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PRACTICE QUESTIONS

SCFHS Remote

ENDOC

Endocrinology

Uploaded by Community B

EDITION

Original Demo

QUESTIONS

8

ISSUED

October 14, 2026

Before you begin

What this is

8 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 55-year-old woman is found on routine testing to have a serum calcium of 11.2 mg/dL (reference 8.5-10.5) with a PTH of 92 pg/mL (reference 15-65). She is asymptomatic. Which of the following is the most appropriate next step in evaluation?

- ☐ A Perform a sestamibi scan of the parathyroid glands
- ☒ B Obtain 24-hour urinary calcium, phosphate, creatinine, and serum 25-hydroxyvitamin D
- ☐ C Proceed directly to parathyroidectomy
- ☐ D Measure serum PTH-related peptide (PTHrP)

ANSWER B

WHY An elevated calcium with an inappropriately elevated or non-suppressed PTH is consistent with primary hyperparathyroidism. Before imaging or surgical referral, the diagnostic workup should include confirmation with a repeat calcium, plus measurement of ionized calcium, serum 25-hydroxyvitamin D (to exclude vitamin D deficiency contributing to secondary hyperparathyroidism), creatinine, and a 24-hour urine collection for calcium (to identify familial hypocalciuric hypercalcemia when urine calcium is low) and creatinine. Sestamibi scanning is used for surgical localization after the biochemical diagnosis is confirmed and surgery is planned. PTHrP is used in the workup of malignancy-associated hypercalcemia, in which PTH is suppressed. Parathyroidectomy is indicated only after a complete biochemical and clinical assessment confirms primary hyperparathyroidism meeting surgical criteria.

QUESTION 2

SINGLE CHOICE

A 51-year-old woman with episodic headaches, palpitations, and paroxysmal hypertension has plasma free metanephrines of 850 pg/mL (reference <90) and normetanephrines of 2100 pg/mL (reference <180). Abdominal MRI shows a 4.5-cm right adrenal mass. Before surgical resection, which of the following preoperative drug regimens is most appropriate?

- ☐ A Propranolol followed by doxazosin, with liberal salt and fluid intake
- ☒ B Phenoxybenzamine followed by a beta-blocker if tachycardia persists, with high salt and fluid intake
- ☐ C Amlodipine followed by an ACE inhibitor, with low-sodium diet
- ☐ D Spironolactone followed by furosemide, with potassium replacement

ANSWER B

WHY Preoperative preparation for pheochromocytoma requires alpha-blockade first (typically phenoxybenzamine or doxazosin) for 7-14 days to control hypertension and allow volume re-expansion, followed by a beta-blocker only if reflex tachycardia develops - never before alpha-blockade, because unopposed alpha stimulation causes hypertensive crisis. A high-sodium diet and liberal fluids are prescribed once alpha-blockade is established to restore intravascular volume. Beta-blocker-first or diuretic regimens are dangerous and incorrect.

QUESTION 3

SINGLE CHOICE

A 36-year-old man presents with polyuria (8 L/day) and polydipsia. Serum sodium is 148 mEq/L, serum osmolality is 305 mOsm/kg, and urine osmolality is 180 mOsm/kg. After desmopressin administration, urine osmolality rises to 650 mOsm/kg. What is the diagnosis?

- ☒ **A Central diabetes insipidus**
- ☐ B Nephrogenic diabetes insipidus
- ☐ C Primary polydipsia
- ☐ D Osmotic diuresis

ANSWER A

WHY The patient has hypernatremia with elevated serum osmolality and inappropriately dilute urine, confirming diabetes insipidus. A robust response to desmopressin (urine osmolality rising to 650 mOsm/kg) indicates the kidneys can respond to ADH, localizing the defect to ADH deficiency from the posterior pituitary - central diabetes insipidus. In nephrogenic diabetes insipidus, the response to desmopressin is minimal. Primary polydipsia typically presents with low-normal or low serum sodium and serum osmolality, not hypernatremia. Osmotic diuresis would show high urine osmolality and an identifiable osmotic substance such as glucose.

