

AMERICAN BOARD OF FAMILY MEDICINE (ABFM) ITE PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Which medication class can be beneficial for chronic laryngitis caused by acid reflux?**
 - A. Antibiotics
 - B. Antihistamines
 - C. Proton pump inhibitors such as omeprazole
 - D. Steroids
- 2. Which finding is a red flag suggesting a pathologic cause of tinnitus?**
 - A. Pulsatile, unilateral tinnitus with asymmetric hearing loss
 - B. Bilateral tinnitus with symmetric hearing loss
 - C. Tinnitus that improves with noise exposure
 - D. Tinnitus lasting less than one week
- 3. The arrhythmia from QT prolongation is more common in patients with prior cardiac history; which is it?**
 - A. Ventricular tachycardia
 - B. Torsades de Pointes
 - C. Atrial fibrillation
 - D. Sinus bradycardia
- 4. What is an expected physiologic change in elderly patients?**
 - A. Reduced heart rate variability
 - B. Decreased arterial compliance
 - C. Lower systolic blood pressure
 - D. Wider pulse pressure
- 5. Which pharmacologic class has been shown to improve mortality in heart failure with reduced ejection fraction (HFrEF)?**
 - A. ACE inhibitors
 - B. Diuretics
 - C. Calcium channel blockers
 - D. Nitrates

- 6. In Dupuytren's contracture, which statement is true?**
- A. Intralesional injection is effective for all grades without contracture
 - B. Surgical release is never indicated
 - C. Intralesional injection reduces the need for later surgery in Grade 3 disease
 - D. Surgical release is indicated if MCPJ contracture is 30° or any PIPJ contracture
- 7. Which of the following is a laboratory finding consistent with von Willebrand disease?**
- A. Normal ristocetin cofactor activity
 - B. Decreased ristocetin cofactor activity
 - C. Elevated platelet count
 - D. Normal bleeding time
- 8. Which finding on Wood's lamp is characteristic of erythrasma?**
- A. Coral pink fluorescence
 - B. Blue fluorescence
 - C. No fluorescence
 - D. Green fluorescence
- 9. What can help to delay definitive surgical therapy in carpal tunnel syndrome?**
- A. Physical therapy-based regimens
 - B. Corticosteroid injections
 - C. Wrist splinting only
 - D. Surgical release
- 10. Positive hip FADIR and FABER tests are most consistent with which diagnosis?**
- A. Hip labral tear
 - B. Hip OA
 - C. Femoral neck fracture
 - D. Trochanteric bursitis

Answers

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1. C
2. A
3. B
4. D
5. A
6. D
7. B
8. A
9. B
10. B

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Explanations

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1. Which medication class can be beneficial for chronic laryngitis caused by acid reflux?

- A. Antibiotics
- B. Antihistamines
- C. Proton pump inhibitors such as omeprazole**
- D. Steroids

Reducing acid exposure is the key to improving chronic laryngitis caused by reflux. When stomach acid refluxes up to the larynx, it irritates the vocal cords and surrounding tissues, leading to persistent hoarseness, throat clearing, and irritation. Proton pump inhibitors, such as omeprazole, block the final step of acid production in the stomach, decreasing overall acid in the refluxate. With less acid contact, the laryngeal mucosa can heal, and symptoms improve. This directly targets the underlying cause rather than trying to treat infection or allergic inflammation. Antibiotics would not help because there is no bacterial infection. Antihistamines address allergy symptoms and won't resolve acid-induced irritation. Steroids don't treat the reflux itself and aren't the standard approach for reflux-related laryngitis.

