal growth without any regression

4. What should the feeding strategy include for infants diagnosed with GORD?

A. More frequent, smaller feeds

B. Withholding all feeds for 24 hours

C. Limiting fluids only to water

D. Complete fasting

5. What is the best initial treatment for a patient presenting with symptoms of pyloric stenosis?

A. Immediate surgery

B. IV hydration

C. Correct electrolyte imbalance

D. Administer antiemetics

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6. What symptom is associated with pyloric stenosis in infants?

A. Diarrhea

B. Constipation

C. Projectile non-bilious vomiting

D. Recurrent abdominal pain

7. What is the primary distinguishing factor between parvovirus B19 and measles?

A. Presence of a dry cough

B. Fever intensity

C. Swollen lymph nodes

D. Type of rash present

8. Following catheter ablation for Wolf-Parkinson-White syndrome, what is the next best management option?

A. Ablation again

B. Emergency surgery

C. Medications such as flecainide or propafenone

D. Increased physical activity

9. What is the major modifiable risk factor associated with cot death?

A. Low birth weight

B. Prone sleeping

C. Parental smoking

D. Infrequent feeding

10. Which feature is key for differentiating pyloric stenosis from malrotation in a neonate?

A. Presence of blood in stool

B. Projectile vomiting

C. Age of the infant

D. Presence of fever

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Answers

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

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Explanations

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1. What developmental aspect is typically delayed in children with Prader-Willi Syndrome?

A. Motor skills

B. Speech

C. Cognitive abilities

D. All of the above

In children with Prader-Willi Syndrome, it is common to observe delays across multiple developmental aspects, which include motor skills, speech, and cognitive abilities. Motor skills tend to develop more slowly in children with this syndrome due to hypotonia, or decreased muscle tone, which is a characteristic feature of Prader-Willi Syndrome. This hypotonia can make it challenging for infants to achieve key milestones such as rolling over, sitting up, and walking at the expected ages. Speech development is also typically delayed in these children. Problems with articulation, a limited vocabulary, and overall communication skills can hinder their language development during early childhood. Cognitive abilities in children with Prader-Willi Syndrome are often affected as well. Individuals may exhibit mild to moderate intellectual disabilities, which can lead to challenges in learning and academic performance compared to their peers. Considering that motor skills, speech, and cognitive abilities are all areas where delays can be observed, it is correct to say that all of the developmental aspects mentioned can be delayed in children with Prader-Willi Syndrome. Thus, the understanding that all these areas are impacted underscores the complex nature of the syndrome and the need for comprehensive support and intervention strategies.

2. In a child less than 2 years old, which type of mass is described as soft, non-tender, and not translucent?

A. Lymphangioma

B. Teratoma

C. Branchial cyst

D. Thyroglossal duct cyst

In children under 2 years old, the features of a mass that is soft, non-tender, and not translucent point towards a branchial cyst. Branchial cysts are typically found along the neck's lateral aspects and are the result of the remnants of developmental structures from embryonic development. They are usually soft to the touch due to their cystic nature and lack of surrounding inflammation, which accounts for the non-tender quality. These cysts are not translucent, which differentiates them from other types of cystic lesions such as lymphangiomas that may exhibit a more fluid-filled, translucent appearance. Teratomas typically present as solid masses containing different types of tissues and can be either tender or non-tender depending on their location and associated complications. Thyroglossal duct cysts, while also soft and non-tender, may present midline and often exhibit some level of translucency, particularly if they are filled with fluid. Given these considerations, the characteristics of the mass in the presented scenario align closely with those of a branchial cyst.

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3. What is a key developmental feature of Rett syndrome?

A. Developmental regression after normal development for 2-3 years

B. Delayed speech and language development

C. Persistent developmental delays from birth

D. Normal growth without any regression

A key developmental feature of Rett syndrome is the pattern of developmental regression that occurs after a period of seemingly normal development, typically around 6 to 18 months of age. Initially, children with Rett syndrome appear to develop normally during the first few years of life, reaching typical milestones such as walking and language skills. However, following this initial phase, they experience a loss of previously acquired skills, which is a hallmark of the syndrome. This developmental regression can manifest as the loss of purposeful hand skills, the onset of repetitive hand movements, and deteriorating social and communication abilities. Such a regression is critical in diagnosing Rett syndrome and distinguishes it from other developmental disorders that typically present with persistent delays from birth. Therefore, the presence of normal early development followed by a significant decline in function is what characterizes this condition.

