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PRACTICE QUESTIONS

Dubai Health Authority (DHA)

INTME

Specialist Internal Medicine Exam

Uploaded by Community B

EDITION

Original Demo

QUESTIONS

8

ISSUED

October 14, 2026

Before you begin

What this is

8 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 42-year-old woman presents with unintentional weight loss of 8 kg over 4 months, proximal muscle weakness, easy bruising, hypertension (BP 162/98 mmHg), and moon facies. Laboratory tests show: fasting glucose 165 mg/dL, potassium 3.0 mmol/L, and suppressed ACTH. What is the most likely underlying cause of this patient's clinical syndrome?

- ☐ A Primary adrenal insufficiency (Addison disease)
- ☐ B ACTH-dependent Cushing syndrome from a pituitary adenoma (Cushing disease)
- ☒ C ACTH-independent Cushing syndrome, most likely from an adrenal adenoma
- ☐ D Ectopic ACTH syndrome from small cell lung carcinoma

ANSWER C

WHY The patient has Cushing syndrome (centripetal obesity, hypertension, hyperglycemia, hypokalemia, proximal weakness). Suppressed ACTH indicates an ACTH-independent source, most commonly an adrenal adenoma. ACTH-dependent Cushing syndrome (pituitary or ectopic) would show elevated or inappropriately normal ACTH. Addison disease presents with hypotension, hyperkalemia, and weight loss without features of cortisol excess. Ectopic ACTH typically occurs in older smokers with lung cancer and rapid onset of severe hypokalemia.

QUESTION 2

SINGLE CHOICE

A 29-year-old man presents with a 6-week history of bloody diarrhea, abdominal cramping, and weight loss. Colonoscopy shows continuous mucosal inflammation starting at the rectum and extending proximally to the splenic flexure, with loss of vascular pattern and pseudopolyps. Biopsies confirm crypt abscesses. Which is the most appropriate first-line therapy for inducing remission in this presentation?

- ☐ A Oral vancomycin
- ☒ B Mesalamine (5-aminosalicylic acid)
- ☐ C Infliximab
- ☐ D Loperamide

ANSWER B

WHY The clinical and endoscopic features are consistent with ulcerative colitis (continuous inflammation limited to the colon, crypt abscesses). For mild-to-moderate disease limited to the rectum and left colon (up to the splenic flexure), oral and rectal 5-aminosalicylic acid (mesalamine) is the first-line therapy to induce remission. Infliximab is reserved for moderate-to-severe or refractory disease. Vancomycin is not indicated, and loperamide is avoided in active inflammatory colitis due to risk of toxic megacolon.

QUESTION 3

MULTIPLE CHOICE

A 58-year-old man with type 2 diabetes mellitus, hypertension, and a recent ischemic stroke has LDL-cholesterol of 135 mg/dL despite lifestyle modification. He is already on atorvastatin 40 mg daily. Which of the following interventions are appropriate additional measures for secondary cardiovascular prevention? (Choose two.)

- ☒ **A** Add ezetimibe to intensify LDL-cholesterol lowering
- ☒ **B** Add a PCSK9 inhibitor for further LDL-cholesterol lowering
- ☐ **C** Add a fibrate as first-line combination with statin
- ☐ **D** Add a thiazide diuretic in preference to a calcium channel blocker

ANSWER A • B

WHY For very high-risk patients (established atherosclerotic cardiovascular disease including prior stroke) who do not reach LDL goals on high-intensity statin, current guidelines recommend adding ezetimibe and, if needed, a PCSK9 inhibitor. Fibrates are not first-line add-ons and have not shown clear outcome benefit with statins. Thiazide vs. calcium channel blocker choice depends on comorbidities and is not specifically mandated for this scenario.

QUESTION 4

MULTIPLE CHOICE

A 72-year-old man presents with sudden onset severe epigastric pain radiating to the back, vomiting, and a serum lipase of 1,250 U/L. Which of the following are appropriate components of early management? (Choose three.)

