Flight Physiology

Share of the exam	Tables	Tested facts
4 to 8%	**3**	**1**

Match the law to the observation	
Law	**What it explains**
Boyle's	Trapped gas expands on ascent: vent the colostomy bag before flight and burp it during, and watch the endotracheal cuff, air splint and IV bag
Charles's	Volume relates to temperature
Dalton's	The partial pressure of oxygen falls with altitude even though the percentage of oxygen is unchanged
Fick's	Diffusion across a membrane
Henry's	Gas coming out of solution

Altitude numbers	
Altitude or figure	**Meaning**
3,000 to 8,000 feet	Starting physiologic altitude of a patient already on supplemental oxygen, whose haemoglobin is already saturated
Above 15,000 feet	Supplemental oxygen alone is no longer sufficient
About 44,800 feet	Body fluids boil at ambient pressure: survival requires a sealed cabin or full pressure suit
79 to 70 per cent saturation	The disturbance stage of hypoxia; blackout is the end point

Environmental numbers	
Stressor	**Figure**
Cabin noise	Around 70 dBA
Vibration	1 to 12 Hz range
Flicker vertigo	Light flickering at about 4 to 20 cycles per second
Temperature lapse	About 3 to 5 degrees Fahrenheit per thousand feet

PEARL

Two counterintuitive consequences: carbon dioxide diffuses faster than oxygen despite being heavier, because its much higher solubility in blood outweighs its mass; and a LARGER cabin decompresses more slowly, because more air must escape to equalise pressure.

TESTED

- [x] On rapid decompression, all occupants including crew immediately breathe 100 per cent oxygen and descend below 10,000 feet. Both EPT and TUC are cut by as much as half, because oxygen flow briefly reverses in the alveoli and depletes the reserve.

Safety and Transport

Share of the exam	Tables	Tested facts
6 to 10%	**2**	**1**

Regulation and numbers	
Item	**Figure**
Governing regulation	14 CFR Part 135
Duty limit	No more than 16 hours on duty within any 24-hour span
Pilot hours	Typically 2,000 total with at least 1,500 in a helicopter, plus an instrument rating
EMS crash fatality rate	About 33 per cent, against about 14 per cent for non-EMS crashes; pilot incapacitation is more than ten times as likely in EMS crashes
Flight following	Real-time radio contact or tracking updates at least every 15 minutes
Scene coordinates	At least two independent sets for the same location

What the 2014 helicopter air ambulance rule requires	
Requirement	**Purpose**
HTAWS	Helicopter terrain awareness and warning systems, against controlled flight into terrain
Instrument rating for every pilot-in-command	A safer transition to instrument flight if weather closes in
FAA-approved preflight risk analysis tool	Systematic weighing of weather, fatigue and mission complexity before accepting a flight
Personal flotation devices	Worn by all crew during overwater flights

TESTED

- [x] Any single crew member, regardless of rank or experience, can stop a flight. An abnormal odour, unusual sound or anything out of place goes to the pilot immediately and clearly.

Airway, Anesthesia, and Analgesics

Share of the exam	Tables	Tested facts
13 to 17%	**3**	**4**

PEARL
Airflow resistance rises by the FOURTH power as the radius halves, so work of breathing increases roughly sixteenfold. That is why a small or partially obstructed tube changes everything.

Settings that get tested

Setting	Value and rationale
Baseline PEEP	Roughly 5 cm H2O: increases functional residual capacity and helps wash out physiologic dead space
Recruitment maneuver	40 to 50 cm H2O for 30 to 40 seconds; the benefit is usually short-lived
I:E for obstruction	1:4 or 1:5
Inverse-ratio ventilation	Poorly tolerated, which is why neuromuscular blockade is often given with it
Raising PEEP in a pressure-targeted mode	Decreases driving pressure (delta P), which can drastically reduce delivered tidal volume

Choosing the induction agent	
Agent	**Profile**
Etomidate	Haemodynamically stable and cerebroprotective, but a single dose can suppress the adrenal cortisol response for 6 to 8 hours or longer
Ketamine	Dissociative with analgesia and amnesia, bronchodilation, minimal respiratory depression, preserved airway reflexes and muscle tone; raises heart rate and blood pressure, useful in the hypotensive asthmatic
Propofol	Rapid on, rapid off, but a significant cardiovascular depressant with exaggerated hypotension in the volume depleted; prolonged high-dose infusion risks propofol-related infusion syndrome

