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# NNP-BC

Neonatal Nurse Practitioner

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**Question: 1143**

A 38-week gestation neonate is born to a mother with a history of opioid use disorder and recent methadone maintenance. At 36 hours of life, the neonate exhibits a Finnegan score of 14, with tremors and poor feeding. What is the most appropriate management?

- A. Administer intravenous fluids and monitor
- B. Initiate morphine therapy
- C. Provide non-pharmacologic interventions

Answer: B

Explanation: A Finnegan score of 14 indicates severe neonatal abstinence syndrome (NAS) requiring pharmacologic treatment. Morphine is the first-line therapy to manage withdrawal symptoms. Non-pharmacologic interventions are insufficient for severe NAS, and intravenous fluids are not indicated unless dehydration is present.

**Question: 1144**

A 32-week preterm neonate with a birth weight of 1.4 kg presents with pallor and poor feeding. Laboratory results show hemoglobin of 8 g/dL (normal: 14-20), mean corpuscular volume (MCV) of 90 fL (normal: 100-120), and reticulocyte count of 1% (normal: 3-7%). The peripheral smear shows microcytic, hypochromic red blood cells. Ferritin is 20 ng/mL (normal: 50-200). What is the most appropriate treatment for this neonate's condition?

- A. Administer folic acid supplementation
- B. Start oral ferrous sulfate therapy
- C. Initiate packed red blood cell transfusion

Answer: C

Explanation: The neonate has iron deficiency anemia, evidenced by low hemoglobin, microcytic hypochromic red cells, low MCV, and low ferritin. In preterm neonates, acute anemia with significant symptoms (pallor, poor feeding) warrants packed red blood cell transfusion to rapidly correct oxygen-carrying capacity. Oral iron therapy is not suitable for preterm infants due to immature gut absorption, and folic acid is indicated for megaloblastic anemia, not iron deficiency.

**Question: 1145**

A term neonate with biliary atresia is diagnosed via intraoperative cholangiogram at 6 weeks of age. The neonate undergoes a Kasai portoenterostomy. Postoperatively, the neonate develops cholangitis, with fever, elevated direct bilirubin (6 mg/dL), and leukocytosis (WBC 18,000/ $\mu$ L). What is the most appropriate antibiotic regimen to treat this complication?

- A. Ampicillin and gentamicin

- B. Ceftriaxone monotherapy
- C. Piperacillin-tazobactam

Answer: C

Explanation: Cholangitis following Kasai portoenterostomy is typically caused by gram-negative bacilli and anaerobes. Piperacillin-tazobactam provides broad-spectrum coverage, including *Pseudomonas* and anaerobes, making it the preferred choice. Ampicillin and gentamicin are less effective against anaerobes. Ceftriaxone is contraindicated in neonates due to its displacement of bilirubin from albumin, increasing kernicterus risk.

**Question: 1146**

A 29-year-old G1P0 at 36 weeks gestation undergoes a Doppler ultrasound due to suspected fetal growth restriction (FGR). The middle cerebral artery (MCA) Doppler shows a decreased pulsatility index (PI), and the umbilical artery Doppler shows reversed end-diastolic flow (REDF). What is the most appropriate management to optimize neonatal outcomes?

- A. Plan for immediate delivery
- B. Perform a biophysical profile (BPP)
- C. Administer betamethasone and monitor weekly

Answer: A

Explanation: Reversed end-diastolic flow in the umbilical artery and a decreased MCA pulsatility index (indicating brain-sparing redistribution) signify severe placental insufficiency and fetal hypoxia in FGR. At 36 weeks, immediate delivery is indicated to prevent stillbirth or further compromise. Betamethasone and monitoring are insufficient given the critical Doppler findings. A BPP may confirm compromise but delays urgent delivery.

**Question: 1147**

A 33-week preterm neonate, appropriate for gestational age (AGA), is admitted to the NICU. On examination, the nurse practitioner notes soft, pliable ears with minimal cartilage, sparse lanugo, and a gelatinous, transparent skin appearance. Using the New Ballard Score, what is the estimated gestational age based on these physical characteristics?

- A. 34–36 weeks
- B. 31–33 weeks
- C. 28–30 weeks

Answer: C

Explanation: The New Ballard Score assesses gestational age based on physical and neuromuscular maturity. Soft, pliable ears with minimal cartilage, sparse lanugo, and gelatinous, transparent skin are

characteristic of extreme prematurity, typically 28–30 weeks gestation. These features indicate underdeveloped physical maturity compared to the 33-week stated age, suggesting the score aligns with an earlier gestational age.

