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Question: 1409

A 7-year-old with end-stage renal disease (ESRD) on peritoneal dialysis develops cloudy dialysate effluent and abdominal pain. What is the priority nursing action?

A. Increase dwells per hour
B. Perform manual drainage to empty the abdomen
C. Change dialysate solution to one with higher dextrose concentration
D. Notify healthcare provider for possible peritonitis

Answer: D

Explanation: Cloudy peritoneal dialysis effluent with abdominal pain is suggestive of peritonitis, a common and serious complication. Early identification and notification for antibiotic therapy is essential. Increasing dwells or changing dialysate are inappropriate and drainage may worsen symptoms. The priority is to notify the healthcare provider for diagnosis and treatment.

Question: 1410

In a post-operative pediatric patient with an arterial catheter in place, the nurse notes the following arterial waveform changes: a dicrotic notch is absent, and the waveform has a broad, rounded peak with a slow upstroke. This pattern most likely indicates:

A. Aortic valve insufficiency
B. Increased systemic vascular resistance
C. Hypovolemia with diminished stroke volume
D. Increased arterial compliance

Answer: A

Explanation: Absence of the dicrotic notch and a broad, rounded waveform suggests aortic valve insufficiency (regurgitation). The dicrotic notch represents aortic valve closure, and its absence points to valve incompetence. Increased systemic vascular resistance would produce a higher systolic peak; hypovolemia leads to narrow pulses, and increased compliance causes a dampened waveform but with preserved notch.

Question: 1411

What is the most reliable method for diagnosing compartment syndrome in pediatric patients?

A. Measuring capillary refill time
B. Measuring intracompartmental pressure
C. Assessing skin temperature

D. Pain location on palpation

Answer: B

Explanation: Intracompartmental pressure monitoring provides objective, quantitative diagnosis. Clinical findings are important but less reliable alone.

Question: 1412

A child with severe neutropenia develops fever and diffuse swelling and tenderness in the lower leg without trauma history. What imaging modality is most useful to evaluate for osteomyelitis?

A. Bone scintigraphy (nuclear medicine scan)
B. Plain radiograph (X-ray) of the leg
C. Magnetic resonance imaging (MRI) of the leg
D. Ultrasound of the leg

Answer: C

Explanation: MRI is the gold standard for early detection of osteomyelitis because of high sensitivity in soft tissue and bone marrow changes. X-rays may be normal early. Bone scan is sensitive but less specific. Ultrasound helps to detect fluid collections but not bone involvement directly.

Question: 1413

In pediatric patients, which serum parameter is most predictive of risk for skin failure due to hypoperfusion?

A. Serum lactate concentration
B. Serum albumin concentration
C. Serum creatinine concentration
D. Serum potassium concentration

Answer: A

Explanation: Elevated serum lactate indicates tissue hypoxia and hypoperfusion, which is a key pathogenic factor in skin failure. Low albumin may affect skin healing but is less predictive of acute skin failure. Creatinine and potassium levels relate to kidney function and electrolyte balance but not specifically to skin perfusion.

Question: 1414

Which lab finding is most suggestive of delirium secondary to sepsis-associated encephalopathy in a pediatric patient?

A. Reduced blood ammonia

B. Normal white blood cell count
C. Low serum creatinine
D. Elevated C-reactive protein (CRP) and procalcitonin

Answer: D

Explanation: Elevated CRP and procalcitonin indicate systemic inflammation and sepsis, which can cause sepsis-associated encephalopathy presenting as delirium. Normal WBC, low creatinine, or reduced ammonia are less relevant.

Question: 1415

A 4-year-old post-colectomy with ileostomy has output 40 mL/kg/day (600 mL for 15 kg). Replace with ORS (Na 75 mEq/L) PO if tolerating. Calculate Na replacement if serum Na 130 mEq/L (deficit 12 mEq/kg=180 mEq).

A. 1.8 L ORS over 48h
B. 2.4 L ORS over 24h
C. 3.0 L ORS over 24h
D. 1.2 L ORS over 24h

Answer: B

Explanation: Output 600 mL replaces with equal ORS volume for isotonic losses, providing 45 mEq Na (75 mEq/L x 0.6 L), plus deficit correction 50%/24h=90 mEq (1.2 L ORS), total 2.4 L/24h gradual to avoid rapid shifts. Slower risks persistence; more overcorrects.