4. What should the feeding strategy include for infants diagnosed with GORD?

A. More frequent, smaller feeds

B. Withholding all feeds for 24 hours

C. Limiting fluids only to water

D. Complete fasting

For infants diagnosed with gastro-oesophageal reflux disease (GORD), the recommended feeding strategy of more frequent, smaller feeds is beneficial for several reasons. Smaller volumes of milk can help reduce the pressure in the stomach, which may alleviate reflux symptoms. When infants consume larger amounts of food in one sitting, the increased volume can lead to more significant intra-abdominal pressure, contributing to the likelihood of reflux episodes. Feeding more frequently allows for better digestion and can help ensure that infants receive sufficient nutrition throughout the day without overwhelming their gastrointestinal tract. This adjusted feeding pattern tends to make it easier for infants to manage their feeds without experiencing discomfort or excessive spitting up, which is a common concern for those with GORD. In contrast, withholding feeds for 24 hours, limiting fluids only to water, or implementing complete fasting would not be appropriate strategies for infants. These approaches could lead to nutritional deficiencies or dehydration, and they would not provide the necessary calories that infants require for growth and development. Thus, focusing on more frequent, smaller feeds is a practical approach to managing GORD in infants while ensuring their nutritional needs are met.

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5. What is the best initial treatment for a patient presenting with symptoms of pyloric stenosis?

A. Immediate surgery

B. IV hydration

C. Correct electrolyte imbalance

D. Administer antiemetics

In cases of pyloric stenosis, the best initial treatment is to correct any electrolyte imbalance. This condition often leads to vomiting due to severe gastric outlet obstruction, which can result in significant dehydration and electrolyte disturbances, particularly hypochloremic, hypokalemic metabolic alkalosis. Addressing these imbalances is crucial because it stabilizes the patient and prepares them for potential surgical intervention. Once the electrolyte levels are normalized and the patient's hydration status is addressed, further treatment options, including surgery or medication, can be considered. Immediate surgery may be a necessary intervention, but it typically follows stabilization through hydration and electrolyte correction. Administering antiemetics may help manage symptoms but does not address the underlying metabolic issues that present in pyloric stenosis. In summary, correcting electrolyte imbalances lays the essential groundwork for effective and safe subsequent treatment plans.

6. What symptom is associated with pyloric stenosis in infants?

A. Diarrhea

B. Constipation

C. Projectile non-bilious vomiting

D. Recurrent abdominal pain

Pyloric stenosis is a condition in infants characterized by the narrowing of the pylorus, the opening from the stomach into the small intestine. This narrowing leads to an obstruction that prevents food from passing effectively into the intestines. One of the hallmark symptoms of this condition is projectile non-bilious vomiting. In infants with pyloric stenosis, the vomit is typically forceful and can occur shortly after feeding, often projecting several feet away from the infant. The vomiting is non-bilious because the obstruction is located before the entry of bile from the liver into the digestive system, meaning that the contents of the vomit come primarily from the stomach. This symptom can lead to significant dehydration and electrolyte imbalances if not addressed promptly, making it a critical sign for diagnosis. Infants with pyloric stenosis may also show signs of hunger shortly after vomiting, as they are still hungry but unable to retain food due to the obstruction. Understanding these symptoms is crucial for early recognition and management of the condition.

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7. What is the primary distinguishing factor between parvovirus B19 and measles?

