

ROSH INTERNAL MEDICINE PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED 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. 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 the management of diabetic ketoacidosis, which electrolyte requires careful monitoring due to risk of shift during insulin therapy?**
 - A. Sodium
 - B. Magnesium
 - C. Potassium
 - D. Phosphate

- 2. A 35-year-old man with retrosternal burning after meals; lifestyle modification recommended for GERD?**
 - A. Avoid caffeine, chocolate, and carbonated beverages
 - B. Avoid foods containing tomatoes, onions, and garlic
 - C. Sleep in a prone position
 - D. Avoid eating a meal six hours before bedtime

- 3. Which physical finding is commonly associated with hypothyroidism and may be observed as periorbital edema?**
 - A. Periorbital edema
 - B. Jaundice
 - C. Exophthalmos
 - D. Erythema nodosum

- 4. In suspected temporal arteritis with headaches and jaw claudication, what is the first priority in management?**
 - A. Arterial biopsy
 - B. Hospital admission
 - C. Immediate ophthalmology referral
 - D. Oral corticosteroid treatment

- 5. A 38-year-old woman with papillary thyroid cancer 2.3 cm with regional lymph node metastasis but no distant metastasis is staged as which stage?**
 - A. Stage II
 - B. Stage IV
 - C. Stage I
 - D. Stage III

- 6. 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
- 7. A 40-year-old with proximal muscle weakness and anti-Jo-1 antibodies; most likely diagnosis?**
- A. Dermatomyositis
 - B. Polymyositis
 - C. Polymyalgia rheumatica
 - D. Systemic lupus erythematosus
- 8. Which radiographic finding is most characteristic of osteoarthritis?**
- A. Symmetric joint space narrowing
 - B. Erosions with periarticular bone loss
 - C. Asymmetric joint space narrowing with subchondral sclerosis and marginal osteophytes
 - D. Uniform cartilage loss
- 9. In noninfectious causes of fever and weight loss with elevated ESR, which gout-like medication should be used with caution due to cardiovascular risk?**
- A. Colchicine
 - B. Corticosteroids
 - C. Allopurinol
 - D. NSAIDs
- 10. Pulmonary function testing in restrictive lung disease typically shows which combination?**
- A. Decreased DLCO
 - B. Increased TLC
 - C. Normal or increased FEV1/FVC, decreased TLC
 - D. Decreased FEV1/FVC

Answers

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

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Explanations

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1. In the management of diabetic ketoacidosis, which electrolyte requires careful monitoring due to risk of shift during insulin therapy?

- A. Sodium
- B. Magnesium
- C. Potassium
- D. Phosphate**

During insulin therapy for diabetic ketoacidosis, electrolytes can shift between the blood and inside cells as glucose goes into cells. Phosphate is especially important because, in DKA, total body phosphate is often depleted from diuresis and poor intake, even if initial serum levels aren't obviously low. Once insulin is started, phosphate moves into cells along with glucose, which can cause a notable drop in serum phosphate. This hypophosphatemia can impair energy production in muscles, including respiratory and cardiac muscles, and may lead to weakness, respiratory failure, or hemolysis if severe. Because of this risk, phosphate levels should be monitored during treatment and replaced if they fall to a low level or if there are signs of deficiency. While other electrolytes also shift during therapy, phosphate has a distinct and potentially serious impact on organ function when it drops in response to insulin.

2. A 35-year-old man with retrosternal burning after meals; lifestyle modification recommended for GERD?

- A. Avoid caffeine, chocolate, and carbonated beverages**
- B. Avoid foods containing tomatoes, onions, and garlic
- C. Sleep in a prone position
- D. Avoid eating a meal six hours before bedtime

In GERD, reducing reflux through lifestyle changes is a key strategy. Caffeine, chocolate, and carbonated beverages are known triggers for many people because they can relax the lower esophageal sphincter or increase gastric distension, making reflux more likely. Therefore, avoiding these items is a practical and broadly applicable modification to lessen retrosternal burning after meals. The other options are less reliable: foods like tomatoes, onions, and garlic can provoke symptoms in some individuals but aren't universal triggers; sleeping in a prone position isn't recommended and can worsen reflux; and delaying meals for six hours before bedtime isn't standard practice (most guidance suggests avoiding eating within a few hours of lying down).

3. Which physical finding is commonly associated with hypothyroidism and may be observed as periorbital edema?

- A. Periorbital edema**
- B. Jaundice
- C. Exophthalmos
- D. Erythema nodosum

In hypothyroidism, a buildup of mucopolysaccharides in the dermis leads to non-pitting edema called myxedema. This often shows up around the eyes as periorbital puffiness, a classic physical finding in untreated or long-standing hypothyroidism. The edema is due to the interstitial accumulation of glycosaminoglycans, not fluid overload from vascular leakage, and it tends to be more prominent in the face and around the eyes. Exophthalmos, by contrast, is more typical of Graves disease (hyperthyroidism) and results from inflammation and enlargement of the extraocular muscles, pushing the eyes forward. Jaundice points to liver or hemolytic processes, not a thyroid-related edema. Erythema nodosum is a panniculitis presenting as tender nodules on the shins, unrelated to thyroid function. So the periorbital swelling described here fits hypothyroidism best because of the myxedematous facial edema pattern.

