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*Critical Care Medicine*

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### Question: 1295

A 17-year-old female is undergoing an appendectomy. She has no family history of anesthetic complications. Shortly after induction with succinylcholine, she develops significant masseter muscle rigidity (MMR) that prevents intubation. Her heart rate increases to 130 bpm, but her  $EtCO_2$  remains 35 mmHg. What is the most appropriate next step?

- A. Continue the procedure with a volatile agent and monitor  $EtCO_2$  closely
- B. Postpone the procedure, monitor for rhabdomyolysis, and consider MH testing later
- C. Abandon the procedure and immediately give dantrolene

**Answer: B**

Explanation: Masseter muscle rigidity (MMR) after succinylcholine is a "warning sign" for Malignant Hyperthermia. While it can be a normal variant in some children, it is associated with a high incidence of MH susceptibility (up to 50%). If the rigidity is so severe that it precludes intubation ("jaw of steel"), the procedure should be postponed if it is elective. The patient must be monitored in an ICU for signs of MH (rising  $EtCO_2$ , fever, acidosis) and rhabdomyolysis (CK levels, myoglobinuria) for at least 24 hours. While some suggest continuing with a non-triggering agent if the surgery is emergent, the safest path for an elective case is to stop and investigate.

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### Question: 1296

A 60-year-old male with a history of heavy smoking presents with sudden onset of

"down and out" deviation of the left eye and a dilated, non-reactive left pupil. He has a severe headache. What is the most urgent diagnostic test?

- A. Hemoglobin A1c
- B. Carotid duplex ultrasound
- C. CT Angiography (CTA) of the head

**Answer: C**

Explanation: A painful third nerve palsy involving the pupil is a "medical emergency" until proven otherwise, as it often signifies a compressive aneurysm of the Posterior Communicating Artery (PComm). A CTA or digital subtraction angiography is required to rule out an aneurysm that may be prone to rupture.

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### Question: 1297

During a difficult intubation of a patient with Ludwig's angina, the clinician uses a bougie. After successful intubation, the patient develops a right-sided tension pneumothorax. What is the most likely mechanism?

- A. Alveolar rupture from excessive bag-mask ventilation
- B. Rupture of a pre-existing bleb
- C. Direct pleuropulmonary injury from the bougie tip

**Answer: C**

Explanation: While bougies are excellent adjuncts for difficult airways, their stiff tips can cause trauma if advanced too deeply or blindly. A common complication is the perforation of a distal bronchus or the lung parenchyma, leading to an immediate pneumothorax. The tip should always be tracked, and resistance (indicating the tip is

in a small airway) should prompt immediate withdrawal before tube advancement.

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### Question: 1298

A 60-year-old patient with septic shock and ARDS is on high-dose vasopressors. Labs reveal TSH 0.2 mU/L (Ref: 0.5–5.0), Free T4 0.9 ng/dL (Ref: 0.8–1.8), and Total T3 40 ng/dL (Ref: 80–200). What is the most likely diagnosis and appropriate intervention?

- A. Myxedema coma; initiate IV levothyroxine
- B. Euthyroid sick syndrome; no thyroid treatment indicated
- C. Secondary hypothyroidism; initiate IV levothyroxine

**Answer: B**

Explanation: Euthyroid Sick Syndrome (or Non-Thyroidal Illness Syndrome) is common in the ICU. The most classic pattern is a low T3 with a normal or low TSH and normal T4. It represents an adaptive response to severe illness, decreasing the metabolic rate. Multiple studies have shown no benefit (and potential harm) in treating these patients with thyroid hormone. Treatment should focus on the underlying critical illness.

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### Question: 1299

A study of ICU morbidity finds that women are less likely to receive invasive mechanical ventilation for the same severity of illness as men, but are more likely to have "Do Not Resuscitate" (DNR) orders placed earlier. This suggests the presence of:

- A. Gender bias in critical care intensity
- B. Greater female preference for palliative care
- C. Physiological differences in lung compliance

**Answer:** A

Explanation: Multiple studies have demonstrated that women in the ICU often receive less aggressive care (lower rates of cardiac catheterization, ventilation, and vasopressors) compared to men with similar physiology. This gender bias often stems from paternalistic assumptions or the downplaying of female symptoms, leading to significant inequities in critical care delivery.

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**Question: 1300**

A patient who underwent a total thyroidectomy 24 hours ago develops circumoral tingling and a positive Chvostek sign. What is the most appropriate immediate intervention?

