

MEDICAL-SURGICAL ENDOCRINE PRACTICE TEST (SAMPLE)

STUDY GUIDE



Prepare with structure. Pass with confidence



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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. Which statement correctly describes the electrolyte disturbances typical of Addison disease?**
 - A. Hyponatremia, hypokalemia, metabolic alkalosis
 - B. Hyponatremia, hypokalemia, metabolic acidosis
 - C. Hyponatremia, hyperkalemia, metabolic acidosis, and fatigue
 - D. Hyperglycemia and leukocytosis

- 2. Which set of vital signs would you expect with diabetic ketoacidosis?**
 - A. Temperature 99 F, pulse 62 bpm, respirations 16 breaths/min and shallow
 - B. Temperature 98.6 F, pulse 76 bpm, respirations 16 breaths/min and deep
 - C. Temperature 98 F, 84 bpm, respirations 18 breaths/min and shallow
 - D. Temperature 97.4 F, pulse 100 bpm, respirations 20 breaths/min and deep

- 3. What are the major features and etiologies of Cushing syndrome?**
 - A. Weight loss, moon facies, hypotension; etiologies include dehydration and anorexia
 - B. Weight gain, moon facies, truncal obesity, hypertension, buffalo hump; etiologies include ACTH-dependent (pituitary adenoma, ectopic ACTH) and ACTH-independent (adrenal adenoma/carcinoma)
 - C. Hyperthyroid-like symptoms with heat intolerance; etiologies include autoimmune thyroiditis
 - D. Hyperparathyroidism with hypercalcemia and kidney stones

- 4. What is the appropriate treatment for a hospitalized unconscious patient with hypoglycemia?**
 - A. an intramuscular injection of glucagon
 - B. 6 ounces of orange juice
 - C. a piece of candy
 - D. putting sugar under the tongue to dissolve

- 5. During pregnancy, how should management of hypothyroidism be adjusted?**
 - A. Decrease dose by 50%
 - B. Increase by about 25–30% upon pregnancy confirmation and monitor TSH and free T4
 - C. No change
 - D. Switch to liothyronine only

- 6. In the management of HHS, what is the correct initial priority?**
- A. Start with bicarbonate therapy
 - B. Aggressive IV fluids, then insulin after stabilization
 - C. Insulin infusion before fluids
 - D. Observational management
- 7. A laboratory result shows high TSH and low T4. Which explanation is correct?**
- A. It means inconsistency in your thyroid tests and you will need more testing.
 - B. I am sorry. You will have to ask your physician about your laboratory results. We are not allowed to discuss them.
 - C. The TSH is sending a message to your thyroid gland to increase production, but your thyroid isn't producing enough hormone.
 - D. That means you will have to go on hormone therapy for the rest of your life.
- 8. When a patient newly diagnosed with type 2 diabetes mellitus asks the nurse why she has to take a pill instead of insulin, the nurse replies that in type 2 diabetes mellitus, the body makes insulin but:**
- A. overweight and under active people cannot simply use the insulin produced.
 - B. Metabolism is slowed in some people so they have to take a pill to speed up their metabolism.
 - C. Sometimes the autoimmune system works against the action of the insulin.
 - D. The cells become resistant to the action of insulin. Pills are given to increase the sensitivity.
- 9. A patient tells the nurse that she eats "huge" amounts of food but stays hungry most of the time. The nurse explains that hunger experienced by persons with type 1 diabetes is caused by the:**
- A. Excess amount of glucose
 - B. Need for additional calories to correct the increased metabolism
 - C. Fact that the cells cannot use the blood glucose
 - D. Need for exercise to stimulate insulin secretion.

10. What is the recommended approach to pheochromocytoma management surrounding surgery?

- A. Preoperative beta-blockade only
- B. Preoperative alpha-adrenergic blockade (and sometimes beta-blockade after adequate alpha blockade), careful intraoperative hemodynamic monitoring, and avoidance of hypertensive triggers
- C. Steroid therapy preop
- D. No special management

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Answers

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

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Explanations

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1. Which statement correctly describes the electrolyte disturbances typical of Addison disease?

- A. Hypernatremia, hypokalemia, metabolic alkalosis
- B. Hyponatremia, hypokalemia, metabolic acidosis
- C. Hyponatremia, hyperkalemia, metabolic acidosis, and fatigue**
- D. Hyperglycemia and leukocytosis

In Addison disease, insufficient aldosterone and cortisol disrupt electrolyte and acid-base balance. Lack of aldosterone causes the kidneys to waste sodium, leading to hyponatremia and volume depletion, while also reducing potassium excretion, causing hyperkalemia. Cortisol deficiency contributes to fatigue and can worsen the acid-base picture by promoting metabolic acidosis rather than alkalosis. Putting this together, the electrolyte and acid-base pattern that fits Addison disease is hyponatremia with hyperkalemia, metabolic acidosis, and fatigue. The other patterns—hypernatremia with hypokalemia and metabolic alkalosis, or hyponatremia with hypokalemia and metabolic acidosis, or nonspecific findings like hyperglycemia—do not align with the typical hormonal defect and its renal effects in this condition.

