

MEDICAL-SURGICAL ENDOCRINE PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://medsurgendocrine.examzify.com>



Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	15

SAMPLE

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

SAMPLE

- 1. What HbA1c targets are recommended for most nonpregnant adults with diabetes and what are exceptions?**
 - A. Generally <7%; less stringent (<7.5–8%) for elderly or those with multiple comorbidities; more stringent (<6.5%) for younger patients without significant hypoglycemia risk
 - B. Generally <6.5% for all patients
 - C. Always <7.0% with no exceptions
 - D. HbA1c targets are not individualized
- 2. What is the difference between central and nephrogenic diabetes insipidus in etiology and management?**
 - A. Central DI due to decreased ADH production; treated with desmopressin; Nephrogenic DI due to renal insensitivity; treated with hydration, thiazide diuretics, and NSAIDs; avoid desmopressin
 - B. Central DI due to increased ADH; Nephrogenic DI due to decreased ADH
 - C. Central DI due to renal insensitivity; Nephrogenic DI due to increased ADH; treated with hydration
 - D. Central DI and Nephrogenic DI are the same
- 3. What is the typical clinical course and management considerations for DKA versus HHS in older adults?**
 - A. HHS is more common in older adults with type 2 diabetes and has higher mortality; management focuses on careful fluid and electrolyte correction.
 - B. DKA is more common in older adults with type 2 diabetes.
 - C. DKA and HHS have identical presentations and outcomes.
 - D. Insulin therapy is contraindicated in older adults with HHS.
- 4. Which of the following best defines the components of metabolic syndrome?**
 - A. Hyponatremia and obesity
 - B. Hyperglycemia only
 - C. Central obesity, hypertension, dyslipidemia (high triglycerides, low HDL), and insulin resistance.
 - D. Hypothyroidism and low blood pressure

- 5. In HHNS, which electrolyte abnormality is most likely?**
- A. Hyperkalemia
 - B. Hyponatremia
 - C. Hypokalemia
 - D. Hyponatremia
- 6. 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
- 7. After thyroidectomy, numbness around the mouth and fingers with muscle cramps most likely indicates which electrolyte disturbance?**
- A. Hyperkalemia
 - B. Hyponatremia
 - C. Hypercalcemia
 - D. Hypocalcemia
- 8. What is a primary goal in the treatment of diabetes mellitus?**
- A. Gaining weight
 - B. Decreasing insulin use
 - C. Stabilizing glucose levels
 - D. Treating complications
- 9. Bromocriptine acts to _____.**
- A. Inhibit the release of prolactin from the anterior pituitary gland.
 - B. Inhibit the production of clotting factor VIII from the posterior pituitary gland.
 - C. Suppress the release of growth hormone from the anterior pituitary gland.
 - D. Suppress the release of antidiuretic hormone from the anterior pituitary gland.
- 10. Which adverse effect is commonly associated with metformin?**
- A. GI upset
 - B. Hypoglycemia
 - C. Hyperkalemia
 - D. Weight gain

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What HbA1c targets are recommended for most nonpregnant adults with diabetes and what are exceptions?

- A. Generally <7%; less stringent (<7.5–8%) for elderly or those with multiple comorbidities; more stringent (<6.5%) for younger patients without significant hypoglycemia risk**
- B. Generally <6.5% for all patients
- C. Always <7.0% with no exceptions
- D. HbA1c targets are not individualized

The main idea being tested is that HbA1c targets for adults with diabetes are individualized based on balancing glycemic benefit with potential risks. For most nonpregnant adults, aiming for an HbA1c below 7% reduces microvascular complications without excessive harm from hypoglycemia or treatment load. There are important exceptions: for younger, healthier patients who can avoid hypoglycemia and adhere to intensive therapy, a tighter target such as less than 6.5% can be appropriate. For older individuals or those with multiple comorbidities, limited life expectancy, or a high risk of hypoglycemia, a less stringent goal, around 7.5% to 8%, is often more suitable. Pregnancy-related targets are different and not part of this nonpregnant scenario, and targets should be tailored to the individual rather than applied uniformly.

