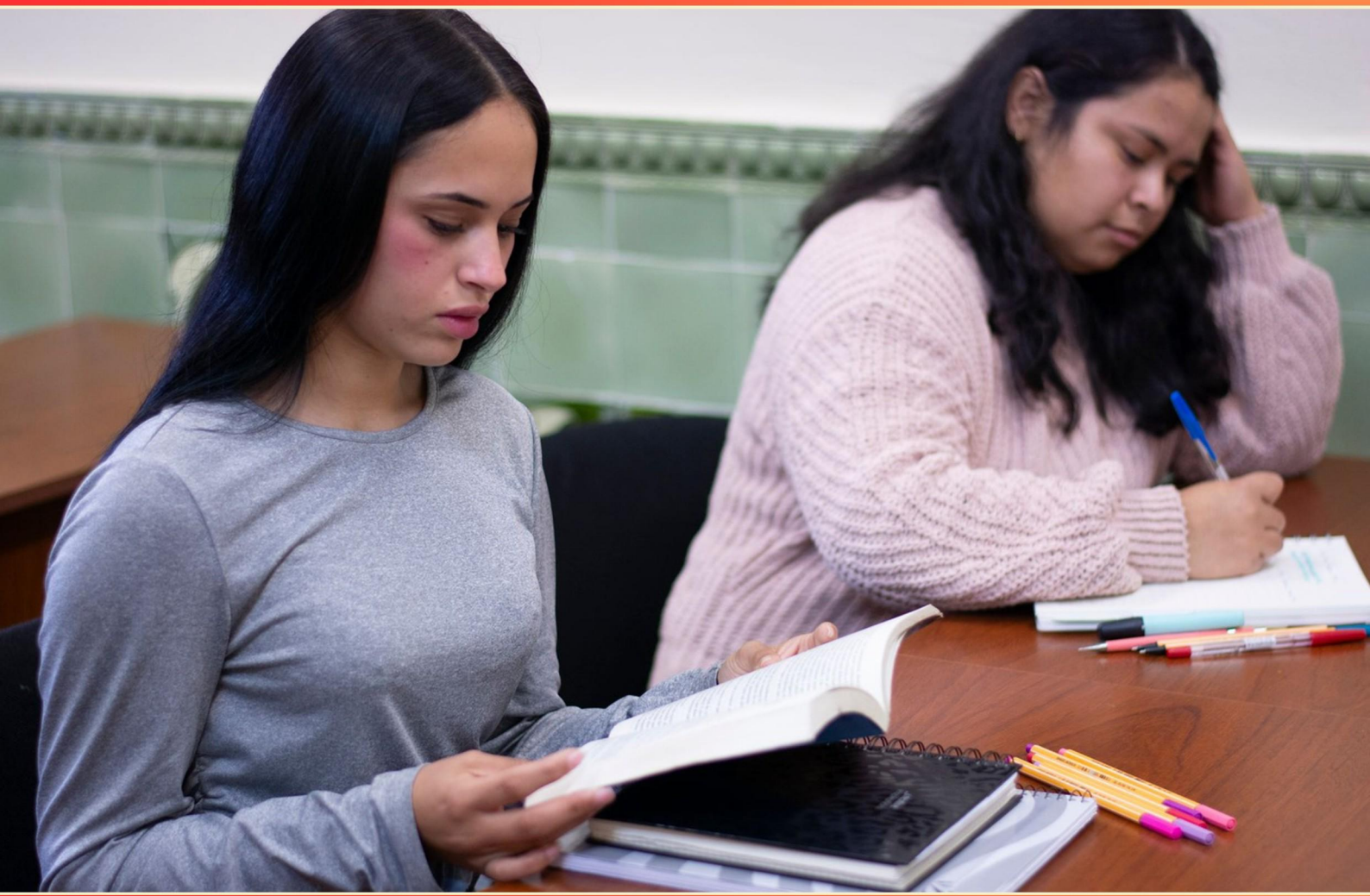
INTERNAL MEDICINE II PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

https://internalmedicine2.examzify.com

Table of Contents

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. Which radiographic finding is typical of rheumatoid arthritis in the hands?

