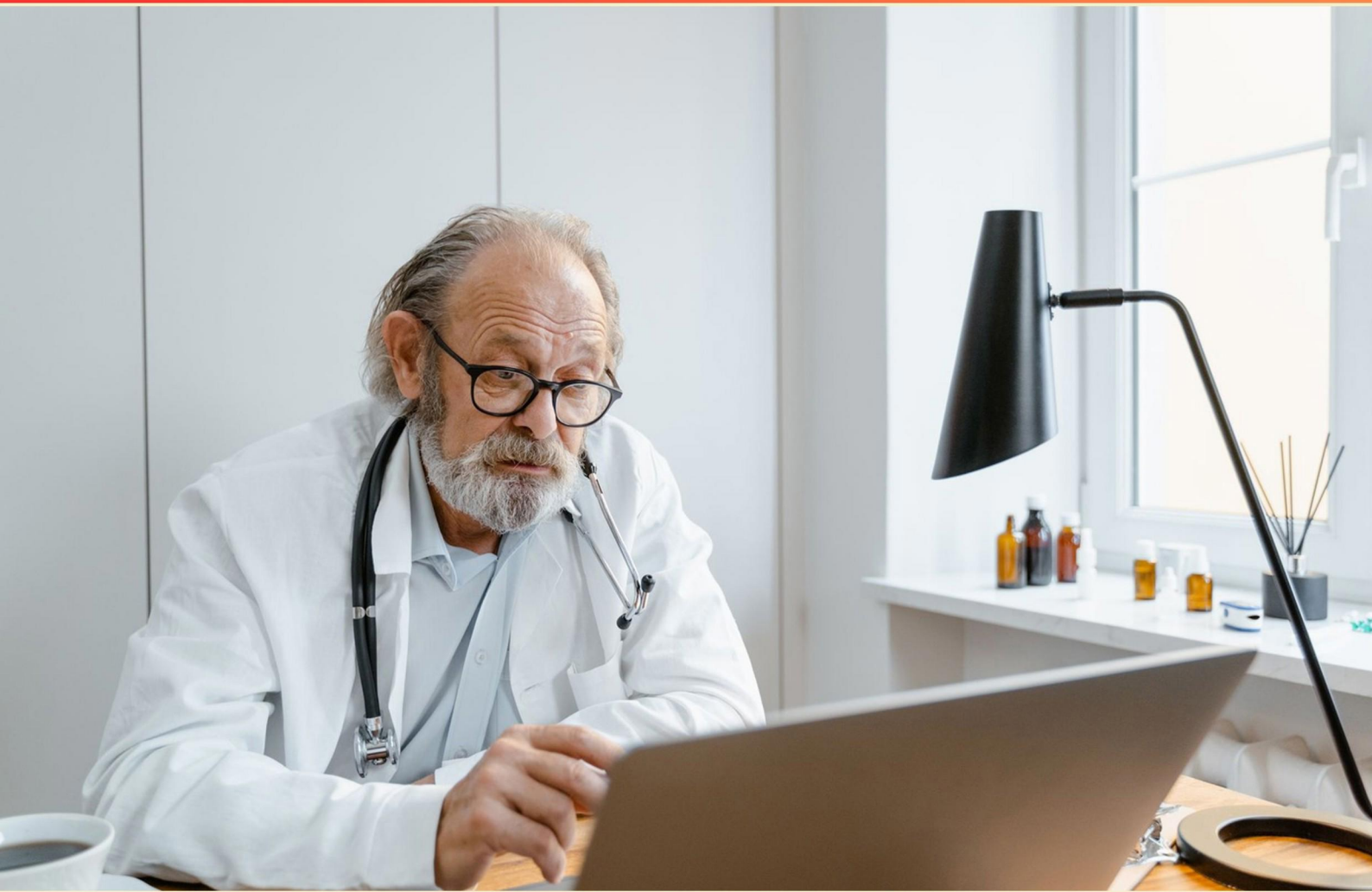


INTERNAL MEDICINE END OF ROTATION (EOR) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