**Question: 1148**

A 36-week neonate, diagnosed prenatally with congenital pulmonary airway malformation (CPAM) via ultrasound, is delivered via elective cesarean section. Postnatally, the neonate is asymptomatic, with oxygen saturation of 98% on room air. Chest CT confirms a macrocystic CPAM in the left lower lobe, measuring 4 cm. The neonatal nurse practitioner is consulted regarding management. Which approach is most appropriate based on current evidence?

- A. Immediate surgical resection of the affected lobe
- B. Observation with serial imaging and outpatient follow-up
- C. Start prophylactic antibiotics to prevent infection

Answer: B

Explanation: Asymptomatic neonates with CPAM, particularly macrocystic lesions, are often managed conservatively with observation and serial imaging due to the potential for spontaneous regression. Surgical resection is reserved for symptomatic cases or those with complications like recurrent infections. Prophylactic antibiotics are not routinely indicated without evidence of infection.

**Question: 1149**

A 30-week preterm neonate develops a bowel perforation secondary to necrotizing enterocolitis. Post-resection, the neonatal nurse practitioner notes a serum sodium of 128 mEq/L and a urine output of 0.5 mL/kg/h. What is the most likely cause of these findings, and what is the appropriate intervention?

- A. Syndrome of inappropriate antidiuretic hormone; fluid restriction
- B. Renal failure; initiate dialysis
- C. Third-space fluid losses; isotonic fluid bolus

Answer: C

Explanation: Bowel perforation in NEC leads to third-space fluid losses into the peritoneal cavity, causing hyponatremia and oliguria from hypovolemia. An isotonic fluid bolus (e.g., normal saline) is required to restore intravascular volume. SIADH would cause hyponatremia but not oliguria, and renal failure is less likely without other signs.

**Question: 1150**

A term neonate, delivered vaginally after a prolonged second stage of labor, is apneic and limp at birth. The delivery room team initiates resuscitation per NRP guidelines, including drying, stimulation, and PPV with a T-piece resuscitator at 20 cm H<sub>2</sub>O pressure and 5 cm H<sub>2</sub>O PEEP. After 30 seconds, the

neonate's heart rate is 80 bpm, but oxygen saturation (SpO<sub>2</sub>) is 60% at 1 minute of life. The pre-ductal SpO<sub>2</sub> target at 1 minute is 60–65%. What is the most appropriate next step to support the neonate's transition to extrauterine life?

- A. Continue PPV with current settings
- B. Administer supplemental oxygen at 30%
- C. Intubate and initiate mechanical ventilation

Answer: A

Explanation: The neonate's SpO<sub>2</sub> of 60% at 1 minute aligns with the NRP target range of 60–65%, indicating appropriate oxygenation for this stage of transition. The heart rate of 80 bpm is improving but not yet optimal (>100 bpm), suggesting that continuing PPV with current settings is appropriate to support ventilation and oxygenation. Supplemental oxygen is not indicated unless SpO<sub>2</sub> falls below the target range. Intubation is reserved for cases of ineffective PPV, prolonged apnea, or other complications not present here.

**Question: 1151**

A 36-week neonate, born via cesarean section, presents with mild respiratory distress and oxygen saturation of 94% on room air. Chest X-ray shows perihilar streaking, suggestive of transient tachypnea of the newborn. The neonatal nurse practitioner notes a maternal history of gestational diabetes. Which laboratory value should be monitored closely due to the risk of secondary complications?

- A. Serum glucose levels
- B. Serum calcium levels
- C. Serum potassium levels

Answer: A

Explanation: Neonates born to mothers with gestational diabetes are at risk for hypoglycemia, which can exacerbate respiratory distress in transient tachypnea of the newborn. Monitoring serum glucose levels is critical to prevent secondary complications. Calcium and potassium are less directly related to this scenario.

**Question: 1152**

A 26-week gestation neonate (800 grams) is in a servo-controlled incubator set to maintain a skin temperature of 36.5°C. The Neonatal Nurse Practitioner observes that the incubator's air temperature fluctuates between 34°C and 37°C, and the neonate's core temperature drops to 35.8°C. Lab values show pH 7.28, PaCO<sub>2</sub> 50 mmHg, and base deficit -6 mEq/L. Which factor is most likely contributing to the neonate's hypothermia, and what should the Neonatal Nurse Practitioner adjust?