A. Atlantoaxial subluxation

B. Marginal erosions

C. Squaring vertebral bodies

D. Femoral head AVN

2. In gout management, what is the approach to acute treatment and long-term urate-lowering therapy?

A. Acute: NSAIDs or colchicine; chronic prevention with allopurinol or febuxostat; start urate-lowering therapy after acute attack resolves; monitor uric acid levels

B. Acute: NSAIDs or colchicine; chronic prevention with probenecid; urate-lowering therapy started during an acute flare

C. Acute: steroids alone; chronic: allopurinol

D. Acute: colchicine therapy only; chronic: febuxostat with no monitoring

3. Raynaud's phenomenon can involve which areas?

A. Fingers only

B. Fingers and possibly other acral regions

C. Palms only

D. Toes only

4. In Sjögren's syndrome, increased risk of lymphoma is associated with which finding

A. Negative Salivary Gland Biopsy

B. Renal Tubular Acidosis

C. Hypercomplementaemia (Elevated C4)

D. Cryoglobulinaemia

5. In acute kidney injury, prerenal azotemia due to hypoperfusion is best managed by:

A. Prerenal AKI due to hypoperfusion; treat with volume resuscitation and address the cause.

B. Intrinsic AKI management relies on nephrotoxin avoidance and dialysis.

C. Prerenal AKI requires immediate nephrology dialysis in all cases.

D. Prerenal AKI is best treated with diuretic therapy and no volume resuscitation.

6. Which imaging modality is preferred for early diagnosis of synovitis in RA?

A. Hand X-ray

B. Wrist MRI

C. Cervical spine CT

D. Chest X-ray

7. In osteoporosis with a T-score of -2.5 or lower, what is the first-line pharmacologic therapy?

A. Denosumab

B. Bisphosphonates

C. Analgetics

D. NSAID

8. Which statement about antiphospholipid syndrome is true?

A. No Abortions Are Needed for Diagnosis

B. Three Abortions Before the 10th Week Are Needed for Diagnosis

C. Abortion Before 20 Weeks Defines the Syndrome

D. Antiphospholipid Antibodies Alone Confirm Diagnosis

9. Not a characteristic autoantibody for mixed connective tissue disease?

A. Anti-U1RNP

B. Anti-U1RNP, anti-SSA

C. Anti-ds-DNA

D. Anti-U1-RNP, anti-phospholipid antibody

10. Which statement describes a side effect NOT associated with steroids?

A. Diabetes mellitus

B. Osteoporosis

C. Avascularis necrosis of femoral head

D. Haemorrhagic cystitis

Answers

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

Explanations

1. Which radiographic finding is typical of rheumatoid arthritis in the hands?

A. Atlantoaxial subluxation

B. Marginal erosions

C. Squaring vertebral bodies

D. Femoral head AVN

In rheumatoid arthritis the inflammatory process targets the synovium of small hand joints, and the destructive pannus that forms at the joint margin erodes adjacent bone. The radiographic hallmark in the hands is marginal erosions—erosions that occur at the margins of the joint, often at the metacarpophalangeal and interphalangeal joints. These erosions accompany juxta-articular osteopenia (loss of bone density near the joints) and progressive joint-space narrowing as the disease advances, eventually leading to characteristic hand deformities. So, the finding described as marginal erosions best fits RA in the hands because it reflects the targeted, margin-destroying bone damage driven by synovial inflammation. Other options point to sites or processes not typical for hand radiographs in RA (for example, cervical spine involvement like atlantoaxial subluxation, which isn't a hand finding; vertebral changes or hip complications like AVN), so they don't represent the classic hand radiographic feature of RA.

2. In gout management, what is the approach to acute treatment and long-term urate-lowering therapy?

A. Acute: NSAIDs or colchicine; chronic prevention with allopurinol or febuxostat; start urate-lowering therapy after acute attack resolves; monitor uric acid levels