- A. Check a stat serum magnesium level
- B. Administer oral calcium carbonate
- C. Administer intravenous calcium gluconate

**Answer:** C

Explanation: Post-thyroidectomy hypocalcemia is usually due to transient or permanent hypoparathyroidism (accidental removal or devascularization of the parathyroid glands). Acute symptomatic hypocalcemia (tingling, tetany, positive Chvostek sign) is a medical emergency due to the risk of laryngospasm and seizures. Intravenous calcium gluconate is the treatment of choice for rapid symptom control.

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## Question: 1301

A 19-year-old male with polyuria and polydipsia has a serum sodium of 152 mEq/L and a urine osmolality of 150 mOsm/kg. After administration of 5 units of aqueous vasopressin, the urine osmolality increases to 450 mOsm/kg. Which of the following is the most likely diagnosis?

- A. Primary polydipsia
- B. Nephrogenic diabetes insipidus
- C. Central diabetes insipidus

**Answer: C**

Explanation: The patient has hypernatremic dilute polyuria, suggesting diabetes insipidus (DI). The response to exogenous vasopressin (ADH) distinguishes between types. A significant increase in urine osmolality (> 50%) indicates a lack of endogenous ADH production, which is diagnostic of Central DI. In Nephrogenic DI, the kidneys are resistant to ADH, and there would be little to no change in urine osmolality.

## Question: 1302

A patient in the ICU with a TBI is being managed with "Tier 1" ICP therapies, including head of bed elevation and sedation. The ICP remains 25 mmHg. The  $P_aCO_2$  is currently 40 mmHg. What is the recommended strategy for carbon dioxide management in this setting?

- A. Maintain  $P_aCO_2$  between 45 and 50 mmHg to promote vasodilation
- B. Temporary hyperventilation to a  $P_aCO_2$  of 30-35 mmHg as a bridge to other

therapies

C. Immediate hyperventilation to a  $P_aCO_2$  of 25 mmHg

**Answer: B**

Explanation: Prolonged hyperventilation should be avoided because it causes cerebral vasoconstriction, which can lead to ischemia. However, brief periods of hyperventilation ( $P_aCO_2$  30-35 mmHg) are acceptable as a temporizing measure for acute ICP spikes while other treatments (like osmotic therapy) are prepared.

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**Question: 1303**

An ICU patient with a history of pituitary surgery develops sudden onset severe headache, visual field defects, and hypotension. What is the most likely diagnosis?

- A. Pituitary apoplexy
- B. Ischemic stroke
- C. Ruptured berry aneurysm

**Answer: A**

Explanation: Pituitary apoplexy is an acute hemorrhage or infarction of the pituitary gland, often occurring in a pre-existing adenoma. It presents with the "classic triad": sudden headache, visual changes (due to compression of the optic chiasm), and hormonal collapse—most critically, acute adrenal insufficiency leading to hypotension. This is a neurosurgical and endocrine emergency. Sheehan syndrome is postpartum pituitary necrosis due to hemorrhagic shock during childbirth.

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**Question: 1304**

A patient in the ICU with a femoral arterial line develops a fever and redness at the site. The catheter is removed and the tip is sent for culture. What is the "gold standard" for diagnosing a catheter-related bloodstream infection (CRBSI) if the catheter is removed?

- A. Positive blood cultures from a peripheral vein and the catheter hub
- B. A positive tip culture with  $> 15$  colony-forming units (CFU) via semiquantitative method
- C. Growth of any organism from the catheter tip

**Answer: B**

Explanation: The Maki roll-plate (semiquantitative) method is used for catheter tip cultures. A result of  $> 15$  CFU, along with the same organism being isolated from a peripheral blood culture, is the diagnostic standard for CRBSI. If the catheter is not removed, a "differential time to positivity" (where the culture from the catheter becomes positive at least 2 hours before the peripheral culture) is used.

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### Question: 1305

A patient is admitted with suspected sulfur mustard (mustard gas) exposure following a chemical warehouse fire. He has erythema and small vesicles on his arms and neck. Which of the following is the hallmark of sulfur mustard toxicity that the ICU team must be prepared for?