- A. Conduction; place a warmed mattress under the neonate

- B. Radiation; add a reflective heat shield to the incubator
- C. Evaporation; increase incubator humidity to 80%

Answer: C

Explanation: The neonate's hypothermia, acidotic pH, and elevated PaCO<sub>2</sub> suggest cold stress, likely due to evaporative heat loss in the incubator. At 26 weeks, the neonate's thin skin and high surface area increase transepidermal water loss, especially if humidity is suboptimal (typically <80% for extreme preterm infants). Increasing humidity to 80% reduces evaporative losses, stabilizing temperature. Conductive losses are minimal in a double-walled incubator, and radiation losses are less likely without specific environmental cues (e.g., cold walls).

**Question: 1153**

A 35-week preterm neonate in the NICU develops widespread flaccid bullae and erosions on the extremities on day 5 of life. Nikolsky's sign is positive, and a skin biopsy reveals intraepidermal cleavage. The nurse practitioner suspects epidermolysis bullosa (EB). Which subtype of EB is most likely based on the clinical and histological findings, and what is the primary management focus?

- A. Dystrophic EB; surgical debridement of lesions
- B. Junctional EB; meticulous wound care and infection prevention
- C. Simplex EB; systemic corticosteroids

Answer: B

Explanation: Junctional epidermolysis bullosa is characterized by flaccid bullae, positive Nikolsky's sign, and intraepidermal cleavage, often presenting in preterm neonates. Meticulous wound care and infection prevention are critical due to the fragility of the skin and risk of sepsis. Dystrophic EB involves deeper cleavage and scarring, while simplex EB is less severe and not typically managed with corticosteroids.

**Question: 1154**

In a busy NICU, a neonatal nurse practitioner is addressing a neonatal safety concern involving medication errors during high-acuity handoffs. A root cause analysis reveals that incomplete verbal handoffs contribute to 60% of errors. The Neonatal Nurse Practitioner proposes a standardized handoff tool using the SBAR (Situation, Background, Assessment, Recommendation) format. After implementation, a post-intervention audit shows a 95% adherence rate. What is the absolute risk reduction (ARR) for incomplete handoffs?

- A. 35%
- B. 55%
- C. 95%

Answer: B

Explanation: ARR is calculated as the difference between the control event rate (pre-intervention

incomplete handoff rate, 60%) and the experimental event rate (post-intervention incomplete handoff rate, 100% - 95% = 5%).  $ARR = 60\% - 5\% = 55\%$ . This represents the absolute reduction in incomplete handoffs due to the SBAR tool.

**Question: 1155**

A 34-week preterm infant with a history of transient tachypnea of the newborn (TTN) is being discharged at 38 weeks corrected age. The infant is on full oral feeds and has gained 25 g/day over the past week. During discharge counseling, the neonatal nurse practitioner discusses safe sleep practices to reduce the risk of SIDS. Which anticipatory guidance is most accurate?

- A. Recommend a firm mattress and back sleeping, avoiding soft bedding
- B. Advise parents to use a wedge to elevate the infant's head during sleep
- C. Suggest co-sleeping to monitor breathing closely

Answer: A

Explanation: Safe sleep practices to reduce SIDS risk include using a firm mattress, placing the infant on their back, and avoiding soft bedding or loose objects. Wedges are not recommended due to suffocation risks, and co-sleeping increases SIDS risk.

**Question: 1156**

A 5-day-old neonate with tricuspid atresia presents with cyanosis (SpO<sub>2</sub> 68%), poor feeding, and a heart rate of 180 bpm. Echocardiography shows a hypoplastic right ventricle and an ASD. Laboratory values include a hemoglobin of 18 g/dL and a hematocrit of 54%. The neonate is started on PGE<sub>1</sub>. What is the most critical nursing intervention to prevent complications from polycythemia in this neonate?

- A. Administer aspirin 5 mg/kg PO daily
- B. Initiate supplemental oxygen
- C. Ensure adequate hydration

Answer: C

Explanation: Polycythemia in tricuspid atresia results from chronic hypoxia, increasing blood viscosity and the risk of thromboembolism. Ensuring adequate hydration reduces viscosity and prevents thrombotic complications. Aspirin is not routinely used in neonates for this purpose. Supplemental oxygen may improve SpO<sub>2</sub> but does not address polycythemia directly.

