EMS

IBSC-TP-C

The International Board of Specialty Certification: Certified Tactical Paramedic

Latest Version: 6.0

Question: 1

A casualty is showing signs of cyanide poisoning after exposure to hazardous materials. Which medication should be administered as an antidote?

A. Atropine
B. Naloxone
C. TXA
D. Sodium thiosulfate

Answer: D

Explanation:
Sodium thiosulfate is an essential component of the antidote regimen for cyanide poisoning. It works by converting cyanide into thiocyanate, a less toxic substance that can be excreted by the kidneys. It is often used in combination with hydroxocobalamin, which binds cyanide to form cyanocobalamin (vitamin B12), or sodium nitrite, which induces methemoglobinemia to sequester cyanide from cellular enzymes.
Atropine is used to counteract nerve agent toxicity and is not effective against cyanide.
Tranexamic acid (TXA) is an antifibrinolytic used to control bleeding and has no role in treating cyanide poisoning.
Naloxone is an opioid antagonist and is ineffective for treating cyanide toxicity.

Question: 2

Which method is most effective for preventing dehydration in tactical environments with prolonged physical exertion?

A. Drinking water only when thirsty.
B. Drinking 1 liter of water at the beginning of the activity.
C. Alternating between water and caffeinated beverages.
D. Using oral rehydration solutions containing electrolytes.

Answer: D

Explanation:
Using oral rehydration solutions containing electrolytes is the most effective method for preventing dehydration in tactical environments. These solutions replenish both water and essential electrolytes, such as sodium and potassium, that are lost through sweat during prolonged physical exertion. Maintaining this balance helps prevent conditions like heat cramps, fatigue, and more severe heat-related illnesses.

Drinking water only when thirsty may lead to underhydration, as thirst is not always a reliable indicator of hydration status during high exertion.
Consuming 1 liter of water at the beginning of the activity can lead to overhydration initially, without sustaining hydration throughout the activity.
Alternating between water and caffeinated beverages is not ideal, as caffeine can have a diuretic effect and exacerbate dehydration in some cases.

Question: 3

What is the primary goal in treating hypovolemic shock?

A. To promote urine production.
B. To increase tissue perfusion and oxygenation.
C. To reduce blood pressure.
D. To increase body temperature.

Answer: B

Explanation:
The primary goal in treating hypovolemic shock is to restore adequate tissue perfusion and oxygenation by replenishing intravascular volume and ensuring sufficient blood flow to vital organs. This is achieved through interventions such as fluid resuscitation, hemorrhage control, and maintaining oxygen delivery to prevent organ failure and improve outcomes.
Reducing blood pressure is incorrect, as hypovolemic shock is characterized by low blood pressure requiring stabilization.
Increasing body temperature is unrelated, although preventing hypothermia is important in trauma care.
Promoting urine production may indicate improving perfusion, but it is a secondary goal rather than the primary focus in hypovolemic shock management.

Question: 4

What is the Babinski's Sign indicative of?

A. Peripheral nerve damage
B. Spinal cord injury
C. Normal reflex activity
D. Cerebral function

Answer: B

Explanation:
Babinski's Sign, observed as an upward extension of the big toe and fanning of the other toes when the sole of the foot is stroked, is an indicator of an upper motor neuron lesion or spinal cord injury. This abnormal reflex in adults points to disruption in the corticospinal tract, which governs voluntary motor control.

Normal reflex activity would not include an upward extension of the big toe; instead, the toes would curl downward in response to stimulation.
Peripheral nerve damage typically affects localized areas and reflexes but does not produce Babinski's Sign.
Cerebral function issues may cause altered mental status or motor deficits but are not directly associated with Babinski's Sign.

Question: 5

What should you do before approaching a helicopter?

A. Run towards the helicopter.
B. Wave to get the crew's attention.
C. Approach immediately.
D. Wait for directions from the crew.

Answer: D

Explanation:
Waiting for direction from the helicopter crew ensures a safe approach by coordinating with their instructions and confirming the rotors and surrounding area are secure. The crew’s signal prevents responders from inadvertently walking into danger zones like the tail rotor or rotor wash, which can be fatal.
Running towards the helicopter is unsafe as it increases the risk of accidents due to lack of awareness or losing balance in the rotor wash.
Approaching immediately without direction could result in entering unsafe zones, as the rotors may still be spinning or the crew may not be ready to guide entry.
Waving to get the crew's attention is unnecessary and potentially distracting; the crew is trained to signal when it is safe to approach.

Question: 6

What should be done with the medical intelligence information once a mission is underway?

A. It should be shared with the media.
B. It should be discarded.
C. It should be updated continuously.
D. It should be filed for future reference.

Answer: B

Explanation:
Medical intelligence information must be updated continuously throughout the mission to account for dynamic changes, such as evolving threats, team member injuries, or situational developments. This ensures that tactical medical providers and commanders can make timely decisions to enhance mission effectiveness and casualty care.

Discarding the information removes critical data needed for in-mission adjustments.
Sharing information with the media breaches operational security and confidentiality.
Filing it for future reference without updates ignores the immediate necessity for actionable intelligence.

Question: 7

You are a tactical paramedic embedded with a law enforcement team during an active shooter situation. One officer sustained a gunshot wound to the leg with arterial bleeding. The area is still under threat. What is your immediate action?

A. Perform a full body assessment before intervening.
B. Apply a tourniquet to stop the arterial bleeding.
C. Drag the officer to cover before initiating care.
D. Apply direct pressure to the wound and secure it with a bandage.