The protective numbers	
Parameter	**Rule**
Tidal volume in ARDS	4 to 6 mL/kg of PREDICTED body weight, the ARDS Network strategy that improved mortality
Plateau pressure	Below 30 cm H2O with poor compliance; below 20 cm H2O for normal adult lungs
Driving pressure	Plateau minus PEEP; keep it below 15 cm H2O
Severe ARDS	Berlin definition: PaO2 to FIO2 ratio below 100 (mild 200 to 300, moderate 100 to 200)
Auto-PEEP	Set external PEEP about 75 per cent below the measured auto-PEEP value

TESTED

- ☑ Physiologic optimisation before induction is the recurring theme: correct hypotension, hypoxaemia, and pH or ventilation problems such as metabolic acidosis BEFORE the drugs. A failed airway is defined by failure to oxygenate or ventilate, not by a number of attempts.
- ☑ A ventilated patient who suddenly crashes with falling output is a tension pneumothorax from barotrauma until proven otherwise: it reduces venous return and cardiac output.
- ☑ A paralysed patient cannot show pain or awareness, so undersedation goes unrecognised and is commonly undertreated; awareness under paralysis is linked to poor outcomes and PTSD. Train-of-four measures blockade depth, not sedation.
- ☑ Continuous waveform end-tidal capnography is the gold standard for confirming tube placement, immediately and continuously. If placement cannot be confirmed by waveform, REMOVE the tube and bag the patient. A colorimetric device turns yellow when CO2 is present.

Cardiac

Share of the exam	Tables	Tested facts
11 to 15%	**5**	**3**

ECG numbers	
Item	**Value**
Calibration	0.04 second per small box, 10 mm per millivolt
Infarction criteria	At least 1 to 2 mm of ST elevation in at least two contiguous leads
Lead aVL on the hexaxial reference	Minus 30 degrees, with the reciprocal at plus 150
Hyperkalaemia threshold	Potassium above 5.5 mEq/L
Wide complex thresholds	Greater than 160 ms with LBBB morphology; greater than 140 ms with RBBB morphology

Who supplies what	
Vessel	**Territory and consequence**
Right coronary artery	SA node in 85 to 90 per cent of people, so an RCA occlusion can silence it: sinus bradycardia and blocks with inferior infarction
Posterior descending	Arises from the RCA in 80 to 85 per cent; supplies the inferior wall, septum and posteromedial papillary muscle
Left anterior descending	Anterior wall, interventricular septum and BOTH bundle branches, so anteroseptal infarction brings conduction blocks and cardiogenic shock

Biomarkers and drugs	
Item	**Rule**
Troponins	Rise 2 to 6 hours after injury, peak 12 to 16 hours; troponin I stays up 5 to 10 days, troponin T 5 to 14 days
Myoglobin	Fast but abandoned for ACS: skeletal muscle injury and renal failure also raise it
IV nitroglycerin	Start 10 mcg/min, titrate in 10 mcg increments, ceiling 200 mcg/min
Transfer antiplatelets	No fibrinolysis given or planned: aspirin 324 mg with ticagrelor 180 mg orally before departure
Fibrinolysis exclusion	A systolic difference greater than 15 mm Hg between arms suggests dissection

Electrolytes on the tracing	
Disturbance	**Signature**
Hyperkalaemia	Tall, narrow, peaked T waves starting above 5.5 mEq/L, then widened PR and QRS, loss of P waves and a sinusoidal pattern
Hypokalaemia	A prominent U wave after the T wave is the commonest finding; it mainly raises torsades susceptibility
Hypocalcaemia	Prolonged ST segment with apparent QTc lengthening; clinically, depressed contractility, wheezing, stridor, bradycardia, crackles, an S3 and tetany
Magnesium	Stabilises the myocardial membrane, works with potassium and opposes calcium

Getting true numbers	
Item	**Rule**
Phlebostatic axis	Fourth intercostal space, mid-chest, level of the atrium and aortic root; each inch of transducer error shifts readings 1.86 mm Hg
Square-wave test	More than two oscillations after a fast flush means underdamping: falsely high systolics, fixed by removing bubbles and keeping tubing under 48 inches
End expiration	Read at the PEAK of the baseline in spontaneous breathing, the VALLEY in mechanical ventilation
PCWP on high PEEP	Above 10 cm H2O of PEEP, subtract 1.5 mm Hg per 5 cm H2O from the measured wedge; document both values
Arterial line contraindications	Extremity ischaemia, site infection, Raynaud disease, prior vascular surgery at the site

TESTED

- ☑ Transcutaneous pacing needs confirmation of MECHANICAL capture, a palpable pulse or a corresponding pulse oximeter waveform, not just electrical capture on the monitor.
- ☑ Ventricular tachycardia is by far the most common cause of a wide complex tachycardia, so any haemodynamically significant wide complex rhythm is treated as VT until proven otherwise, and an UNSTABLE one gets synchronized cardioversion.
- ☑ Irregular wide complex tachycardia in WPW is atrial fibrillation over the accessory pathway: give slow IV procainamide and AVOID adenosine and amiodarone, both of which can precipitate ventricular fibrillation by leaving only the bypass tract conducting.

