Self-Evaluation Quiz

The questions in this self-evaluation quiz are based on the articles in this issue of the journal. Each of the questions or statements is followed by five possible answers or completions. Select all of the correct answers to each of the questions and circle the corresponding letters. The answers appear on the inside front cover of this issue.

As an organization accredited for continuing medical education, the American Academy of Pediatrics certifies that this continuing medical education activity, when used and completed as directed, meets the criteria for two hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association and two hours of PREP credit.

To earn two hours of Category 1 credit and two hours of PREP credit for this quiz, you must currently be enrolled in PREP or subscribing to PEDIATRICS IN REVIEW. You will receive two quiz reply cards this year along with a letter acknowledging your enrollment or subscription. Each card provides space to answer the questions from five issues of the journal. Please use CARD #1 for responses to the questions in the *July through November* issues and CARD #2 for the *December through April* issues. To receive proper credit, both cards MUST be returned by June 30, 1987.

We invite your specific comments about the relevance of each of the articles and any other comments you wish to make about the journal. You may enclose your comments with your quiz reply cards, or send them directly to: PEDIATRICS IN REVIEW, American Academy of Pediatrics, 141 Northwest Point Road, PO Box 927, Elk Grove Village, IL 60007.

1. Which *one* of the following would *not* be appropriate advice to parents experiencing an impending death of a newborn? Sibling(s) should:

A. Be told what is going on as soon as possible, so as to allow for anticipatory coping and grieving.
B. Preferably be told by their parents, not helping professionals.
C. Not be allowed to see or touch a deformed or dead baby.
D. Be allowed frequent contact with their mother while she is in the hospital.
E. If there are no complicating factors, be expected to get over most of their regressive behaviors within a few weeks.

2. Which *one* of the following is *least likely* to be a true statement?

A. Essentially all normal children older than 2 years of age have at least a rudimentary concept of death.
B. Often in children younger than 5 years of age the concept of death involves issues of abandonment and punishment.
C. The ability of parents to help their children is limited by how well they themselves are coping.
D. When under stress, children tend to respond in keeping with their previous methods of reacting.
E. A dead deformed newborn should not be given a name or a formal funeral.

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3. Disorders of which *one* of the following are typically associated with increased muscle tone and increased deep tendon reflexes?

A. Upper motor neuron.
B. Lower motor neuron.
C. Cerebellum.
D. Basal ganglia (extrapyramidal).
E. Muscle.

4. Which *one* of the following is *least likely* to be a true statement?

A. Peripheral nerve dysfunction is frequently associated with sensory loss.
B. Electromyographic and nerve conduction studies differentiate between primary muscle and denervation disorders.
C. Cranial nerve palsies are uncommon in disorders of the neuromuscular junction (infantile botulism, myasthenia gravis).
D. Signs of oculomotor and/or bulbar dysfunction (dysphagia, dysarthria) localize the site of abnormality to be brainstem.
E. Spinal cord diseases are frequently associated with bladder and bowel dysfunction.

5. Which *one* of the following is *not* correct?

A. Infantile botulism—dysphagia, constipation, hypotonia, sluggishly reactive pupils.
B. Myasthenia gravis—ptosis, dysphagia, exertional weakness, normal deep tendon reflexes.
C. Charcot-Marie-Tooth disease—pes cavus, decreased ankle jerks, steppage gait.
D. Guillian-Barre syndrome—back pain, fixed rapidly evolving level of weakness and sensory loss, urinary retention, normal CSF findings.
E. Wernig-Hoffman disease—progressive weakness, hypotonia, absent deep tendon reflexes, tongue fasciculations.

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6. Which *one* of the following associations is *least likely* to be true?

A. Goal of discipline: socialization.
B. Restrictive child rearing: high value on obedience, absolute standards; creativity, autonomy, verbal give and take less important.
C. Permissive child rearing: high acceptance of child's impulses, desires, individuality; use reasoning rather than force.
D. Authoritative child rearing: rely on parental authority, enforce standards, encourage verbal exchange, explore child's reasons for his/her behavior.
E. Restrictive child rearing: poor long-term outcome with frequent pathologic aggressiveness.

7. Good general recommendations for parents include all *except* which *one* of the following?

A. Make it clear when the child has absolutely no choice in the matter.
B. Suppress feelings of anger when your child misbehaves.
C. Encourage spontaneity and choice when it is safe.
D. Avoid trying to control areas that cannot be controlled.
E. Investigate reasons for misbehavior.

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8. True statements pertaining to adolescents with the diagnosis attentional deficit disorder/hyperactivity (ADDH) in childhood include:

A. The most common age for behavior to normalize is at about 15 to 16 years.
B. Few continue to have similar problems by 18 years of age.
C. They are at increased risk for drug abuse if treated with psychostimulants during childhood.
D. Those having academic and social problems in junior high school rarely improve when in senior high school.
E. Those who were aggressive children are at significantly increased risk for antisocial behavior.

9. Older adolescents with continued symptoms of ADDH are at increased risk for:

A. Depression.
B. Substance abuse.
C. Schizophrenia.
D. Anxiety disorder.
E. Antisocial disorder.

10. Adolescents with ADDH:

A. Are less likely than their mothers to report symptoms of restlessness, inattention, and impulsivity.
B. Have essentially the same symptoms as children with ADDH.
C. Are more likely to have residual ADDH (attentional deficit disorder without hyperactivity) than the full syndrome.
D. Have a poorer long-term prognosis if they are girls.
E. Normally do not perceive that their difficulties are due to inattention, impulsivity, and hyperactivity.

11. True statements regarding the use of methylphenidate (Ritalin) in treating adolescents with ADDH include:

A. It is usually more effective than pemoline (Cylert).
B. The dose required is typically the same as that for children.
C. Underdosing is a frequent management error.
D. The "nonresponder" as a child is very unlikely to respond as an adolescent.
E. Parents should be given the responsibility for determining when to change the dose.

AAP Continuing Education Calendar

1987	January 8–11	2nd Annual Vail Infectious Disease Seminar (with the AAP Colorado Chapter)	*Vail, Colorado*
	February 5–7	Current Concepts in Pediatric Medicine (with the San Diego Children's Hospital)	*San Diego, California*
	March 5–7	Pediatric Advances	*Poipu Beach, Kauai, Hawaii*
	April 3–5	Advances in Dermatology/ Immunology	*Washington, DC*
	May 8–14	**Spring Session**	***San Francisco, California***
	May 21–23	Pediatric Advances (with the AAP Pennsylvania Chapter)	*Hilton Head, South Carolina*
	June 4–6	Pediatric Advances	*Williamsburg, Virginia*
	June 19–21	Pediatric Advances	*Toronto, Ontario, Canada*
	October 31–November 5	**Annual Meeting**	***New Orleans, Louisiana***
1988	**May 14–19**	**Spring Session**	***New York City***
	October 15–20	**Annual Meeting**	***San Francisco, California***
1989	**October 21–26**	**Annual Meeting**	***Chicago, Illinois***
1990	**October 6–11**	**Annual Meeting**	***Boston, Massachusetts***
1991	**October 26–31**	**Annual Meeting**	***New Orleans, Louisiana***
1992	**October 10–15**	**Annual Meeting**	***San Francisco, California***

These programs feature subject matter which is coordinated with the PREP curriculum and are eligible for PREP credits.

For further information, contact: CME, Department of Education, American Academy of Pediatrics, PO Box 927, Elk Grove Village, IL 60009-0927. (800) 433-9016. In Illinois (800) 421-0589.

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