

American Board of Surgery In-Training Examination (ABSITE) Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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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

- 1. What is the total bile pool weight in grams?**
 - A. 6 grams**
 - B. 10 grams**
 - C. 15 grams**
 - D. 20 grams**

- 2. What preparation is required for an I-131 scan?**
 - A. Stop all medications three weeks prior**
 - B. Remain euthyroid during the scan**
 - C. Become hypothyroid by stopping thyroid hormone**
 - D. Increase intake of iodine-rich foods**

- 3. In children older than 2 years, what is the most common intra-abdominal tumor?**
 - A. Hepatoblastoma**
 - B. Wilms tumor**
 - C. Neuroblastoma**
 - D. Germ cell tumor**

- 4. What logistic factor is not required for low molecular weight heparin administration?**
 - A. Monitoring activated partial thromboplastin time (aPTT)**
 - B. Weight-based dosing adjustments**
 - C. Baseline kidney function tests**
 - D. Monitoring platelet counts**

- 5. For patients with atypical ductal hyperplasia, atypical lobular hyperplasia, or LCIS, what is the most appropriate treatment approach?**
 - A. Immediate mastectomy**
 - B. Observation without treatment**
 - C. Resection of the lesion**
 - D. Hormonal therapy only**

- 6. What are the three symptoms prominently associated with Boerhaave's syndrome?**
- A. Nausea, vomiting, abdominal pain**
 - B. Respiratory distress, chest pain, fever**
 - C. Heartburn, dysphagia, weight loss**
 - D. Fatigue, malaise, cough**
- 7. Which nerve wraps around the head of the fibula and lies laterally below the knee?**
- A. Tibial nerve**
 - B. Common peroneal nerve**
 - C. Femoral nerve**
 - D. Obturator nerve**
- 8. What is the staging indication for metastasis in Hodgkin's disease?**
- A. Mets to adjacent lymph nodes is Stage II**
 - B. Mets to distant sites is Stage III**
 - C. Mets to bone/lung is Stage IV**
 - D. Mets to liver is Stage II**
- 9. What are the two primary routes for pyogenic liver abscess?**
- A. Portal vein drainage and direct trauma**
 - B. Biliary infection and portal vein seeding**
 - C. Hematogenous spread and direct infection**
 - D. Viral infection and autoimmune response**
- 10. What is the scoring for GCS eyes?**
- A. 4 spontaneous, 3 to command, 2 to pain, 1 none**
 - B. 5 spontaneous, 3 to command, 2 to pain, 1 none**
 - C. 4 to command, 3 to pain, 2 spontaneous, 1 none**
 - D. 4 spontaneous, 2 to command, 1 to pain, 3 none**

Answers

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

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Explanations

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1. What is the total bile pool weight in grams?

- A. 6 grams**
- B. 10 grams
- C. 15 grams
- D. 20 grams

The total bile pool weight in the human body is generally considered to be around 3 to 5 grams. However, in some contexts, particularly in textbooks and clinical references specific to surgical studies, it can be referred to as approximately 10 grams. Thus, 10 grams is often cited as a recognized average for the bile pool weight. The choice indicating 6 grams, while potentially based on specific theoretical scenarios or variations in individual physiology, does not align with the established average values commonly referenced in medical literature. In the context of understanding bile physiology, it's important to note that the liver synthesizes bile continuously, and the total bile pool represents the amount of bile present in the gallbladder and bile ducts at any given time. Assessing this information is crucial for a deep understanding of gallbladder function, the enterohepatic circulation of bile acids, and their role in fat digestion. Accurate knowledge of bile pool measurements can impact decisions in clinical settings, such as managing gallbladder disease or evaluating the dynamics of bile acid circulation. Therefore, recognizing the total bile pool within the expected range, closer to 10 grams, provides a better framework for comprehending the physiological processes involved.

2. What preparation is required for an I-131 scan?

- A. Stop all medications three weeks prior
- B. Remain euthyroid during the scan
- C. Become hypothyroid by stopping thyroid hormone**
- D. Increase intake of iodine-rich foods

For an I-131 scan, the preparation involves ensuring that the thyroid gland is in a state where it can uptake the radioactive iodine effectively, which typically is achieved by inducing a hypothyroid state in the patient. This is usually done by withdrawing thyroid hormone therapy in patients who are on it. The rationale is that when thyroid hormone levels are low, the thyroid gland will be more active in absorbing iodine, thus providing clearer and more accurate imaging results during the scan. Being hypothyroid prior to the scan helps in maximizing the sensitivity of the scan by stimulating the thyroid's uptake of the administered radioiodine. Patients may be instructed to stop thyroid hormone therapy for a period (often around four weeks) to ensure this hypothyroid state is achieved. Remaining euthyroid during the scan would not provide the same benefit for uptake as a hypothyroid state, as a euthyroid patient would not exhibit the same drive for iodine absorption. Likewise, stopping all medications indiscriminately may disrupt the management of other conditions without specifically aiding the I-131 scan process. Increasing intake of iodine-rich foods is counterproductive, as it can saturate the thyroid gland with iodine and decrease the uptake of the radioactive iodine, which could negatively impact the scan results.

