

ROSH Gastrointestinal Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

This is a sample study guide. To access the full version with hundreds of questions,

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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. Don't worry about getting everything right, 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, and take breaks to retain information better.

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.

7. Use Other Tools

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!

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Questions

- 1. Which demographic is most commonly affected by pyloric stenosis?**
 - A. Infants**
 - B. Adolescents**
 - C. Adults**
 - D. Elderly**
- 2. Which physical exam finding is most suggestive of appendicitis?**
 - A. Kehr's sign**
 - B. Murphy's sign**
 - C. Rovsing's sign**
 - D. Scarf sign**
- 3. Which sign is considered positive when a patient experiences pain in the right lower quadrant upon palpation of the left lower quadrant?**
 - A. McBurney's sign**
 - B. Obturator sign**
 - C. Psoas sign**
 - D. Rovsing sign**
- 4. Which gastrointestinal condition is known for causing progressive abdominal pain during the night?**
 - A. Gastroesophageal reflux disease**
 - B. Irritable bowel syndrome**
 - C. Peptic ulcer disease**
 - D. Diverticulitis**
- 5. In patients with suspected spontaneous bacterial peritonitis, what white blood cell count in ascitic fluid warrants antibiotic treatment?**
 - A. Ascitic fluid pH of 7.35**
 - B. WBC of 275 cells/mm³ with 20% lymphocytes**
 - C. WBC of 370 cells/mm³ with 90% neutrophils**
 - D. WBC of 500 cells/mm³ with 40% neutrophils**

- 6. What type of dietary restriction is necessary for patients diagnosed with celiac disease?**
- A. Low-fat diet**
 - B. Gluten-free diet**
 - C. Low-sugar diet**
 - D. Vegetarian diet**
- 7. What is the most appropriate intravenous antibiotic for a patient with alcoholic cirrhosis presenting with fever and ascitic fluid indicating infection?**
- A. Ampicillin**
 - B. Cefotaxime**
 - C. Sulfamethoxazole/trimethoprim**
 - D. Vancomycin**
- 8. What imaging study is considered highly specific for diagnosing small bowel obstruction?**
- A. Abdominal X-ray**
 - B. CT scan of the abdomen**
 - C. Ultrasound**
 - D. Plain radiography**
- 9. What is the most common cause of pruritus ani in the pediatric patient population?**
- A. Candida**
 - B. Lichen planus**
 - C. Pinworms**
 - D. Seborrheic dermatitis**
- 10. Which diagnostic modality is typically used for evaluating suspected bowel obstruction?**
- A. MRI**
 - B. Ultrasound**
 - C. CT scan**
 - D. X-ray**

Answers

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

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Explanations

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1. Which demographic is most commonly affected by pyloric stenosis?

A. Infants

B. Adolescents

C. Adults

D. Elderly

Pyloric stenosis is a condition that primarily affects infants, particularly those who are less than six months old. In this condition, the pylorus, which is the opening from the stomach into the small intestine, becomes narrowed, leading to severe vomiting and dehydration. The reasons for its higher incidence in infants may be related to developmental factors in utero or early in life, as it is not commonly found in older children or adults. The condition is typically diagnosed within the first few weeks after birth, and the majority of cases occur in male infants compared to females. Understanding this demographic is crucial for timely diagnosis and management, as untreated pyloric stenosis can lead to serious complications in this vulnerable age group. In contrast, pyloric stenosis is rarely seen in adolescents, adults, or the elderly, as these populations are outside the typical age range for this diagnosis. Conditions affecting the gastrointestinal tract in these older age groups usually present very differently and may involve other types of gastrointestinal pathology.

2. Which physical exam finding is most suggestive of appendicitis?

A. Kehr's sign

B. Murphy's sign

C. Rovsing's sign

D. Scarf sign

Rovsing's sign is a physical exam finding that is considered most suggestive of appendicitis. It refers to the pain that is felt in the right lower quadrant when pressure is applied to the left lower quadrant of the abdomen. This phenomenon occurs because of the shared nerve pathways in the abdominal cavity. The irritation or inflammation associated with appendicitis can cause referred pain, so the eliciting of pain in the right lower quadrant upon palpation of the left is an important indicator for the diagnosis of appendicitis. In contrast, the other signs listed have different clinical implications. Kehr's sign, which is characterized by referred pain to the left shoulder due to irritation of the diaphragm (often associated with splenic issues), does not specifically indicate appendicitis. Murphy's sign, indicating gallbladder disease, involves pain upon deep palpation during inspiration, which is not relevant for appendicitis. The Scarf sign is primarily associated with hypermobility and is not relevant to acute abdominal issues like appendicitis. Thus, the presentation of Rovsing's sign aligns closely with the pathophysiology of appendicitis, making it the most suggestive physical exam finding in this context.