2. Which finding is a red flag suggesting a pathologic cause of tinnitus?

- A. Pulsatile, unilateral tinnitus with asymmetric hearing loss**
- B. Bilateral tinnitus with symmetric hearing loss
- C. Tinnitus that improves with noise exposure
- D. Tinnitus lasting less than one week

Red flags in tinnitus evaluation are features that point to a potentially serious, non-benign cause. The finding described—pulsatile, unilateral tinnitus with asymmetric hearing loss—strongly suggests a pathologic process such as a vascular abnormality or a retrocochlear lesion. Pulsatile tinnitus means the sound aligns with the heartbeat, which often comes from abnormal blood flow in nearby vessels or a vascular tumor. When it's confined to one ear and accompanied by asymmetric hearing loss, it raises concern for conditions like a glomus tumor, carotid or dural vascular anomaly, or a vestibular schwannoma, all of which can require imaging and specialist assessment. Most tinnitus seen in primary care is nonpulsatile, bilateral, and associated with symmetric hearing loss from noise exposure or age-related changes, which is generally not a red flag. Tinnitus that improves with noise exposure or lasts only a short time without focal deficits is less concerning for serious pathology. Because the pulsatile, unilateral pattern with asymmetric hearing loss points toward a possible structural or vascular problem, this finding warrants appropriate workup, including imaging (such as MRI with contrast and possibly vascular imaging) and referral for further evaluation.

3. The arrhythmia from QT prolongation is more common in patients with prior cardiac history; which is it?

- A. Ventricular tachycardia
- B. Torsades de Pointes**
- C. Atrial fibrillation
- D. Sinus bradycardia

QT prolongation sets the stage for a specific dangerous ventricular tachyarrhythmia: Torsades de Pointes. When the heart's repolarization is unusually extended, early afterdepolarizations can trigger a rapid, twisting ventricular rhythm. This arrhythmia is often pause- or bradycardia-dependent and can be precipitated by factors common in people with prior cardiac history, such as electrolyte abnormalities, certain drugs, or underlying structural heart disease. On ECG, Torsades de Pointes appears as a polymorphic VT with QRS complexes that twist around the baseline, a distinct pattern that distinguishes it from other rhythms. If not promptly treated, it can degenerate into ventricular fibrillation. The other options don't have the same direct link to QT duration: a general ventricular tachycardia can arise from various substrates, atrial fibrillation is an atrial rhythm disturbance, and sinus bradycardia is simply a slow heart rate that isn't itself caused by QT length.

4. What is an expected physiologic change in elderly patients?

- A. Reduced heart rate variability
- B. Decreased arterial compliance
- C. Lower systolic blood pressure
- D. Wider pulse pressure**

As people age, large arteries become stiffer due to structural changes in the vessel wall. This arterial stiffening reduces the aorta's ability to recoil during systole, so systolic blood pressure tends to rise. Diastolic pressure tends to stay the same or decline a bit, which widens the gap between systolic and diastolic pressures. That widening is the pulse pressure, and it becomes more pronounced in the elderly. For example, going from about 120/80 to something like 150/85 illustrates the increased pulse pressure. This arterial stiffness-driven change is the classic, expected physiologic pattern in aging. While other age-related changes exist (such as some reduction in heart rate variability), the hallmark finding is a wider pulse pressure.

5. Which pharmacologic class has been shown to improve mortality in heart failure with reduced ejection fraction (HFrEF)?

- A. ACE inhibitors**
- B. Diuretics
- C. Calcium channel blockers
- D. Nitrates

Blocking the renin-angiotensin-aldosterone system with ACE inhibitors reduces mortality in heart failure with reduced ejection fraction by slowing maladaptive remodeling, lowering afterload, and dampening harmful neurohormonal activation. Large randomized trials like CONSENSUS and SOLVD showed clear survival benefits and fewer hospitalizations with ACE inhibitors in patients with reduced EF. Diuretics help symptoms and fluid management but don't improve long-term survival. Calcium channel blockers generally do not improve mortality in HFrEF and can be harmful in some cases, while nitrates (without hydralazine) lack broad mortality benefit though the hydralazine-nitrate combo has shown benefit in specific subgroups. Thus, ACE inhibitors have the strongest, widely demonstrated mortality benefit in this population.

6. In Dupuytren's contracture, which statement is true?

- A. Intralesional injection is effective for all grades without contracture
- B. Surgical release is never indicated
- C. Intralesional injection reduces the need for later surgery in Grade 3 disease
- D. Surgical release is indicated if MCPJ contracture is 30° or any PIPJ contracture**

Dupuytren's contracture management hinges on how much the joints are affected and how that impairment limits hand function. When the MCP joint contracture reaches about 30 degrees or more, or there is any contracture at the PIP joint, surgical release is typically indicated because nonoperative approaches won't reliably restore full extension and function is at risk of further decline. Intralesional injections can help in some cases by weakening cords and improving motion, but they aren't universally effective across all stages of disease, and in more advanced disease they often don't prevent the need for later surgery. Therefore, the statement that surgical release is indicated at MCPJ contracture of 30 degrees or any PIPJ contracture reflects established treatment thresholds.