B. Acute: NSAIDs or colchicine; chronic prevention with probenecid; urate-lowering therapy started during an acute flare

C. Acute: steroids alone; chronic: allopurinol

D. Acute: colchicine therapy only; chronic: febuxostat with no monitoring

Managing an acute gout attack while planning long-term urate-lowering therapy requires separating immediate anti-inflammatory care from chronic urate control. For the acute flare, use anti-inflammatory treatment to rapidly relieve pain and inflammation—nonsteroidal anti-inflammatory drugs or colchicine are first choices, with steroids reserved if NSAIDs or colchicine are not suitable. This addresses the current inflammation and helps the patient regain function quickly. For long-term prevention, aim to lower serum urate with a xanthine oxidase inhibitor such as allopurinol or febuxostat. Start urate-lowering therapy after the acute attack has resolved, not during the flare, to avoid prolonging or worsening inflammation. When initiating urate-lowering therapy, it's common to add flare prophylaxis with low-dose colchicine or NSAIDs for several months to prevent new attacks during the adjustment period. The goal is to reach and maintain a target serum urate—generally below 6 mg/dL, and even lower (below 5 mg/dL) if tophi are present—through regular monitoring and dose adjustment. Probenecid is an option in patients with good renal function and underexcretion, but it's not universally used and still benefits from urate level monitoring. Overall, treatment combines effective control of the acute episode with careful, monitored reduction of uric acid to prevent future flares.

3. Raynaud's phenomenon can involve which areas?

A. Fingers only

B. Fingers and possibly other acral regions

C. Palms only

D. Toes only

Raynaud's phenomenon is episodic vasospasm of the small arteries in distal extremities in response to cold or stress. The most common sites are the fingers, and the toes often participate as well; it can also involve other acral regions such as the nose, ears, or lips during an attack. It is not limited to a single area like just the fingers or just the palms, and it commonly affects multiple acral sites. Therefore, describing it as involving the fingers and possibly other acral regions best fits the pattern.

4. In Sjögren's syndrome, increased risk of lymphoma is associated with which finding

A. Negative Salivary Gland Biopsy

B. Renal Tubular Acidosis

C. Hypercomplementaemia (Elevated C4)

D. Cryoglobulinaemia

In Sjögren's syndrome, the risk of developing lymphoma is linked to evidence of abnormal B-cell activity, and cryoglobulinemia is a key indicator of that process. Cryoglobulins are immunoglobulins that precipitate at cold temperatures and reflect a clonal or oligoclonal B-cell proliferation with immune complex formation. This underlying B-cell dysregulation correlates with an increased risk of lymphoproliferative disorders, including lymphoma, in Sjögren's patients. Cryoglobulinemia is often accompanied by reduced complement levels due to immune complex–mediated activation, which further signals active immune dysregulation. The other options don't carry the same risk signal. A negative salivary gland biopsy would not specifically indicate higher lymphoma risk. Renal tubular acidosis is a renal manifestation of Sjögren's, not a marker for lymphoma risk. Hypercomplementaemia (elevated C4) is not characteristic of the cryoglobulin–associated processes seen with escalating lymphoma risk; in fact, complement is typically consumed, leading to lower levels.

5. In acute kidney injury, prerenal azotemia due to hypoperfusion is best managed by:

A. Prerenal AKI due to hypoperfusion; treat with volume resuscitation and address the cause.

B. Intrinsic AKI management relies on nephrotoxin avoidance and dialysis.

C. Prerenal AKI requires immediate nephrology dialysis in all cases.

D. Prerenal AKI is best treated with diuretic therapy and no volume resuscitation.

When prerenal AKI is caused by hypoperfusion, the kidneys are structurally intact but not receiving enough blood flow. The priority is to restore renal perfusion and fix the underlying cause of the reduced forward flow. This is best achieved with volume repletion using appropriate IV fluids (often isotonic crystalloids) and by addressing factors driving the low effective circulating volume or low blood pressure (such as dehydration, hemorrhage, sepsis, or heart failure with poor forward flow). As kidney perfusion improves, GFR increases and creatinine and azotemia typically improve. Dialysis is not the first step in this scenario; it's reserved for situations where AKI persists despite restoration of perfusion or for life-threatening complications (severe hyperkalemia, acidosis, uremia, or refractory fluid overload). Diuretics do not correct the underlying perfusion problem and are not the primary treatment for prerenal azotemia, though they may be used later if volume overload becomes an issue after perfusion is restored. Helpful context: prerenal azotemia often shows a low urine sodium and a high BUN/creatinine ratio, reflecting preserved tubular function and avid reabsorption due to reduced perfusion. These signs typically improve with successful volume resuscitation and correction of the underlying cause.