3. Which sign is considered positive when a patient experiences pain in the right lower quadrant upon palpation of the left lower quadrant?

A. McBurney's sign

B. Obturator sign

C. Psoas sign

D. Rovsing sign

The sign that indicates a positive response when a patient experiences pain in the right lower quadrant upon palpation of the left lower quadrant is known as Rovsing's sign. When a clinician palpates the left lower quadrant, it may cause referred pain in the right lower quadrant, suggesting irritation of the peritoneum. This phenomenon occurs typically in cases of appendicitis, where inflammation of the appendix can cause discomfort in the areas adjacent to it. Rovsing's sign is specifically associated with pain elicited in the opposite quadrant, which provides useful diagnostic insight regarding conditions such as appendicitis. Recognizing this sign can help clinicians make prompt decisions regarding further evaluation or surgical intervention.

4. Which gastrointestinal condition is known for causing progressive abdominal pain during the night?

A. Gastroesophageal reflux disease

B. Irritable bowel syndrome

C. Peptic ulcer disease

D. Diverticulitis

Peptic ulcer disease is characterized by the presence of ulcers in the stomach or the duodenum, and it is known for causing progressive abdominal pain, especially during the night. This is often due to the increased secretion of gastric acid while the individual is lying down, which can exacerbate pain associated with ulcers. Patients frequently report that their pain occurs in cycles and may be relieved by food or antacids, but it can also worsen when the stomach is empty, a scenario common during nighttime. In contrast, gastroesophageal reflux disease primarily presents with symptoms like heartburn and regurgitation, which can also worsen at night but are not specifically tied to progressive abdominal pain. Irritable bowel syndrome is often associated with fluctuations in bowel habits, abdominal discomfort, and bloating rather than consistent night-time pain. Diverticulitis typically presents with left lower quadrant pain and is more associated with changes in bowel habits rather than progressive pain during the night. Understanding these distinctions helps elucidate why peptic ulcer disease is correctly identified as the condition that commonly causes progressive abdominal pain during the night.

5. In patients with suspected spontaneous bacterial peritonitis, what white blood cell count in ascitic fluid warrants antibiotic treatment?

- A. Ascitic fluid pH of 7.35**
- B. WBC of 275 cells/mm³ with 20% lymphocytes**
- C. WBC of 370 cells/mm³ with 90% neutrophils**
- D. WBC of 500 cells/mm³ with 40% neutrophils**

In the context of spontaneous bacterial peritonitis (SBP), the key factor that determines the need for antibiotic treatment is the presence of neutrophils in the ascitic fluid. A white blood cell count greater than 250 cells/mm³ is traditionally used as a threshold to initiate antibiotic therapy. In this case, the option indicating a white blood cell count of 500 cells/mm³ with 40% neutrophils is particularly noteworthy. This option shows that although 40% of the white blood cells are neutrophils, the sheer count of total white blood cells being 500 means there are potentially enough neutrophils present (which would be 200 neutrophils) to indicate a significant bacterial infection. A higher neutrophil count is classically associated with SBP, leading to the consensus that treatment should commence to prevent further complications. Other choices present lower white blood cell counts or an inadequate percentage of neutrophils, which does not meet the threshold for treating suspected SBP. Hence, the selection that identifies a total count of 500 cells/mm³ with a significant number of neutrophils accurately reflects the clinical guidelines that mandate starting antibiotics in this critical scenario.

6. What type of dietary restriction is necessary for patients diagnosed with celiac disease?

- A. Low-fat diet**
- B. Gluten-free diet**
- C. Low-sugar diet**
- D. Vegetarian diet**

For patients diagnosed with celiac disease, a gluten-free diet is essential. Celiac disease is an autoimmune condition where the ingestion of gluten, a protein found in wheat, barley, and rye, triggers an immune response that damages the lining of the small intestine. This damage can lead to malabsorption of nutrients, gastrointestinal symptoms, and a variety of other health issues. By adhering to a strict gluten-free diet, patients can effectively manage their symptoms and promote healing of the intestinal lining. This dietary adjustment eliminates all sources of gluten, allowing the gastrointestinal tract to recover and function properly. In contrast, other dietary restrictions such as low-fat, low-sugar, or vegetarian diets do not address the specific gluten intolerance associated with celiac disease and, therefore, are not effective or appropriate for managing this condition.

7. What is the most appropriate intravenous antibiotic for a patient with alcoholic cirrhosis presenting with fever and ascitic fluid indicating infection?