7. Which of the following is a laboratory finding consistent with von Willebrand disease?

- A. Normal ristocetin cofactor activity
- B. Decreased ristocetin cofactor activity**
- C. Elevated platelet count
- D. Normal bleeding time

The key concept is how von Willebrand factor enables platelets to adhere and form a plug, which is tested by the ristocetin cofactor assay. In this test, ristocetin induces platelets to clump in a manner that depends on functional von Willebrand factor. When vWF is deficient or dysfunctional, this ristocetin-induced platelet agglutination is reduced, so the ristocetin cofactor activity is decreased. That's why a decreased vWF ristocetin cofactor activity is the lab finding consistent with von Willebrand disease. A normal result would suggest normal vWF function, an elevated platelet count isn't typical for vWD, and bleeding time is usually prolonged rather than normal in vWD.

8. Which finding on Wood's lamp is characteristic of erythrasma?

- A. Coral pink fluorescence**
- B. Blue fluorescence
- C. No fluorescence
- D. Green fluorescence

*Erythrasma is caused by *Corynebacterium minutissimum*, and under Wood's lamp it produces porphyrins that glow with a coral pink (coral red) fluorescence in the affected intertriginous areas. This distinctive shine helps distinguish it from other causes of itchy or scaly intertriginous rashes, such as tinea versicolor (which typically shows yellow-gold fluorescence) or bacterial/fungal infections that may not fluoresce or glow a different color. The coral pink signal is the hallmark, directing you toward erythrasma when you see it.*

9. What can help to delay definitive surgical therapy in carpal tunnel syndrome?

- A. Physical therapy-based regimens
- B. Corticosteroid injections**
- C. Wrist splinting only
- D. Surgical release

Corticosteroid injections into the carpal tunnel reduce local inflammation and median nerve compression, often giving rapid symptom relief. This short-term improvement can delay the need for definitive surgical release in patients with mild to moderate carpal tunnel syndrome, providing time to reassess or manage symptoms nonoperatively. It's not a cure, and relief may wane over time or with repeated injections, but for many patients it offers a meaningful bridge to surgery or indefinitely to avoid it if symptoms stay controlled. Other nonoperative approaches like splinting can help, but they typically don't provide as robust or durable a delay in the need for surgery as injections in the right patient.

10. Positive hip FADIR and FABER tests are most consistent with which diagnosis?

- A. Hip labral tear
- B. Hip OA**
- C. Femoral neck fracture
- D. Trochanteric bursitis

FADIR and FABER are provocative maneuvers that stress the hip joint to reveal intra-articular pathology. FADIR (flexion with adduction and internal rotation) compresses the anterior–superior acetabulum against the femoral head, often reproducing deep groin pain when there is joint impingement, labral disease, or other intra-articular issues. FABER (flexion, abduction, external rotation) places the femoral head against the acetabulum in a way that also stresses the joint; pain in the groin or anterior hip with this test points toward intra-articular pathology rather than pure soft-tissue or extra-articular causes. When both tests are positive, it suggests intra-articular disease rather than an extra-articular source such as trochanteric bursitis. Among the given possibilities, osteoarthritis of the hip is the scenario most likely to yield this pattern, as degenerative changes produce joint-space narrowing and impingement that provoke pain with these motions. Labral tear can also produce positive results, but OA is more commonly associated with a pattern where both provocative maneuvers are clearly painful, especially in an older patient with degenerative changes. A femoral neck fracture presents acutely with severe pain and inability to bear weight, not a pattern best explained by these provocative tests. Trochanteric bursitis typically causes lateral hip pain and a different pain pattern rather than the deep groin pain elicited by both maneuvers.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

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We wish you the very best on your exam journey. You've got this!

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