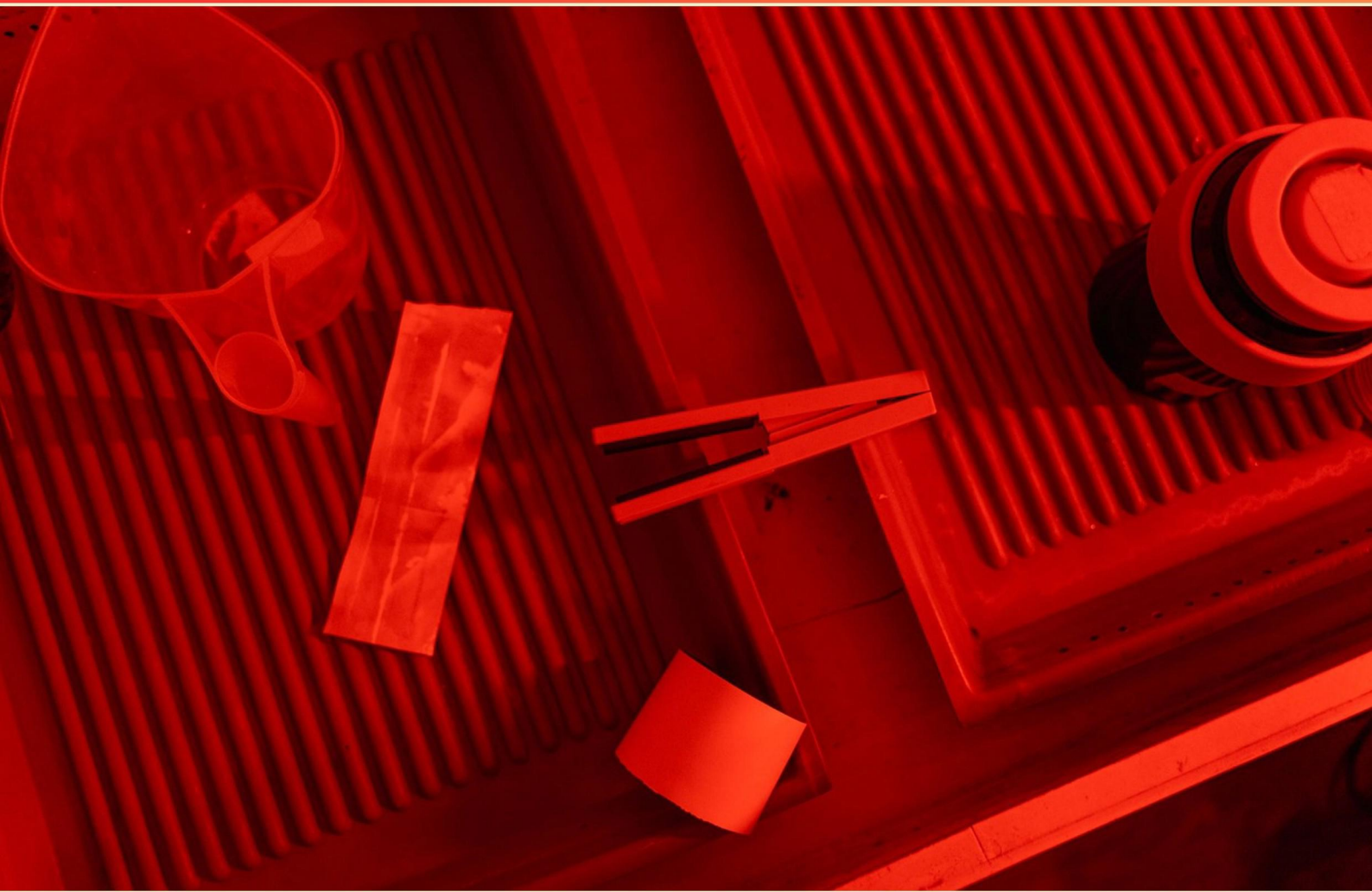


FUNDAMENTALS OF LAPAROSCOPIC SURGERY (FLS) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://laparoscopicsurgeryfls.examzify.com>