2. What is the difference between central and nephrogenic diabetes insipidus in etiology and management?

- A. Central DI due to decreased ADH production; treated with desmopressin; Nephrogenic DI due to renal insensitivity; treated with hydration, thiazide diuretics, and NSAIDs; avoid desmopressin**
- B. Central DI due to increased ADH; Nephrogenic DI due to decreased ADH
- C. Central DI due to renal insensitivity; Nephrogenic DI due to increased ADH; treated with hydration
- D. Central DI and Nephrogenic DI are the same

Central versus nephrogenic diabetes insipidus reflect where the problem lies and how it's best treated. In central diabetes insipidus, there is a deficiency of ADH production or release from the hypothalamus/pituitary. The kidneys are capable of responding to ADH, so replacing it with desmopressin (DDAVP) normalizes water reabsorption and reduces urine volume, with careful monitoring of hydration and electrolyte status. In nephrogenic diabetes insipidus, ADH is adequate or even elevated, but the kidneys don't respond to it due to receptor or collecting duct insensitivity (or drugs/toxic effects). Since the ADH signal can't be used, giving desmopressin won't effectively curb polyuria. Management aims to reduce free water loss and protect hydration: ensure sufficient fluids, use thiazide diuretics to induce mild volume depletion that paradoxically lowers urine output, and add NSAIDs to diminish prostaglandin-mediated diuresis. Desmopressin is avoided because it won't help the kidney's resistance to ADH. So the best answer aligns with a deficiency of ADH treated by replacement, versus renal insensitivity treated with hydration plus agents that reduce urine flow, rather than ADH replacement.

3. What is the typical clinical course and management considerations for DKA versus HHS in older adults?

- A. HHS is more common in older adults with type 2 diabetes and has higher mortality; management focuses on careful fluid and electrolyte correction.**
- B. DKA is more common in older adults with type 2 diabetes.
- C. DKA and HHS have identical presentations and outcomes.
- D. Insulin therapy is contraindicated in older adults with HHS.

In older adults with type 2 diabetes, hyperosmolar hyperglycemic state is the typical scenario and carries a higher mortality than DKA, largely because of profound dehydration and multiple comorbidities. The management emphasis is on meticulous fluid resuscitation and careful electrolyte correction to restore volume and reduce hyperosmolarity, with insulin therapy begun after adequate hydration to avoid rapid shifts in osmolality; close monitoring of potassium and renal function is essential, and bicarbonate is reserved for only severe acidosis. This contrasts with diabetic ketoacidosis, which is more common in younger patients with type 1 diabetes and presents with ketosis and acidosis, guiding a somewhat different balance of fluids, insulin, and electrolyte management. The idea that DKA is more common in older adults or that insulin is contraindicated in older adults with HHS does not fit the typical pattern.

4. Which of the following best defines the components of metabolic syndrome?

- A. Hyponatremia and obesity
- B. Hyperglycemia only
- C. Central obesity, hypertension, dyslipidemia (high triglycerides, low HDL), and insulin resistance.**
- D. Hypothyroidism and low blood pressure

Metabolic syndrome is a cluster of interrelated risk factors that together raise the risk for heart disease and type 2 diabetes. A central feature is abdominal (central) obesity, and when combined with high blood pressure, dyslipidemia (high triglycerides and low HDL cholesterol), and insulin resistance, it defines the syndrome. This mix of factors reflects a shared metabolic disturbance that amplifies cardiovascular risk far more than any single abnormality alone. In practice, diagnosis is based on meeting several criteria, linking the obesity-related, lipid, blood pressure, and glucose abnormalities. Hyponatremia isn't part of this pattern, having obesity or hyperglycemia alone isn't sufficient to define the syndrome, and hypothyroidism with low blood pressure doesn't capture the characteristic cluster of central obesity, hypertension, and dyslipidemia with insulin resistance.