**Question: 1157**

A 34-week preterm neonate is diagnosed with Beckwith-Wiedemann syndrome based on clinical findings of macrosomia, hemihypertrophy, and an elevated alpha-fetoprotein level. The neonate's abdominal ultrasound reveals visceromegaly, and the neonate is at increased risk for Wilms tumor. Which of the

following is the most appropriate screening protocol to monitor for malignancy in this neonate?

- A. Abdominal ultrasound every 3 months until age 8 years
- B. Annual CT scan of the abdomen
- C. Serum alpha-fetoprotein levels annually

Answer: A

Explanation: Neonates with Beckwith-Wiedemann syndrome are at increased risk for embryonal tumors, particularly Wilms tumor and hepatoblastoma, due to imprinting defects on chromosome 11p15. The recommended screening protocol includes abdominal ultrasound every 3 months until age 8 years to detect tumors early, as this imaging modality is non-invasive and effective. Annual CT scans expose the neonate to unnecessary radiation, and while alpha-fetoprotein levels are monitored, they are typically checked every 6-12 weeks, not annually, and are not the primary screening method.

**Question: 1158**

A term neonate with a TSB of 21 mg/dL at 72 hours of life is receiving intensive phototherapy. The direct bilirubin is 0.8 mg/dL, and the neonate has a positive direct Coombs test, indicating ABO incompatibility. The hemoglobin is 12 g/dL. After 12 hours, the TSB is 20 mg/dL, and the neonate is clinically stable. What is the most appropriate adjunctive therapy to reduce the need for exchange transfusion?

- A. Administer phenobarbital 5 mg/kg/day
- B. Initiate IVIG at 1 g/kg
- C. Perform an albumin infusion at 1 g/kg

Answer: B

Explanation: In ABO incompatibility with persistent hyperbilirubinemia despite phototherapy, IVIG at 1 g/kg reduces hemolysis by blocking Fc receptors, lowering bilirubin production. Phenobarbital is used for Crigler-Najjar syndrome, not ABO incompatibility. Albumin infusion is not standard for this indication.

**Question: 1159**

A 29-week preterm neonate exhibits jitteriness and poor feeding. The mother used SSRIs during pregnancy. Serum glucose is 48 mg/dL, calcium is 8.8 mg/dL, and aEEG is normal. What is the most appropriate management?

- A. Administer calcium gluconate for hypocalcemia
- B. Initiate phenobarbital for suspected seizures
- C. Observe for SSRI withdrawal and provide supportive care

Answer: C

Explanation: Jitteriness with SSRI exposure and normal labs/aEEG suggests withdrawal. Supportive care and observation are appropriate. Calcium is normal, and phenobarbital is unnecessary without seizures.

**Question: 1160**

A 35-week preterm neonate, born via cesarean section, requires PPV in the delivery room due to apnea. After 60 seconds of effective PPV, the heart rate is 70 bpm, and SpO<sub>2</sub> is 75% (target: 70–75%). The team suspects persistent pulmonary hypertension of the newborn (PPHN). Which intervention is most likely to address the underlying pathophysiology of PPHN in this scenario?

- A. Administer inhaled nitric oxide via endotracheal tube
- B. Start dopamine infusion
- C. Increase oxygen to 100% during PPV

Answer: C

Explanation: PPHN is characterized by persistent constriction of pulmonary vasculature, leading to hypoxemia. Increasing oxygen to 100% during PPV can promote pulmonary vasodilation and improve oxygenation, which is critical in the acute setting of resuscitation. Inhaled nitric oxide is a targeted therapy for PPHN but is typically initiated in a NICU setting, not during delivery room resuscitation. Dopamine is not a first-line treatment for PPHN-related hypoxemia.

**Question: 1161**

A NICU serves a diverse population, including a 33-week neonate whose parents speak limited English and request a traditional herbal remedy for jaundice. The Neonatal Nurse Practitioner must balance cultural sensitivity with evidence-based practice. Which action best upholds the principle of beneficence while ensuring safe care, considering the neonate's bilirubin level of 18 mg/dL?

- A. Explain the risks of untested remedies and recommend phototherapy alone
- B. Allow the herbal remedy alongside phototherapy to respect cultural preferences
- C. Administer the herbal remedy under medical supervision

Answer: A

Explanation: Beneficence prioritizes the neonate's well-being. A bilirubin level of 18 mg/dL requires evidence-based phototherapy to prevent kernicterus, per AAP guidelines. Explaining the risks of untested herbal remedies ensures safe care while respecting cultural dialogue, aligning with ANA ethical standards. Allowing or administering the remedy risks delaying effective treatment, compromising beneficence, as herbal remedies lack evidence in neonatal jaundice management.