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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 primary infection associated with most duodenal and peptic ulcers?**
 - A. CMV
 - B. H Pylori
 - C. HSV
 - D. Clostridium difficile
- 2. When considering the management of certain arrhythmias, what should be done regarding AV nodal blocking agents when AF is present with WPW?**
 - A. They should be used cautiously
 - B. They should be avoided
 - C. They should be the first line of treatment
 - D. They should always be combined with other treatments
- 3. Which type of hepatitis is known to potentially become chronic?**
 - A. Hepatitis A
 - B. Hepatitis B
 - C. Hepatitis E
 - D. Hepatitis F
- 4. What long-term treatment is commonly used for hypercalcemia?**
 - A. Selective serotonin reuptake inhibitors
 - B. Calcium supplements
 - C. Bisphosphonates
 - D. Thiazide diuretics
- 5. What is the typical initial change seen on an EKG in the case of a STEMI?**
 - A. Increase in amplitude of T wave
 - B. Development of Q waves
 - C. Resolution of ST-segment elevation
 - D. ST segment elevation

- 6. Which of the following statements about Ribavirin is true?**
- A. It is used to treat HepB infections.
 - B. It is teratogenic and used to treat HCV.
 - C. It is safe for pregnant women.
 - D. It is an effective treatment for cirrhosis.
- 7. What is a common complication of cirrhosis that arises from portal vein hypertension?**
- A. Esophageal varices
 - B. Ascites
 - C. Hepatic encephalopathy
 - D. Hepatorenal syndrome
- 8. What symptom is not typically associated with acute adrenal insufficiency?**
- A. Headache
 - B. Nausea and vomiting
 - C. Constipation
 - D. Diarrhea and abdominal pain
- 9. Primary biliary cirrhosis commonly presents in which demographic?**
- A. Older men
 - B. Middle aged women
 - C. Children
 - D. Elderly individuals
- 10. Which lumbar disc level is associated with pain radiating to the anterolateral leg and great toe?**
- A. L3-L4
 - B. L4-L5
 - C. L5-S1
 - D. L2-L3

Answers

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

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Explanations

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1. What is the primary infection associated with most duodenal and peptic ulcers?

- A. CMV
- B. H Pylori**
- C. HSV
- D. Clostridium difficile

The primary infection associated with most duodenal and peptic ulcers is Helicobacter pylori (H. pylori). This bacterium is known to colonize the gastric epithelium and is intricately linked to the pathogenesis of peptic ulcers due to its ability to disrupt the mucosal barrier and lead to gastric inflammation (chronic gastritis). H. pylori can survive in the acidic environment of the stomach and causes damage to the gastric lining, which results in ulceration. The presence of H. pylori is a major risk factor for the development of both gastric and duodenal ulcers. Treatment typically involves a combination of antibiotics and proton pump inhibitors to eradicate the infection and aid in healing the ulcer. The other options mentioned do not have a significant association with the formation of duodenal and peptic ulcers. Cytomegalovirus (CMV) is linked to ulcers primarily in immunocompromised patients, herpes simplex virus (HSV) can cause esophageal ulcers, and Clostridium difficile is generally associated with antibiotic-associated diarrhea and colitis rather than peptic ulcer disease. Thus, the connection of H. pylori with peptic ulcers is well-documented in clinical literature, making it the most relevant answer to this

2. When considering the management of certain arrhythmias, what should be done regarding AV nodal blocking agents when AF is present with WPW?

- A. They should be used cautiously
- B. They should be avoided**
- C. They should be the first line of treatment
- D. They should always be combined with other treatments

In the context of atrial fibrillation (AF) with Wolff-Parkinson-White (WPW) syndrome, the use of AV nodal blocking agents such as beta-blockers, calcium channel blockers, or digoxin poses significant risks and is therefore avoided. The reason for this is that these agents can lead to an increased conduction velocity through the accessory pathway associated with WPW, which can exacerbate the arrhythmia and potentially lead to dangerous tachyarrhythmias, such as atrial fibrillation with rapid ventricular response. In patients with WPW syndrome, the presence of an accessory conduction pathway allows for the potential development of reentrant tachycardias. When AF is present, the rapid atrial rate can be transmitted through the accessory pathway instead of the AV node, leading to a high ventricular response and possibly resulting in hemodynamic instability or even ventricular fibrillation. The correct management approach for AF in the context of WPW is to focus on strategies that effectively eliminate the accessory pathway or control the rhythm through other means. These may include the use of antiarrhythmic medications that do not block the AV node or procedures like catheter ablation aimed at interrupting the accessory pathway. Given these factors, avoiding AV nodal

