

PANCE ENDOCRINOLOGY PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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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 best describes the role of TSH suppression in differentiated thyroid cancer management?**
 - A. Do nothing; monitor clinically
 - B. Use radioactive iodine therapy exclusively to suppress TSH
 - C. Levothyroxine to suppress TSH to below the reference range
 - D. Levothyroxine to suppress TSH above the reference range
- 2. What ultrasound finding most commonly prompts fine-needle aspiration biopsy in thyroid nodules?**
 - A. Suspicious features such as irregular margins or microcalcifications
 - B. Simple cyst with anechoic fluid
 - C. Homogeneous iso-echoic solid nodule with smooth margins
 - D. Comet-tail artifact
- 3. Which is an absolute contraindication to testosterone therapy?**
 - A. Controlled hypertension
 - B. Prostate cancer
 - C. Mild hyperlipidemia
 - D. Age over 70
- 4. After an elevated IGF-1 level suggests acromegaly, what is the next step to confirm?**
 - A. MRI pituitary with contrast first
 - B. Bone density scan
 - C. Serum prolactin elevation
 - D. Lack of suppression of GH on an oral glucose tolerance test
- 5. In established type 1 diabetes, C-peptide levels are typically?**
 - A. High
 - B. Low
 - C. Normal
 - D. Absent

- 6. Which statement about GLP-1 receptor agonists is true?**
- A. Most are injectable
 - B. They are primarily oral
 - C. They do not affect gastric emptying
 - D. They always cause hypoglycemia
- 7. Osteopenia is defined by a T-score in which range?**
- A. -1.0 to -2.5
 - B. -2.5 or lower
 - C. -0.5 to -1.5
 - D. 0 to -0.5
- 8. In secondary (central) hypogonadism, what is the pattern of testosterone and LH/FSH?**
- A. Low testosterone with high LH/FSH
 - B. Low testosterone with low or normal LH/FSH
 - C. High testosterone with normal LH/FSH
 - D. Low testosterone with low LH/FSH
- 9. Which is a common adverse effect associated with sulfonylureas?**
- A. Hypoglycemia
 - B. Weight loss
 - C. Hypertension
 - D. Renal failure
- 10. Best drug choice for patient with ASCVD or high risk, kidney disease, or HF?**
- A. SGLT2 inhibitors or GLP-1 receptor agonists
 - B. DPP-4 inhibitors
 - C. Metformin
 - D. Alpha-glucosidase inhibitors

Answers

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

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Explanations

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1. Which statement best describes the role of TSH suppression in differentiated thyroid cancer management?

- A. Do nothing; monitor clinically
- B. Use radioactive iodine therapy exclusively to suppress TSH
- C. Levothyroxine to suppress TSH to below the reference range**
- D. Levothyroxine to suppress TSH above the reference range

TSH acts as a growth signal for thyroid cells, including residual cancer cells in differentiated thyroid cancer. Keeping TSH suppressed minimizes this stimulus, reducing the risk of cancer recurrence or progression. Levothyroxine is used to keep TSH below the normal reference range, which is the best way to achieve this suppression. In higher-risk patients, targets may be even more stringent (often below 0.1 mIU/L), but the core idea is suppression of TSH to limit cancer cell growth. The other approaches either ignore the growth-stimulating role of TSH, rely on radioactive iodine for purposes other than suppression, or keep TSH at or above normal levels, which would promote stimulation of any remaining cancer cells.

2. What ultrasound finding most commonly prompts fine-needle aspiration biopsy in thyroid nodules?

- A. Suspicious features such as irregular margins or microcalcifications**
- B. Simple cyst with anechoic fluid
- C. Homogeneous iso-echoic solid nodule with smooth margins
- D. Comet-tail artifact

Ultrasound risk features guide whether a thyroid nodule should be biopsied. The finding that most often leads to fine-needle aspiration is the presence of suspicious characteristics, specifically irregular margins and microcalcifications, which meaningfully increase the likelihood of malignancy—most classically papillary thyroid carcinoma. These features push clinicians to obtain cytology to confirm or exclude cancer, even if the nodule isn't very large. By contrast, a simple cyst with anechoic fluid is usually benign and monitored or aspirated for relief rather than biopsied for cancer; a homogeneous iso-echoic solid nodule with smooth margins tends to be low risk and may be managed with observation or biopsy only if larger or accompanied by other risk features; a comet-tail artifact is typically seen in benign colloid nodules and does not prompt biopsy.

3. Which is an absolute contraindication to testosterone therapy?

- A. Controlled hypertension
- B. Prostate cancer
- C. Mild hyperlipidemia**
- D. Age over 70

Testosterone therapy is avoided when there are cancers that could be driven by androgens. The clearest absolute contraindication is known or suspected prostate cancer, because testosterone can stimulate prostate tissue and potentially accelerate tumor growth. That makes prostate cancer the primary contraindication to start or continue therapy. Controlled hypertension, mild hyperlipidemia, and age over 70 are not by themselves absolute blockers to testosterone treatment. Hypertension can be managed and monitored; mild lipid abnormalities can be addressed with lifestyle changes or therapy; and age alone doesn't disqualify treatment, though all risks and benefits should be weighed in older patients.