3. In children older than 2 years, what is the most common intra-abdominal tumor?

- A. Hepatoblastoma**
- B. Wilms tumor**
- C. Neuroblastoma**
- D. Germ cell tumor**

In children older than 2 years, Wilms tumor is indeed the most common intra-abdominal tumor. This type of cancer arises from kidney tissues and is typically seen in preschool-aged children, with the peak incidence occurring between ages 2 and 5. Wilms tumor is not only a common pediatric malignancy but is also characterized by its relatively favorable prognosis compared to other pediatric tumors. The disease often presents as an abdominal mass, and treatment generally includes a combination of surgery and chemotherapy. While hepatoblastoma can also occur in young children, its peak incidence is typically in children younger than 3 years, making it less prevalent in those over 2 years. Neuroblastoma, although it is the most common extrarenal solid tumor in children, tends to occur primarily in infants and younger children. Germ cell tumors can present as intra-abdominal masses, but they are less common than Wilms tumor in the specified age group. Overall, the age-defined epidemiology and the typical characteristics of Wilms tumor make it the correct answer in this context.

4. What logistic factor is not required for low molecular weight heparin administration?

- A. Monitoring activated partial thromboplastin time (aPTT)**
- B. Weight-based dosing adjustments**
- C. Baseline kidney function tests**
- D. Monitoring platelet counts**

Low molecular weight heparin (LMWH) is designed to provide anticoagulation with a more predictable pharmacokinetic profile compared to unfractionated heparin (UFH). One of the key logistical factors that distinguishes LMWH is that it typically does not require routine monitoring of activated partial thromboplastin time (aPTT) for therapeutic efficacy. The rationale for this is that LMWH acts more uniformly in the body and has a more consistent effect on factor Xa inhibition, which means the dosage can be determined based on fixed weight-based protocols, rather than needing to adjust doses based on aPTT levels that are more relevant to unfractionated heparin. Hence, the simplicity of administering LMWH without the need for aPTT monitoring is one of its advantages. In contrast, other logistical factors associated with LMWH administration, such as weight-based dosing adjustments, baseline kidney function tests, and monitoring platelet counts, are important considerations. Weight-based dosing ensures that patients receive the appropriate therapeutic dose according to their body weight. Baseline kidney function tests are necessary because kidney impairment can affect the clearance of LMWH, necessitating dosage adjustments to prevent accumulation and the risk of bleeding. Monitoring platelet counts is important primarily due to the risk

5. For patients with atypical ductal hyperplasia, atypical lobular hyperplasia, or LCIS, what is the most appropriate treatment approach?

- A. Immediate mastectomy**
- B. Observation without treatment**
- C. Resection of the lesion**
- D. Hormonal therapy only**

The most appropriate treatment approach for patients with atypical ductal hyperplasia (ADH), atypical lobular hyperplasia (ALH), or lobular carcinoma in situ (LCIS) is resection of the lesion. These conditions are considered markers of increased breast cancer risk rather than cancer themselves. Resection of the lesion provides a definitive diagnosis and helps rule out the presence of more extensive disease. Additionally, it allows for the careful assessment of the tissue for any unsuspected invasive cancer, which can be particularly important given the associated risk factors. Mastectomy is generally not indicated simply for the presence of atypical hyperplasia or LCIS, as these findings do not usually merit such a radical approach. Observation may be appropriate in certain low-risk cases, but being proactive and removing the lesions often provides the best balance between minimizing risk and addressing any potential malignancy. Hormonal therapy is also an option in some scenarios related to risk reduction, but it is not typically the first-line treatment for these lesions without taking steps to remove them.

6. What are the three symptoms prominently associated with Boerhaave's syndrome?

- A. Nausea, vomiting, abdominal pain**
- B. Respiratory distress, chest pain, fever**
- C. Heartburn, dysphagia, weight loss**
- D. Fatigue, malaise, cough**

Boerhaave's syndrome is a spontaneous rupture of the esophagus, often due to severe vomiting or other forms of pressure, and it presents with a specific set of symptoms primarily related to the chest and respiratory system due to the resultant mediastinitis and possible pleural effusion. Respiratory distress is significant because, following the esophageal rupture, air can escape into the mediastinum or pleural space, leading to complications like pneumothorax or pleuritis, which manifest as difficulty in breathing. Chest pain is a direct result of the esophageal rupture and subsequent irritation or inflammation of the surrounding structures. Fever often accompanies this condition due to the body's inflammatory response to infection following the rupture and the potential development of mediastinitis. The presence of these three symptoms—respiratory distress, chest pain, and fever—aligns with the clinical picture seen in Boerhaave's syndrome and highlights the seriousness of the condition, requiring prompt recognition and treatment. In contrast, other options present symptoms that are more general or associated with different gastrointestinal or systemic conditions rather than the specific acute presentation seen in Boerhaave's syndrome.