Answer: C

Explanation:
In a high-threat environment under " Care Under Fire" principles, the immediate priority is to remove the casualty from the direct threat to a safer position before initiating medical care. Attempting to control bleeding while still exposed to active threats increases the risk to both the casualty and the responder. Once in cover, massive hemorrhage control can be addressed using a tourniquet as a priority.
A full body assessment is inappropriate in a high-threat situation, as it delays evacuation and puts both the responder and the casualty in greater danger. While applying a tourniquet is a critical step, it is secondary to moving the casualty to cover in an active threat scenario.
Applying direct pressure and securing a bandage is also inappropriate during Care Under Fire, as it is both time-consuming and less effective than a tourniquet for arterial bleeding.

Question: 8

What is the adult goal urine output (UOP) range for patients requiring fluid resuscitation?

A. 30-50 ml/hr
B. 70-100 ml/hr
C. 10-20 ml/hr
D. 50-70 ml/hr

Answer: A

Explanation:
A goal urine output of 30-50 ml/hr is an important clinical indicator of adequate kidney perfusion and effective fluid resuscitation in adults. This range demonstrates restored blood volume and cardiac output, ensuring vital organs receive sufficient oxygen and nutrients.

50-70 ml/hr exceeds the typical target range and may indicate over-resuscitation, leading to complications such as fluid overload.
10-20 ml/hr suggests inadequate perfusion or ongoing shock, requiring further resuscitation efforts.
70-100 ml/hr is not a standard target and may result from excessive fluid administration or pathological conditions.

Question: 9

What is a key practice to ensure field sanitation?

A. Ensure adequate handwashing facilities.
B. Use only water for cleaning.
C. Keep waste near fresh food.
D. Store food at room temperature.

Answer: A

Explanation:
Proper hand hygiene is a critical practice in field sanitation to prevent the spread of pathogens and diseases. Ensuring that adequate handwashing facilities with soap and clean water are available helps reduce the risk of illnesses caused by cross-contamination, especially in environments where food preparation, waste disposal, and personal hygiene are challenging.
Storing food at room temperature increases the risk of bacterial growth, leading to foodborne illnesses. Proper refrigeration or storage practices are essential to maintain food safety.
Waste near fresh food creates a significant contamination risk, increasing the likelihood of disease transmission through pests or direct contact. Waste must be disposed of far from food preparation areas.
Using only water for cleaning is inadequate, as soap or sanitizing agents are necessary to effectively remove pathogens from hands, utensils, and surfaces.

Question: 10

A casualty presents with distended neck veins, muffled heart sounds, and hypotension following blunt trauma'. What is the most likely diagnosis?

A. Massive hemothorax
B. Tension pneumothorax
C. Cardiac tamponade
D. Neurogenic shock

Answer: C

Explanation:
Cardiac tamponade is the most likely diagnosis in this scenario. It is characterized by Beck's triad: distended neck veins, muffled heart sounds, and hypotension. These signs occur due to the accumulation of fluid or blood in the pericardial sac, which compresses the heart, impeding its ability to

fill and pump effectively. Immediate intervention, such as pericardiocentesis, is critical to restore cardiac function.
Tension pneumothorax can also cause hypotension and distended neck veins but is distinguished by hyperresonance to percussion and absent breath sounds on the affected side, not muffled heart sounds.
Neurogenic shock results from spinal cord injury and causes hypotension without distended neck veins or muffled heart sounds.
Massive hemothorax leads to hypotension and diminished or absent breath sounds but is associated with dullness to percussion rather than signs of cardiac tamponade.

Question: 11

What defines a massive hemothorax in a trauma patient?

A. Any intrapleural bleeding detected on imaging.
B. Blood accumulation resulting in respiratory compromise regardless of volume.
C. Blood loss exceeding 1,500 mL or approximately 1/3 of the patient's total blood volume.
D. Accumulation of more than 1,000 mL of blood in the pleural cavity.

Answer: C

Explanation:
A massive hemothorax is defined as blood loss greater than 1,500 mL or approximately 1/3 of the patient's total blood volume into the pleural cavity. This degree of hemorrhage can cause severe hemodynamic instability, hypoxia, and respiratory failure. Prompt recognition and intervention, such as chest tube thoracostomy or thoracotomy, are critical to stabilize the patient and prevent further decompensation.
An accumulation of 1,000 mL of blood may indicate significant bleeding but does not meet the threshold for a massive hemothorax.
Blood causing respiratory compromise, regardless of volume, describes the functional impact rather than the definition of massive hemothorax.
Any intrapleural bleeding detected on imaging includes minor hemothoraces, which are less likely to cause life-threatening complications.

Question: 12

What is the primary advantage of using a supraglottic airway device in a tactical setting?

A. It bypasses the need for oxygen supplementation.
B. It is quick and easy to insert under stress.
C. It requires no confirmation of placement.
D. It provides a definitive airway.

Answer: B

Explanation:

The primary advantage of using a supraglottic airway (SGA) device in a tactical setting is its rapid and straightforward insertion, making it highly effective in high-stress or austere environments. SGAs are designed to be placed without requiring advanced airway management skills or extensive equipment, allowing for quick stabilization of a casualty's airway during critical situations.
SGAs do not provide a definitive airway, because they do not protect against aspiration like an endotracheal tube does.
Placement of a supraglottic airway device still requires confirmation, typically through auscultation and monitoring of ventilation efficacy.
While SGAs facilitate ventilation, they do not eliminate the need for oxygen supplementation in hypoxic patients.

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