Medical Emergencies

Share of the exam	Tables	Tested facts
11 to 15%	**10**	**2**

The numbers	
Item	**Value**
Hyperosmolar hyperglycaemic state	Serum osmolality above 320 mmol/kg with hyperglycaemia but without significant ketoacidosis
DKA resolution	Return of the anion gap to normal, not the glucose alone
Sodium correction rate	4 to 6 mEq/L per 24 hours; faster risks harm
pH threshold for specific measures	Below 6.90
Alkalinisation target	Urine pH 7 to 8.5, with hypokalaemia extremely common and watched closely
Normal oxygen extraction ratio	25 per cent; it must rise substantially to compensate for falling delivery

Toxicology pairs	
Poison	**Rule**
Caustic ingestion	Small amount of water or milk; do NOT induce vomiting, do NOT neutralise
Acid versus alkali	Acids cause coagulation necrosis, limiting depth; alkalis cause liquefactive necrosis, penetrating deeper
Hydrocarbon	Induced vomiting may increase pulmonary toxicity through aspiration
Non-selective beta blockade	Beta-1 and beta-2 effects together: bronchospasm and hypoglycaemia included
Dabigatran	Idarucizumab inactivates it; dialysis is an alternative

Toxidrome recognition

Toxidrome	Picture and treatment
Sympathomimetic	Tachycardia, hypertension, agitation, hyperthermia, dilated pupils and WET, diaphoretic skin; benzodiazepines for sedation and seizure control
Anticholinergic	The same autonomic picture with HOT, DRY skin, ileus, delirium and urinary retention from muscarinic blockade by antihistamines, TCAs, atropine or jimson weed; severe cases may receive physostigmine, only after toxicologist consultation
Cholinergic	SLUDGEM secretions with bronchorrhoea and bronchospasm from cholinesterase inhibitors; atropine in doses far above ACLS dosing plus pralidoxime, with airway and ventilation a high priority
Opioid	Best viewed as a subset of the sedative-hypnotic syndrome; both are treated with airway, ventilation and circulatory support, but only opioid syndrome has a reliable specific antidote

What charcoal can and cannot do

Category	Rule
Not adsorbed	Iron, lithium, certain heavy metals, hydrocarbons and alcohols
Contraindicated	Caustics, which charcoal does not adsorb and whose imaging it obscures; hydrocarbons, because vomiting after charcoal risks aspiration
Gut dialysis	Charcoal lowers levels of theophylline, phenytoin, carbamazepine, salicylates and digoxin even after systemic absorption
Whole-bowel irrigation	Iron and heavy metal ingestions, plus large sustained-release or enteric-coated ingestions and body packers or stuffers
Gastric lavage	Only within 1 hour of a life-threatening ingestion; it is invasive, delays charcoal or an oral antidote, and may push toxin further along the gut

Overdose numbers

Poisoning	Rule
TCA with QRS above 100 ms	Up to 34 per cent seizure risk and up to 14 per cent life-threatening arrhythmia risk; alkalinise the serum with sodium bicarbonate
Beta blocker	Glucagon 5 to 10 mg IV then an infusion, acting through its own receptor independent of the blocked beta receptor; refractory cases get high-dose insulin with glucose and IV lipid emulsion, with ECMO at some centres
Calcium channel blocker	IV calcium first; methylene blue is noted specifically for amlodipine toxicity
Salicylate dialysis	Level above 100 mg/dL, or above 90 mg/dL with impaired renal function
Hydrogen peroxide	Concentrations above 9 per cent can generate enough gas to cause systemic air embolism

Transmission precautions

Category	Rule
Droplet	Particles larger than 5 micrometres travelling short distances, as with pertussis; surgical mask for the crew
Airborne	Droplet nuclei of 5 micrometres or smaller that stay suspended over distance and time: TB, measles, varicella, viral haemorrhagic fevers; N95 and ideally a negative-pressure environment