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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. Why should ports be removed under direct lap visualization?**
 - A. Bleeding may not be evident during procedure, and may not be evident externally after port is removed
 - B. It speeds up the procedure
 - C. It reduces infection risk
 - D. It improves cosmetic appearance
- 2. What is the typical intraabdominal pressure and CO2 volume used during laparoscopy?**
 - A. 8-12 mmHg; 4-6 L
 - B. 15-20 mmHg; 0.5-1 L
 - C. 10-15 mmHg; 1-3 L
 - D. 5-8 mmHg; 5-10 L
- 3. Which practice best reduces the risk of dropping a ring during peg transfer?**
 - A. Using high-speed jerky motions to move rings.
 - B. Transferring rings with one instrument only.
 - C. Visualizing the field but not touching the ring.
 - D. Maintaining a stable grip and performing a controlled transfer.
- 4. Which finding is a relative contraindication to laparoscopic appendectomy?**
 - A. Phlegmon
 - B. Large abscess
 - C. Simple appendicitis
 - D. Cholecystitis
- 5. Name two safety steps for establishing pneumoperitoneum.**
 - A. Confirming insufflation.
 - B. Selecting an appropriate entry technique (Veress or open), confirming insufflation.
 - C. Using excessive insufflation rate.
 - D. Entering through the left upper quadrant only.

- 6. Which statement best describes the pulmonary response to CO₂ pneumoperitoneum?**
- A. Decreased tidal volume
 - B. Increased functional residual capacity
 - C. Decreased respiratory rate
 - D. Increased minute ventilation to eliminate absorbed CO₂
- 7. Which finding increases the risk of enterotomy due to adhesions during laparoscopy?**
- A. Previous abdominal surgery
 - B. No prior abdominal procedures
 - C. Pregnancy
 - D. Recent upper respiratory infection
- 8. Which CO₂-related change tends to be greatest in the first 20 minutes of pneumoperitoneum?**
- A. Blood pH falls most after 2 hours
 - B. White blood cell count rises
 - C. Platelet count decreases
 - D. End tidal CO₂ increases the most
- 9. What is the ergonomic position recommended for intracorporeal knot tying?**
- A. Elbows flexed at 90 degrees and ports at least 10 cm apart
 - B. Elbows fully extended with ports less than 5 cm apart
 - C. Elbows at 120 degrees with ports at least 20 cm apart
 - D. Arms resting with no specified port distance
- 10. Which finding is a preoperative consideration for gaining access through the umbilicus?**
- A. Umbilical abnormalities
 - B. Past abdominal surgery
 - C. Normal umbilicus
 - D. No scar

Answers

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

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Explanations

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1. Why should ports be removed under direct lap visualization?

- A. Bleeding may not be evident during procedure, and may not be evident externally after port is removed
- B. It speeds up the procedure
- C. It reduces infection risk
- D. It improves cosmetic appearance

The key idea is to ensure bleeding is detected and controlled, even if it isn't obvious during the procedure. Ports create a tract from the skin into the abdominal cavity, and when a port is withdrawn, bleeding can be occult—hidden in the tract or inside the peritoneal cavity and not visible externally while the instrument is in place or after it's removed. Removing the port under direct laparoscopy lets you inspect the tract as you withdraw, identify any active bleeding from vessels or surrounding tissue, and achieve hemostasis immediately with cautery, clips, or careful suturing. This helps prevent delayed hemorrhage that might only become apparent after the port is out. While faster removal, infection risk, and cosmetic appearance are considerations in practice, the primary safety benefit of direct visualization during port removal is ensuring proper hemostasis.

2. What is the typical intraabdominal pressure and CO₂ volume used during laparoscopy?

- A. 8-12 mmHg; 4-6 L
- B. 15-20 mmHg; 0.5-1 L
- C. 10-15 mmHg; 1-3 L
- D. 5-8 mmHg; 5-10 L

During laparoscopy, a pneumoperitoneum is created with CO₂ to lift the abdominal wall and create space for visualization and instrument manipulation. The target intraabdominal pressure is kept in a moderate range to balance adequate working space with minimizing physiologic disturbance. About 10 to 15 mmHg is the typical pressure used; this provides sufficient cavity space for most adult cases without causing excessive cardiorespiratory compromise. The amount of CO₂ delivered to maintain that pressure is usually around 1 to 3 liters. This reflects the volume needed to establish and sustain the pneumoperitoneum against tissue compliance and any minor leaks. Larger volumes, such as 4–6 liters, would suggest unnecessary excess gas or leaks and raise risk of hypercarbia or other issues. Very small volumes, like 0.5–1 liter, may be insufficient to maintain adequate pressure in many patients, and volumes as high as 5–10 liters exceed normal practice and are unsafe. So the typical combination is approximately 10–15 mmHg with about 1–3 liters of CO₂.

