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# ABEM-EMC

Emergency Medicine Certificate (EMC)

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### Question: 1084

A 60-year-old man on warfarin for atrial fibrillation presents after a fall with a large expanding scalp hematoma. He is alert, HR 98, BP 110/70, SpO<sub>2</sub> 98%. INR is 6.2. CT head shows no intracranial hemorrhage or mass effect. Which is the most appropriate next intervention?

- A. Hold warfarin for 24 hours and repeat INR
- B. Administer vitamin K 10 mg orally and discharge with instructions
- C. Administer fresh frozen plasma 4 units and vitamin K 10 mg IV
- D. Administer 4-factor prothrombin complex concentrate (PCC) and vitamin K 10 mg IV

**Answer: D**

Explanation: In a patient with warfarin-associated supratherapeutic INR and an expanding hematoma, rapid reversal is indicated to prevent progression to intracranial hemorrhage. 4-factor prothrombin complex concentrate is preferred over fresh frozen plasma because it reverses INR more quickly, with lower fluid load and fewer complications. Vitamin K should be given concurrently to sustain reversal. Holding warfarin and observing is appropriate only for asymptomatic patients with only mildly elevated INR and no risk of bleeding. Fresh frozen plasma is effective but slower and less predictable than PCC and is generally reserved when PCC is unavailable. Oral vitamin K alone is too slow for an acute, expanding hematoma.

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### Question: 1085

A 28-year-old woman presents with fever, hypotension, diffuse erythematous rash,

and multiorgan dysfunction after recent tampon use. What is the most likely diagnosis?

- A. Scarlet fever
- B. Toxic shock syndrome
- C. Cellulitis
- D. Stevens-Johnson syndrome

**Answer: B**

Explanation: Toxic shock syndrome is associated with toxin-producing *Staphylococcus aureus* and presents with fever, rash, hypotension, and multiorgan involvement, often linked to tampon use.

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### **Question: 1086**

A 38-year-old woman with breast cancer that has metastasized to bone presents with intractable pain and severe fatigue. She says, “I just want to go home and be with my children, even if I die sooner.” Her oncologist has recommended high-dose opioids and inpatient hospice, but she is refusing admission. The emergency physician must discuss goals of care. Which of the following statements best aligns with end-of-life communication and rapport building?

- A. “I understand you want to be at home with your children; let’s talk about what services (hospice, home nursing, medications) we can put in place to keep you as comfortable as possible there.”
- B. “You are being selfish; your family needs you alive, even if you are in pain.”
- C. “We will not let you die at home; you must stay here and follow our plan.”
- D. “If you go home, it’s your choice, but we cannot help you if you get worse.”

**Answer:** A

Explanation: In end-of-life discussions, aligning care with patient values while ensuring safety and comfort is key. The statement in option honors the patient's desire to die at home, reframes the conversation from "giving up" to "supporting comfort," and actively proposes concrete services that can make this possible.

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**Question: 1087**

A 19-year-old woman presents with right lower quadrant abdominal pain, fever, and rebound tenderness. What is the most likely diagnosis?

- A. Pneumothorax
- B. Appendicitis
- C. Diverticulitis
- D. Myocardial infarction

**Answer:** B

Explanation: Classic presentation of appendicitis includes RLQ pain, fever, and peritoneal signs.

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**Question: 1088**

A COPD patient presents with worsening dyspnea. ABG shows pH 7.25 and CO<sub>2</sub> 70 mmHg, but the patient is alert and cooperative. What is the most appropriate management?

- A. Non-invasive ventilation

- B. High-dose diuretics
- C. Immediate intubation
- D. No intervention required

**Answer:** A

Explanation: Non-invasive ventilation is first-line for hypercapnic COPD exacerbation.

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**Question: 1089**

A 70-year-old woman with a history of atrial fibrillation, hypertension, and peripheral vascular disease presents with sudden onset of left-sided weakness and global aphasia. NIHSS is 22. CT head is negative for hemorrhage. The stroke team estimates that intravenous thrombolysis can be started within 120 minutes of symptom onset, but the nearest comprehensive stroke center is 2 hours away. The patient's son is present and states that his mother previously said, "I wouldn't want to live if I could never talk again." Which of the following is the most appropriate next step?