7. Which nerve wraps around the head of the fibula and lies laterally below the knee?

- A. Tibial nerve**
- B. Common peroneal nerve**
- C. Femoral nerve**
- D. Obturator nerve**

The common peroneal nerve is responsible for innervating the muscles that control ankle and toe movements and is an important structure in the lower limb. Its pathway involves wrapping around the head of the fibula, which is located laterally just below the knee. This positioning makes it particularly vulnerable to injury, especially with trauma to the fibular head, which can lead to foot drop due to its role in innervating the muscles responsible for dorsiflexion. The common peroneal nerve branches from the sciatic nerve and travels laterally around the fibula, then divides into the superficial and deep peroneal nerves. This anatomical feature is essential for a proper understanding of lower limb function and potential sites of nerve injury. In contrast, the tibial nerve runs more medially and continues down the posterior compartment of the leg, while the femoral and obturator nerves are primarily associated with the anterior and medial compartments of the thigh, respectively. Therefore, the common peroneal nerve is the correct choice due to its specific anatomical course around the fibula and its location below the knee.

8. What is the staging indication for metastasis in Hodgkin's disease?

- A. Mets to adjacent lymph nodes is Stage II**
- B. Mets to distant sites is Stage III**
- C. Mets to bone/lung is Stage IV**
- D. Mets to liver is Stage II**

In the context of Hodgkin's disease, the staging system is crucial for determining the extent of the disease and guiding treatment decisions. The correct indication for staging metastasis in Hodgkin's disease is that metastasis to bony structures or the lungs is classified as Stage IV. Stage IV signifies the dissemination of the disease beyond the lymphatic system to distant sites, which can include the bone marrow and lungs. This stage reflects a more advanced disease and often necessitates a more aggressive treatment approach. When assessing the other choices, it's important to note the specific criteria that define each stage. For instance, Stage II involves involvement of two or more lymph node regions on the same side of the diaphragm, while Stage III includes involvement on both sides of the diaphragm but still primarily affects lymph nodes. Recognizing this classification can aid in understanding why those options would not be correct in the context of metastatic spread, as they do not indicate the extent of distant disease involvement that characterizes Stage IV.

9. What are the two primary routes for pyogenic liver abscess?

- A. Portal vein drainage and direct trauma**
- B. Biliary infection and portal vein seeding**
- C. Hematogenous spread and direct infection**
- D. Viral infection and autoimmune response**

The formation of pyogenic liver abscesses primarily arises from two mechanisms: biliary infection and portal vein seeding. Biliary infection often stems from conditions like cholangitis or obstructive jaundice, where bacteria can ascend from the duodenum into the biliary tree and subsequently invade the liver. This route is significant in the development of liver abscesses, especially in patients with underlying biliary pathology such as stones or strictures. Portal vein seeding refers to the way bacteria can enter the portal circulation and reach the liver from various sources, such as intra-abdominal infections (like appendicitis or diverticulitis) or infections in the gastrointestinal tract. This mechanism illustrates how systemic infection can lead directly to localized liver pathology, resulting in abscess formation. In summary, understanding these routes highlights the role of both biliary and vascular pathways in the pathogenesis of pyogenic liver abscesses, making this option the most accurate among the given choices.

10. What is the scoring for GCS eyes?

- A. 4 spontaneous, 3 to command, 2 to pain, 1 none**
- B. 5 spontaneous, 3 to command, 2 to pain, 1 none**
- C. 4 to command, 3 to pain, 2 spontaneous, 1 none**
- D. 4 spontaneous, 2 to command, 1 to pain, 3 none**

The correct scoring for the eye-opening response in the Glasgow Coma Scale (GCS) categorizes responses as follows: a score of 4 is given for spontaneous eye opening, which indicates that the patient opens their eyes without any external stimulus; a score of 3 is awarded if the eyes open in response to verbal command; a score of 2 is assigned if the eyes only open in response to painful stimuli; and a score of 1 designates no eye opening at all. This scoring is essential in assessing a patient's level of consciousness and helps in determining the severity of a head injury or the effects of certain medical conditions. The GCS is a critical component in evaluating neurological function, and understanding these specific scoring criteria is foundational for effective patient assessment in both acute and clinical settings.

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:

<https://absite.examzify.com>

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