3. Which practice best reduces the risk of dropping a ring during peg transfer?

- A. Using high-speed jerky motions to move rings.
- B. Transferring rings with one instrument only.
- C. Visualizing the field but not touching the ring.
- D. Maintaining a stable grip and performing a controlled transfer.

Maintaining a stable grip and performing a controlled transfer minimizes the risk of dropping the ring during peg transfer. When you move a ring, using two instruments in a deliberate, well-coordinated way lets you control both the grip on the ring and its trajectory to the target peg. A steady grip reduces unexpected slips, while a smooth, planned transfer avoids the sudden accelerations that can throw the ring out of the instrument jaws. In contrast, high-speed jerky motions create momentum and instability; using only one instrument decreases control and increases the chance of losing the ring; and simply visualizing the field without touching the ring doesn't accomplish the transfer and doesn't address how to prevent drops. So, practicing a secure hold and a calm, controlled transfer is the best way to reduce dropping the ring.

4. Which finding is a relative contraindication to laparoscopic appendectomy?

- A. Phlegmon
- B. Large abscess
- C. Simple appendicitis
- D. Cholecystitis

A phlegmon signals a localized but intense inflammatory reaction with swollen, indistinct tissue planes around the appendix. This makes it hard to safely identify and dissect the structures laparoscopically because the anatomy is obscured and the tissue is friable, increasing the risk of inadvertent injury to surrounding bowel or vessels and making complete removal of the appendix more difficult. Because of these safety concerns, a phlegmon is considered a relative contraindication to proceeding with laparoscopic appendectomy; many surgeons would opt for conversion to an open approach or staged management depending on the situation. In contrast, a simple appendicitis situation is straightforward for laparoscopy, and a large abscess, while more challenging, can often be addressed with drainage or managed with conversion if needed. Cholecystitis involves the gallbladder and is not a direct issue with the appendix, so it doesn't factor as a contraindication to laparoscopic appendectomy.

5. Name two safety steps for establishing pneumoperitoneum.

- A. Confirming insufflation.
- B. Selecting an appropriate entry technique (Veress or open), confirming insufflation.
- C. Using excessive insufflation rate.
- D. Entering through the left upper quadrant only.

Establishing pneumoperitoneum safely hinges on how you gain access and how you verify that the space is truly the peritoneal cavity. The two safety steps are choosing an appropriate entry technique (Veress needle versus open/Hasson) and confirming that insufflation has been achieved correctly. Selecting the right method for entering the abdomen reduces the risk of injuring internal organs or vessels during access, and it accounts for patient factors such as prior surgeries or adhesions. After entry, confirming insufflation ensures the gas is in the peritoneal cavity, at a safe pressure, and that there isn't extraperitoneal gas or malposition, which validates that a true pneumoperitoneum has been established. Relying on only one of these steps falls short: confirming insufflation alone doesn't address the safest way to gain entry, excessive insufflation rate is dangerous, and entering through a nonstandard site like the left upper quadrant is not a reliable safety measure.

6. Which statement best describes the pulmonary response to CO₂ pneumoperitoneum?

- A. Decreased tidal volume
- B. Increased functional residual capacity
- C. Decreased respiratory rate
- D. Increased minute ventilation to eliminate absorbed CO₂**

CO₂ from the pneumoperitoneum is absorbed into the bloodstream, raising PaCO₂ and stimulating the body's ventilatory drive. The lungs respond by increasing alveolar ventilation to blow off the excess CO₂. This results in a higher minute ventilation, which is achieved by increasing tidal volume and/or respiratory rate. That is why the statement describing an increase in minute ventilation to eliminate absorbed CO₂ is the best choice. In more detail, minute ventilation equals tidal volume times respiratory rate, and hypercapnia from CO₂ absorption prompts the respiratory centers to boost ventilation. Under anesthesia this is often achieved by increasing tidal volume and/or rate on the ventilator to maintain normocapnia. Why the other options don't fit: lowering tidal volume would hamper CO₂ clearance, whereas the typical response is to increase ventilation. Functional residual capacity tends to decrease rather than increase with CO₂ pneumoperitoneum due to diaphragmatic elevation and decreased chest wall compliance. Respiratory rate generally rises in response to hypercapnia, not falls.