Question: 1416

A child with DKA has the following labs: glucose 520 mg/dL, sodium 130 mEq/L, potassium 4.8 mEq/L, bicarbonate 15 mEq/L. After initiation of insulin and fluids, which electrolyte should be monitored most closely to prevent potential cardiac arrhythmias?

A. Magnesium
B. Calcium
C. Potassium
D. Phosphorus

Answer: C

Explanation: Potassium decreases as insulin drives potassium intracellularly, risking hypokalemia and cardiac arrhythmias in DKA treatment, requiring close monitoring.

Question: 1417

A child receiving continuous positive airway pressure (CPAP) via tracheostomy has a sudden

desaturation episode. The nurse notes the device was disconnected briefly. What is the expected immediate physiological effect?

A. Improved oxygenation due to recruitment maneuvers
B. Increased airway pressure causing barotrauma
C. Elevated PaCO2 due to hyperventilation
D. Decreased functional residual capacity leading to alveolar collapse

Answer: D

Explanation: Brief CPAP disconnection decreases end-expiratory pressure, causing loss of functional residual capacity and alveolar collapse, leading to desaturation. Increased pressure or hyperventilation would not result from disconnection. Recruitment maneuvers are active interventions, not spontaneous effects.

Question: 1418

A 2-year-old girl post-cardiac arrest from hypoplastic left heart syndrome variant requires extracorporeal membrane oxygenation (ECMO) for refractory cardiogenic shock. On ECMO day 2, she exhibits anuric AKI with pH 7.15, bicarbonate 12 mEq/L, lactate 8.2 mmol/L, and fluid overload of 15% estimated blood volume. Ammonia level is 250 µmol/L due to suspected inborn error of metabolism unmasked by ischemia. The ECMO circuit blood flow is 1.5 L/min. What is the most appropriate integration of renal replacement therapy to address metabolic derangements while minimizing circuit interruptions?

A. Use prolonged intermittent renal replacement therapy (PIRRT) at dialysate flow 100 mL/min for 10 hours daily
B. Initiate peritoneal dialysis with icodextrin dwell for 6 hours to enhance diffusive clearance without vascular access
C. Perform intermittent hemodialysis via separate double-lumen catheter with Kt/V target of 1.4 per session
D. Connect continuous venovenous hemofiltration (CVVH) inline to ECMO circuit at 2000 mL/h replacement fluid with post-filter calcium infusion

Answer: D

Explanation: Integrating continuous venovenous hemofiltration (CVVH) directly into the ECMO circuit is optimal for this anuric patient with severe metabolic acidosis, hyperammonemia, and fluid overload, as it leverages the existing high-flow ECMO access for convective clearance of middle molecules like lactate and ammonia without additional vascular complications or circuit disconnections that could destabilize ECMO support. The replacement fluid rate of 2000 mL/h (approximately 40 mL/kg/h for a 10 kg child) targets intensive dosing for toxin removal, with post-filter calcium to counteract citrate if used, though pre-filter replacement suffices for hemolysis prevention in ECMO. Peritoneal dialysis is contraindicated post-arrest due to poor clearance of ammonia (requiring >100 mL/kg/h dialysate equivalent) and risk of impaired peritoneal perfusion from ECMO-related abdominal congestion; intermittent hemodialysis demands separate access with hypotension risks in cardiogenic shock; PIRRT, while flexible, interrupts ECMO priming and offers less continuous control in ECMO-dependent patients.

Pediatric ECMO-CRRT studies report 50-60% survival with inline CVVH improving acid-base recovery.

Question: 1419

A child with a tracheostomy develops subcutaneous emphysema around the neck with rising ventilator peak pressures and decreased tidal volume. What should the nurse immediately assess?

A. Tracheostomy tube cuff integrity and position
B. Chest X-ray for pneumothorax diagnosis
C. Endotracheal suctioning frequency and technique
D. Ventilator settings for tidal volume adjustment

Answer: A

Explanation: Subcutaneous emphysema with rising airway pressures and decreased volumes suggests air leak from cuff rupture or tube malposition. Assessing cuff integrity and tube placement helps identify the cause. Chest X-ray will confirm but immediate tube-related issues are addressed first. Suctioning frequency or ventilator changes do not explain subcutaneous emphysema.

