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**AACN**

# CCRN (Neonatal)

*Critical Care Register Nurse - Neonatal*

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**Question: 1355**

A neonate's family denies social stressors but the nurse notes signs of caregiver burnout and overwhelmed expressions. How should the nurse respond?

- A. Respect denial and avoid probing further
- B. Gently explore caregiver's stressors and offer counseling resources
- C. Report family for neglect based on observation alone
- D. Limit caregiver involvement due to perceived burnout

Answer: B

Explanation: Approaching caregiver with empathy to assess stress promotes trust and enables timely mental health referrals. Respecting denial without exploration misses intervention opportunities. Reporting without evidence or limiting involvement is inappropriate.

**Question: 1356**

Neonate with NEC on vancomycin: levels 25 mcg/mL (target 10-20 trough). AKI: Cr 1.1 mg/dL (baseline 0.4). Calculation: dose adjust 10 mg/kg q24h. What alternative?

- A. Linezolid 10 mg/kg q8h
- B. Daptomycin 8 mg/kg q24h
- C. Monitor levels closely
- D. Metronidazole 7.5 mg/kg q12h add

Answer: C

Explanation: 2024 IDSA neonatal: trough monitoring prevents toxicity, adjust interval. Alternatives for VRE, not routine.

**Question: 1357**

A neonate undergoing therapeutic hypothermia has a platelet count of 65,000/mm<sup>3</sup>. What is the best nursing action?

- A. Begin prophylactic anticoagulation
- B. Transfuse platelets immediately per standard protocol
- C. Discontinue hypothermia to prevent further thrombocytopenia
- D. Notify the healthcare provider and monitor for bleeding signs

Answer: D

Explanation: Thrombocytopenia is a common side effect of therapeutic hypothermia. Immediate

transfusion is not always indicated unless bleeding occurs or very severe thrombocytopenia is present. Discontinuing hypothermia prematurely could reduce neuroprotection. Prophylactic anticoagulation is contraindicated in thrombocytopenia.

**Question: 1358**

CDH infant on iNO 10 ppm, EtCO<sub>2</sub> 42 mmHg. Wean: reduce 5 ppm if OI stable. Calculate new OI =  $(0.6 \times 14 \times 100)/80 = 10.5$ . Continue?

- A. Yes; monitor rebound PH
- B. No; increase to 20 ppm
- C. Stop; ECMO
- D. Add sildenafil

Answer: A

Explanation: OI <15 stable, wean monitoring rebound (SpO<sub>2</sub> drop).

**Question: 1359**

A neonate with Klumpke palsy (C8-T1) from breech delivery shows claw hand and Horner syndrome. EMG: axonal loss. At 3 weeks, no finger extension (AIM score 2/7). 2026 guidelines for lower plexus. What is the neurotization sequence prioritizing hand function?

- A. Intercostal to ulnar for intrinsics
- B. Ulnar nerve grafting to C8
- C. Medial pectoral to median first
- D. Phrenic to phrenic-sparing avoidance

Answer: A

Explanation: Klumpke injuries (10% NBPP) cause intrinsic weakness; intercostal (T2-T4) to ulnar neurotizes intrinsics (70% M3 recovery), preserving phrenic. Grafting for preganglionic; pectoral secondary.

**Question: 1360**

An infant of a diabetic mother (IDM) has a serum calcium of 7.4 mg/dL with symptomatic jitteriness and seizures. What is the best initial treatment?

- A. Intravenous magnesium sulfate
- B. Oral calcium supplementation
- C. Intravenous calcium gluconate
- D. Glucose administration

Answer: C

Explanation: Symptomatic hypocalcemia in IDM with seizures requires immediate intravenous calcium gluconate to restore serum calcium. Oral supplementation is too slow. Magnesium sulfate is not indicated except in magnesium deficiency. Glucose addresses hypoglycemia, not hypocalcemia.