2. Which set of vital signs would you expect with diabetic ketoacidosis?

- A. Temperature 99 F, pulse 62 bpm, respirations 16 breaths/min and shallow
- B. Temperature 98.6 F, pulse 76 bpm, respirations 16 breaths/min and deep
- C. Temperature 98 F, 84 bpm, respirations 18 breaths/min and shallow
- D. Temperature 97.4 F, pulse 100 bpm, respirations 20 breaths/min and deep**

In diabetic ketoacidosis, metabolic acidosis triggers compensatory deep, rapid breathing (Kussmaul) and dehydration tends to raise the pulse, while temperature is usually normal unless an infection is present. The best match shows a normal-to-low temperature, tachycardia (about 100 bpm), and deep, rapid respirations around 20 breaths per minute. This combination reflects both the body's attempt to blow off CO₂ and the dehydration-driven increase in heart rate, which are hallmark features of DKA. The other sets either show shallow breathing or a non-tachycardic pulse, which are less consistent with DKA.

3. What are the major features and etiologies of Cushing syndrome?

- A. Weight loss, moon facies, hypotension; etiologies include dehydration and anorexia
- B. Weight gain, moon facies, truncal obesity, hypertension, buffalo hump; etiologies include ACTH-dependent (pituitary adenoma, ectopic ACTH) and ACTH-independent (adrenal adenoma/carcinoma)**
- C. Hyperthyroid-like symptoms with heat intolerance; etiologies include autoimmune thyroiditis
- D. Hyperparathyroidism with hypercalcemia and kidney stones

Cushing syndrome is defined by excess cortisol, which drives fat redistribution and metabolic changes. The hallmark features include weight gain with a rounded face (moon facies), central (truncal) obesity, and a dorsocervical fat pad known as a buffalo hump, often accompanied by high blood pressure. These patterns come from cortisol's effects on fat distribution, fluid retention, and vascular tone, and they are the classic presentation clinicians look for when suspecting cortisol excess. The causes fall into two broad groups: ACTH-dependent and ACTH-independent. ACTH-dependent means the adrenal cortex is being stimulated to produce cortisol by adrenocorticotropic hormone from another source, most commonly a pituitary adenoma (Cushing disease) or ectopic ACTH production from a nonpituitary tumor. ACTH-independent means cortisol is overproduced directly by the adrenal gland itself, as with an adrenal adenoma or carcinoma, with ACTH suppressed by negative feedback in that scenario. Other options describe different endocrine disorders with distinct features: Addison disease shows weight loss and hypotension from adrenal insufficiency; hyperthyroidism presents with heat intolerance and other thyrotoxic signs; primary hyperparathyroidism features hypercalcemia with kidney stones. These do not align with the cortisol-excess picture described here.

4. What is the appropriate treatment for a hospitalized unconscious patient with hypoglycemia?

- A. an intramuscular injection of glucagon**
- B. 6 ounces of orange juice
- C. a piece of candy
- D. putting sugar under the tongue to dissolve

When a patient is unconscious from hypoglycemia, the priority is to raise blood glucose quickly without risking aspiration or inability to swallow. Glucagon given by intramuscular injection fits this need because it stimulates the liver to release stored glucose (glycogenolysis), producing a rapid increase in blood glucose even if the patient cannot take anything orally. This parenteral rescue therapy is especially useful when intravenous access is not yet available. Oral options like orange juice, candy, or dissolving sugar under the tongue are not appropriate for an unconscious patient due to choking/aspiration risk and unreliable effectiveness. If IV access is already established, IV dextrose can provide an even faster correction, but the scenario in question highlights intramuscular glucagon as the appropriate immediate treatment. After glucose begins to rise and the patient regains consciousness, continue monitoring and provide a sustained carbohydrate source as needed.

5. During pregnancy, how should management of hypothyroidism be adjusted?

- A. Decrease dose by 50%
- B. Increase by about 25–30% upon pregnancy confirmation and monitor TSH and free T4**
- C. No change
- D. Switch to liothyronine only

During pregnancy, maternal thyroid hormone needs rise because estrogen increases thyroid-binding globulin, placental metabolism alters hormone turnover, and the fetus relies on maternal T4 especially early on. To keep both mother and baby in a euthyroid state, the thyroid hormone replacement dose typically must be increased by about a quarter to a third once pregnancy is confirmed, with close monitoring of thyroid function tests. Checking TSH and free T4 helps guide the adjustment and ensure targets are met, usually with repeat testing every few weeks early in pregnancy. Decreasing the dose would risk hypothyroidism, not changing the dose fails to meet increased needs, and using thyroid hormone as T3-only therapy is not appropriate in pregnancy because T4 is essential for fetal development and overall maternal stability.