- A. Discuss the risks and benefits of thrombolysis with the son, explore the patient's prior values, and document a shared decision-making discussion.
- B. Withhold thrombolysis and arrange rapid transfer to the comprehensive stroke center for mechanical thrombectomy only.
- C. Delay all intervention until the daughter, named health-care proxy, can be reached by phone.
- D. Initiate intravenous alteplase immediately under implied consent and explain the decision to the family afterward.

**Answer:** A

Explanation: In a patient with severe strokes and prior vague advance directives, the standard is to involve the legally authorized surrogate in a shared-decision-making conversation. The emergency physician should explain the likely benefit of alteplase (reduced disability) and the risk of symptomatic intracranial hemorrhage, while clarifying the patient's previously expressed values. Documenting this discussion ensures alignment with the patient's wishes and supports medico-legal standards. Withholding therapy or acting unilaterally may misalign with the patient's values and increase risk.

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**Question: 1090**

During ultrasound, no cardiac activity is seen in pulseless patient. Best interpretation?

- A. Confirm death after clinical correlation
- B. Repeat scan after 24 hours
- C. Assume artifact only
- D. Start antibiotics

**Answer:** A

Explanation: Absence of cardiac activity on ultrasound supports cardiac arrest, but must correlate clinically.

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**Question: 1091**

A 36-year-old woman with a history of asthma presents with 2 hours of progressive

dyspnea, wheezing, and decreased peak expiratory flow. She is tachypneic, using accessory muscles, with prolonged expiratory phase and diminished breath sounds. Peak inspiratory pressures on bag-valve-mask exceed 40 cm H<sub>2</sub>O. The team plans rapid-sequence intubation. Which of the following is the most appropriate neuromuscular blocker and dosage?

- A. Succinylcholine 1.5 mg/kg IV.
- B. Rocuronium 1.2 mg/kg IV.
- C. Vecuronium 0.1 mg/kg IV.
- D. Rocuronium 0.6 mg/kg IV.

**Answer: B**

Explanation: In a patient with severe asthma, rapid-sequence intubation requires a neuromuscular blocker that achieves intubating conditions within roughly 60 seconds while minimizing the risk of hyperkalemia. High-dose rocuronium (1.0–1.2 mg/kg IV) provides succinylcholine-like onset without the potassium-elevating effects of depolarizing agents. Standard-dose rocuronium (0.6 mg/kg, B) has a slower onset; vecuronium is even slower; and succinylcholine is contraindicated in patients with undiagnosed muscle disease or rhabdomyolysis, which cannot be excluded in this setting.

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### Question: 1092

A mother refuses lumbar puncture for her 2-year-old child with suspected meningitis. The child is lethargic and febrile. What is the best next step?

- A. Administer antibiotics without further discussion
- B. Seek ethics consultation immediately
- C. Respect refusal and discharge patient
- D. Explain urgency and proceed if life-threatening

**Answer: D**

Explanation: In pediatrics, if refusal places child at serious risk of harm or death, clinicians may override consent after explaining urgency and documenting medical necessity.

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### Question: 1093

A family is informed that their loved one has suffered irreversible brain injury and meets criteria for brain death. They respond with anger and insist that the patient is still alive. What is the most appropriate initial response?

- A. "The diagnosis is medically confirmed and not open to debate."
- B. "You are misunderstanding what brain death means."
- C. "We will now proceed with organ donation discussions."
- D. "I understand this is very painful and difficult to accept."

**Answer: D**

Explanation: The first step in managing emotionally charged conversations is empathy and validation. Recognizing grief and distress helps de-escalate conflict and maintains therapeutic communication. Direct confrontation or immediate procedural discussion increases resistance.

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### Question: 1094

A 62-year-old man with severe septic shock and multiple failed attempts at

peripheral intravenous access arrives in the ED with a systolic blood pressure of 68 mmHg despite vasopressors. The emergency physician plans ultrasound-guided central venous catheterization. Which of the following is the most appropriate initial site choice and technique?