QUESTION 4

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 5

SINGLE CHOICE

A 32-year-old woman who is 28 weeks pregnant has a 1-hour 50-g glucose challenge test result of 168 mg/dL. The 3-hour 100-g oral glucose tolerance test yields: fasting 95 mg/dL, 1-hour 200 mg/dL, 2-hour 168 mg/dL, 3-hour 140 mg/dL. Which of the following is the most appropriate initial management?

- ☐ A No intervention; only one abnormal value meets the Carpenter-Coustan thresholds, so GDM is not diagnosed
- ☒ B Diagnose GDM by the IADPSG/2010 WHO one-step criteria and start medical nutrition therapy and self-monitoring of blood glucose
- ☐ C Immediately initiate insulin therapy because she has failed the 1-hour screen
- ☐ D Schedule induction at 37 weeks regardless of subsequent glucose control

ANSWER B

WHY Using the one-step IADPSG/WHO 2013 criteria, GDM is diagnosed if any one of the following 75-g OGTT thresholds is met or exceeded: fasting ≥ 92 mg/dL, 1-hour ≥ 180 mg/dL, 2-hour ≥ 153 mg/dL. The patient's 2-hour value of 168 mg/dL exceeds the 75-g 2-hour threshold, so GDM is established. Initial management is medical nutrition therapy, physical activity, and self-monitoring of blood glucose; pharmacologic therapy is added if glycemic targets are not met within ~1-2 weeks. Under the older two-step 100-g Carpenter-Coustan approach, two or more abnormal values are required, and this patient would not have met criteria. The one-step approach has higher sensitivity and is the current standard in many guidelines, including Saudi MoH/SCFHS guidance.

QUESTION 6

SINGLE CHOICE

A 49-year-old man with type 2 diabetes mellitus and a prior inferior myocardial infarction has LDL cholesterol 96 mg/dL on atorvastatin 40 mg. His blood pressure is 128/78 mmHg and HbA1c is 7.4%. According to current secondary prevention guidelines, what is the most appropriate next step in lipid management?

- ☐ A Continue atorvastatin 40 mg and add ezetimibe
- ☐ B Continue atorvastatin 40 mg with no changes
- ☒ C Increase atorvastatin to 80 mg and add ezetimibe
- ☐ D Discontinue statin and start a fibrate

ANSWER C

WHY In very high-risk patients with established atherosclerotic cardiovascular disease (including prior MI), current guidelines recommend an LDL-C goal of <70 mg/dL, with a goal of <55 mg/dL in many recent recommendations. Adding ezetimibe to high-intensity statin (atorvastatin 40-80 mg or rosuvastatin 20-40 mg) provides an additional ~20% LDL reduction and is supported by outcome data (IMPROVE-IT). Fibrates have not shown cardiovascular benefit when added to statins in patients with diabetes and prior MI.

QUESTION 7

SINGLE CHOICE

A 39-year-old woman undergoes total thyroidectomy for a 4.0-cm papillary thyroid carcinoma with microscopic extrathyroidal extension into perithyroidal soft tissue, without lymphovascular invasion, and with 2 of 6 central compartment nodes positive for metastasis (largest focus 0.3 cm, no extranodal extension). No gross residual disease remains. According to the 2015 ATA risk stratification system, into which postoperative risk category does she fall?

- ☐ A Low risk
- ☒ B Intermediate risk
- ☐ C High risk
- ☐ D Cannot be classified until postoperative stimulated thyroglobulin is measured
- ☐ E Very low risk

ANSWER B

WHY Under the 2015 ATA guidelines, intermediate risk includes any of: microscopic extrathyroidal extension, cervical lymph node metastases (>5 nodes, or any node <3 cm with extranodal extension, or any node >3 cm), or aggressive histologic variants. This patient has microscopic extrathyroidal extension and 2 metastatic central nodes, placing her in the intermediate-risk category. Routine RAI ablation is generally recommended for intermediate-risk DTC.

QUESTION 8

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.