

FUNDAMENTALS OF ENDOSCOPIC SURGERY (FES) WRITTEN PRACTICE EXAM (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. What is the goal of endoscopic transection techniques in PEG placement?**
 - A. Reducing recovery time
 - B. Increasing patient comfort
 - C. Minimizing risk of complications
 - D. Facilitating quick nutritional access
- 2. Which is an advantage of laparoscopic endobiliary stenting?**
 - A. Requires advanced suturing skills
 - B. It can be performed in the outpatient setting
 - C. Has many complications
 - D. Minimizes the need for ERCP
- 3. Which of the following is NOT an advantage of laparoscopic endobiliary stenting?**
 - A. Requires advanced suturing skills
 - B. Protects against complications from residual stones
 - C. Can be performed as outpatient
 - D. Has few complications
- 4. Which condition can effectively be treated with radiofrequency ablative techniques?**
 - A. Adenomatous polyps
 - B. Dysplastic Barrett's epithelium
 - C. Infectious bowel disease
 - D. Colon cancer
- 5. When should screening for HNPCC begin in individuals at risk?**
 - A. At age 30-35
 - B. At age 25-30
 - C. At age 20-25 or 10 years younger than the youngest diagnosis
 - D. At age 18-23

- 6. What is a known complication of sedation during upper GI endoscopy?**
- A. Severe hypotension
 - B. Cardiopulmonary complications
 - C. Gastrointestinal bleeding
 - D. Sepsis
- 7. What is the recommended time frame for upper endoscopy after sclerotherapy for esophageal varices?**
- A. Every week
 - B. Every 6-8 weeks
 - C. Every 3 months
 - D. Once a year
- 8. How should early PEG tube dislodgement be treated?**
- A. With oral medication
 - B. With NG decompression and IV antibiotics
 - C. With surgical intervention
 - D. With immediate replacement of the tube
- 9. What condition does jaundice typically indicate?**
- A. Inflammation of the pancreas
 - B. Hepatic failure
 - C. Biliary obstruction
 - D. Gastric ulcer
- 10. What is the maximum limit of dilation regarding the number of successive sizes?**
- A. 1 size
 - B. 2 sizes
 - C. 3 sizes
 - D. 4 sizes

Answers

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

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Explanations

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1. What is the goal of endoscopic transection techniques in PEG placement?

- A. Reducing recovery time
- B. Increasing patient comfort
- C. Minimizing risk of complications**
- D. Facilitating quick nutritional access

The goal of endoscopic transection techniques in percutaneous endoscopic gastrostomy (PEG) placement fundamentally focuses on minimizing the risk of complications. These techniques aim to perform the procedure more safely by ensuring that the tissue is handled delicately and that the placement of the PEG tube is executed in a way that reduces the chances of inadvertent injury to surrounding organs, excessive bleeding, or infection. By utilizing endoscopic transection methods, surgeons can visualize the anatomical structures clearly and precisely. This enhanced visualization allows for more controlled maneuvers during the placement, directly contributing to a safer procedure. Furthermore, minimizing complications is essential as it not only impacts patient safety but also influences overall recovery time, comfort, and the speed of nutritional access thereafter. Therefore, while other factors such as recovery time, patient comfort, and nutritional access are important, the primary focus of these techniques remains on reducing complications, ensuring that patients experience safer outcomes from their PEG placements.

2. Which is an advantage of laparoscopic endobiliary stenting?

- A. Requires advanced suturing skills
- B. It can be performed in the outpatient setting**
- C. Has many complications
- D. Minimizes the need for ERCP

Laparoscopic endobiliary stenting offers several advantages, one of which is its suitability for outpatient procedures. This approach allows patients to undergo the stenting process with minimal invasion, leading to shorter recovery times and the possibility of same-day discharge. The outpatient setting can enhance patient convenience and resource efficiency, contributing to overall improved healthcare delivery. In the context of laparoscopic endobiliary stenting, the other options do not reflect beneficial characteristics of the procedure. Advanced suturing skills are not a defining advantage; rather, the technique aims to streamline the process and reduce the need for more complex surgical interventions. The presence of many complications implies a disadvantage rather than an advantage, as the goal is to provide a safer and more effective solution for managing biliary obstructions. Lastly, while laparoscopic endobiliary stenting can reduce the reliance on endoscopic retrograde cholangiopancreatography (ERCP) for certain cases, this does not stand out as a primary advantage of the stenting procedure itself. Therefore, the fact that it can be performed on an outpatient basis represents a significant benefit for patient care and procedural efficiency.

