

Internal Medicine II Practice Test (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 considered the most serious organ involvement in SLE?**
 - A. polyarthritis**
 - B. lupus nephritis**
 - C. acute cutaneous eruption**
 - D. pleuritis**

- 2. How do you interpret a serum-ascites albumin gradient (SAAG) and what does SAAG ≥ 1.1 g/dL indicate?**
 - A. SAAG ≥ 1.1 indicates portal hypertension as the cause of ascites; SAAG < 1.1 suggests non-portal hypertension etiologies**
 - B. SAAG ≥ 1.1 indicates infection**
 - C. SAAG ≥ 1.1 indicates nephrotic syndrome**
 - D. SAAG ≥ 1.1 is a normal value**

- 3. In prerenal AKI, which combination best describes expected urinary indices?**
 - A. FeNa $> 2\%$, urine Na > 40 , low urine osmolality.**
 - B. FeNa $< 1\%$, urine Na < 20 , urine osmolality > 500 .**
 - C. FeNa $> 1\%$, urine Na 20-40.**
 - D. FeNa $< 1\%$, urine Na > 40 .**

- 4. In STEMI management, what is the correct action when PCI cannot be performed within 120 minutes?**
 - A. Administer fibrinolytic therapy**
 - B. Proceed to immediate CABG**
 - C. Continue with antiplatelets without reperfusion**
 - D. Observational care only**

- 5. In hypocalcemia presenting with tetany, what is the initial management and evaluation steps?**
 - A. Administer IV calcium gluconate; check magnesium; correct albumin and vitamin D as needed; monitor for arrhythmias**
 - B. Oral calcium only; check magnesium**
 - C. Administer phosphate**
 - D. Monitor for arrhythmias only**

- 6. Which HLA type is most strongly associated with reactive arthritis?**
- A. HLA-B27 positivity**
 - B. HLA-B7 positivity**
 - C. Rheumatoid factor positivity**
 - D. Anti-CCP positivity**
- 7. Hyponatremia with euvolemia due to SIADH—what is the recommended initial management and the safe rate of correction?**
- A. Fluid restriction only**
 - B. Fluid restriction and addressing underlying cause; correct sodium no more than 6-8 mEq/L in 24 hours**
 - C. Hypertonic saline**
 - D. Demeclocycline as first-line**
- 8. Which circumstances are optimal to minimize fetal complications when a patient with lupus is pregnant**
- A. If SLE Activity Just Ended Because Drug Concentrations Are Highest in the Patient**
 - B. Conception After 3 Months of Remission at Least**
 - C. Conception After 6 Months of Remission at Least**
 - D. Lupus Is Active Because the Patient Is Strictly Controlled During Activity**
- 9. In a stable COPD patient with resting SpO₂ of 89%, what is the recommended target oxygen saturation range and when is long-term oxygen therapy indicated?**
- A. 88-92% with LTOT indicated if PaO₂ ≤55 mmHg or SpO₂ ≤88% with hypoxemia-related complications**
 - B. 94-98% with LTOT indicated if PaO₂ ≤60**
 - C. 90-92% with LTOT indicated if SpO₂ ≤90%**
 - D. 85-90% with LTOT indicated if PaO₂ ≤50**

10. Which statement best describes the initial management priorities for diabetic ketoacidosis and hyperglycemic hyperosmolar state?

- A. Isotonic IV fluids, electrolyte-based insulin therapy, and potassium management**
- B. Aggressive bicarbonate therapy for all**
- C. Fluid restriction and no insulin**
- D. Insulin therapy alone without fluid resuscitation**

Answers

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

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Explanations

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1. What is considered the most serious organ involvement in SLE?

- A. polyarthrititis**
- B. lupus nephritis**
- C. acute cutaneous eruption**
- D. pleuritis**

The most serious organ involvement in SLE is kidney disease. Lupus nephritis results from immune complex deposition in the glomeruli, triggering inflammation that can rapidly impair filtration. Patients may present with proteinuria, hematuria, and rising creatinine, and without effective treatment this can progress to nephrotic syndrome, irreversible kidney scarring, and eventual end-stage renal disease requiring dialysis or transplant. Because loss of renal function is a major driver of morbidity and mortality in SLE, kidney involvement stands out as the most critical organ system to monitor and treat early. Joint involvement is common and can cause significant disability, but it is usually non-life-threatening and non-renal in nature. Skin eruptions and serositis can be troublesome and reflect disease activity, yet they do not carry the same risk of irreversible organ failure as lupus nephritis.

