

NBME Surgery Shelf 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

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- 1. For DVT prophylaxis in postoperative patients, what is a commonly used approach?**
 - A. Mechanical devices only**
 - B. Warfarin for 6 weeks**
 - C. Aspirin alone**
 - D. Pharmacologic prophylaxis with low-molecular-weight heparin (LMWH)**

- 2. For patients with colorectal cancer presenting with obstruction, what is an immediate intervention to relieve the obstruction?**
 - A. Emergency resection**
 - B. Water-soluble contrast enema or stenting as bridge to definitive surgery**
 - C. Immediate colostomy**
 - D. Observation and NG decompression**

- 3. The FAST exam in trauma is primarily used to detect which finding?**
 - A. Intra-abdominal gas**
 - B. Free intraperitoneal fluid suggesting intra-abdominal injury**
 - C. Pericardial effusion**
 - D. Retroperitoneal hematoma**

- 4. Which management approach is appropriate for symptomatic primary hyperparathyroidism?**
 - A. Observation only**
 - B. Chemotherapy**
 - C. Radiation therapy**
 - D. Parathyroidectomy**

- 5. A previously healthy adolescent with intermittent right anterior thigh pain and limp; 25th percentile height and weight; limited abduction and internal rotation of the hip. What is the most likely diagnosis?**
- A. Avascular necrosis of the femoral head (Legg-Calvé-Perthes disease)**
 - B. Slipped Capital Femoral Epiphysis**
 - C. Septic arthritis**
 - D. Osteomyelitis**
- 6. When is nutritional support indicated in the surgical patient?**
- A. After 24 hours**
 - B. Only for malnourished preop**
 - C. In patients unable to meet nutritional needs orally for more than 7-10 days or when malnutrition is present**
 - D. Immediately post-op**
- 7. In trauma resuscitation, what is the role of prehospital blood products?**
- A. They replace crystalloids entirely**
 - B. They reduce infection risk**
 - C. They are never used**
 - D. They improve initial hemodynamics and oxygen delivery when crystalloids would cause dilutional coagulopathy**
- 8. For resectable pancreatic cancer, what is a key determinant of survival?**
- A. Adjuvant chemotherapy**
 - B. Radiation therapy**
 - C. Complete surgical resection with negative margins and absence of distant metastasis**
 - D. Tumor size**
- 9. Which nerve is at risk with a shoulder dislocation?**
- A. Axillary**
 - B. Median**
 - C. Ulnar**
 - D. Radial**

- 10. Which condition is a relative contraindication to laparoscopic repair, depending on surgeon experience?**
- A. Unstable cardiopulmonary physiology**
 - B. Extensive intra-abdominal adhesions from prior surgeries**
 - C. No prior surgeries**
 - D. Obesity with good cardiopulmonary status**

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Answers

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

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Explanations

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1. For DVT prophylaxis in postoperative patients, what is a commonly used approach?

A. Mechanical devices only

B. Warfarin for 6 weeks

C. Aspirin alone

D. Pharmacologic prophylaxis with low-molecular-weight heparin (LMWH)

Preventing post-op venous thromboembolism relies on pharmacologic prevention because it addresses the clotting tendency directly. Low-molecular-weight heparin is commonly used because its effect is predictable after a subcutaneous injection, it doesn't require routine lab monitoring, and it has a favorable safety profile with a lower risk of heparin-induced thrombocytopenia compared with unfractionated heparin. It provides rapid protection after surgery and is more effective for DVT prevention than aspirin alone. Warfarin is less ideal in the immediate postoperative period due to slow onset, need for INR monitoring, and dietary/drug interactions. Mechanical devices like compression stockings or pneumatic devices help reduce risk but are not as effective when used alone in many surgical patients. Therefore, pharmacologic prophylaxis with LMWH is the commonly used approach.

2. For patients with colorectal cancer presenting with obstruction, what is an immediate intervention to relieve the obstruction?