3. Which of the following is NOT an advantage of laparoscopic endobiliary stenting?

- A. Requires advanced suturing skills**
- B. Protects against complications from residual stones
- C. Can be performed as outpatient
- D. Has few complications

Laparoscopic endobiliary stenting offers several advantages, making it an effective minimally invasive procedure for managing bile duct obstructions. The choice regarding advanced suturing skills points out a limitation rather than an advantage of this technique. Laparoscopic procedures, including endobiliary stenting, typically employ techniques that might minimize the need for complex suturing, making them accessible to surgeons without advanced suturing skills. The other aspects highlight the key benefits of laparoscopy in this context. For instance, protecting against complications from residual stones is critical, as stenting can help maintain bile duct patency and prevent related issues. The outpatient nature of the procedure is another advantage, allowing many patients to return home the same day without extended hospital stays. Lastly, the fact that laparoscopic endobiliary stenting generally has few complications emphasizes its safety profile compared to more invasive alternatives. Thus, the need for advanced suturing skills stands out as the only option that does not align with the benefits of laparoscopic endobiliary stenting, making it the correct answer to the question.

4. Which condition can effectively be treated with radiofrequency ablative techniques?

- A. Adenomatous polyps
- B. Dysplastic Barrett's epithelium**
- C. Infectious bowel disease
- D. Colon cancer

Radiofrequency ablation is a technique that utilizes heat generated by radio waves to destroy abnormal tissue. Within the context of gastrointestinal conditions, it is particularly effective for treating dysplastic Barrett's epithelium. This condition involves the transformation of the normal esophageal lining to a precancerous state due to chronic gastroesophageal reflux disease (GERD). Barrett's esophagus presents a significant risk for the development of esophageal adenocarcinoma. Radiofrequency ablation is advantageous in this scenario because it can selectively target and eliminate the dysplastic cells while preserving the underlying healthy tissue, ultimately reducing the risk of progression to cancer. In contrast, adenomatous polyps, while they may require removal, are not typically treated with radiofrequency ablation but rather with polypectomy. Infectious bowel disease often necessitates medical management and may require surgical intervention but is not treated with ablation techniques. Colon cancer management primarily involves surgical resection and possibly chemotherapy, rather than using radiofrequency ablation as a first-line treatment modality. Thus, the specificity of radiofrequency ablation for dysplastic Barrett's epithelium distinguishes it as the appropriate condition effectively treated by this technique.

5. When should screening for HNPCC begin in individuals at risk?

- A. At age 30-35
- B. At age 25-30
- C. At age 20-25 or 10 years younger than the youngest diagnosis**
- D. At age 18-23

Screening for Hereditary Non-Polyposis Colorectal Cancer (HNPCC), also known as Lynch Syndrome, should begin at age 20-25 or 10 years younger than the age at which the youngest family member was diagnosed with colorectal cancer. This approach is based on the understanding that individuals with HNPCC have a significantly increased lifetime risk of developing colorectal and other associated cancers. Early surveillance allows for timely interventions that can greatly improve prognosis and survival rates. By starting screening at this early age or relative to the age of diagnosis in the family, healthcare providers can monitor high-risk individuals more closely and potentially detect malignancies at an earlier, more treatable stage. This practice acknowledges the genetic nature of the syndrome and intends to catch cancers before symptoms present or at a more curable stage. The age thresholds provided in other options do not align with the recommended guidelines and may miss critical early detection opportunities, underscoring the importance of following established clinical recommendations tailored for those at increased risk due to family history.

6. What is a known complication of sedation during upper GI endoscopy?

- A. Severe hypotension
- B. Cardiopulmonary complications**
- C. Gastrointestinal bleeding
- D. Sepsis

In the context of sedation during upper gastrointestinal (GI) endoscopy, cardiopulmonary complications are a recognized risk. These complications can arise because sedation often involves the use of medications that can depress respiratory function or cause cardiovascular instability. For instance, sedatives like benzodiazepines and opioids can lead to respiratory depression, decreased airway reflexes, and alterations in cardiovascular parameters such as heart rate and blood pressure. Patients with underlying health conditions, such as respiratory diseases or cardiovascular issues, may be at higher risk for these complications. During the procedure, vigilant monitoring of the patient's vital signs is essential to detect and manage any potential complications immediately. On the other hand, while severe hypotension can occur as a side effect of sedation, it is more specifically linked to the cardiovascular aspects of a broader category of cardiopulmonary complications. Gastrointestinal bleeding and sepsis, while they can occur in the context of upper GI procedures, are not directly tied to the sedation process itself but rather to procedural risks or post-procedural complications unrelated to sedation. Thus, cardiopulmonary complications are the most pertinent concern in the context of sedation during an upper GI endoscopy.