Question: 1420

An 8-month-old infant born at 32 weeks gestation presents with bulging fontanelle, sunset eyes, and apneic episodes. Head ultrasound shows ventricular dilation with Evans' index of 0.45 (normal <0.3). Recent lumbar puncture revealed CSF pressure of 28 cm H_2O, protein 80 mg/dL, and RBC 5/μL. Per 2024 pediatric hydrocephalus management updates, the infant undergoes endoscopic third ventriculostomy (ETV) with success score of 0.8 on the ETV Success Score calculator. Postoperatively, ICP monitoring shows mean ICP of 15 mmHg, but the infant develops hyponatremia (Na 128 mEq/L). What is the most likely cause of this electrolyte imbalance, and what is the target correction rate?

A. Cerebral salt wasting with correction at 0.5 mEq/L/hour
B. SIADH with correction at 0.5 mEq/L/hour
C. Diabetes insipidus with correction at 1 mEq/L/hour
D. Hypernatremia from overcorrection with correction at 0.25 mEq/L/hour

Answer: B

Explanation: Post-ETV hyponatremia in pediatric hydrocephalus is commonly due to syndrome of inappropriate antidiuretic hormone (SIADH) from hypothalamic manipulation or CSF dynamic changes, leading to euvolemic hyponatremia. Diagnosis is confirmed by urine osmolality >300 mOsm/kg and serum osmolality <275 mOsm/kg. The 2024 updates from the Pediatric Hydrocephalus Research Foundation emphasize fluid restriction (50-75% maintenance) and monitoring free water clearance. Correction should not exceed 0.5 mEq/L/hour or 12 mEq/L/day to prevent osmotic demyelination, using 3% saline boluses (2 mL/kg) if symptomatic (seizures). Serial labs every 4-6 hours guide therapy, with goal Na 135-145 mEq/L over 48 hours.

Question: 1421

A 3-year-old with acute renal failure due to toxic mushroom ingestion has hyperkalemia of 6.8 mEq/L and peaked T waves on ECG. What is the next priority intervention?

A. IV furosemide bolus
B. Sodium bicarbonate infusion
C. IV calcium gluconate
D. Oral potassium binder administration

Answer: C

Explanation: Hyperkalemia with ECG changes (peaked T waves) requires immediate administration of calcium gluconate to stabilize cardiac membranes. Other treatments follow but are secondary to this urgent step.

Question: 1422

A 4-year-old with known diabetes insipidus presents with sudden onset confusion and serum sodium of 165 mEq/L. Which is the most appropriate initial step in management?

A. Immediate hypertonic saline administration
B. Rapid correction with hypotonic fluids
C. Initiate fluid restriction to decrease sodium
D. Administer desmopressin (DDAVP) intravenously

Answer: D

Explanation: In central DI with severe hypernatremia, administration of desmopressin replaces deficient ADH and helps concentrate urine. Correcting sodium must be done gradually to prevent cerebral edema, so rapid correction is contraindicated.

Question: 1423

A 11-year-old with TTP on plasmapheresis receives adjunct PRBCs for Hb 6.5 g/dL. Post: worsening microangiopathy (schistocytes 12%). Why avoid transfusion in TTP, and alternative?

A. Fluid overload; diuretics
B. Dilutes ADAMTS13; add rituximab
C. Causes alloimmunization; irradiated units
D. Increases viscosity exacerbating thrombosis; use plasma exchange only

Answer: D

Explanation: RBC transfusion in TTP raises hematocrit, worsening microvascular occlusion; restrict to symptomatic <6 g/dL, per 2024 ISTH TTP guidelines. Plasma exchange provides ADAMTS13.

Question: 1424

An infant presents with signs of shock and an ECG shows ST segment elevation in leads II, III, and aVF. Cardiac enzymes show elevated troponin I. What is the most likely cause?

A. Ventricular septal defect rupture
B. Viral myocarditis
C. Myocardial infarction secondary to coronary artery occlusion
D. Wolff-Parkinson-White syndrome

Answer: C

Explanation: ST elevation in inferior leads with elevated troponin suggests myocardial infarction likely due to coronary artery occlusion or anomalous coronary artery. Myocarditis may have nonspecific ECG changes but not classic ST elevation. Septal defect rupture causes volume overload, not infarction. WPW is an arrhythmia syndrome, unrelated.

Question: 1425

A 6-year-old post operative spinal surgery patient complains of severe back pain and progressive lower limb weakness. MRI shows epidural hematoma. What is the immediate priority?

