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39	A	B	C	D	E

PRACTICE QUESTIONS

Dubai Health Authority (DHA)

INTME

Specialist Internal Medicine Exam

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EDITION

Original Demo

QUESTIONS

6

ISSUED

October 14, 2026

Before you begin

What this is

6 practice questions for Dubai Health Authority (DHA) **INTME**, each with its answer key and an explanation. Answer a question before you read its key - the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, **INTME**
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

Licence

Free Mometrix practice demo. The complete question bank is available through a paid account.

QUESTION 1

SINGLE CHOICE

A 58-year-old man with a urinary tract infection presents with hypotension (BP 86/52 mmHg), tachycardia (124/min), lactate of 4.5 mmol/L, and temperature 39.2°C despite receiving 30 mL/kg of crystalloid resuscitation. Which intervention is most appropriate next?

- ☐ A Continue IV fluids only
- ☒ B Start norepinephrine
- ☐ C Start hydrocortisone only after fluid resuscitation fails
- ☐ D Restrict further fluids and start dopamine

ANSWER B

WHY Per the Surviving Sepsis Campaign guidelines, in septic shock with persistent hypotension and elevated lactate after adequate fluid resuscitation, vasopressors should be initiated immediately, with norepinephrine as the first-line agent. Hydrocortisone is added only if vasopressors are required to maintain MAP ≥ 65 mmHg despite adequate fluid resuscitation. Dopamine is no longer first-line due to greater arrhythmogenic risk.

QUESTION 2

MULTIPLE CHOICE

A 60-year-old man with ischemic cardiomyopathy and LVEF 28% (NYHA class II) is currently on enalapril, carvedilol, and furosemide. His blood pressure is 110/72 mmHg, heart rate 68/min, potassium 4.6 mEq/L, eGFR 55 mL/min/1.73 m². Which of the following additional medications have proven mortality benefit in HFrEF and would be appropriate to add? (Choose two.)

- ☒ **A** Spironolactone
- ☐ **B** Verapamil
- ☒ **C** Sacubitril/valsartan (ARNI)
- ☐ **D** Diltiazem
- ☐ **E** Ivabradine

ANSWER A - C

WHY Spironolactone has established mortality benefit in HFrEF (NYHA II-IV, EF ≤35%) per the RALES trial, and this patient has suitable renal function and potassium. Switching from ACE inhibitor to sacubitril/valsartan (ARNI) further reduces cardiovascular mortality and hospitalization (PARADIGM-HF). Non-dihydropyridine calcium channel blockers (verapamil, diltiazem) are contraindicated in HFrEF due to negative inotropic effects. Ivabradine reduces hospitalizations but only in patients in sinus rhythm with resting HR ≥70/min despite maximally tolerated beta-blocker - and does not have a mortality benefit on its own.

QUESTION 3

SINGLE CHOICE

A 60-year-old man with chronic kidney disease (eGFR 22 mL/min/1.73 m²), hypertension, and type 2 diabetes has persistent albuminuria despite being on an ACE inhibitor at maximum tolerated dose. His serum potassium is 4.8 mmol/L and blood pressure is 138/82 mmHg. Which is the most appropriate next step?

- ☐ A Discontinue the ACE inhibitor due to nephrotoxicity risk
- ☒ B Add a non-steroidal mineralocorticoid receptor antagonist (e.g., finerenone)
- ☐ C Initiate chronic hemodialysis immediately
- ☐ D Add a thiazide diuretic

ANSWER B

WHY In CKD patients with diabetes and albuminuria already on an ACE inhibitor (or ARB), adding finerenone reduces progression of kidney disease and cardiovascular events. ACE inhibitors should not be stopped unless true intolerance or severe hyperkalemia develops. Dialysis is not indicated at this eGFR without uremic symptoms. Thiazide diuretics are less effective when eGFR is below 30.

QUESTION 4

SINGLE CHOICE

A 66-year-old man with chronic heart failure (LVEF 28%) on enalapril, carvedilol, and furosemide presents with progressive dyspnea, orthopnea, and bilateral lower limb edema over 2 weeks. Blood pressure is 148/86 mmHg, heart rate 96/min, and oxygen saturation 92% on room air. Jugular venous pressure is elevated and there are bibasilar crackles. Which is the most appropriate next step in management?

- ☒ **A** Initiate intravenous loop diuretic therapy
- ☐ **B** Add ivabradine
- ☐ **C** Start a sodium-glucose cotransporter 2 (SGLT2) inhibitor and discharge
- ☐ **D** Refer urgently for cardiac resynchronization therapy

ANSWER A

WHY The patient has signs of acute decompensated heart failure with volume overload (elevated JVP, crackles, peripheral edema). First-line management is intravenous loop diuretics to relieve congestion. SGLT2 inhibitors are useful long-term but not in isolation for acute decompensation. Ivabradine is only for stable symptomatic patients in sinus rhythm with HR ≥ 70 despite maximum tolerated beta-blocker. CRT requires evaluation after optimization of medical therapy.

QUESTION 5

SINGLE CHOICE

A 32-year-old premenopausal woman presents with fatigue. Labs: hemoglobin 9.8 g/dL, MCV 72 fL, ferritin 8 ng/mL, serum iron 30 µg/dL, TIBC 420 µg/dL, transferrin saturation 7%. Which is the most appropriate next step?

- ☐ A Vitamin B12 supplementation
- ☒ B Oral iron supplementation and evaluation for cause of blood loss
- ☐ C Erythropoietin injection
- ☐ D Plasma transfusion

ANSWER B

WHY The lab findings (microcytic anemia, very low ferritin, low iron, high TIBC, low transferrin saturation) are classic for iron deficiency anemia. In a premenopausal woman, menstrual blood loss is the most common cause, but gastrointestinal sources must be considered and evaluated if clinically indicated. Treatment is oral iron supplementation. Vitamin B12 deficiency produces macrocytic anemia. Erythropoietin is not first-line and is inappropriate before correcting iron deficiency. Plasma transfusion is not indicated.

QUESTION 6

SINGLE CHOICE

A 52-year-old man with type 2 diabetes mellitus, obesity (BMI 33 kg/m²), and chronic kidney disease (eGFR 38 mL/min/1.73 m²) has HbA1c of 8.6% despite metformin 1 g twice daily. Which add-on agent is most appropriate given his comorbidity profile?

- ☐ A Glipizide (sulfonylurea)
- ☒ B Empagliflozin (SGLT2 inhibitor)
- ☐ C Pioglitazone (thiazolidinedione)
- ☐ D Sitagliptin (DPP-4 inhibitor)

ANSWER B

WHY SGLT2 inhibitors (e.g., empagliflozin) are recommended in patients with type 2 diabetes and established cardiovascular disease or chronic kidney disease because they reduce progression of CKD and cardiovascular outcomes. Sulfonylureas cause weight gain and hypoglycemia. Pioglitazone causes fluid retention and is contraindicated in CKD with volume overload risk. DPP-4 inhibitors are reasonable but do not have the strong cardiorenal benefits of SGLT2 inhibitors.