6. Which imaging modality is preferred for early diagnosis of synovitis in RA?

A. Hand X-ray

B. Wrist MRI

C. Cervical spine CT

D. Chest X-ray

Early rheumatoid arthritis presents with inflammation of the synovial lining, so imaging that visualizes soft tissue and inflammatory activity is most helpful. Wrist MRI provides high sensitivity for detecting synovitis, tenosynovitis, and bone marrow edema, often before any erosions appear on X-ray. Contrast-enhanced MRI highlights inflamed synovium, aiding early diagnosis and timely initiation of therapy to prevent joint damage. Hand X-ray mainly shows erosions that develop later, making it less useful for early detection. Cervical spine CT focuses on bone anatomy and is not sensitive for soft-tissue inflammation, and chest X-ray isn't used to assess limb synovitis. Therefore, wrist MRI is the preferred modality for early diagnosis of synovitis in RA.

7. In osteoporosis with a T-score of -2.5 or lower, what is the first-line pharmacologic therapy?

A. Denosumab

B. Bisphosphonates

C. Analgetics

D. NSAID

When osteoporosis is defined by a T-score of -2.5 or lower, the first-line pharmacologic therapy is a bisphosphonate because these drugs directly reduce bone resorption by osteoclasts, leading to preservation or gain in bone density and a proven reduction in fracture risk. They bind to bone surfaces and inhibit osteoclast activity, with oral options like alendronate or risedronate and an alternative intravenous form, zoledronic acid, for those who prefer not to or cannot take pills daily or weekly. While denosumab can also reduce fracture risk, it is typically considered after bisphosphonates or in patients who cannot take them. Analgesics and NSAIDs do not treat osteoporosis or prevent fractures; they only address pain, so they are not disease-modifying therapies.

8. Which statement about antiphospholipid syndrome is true?

A. No Abortions Are Needed for Diagnosis

B. Three Abortions Before the 10th Week Are Needed for Diagnosis

C. Abortion Before 20 Weeks Defines the Syndrome

D. Antiphospholipid Antibodies Alone Confirm Diagnosis

Antiphospholipid syndrome is diagnosed when there is both a clinical event consistent with APS and persistent antiphospholipid antibodies. For pregnancy-related criteria, you can have three or more consecutive spontaneous abortions before 10 weeks, or a fetal death after 10 weeks, or a premature birth before 34 weeks due to placental insufficiency, eclampsia, or preeclampsia. The antibodies must be present on two occasions at least 12 weeks apart. So, recognizing that three consecutive abortions before 10 weeks is one of the valid obstetric criteria explains why this statement is true. The other options are not correct because antibodies alone do not confirm the diagnosis, abortion before 20 weeks is not the defined threshold, and abortions by themselves do not meet the diagnostic requirement without the accompanying clinical and persistent antibody criteria.

9. Not a characteristic autoantibody for mixed connective tissue disease?

A. Anti-U1RNP

B. Anti-U1RNP, anti-SSA

C. Anti-ds-DNA

D. Anti-U1-RNP, anti-phospholipid antibody

Autoimmune overlap in mixed connective tissue disease centers on antibodies against U1-RNP. This antibody is a defining feature and explains the blend of lupus-like, scleroderma-like, and myositis symptoms seen in MCTD. Other antibodies can appear variably, such as anti-SSA or anti-phospholipid antibodies, but the hallmark is anti-U1RNP. Anti-dsDNA, on the other hand, is highly specific for systemic lupus erythematosus and is strongly associated with lupus nephritis. It is not characteristic of mixed connective tissue disease, which is why it's the best choice for not fitting the typical autoantibody pattern of MCTD.

10. Which statement describes a side effect NOT associated with steroids?

A. Diabetes mellitus

B. Osteoporosis

C. Avascularis necrosis of femoral head

D. Haemorrhagic cystitis

Systemic corticosteroids have well-known effects on glucose metabolism, bone health, and blood supply to bone. They can cause hyperglycemia and diabetes mellitus by increasing hepatic glucose production and promoting insulin resistance, especially with long-term use. They promote osteoporosis by inhibiting osteoblast activity, increasing osteoclast-mediated bone resorption, and reducing calcium absorption, leading to reduced bone density. They also raise the risk of avascular necrosis of the femoral head, likely related to vascular compromise and lipid metabolism effects in the setting of high-dose therapy. Hemorrhagic cystitis is not a typical steroid-related adverse effect; it is more commonly associated with certain chemotherapy agents (like cyclophosphamide or ifosfamide) due to toxic metabolites. Therefore, the statement describing a side effect not associated with steroids is hemorrhagic cystitis.

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!