**Question: 1162**

A term neonate with a karyotype of 45,XO presents with lymphedema, a webbed neck, and a bicuspid

aortic valve on echocardiogram, consistent with Turner syndrome. The neonate's growth hormone levels are normal, but her IGF-1 level is low at 30 ng/mL (normal: 50-150 ng/mL). Which of the following is the most appropriate intervention to address the neonate's growth concerns in the long term?

- A. Growth hormone therapy
- B. Monitor growth without intervention
- C. Vitamin D supplementation

Answer: A

Explanation: The neonate's diagnosis of Turner syndrome, confirmed by a 45,XO karyotype, is associated with short stature due to SHOX gene haploinsufficiency, as evidenced by the low IGF-1 level despite normal growth hormone levels. Growth hormone therapy is recommended to improve final adult height in girls with Turner syndrome, typically started in early childhood but planned for in neonates with confirmed diagnosis. Monitoring without intervention risks suboptimal growth, and vitamin D supplementation is unrelated to the growth concerns in this context.

**Question: 1163**

A 30-week preterm neonate in the NICU develops a temperature of 38.5°C, lethargy, and poor feeding on day 7 of life. Laboratory results show a white blood cell count of 22,000/mm<sup>3</sup>, C-reactive protein of 15 mg/L, and a blood culture pending. Lumbar puncture reveals cerebrospinal fluid with 50 white blood cells/mm<sup>3</sup> (80% neutrophils), glucose of 30 mg/dL, and protein of 150 mg/dL. Which antibiotic regimen is most appropriate for suspected neonatal sepsis and meningitis?

- A. Vancomycin 15 mg/kg every 12 hours and ceftazidime 50 mg/kg every 12 hours
- B. Ampicillin 100 mg/kg/day and gentamicin 4 mg/kg every 24 hours
- C. Ampicillin 100 mg/kg/day and cefotaxime 100 mg/kg/day

Answer: C

Explanation: The neonate's presentation and CSF findings suggest late-onset neonatal sepsis with meningitis, likely caused by group B Streptococcus or gram-negative organisms. Ampicillin and cefotaxime provide broad-spectrum coverage for these pathogens, with cefotaxime preferred over gentamicin for meningitis due to better CSF penetration. Vancomycin and ceftazidime are used for resistant organisms, but there is no indication of methicillin-resistant Staphylococcus aureus or Pseudomonas in this scenario.

**Question: 1164**

A 26-week gestational age neonate with necrotizing enterocolitis is in critical condition, limiting parental access due to frequent medical interventions. The parents express frustration over their inability to bond with their infant. Which intervention best addresses this barrier to parent-infant interaction while maintaining medical stability?

- A. Postpone all parental interactions until the infant is medically stable

- B. Allow brief parental visits during stable periods with nurse supervision
- C. Provide a video feed of the infant to the parents' waiting area

Answer: B

Explanation: Allowing brief, supervised parental visits during stable periods balances medical needs with opportunities for bonding, addressing the barrier to interaction. Postponing all interactions exacerbates emotional distress and hinders attachment, while a video feed, though supportive, does not facilitate direct physical or emotional connection.

**Question: 1165**

A term neonate presents with pulmonary hypoplasia, bilateral renal agenesis, and potter facies, consistent with Potter sequence. The neonate's chest X-ray shows small lung fields, and the arterial blood gas reveals pH 7.22, PaCO<sub>2</sub> 60 mmHg, and HCO<sub>3</sub><sup>-</sup> 24 mEq/L. The neonate is intubated and on synchronized intermittent mandatory ventilation (SIMV). Which of the following is the most appropriate adjustment to the ventilator settings to address the respiratory acidosis?

- A. Increase peak inspiratory pressure to 35 cmH<sub>2</sub>O
- B. Comfort care with no ventilator adjustments
- C. Increase respiratory rate to 60 breaths/min

Answer: B

Explanation: Potter sequence with bilateral renal agenesis results in severe pulmonary hypoplasia, leading to inadequate gas exchange, as seen in the respiratory acidosis and small lung fields on X-ray. The prognosis is fatal due to the inability to sustain ventilation. Adjusting ventilator settings, such as increasing peak inspiratory pressure or respiratory rate, is unlikely to improve outcomes and may cause harm. Comfort care with no further ventilator adjustments is the most appropriate approach, focusing on family support.

