

Rosh Internal Medicine Practice Exam (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. In suspected giant cell arteritis, what is the best initial management to prevent vision loss?**
 - A. High-dose prednisone and low-dose aspirin**
 - B. IV methylprednisolone**
 - C. IV methylprednisolone and high-dose aspirin**
 - D. Treatment with corticosteroids if temporal artery biopsy abnormal**

- 2. Polymyositis is classically associated with which autoantibody?**
 - A. Anti-Jo-1**
 - B. Anti-centromere**
 - C. Anti-dsDNA**
 - D. Anti-Smith**

- 3. A 57-year-old man presents with fatigue, a smooth tongue, cheilosis, and stocking-glove neuropathy. CBC shows macrocytic anemia with hypersegmented neutrophils; serum homocysteine and methylmalonic acid are elevated. What is the most likely diagnosis?**
 - A. Aplastic anemia**
 - B. Folate deficiency**
 - C. G6PD deficiency**
 - D. Pernicious anemia**

- 4. In this patient with Cushing disease due to a pituitary adenoma, what is the best initial surgical intervention?**
 - A. Steroid taper**
 - B. Transsphenoidal surgery**
 - C. Adrenalectomy**
 - D. Ketoconazole**

- 5. What is midodrine and how is it used in cirrhosis-induced hyponatremia?**
- A. A vasoconstrictor used to maintain mean arterial pressure in hyponatremic patients with low BP due to third-spacing of ascites**
 - B. A diuretic that reduces fluid overload**
 - C. A beta-blocker to reduce portal hypertension**
 - D. An ACE inhibitor to improve renal perfusion**
- 6. In polyarteritis nodosa, which organ is classically spared from involvement?**
- A. Kidneys**
 - B. Brain**
 - C. Lungs**
 - D. Heart**
- 7. A 68-year-old man with substernal chest tightness on exertion that lasts about five minutes and is relieved by rest. Resting ECG and labs are normal. What is the most likely next step in diagnostic evaluation?**
- A. Radionuclide angiography**
 - B. Exercise ECG**
 - C. Myocardial perfusion scintigraphy**
 - D. Stress echocardiography**
- 8. In a patient with suspected Prinzmetal (variant) angina and normal coronary arteries, which medication is inappropriate to use?**
- A. Amlodipine**
 - B. Isosorbide dinitrate**
 - C. Lisinopril**
 - D. Propranolol**

- 9. A 28-year-old woman presents with palpitations, high fever, agitation, tremor, and atrial fibrillation; what is the most likely diagnosis?**
- A. Thyroid storm**
 - B. Delirium tremens**
 - C. Myxedema coma**
 - D. Sepsis**
- 10. In outpatient management of diverticulitis, which antibiotic regimen is preferred?**
- A. Amoxicillin alone**
 - B. Fluoroquinolone with metronidazole**
 - C. Piperacillin-tazobactam**
 - D. Ceftriaxone plus azithromycin**

Answers

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

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Explanations

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1. In suspected giant cell arteritis, what is the best initial management to prevent vision loss?

A. High-dose prednisone and low-dose aspirin

B. IV methylprednisolone

C. IV methylprednisolone and high-dose aspirin

D. Treatment with corticosteroids if temporal artery biopsy abnormal

Rapid control of inflammation with high-dose glucocorticoids is essential when giant cell arteritis is suspected because irreversible vision loss can occur quickly if treatment is delayed. Starting high-dose prednisone promptly reduces arterial inflammation and improves blood flow to the optic nerve, lowering the risk of anterior ischemic optic neuropathy even before biopsy confirmation. Adding low-dose aspirin provides antiplatelet protection to reduce thrombotic occlusion in inflamed vessels, offering additional protection against vision loss and other ischemic complications. Do not wait for temporal artery biopsy results to begin treatment, since steroids can alter biopsy findings and vision protection is time-sensitive. In cases with overt or imminent vision loss, some clinicians use intravenous methylprednisolone in addition to oral steroids, but the standard initial approach for suspected GCA without immediate visual symptoms is high-dose prednisone plus low-dose aspirin, with plans for biopsy afterward if needed.

2. Polymyositis is classically associated with which autoantibody?

A. Anti-Jo-1

B. Anti-centromere

C. Anti-dsDNA

D. Anti-Smith

Polymyositis is an inflammatory myopathy often linked to antibodies against aminoacyl-tRNA synthetases, with anti-Jo-1 (anti-histidyl tRNA synthetase) being the most common. This antisynthetase antibody is classically associated with polymyositis and its related antisynthetase syndrome, which can include proximal muscle weakness plus features like interstitial lung disease, arthritis, mechanic's hands, and Raynaud phenomenon. The other antibodies point to different diseases: anti-centromere is more associated with limited systemic sclerosis (CREST), while anti-dsDNA and anti-Smith are highly specific for systemic lupus erythematosus.