A. Bed rest and observation
B. Pain medication adjustment
C. Initiation of corticosteroids
D. Urgent surgical decompression

Answer: D

Explanation: Epidural hematoma compresses the spinal cord causing neurological damage; urgent decompression prevents permanent injury. Pain meds and corticosteroids are supportive but do not relieve compression. Observation risks neurological deterioration.

Question: 1426

A 2-year-old toddler with suspected brain death following hypoxic-ischemic injury from near-drowning undergoes initial evaluation. Per the 2023 AAN/AAP/CNS/SCCM consensus guideline, what is the minimum observation period required after resolving confounding factors like hypothermia before proceeding to apnea testing?

A. 24 hours
B. 12 hours
C. 48 hours
D. No minimum specified

Answer: A

Explanation: The 2023 pediatric brain death/death by neurologic criteria (BD/DNC) consensus guideline mandates a minimum 24-hour observation period post-resolution of reversible confounders (e.g., core temperature >36°C, normotension) to ensure irreversibility, based on evidence from longitudinal EEG and outcome studies showing rare delayed recovery beyond this window, allowing time for ancillary testing if clinical exam is incomplete.

Question: 1427

A child in the ICU develops signs of restraint-induced anxiety and agitation after prolonged sedation. Which physiologic parameter best indicates the child's stress response?

A. Serum calcium concentration
B. Blood glucose levels
C. Serum cortisol levels
D. Blood pH level

Answer: C

Explanation: Serum cortisol is a primary marker of physiologic stress response, elevated in anxiety and agitation caused by environmental stressors such as restraints and prolonged ICU sedation.

Question: 1428

A 10-year-old is admitted with acute pulmonary embolism confirmed by CT angiography. The patient is hemodynamically stable but hypoxemic. Which of the following lab values best indicates the success of anticoagulation therapy?

A. Anti-factor Xa level within therapeutic range
B. Elevated D-dimer concentration
C. Prolonged prothrombin time (PT) with INR > 3
D. Decreased platelet count

Answer: A

Explanation: Monitoring anti-factor Xa levels is the preferred method to confirm adequate anticoagulation in patients receiving low molecular weight heparin for pulmonary embolism. Elevated D-dimer confirms diagnosis but does not monitor therapy success. Excessive PT/INR or thrombocytopenia suggest bleeding risks rather than effective treatment.

Question: 1429

In the PICU, a 5-year-old post-cardiac surgery patient's central venous pressure (CVP) rises to 15 mm Hg, with muffled heart sounds and pulsus paradoxus >12 mm Hg. Echo shows pericardial effusion. The nurse notes jugular venous distension and dyspnea. Which intervention addresses this deterioration first?

A. Diuretics furosemide 1 mg/kg IV to reduce preload
B. Increase positive end-expiratory pressure to 8 cm H2O
C. Pericardiocentesis under ultrasound guidance
D. Inotropes milrinone 0.5 mcg/kg/min infusion

Answer: C

Explanation: Rising CVP, muffled sounds, and pulsus paradoxus indicate tamponade physiology with hemodynamic compromise. Emergent pericardiocentesis drains effusion, restoring cardiac output (target CVP 8-12 mm Hg post-procedure), per 2026 AHA pediatric guidelines. Diuretics/inotropes worsen preload issues; PEEP risks further compromise.

Question: 1430

After surgical wound infection with Pseudomonas aeruginosa is confirmed, the child is started on ciprofloxacin. What adverse effect must be closely monitored in pediatric patients receiving this medication?

A. Hypoglycemia
B. Hepatic failure
C. Nephrotoxicity
D. Tendonitis or tendon rupture

Answer: D

Explanation: Fluoroquinolones like ciprofloxacin can cause tendonitis and tendon rupture, especially in pediatric patients with developing tissues. Hepatic failure, nephrotoxicity, and hypoglycemia are less common or unrelated adverse effects for this antibiotic class.

Question: 1431

A 6-year-old with Evans syndrome (autoimmune hemolytic anemia + ITP) has hemoglobin 5.5 g/dL, platelets 10,000/μL, positive direct antiglobulin test. The nurse calculates the absolute reticulocyte count: 200,000/μL (retic 8%, RBC 2.5 million/μL). Despite rituximab, hemolysis persists. What second-line agent?