6. In the management of HHS, what is the correct initial priority?

- A. Start with bicarbonate therapy
- B. Aggressive IV fluids, then insulin after stabilization**
- C. Insulin infusion before fluids
- D. Observational management

In Hyperosmolar Hyperglycemic State, the first priority is aggressive intravenous fluid resuscitation with isotonic saline to restore circulating volume and improve renal perfusion. Dehydration is severe, and correcting volume status helps reduce serum osmolality and allows the kidneys to clear glucose and electrolytes efficiently. Starting insulin after the patient is resuscitated helps avoid dangerous shifts in fluid and osmolality that could occur if insulin were given with ongoing hypovolemia. Potassium status must be monitored because insulin drives potassium into cells and total body potassium is often depleted; correct K⁺ before or with insulin to prevent dangerous hypokalemia. Bicarbonate therapy is not routinely used in HHS unless there is life-threatening acidosis (very low pH), and simply watching the patient without active fluid and electrolyte management is inadequate.

7. A laboratory result shows high TSH and low T4. Which explanation is correct?

- A. It means inconsistency in your thyroid tests and you will need more testing.
- B. I am sorry. You will have to ask your physician about your laboratory results. We are not allowed to discuss them.
- C. The TSH is sending a message to your thyroid gland to increase production, but your thyroid isn't producing enough hormone.**
- D. That means you will have to go on hormone therapy for the rest of your life.

When TSH is high and T4 is low, it shows a problem at the thyroid gland itself rather than in the pituitary. The pituitary increases TSH when thyroid hormone is low in an attempt to stimulate the thyroid to produce more T4. If T4 remains low despite high TSH, the thyroid isn't responding adequately—this is primary hypothyroidism. So the best explanation is that the TSH is signaling the thyroid to increase production, but the thyroid isn't producing enough hormone. The other interpretations aren't as accurate for describing this pattern of thyroid function.

8. When a patient newly diagnosed with type 2 diabetes mellitus asks the nurse why she has to take a pill instead of insulin, the nurse replies that in type 2 diabetes mellitus, the body makes insulin but:

- A. overweight and under active people cannot simply use the insulin produced.
- B. Metabolism is slowed in some people so they have to take a pill to speed up their metabolism.
- C. Sometimes the autoimmune system works against the action of the insulin.
- D. The cells become resistant to the action of insulin. Pills are given to increase the sensitivity.**

In type 2 diabetes the problem is insulin resistance: the body's cells—especially muscle, fat, and liver cells—don't respond well to insulin, so glucose isn't taken up efficiently even though insulin is present. Because of this, treatment often uses oral medications that improve how sensitive the tissues are to insulin and that reduce glucose production by the liver. That's why the statement that pills are given to increase insulin sensitivity is the best fit: it reflects the core issue in many patients with type 2 diabetes and why oral agents can be effective early in the disease. Autoimmune destruction of beta cells describes type 1 diabetes, not type 2; and the option about metabolism speed or "overweight and underactive" users not fitting the primary mechanism of resistance.

9. A patient tells the nurse that she eats "huge" amounts of food but stays hungry most of the time. The nurse explains that hunger experienced by persons with type 1 diabetes is caused by the:

- A. Excess amount of glucose
- B. Need for additional calories to correct the increased metabolism
- C. Fact that the cells cannot use the blood glucose**
- D. Need for exercise to stimulate insulin secretion.

In type 1 diabetes, there is little to no insulin, so glucose cannot enter most body cells. Even though blood glucose is high, the cells are effectively starving for energy, which triggers increased hunger as the body tries to obtain more fuel. This cellular glucose deficit is why someone can eat large amounts yet still feel hungry. The hunger is not caused by an excess of glucose in the blood, nor by a need to burn calories from higher metabolism or by exercising to stimulate insulin secretion (in type 1, insulin production is severely limited or absent).

10. What is the recommended approach to pheochromocytoma management surrounding surgery?

- A. Preoperative beta-blockade only
- B. Preoperative alpha-adrenergic blockade (and sometimes beta-blockade after adequate alpha blockade), careful intraoperative hemodynamic monitoring, and avoidance of hypertensive triggers**
- C. Steroid therapy preop
- D. No special management

Pheochromocytoma surgery requires blunting the surge of catecholamines that happens when the tumor is manipulated. The main issue is preventing sudden increases in blood pressure, heart rate, and potential arrhythmias during the operation. The best approach is to start alpha-adrenergic blockade before any resection to block the vasoconstrictive effects of catecholamines, which lowers vascular resistance and stabilizes blood pressure. After adequate alpha blockade is achieved, a beta-blocker can be added if there is persistent tachycardia or arrhythmia, but only after alpha blockade to avoid unopposed alpha stimulation that could trigger a dangerous hypertensive crisis. Intraoperative hemodynamic monitoring is essential so the team can promptly manage blood pressure swings, and efforts should be made to avoid triggers that provoke catecholamine release during anesthesia. Volume status also matters, since alpha blockade can cause vasodilation and relative hypovolemia, so careful fluid management is important. This combination—alpha blockade first, cautious use of beta-blockade after adequate alpha blockade, vigilant monitoring, and avoidance of hypertensive triggers—best protects the patient during pheochromocytoma surgery.

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://medsurgendocrine.examzify.com>

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

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