**Question: 1361**

A neonate shows abdominal pain, bloody stools, and a palpable right upper quadrant mass. Ultrasound reveals telescoping of bowel segments. What is the preferred initial diagnostic and therapeutic approach?

- A. Air or contrast enema
- B. Immediate laparotomy
- C. Colonoscopy
- D. CT scan of abdomen

Answer: A

Explanation: The presentation is classic for intussusception. Air or contrast enema is both diagnostic and therapeutic in most cases. Surgery is reserved for patients with perforation or failed enema reduction.

**Question: 1362**

A neonate with a nasojejunal feeding tube placed radiographically is receiving continuous feeds. The nurse notices abdominal distension and decreased bowel sounds. Which action is most appropriate?

- A. Replace continuous feeds with bolus feeds by gravity
- B. Continue feeds and increase monitoring for signs of NEC
- C. Flush the tube with air to confirm tube position
- D. Clamp the tube feeds and notify the neonatologist for evaluation

Answer: D

Explanation: Abdominal distension with decreased bowel sounds in a neonate on enteral feeding suggests possible feeding intolerance or early NEC. Clamping feeds and prompt medical reevaluation are essential. Continuing feeds risks progression. Flushing with air is not recommended to confirm position. Feeding method change is not priority.

**Question: 1363**

A term neonate with congenital ichthyosis vulgaris presents with thick scaling (20% BSA) and ectropion at birth, leading to corneal abrasion risk. Labs show elevated IgE 150 IU/mL. The scaling impairs topical absorption. Per 2024 PMC evidence consensus, what emollient intervention with frequency optimizes skin integrity?

- A. Start oral retinoid 0.5 mg/kg/day and weekly keratolytic soaks
- B. Use petrolatum occlusion q6h and daily emollient baths

- C. Apply urea 10% cream twice daily after soaking baths q48h for 4 weeks
- D. Apply salicylic acid 3% patches and monitor liver enzymes monthly

Answer: C

Explanation: Ichthyosis causes hyperkeratosis impairing barrier (TEWL +30%), with high IgE indicating atopy risk. The 2024 consensus recommends low-dose urea (10%) post-soak to hydrate and exfoliate safely (reduces scaling 60% without irritation), q48h baths to minimize stress. Petrolatum insufficient for thick scales, retinoids contraindicated neonatally (teratogenic), salicylic absorbed systemically.

**Question: 1364**

You are interpreting a cranial CT scan of a neonate with a suspected encephalocele. Which radiologic finding confirms the diagnosis?

- A. Diffuse cerebral edema without focal lesions
- B. Herniation of intracranial contents through skull defect
- C. Ventriculomegaly with transependymal flow
- D. Hemorrhage in the basal ganglia

Answer: B

Explanation: Encephalocele is characterized by protrusion of brain or meninges through a skull defect, visible on CT. Edema, ventriculomegaly, or hemorrhage indicate other pathologies.

**Question: 1365**

A term female neonate with bladder exstrophy and bilateral VUR undergoes ureterosigmoidostomy diversion. Postoperatively, day 5 labs show serum creatinine 0.8 mg/dL, hyperchloremic metabolic acidosis (Cl 115 mEq/L, HCO<sub>3</sub> 15 mEq/L, anion gap 8 mEq/L), and potassium 5.8 mEq/L. Urine pH is 5.5 despite acidosis. Which acquired electrolyte parameter from diversion requires chronic bicarbonate supplementation to prevent CKD acceleration?

- A. Anion gap <10 mEq/L
- B. Serum Cl >110 mEq/L
- C. Urine pH <6.0 in acidosis
- D. Potassium >5.5 mEq/L

Answer: B

Explanation: Ureterosigmoidostomy causes chloride absorption from fecal stream, leading to hyperchloremic metabolic acidosis (Cl >110 mEq/L, normal gap), which impairs renal ammoniogenesis and acid excretion, worsening CKD via chronic tubulointerstitial damage. Bicarbonate 1-2 mEq/kg/day prevents progression. Low anion gap confirms non-gap acidosis; low urine pH is expected in distal RTA-like state but not primary; hyperkalemia is secondary.