4. In suspected temporal arteritis with headaches and jaw claudication, what is the first priority in management?

- A. Arterial biopsy
- B. Hospital admission
- C. Immediate ophthalmology referral

D. Oral corticosteroid treatment

Starting high-dose corticosteroids immediately is the top priority in suspected giant cell arteritis. The threat of irreversible vision loss from ophthalmic artery involvement means you cannot wait for biopsy or lab tests to confirm the diagnosis. Begin effective anti-inflammatory treatment at once—for most patients this is oral prednisone 40–60 mg daily (about 1 mg/kg/day). If there are signs of acute visual risk or actual vision changes, use intravenous methylprednisolone, such as 1 g daily for 3 days, then continue with an oral taper. After therapy is started, pursue diagnostic confirmation with temporal artery biopsy and supportive tests (ESR/CRP, imaging if available). Note that steroids can affect biopsy results if given too long before the procedure, but patient safety and vision protection take priority. If ocular symptoms are present, involve ophthalmology promptly, but treatment should not be delayed for that referral. Hospital admission is considered based on overall risk and comorbidities, not as the initial step in all cases.

5. A 38-year-old woman with papillary thyroid cancer 2.3 cm with regional lymph node metastasis but no distant metastasis is staged as which stage?

- A. Stage II
- B. Stage IV
- C. Stage I**
- D. Stage III

In papillary thyroid cancer, age is a major driver of stage. For younger patients, nodal involvement does not automatically upstage the disease as long as there is no distant metastasis. A 2.3 cm tumor places her in a mid T category, and regional lymph node metastasis (N1) with no distant spread (M0) would still be staged as an early, favorable stage in this age group. So, despite the regional metastasis, she remains Stage I because distant metastasis is absent and her age falls into the group where nodal disease does not by itself elevate the stage. If distant metastasis were present or if the patient were older, the stage would be higher.

6. 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.

7. A 40-year-old with proximal muscle weakness and anti-Jo-1 antibodies; most likely diagnosis?

- A. Dermatomyositis
- B. Polymyositis**
- C. Polymyalgia rheumatica
- D. Systemic lupus erythematosus

Proximal symmetric muscle weakness in adults with an antisynthetase antibody points to an inflammatory myopathy, specifically the antisynthetase syndrome. The anti-Jo-1 antibody is classically associated with this condition and with inflammatory myopathies driven by immune-mediated muscle fiber damage.

Dermatomyositis would add characteristic skin findings such as a heliotrope rash or Gottron papules, which aren't described here, making polymyositis the more likely diagnosis. Polymyalgia rheumatica occurs in older individuals with shoulder girdle stiffness and morning stiffness but not true myopathic weakness and is not linked to anti-Jo-1. SLE would present with a broader systemic pattern and different antibodies.

8. Which radiographic finding is most characteristic of osteoarthritis?

- A. Symmetric joint space narrowing
- B. Erosions with periarticular bone loss
- C. Asymmetric joint space narrowing with subchondral sclerosis and marginal osteophytes**
- D. Uniform cartilage loss

Osteoarthritis shows degenerative changes that are typically uneven in a joint, reflecting focal cartilage loss and bone response. On radiographs, the hallmark is asymmetric joint space narrowing because cartilage wears away more on one side, often with the medial compartment affected first. This is accompanied by subchondral sclerosis, where the exposed bone thickens and becomes denser from increased load, and marginal osteophytes, which are bony projections at the joint margins formed as a reaction to surface irregularities. These features together—asymmetric joint space loss plus subchondral sclerosis and osteophyte formation—best characterize osteoarthritis. Inflammatory arthritis, like rheumatoid, usually shows symmetric joint space narrowing with erosions and periarticular bone loss, not this combination. Uniform cartilage loss is not the typical pattern for OA.

9. In noninfectious causes of fever and weight loss with elevated ESR, which gout-like medication should be used with caution due to cardiovascular risk?

- A. Colchicine
- B. Corticosteroids
- C. Allopurinol
- D. NSAIDs**

The main idea is that NSAIDs, though useful for inflammation, carry notable cardiovascular risks. NSAIDs can raise blood pressure, cause fluid retention, and impair renal function; these effects can contribute to heart attack or stroke, especially with long-term use, high doses, in older individuals, or in those with existing cardiovascular disease or risk factors. In noninfectious conditions that drive fever and weight loss with a high ESR, you might consider anti-inflammatory therapy, but using NSAIDs requires caution because of this cardiovascular risk. The other gout like medications have different risk profiles: colchicine mainly causes GI upset and potential cytopenias, corticosteroids have metabolic effects that can influence cardiovascular risk in the long term but are not as directly linked to acute cardiovascular events, and allopurinol does not carry the same inherent CV risk. Hence, the option to use with caution for cardiovascular risk is the NSAIDs.

10. Pulmonary function testing in restrictive lung disease typically shows which combination?

A. Decreased DLCO

B. Increased TLC

C. Normal or increased FEV1/FVC, decreased TLC

D. Decreased FEV1/FVC

In restrictive lung disease, the primary issue is reduced lung volumes, especially total lung capacity. On pulmonary function tests, this shows up as a decreased TLC, while the proportion of air exhaled in the first fraction of the breath (FEV1) relative to the total exhaled volume (FVC) is preserved or even increased, so the FEV1/FVC ratio is normal or higher. Diffusion capacity (DLCO) can be normal or reduced depending on the underlying cause (e.g., interstitial fibrosis often lowers DLCO, while chest wall or neuromuscular restriction may not). Therefore the best combination that reflects typical restrictive physiology is decreased TLC with a normal or increased FEV1/FVC.

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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:

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

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