2. How do you interpret a serum-ascites albumin gradient (SAAG) and what does $\text{SAAG} \geq 1.1$ g/dL indicate?

- A. $\text{SAAG} \geq 1.1$ indicates portal hypertension as the cause of ascites; $\text{SAAG} < 1.1$ suggests non-portal hypertension etiologies**
- B. $\text{SAAG} \geq 1.1$ indicates infection**
- C. $\text{SAAG} \geq 1.1$ indicates nephrotic syndrome**
- D. $\text{SAAG} \geq 1.1$ is a normal value**

SAAG helps separate ascites caused by high portal pressure from ascites due to other peritoneal processes. It's the difference between the serum albumin and the albumin in the ascitic fluid. When the gradient is at least 1.1 g/dL, it indicates that portal hypertension is driving the fluid into the peritoneal cavity, as seen with cirrhosis, congestive heart failure, or Budd-Chiari syndrome. In these situations, hydrostatic pressure pushes fluid into the space while keeping the albumin concentration in the ascitic fluid relatively low, yielding a high SAAG. If the gradient is less than 1.1 g/dL, that points away from portal hypertension and toward non-portal hypertensive causes of ascites such as infection (e.g., tuberculous peritonitis), malignancy, pancreatitis, or nephrotic syndrome, where the peritoneal disease or systemic factors dominate rather than portal pressure. So $\text{SAAG} \geq 1.1$ g/dL indicates portal hypertension as the likely cause of ascites.

3. In prerenal AKI, which combination best describes expected urinary indices?

- A. FeNa >2%, urine Na >40, low urine osmolality.
- B. FeNa <1%, urine Na <20, urine osmolality >500.**
- C. FeNa >1%, urine Na 20-40.
- D. FeNa <1%, urine Na >40.

When renal perfusion drops, the kidney responds by increasing reabsorption of sodium and water to preserve blood flow and volume. That means the urine becomes highly concentrated and sodium loss is minimized. So the expected urinary profile in prerenal AKI is a very low fractional excretion of sodium (FeNa < 1%), low urine sodium (typically < 20 mEq/L), and a high urine osmolality (often > 500 mOsm/kg). This pattern reflects intact tubular function with avid reabsorption due to hypoperfusion. Why this pattern fits best: a low FeNa shows the kidney is holding onto sodium, not wasting it, because perfusion is reduced but the tubules are still working to reclaim Na and water. The low urine Na corroborates that little sodium is being excreted, and the high osmolality indicates concentrated urine from water reabsorption. Patterns that don't fit prerenal AKI help distinguish from intrinsic renal injury like ATN, where damage impairs tubule reabsorption, leading to higher FeNa (often >2%), higher urine Na (>40), and dilute urine with lower osmolality. A scenario with FeNa < 1% but high urine Na (>40) or with FeNa > 1% and urine Na 20-40 would also be inconsistent with prerenal physiology.

4. In STEMI management, what is the correct action when PCI cannot be performed within 120 minutes?

- A. Administer fibrinolytic therapy
- B. Proceed to immediate CABG
- C. Continue with antiplatelets without reperfusion
- D. Observational care only**

Reperfusion as soon as possible is the priority in STEMI. If primary PCI cannot be performed within the 120-minute window, the next step is to administer fibrinolytic therapy promptly, provided there are no contraindications. Restoring blood flow quickly limits myocardial damage, improves survival, and can bridge the patient to definitive coronary intervention later (a pharmacoinvasive approach) with urgent transfer for angiography and possible PCI. Emergent CABG is not the first-line reperfusion strategy in this scenario, since it is not typically available or rapid enough in the acute setting and PCI remains the preferred method when feasible. Simply giving antiplatelets without reperfusion or opting for observation leaves the heart muscle at ongoing risk of infarction.

5. In hypocalcemia presenting with tetany, what is the initial management and evaluation steps?

A. Administer IV calcium gluconate; check magnesium; correct albumin and vitamin D as needed; monitor for arrhythmias

B. Oral calcium only; check magnesium

C. Administer phosphate

D. Monitor for arrhythmias only

The key idea is that acute symptomatic hypocalcemia with tetany requires rapid calcium replacement plus evaluation for factors that modulate calcium balance. Start IV calcium gluconate to quickly raise the serum ionized calcium and relieve neuromuscular irritability, because oral calcium alone cannot correct a dangerous, symptomatic deficit fast enough. While calcium is being given, assess and correct contributing factors, especially magnesium, since hypomagnesemia can suppress PTH secretion and action and make hypocalcemia refractory; low magnesium often needs to be corrected before calcium normalizes. Also evaluate factors that influence calcium measurements and long-term status. Checking albumin helps interpret total calcium because low albumin lowers total calcium without necessarily changing ionized calcium; if albumin is abnormal, a corrected calcium calculation or, ideally, measurement of ionized calcium guides therapy. Checking vitamin D status and providing supplementation as needed addresses one common cause of hypocalcemia and supports ongoing calcium absorption and homeostasis. Continuous monitoring for arrhythmias is essential because rapid calcium administration and electrolyte shifts can affect cardiac conduction; adjust therapy based on ECG and clinical response. In contrast, giving oral calcium alone won't treat an acute tetany, administering phosphate would worsen the calcium deficit, and monitoring without treatment fails to address the immediate threat.