Hypersensitivity types

Type	Mechanism and example
I	Immediate, IgE on mast cells and basophils degranulating within minutes: atopy and anaphylaxis
II	Cytotoxic: IgG or IgM binds a cell-surface antigen and complement lyses the cell: transfusion reactions, haemolytic disease of the newborn
III	Circulating antigen-antibody complexes deposit in tissue
IV	Delayed, cell mediated by macrophages and T cells, onset hours to days: poison ivy contact dermatitis

Acid base numbers	
Rule	**Value**
Winters formula	Expected PaCO2 = (1.5 x HCO3) + 8, plus or minus 2; a measured PaCO2 above the prediction means a concurrent respiratory acidosis
Metabolic alkalosis compensation	PCO2 rises about 0.7 mm Hg per 1 mmol/L rise in bicarbonate; urgent treatment when bicarbonate exceeds 40 or pH exceeds 7.55
Base excess	Normal minus 2 to plus 3 mEq/L; deficits are mild to minus 6, moderate to minus 15, severe beyond
Compensation	Never overshoots

Oxygen and lactate	
Item	**Rule**
Rightward curve shift	Increased PaCO2, increased 2,3-BPG, increased temperature, decreased pH: oxygen unloads more readily
Carboxyhaemoglobin	Pulse oximetry and calculated saturation both count it as if it were oxyhaemoglobin, giving falsely reassuring values
Lactate	Above 2 mmol/L means inadequate perfusion; it responds slowly over hours, so serial values reveal the trend, and a rising lactate is perhaps the most ominous sign in septic shock
Sensitivity	A highly sensitive test such as D-dimer rules disease out; its frequent false positives make it poor at ruling in

Transfusion rules	
Item	**Rule**
Massive transfusion	More than 10 units of red cells in 24 hours; give PRBCs, plasma and platelets 1:1:1
Whole blood	Reserved for acute loss of at least 25 per cent of blood volume; simpler and more concentrated than components, with no demonstrated outcome advantage
Emergency uncrossmatched	Type O, Rh-negative blood or plasma, carrying no A, B or D antigen
Universal recipient	Type AB patients make no anti-A or anti-B antibodies
Fresh frozen plasma	Needs ABO compatibility but not Rh matching, must run within 24 hours of thawing, and its citrate binds calcium, so watch for hypocalcaemia
Febrile reactions	Driven by donor white cells; prevented with leukocyte-reduced products
TRALI versus TACO	TRALI is neutrophil activation in the lung producing an ARDS-like injury; TACO is volume overload in cardiac or pulmonary disease

TESTED

- ☑ In sympathomimetic toxicity never block beta receptors alone: unopposed alpha vasoconstriction can worsen hypertension. Typical antipsychotics such as haloperidol are also avoided in amphetamine overdose because they inhibit effective cooling and lower the seizure threshold.
- ☑ A persistent large base deficit with normal vital signs means a source of continued shock should be sought; do not let the numbers on the monitor overrule the chemistry.

Neurological

Share of the exam	Tables	Tested facts
9 to 13%	**2**	**1**

Eye signs that localise

Finding	Lesion
Fixed dilated pupil, ptosis, eye down and out	Oculomotor (CN III) palsy, classically from the uncus herniating over the tentorium and compressing the nerve
Eye resting higher, vertical diplopia worst looking down and in	Trochlear (CN IV) palsy of the superior oblique
Eye cannot move laterally, cross-eyed look, horizontal diplopia	Abducens (CN VI) palsy: the unopposed medial rectus pulls the globe inward
Loss of the corneal blink	Afferent CN V, efferent CN VII: the reflex arc tests the pons
Tongue deviates to one side	Hypoglossal (CN XII) lesion on the SAME side the tongue points, pushed there by the intact genioglossus

The intracranial bleeds

Bleed	Signature
Epidural	Middle meningeal artery torn by a temporal blow; unconsciousness, a LUCID INTERVAL, then deterioration as renewed arterial bleeding strips the dura; lens-shaped on CT
Acute subdural	Torn bridging veins; crescent-shaped high-attenuation collection, symptoms within 24 hours
Chronic subdural	Manifests beyond two weeks and is fluid only, with slowly progressive headache, slowed cognition and drowsiness
Diffuse axonal injury	Shearing of white matter tracts in the corpus callosum, brainstem and cerebellum: immediate unconsciousness, prolonged confusion, no mass lesion on early CT

TESTED

- ☑ Cerebral perfusion pressure target is 70 to 90 mmHg or higher, and even a SINGLE hypotensive episode is associated with significantly increased morbidity and mortality. Pressure comes before pressure-lowering.