A. Emergency resection

B. Water-soluble contrast enema or stenting as bridge to definitive surgery

C. Immediate colostomy

D. Observation and NG decompression

When colorectal cancer causes a bowel obstruction, the priority is to relieve the blockage and convert an emergency situation into a planned, elective operation for cancer cure. Using a bridge to definitive surgery achieves this by decompressing the obstructed colon with a less invasive method, then proceeding to definitive resection under more favorable conditions. A water-soluble contrast enema can provide hydrostatic relief and help localize the obstruction, and placing a colonic stent can quickly decompress the blocked segment, turning an emergency colectomy into an elective procedure with better outcomes. Relying on observation with NG decompression leaves the obstruction unresolved and risks deterioration, while emergency resection or immediate diversion without prior decompression carries higher morbidity in the obstructed setting. Thus, decompression with a bridge to surgery—via contrast enema or stenting—is the best immediate strategy.

3. The FAST exam in trauma is primarily used to detect which finding?

A. Intra-abdominal gas

B. Free intraperitoneal fluid suggesting intra-abdominal injury

C. Pericardial effusion

D. Retroperitoneal hematoma

In trauma care, the FAST exam is a bedside ultrasound aimed at rapidly identifying free fluid in the abdominal and pericardial spaces. Its main purpose is to detect free intraperitoneal fluid that suggests intra-abdominal injury or active hemorrhage, which helps decide if urgent surgical intervention or rapid resuscitation is needed. The exam views potential spaces where fluid collects, such as the hepatorenal recess (Morison's pouch), the splenorenal recess, the pelvis, and a cardiac window for possible tamponade. Gas patterns or bowel findings aren't the primary target, and while pericardial fluid can be seen, the crucial takeaway is free intraperitoneal fluid. FAST is less reliable for retroperitoneal injuries, which may require CT for evaluation.

4. Which management approach is appropriate for symptomatic primary hyperparathyroidism?

A. Observation only

B. Chemotherapy

C. Radiation therapy

D. Parathyroidectomy

When symptoms accompany primary hyperparathyroidism, the definitive treatment is removing the overactive parathyroid tissue (parathyroidectomy). The excess PTH drives hypercalcemia, which leads to bone loss, kidney stones, fatigue, and neuropsychiatric symptoms; removing the source corrects the calcium imbalance and often reverses or improves these manifestations. Non-surgical options like observation do not relieve symptoms, and therapies such as chemotherapy or radiation are not appropriate because they do not address the excess PTH production from the parathyroid glands. Parathyroidectomy is curative in most patients and directly treats the underlying problem.

5. A previously healthy adolescent with intermittent right anterior thigh pain and limp; 25th percentile height and weight; limited abduction and internal rotation of the hip. What is the most likely diagnosis?

- A. Avascular necrosis of the femoral head (Legg-Calvé-Perthes disease)**
- B. Slipped Capital Femoral Epiphysis**
- C. Septic arthritis**
- D. Osteomyelitis**

In an adolescent with hip or referred thigh pain and a limp, a key clue is loss of hip motion, especially internal rotation, with an otherwise nonacute course. This pattern points to a problem at the proximal femur or femoral head rather than an acute joint infection. Slipped capital femoral epiphysis is the classic diagnosis in this age group: a physis that has slipped allows the femoral head to sit out of place, leading to limited internal rotation and abduction, and the pain is often felt in the anterior thigh or groin with a limp. The presentation is typically subacute rather than rapidly progressive, and systemic symptoms are usually absent. Avascular necrosis (Legg-Calvé-Perthes) tends to occur in younger children (roughly ages 4-8) and presents with a more insidious limp with often more longstanding changes in gait and radiographs showing femoral head changes over time. Septic arthritis would present with an acute onset of severe hip pain, fever, and systemic toxicity, often with a marked inability to bear weight and joint swelling. Osteomyelitis would involve bone infection with fever and focal bone pain, again usually more acute and with systemic signs. Thus the most likely diagnosis in this adolescent with intermittent anterior thigh pain, limp, and limited hip motion is slipped capital femoral epiphysis.

6. When is nutritional support indicated in the surgical patient?

- A. After 24 hours**
- B. Only for malnourished preop**
- C. In patients unable to meet nutritional needs orally for more than 7-10 days or when malnutrition is present**
- D. Immediately post-op**

In surgical patients, providing nutritional support is guided by the ability to meet energy and protein needs, not by a fixed post-op time. The essential idea is to initiate support when oral intake cannot meet nutritional requirements for a meaningful period or when the patient is malnourished, because adequate nutrition supports wound healing and immune function. The most appropriate criterion is starting enteral or parenteral nutrition when oral intake is unable to meet needs for about 7-10 days, or when malnutrition is present, as this captures both the duration of needed support and the malnourished state. If the digestive tract is functioning, enteral nutrition is preferred; if not, parenteral nutrition is used. Choices like feeding immediately after surgery or only after 24 hours don't apply to all patients, and limiting nutrition to preoperative malnutrition alone misses those who become unable to meet needs postoperatively.