3. Which type of hepatitis is known to potentially become chronic?

- A. Hepatitis A
- B. Hepatitis B**
- C. Hepatitis E
- D. Hepatitis F

Hepatitis B is known to potentially become chronic due to the nature of the virus and the immune response it elicits. Unlike Hepatitis A and Hepatitis E, which typically cause acute infections that resolve on their own without leading to chronic disease, Hepatitis B has a significant risk of progressing to a chronic stage, especially in certain populations—such as infants or those with weakened immune systems. The chronic infection can lead to long-term complications, including cirrhosis and hepatocellular carcinoma. Chronic Hepatitis B infection is characterized by the persistence of the virus in the liver and the presence of Hepatitis B surface antigens over six months. The body's immune response often fails to eliminate the virus entirely, which is a primary reason why medical management and monitoring are crucial for patients with chronic Hepatitis B. In contrast, Hepatitis A is always self-limiting, with no risk of becoming chronic, and Hepatitis E, while it can have serious acute effects, rarely develops into a chronic condition in healthy individuals. Hepatitis F is lesser-known and not typically discussed in the same context regarding chronicity as the other forms. Therefore, Hepatitis B is the correct answer as it is the most commonly recognized type of hepatitis that can

4. What long-term treatment is commonly used for hypercalcemia?

- A. Selective serotonin reuptake inhibitors
- B. Calcium supplements
- C. Bisphosphonates**
- D. Thiazide diuretics

The commonly used long-term treatment for hypercalcemia is bisphosphonates. These medications are effective in inhibiting osteoclast-mediated bone resorption, thus reducing the release of calcium from the bones into the bloodstream. This mechanism makes bisphosphonates particularly useful in cases of hypercalcemia related to conditions such as malignancy, primary hyperparathyroidism, or immobilization. Bisphosphonates, such as zoledronic acid and pamidronate, are often administered intravenously for rapid correction of hypercalcemia and can result in significant reductions in serum calcium levels. Their long-term use can help manage chronic hypercalcemia by stabilizing calcium levels and preventing potential complications associated with elevated calcium. In contrast, other options are less suitable or contraindicated for treating hypercalcemia. Selective serotonin reuptake inhibitors do not influence calcium metabolism. Calcium supplements would exacerbate hypercalcemia rather than alleviate it. Thiazide diuretics can increase serum calcium levels by promoting calcium reabsorption in the kidneys, making them counterproductive in hypercalcemic patients. Therefore, bisphosphonates are the preferred choice for long-term management of hypercalcemia.

5. What is the typical initial change seen on an EKG in the case of a STEMI?

- A. Increase in amplitude of T wave
- B. Development of Q waves
- C. Resolution of ST-segment elevation

D. ST segment elevation

In the context of a STEMI (ST-Elevation Myocardial Infarction), the typical initial change seen on an EKG is ST-segment elevation. This elevation is a hallmark sign indicating that there is an acute injury to the myocardial tissue due to inadequate blood supply, often as a result of thrombus formation within a coronary artery. During a STEMI, the affected myocardial cells undergo a shift in their electrical activity, leading to an elevation of the ST segment above the baseline on the EKG. This reflects the ongoing ischemia and the acute nature of the cardiac event. The ST-segment elevation is typically observed in the leads that correspond to the area of the myocardium at risk. The development of Q waves is a later change that occurs during a STEMI as necrosis progresses; it is not immediate and signifies a more established myocardial infarction. An increase in the amplitude of T waves can occur in other conditions but is not a characteristic initial change associated specifically with STEMI. Resolution of ST-segment elevation occurs as the myocardial injury is addressed, either through restoration of blood flow or through other therapeutic interventions, but it does not represent an initial change. Recognizing ST-segment elevation on an EKG is crucial for prompt

6. Which of the following statements about Ribavirin is true?

- A. It is used to treat HepB infections.
- B. It is teratogenic and used to treat HCV.
- C. It is safe for pregnant women.
- D. It is an effective treatment for cirrhosis.

Ribavirin is an antiviral medication that is indeed teratogenic, meaning it can cause developmental abnormalities in a fetus if a pregnant woman is exposed to it. This property necessitates that women of childbearing age be advised to avoid pregnancy while receiving ribavirin therapy and to use effective contraception during treatment and for a period after treatment completion. Additionally, ribavirin is commonly used in the treatment of chronic hepatitis C (HCV), often in combination with other antiviral medications such as direct-acting antivirals to enhance efficacy. The other statements do not hold true in the context of ribavirin's clinical use. While ribavirin is an effective antiviral, it is not typically used for treating hepatitis B (HepB) infections, nor is it considered safe for pregnant women due to its teratogenic effects. Ribavirin also does not serve as a treatment option for cirrhosis directly, as cirrhosis is a late-stage liver disease that requires management of the underlying cause rather than a specific antiviral therapy. Thus, the assertion regarding ribavirin being teratogenic and utilized for hepatitis C fits its profile and clinical indications accurately.