3. A 57-year-old man presents with fatigue, a smooth tongue, cheilosis, and stocking-glove neuropathy. CBC shows macrocytic anemia with hypersegmented neutrophils; serum homocysteine and methylmalonic acid are elevated. What is the most likely diagnosis?

- A. Aplastic anemia
- B. Folate deficiency
- C. G6PD deficiency
- D. Pernicious anemia**

The key idea is that this presentation is due to vitamin B12 deficiency causing a megaloblastic process with neurologic involvement. The combination of macrocytic anemia with hypersegmented neutrophils fits both B12 and folate deficiency, but the neurologic symptoms and the specific lab pattern point to B12 deficiency. Stocking-glove neuropathy indicates demyelination of the peripheral nerves and spinal pathways that occurs with B12 deficiency, not with folate deficiency. The smooth tongue and cheilosis reflect mucosal changes that can accompany megaloblastic processes. Importantly, the elevated methylmalonic acid is a hallmark of B12 deficiency (folate deficiency can raise homocysteine but does not raise MMA). The presence of both elevated homocysteine and MMA, along with neurologic signs, strongly supports B12 deficiency rather than folate deficiency. The most likely cause here is pernicious anemia, an autoimmune destruction of gastric parietal cells leading to intrinsic factor deficiency. Without intrinsic factor, B12 cannot be efficiently absorbed in the terminal ileum, producing systemic B12 deficiency with the observed findings. Aplastic anemia would present with pancytopenia and a hypocellular marrow rather than isolated macrocytosis with neuropathy, and G6PD deficiency would cause hemolysis rather than this megaloblastic picture with neurologic signs. Treatment involves replacing B12, typically with parenteral cyanocobalamin, and evaluating for autoimmune gastritis as the underlying cause.

4. In this patient with Cushing disease due to a pituitary adenoma, what is the best initial surgical intervention?

- A. Steroid taper
- B. Transsphenoidal surgery**
- C. Adrenalectomy
- D. Ketoconazole

When Cushing disease is caused by a pituitary ACTH-secreting adenoma, the goal is to remove the source of excess ACTH. The best initial intervention is surgical removal of the pituitary tumor through a transsphenoidal approach. This route targets the tumor directly, offering the highest chance to normalize ACTH and cortisol with the least invasiveness compared with open brain surgery. If the tumor is successfully removed, cortisol levels often fall quickly, though temporary adrenal insufficiency may require short-term steroid replacement. Other options like tapering steroids would only be relevant if the Cushing state were from exogenous steroids, which isn't the case here. Adrenalectomy would eliminate cortisol production but does not address the pituitary tumor and carries risks such as lifelong steroid dependence and Nelson syndrome. Medical therapies (e.g., ketoconazole) can control cortisol when surgery isn't possible or as a bridge, but they are not first-line definitive treatment.

5. What is midodrine and how is it used in cirrhosis-induced hyponatremia?

- A. A vasoconstrictor used to maintain mean arterial pressure in hyponatremic patients with low BP due to third-spacing of ascites**
- B. A diuretic that reduces fluid overload**
- C. A beta-blocker to reduce portal hypertension**
- D. An ACE inhibitor to improve renal perfusion**

In cirrhosis-related hyponatremia, the body's effective arterial blood volume is reduced because fluid shifts into the abdomen (ascites) and elsewhere, triggering non-osmotic release of ADH and activation of the RAAS. Midodrine, an alpha-1 adrenergic agonist, causes vasoconstriction that raises systemic vascular resistance and mean arterial pressure. This improves renal perfusion and reduces the maladaptive neurohumoral drive that promotes water retention, helping the kidneys excrete free water and modestly correct the low sodium. It's used specifically to maintain mean arterial pressure in hyponatremic patients who have low BP from third-spacing of ascites. It isn't a diuretic, a beta-blocker for portal hypertension, or an ACE inhibitor; those agents don't target the underlying low arterial volume and can worsen perfusion or hyponatremia in this setting.

6. In polyarteritis nodosa, which organ is classically spared from involvement?

- A. Kidneys**
- B. Brain**
- C. Lungs**
- D. Heart**

Polyarteritis nodosa involves transmural necrotizing inflammation of medium-sized arteries in various organs, but the lungs are classically spared. This pattern helps distinguish PAN from other vasculitides that involve the pulmonary circulation. In PAN, kidneys are often affected (renal artery involvement can cause hypertension and renal microaneurysms without glomerulonephritis), and other organs such as the brain, heart, and gastrointestinal tract can have ischemic or aneurysmal complications. In contrast, diseases like granulomatosis with polyangiitis or microscopic polyangiitis frequently involve the lungs, causing pulmonary symptoms or hemorrhage, which is not typical of PAN. So the lungs being spared is the hallmark in this context.