- A. Ampicillin
- B. Cefotaxime**
- C. Sulfamethoxazole/trimethoprim
- D. Vancomycin

Cefotaxime is the most appropriate intravenous antibiotic for a patient with alcoholic cirrhosis who presents with fever and ascitic fluid suggesting infection, particularly if there's a concern for spontaneous bacterial peritonitis (SBP). Patients with cirrhosis are at an increased risk for infections due to altered immune responses and potential bacterial translocation from the gut. Cefotaxime is a broad-spectrum cephalosporin antibiotic that is effective against common pathogens associated with SBP, particularly *Escherichia coli* and *Klebsiella pneumoniae*. It penetrates well into the ascitic fluid, making it especially suitable for treating infections in patients with ascites. The selection of cefotaxime aligns with evidence-based guidelines for treating SBP, which recommend it as a first-line therapy due to its efficacy and safety profile in this patient population. This antibiotic also has a good dosing regimen, which suits the acute setting often seen in cirrhosis patients. Other antibiotics listed have roles in treating different infections but do not match the specific clinical scenario as effectively as cefotaxime does. Ampicillin is less effective against the Gram-negative pathogens typical in SBP. Sulfamethoxazole/trimethoprim has limited

8. What imaging study is considered highly specific for diagnosing small bowel obstruction?

- A. Abdominal X-ray
- B. CT scan of the abdomen**
- C. Ultrasound
- D. Plain radiography

A CT scan of the abdomen is highly specific for diagnosing small bowel obstruction due to its ability to provide detailed images of the abdominal structures, allowing for clear visualization of the small intestine and any potential blockages. The CT scan can identify the presence and location of an obstruction, assess the degree of distension in the bowel, and evaluate for complications such as ischemia or perforation. It can also help differentiate between various causes of obstruction, such as adhesions, tumors, or hernias, thereby guiding appropriate management. Other imaging studies, while useful, do not provide the same level of specificity or detail. For instance, abdominal X-rays can indicate signs of obstruction, such as air-fluid levels and dilated loops of bowel, but they may miss subtle cases or provide limited information on the cause. Ultrasound can be particularly helpful for pediatric cases or in certain populations, but it is operator-dependent and may not visualize the bowel as clearly as a CT. Plain radiography is essentially the same as an abdominal X-ray and suffers from similar limitations in specificity for diagnosing small bowel obstructions. Overall, the combination of detailed visualization and the ability to assess for complications makes a CT scan the preferred imaging modality for a confident diagnosis of small bowel obstruction.

9. What is the most common cause of pruritus ani in the pediatric patient population?

- A. Candida**
- B. Lichen planus**
- C. Pinworms**
- D. Seborrheic dermatitis**

The most common cause of pruritus ani in the pediatric population is pinworms, also known as *Enterobius vermicularis*. This intestinal parasitic infection is particularly prevalent among children, often leading to intense itching around the anal area. The lifecycle of pinworms involves the female worm laying eggs in the perianal region, which can cause irritation and the characteristic itching, especially at night when the eggs are laid. Parents may notice their child scratching the area, which can lead to secondary infections if skin integrity is compromised. In a school setting, pinworm infections can easily spread among children, making it a common concern in pediatric care. Identifying and treating pinworm infections typically involves the use of antiparasitic medications, along with measures to improve hygiene and prevent reinfection, such as frequent hand washing. While other causes such as Candida, lichen planus, and seborrheic dermatitis can contribute to skin issues in children, they are less commonly associated with isolated pruritus ani compared to the significantly higher incidence linked with pinworm infections.

10. Which diagnostic modality is typically used for evaluating suspected bowel obstruction?

- A. MRI**
- B. Ultrasound**
- C. CT scan**
- D. X-ray**

The CT scan is considered the gold standard for evaluating suspected bowel obstruction due to its high sensitivity and specificity. It provides detailed cross-sectional images of the abdomen, allowing clinicians to visualize the intestines, identify the site of blockage, and assess any associated complications such as perforation or infarction. CT scans can also help in determining the extent of the obstruction and any underlying causes, such as tumors or adhesions, which is critical for guiding management. Other options, while useful in certain contexts, are generally less effective for this specific indication. For instance, MRI is not commonly used for bowel obstruction evaluation due to the time required for the scan and the challenges associated with imaging moving organs. Ultrasound can be useful, especially in pediatric populations or during pregnancy, but it has limitations in assessing the entire bowel and may not provide sufficient detail in adult cases. X-rays can identify air-fluid levels and general bowel distention but lack the detailed diagnostic capability that a CT scan offers, often leading to missed diagnosis or inadequate information on the cause of obstruction.

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://rosh-gastrointestinal.examzify.com>

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