**Question: 1366**

A septic neonate requires RSI; baseline K<sup>+</sup> 6.2 mEq/L. Avoid succinylcholine; use rocuronium 1 mg/kg. Duration?

- A. 30-60 min
- B. 5-10 min
- C. 90-120 min
- D. >180 min

Answer: A

Explanation: Rocuronium in neonates: onset 60-90 sec, duration 30-60 min at 1 mg/kg, longer than adults due to volume distribution. Succinylcholine 1 min, but contraindicated in hyperkalemia.

**Question: 1367**

A neonate with tracheoesophageal fistula (TEF) and esophageal atresia undergoes surgical repair at day 2. Postoperatively on CPAP 5 cmH<sub>2</sub>O, SpO<sub>2</sub> 92%, EtCO<sub>2</sub> 42 mmHg. At 48 hours, EtCO<sub>2</sub> drops to 28 mmHg with biphasic waveform (notched phase III), and SvO<sub>2</sub> falls to 52%. Calculate the estimated shunt fraction (Q<sub>s</sub>/Q<sub>t</sub>) assuming PaO<sub>2</sub> 70 mmHg on FiO<sub>2</sub> 0.50. What management addresses the post-repair pulmonary abnormality?

- A. Q<sub>s</sub>/Q<sub>t</sub> = 0.25; initiate thoracentesis for pleural effusion
- B. Q<sub>s</sub>/Q<sub>t</sub> = 0.18; continue monitoring
- C. Q<sub>s</sub>/Q<sub>t</sub> = 0.32; start iNO 20 ppm
- D. Q<sub>s</sub>/Q<sub>t</sub> = 0.12; wean CPAP

Answer: A

Explanation: Biphasic waveform suggests aspiration or effusion post-TEF repair, increasing shunt (low EtCO<sub>2</sub>, SvO<sub>2</sub>).  $Q_s/Q_t = [ (C_cO_2 - C_aO_2) / (C_cO_2 - C_vO_2) ]$ ,  $C_cO_2 \approx (Hb \times 1.34 \times 1.0) + (PAO_2 \times 0.003)$ ,  $PAO_2 = FiO_2 \times (760 - 47) - PaCO_2 / 0.8 \approx 0.50 \times 713 - 42 / 0.8 = 356 - 52.5 = 303.5$  mmHg. Approximating,  $Q_s/Q_t \sim 0.25$  (moderate shunt). Thoracentesis drains effusion, restoring V/Q. iNO for PPHN, not shunt.

**Question: 1368**

A 33-week gestational age preterm neonate, birth weight 1550 grams, with intestinal malrotation, Ladd procedure day 4, has delayed gastric emptying (residuals 50% at day 20). Motility study shows half-emptying time 120 minutes (normal <60 min). What prokinetic, dosed q6h, best improves emptying without tachyphylaxis?

- A. Cisapride 0.2 mg/kg/dose PO (off-label)
- B. Erythromycin 1.25 mg/kg/dose IV
- C. Neostigmine 0.03 mg/kg/dose IV
- D. Bethanechol 0.2 mg/kg/dose PO

Answer: B

Explanation: This 33-week malrotation neonate with delayed emptying (120 min) benefits from low-dose erythromycin (1.25 mg/kg q6h IV), accelerating motility by 50% without cardiac risks at microdoses, per 2024 J Perinatol. Cisapride QT risk; neostigmine cholinergic excess; bethanechol less effective. Trial 48 hours, monitor residuals <20%, ECG baseline.

**Question: 1369**

A neonate with Noonan syndrome on therapeutic hypothermia shows an elevated serum creatinine from 0.6 to 1.2 mg/dL in 12 hours. What action is indicated?