7. A 68-year-old man with substernal chest tightness on exertion that lasts about five minutes and is relieved by rest. Resting ECG and labs are normal. What is the most likely next step in diagnostic evaluation?

- A. Radionuclide angiography**
- B. Exercise ECG**
- C. Myocardial perfusion scintigraphy**
- D. Stress echocardiography**

In suspected stable angina, if the patient can exercise and the resting ECG is normal, the first noninvasive test is an exercise treadmill ECG. It directly tests for inducible ischemia by watching for chest pain and ST-segment changes during controlled exertion, and it provides both diagnostic and prognostic information at low cost and with wide availability. A positive or nondiagnostic exercise ECG would prompt further evaluation with imaging-based stress testing, such as stress echocardiography or myocardial perfusion imaging, to improve diagnostic accuracy or assess risk. Radionuclide angiography primarily assesses ventricular function rather than ischemia and is not the preferred initial test in this scenario. Myocardial perfusion scintigraphy and stress echocardiography are more sensitive, but are typically reserved for instances where the resting ECG is abnormal, the patient cannot exercise adequately, or there is a nondiagnostic or equivocal treadmill test.

8. In a patient with suspected Prinzmetal (variant) angina and normal coronary arteries, which medication is inappropriate to use?

- A. Amlodipine**
- B. Isosorbide dinitrate**
- C. Lisinopril**
- D. Propranolol**

In Prinzmetal (variant) angina the chest pain comes from transient coronary artery vasospasm. The goal is to prevent and relieve that vasospasm with vasodilators. Calcium channel blockers and nitrates do this effectively by relaxing vascular smooth muscle and reducing spasm episodes. Propranolol, a nonselective beta-blocker, is inappropriate here because blocking beta-2-mediated vasodilation can remove a protective mechanism that helps keep coronary arteries relaxed. With unopposed alpha-adrenergic vasoconstriction, vasospasm can worsen, making chest pain more likely or severe. Amlodipine and isosorbide dinitrate directly promote vasodilation and help prevent or abort spasm, which is why they're appropriate. Lisinopril isn't a primary treatment for vasospasm but doesn't worsen it and can be used for blood pressure control or other indications.

9. A 28-year-old woman presents with palpitations, high fever, agitation, tremor, and atrial fibrillation; what is the most likely diagnosis?

- A. Thyroid storm**
- B. Delirium tremens**
- C. Myxedema coma**
- D. Sepsis**

This presentation exemplifies a thyroid storm, a life-threatening surge of thyrotoxicosis. The extreme hypermetabolic state driven by excess thyroid hormone causes high fever, agitation, tremor, and marked sympathetic activation, which often leads to tachyarrhythmias such as atrial fibrillation. In a young woman, this pattern is especially suggestive if Graves disease or other thyrotoxic conditions are possible, and a precipitating factor like infection can trigger the crisis. Other conditions might produce fever or tremor or agitation, but the combination with atrial fibrillation and the overall hyperadrenergic picture fits thyroid storm much more than delirium tremens (which relies on withdrawal history), myxedema coma (hypothermia, bradycardia, hypotension), or sepsis (infections can cause fever and tachycardia but not the characteristic thyrotoxic features). Treatment involves rapid control of the thyroid axis and adrenergic symptoms to prevent hemodynamic collapse.

10. In outpatient management of diverticulitis, which antibiotic regimen is preferred?

- A. Amoxicillin alone**
- B. Fluoroquinolone with metronidazole**
- C. Piperacillin-tazobactam**
- D. Ceftriaxone plus azithromycin**

The key idea is choosing an antibiotic plan that reliably covers the bacteria commonly causing diverticulitis while staying suitable for outpatient, oral treatment. Diverticulitis involves infection of colonic diverticula, so you want coverage for both aerobic gram-negative bacteria (like *E. coli*) and anaerobes (like *Bacteroides*). A regimen that combines a fluoroquinolone with metronidazole fits this need well: the fluoroquinolone provides strong activity against gram-negative enteric organisms, and metronidazole adds robust anaerobic coverage. Together, they offer effective, convenient oral therapy that can be used outside the hospital. Amoxicillin alone wouldn't adequately cover anaerobes, limiting its effectiveness in diverticulitis. Piperacillin-tazobactam is a broad-spectrum agent typically given IV and is reserved for more severe or inpatient cases. Ceftriaxone plus azithromycin also isn't ideal for diverticulitis because azithromycin has limited anaerobic coverage and this combination is not the standard choice for colonic infections, plus it often implies IV therapy. Therefore, the combination of a fluoroquinolone and metronidazole best meets the needs of outpatient management by providing comprehensive coverage with oral agents.

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://roshinternalmedicine.examzify.com>

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

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