7. In trauma resuscitation, what is the role of prehospital blood products?

- A. They replace crystalloids entirely**
- B. They reduce infection risk**
- C. They are never used**
- D. They improve initial hemodynamics and oxygen delivery when crystalloids would cause dilutional coagulopathy**

In trauma resuscitation, the goal is to restore circulating volume and oxygen delivery without worsening coagulopathy. Giving large amounts of crystalloids can dilute coagulation factors and platelets, leading to dilutional coagulopathy and continued bleeding. Prehospital blood products—red blood cells for oxygen-carrying capacity and plasma (with platelets as available) for coagulation factors—provide volume and hemostatic components without causing this dilution. Early transfusion helps stabilize blood pressure and improve tissue oxygen delivery before definitive care, making their use in the prehospital setting beneficial when crystalloids would otherwise cause dilutional coagulopathy. They do not replace crystalloids entirely, and infection risk isn't the primary benefit.

8. For resectable pancreatic cancer, what is a key determinant of survival?

- A. Adjuvant chemotherapy**
- B. Radiation therapy**
- C. Complete surgical resection with negative margins and absence of distant metastasis**
- D. Tumor size**

In resectable pancreatic cancer, survival is driven most by whether the tumor can be removed completely and whether the disease has spread beyond the pancreas. A complete surgical resection with negative margins means there are no cancer cells at the edges of the removed tissue (an R0 resection), which provides the best chance to control the disease locally. Equally crucial is the absence of distant metastasis; if cancer has already spread, removing the primary tumor won't yield long-term cure, and survival is limited despite a clean local operation. Adjuvant chemotherapy can improve outcomes after a complete resection, and radiation therapy may help in certain situations, but these factors cannot overcome the prognosis established by positive margins or systemic spread. Tumor size by itself is not as reliable a predictor of survival as the combination of achieving negative margins and absence of metastasis.

9. Which nerve is at risk with a shoulder dislocation?

- A. Axillary**
- B. Median**
- C. Ulnar**
- D. Radial**

Nerve most at risk with a shoulder dislocation is the axillary nerve. Its course is right around the surgical neck of the humerus, passing through the quadrangular space with the posterior circumflex humeral artery. In an anterior shoulder dislocation, the head of the humerus can stretch or compress this nerve as it exits the glenohumeral joint. Injury to the axillary nerve leads to weakness of the deltoid and teres minor, so abduction of the arm beyond about the first 15 degrees is lost, and there is often sensory loss over the skin over the lateral shoulder. The other nerves mentioned (median, ulnar, radial) are not routinely at risk from a shoulder dislocation because their courses are more distal or separate from the joint itself.

10. Which condition is a relative contraindication to laparoscopic repair, depending on surgeon experience?

- A. Unstable cardiopulmonary physiology**
- B. Extensive intra-abdominal adhesions from prior surgeries**
- C. No prior surgeries**
- D. Obesity with good cardiopulmonary status**

Laparoscopic repair becomes more difficult when patient factors raise the risk of injury or make visualization and instrument handling harder, and how aggressively a surgeon proceeds can depend on their experience. Unstable cardiopulmonary physiology is an absolute concern because the pneumoperitoneum and positioning can worsen gas exchange and hemodynamics, making laparoscopy dangerous in those patients. Extensive intra-abdominal adhesions from prior surgeries increase the risk of bowel injury during entry and dissection and raise the likelihood of needing to convert to an open procedure; this is a classic relative contraindication that experienced surgeons may still manage with careful technique, but it's much more challenging. No prior surgeries means there are no adhesions to contend with, and entry and dissection are typically easier, not harder. In general, this scenario does not constitute a contraindication; if anything, it favors laparoscopy, unless other factors weren't captured in the question. Obesity with good cardiopulmonary status can complicate the procedure because of limited working space and visualization, but it's considered a relative factor that a skilled laparoscopic surgeon may overcome with technique and planning.

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://nbmesurgeryshelf.examzify.com>

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

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