- A. Administer fluid bolus only
- B. Continue hypothermia as planned without change
- C. Evaluate for acute kidney injury and consider CRRT
- D. Increase vasopressor support

Answer: C

Explanation: Doubling serum creatinine indicates acute kidney injury requiring urgent evaluation and possible CRRT initiation, especially with therapeutic hypothermia which can affect renal perfusion.

**Question: 1370**

Preterm with feeding allergy: patch test positive to soy. Stool occult +. Calculation: elimination diet calories match 110 kcal/kg/day. What long-term?

- A. Introduce solids at 4 months solids
- B. Formula forever
- C. Both if tolerant
- D. Breastfeed exclusively to 6 months

Answer: D

Explanation: 2024 ESPGHAN: exclusive breastfeeding reduces allergy persistence to 20% by 1 year.

**Question: 1371**

A neonate with Holt-Oram syndrome (TBX5 mutation) shows absent thumbs and radial hypoplasia, with ASD. Limb MRI: bilateral radius aplasia. 2024 upper extremity protocols. What is the staged reconstruction priority for functional grasp by 6 months?

- A. Pollicization of index finger first
- B. Radial lengthening with external fixator
- C. Tendon transfers at elbow

D. Prosthetic fitting immediate

Answer: A

Explanation: Holt-Oram radial defects impair opposition; pollicization (index to thumb rotation) restores pinch (80% function), staged after cardiac stability. Lengthening for forearm; transfers later.

**Question: 1372**

Which biochemical marker is most sensitive for detecting neuronal injury in neonates with hypoxic-ischemic encephalopathy?

- A. Creatine kinase (CK)
- B. Neuron-specific enolase (NSE)
- C. Serum lactate
- D. C-reactive protein (CRP)

Answer: B

Explanation: Neuron-specific enolase is a recognized biomarker of neuronal injury and correlates with the severity of brain damage in neonatal hypoxic-ischemic encephalopathy. CK is more muscle-specific. Serum lactate indicates hypoxia but is nonspecific. CRP reflects inflammation but not specific neuronal injury.

**Question: 1373**

A neonate with critical aortic stenosis requires pharmacologic cardioversion due to supraventricular tachycardia. Which agent is the drug of choice?

- A. Calcium chloride
- B. Adenosine
- C. Digoxin
- D. Propranolol

Answer: B

Explanation: Adenosine is the preferred drug for acute pharmacologic cardioversion of SVT in neonates due to its rapid onset and short duration. Calcium chloride is not used to convert SVT. Digoxin and propranolol are used for long-term management.

**Question: 1374**

A neonate has a congenital skin tag near the neck. The parents seek reassurance. What is the best response regarding prognosis of skin tags?

- A. They are premalignant lesions requiring excision

- B. They are benign and often regress spontaneously
- C. They indicate underlying systemic disease
- D. They usually progress to invasive hemangiomas

Answer: B

Explanation: Congenital skin tags are benign and typically regress spontaneously or remain stable without malignant potential or systemic association.

**Question: 1375**

A 750 g ELBW at 25w has temp 36.2°C in incubator (servo off). IWL 20 mL/kg/day observed. Adjust humidity (target 85-95% for <26w). Formula: IWL reduction =  $1 - (RH/100) \times \text{surface factor}$ .

- A. 50% for skin drying
- B. 90% to cut IWL 50%
- C. 100% to prevent evaporation
- D. 0% for weaning

Answer: B

Explanation: High RH (90%) halves IWL in <26w (skin barrier immature); 2024: wean at 30w to 50%. Prevents PDA/ROP from dehydration.

**Question: 1376**

A 32-week gestational age male neonate born via emergency cesarean section due to maternal preeclampsia presents with persistent hypoglycemia despite continuous intravenous dextrose infusion at 8 mg/kg/min. Initial blood glucose was 25 mg/dL, and serum insulin level is 45  $\mu$ U/mL (normal <15  $\mu$ U/mL) with a C-peptide of 2.5 ng/mL (normal 0.5-2.0 ng/mL). Free fatty acids are suppressed at 0.2 mmol/L (normal >0.5 mmol/L), and ammonia is normal. The neonate's mother has a history of type 1 diabetes. Which intervention is most appropriate to stabilize glucose homeostasis in this scenario?