7. What is a common complication of cirrhosis that arises from portal vein hypertension?

- A. Esophageal varices**
- B. Ascites
- C. Hepatic encephalopathy
- D. Hepatorenal syndrome

Esophageal varices are a common complication of cirrhosis that occur due to portal vein hypertension. When liver cirrhosis leads to increased portal pressure, it causes the veins in the esophagus to become engorged. These engorged veins are referred to as varices and are at risk of rupture, leading to potentially life-threatening gastrointestinal bleeding. This condition is particularly concerning because patients with cirrhosis often have coagulopathy due to impaired liver function, thus exacerbating the consequences of any bleeding that might occur. Other complications associated with cirrhosis, such as ascites, hepatic encephalopathy, and hepatorenal syndrome, are also significant but arise from different mechanisms related to liver dysfunction and portal hypertension. Ascites refers to the accumulation of fluid in the abdominal cavity due to high portal pressure and low albumin levels, hepatic encephalopathy relates to the buildup of toxins due to liver failure affecting brain function, and hepatorenal syndrome involves a decline in kidney function secondary to severe liver disease. Each of these complications arises from the overall effects of liver failure and portal hypertension, but esophageal varices specifically are a direct consequence of the increased pressure in the portal venous system leading to the dilation of veins in

8. What symptom is not typically associated with acute adrenal insufficiency?

- A. Headache
- B. Nausea and vomiting
- C. Constipation**
- D. Diarrhea and abdominal pain

Acute adrenal insufficiency, also known as adrenal crisis, is a critical condition that arises when the body does not produce enough cortisol. The symptoms associated with this condition are primarily a result of acute glucocorticoid deficiency and include significant gastrointestinal disturbances, such as nausea and vomiting, as well as abdominal pain and diarrhea. Headaches can also occur due to a variety of factors, including stress, hypovolemia, or electrolyte imbalances typically seen in those who are in crisis. However, constipation is not one of the common symptoms associated with acute adrenal insufficiency. In fact, the gastrointestinal tract often offers clues to the presence of the condition, which usually manifests with increased gastrointestinal motility rather than decreased. Therefore, the presence of constipation would not align with the clinical presentation generally observed in acute adrenal crisis, making it the symptom least likely to be associated with this condition.

9. Primary biliary cirrhosis commonly presents in which demographic?

- A. Older men
- B. Middle aged women**
- C. Children
- D. Elderly individuals

Primary biliary cirrhosis, now more commonly referred to as primary biliary cholangitis (PBC), primarily affects middle-aged women. The typical demographic is women aged between 40 and 60 years old, indicating that this condition has a strong gender predilection, making it significantly more prevalent in females than males. Epidemiological studies support this finding, showing that the female-to-male ratio can be as high as 10:1. The condition is characterized by inflammation and eventual destruction of the small bile ducts within the liver, leading to cholestasis and liver damage over time. Symptoms may include fatigue, pruritus (itching), and jaundice, which tend to manifest once the disease progresses. While elderly individuals also have liver diseases, they are not the primary demographic for primary biliary cholangitis. Similarly, children are rarely affected by this condition, and older men are even less likely to present with it, considering the strong female predominance. Thus, the correct answer accurately reflects the typical patient profile for primary biliary cirrhosis.

10. Which lumbar disc level is associated with pain radiating to the anterolateral leg and great toe?

- A. L3-L4
- B. L4-L5**
- C. L5-S1
- D. L2-L3

The lumbar disc level associated with pain radiating to the anterolateral leg and great toe is indeed the L4-L5 level. At this location, the herniation can affect the L4 nerve root, which supplies sensation to the anterior and lateral aspects of the leg and extends down to innervate the great toe. The L4-L5 intervertebral disc is particularly relevant in the context of a herniated disc resulting in symptoms like lower back pain and neurological issues. Patients may experience symptoms such as weakness in dorsiflexion of the foot or difficulty walking on their heels. Understanding the dermatomes associated with each lumbar nerve root further clarifies this. The L4 dermatome covers the medial side of the leg and the great toe, while the L5 nerve root covers the more lateral aspect of the leg and provides sensation to the area around the dorsum of the foot. By contrast, the other lumbar disc levels impact different areas. For instance, L3-L4 primarily affects the medial aspect of the thigh and knee, L5-S1 influences the posterior aspect of the leg and the lateral aspect of the foot, and L2-L3 is linked more with the proximal thigh area. Therefore, the L4

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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