- A. Left internal jugular vein using an in-plane, long-axis approach with a 22-cm, 5-Fr peripherally-inserted central catheter.
- B. Right subclavian vein using a landmark-based technique with a 15-cm, 7-Fr Hickman-type catheter.
- C. Right internal jugular vein using an in-plane, short-axis approach with a 20-cm, 7-Fr triple-lumen catheter.
- D. Left femoral vein using an out-of-plane, short-axis approach with a 15-cm, 5-Fr single-lumen catheter.

**Answer:** C

Explanation: In a critically ill, hypotensive patient requiring central access, the right internal jugular vein is preferred because it has a straighter course to the superior vena cava, lower risk of pneumothorax than the subclavian, and lower risk of line-associated infection and thrombosis than the femoral. The in-plane, short-axis ultrasound technique minimizes complications and allows real-time visualization of the needle and vessel. A 7-Fr triple-lumen catheter is appropriate for multi-drug infusions in septic shock. Femoral-site placement is acceptable in resuscitation, but jugular is preferred; subclavian landmark-based insertion has higher complication rates; and a long-peripheral PICC-type line is inappropriate for emergent vasopressor access.

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## Question: 1095

A patient with urinary retention has renal failure. Cause?

- A. Post-renal obstruction
- B. Stroke
- C. Pulmonary embolism
- D. Hepatic failure

**Answer:** A

Explanation: Urinary obstruction causes post-renal AKI.

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**Question: 1096**

A 45-year-old woman with RA presents with 3 days of painful right-hand swelling and warmth. Synovial fluid shows WBC 2,000/mm<sup>3</sup>, 40% neutrophils, negative crystals. Which is the most appropriate next step?

- A. Administer oral NSAIDs and methotrexate
- B. Administer IV fluids and NSAIDs
- C. Administer IV antibiotics
- D. Administer IV corticosteroids and methotrexate

**Answer:** A

Explanation: Inflammatory arthritis likely; NSAIDs and methotrexate are appropriate. IV antibiotics are not indicated without infection.

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**Question: 1097**

A 32-year-old male presents with a deep laceration to his right forearm from a glass bottle. He is refusing to allow the physician to examine or close the wound, stating that he "doesn't trust doctors." He is alert, oriented, and his speech is coherent. He understands that the wound may become infected or lead to nerve damage if not treated. According to systems-based practice and legal standards, what is the next best step?

- A. Notify the police that the patient is a danger to himself and require an involuntary hold
- B. Administer a sedative to allow for a safe examination of the wound
- C. Contact the hospital's legal counsel to obtain an emergency court order
- D. Document the patient's decision-making capacity and have him sign a Refusal of Care form

**Answer: D**

Explanation: Competent adults have the legal and ethical right to refuse medical treatment, even if that treatment is life- or limb-saving. If the physician determines the patient has the capacity to understand the risks and benefits—which includes being alert, oriented, and demonstrating an understanding of the consequences—the patient's autonomy must be respected. The physician should document the discussion thoroughly and have the patient sign a "Leaving Against Medical Advice" or refusal form. Forcing treatment would constitute battery.

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### **Question: 1098**

A 45-year-old male with no significant past medical history is brought to the ED by his wife for "acting strange." The wife explains that he has been increasingly irritable and forgetful. During the interview, the patient becomes defensive, crossing his arms and looking away while stating, "I'm only here because she made me come." Which active listening technique is most appropriate to de-escalate the tension and build

rapport?

- A. Asking the wife to step out of the room to decrease the patient's perceived pressure
- B. Reflecting the patient's emotion by saying, "It sounds like you're feeling frustrated about being here"
- C. Stating clearly that the medical evaluation is mandatory for his safety and legal discharge
- D. Mirroring the patient's body language to show subconscious alignment with his stance

**Answer: B**

Explanation: Reflective listening is a core component of active listening and empathy. By naming the emotion the patient is displaying (frustration), the physician validates the patient's experience without necessarily agreeing with his perspective. This technique often de-escalates defensive behavior and encourages the patient to share more information. Direct confrontation or ignoring the emotional subtext usually increases resistance.