5. In HHNS, which electrolyte abnormality is most likely?

- A. Hyperkalemia
- B. Hypernatremia**
- C. Hypokalemia
- D. Hyponatremia

In HHNS, massive fluid loss from osmotic diuresis leaves the patient severely dehydrated, and that dehydration concentrates the serum sodium. Severe hyperglycemia drives an intense osmotic diuretic effect, so water is wasted in the urine and the circulating sodium rises, making hypernatremia the most likely electrolyte disturbance. Keep in mind that potassium balance can be tricky: initially serum potassium may be high or normal due to insulin deficiency and acidosis, but total body potassium is depleted and can drop with treatment. Hyponatremia is less characteristic of HHNS because the dominant process is water loss with rising sodium concentration rather than water excess.

6. 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.

7. After thyroidectomy, numbness around the mouth and fingers with muscle cramps most likely indicates which electrolyte disturbance?

- A. Hyperkalemia
- B. Hyponatremia
- C. Hypercalcemia
- D. Hypocalcemia**

Low calcium levels (hypocalcemia) explain numbness around the mouth and in the fingers with muscle cramps after thyroidectomy. The parathyroid glands, which regulate calcium via parathyroid hormone, are at risk during thyroid surgery. If they're damaged or removed, PTH drops and calcium falls. Calcium helps stabilize nerve and muscle cell membranes; when calcium is low, nerves become more excitable, producing tingling around the mouth and in the extremities and causing cramps or tetany. You may also see signs like Chvostek or Trousseau, which reflect this increased neuromuscular excitability. This isn't driven by potassium, sodium, or calcium elevation. Hyperkalemia typically causes muscle weakness and cardiac rhythm problems; hyponatremia leads to confusion and seizures; hypercalcemia causes weakness and constipation. The symptom pattern described—perioral numbness with muscle cramps—fits hypocalcemia best.

8. What is a primary goal in the treatment of diabetes mellitus?

- A. Gaining weight
- B. Decreasing insulin use
- C. Stabilizing glucose levels**
- D. Treating complications

Stabilizing glucose levels is the central aim of diabetes treatment because keeping blood sugar in or near the target range prevents both the immediate symptoms of high or low blood glucose and the long-term damage that can affect eyes, kidneys, nerves, heart, and vessels. Treatments—whether lifestyle changes, oral medications, or insulin—are all aimed at maintaining steady glucose rather than allowing wide fluctuations. While individual targets vary, the goal is near-normal glycemia, which lowers the risk of complications over time. Weight gain or simply reducing insulin use aren't universal objectives. Weight changes can occur with therapy and aren't the primary goal; many patients still need ongoing insulin to achieve good control. Treating complications remains essential, but preventing them comes from achieving stable glucose, not from addressing complications alone.

9. Bromocriptine acts to _____.

- A. Inhibit the release of prolactin from the anterior pituitary gland.
- B. Inhibit the production of clotting factor VIII from the posterior pituitary gland.
- C. Suppress the release of growth hormone from the anterior pituitary gland.
- D. Suppress the release of antidiuretic hormone from the anterior pituitary gland.

Bromocriptine acts by mimicking dopamine and stimulating D2 receptors on lactotrophs in the anterior pituitary, which inhibits prolactin secretion. This is why it's used to treat hyperprolactinemia and prolactin-secreting pituitary tumors—the dopamine signal keeps prolactin levels in check. The other options mix up sources and hormones: clotting factor VIII isn't produced by the pituitary, and the posterior pituitary releases ADH and oxytocin, not clotting factors; growth hormone release is regulated mainly by GHRH and somatostatin, and while dopamine can influence pituitary hormones in some contexts, the primary action of bromocriptine is prolactin suppression.

10. Which adverse effect is commonly associated with metformin?

- A. GI upset
- B. Hypoglycemia
- C. Hyperkalemia
- D. Weight gain

Gastrointestinal upset is the most common adverse effect seen with metformin. Nausea, abdominal discomfort, bloating, and diarrhea frequently appear, especially when starting therapy or when doses are high. These effects are usually dose-related and tend to improve over time or with slower titration. Taking metformin with meals and using an extended-release formulation can help minimize these symptoms. Hypoglycemia is not typical with metformin alone because it does not increase insulin secretion; however, the risk rises when metformin is used in combination with other glucose-lowering agents. Hyperkalemia is not a characteristic adverse effect of metformin. Weight gain is not expected; metformin more commonly causes weight stability or even modest weight loss in some patients.

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!

SAMPLE