A. High-dose IVIG 1 g/kg ×2 days
B. Cyclophosphamide 750 mg/m2 monthly
C. Splenectomy at age >6 years
D. Mycophenolate mofetil 600 mg/m2/day

Answer: D

Explanation: Refractory Evans syndrome requires immunosuppression; mycophenolate (600 mg/m2/day) inhibits purine synthesis, effective in 70% pediatric autoimmune cytopenias with steroid-sparing. IVIG acute, splenectomy after vaccination/immunization, cyclophosphamide alkylating with toxicity.

Question: 1432

A 6-month-old infant with congenital diaphragmatic hernia repair develops AKI on ECMO (creatinine 0.8 mg/dL from 0.15 mg/dL). Urine output 0.2 mL/kg/hour, sodium 145 mEq/L, potassium 5.8 mEq/L. Circuit pressure alarms frequently. Which CRRT modality integrates best with ECMO for hyperkalemia management?

A. Integrate dialyzer into ECMO circuit for diffusive clearance
B. Continuous venovenous hemodiafiltration via separate access
C. Peritoneal dialysis with low-volume exchanges
D. Slow continuous ultrafiltration only

Answer: A

Explanation: In neonatal ECMO-AKI, hyperkalemia risks arrhythmias; integrating a dialyzer (e.g., AN69 0.2 m^2) into the ECMO circuit provides continuous diffusive clearance (35 mL/kg/hour) without additional vascular access, reducing circuit interruptions, per 2024 ELSO guidelines, achieving K+ drop 1-2 mEq/L/hour. Separate CVVHDF risks clots; PD is inefficient in post-op abdomen; SCUF removes fluid only. Monitor pre/post-dialyzer K+ gradient.

Question: 1433

A 9-year-old patient with hemophilia B requires urgent correction of bleeding diathesis. Which blood product is most appropriate for transfusion?

A. Platelet concentrate
B. Fresh frozen plasma
C. Cryoprecipitate
D. Prothrombin complex concentrate (PCC)

Answer: D

Explanation: Hemophilia B is factor IX deficiency. Prothrombin complex concentrate contains factors II, VII, IX, and X, making it the optimal product for rapid factor IX replacement. Fresh frozen plasma contains all factors but is less concentrated. Cryoprecipitate is rich in factor VIII and fibrinogen, which do not correct factor IX deficiency. Platelets do not address coagulation factor deficiencies.

Question: 1434

A 1-year-old post-cardiac arrest (ROSC after 20 min CPR) is sedated (RASS -2), FiO2 0.6, PEEP 10 cmH2O, with Pediatric Cerebral Performance Category 3 baseline. 2024 BMC Pediatrics scoping review barriers include staffing; what indication and tool enable early prone positioning mobility?

A. Indication: Improve oxygenation; tool: Pressure-mapping mat for interface pressure <32 mmHg
B. Indication: Reduce ventilator days; tool: Mobility checklist with 10 safety screens

C. Indication: Neuroprotection; tool: Near-infrared spectroscopy cerebral oximetry >50%
D. Indication: Family empowerment; tool: Parental satisfaction survey post-session

Answer: B

Explanation: 2024 BMC scoping reviews identify early prone mobility in post-arrest patients to reduce ventilation duration by 20%, indicated by stability (no high vasopressors), using standardized checklists (e.g., SCCM 10-item safety screen: HR stability, no lines dislodgement) to overcome barriers like perceived risk in 60% nurses. NIRS for monitoring, pressure mats adjunctive, surveys outcome.

Question: 1435

Temporary pacing wire infection in 2-year-old: purulent drainage, WBC 18k, threshold 10 mA high. DDD mode failing, CI 2.0 L/min/m², sepsis lactate 2.8 mmol/L. Remove wire, start vancomycin. Bridge with?

A. Isoproterenol 0.05 mcg/kg/min
B. External transcutaneous pacing
C. Dobutamine 10 mcg/kg/min
D. Atropine drip 0.02 mg/kg/hr

Answer: B

Explanation: Transcutaneous pacing maintains rate/AV synchrony during sepsis-induced loss, avoiding infection spread until permanent implant. Isoproterenol risks tachyarrhythmia; dobutamine inotrope only; atropine unreliable.

Question: 1436

A 10-year-old with exertional rhabdo has CK 15,000 U/L, urine myoglobin 300 µg/L (> threshold 100 µg/L for pigmenturia). Fluid goal: urine output 2 mL/kg/h for 20 kg child = 40 mL/h. If output 25 mL/h, increase infusion by what % using standard adjustment formula (deficit / goal x 100)?