7. Which finding increases the risk of enterotomy due to adhesions during laparoscopy?

- A. Previous abdominal surgery**
- B. No prior abdominal procedures
- C. Pregnancy
- D. Recent upper respiratory infection

Adhesions from prior abdominal surgery increase the risk of enterotomy during laparoscopy because scar tissue can bind loops of intestine to the abdominal wall or to other organs, altering normal anatomy. When the abdomen is entered or adhesions are encountered, there's a real chance of injuring a loop of bowel that is stuck or tethered in an unexpected position. Prior abdominal surgery is the strongest risk factor for these adhesions, so it raises the likelihood of enterotomy during laparoscopic access or dissection. Not having had abdominal procedures means fewer adhesions; pregnancy doesn't create adhesions, and a recent upper respiratory infection is unrelated to intra-abdominal adhesions.

8. Which CO₂-related change tends to be greatest in the first 20 minutes of pneumoperitoneum?

- A. Blood pH falls most after 2 hours
- B. White blood cell count rises
- C. Platelet count decreases
- D. End tidal CO₂ increases the most**

During pneumoperitoneum with CO₂, the gas is absorbed across the peritoneal surfaces into the bloodstream. In the first 20 minutes, this rapid diffusion raises arterial CO₂ levels, and the amount of CO₂ being exhaled per breath (end-tidal CO₂) increases accordingly. Capnography tracks this closely, so the end-tidal CO₂ rises most early on. Other changes, like WBC or platelet shifts, are not immediate responses to CO₂ insufflation, and a pH drop due to hypercapnia tends to develop later rather than right at the 20-minute mark. So the most pronounced early CO₂-related change is the rise in end-tidal CO₂.

9. What is the ergonomic position recommended for intracorporeal knot tying?

- A. Elbows flexed at 90 degrees and ports at least 10 cm apart**
- B. Elbows fully extended with ports less than 5 cm apart
- C. Elbows at 120 degrees with ports at least 20 cm apart
- D. Arms resting with no specified port distance

For intracorporeal knot tying, maintaining a neutral, comfortable posture with adequate working space is essential to control and precision. The recommended setup is elbows flexed at about 90 degrees and ports spaced at least 10 cm apart. This elbow angle keeps the arms in a midline, joint-friendly position that reduces shoulder and neck strain while allowing stable, dexterous instrument control. Having the ports at least 10 cm apart provides proper triangulation, giving enough room to maneuver each instrument without external collisions or crowding, which is crucial for precise knot tying inside the abdomen. Other configurations tend to compromise ergonomics: elbows fully extended create unnecessary tension and fatigue, especially during long procedures; ports that are too close (<5 cm) limit range of motion and increase instrument clashes; and simply resting the arms with no specified port distance fails to establish the necessary working geometry for effective intracorporeal knot tying.

10. Which finding is a preoperative consideration for gaining access through the umbilicus?

- A. Umbilical abnormalities**
- B. Past abdominal surgery
- C. Normal umbilicus
- D. No scar

Gaining access through the umbilicus hinges on the condition of the umbilical region itself. Umbilical abnormalities—such as a hernia, scar tissue from prior procedures, infection, or deformity—directly complicate trocar or Veress needle entry, increasing the risk of injury or failed access. If such abnormalities are present, the safest plan is to avoid the umbilical route or modify the approach, making this a key preoperative consideration. A normal umbilicus with no scar is favorable for entry, since there's no inherent obstacle to access. While a history of prior abdominal surgery raises concern for adhesions that could affect any entry point, it does not directly describe the condition of the umbilical site itself. Therefore, the direct finding that most influences the safety and feasibility of umbilical entry is the presence of an umbilical abnormality.

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://laparoscopicsurgeryfls.examzify.com>

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

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