- A. Immediate hepatic failure and coagulopathy
- B. Delayed bone marrow suppression and pancytopenia
- C. Acute renal failure due to myoglobinuria

**Answer: B**

Explanation: Sulfur mustard is an alkylating agent. Beyond the immediate skin, eye, and airway burns, it is systemically absorbed and can cause significant DNA damage. The most serious systemic effect is delayed bone marrow suppression (appearing 7–14 days post-exposure), which leads to profound neutropenia and increases the risk of sepsis.

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**Question: 1306**

Following a transsphenoidal resection of a pituitary macroadenoma, a patient develops polyuria (500 mL/hr) and a serum sodium of 152 mEq/L. Urine osmolality is 120 mOsm/kg. A trial of 2 mcg of intravenous desmopressin (DDAVP) is administered. One hour later, the urine osmolality increases to 450 mOsm/kg. Which of the following is the most likely diagnosis?

- A. Central diabetes insipidus
- B. Nephrogenic diabetes insipidus
- C. Cerebral salt wasting

**Answer: A**

Explanation: The clinical picture of polyuria, hypernatremia, and dilute urine (< 300 mOsm/kg) following neurosurgery is highly suggestive of Diabetes Insipidus (DI). The significant increase in urine osmolality (more than 50%) after DDAVP administration confirms Central DI, indicating that the kidneys are responsive to ADH, but the posterior pituitary is failing to secrete it. Nephrogenic DI would show little to no response to DDAVP.

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### Question: 1307

A patient with severe Crohn's disease and a high-output ileostomy is admitted with weakness. Lab values: Na 135 mEq/L, K 2.8 mEq/L, Cl 112 mEq/L, HCO<sub>3</sub> 14 mEq/L. ABG: pH 7.28, PCO<sub>2</sub> 30 mmHg. What is the calculated urinary anion gap (UAG) likely to be?

- A. Highly negative
- B. Near zero
- C. Highly positive

**Answer:** A

Explanation: The patient has a non-anion gap metabolic acidosis (NAGMA) from GI losses (ileostomy). In NAGMA, the UAG ( $\text{Na} + \text{K} - \text{Cl}$ ) helps differentiate renal from extra-renal causes. In GI loss, the kidneys should be able to excrete ammonium ( $\text{NH}_4^+$ ) paired with chloride to compensate for the acidosis. Therefore, the urinary chloride will be much higher than the sum of sodium and potassium, resulting in a negative UAG (typically less than -20). A positive UAG would suggest Renal Tubular Acidosis (RTA).

### Question: 1308

An ICU nurse practitioner is documenting a patient encounter. To ensure "Billing Integrity" and avoid "Upcoding," the practitioner must ensure that the level of Service (e.g., 99291 for critical care) is supported by:

- A. The amount of time spent by the nurse at the bedside
- B. The total time spent by the provider in direct critical care, excluding time spent on

separately billable procedures

C. The patient's insurance provider's preference

**Answer: B**

Explanation: Critical care billing codes (99291, 99292) are time-based. The time documented must represent the provider's actual time spent in direct care of the critically ill patient. Crucially, time spent on separately billable procedures (like placing a central line, 36556) cannot be counted toward the "critical care time" to avoid "double dipping" or upcoding.

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**Question: 1309**

A patient has a suspected aortic dissection. A TEE is performed. Which of the following is the most reliable ultrasound sign of an intimal flap in the descending aorta?

- A. Presence of a pleural effusion
- B. An increase in the diameter of the aorta to  $> 4.0$  cm
- C. A bright, linear echo that moves independently of the aortic wall

**Answer: C**

Explanation: The hallmark of aortic dissection on ultrasound (TEE or TTE) is the visualization of an intimal flap, which appears as a thin, mobile, linear structure within the aortic lumen that separates the "true" and "false" lumens. Independent motion of this flap compared to the aortic wall is highly characteristic.

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**Question: 1310**

During the management of a patient with SJS/TEN, a clinician notes the development of "symblepharon." This complication is a result of what pathophysiological process?

- A. Full-thickness necrosis of the cornea
- B. Adhesions between the bulbar and palpebral conjunctiva
- C. Increased intraocular pressure due to trabecular meshwork edema

**Answer:** B

Explanation: Ocular involvement occurs in up to 80% of SJS/TEN cases. The pathophysiology involves intense inflammation of the conjunctival mucosa, leading to erosions. As these denuded surfaces heal, fibrous bridges can form between the eyelid (palpebral) and the globe (bulbar) conjunctiva, known as symblepharon. This can lead to blindness and requires aggressive ophthalmic lubrication and often amniotic membrane grafting.