**Question: 1166**

A neonate undergoes newborn screening, which reveals an elevated phenylalanine level of 15 mg/dL (normal: <2 mg/dL), suggestive of phenylketonuria (PKU). The neonatal nurse practitioner confirms the diagnosis with repeat testing and initiates a low-phenylalanine diet. What is the primary goal of this dietary intervention?

- A. Prevent neurotoxicity from phenylalanine accumulation
- B. Promote tyrosine synthesis
- C. Reduce homogentisic acid production

Answer: A

Explanation: In PKU, phenylalanine accumulation is neurotoxic, leading to intellectual disability if untreated. A low-phenylalanine diet prevents this by limiting substrate intake. Tyrosine supplementation

may be needed but is not the primary goal. Homogentisic acid is unrelated to PKU.

**Question: 1167**

A term neonate undergoes surgical repair for Hirschsprung disease, confirmed by rectal biopsy showing absent ganglion cells. Postoperatively, the infant develops abdominal distension and fever. An abdominal X-ray shows air-fluid levels and dilated loops of bowel. What is the most likely complication, and what is the immediate nursing action?

- A. Administer broad-spectrum antibiotics
- B. Reposition the infant to relieve pressure
- C. Notify the surgical team for suspected obstruction

Answer: C

Explanation: Postoperative Hirschsprung disease patients are at risk for enterocolitis or obstruction. Abdominal distension, fever, and X-ray findings suggest a bowel obstruction, possibly due to stricture or residual aganglionic segment. Immediate notification of the surgical team is critical for evaluation and potential intervention. Antibiotics may follow, but surgical assessment is the priority. Repositioning does not address the obstruction.

**Question: 1168**

A 30-week preterm neonate with a suspected methicillin-resistant *Staphylococcus aureus* (MRSA) infection is prescribed vancomycin and gentamicin. The Neonatal Nurse Practitioner must monitor for synergistic antimicrobial effects and potential toxicities. Given gentamicin's nephrotoxic potential, the neonate's baseline serum creatinine is 0.9 mg/dL, and the estimated GFR is 25 mL/min/1.73 m<sup>2</sup>. After 72 hours, the gentamicin peak level is 8 mcg/mL (target: 5–10 mcg/mL), and the trough is 2.5 mcg/mL (target: <2 mcg/mL). What is the most appropriate adjustment to the gentamicin regimen?

- A. Increase the dose to 5 mg/kg every 24 hours
- B. Discontinue gentamicin and switch to clindamycin
- C. Extend the dosing interval to every 36 hours

Answer: C

Explanation: The elevated gentamicin trough (2.5 mcg/mL) indicates reduced clearance, likely due to the neonate's immature renal function (low GFR). Extending the dosing interval to every 36 hours allows more time for drug clearance, reducing the risk of nephrotoxicity while maintaining therapeutic peak levels. Increasing the dose risks further toxicity, and switching to clindamycin is unnecessary as the current regimen is appropriate for MRSA coverage when adjusted properly.

**Question: 1169**

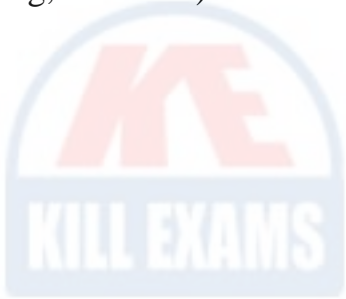
A term neonate with a history of polyhydramnios presents with excessive oral secretions and choking

during the first feed. A chest radiograph shows a coiled nasogastric tube in the proximal esophagus and gas in the stomach. The neonatal nurse practitioner suspects tracheoesophageal fistula (TEF). What is the most likely type of TEF, and what is the initial management?

- A. Proximal esophageal atresia with distal TEF; surgical consultation
- B. H-type TEF; initiate enteral feeds cautiously
- C. Isolated esophageal atresia; place a gastrostomy tube

Answer: A

Explanation: The presentation of excessive secretions, choking, and a radiograph showing a coiled NG tube with distal bowel gas is classic for esophageal atresia with a distal tracheoesophageal fistula (Type C, the most common form). Immediate surgical consultation is required for repair, along with supportive care (e.g., suctioning, IV fluids). Enteral feeds are contraindicated, and isolated atresia would show no distal gas.



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