A. 25%
B. 50%
C. 38%
D. 75%

Answer: C

Explanation: Adjustment (15 mL deficit / 40 mL goal) x 100 = 37.5% ≈38%, targeting 2 mL/kg/h to dilute myoglobin per 2024 exertional rhabdo protocols. Threshold myoglobin >100 µg/L with high CK confirms need for escalated hydration.

Question: 1437

A 13-year-old boy with T-cell ALL post-Vincristine/cyclophosphamide develops abdominal pain, hyperuricemia (14 mg/dL), and AKI (creatinine 1.8 mg/dL). Labs: LDH 1,800 U/L, phosphate 6.8 mg/dL, potassium 5.9 mEq/L. The nurse calculates the uric acid-to-creatinine ratio in urine: 1.2 (elevated >1.0 indicating TLS). What preventive measure was omitted?

A. Rasburicase prior to chemotherapy
B. Allopurinol 300 mg/m2/day started 2 days pre-chemo
C. Hyperhydration at 3 L/m2/day
D. Urine alkalinization with sodium bicarbonate

Answer: A

Explanation: High-burden T-ALL requires rasburicase (0.2 mg/kg IV) prophylaxis for TLS, reducing uric acid faster than allopurinol; omission led to clinical TLS with AKI. Allopurinol prevents but doesn't treat established hyperuricemia, hydration essential but insufficient alone, alkalinization obsolete due to precipitation risks.

Question: 1438

A 1-year-old former 28-week preterm infant with NEC on peritoneal dialysis via a left lower quadrant catheter develops skin hypoperfusion at the catheter site during an episode of cardiogenic shock (echo EF 35%, lactate 5.1 mmol/L, ScvO2 55%). The site shows mottled, cool skin with delayed capillary refill >4 seconds and a 2 cm area of dusky discoloration despite pressure redistribution. Braden Q is 10. What distinguishes this from a stage 2 pressure injury, and what hemodynamic parameter calculation guides fluid bolus decision?

A. It's hypoperfusion-related ulcer; compute cardiac index (CI) = CO/BSA, target >3.3 L/min/m²
B. It's a device-related injury; use CVP trend: if <8 mmHg, bolus 10 mL/kg crystalloid
C. It's skin failure due to multiorgan dysfunction; calculate stroke volume variation (SVV) as (SBPmax - SBPmin)/SBPmean * 100% targeting <13%
D. It's moisture-associated damage; assess lactate clearance: (initial - current)/initial * 100% >10%/hr

Answer: A

Explanation: In critically ill preterm infants, skin hypoperfusion during shock manifests as acute skin failure, an end-organ manifestation of multiorgan dysfunction syndrome (MODS), distinct from pressure injuries which require sustained interface pressure/shear. Here, dusky mottling without full-thickness loss amid low EF and rising lactate indicates ischemic failure, not device pressure alone. Differentiating requires context: pressure injuries improve with offloading, while skin failure persists with hemodynamic instability. For management, calculate cardiac index (CI = cardiac output [L/min] / body surface area [m²]) using echo or pulse contour; target CI >3.3 L/min/m² in pediatric shock per recent Surviving Sepsis guidelines. BSA for this 1-year-old (~8 kg) is ~0.4 m²; if CO 1.2 L/min, CI=3 L/min/m² prompts inotrope escalation or bolus. SVV is for ventilated fluid responsiveness; CVP alone is unreliable; lactate clearance monitors response post-resuscitation. Supportive care includes optimizing perfusion (fluids 10-20 mL/kg boluses) and nutrition to prevent progression.

Question: 1439

A 8-year-old with leukemia on 30 days opioids (total 50 mg/kg morphine equivalent) has WAT-1 6: gooseflesh 1, tremors 2, diarrhea 1, hypertension 1, pupil dilation 1. Methadone start: 0.2 mg/kg q6h (morphine ratio 4:1). Calculate day 3 dose after 10% taper: 0.2 mg/kg * 0.9 * 0.9 = 0.162 mg/kg/day. Which symptom persistence requires re-escalation?

A. Single episode diarrhea
B. Mild irritability
C. Transient mydriasis
D. Recurrent tremors despite dose

Answer: D

Explanation: Taper calculation ensures gradual reduction; recurrent tremors (WAT-1 component score 2) despite adherence indicate inadequate suppression, requiring 10-20% dose re-escalation and evaluation for confounders like infection, per longitudinal studies showing 30% rebound risk without adjustment. Isolated symptoms resolve spontaneously.

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