6. Which HLA type is most strongly associated with reactive arthritis?

A. HLA-B27 positivity

B. HLA-B7 positivity

C. Rheumatoid factor positivity

D. Anti-CCP positivity

Reactive arthritis is part of the seronegative spondyloarthropathies, and the strongest genetic association is with HLA-B27. This antigen is present at a much higher frequency in people who develop reactive arthritis after a GI or GU infection, and its presence can influence disease features and course, though it's not required for diagnosis. HLA-B7 does not have a notable link to this condition. Rheumatoid factor and anti-CCP antibodies are typical markers of rheumatoid arthritis and are usually negative in reactive arthritis, reflecting the seronegative nature of this group.

7. Hyponatremia with euvolemia due to SIADH—what is the recommended initial management and the safe rate of correction?

A. Fluid restriction only

B. Fluid restriction and addressing underlying cause; correct sodium no more than 6-8 mEq/L in 24 hours

C. Hypertonic saline

D. Demeclocycline as first-line

In SIADH causing euvolemic hyponatremia, the key is to reduce free water intake and treat the underlying cause, allowing the kidney to excrete the excess water and sodium to rise gradually. Fluid restriction is the main initial step, paired with addressing what's driving ADH excess (such as stopping offending medications or treating an underlying illness). The safest rate of correction is about 6-8 mEq/L of serum sodium in the first 24 hours, with strict monitoring to avoid overshoot that can cause osmotic demyelination syndrome. Hypertonic saline is reserved for severe, life-threatening symptoms, not routine initial management of euvolemic SIADH, and demeclocycline is not a first-line therapy but can be considered in more resistant cases or long-term management along with other agents.

8. Which circumstances are optimal to minimize fetal complications when a patient with lupus is pregnant

A. If SLE Activity Just Ended Because Drug Concentrations Are Highest in the Patient

B. Conception After 3 Months of Remission at Least

C. Conception After 6 Months of Remission at Least

D. Lupus Is Active Because the Patient Is Strictly Controlled During Activity

Conceiving when lupus is in prolonged quiescence minimizes the risk of fetal complications. The best timing is after at least six months of remission. When disease activity is present during pregnancy, there's a higher risk of adverse outcomes for the fetus, including fetal loss, preterm birth, fetal growth restriction, and neonatal lupus, and there's also a greater chance of maternal complications like preeclampsia. Achieving and maintaining remission for six months before conception reduces these risks more effectively than shorter remission periods. In contrast, trying to conceive during or right after a flare does not optimize fetal safety, and timing around drug levels isn't the main driver of fetal risk.

9. In a stable COPD patient with resting SpO₂ of 89%, what is the recommended target oxygen saturation range and when is long-term oxygen therapy indicated?

A. 88-92% with LTOT indicated if PaO₂ ≤55 mmHg or SpO₂ ≤88% with hypoxemia-related complications

B. 94-98% with LTOT indicated if PaO₂ ≤60

C. 90-92% with LTOT indicated if SpO₂ ≤90%

D. 85-90% with LTOT indicated if PaO₂ ≤50

The main idea here is how to manage oxygen in stable COPD: keep resting oxygen saturation in a safe, narrow range to prevent both hypoxemia and CO₂ retention, and reserve long-term oxygen therapy for true chronic hypoxemia. In stable COPD, aim for an SpO₂ of about 88-92%. This range provides enough oxygenation while minimizing the risk of depressing drive to breathe if carbon dioxide is already elevated. Long-term oxygen therapy improves survival only in patients with documented chronic hypoxemia, defined by a PaO₂ of 55 mmHg or less, or an SpO₂ of 88% or less on room air, especially if there are hypoxemia-related complications such as polycythemia, pulmonary hypertension, or right-sided heart strain. LTOT may also be considered if PaO₂ is 56-59 mmHg or SpO₂ 89-92% but there are complications. For this patient with resting SpO₂ 89%, the saturation is within the target range. LTOT would be indicated based on the hypoxemia thresholds above (PaO₂ ≤55 or SpO₂ ≤88% with complications), not solely on having an SpO₂ of 89%.

10. Which statement best describes the initial management priorities for diabetic ketoacidosis and hyperglycemic hyperosmolar state?

A. Isotonic IV fluids, electrolyte-based insulin therapy, and potassium management

B. Aggressive bicarbonate therapy for all

C. Fluid restriction and no insulin

D. Insulin therapy alone without fluid resuscitation

The essential idea is that initial management of diabetic ketoacidosis and hyperglycemic hyperosmolar state centers on restoring circulation with IV fluids, starting insulin to correct hyperglycemia and ketosis, and carefully balancing electrolytes, especially potassium. Begin with isotonic saline to fix volume depletion and improve perfusion; this sets the stage for effective insulin action and renal clearance of glucose and ketones. Insulin should be started after adequate fluid resuscitation, but only when the potassium level is being monitored because insulin drives potassium into cells and can precipitate dangerous hypokalemia. Since patients often have depleted total body potassium even if serum levels are normal or high, potassium repletion is often required early and adjusted to keep serum potassium in the normal range. Bicarbonate is not routinely given to all patients; it's reserved for a severely acidemic subset (for example, extremely low pH), rather than as a standard step. Options that emphasize fluid restriction, or insulin without fluids, or universal bicarbonate use, don't address the critical first steps of resuscitation and safe electrolyte management.

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://internalmedicine2.examzify.com>

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