Trauma/Burn

Share of the exam	Tables	Tested facts
10 to 14%	**3**	**1**

Trauma numbers	
Item	**Value**
TXA	Greatest mortality benefit within 3 hours: 1 gram bolus, then an infusion
Normal saline caution	Large volumes cause hyperchloraemic metabolic acidosis
Platelets	Stored at room temperature under constant agitation, shelf life about 5 days
Pelvic fractures	Approximately 60 to 70 per cent from motor vehicle crashes
Splenic flow	About 5 per cent of circulating blood volume filters through every minute
Urine output target	0.5 to 1.0 mL/kg/h
Fat embolism syndrome	69 per cent fracture-associated, about half tibial; 31 per cent from soft tissue without fracture
Class III haemorrhage	Roughly 1,500 mL, with 500 to 1,000 mL as the adjacent threshold

Reversal agents	
Anticoagulant	**Reversal**
Warfarin	Four-factor prothrombin complex concentrate, carrying factors II, VII, IX and X, plus vitamin K
Dabigatran	Idarucizumab, with dialysis as the fallback
Factor Xa inhibitors (apixaban, rivaroxaban)	Andexanet alfa; four-factor PCC is also used in practice
Unfractionated heparin	Protamine

Blood loss by closed fracture	
Fracture	**Estimated loss**
Rib	125 mL
Radius or ulna	250 to 500 mL
Humerus	500 to 750 mL
Tibia or fibula	500 to 1,000 mL
Femur	1,000 to 2,000 mL

TESTED

- [x] Singed nasal hairs alone are NOT sufficient to commit to intubation, and cyanide poisoning in an enclosed-space fire is treated with hydroxocobalamin.

Maternal Fetal and Neonatal

Share of the exam	Tables	Tested facts
5 to 9%	**1**	**2**

Decelerations and accelerations	
Pattern	**Rule**
Variable deceleration	Abrupt onset, short duration, shape varying contraction to contraction: umbilical cord compression
Early versus late	Both are gradual; the early nadir coincides with the contraction peak (head compression), the late nadir follows the peak
Prolonged deceleration	An abrupt drop lasting 2 to less than 10 minutes
Acceleration at or beyond 32 weeks	At least 15 beats above baseline for at least 15 seconds
Acceleration before 32 weeks	The threshold drops to at least 10 beats for at least 10 seconds

TESTED

- ☑ Hypertension and proteinuria are absent in about 15 per cent of HELLP syndrome cases, which is what makes the diagnosis easy to miss.
- ☑ Naloxone may precipitate seizures or acute withdrawal in an opioid-exposed neonate, so it is not given reflexively.

Pediatric

Share of the exam	Tables	Tested facts
6 to 10%	**1**	**1**

Paediatric pharmacology and numbers	
Item	**Rule**
Racemic epinephrine in epiglottitis	Contraindicated: it can worsen swelling
Corticosteroids in asthma	Take about 4 to 6 hours: complement, not replace, the immediate agent
Inhaled corticosteroids	For children older than 18 months with a strong family history of asthma or atopy, continued only on response
Calcium in hyperkalaemia	Stabilises the myocardial membrane
Hypocalcaemia from hyperphosphataemia	Correcting the calcium rapidly is the wrong move
First-degree block in a child	PR above about 0.16 second
Monitoring leads	Never at the level of the diaphragm: use the lower abdomen or thighs
Brudzinski sign	Avoided where cervical spine injury is suspected; blood volume about 800 mL appears as a figure

TESTED

- [x] Children maintain a normal blood pressure well into shock through catecholamine-driven tachycardia, so hypotension is LATE. Fluid resuscitation is 60 mL/kg total, given as three boluses.

Professional Considerations

Share of the exam	Tables	Tested facts
4 to 8%	**1**	**0**

PEARL
SBAR was developed by the US Navy for nuclear submarines, duty hours cap at 80 in the named standard, an employee assistance programme is the named resource, and resilience is built on biology or genetics, attachment, and control.

Just culture sorts behaviour three ways

Category	Definition and response
Human error	An unintentional slip anyone similarly placed could have made: treated as a SYSTEM failure to correct, not punished
At-risk behaviour	A conscious shortcut whose risk is underestimated, such as habitually skipping a required independent pump check: coach and retrain
Reckless behaviour	Consciously ignoring a known, required safety step: accountability applies

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