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### Question: 1311

A 50-year-old male with a history of hypertension and DM2 is admitted with a hypertensive emergency. His creatinine is 3.5 mg/dL (baseline 1.1). His urine output is 100 mL over 12 hours. Which RIFLE category does this patient meet?

- A. Loss
- B. Injury
- C. Failure

**Answer:** C

Explanation: According to RIFLE criteria, "Failure" is defined as a 3-fold increase in creatinine, a creatinine  $> 4$  mg/dL with an acute rise of at least 0.5, or urine output  $< 0.3$  mL/kg/hr for 24 hours or anuria for 12 hours. This patient's creatinine has more than tripled ( $1.1 \times 3 = 3.3$ ), and his urine output is significantly low, placing him in the Failure category.

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### Question: 1312

During the management of a pregnant trauma patient at 26 weeks gestation, which of the following is the most sensitive early indicator of maternal hypovolemia and impending shock?

- A. Maternal bradycardia
- B. Fetal heart rate abnormalities
- C. Maternal hypotension

**Answer: B**

Explanation: Due to the physiological increase in blood volume (40-50%) during pregnancy, a mother can lose up to 30-35% of her blood volume before her own blood pressure drops. However, the body compensates by shunting blood away from the "non-essential" uteroplacental circulation to protect maternal vital organs. Therefore, fetal distress or abnormal fetal heart rate patterns are often the first clinical signs of maternal hemodynamic compromise.

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### Question: 1313

A 60-year-old patient with a history of IV drug use is admitted with endocarditis and requires pressor support. A nurse says, "Why are we wasting an ICU bed on someone who did this to themselves?" A colleague responds by saying, "Every patient deserves our highest level of care regardless of how they got here." In this scenario, the colleague is acting as:

- A. A bystander
- B. An upstander
- C. An ally

**Answer:** B

Explanation: An upstander is an individual who observes a microaggression or biased behavior and actively intervenes to address it. By directly challenging the stigmatizing comment, the colleague promotes an inclusive and ethical culture. This differs from a bystander, who remains silent, or an ally, which is a broader long-term identity and commitment.

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### Question: 1314

A patient in the ICU has developed "short bowel syndrome" following a massive mesenteric infarction requiring resection of the majority of the jejunum and ileum, leaving only 50 cm of small bowel. Which of the following is the most significant concern regarding the use of Total Parenteral Nutrition (TPN) in this patient over the next several months?

- A. Hypermagnesemia
- B. Iron overload
- C. Intestinal failure-associated liver disease (IFALD)

**Answer: C**

Explanation: Intestinal failure-associated liver disease (IFALD) is a serious complication of long-term TPN, characterized by steatosis, cholestasis, and potentially cirrhosis. It is caused by the lack of enteral stimulation, continuous carbohydrate infusion, and certain lipid formulations (particularly older soy-based emulsions). Management involves cyclic TPN and attempting even minimal enteral feeds to stimulate gallbladder contraction.

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**Question: 1315**

In a trial comparing two antibiotics for pneumonia, the 95% Confidence Interval for the Relative Risk of treatment failure was 0.65 to 0.95. What can be inferred about the p-value for this comparison?

- A.  $p < 0.05$
- B.  $p > 0.05$
- C.  $p = 0.05$

**Answer: A**

Explanation: For ratios (like Relative Risk or Odds Ratio), the null hypothesis value is 1.0 (indicating no difference in risk between groups). If the 95% Confidence Interval does not include 1.0, the result is statistically significant at the  $\alpha = 0.05$  level, which corresponds to a  $p < 0.05$ . Since the interval 0.65 to 0.95 is entirely below 1.0, the p-value must be less than 0.05.

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**Question: 1316**

A patient with refractory hypokalemia is found to have a high urine pH (6.5), a negative serum anion gap, and a positive urine anion gap. Which of the following is the most likely diagnosis?

- A. Distal RTA (Type 1)
- B. Fanconi Syndrome
- C. Ethylene glycol ingestion

**Answer:** A

Explanation: Distal RTA (Type 1) is characterized by an inability of the alpha-intercalated cells in the collecting duct to secrete  $H^+$ . This leads to a high urine pH (always  $> 5.5$ ) and a positive urine anion gap (indicating failure to excrete  $NH_4^+$ ). It is frequently associated with severe hypokalemia.

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