4. After an elevated IGF-1 level suggests acromegaly, what is the next step to confirm?

- A. MRI pituitary with contrast first
- B. Bone density scan
- C. Serum prolactin elevation

D. Lack of suppression of GH on an oral glucose tolerance test

Elevated IGF-1 indicates GH excess but doesn't prove active acromegaly on its own. The next step is a dynamic test that shows whether GH secretion is truly autonomous: an oral glucose tolerance test with measurement of GH. In normal individuals, glucose intake suppresses GH to very low levels. In acromegaly, GH fails to suppress (typically remaining elevated, not dropping below about 1 ng/mL). This lack of suppression confirms biochemical acromegaly. After this confirmation, pituitary MRI with contrast is used to locate the adenoma. The other options don't provide the confirmatory evidence needed: bone density assesses complications, prolactin elevation isn't diagnostic of GH excess, and MRI is done after confirming the diagnosis.

5. In established type 1 diabetes, C-peptide levels are typically?

- A. High
- B. Low**
- C. Normal
- D. Absent

C-peptide is released in equal amounts with endogenous insulin from functioning pancreatic beta cells, so it serves as a marker of the body's own insulin production. In established type 1 diabetes, autoimmune destruction severely reduces or eliminates beta-cell function, leading to very little or no endogenous insulin being produced. As a result, C-peptide levels fall to low (often undetectable) levels. Exogenous insulin therapy does not raise C-peptide because that insulin comes from outside the body. Some residual beta-cell activity can exist early on, but over time C-peptide typically becomes low, which is why low C-peptide is the typical finding in established type 1 diabetes.

6. Which statement about GLP-1 receptor agonists is true?

- A. Most are injectable**
- B. They are primarily oral
- C. They do not affect gastric emptying
- D. They always cause hypoglycemia

GLP-1 receptor agonists mimic the incretin GLP-1, boosting glucose-dependent insulin secretion, suppressing glucagon, slowing gastric emptying, and reducing appetite. Because they are peptide-based drugs, most are given by injection rather than taken orally; although there is an oral form of at least one agent, the majority remain injectable, making that statement the true one. They do slow gastric emptying, so the claim that they do not affect gastric emptying is false. They have a low risk of hypoglycemia when used alone because their insulin release is glucose-dependent; hypoglycemia risk rises mainly when combined with other agents like insulin or sulfonylureas, so the statement that they always cause hypoglycemia is not correct.

7. Osteopenia is defined by a T-score in which range?

- A. -1.0 to -2.5**
- B. -2.5 or lower
- C. -0.5 to -1.5
- D. 0 to -0.5

Bone density is categorized by the T-score from DXA scans. A normal T-score is -1.0 or higher. Osteopenia sits below normal but above osteoporosis, typically spanning from -1.0 down to -2.5. Osteoporosis is defined as -2.5 or lower. So the range that defines osteopenia is -1.0 to -2.5. The other ranges correspond to normal bone density or to osteoporosis, not osteopenia, and thus don't fit the definition.

8. In secondary (central) hypogonadism, what is the pattern of testosterone and LH/FSH?

- A. Low testosterone with high LH/FSH
- B. Low testosterone with low or normal LH/FSH**
- C. High testosterone with normal LH/FSH
- D. Low testosterone with low LH/FSH

Central (secondary) hypogonadism occurs when the hypothalamus or pituitary fails to provide enough GnRH and gonadotropins. With reduced LH and FSH signaling, the testes produce less testosterone, so testosterone is low. Because the pituitary isn't driving high LH/FSH in response to the low testosterone, those gonadotropins are low or inappropriately normal for the level of testosterone. This contrasts with primary hypogonadism, where testicular failure leads to low testosterone but compensatory high LH and FSH due to loss of negative feedback.

9. Which is a common adverse effect associated with sulfonylureas?

- A. Hypoglycemia**
- B. Weight loss
- C. Hypertension
- D. Renal failure

Sulfonylureas stimulate insulin release from pancreatic beta cells, which lowers blood glucose. Because this increases circulating insulin, the most common adverse effect is hypoglycemia, especially if meals are missed, in older adults, with renal/hepatic impairment, or when combined with other glucose-lowering drugs. The symptoms can range from tremor and sweating to confusion, and management involves rapid-acting carbohydrates and adjusting therapy to reduce this risk. Other choices don't fit as typical adverse effects: hypertension and renal failure aren't direct drug-related outcomes, and weight loss isn't expected (these agents more often cause weight gain due to higher insulin levels).

10. Best drug choice for patient with ASCVD or high risk, kidney disease, or HF?

A. SGLT2 inhibitors or GLP-1 receptor agonists

B. DPP-4 inhibitors

C. Metformin

D. Alpha-glucosidase inhibitors

Focusing on therapies that reduce cardiovascular risk and protect kidney and heart function is key when faced with ASCVD risk, kidney disease, or heart failure. SGLT2 inhibitors and GLP-1 receptor agonists provide these benefits beyond lowering blood glucose. For SGLT2 inhibitors, trials show decreased hospitalization for heart failure, slowing of CKD progression, and reduction in major adverse cardiovascular events in patients with diabetes and cardiovascular disease, with benefits extending to patients with heart failure or CKD even without diabetes. GLP-1 receptor agonists also lower major adverse cardiovascular events in patients at high ASCVD risk and offer advantages like weight loss, which can help overall metabolic health. Other agents lack such robust cardiovascular or renal protection; DPP-4 inhibitors have neutral CV effects, metformin's use is limited by CKD considerations, and alpha-glucosidase inhibitors do not provide cardiovascular or kidney benefits. Therefore, the best drug choice in this scenario is either an SGLT2 inhibitor or a GLP-1 receptor agonist.

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://panceendocrinology.examzify.com>

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

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