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**Question: 1099**

A trauma patient has hypotension, distended neck veins, and tracheal deviation. Breath sounds are absent on the right. What is the next step?

- A. Pericardiocentesis
- B. CT chest
- C. Chest X-ray
- D. Needle decompression

**Answer: D**

Explanation: Classic tension pneumothorax requires immediate decompression without imaging. Delay significantly increases mortality.

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### Question: 1100

A 19-year-old male is brought to the ED by his roommate after a generalized tonic-clonic seizure. The roommate states the seizure lasted 5 minutes, stopped, and then another one began 2 minutes later without the patient regaining consciousness. On arrival, the patient is still seizing. You have already administered 4 mg of IV lorazepam. What is the most appropriate next pharmacological intervention?

- A. Administer a second dose of 4 mg intravenous lorazepam
- B. Intubate the patient and start a propofol infusion
- C. Start a continuous infusion of midazolam at 0.2 mg/kg/hr
- D. Initiate a loading dose of fosphenytoin at 20 mg PE/kg

**Answer: D**

Explanation: The patient is in status epilepticus (defined as a seizure lasting > 5 minutes or recurrent seizures without a return to baseline). After the first-line treatment with a benzodiazepine (like lorazepam 4 mg), the standard second-line treatment is a long-acting anticonvulsant. Fosphenytoin (20 mg PE/kg), valproic acid (40 mg/kg), or levetiracetam (60 mg/kg) are all appropriate evidence-based choices. If the second-line agent fails, then the patient progresses to third-line therapy, which involves general anesthesia (e.g., propofol, midazolam, or phenobarbital) and airway protection.

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### Question: 1101

A 40-year-old man is rescued from a house fire and presents with headache, confusion, and nausea. Pulse oximetry reads 99% despite clinical deterioration. What is the most likely diagnosis?

- A. Heat stroke
- B. Methanol toxicity
- C. Cyanide poisoning
- D. Carbon monoxide poisoning

**Answer:** D

Explanation: Carbon monoxide poisoning presents with neurologic symptoms and falsely normal oxygen saturation readings due to inability of pulse oximetry to distinguish carboxyhemoglobin from oxyhemoglobin. High-flow oxygen is essential treatment.

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### Question: 1102

A 70-year-old female presents with acute abdominal pain and distension. She has a history of atrial fibrillation and is not on anticoagulation. Her lactate is 4.5 mmol/L. A CT abdomen with IV contrast shows a lack of enhancement in the wall of the small bowel and an arterial thrombus in the superior mesenteric artery. What is the most appropriate next step in management?

- A. Initiate a heparin infusion and consult general surgery for emergent laparotomy
- B. Administer 1000 mL of normal saline and repeat the lactate in 2 hours
- C. Consult interventional radiology for catheter-directed thrombolysis
- D. Start broad-spectrum antibiotics and perform a colonoscopy

**Answer: A**

Explanation: Acute mesenteric ischemia (AMI) is a surgical emergency with very high mortality. The diagnosis is confirmed by CT angiography showing SMA thrombosis. Immediate management includes fluid resuscitation, systemic anticoagulation with heparin (to prevent clot propagation), and emergent surgical consultation for revascularization and/or resection of necrotic bowel. While IR may play a role in some cases, the presence of elevated lactate and CT findings suggestive of bowel ischemia usually mandate surgical exploration.

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**Question: 1103**

A patient presents with migraine headache, normal neurological exam, and no red flags. What is appropriate management?

- A. ICU admission required
- B. CT scan for all patients mandatory
- C. NSAIDs and antiemetics outpatient
- D. Immediate thrombolysis

**Answer: C**

Explanation: Uncomplicated migraine is treated symptomatically.

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**Question: 1104**

A patient with stroke symptoms arrives. ED CT scanner is occupied. What is best action?

- A. Treat without imaging
- B. Transfer immediately
- C. Activate stroke protocol and prioritize imaging
- D. Wait until scanner available

**Answer:** C

Explanation: Stroke systems prioritize rapid imaging and pathway activation.

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