A. Presence of a dry cough

B. Fever intensity

C. Swollen lymph nodes

D. Type of rash present

The primary distinguishing factor between parvovirus B19 and measles indeed lies in the types of rashes that each virus produces, making the answer related to the characteristics of the rash present. Parvovirus B19 typically causes a "slapped cheek" rash in children, which is bright red and can have a lacy pattern that may appear on the body as well. This rash usually follows a mild febrile illness, often with minimal other symptoms. In contrast, measles is characterized by a distinctive progression of rash, starting as small red spots that coalesce, beginning at the head and moving downwards. The measles rash usually appears several days after the onset of fever and is associated with Koplik spots in the buccal mucosa. This understanding of the rash types is crucial for clinical differentiation because it also indicates the underlying pathophysiology and the potential for complications. The other possible distinctions provided in the choices, while they may vary, do not offer as clear a diagnostic criterion as the specific nature of the rash does.

8. Following catheter ablation for Wolf-Parkinson-White syndrome, what is the next best management option?

A. Ablation again

B. Emergency surgery

C. Medications such as flecainide or propafenone

D. Increased physical activity

In the management of Wolf-Parkinson-White (WPW) syndrome, catheter ablation is considered a curative procedure for patients experiencing symptomatic episodes of tachycardia. However, in cases where the initial ablation does not completely eliminate the accessory pathway or where patients continue to experience symptoms, the next best management option includes the use of antiarrhythmic medications such as flecainide or propafenone. These medications are effective in controlling and preventing reoccurrence of arrhythmias associated with WPW syndrome. Flecainide and propafenone belong to a class of antiarrhythmic drugs that work by stabilizing the cardiac membrane and can help in managing or preventing tachycardia episodes. Their role is particularly important when there is a need for rhythm control post-ablation or in patients who are not candidates for another procedure. Other options, such as performing another ablation or suggesting emergency surgery, may not be immediately indicated unless there are severe complications or persistent life-threatening arrhythmias. Increased physical activity is generally encouraged for overall heart health but may not specifically address the need for arrhythmia control following ablation. Therefore, utilizing medications like flecainide or propafenone is a strategic approach to

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9. What is the major modifiable risk factor associated with cot death?

A. Low birth weight

B. Prone sleeping

C. Parental smoking

D. Infrequent feeding

The major modifiable risk factor associated with cot death, also known as sudden infant death syndrome (SIDS), is prone sleeping. Research has shown that placing an infant on their stomach or side to sleep significantly increases the risk of SIDS. When infants are positioned in this manner, it can lead to difficulties in breathing and an increased likelihood of rebreathing carbon dioxide, both of which can contribute to this tragic outcome. Public health campaigns have effectively educated parents and caregivers about the dangers of prone sleeping, promoting safe sleep practices that recommend placing infants on their backs during sleep. This change in sleeping position has been associated with a marked decline in SIDS rates in many countries. While low birth weight, parental smoking, and infrequent feeding are also risk factors associated with SIDS, they are not modifiable in the same direct way as sleeping position. For instance, while addressing parental smoking can reduce risk, it is not as universally actionable as simply ensuring that an infant sleeps on their back. Thus, the emphasis on sleeping position is critical for preventing cot death.

10. Which feature is key for differentiating pyloric stenosis from malrotation in a neonate?

A. Presence of blood in stool

B. Projectile vomiting

C. Age of the infant

D. Presence of fever

Projectile vomiting is a key feature that helps differentiate pyloric stenosis from malrotation in neonates. Pyloric stenosis is characterized by a hypertrophy of the pylorus, which leads to a narrowing of the pyloric channel and causes severe, non-bilious projectile vomiting after feeding. This type of vomiting occurs because the food cannot pass from the stomach into the duodenum, leading to a forceful expulsion. In contrast, malrotation typically presents with bilious vomiting and can lead to more acute abdominal symptoms due to intestinal obstruction or volvulus, where the intestines twist around themselves. While malrotation may also cause vomiting, the presence of bile distinguishes it from pyloric stenosis. The projectile nature of the vomiting in pyloric stenosis is a hallmark feature that clinicians look for during evaluation. Age of the infant, presence of fever, and blood in the stool may provide some context in the clinical picture but are not as definitive in distinguishing between these two conditions as projectile vomiting is.

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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://plabpediatrics.examzify.com

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

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