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PRACTICE QUESTIONS

SCFHS Remote

ENDOC

Endocrinology

Uploaded by Community A

EDITION

Original Demo

QUESTIONS

6

ISSUED

October 14, 2026

Before you begin

What this is

6 practice questions for SCFHS Remote **ENDOC** , 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, **ENDOC**
- 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 44-year-old woman with confirmed primary adrenal insufficiency on hydrocortisone 10 mg/morning and 5 mg/afternoon develops a fever of 38.9°C, productive cough, and vomiting. She is unable to tolerate oral intake. What is the most appropriate immediate management?

- ☐ A Double the oral hydrocortisone dose and arrange outpatient follow-up
- ☐ B Switch oral hydrocortisone to an equivalent oral dexamethasone dose
- ☒ C Administer intramuscular hydrocortisone 100 mg immediately and arrange hospital admission for IV fluids and IV hydrocortisone
- ☐ D Discontinue hydrocortisone until the infection resolves to allow proper assessment of adrenal recovery

ANSWER C

WHY Patients with primary adrenal insufficiency require stress-dose steroids during major illness, especially when vomiting precludes oral absorption. The standard sick-day rule is to administer hydrocortisone 100 mg IM (or IV) immediately and seek hospital care for IV fluid resuscitation and continuous IV hydrocortisone (200 mg/24 h). Doubling oral doses is inadequate when oral intake is not tolerated. Switching to dexamethasone loses both glucocorticoid and mineralocorticoid replacement and is incorrect. Stopping hydrocortisone risks adrenal crisis.

QUESTION 2

SINGLE CHOICE

A 42-year-old woman with Graves disease is started on methimazole 30 mg daily. Four weeks later she develops fever, sore throat, and severe fatigue. Laboratory testing reveals an absolute neutrophil count of $0.4 \times 10^9/L$. Which of the following is the most appropriate next step in management?

- ☐ A Continue methimazole and add prophylactic granulocyte colony-stimulating factor (G-CSF)
- ☐ B Continue methimazole at the same dose and obtain a bone marrow biopsy
- ☒ C Immediately discontinue methimazole and do not restart any thionamide
- ☐ D Reduce methimazole to 10 mg daily and monitor weekly until recovery

ANSWER C

WHY Methimazole-induced agranulocytosis ($ANC < 0.5 \times 10^9/L$) is an idiosyncratic, potentially life-threatening reaction. The thionamide must be stopped immediately and should not be reintroduced because recurrence can be fatal. Definitive therapy for Graves disease (radioactive iodine or thyroidectomy) is then planned once the patient is stable. Continuing, dose-reducing, or simply adding G-CSF without stopping the offending drug is incorrect management.

QUESTION 3

SINGLE CHOICE

A 31-year-old woman who is 9 weeks pregnant is found to have TSH 6.8 mIU/L (reference 0.4-4.0), free T4 1.0 ng/dL (within the non-pregnant reference range), and positive anti-TPO antibodies. She is asymptomatic. Which of the following is the most appropriate next step?

- ☐ A Reassure and repeat thyroid function tests in the second trimester
- ☒ B Initiate levothyroxine therapy
- ☐ C Initiate methimazole
- ☐ D Initiate lithium therapy

ANSWER B

WHY In pregnancy, the upper reference limit for TSH is lower (typically <4.0 mIU/L, with many guidelines recommending <2.5 in the first trimester or use of trimester-specific ranges). A TSH above the pregnancy-specific reference range with positive anti-TPO antibodies indicates subclinical hypothyroidism in pregnancy, which is associated with adverse maternal and fetal outcomes. Levothyroxine is the treatment of choice to maintain TSH within the trimester-specific reference range. Methimazole is teratogenic (aplasia cutis, choanal/esophageal atresia) and is avoided in the first trimester. Lithium has no role in hypothyroidism.

QUESTION 4

SINGLE CHOICE

A 54-year-old woman undergoes abdominal CT for unrelated reasons, and a 2.4-cm left adrenal mass with a Hounsfield unit of 10 (non-contrast) is identified. She has no clinical features of Cushing syndrome, no history of malignancy, and a normal plasma metanephrine. What is the most appropriate next step?

- ☐ A Immediate adrenalectomy
- ☐ B Repeat imaging in 3 months
- ☒ C 1-mg overnight dexamethasone suppression test and assessment of autonomous cortisol excess
- ☐ D Fine-needle aspiration of the adrenal mass
- ☐ E MIBG scintigraphy

ANSWER C

WHY For an adrenal incidentaloma with benign imaging features (size <4 cm, Hounsfield units <10 on non-contrast CT, no concerning features), the standard endocrine workup includes assessment for (1) autonomous cortisol secretion using the 1-mg overnight dexamethasone suppression test, (2) catecholamine excess with plasma or urine metanephrines (already negative here), and (3) primary aldosteronism in hypertensive patients. FNA is not useful for distinguishing benign from malignant adrenal lesions and should be avoided unless an extra-adrenal metastasis is suspected. Adrenalectomy is reserved for confirmed functional or clearly malignant lesions. Routine 3-month imaging is used after the biochemical workup is complete. MIBG is reserved for confirming pheochromocytoma when biochemical screening is positive.

QUESTION 5

SINGLE CHOICE

A 47-year-old man presents with recurrent fasting neuroglycopenic symptoms. During a supervised fast, plasma glucose drops to 38 mg/dL (2.1 mmol/L) with simultaneous insulin 14 μ U/mL (inappropriately elevated), C-peptide 2.8 ng/mL (elevated), and negative sulfonylurea screen. What is the most likely diagnosis?

- ☐ A Exogenous insulin administration
- ☒ B Insulinoma
- ☐ C Adrenal insufficiency
- ☐ D Non-islet cell tumor hypoglycemia

ANSWER B

WHY Whipple's triad is satisfied (symptoms of hypoglycemia, low plasma glucose, relief with glucose). During hypoglycemia, endogenous insulin and C-peptide are both inappropriately elevated and the sulfonylurea screen is negative, which is the classic biochemical signature of an insulinoma. In exogenous insulin administration, insulin is elevated but C-peptide is suppressed (because exogenous insulin suppresses endogenous insulin secretion). In adrenal insufficiency, insulin is appropriately suppressed. Non-islet cell tumor hypoglycemia typically presents with low insulin, low C-peptide, and elevated IGF-2.

QUESTION 6

SINGLE CHOICE

A 38-year-old man with confirmed primary adrenal insufficiency on hydrocortisone 15 mg morning and 5 mg afternoon, plus fludrocortisone 0.1 mg daily, develops fever (39 °C) and productive cough. He is alert and able to take oral fluids. Which of the following is the most appropriate adjustment of glucocorticoid therapy?

- ☒ **A** Double the usual oral dose until recovery, and seek medical care if vomiting occurs
- ☐ **B** Stop oral hydrocortisone and start intravenous hydrocortisone 50 mg every 6 hours
- ☐ **C** Continue current doses and add oral ibuprofen for fever
- ☐ **D** Switch to oral dexamethasone 4 mg daily until recovery

ANSWER A

WHY In primary adrenal insufficiency, minor to moderate physiologic stress (fever, infection, minor procedure) requires doubling or tripling the usual glucocorticoid dose until recovery (sick-day rules). Parenteral hydrocortisone is reserved for severe illness, surgery, trauma, or vomiting/diarrhea that precludes oral intake. Dexamethasone is not appropriate for adrenal crisis because it lacks mineralocorticoid activity and produces unreliable glucocorticoid replacement. NSAIDs do not replace glucocorticoid stress dosing.