- ☒ **A** Aggressive IV crystalloid resuscitation
- ☐ **B** Immediate oral feeding regardless of symptoms
- ☒ **C** Assessment for gallstone etiology with abdominal ultrasound
- ☒ **D** IV opioid analgesia for pain control
- ☐ **E** Endoscopic retrograde cholangiopancreatography (ERCP) in all patients

ANSWER A - C - D

WHY Early management of acute pancreatitis includes aggressive isotonic crystalloid resuscitation (especially in the first 24 hours), adequate pain control with IV opioids, and identification of gallstone etiology with abdominal ultrasound. Oral feeding should be reintroduced early only if tolerated; patients with ileus or vomiting should remain NPO. ERCP is indicated only in patients with cholangitis or persistent biliary obstruction, not routinely in all cases.

QUESTION 5

SINGLE CHOICE

A 54-year-old man with type 2 diabetes mellitus, hypertension, and established cardiovascular disease is reviewed. His HbA1c is 8.1%, eGFR is 65 mL/min/1.73 m², BMI is 31 kg/m², and he has a history of heart failure (NYHA class II). Which is the most appropriate addition to his regimen to provide both cardiovascular and renal benefit?

- ☐ A Glipizide
- ☒ B Empagliflozin
- ☐ C Pioglitazone
- ☐ D Sitagliptin

ANSWER B

WHY Empagliflozin is an SGLT2 inhibitor with proven cardiovascular benefit (reduction in cardiovascular death and heart failure hospitalization) and renoprotective effect in patients with type 2 diabetes and established cardiovascular disease, including those with heart failure. Glipizide has no proven cardiovascular or renal benefit. Pioglitazone is contraindicated in heart failure due to fluid retention. Sitagliptin is cardiovascular safe (neutral) but does not reduce heart failure or renal outcomes.

QUESTION 6

SINGLE CHOICE

A 62-year-old man presents to the emergency department with retrosternal chest pain for 90 minutes. ECG shows ST elevation of 3 mm in leads II, III, and aVF. He is hemodynamically stable, blood pressure 140/85 mmHg, heart rate 92/min. Aspirin and atorvastatin are given. What is the next most appropriate management step?

- ☐ A Thrombolytic therapy with streptokinase
- ☒ B Primary percutaneous coronary intervention (PCI) within 90 minutes of first medical contact
- ☐ C Heparin and discharge if symptoms resolve
- ☐ D Exercise stress test before discharge

ANSWER B

WHY The patient has an inferior wall ST-elevation myocardial infarction (STEMI). Primary PCI is the preferred reperfusion strategy when it can be performed in a timely manner (within 90 minutes of first medical contact in a PCI-capable center), as it is superior to thrombolysis in terms of mortality, reinfarction, and stroke. Thrombolysis is reserved for situations where PCI is not available within 120 minutes. Discharging without definitive reperfusion or performing a stress test is inappropriate.

QUESTION 7

SINGLE CHOICE

A 67-year-old man with a long history of alcohol use presents with progressive dyspnea. Chest X-ray shows a large right-sided pleural effusion. Thoracentesis yields fluid with the following characteristics: pleural fluid protein 5.2 g/dL (serum 6.8), pleural fluid LDH 320 U/L (serum 240), and pleural fluid to serum LDH ratio of 1.33. Which of the following best categorizes this effusion?

- ☐ A Transudate
- ☒ B Exudate by Light's criteria
- ☐ C Indeterminate - additional studies required
- ☐ D Hemothorax

ANSWER B

WHY Light's criteria identify an exudate if any one of the following is met: pleural protein/serum protein >0.5 , pleural LDH/serum LDH >0.6 , or pleural LDH $>2/3$ upper limit of normal serum LDH. Here, the pleural/serum LDH ratio of 1.33 (>0.6) qualifies this as an exudate, often due to parapneumonic effusion or malignant effusion in alcoholics.

QUESTION 8

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 $\leq$ 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 $\geq$ 70/min despite maximally tolerated beta-blocker - and does not have a mortality benefit on its own.