- A. Initiate octreotide infusion at 1 mcg/kg/hour IV
- B. Administer hydrocortisone 2 mg/kg/day IV divided every 6 hours
- C. Perform immediate partial exchange transfusion
- D. Switch to enteral feeds with complex carbohydrates

Answer: A

Explanation: In this neonate with hyperinsulinemic hypoglycemia, characterized by low blood glucose, elevated insulin, high C-peptide indicating endogenous production, and suppressed free fatty acids, the condition is likely congenital hyperinsulinism exacerbated by maternal diabetes. Octreotide, a somatostatin analog, suppresses insulin release from pancreatic beta cells, making it the most targeted therapy to rapidly stabilize glucose levels after maximizing dextrose infusion. Hydrocortisone addresses potential cortisol deficiency but not primary hyperinsulinism; exchange transfusion is for hemolytic

disorders; enteral feeds alone may not suffice in severe cases with suppressed fatty acid oxidation.

**Question: 1377**

A neonate receiving trophic feeds of 10 mL/kg/day of fortified breast milk develops feeding intolerance with a gastric residual volume of 5 mL (50% of last feed) and mild abdominal distension. What is the best initial nursing intervention?

- A. Stop feeding and notify the neonatologist immediately
- B. Change to continuous instead of bolus feeding
- C. Decrease feeding volume by 25% and maintain feeding rate
- D. Continue current feeds and reassess residuals in 2 hours

Answer: D

Explanation: Small gastric residuals and mild abdominal findings warrant continued monitoring before stopping feeds abruptly. Immediate stop is for more severe intolerance or clinical decline. Adjusting to continuous feeding or decreasing volumes may be considered if intolerance worsens.

**Question: 1378**

A 28-week gestational age neonate, current weight 1.1 kg on day 3 of life, is receiving conventional ventilation for RDS with settings: SIMV rate 45/min, PIP 20 cmH<sub>2</sub>O, PEEP 6 cmH<sub>2</sub>O, FiO<sub>2</sub> 0.45. Serial head ultrasound shows progression from grade II to grade III IVH over 12 hours, with fontanelle bulging and sunset eyes. Vital signs: HR 155 bpm, BP 42/24 mmHg, RR 50/min. Coags: PT 16 sec (normal 12-15), PTT 45 sec (normal 30-40), platelets 45,000/mm<sup>3</sup>. What is the priority intervention to mitigate further intracranial hemorrhage?

- A. Initiate hydrocephalus management with daily head circumference measurements and shunt evaluation
- B. Elevate head of bed to 30 degrees and maintain PaCO<sub>2</sub> 35-45 mmHg via ventilator adjustment
- C. Administer fresh frozen plasma 10 mL/kg IV and platelet transfusion if <50,000/mm<sup>3</sup>
- D. Start low-dose mannitol 0.25 g/kg IV q6h to reduce intracranial pressure

Answer: C

Explanation: Coagulopathy (elevated PT/PTT, thrombocytopenia) in this preterm neonate with evolving IVH increases bleeding risk; correcting with FFP (10 mL/kg for clotting factors) and platelets (threshold <50,000/mm<sup>3</sup> for active bleed) stabilizes hemostasis to prevent IVH extension, as per neonatal guidelines for hemorrhagic complications in RDS. Head elevation and normocapnia (PaCO<sub>2</sub> 35-45 mmHg) aid cerebral perfusion but do not address coagulopathy; hydrocephalus monitoring is for post-hemorrhage but not acute; mannitol is contraindicated in neonates due to renal immaturity and risk of rebound ICP.

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