7. What is the recommended time frame for upper endoscopy after sclerotherapy for esophageal varices?

- A. Every week
- B. Every 6-8 weeks**
- C. Every 3 months
- D. Once a year

The recommended time frame for performing upper endoscopy after sclerotherapy for esophageal varices is every 6-8 weeks. This schedule is essential for monitoring the treatment's effectiveness, assessing for potential complications, and determining if additional sclerotherapy sessions are necessary. Sclerotherapy aims to reduce the size of the varices and decrease the risk of bleeding. During follow-up endoscopies, clinicians can evaluate the healing process, check for any recurrence of varices, and ensure that the treatment is achieving its desired outcomes. Performing the procedure at this interval allows healthcare providers to make timely adjustments to the management plan based on the patient's condition. The guidelines emphasize this follow-up period because it strikes a balance between monitoring efficiency and avoiding unnecessary procedures too frequently, which could expose patients to risks or complications. Therefore, the 6-8 week timeframe is considered optimal for these evaluations after initial sclerotherapy interventions.

8. How should early PEG tube dislodgement be treated?

- A. With oral medication
- B. With NG decompression and IV antibiotics**
- C. With surgical intervention
- D. With immediate replacement of the tube

Early dislodgement of a percutaneous endoscopic gastrostomy (PEG) tube is a critical situation that requires prompt and appropriate management. The appropriate treatment involves using nasogastric (NG) decompression to help relieve any gastric pressure, as the stomach may require drainage following dislodgement. Additionally, administering intravenous antibiotics is important because dislodgement can lead to the risk of infection, including peritonitis or abscess formation if the tube has caused any damage to the surrounding tissues. In contrast, simply replacing the tube immediately is not advisable in many cases, as there may be a risk of misplaced replacement or injury to the tracts that could lead to further complications. While surgical intervention might be necessary in certain severe cases, it is not the first-line management for early PEG dislodgement. Likewise, oral medication would not address the acute problems associated with dislodgement, making it an inappropriate choice in this scenario. Thus, the combination of NG decompression and IV antibiotics serves a dual purpose: managing the immediate physical effects of dislodgement and preventing potential infections, thereby representing the standard of care in this situation.

9. What condition does jaundice typically indicate?

- A. Inflammation of the pancreas
- B. Hepatic failure
- C. Biliary obstruction**
- D. Gastric ulcer

Jaundice is characterized by a yellowing of the skin and eyes due to an accumulation of bilirubin in the bloodstream. This condition typically indicates an issue with the liver's ability to process bilirubin or a blockage in the bile ducts that prevents bilirubin from being excreted from the liver. Biliary obstruction is the most direct cause of jaundice, as it includes conditions like gallstones or strictures that impede the normal flow of bile. When bile cannot reach the intestines, bilirubin levels in the blood rise, leading to jaundice. While hepatic failure can also cause jaundice due to the liver's decreased ability to process bilirubin, the presence of jaundice specifically in the context of biliary obstruction highlights the obstructive nature of the condition. Therefore, when considering jaundice specifically, biliary obstruction serves as a clear and immediate cause.

10. What is the maximum limit of dilation regarding the number of successive sizes?

- A. 1 size
- B. 2 sizes
- C. 3 sizes**
- D. 4 sizes

In endoscopic surgery, the concept of dilation primarily refers to the process of gradually increasing the size of a dilator used to widen a structure, such as a lumen or passage, to facilitate medical procedures. The maximum limit of dilation in terms of successive sizes that can be applied is typically three sizes. This means that progressing beyond this limit may increase the risk of complications and injury to surrounding tissues while offering diminishing returns in terms of utility. The rationale behind restricting dilation to three successive sizes could be related to maintaining tissue integrity and minimizing trauma during the procedure. When tissue is dilated excessively, it can become increasingly fragile, leading to potential complications such as perforation or bleeding. Therefore, adhering to a maximum of three successive sizes helps ensure that the procedure remains within a safe and effective range, optimizing patient outcomes while reducing risks. In practice, surgeons are trained to recognize the limits of their methods and to use dilation judiciously. This principle is critical in endoscopic procedures, where precision and care are paramount. Thus, understanding the maximum limit of dilation is essential for safe surgical practice.

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://fundamentalsofendoscopicsurgery.examzify.com>

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

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