CEU TEST QUESTIONS
Select the best answer for each question.
Use the answer sheet to record your responses.

Article 1. Laryngeal Structure and Function in the Pediatric Larynx: Clinical Applications

1. A congenital voice disorder is defined as a disorder:
   A. resulting from the behaviors elicited by the child
   B. existing at birth that is either hereditary or due to an influence(s) occurring during gestation up to the moment of birth.
   C. whereby neurological damage has impaired the function of the recurrent laryngeal nerves
   D. that affects both breathing and voice function

2. When evaluating pediatric voice, there are a number of factors to consider. Which factor would help the clinician interpret the laryngeal endoscopic image?
   A. knowledge of the existence of laryngeal anatomical and functional differences between pediatrics and adults
   B. knowledge that the endoscope used with children is larger than that used with adults
   C. knowledge of image distortion and the details of how endoscopes work
   D. knowledge that children with voice disorders will “grow” out of them once they reach puberty

3. The total vocal fold length of a child’s membranous portion of the vocal fold as compared to an adult’s is:
   A. more
   B. less
   C. equal
   D. twice as much

4. The pediatric larynx lies between which two cervical levels in comparison to an adult’s where the laryngeal position is located approximately at the sixth and seventh cervical levels?
   A. fourth and fifth
   B. seventh and eighth
   C. first and third
   D. third and fourth
5. Respiratory muscle strength training presented for the case of bilateral abductor paralysis showed that:

A. strengthening expiratory muscles caused the vocal folds to open better
B. the program was time intensive regardless of the positive results
C. the program would work only with cases of abductor paralysis
D. strengthening inspiratory muscles resulted in greater respiratory pressures, at least in this case

6. The general consensus of opinion suggests that vocal nodules are:

A. an irritation of the vocal process of the arytenoids
B. an edema or hemorrhage of some part of the mucosal layer
C. a result of trauma to the larynx
D. a result of a soft, compensatory phonatory style

**Article 2. Quick Screen for Voice and Supplementary Documents for Identifying Pediatric Voice Disorders**

7. The percentage of children with voice disorders on the caseloads of speech-language pathologists (SLPs) has been estimated at:

A. less than 5%
B. 10%
C. 15%
D. 30%

8. When compared with commonly cited prevalence figures of 6% to 9%, the percentage of children who failed the Quick Screen for Voice was:

A. lower than 6% to 9%
B. in agreement with 6% to 9%
C. higher than 6% to 9%
D. higher than 40%

9. One common reason why medically fragile infants may be at risk of developing a voice disorder is:

A. lack of stimulation as an infant
B. delay in attending school
C. frustration with academic performance
D. multiple and/or traumatic intubations

10. One way that a voice disorder may affect a child’s education is:

A. it may decrease the child’s ability to interact effectively in the classroom
B. it may impair intellectual functioning
C. it may prohibit the child from participating in extracurricular activities
D. it may increase the child’s susceptibility to upper respiratory infections
11. The majority of voice disorders in children are due to:

   A. personality-related causes
   B. medical causes
   C. lack of respiratory support
   D. misuse of the voice

**Article 3. Treatment of Voice Disorders in Children**

12. SLPs in schools report that children with voice disorders represent what percentage of their caseload?

   A. 2% to 4%
   B. 10% to 15%
   C. almost half
   D. 1%

13. Respiratory tract infections, asthma and allergies, and gastroesophageal reflux often co-occur in children with voice disorders.

   A. true
   B. false

14. The following statement is true about classroom teachers in K–12:

   A. they always provide good voice models for students
   B. they can often identify children with voice disorders
   C. there are good published data regarding teacher referral of children with voice disorders to the school SLP
   D. they are at very low risk themselves for developing a voice disorder

15. SLPs in the schools are more likely to take dysphonic children on their school caseloads if they have:

   A. attended a workshop on voice disorders in the past 3 years and have the ASHA Certificate of Clinical Competence
   B. small caseloads
   C. completed their MA in the past 3 years
   D. more than 10 years of clinical practice experience
Article 4. Treating Voice Disorders in the School-Based Setting: Working Within the Framework of IDEA

16. Students who have been diagnosed with voice disorders may fail to receive therapeutic services because:
   A. classroom teachers do not want the child to miss any classroom instruction
   B. there is a misperception that the voice disorder will not adversely affect academic performance
   C. the voice disorder is not severe enough to warrant voice therapy
   D. the parent does not believe that the child has a problem

17. If a child is referred to an otolaryngologist for a laryngeal examination but never follows through, what is the role of the SLP?
   A. wait until the next year to see if the child still has a voice problem
   B. start voice therapy
   C. try to make arrangements for a free community-based clinic with an otolaryngologist in the community
   D. ask the classroom teacher to initiate voice therapy in the academic environment

18. If a child’s vocal behavior and verbal affect do not match the profile of vocal abuse/misuse, what is the role of the SLP?
   A. continue with the current voice therapy program
   B. increase the number of voice therapy sessions for the child
   C. withdraw the child from voice therapy
   D. refer the child to an otolaryngologist for another laryngeal exam

Article 6. Paradoxical Vocal Fold Motion in Children and Adolescents

19. The breathing exercise designed for a child with paradoxical vocal fold motion (PVFM) should be initiated:
   A. after the attack is over
   B. only if inhalers do not work
   C. only if the child is afraid of losing consciousness
   D. with the onset of identification of the first physical trigger and breathing difficulties

20. PVFM co-occurs with asthma in what percentage of cases?
   A. 100
   B. 50
   C. 10
   D. 20
21. The relaxation and attention phase of the behavioral program is vital to develop:
   A. identification of physical triggers of a PVFM attack
   B. lower abdominal breathing
   C. gastroesophageal reflux disease
   D. better athletic ability

**Article 7. Assessing and Managing Medically Fragile Children: Tracheostomy and Ventilatory Support**

22. Use of a tracheostomy speaking valve is contraindicated:
   A. when there is tracheal or laryngeal obstruction and medical clearance has not been provided
   B. for children younger than 1 year of age
   C. with individuals who are ventilator dependent
   D. when voice is already produced with an open tracheostomy tube

23. Children who have tracheostomies on a long-term basis:
   A. always need speech therapy
   B. generally have no articulation difficulties once they start vocalizing
   C. generally have delayed articulation skills, but quickly “catch up” once they start vocalizing
   D. may exhibit deviant sound production patterns

24. An individual with a tracheostomy who is ventilator dependent:
   A. cannot vocalize if he or she has a cuffed tracheostomy tube
   B. will not have the option of using a tracheostomy speaking valve because these devices do not work with a ventilator
   C. may be a candidate for use of a tracheostomy speaking valve if deflation of the tracheostomy tube cuff is tolerated
   D. will not be integrated into educational or community settings.

25. When conducting an evaluation and intervention with a child with a tracheostomy, it is important to understand that:
   A. status may change as a result of development, the disease process, or medical intervention
   B. the ultimate goal is decannulation
   C. intervention should be delayed until a complete voice evaluation is completed
   D. improved voice quality is an unrealistic treatment goal