ENDOCRINE DISORDER PRACTICE TEST (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.

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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!

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Questions

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1. Glucagon carried for emergency use by a family for a client with diabetes should be used to treat which condition?

A. Diabetic ketoacidosis

B. Hyperglycemia from insufficient insulin

C. Hyperglycemia occurring on sick days

D. Hypoglycemia from insulin overdose

2. In myxedema coma, which additional therapy should be considered due to potential adrenal insufficiency?

A. Dexamethasone

B. Hydrocortisone

C. Prednisone

D. Fludrocortisone

3. In thyroid storm, which statement correctly reflects the timing for iodide therapy relative to PTU?

A. Iodide therapy before PTU

B. PTU only

C. PTU and iodine simultaneously

D. PTU, followed by iodide after PTU, plus steroids

4. Which finding would most strongly suggest diabetes insipidus following hypophysectomy?

A. Increased urine output with low urine specific gravity

B. Decreased urine output with high urine specific gravity

C. Elevated serum glucose

D. Bradycardia

5. Which hormone is deficient in central diabetes insipidus?

A. Thyroid-stimulating hormone.

B. Growth hormone.

C. Antidiuretic hormone.

D. Prolactin.

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6. Which class of medications commonly causes hyperprolactinemia by blocking dopamine D2 receptors?

A. Dopamine antagonists (antipsychotics).

B. Serotonin reuptake inhibitors.

C. Beta blockers.

D. ACE inhibitors.

7. In MEN2A, what two additional endocrinopathies co-occur with medullary thyroid carcinoma?

A. Pheochromocytoma and primary hyperparathyroidism

B. Graves disease and Addison disease

C. Cushing syndrome and hypoparathyroidism

D. Hashimoto thyroiditis and diabetes mellitus type 1

8. Which client complaint would indicate a hypoglycemic reaction?

A. Tremors and double vision

B. Anorexia and blurred vision

C. Hot, dry skin and weakness

D. Muscle cramps and elevated temperature

9. In a client with hypoparathyroidism, which dietary pattern is most appropriate?

A. High in phosphorus and low in calcium

B. Low in phosphorus and low in calcium

C. Low in phosphorus and high in calcium

D. High in phosphorus and high in calcium

10. Postoperative hypophysectomy: thirst and polyuria; which parameter should be checked next to assess for the expected complication?

A. Serum glucose

B. Blood pressure

C. Respiratory rate

D. Urine specific gravity

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Answers

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

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Explanations

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1. Glucagon carried for emergency use by a family for a client with diabetes should be used to treat which condition?

A. Diabetic ketoacidosis

B. Hyperglycemia from insufficient insulin

C. Hyperglycemia occurring on sick days

D. Hypoglycemia from insulin overdose

Glucagon is used in emergency care to raise blood glucose during a severe hypoglycemic episode when the person cannot safely swallow or when IV glucose isn't readily available. It works by signaling the liver to release stored glucose into the bloodstream (glycogenolysis and gluconeogenesis), so blood sugar rises quickly and the person can regain consciousness and responsiveness. Because its job is to increase glucose, glucagon is specifically for hypoglycemia—such as hypoglycemia from insulin overdose or missed meals. It isn't for high blood sugar conditions like diabetic ketoacidosis or other forms of hyperglycemia, which require insulin, fluids, and electrolyte management. So the correct context for using glucagon is hypoglycemia caused by too much insulin.

2. In myxedema coma, which additional therapy should be considered due to potential adrenal insufficiency?

A. Dexamethasone

B. Hydrocortisone

C. Prednisone

D. Fludrocortisone

Adrenal function can be compromised in myxedema coma, and starting thyroid hormone replacement increases metabolic demand. If the adrenal axis is insufficient, a crisis can be triggered unless glucocorticoid support is given. Hydrocortisone is preferred because it provides both glucocorticoid and mineralocorticoid activity, helping with stress-related cortisol needs and supporting blood pressure and electrolyte balance in the acute setting. In contrast, dexamethasone, while a potent glucocorticoid, lacks mineralocorticoid activity and can interfere with certain adrenal tests; prednisone is a glucocorticoid but is slower to act and may not address immediate mineralocorticoid needs; fludrocortisone is mainly a mineralocorticoid and not suitable as the initial glucocorticoid replacement in an acute crisis. Therefore, hydrocortisone is the best initial therapy to cover potential adrenal insufficiency in myxedema coma.

3. In thyroid storm, which statement correctly reflects the timing for iodide therapy relative to PTU?

A. Iodide therapy before PTU

B. PTU only

C. PTU and iodine simultaneously

D. PTU, followed by iodide after PTU, plus steroids

In thyroid storm you want rapid control of hormone levels by first stopping new hormone production, then quickly blocking release of what's already stored, while supporting peripheral effects. Propylthiouracil (PTU) does the crucial job of inhibiting thyroid hormone synthesis (and also decreases T4 to T3 conversion). Once synthesis is being blocked, giving iodide can promptly shut down the release of stored thyroid hormone. Because iodide can, in the absence of synthesis blockade, potentially sustain or increase hormone production in some scenarios, it's given after PTU so that synthesis is already suppressed when iodide acts. Adding steroids helps reduce peripheral conversion of T4 to T3 and treats potential adrenal insufficiency, providing broad stabilization. So the preferred sequence is PTU first, followed by iodide, with steroids.

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4. Which finding would most strongly suggest diabetes insipidus following hypophysectomy?

A. Increased urine output with low urine specific gravity

B. Decreased urine output with high urine specific gravity

C. Elevated serum glucose

D. Bradycardia

Central diabetes insipidus after hypophysectomy arises because ADH (vasopressin) production or release from the posterior pituitary is disrupted. Without ADH, the collecting ducts in the kidney cannot reabsorb water effectively, so a large volume of very dilute urine is produced. That's why an increased urine output paired with a low urine specific gravity best signals DI in this setting—the urine is dilute even though you're making a lot of it. In contrast, urine that is highly concentrated (high specific gravity) would not fit DI; elevated serum glucose would point toward diabetes mellitus with glycosuria as a cause of polyuria; bradycardia isn't a hallmark finding of DI. So the combination of polyuria with dilute urine specifically points to central DI after hypophysectomy.

5. Which hormone is deficient in central diabetes insipidus?

A. Thyroid-stimulating hormone.

B. Growth hormone.

C. Antidiuretic hormone.

D. Prolactin.

Central diabetes insipidus occurs when there is not enough antidiuretic hormone (ADH) to tell the kidneys to conserve water. ADH normally acts on the kidney's collecting ducts to increase water reabsorption, which concentrates the urine. When ADH is deficient, the kidneys reabsorb less water, producing large volumes of dilute urine and triggering increased thirst. Among the hormones listed, only antidiuretic hormone is directly involved in this process; thyroid-stimulating hormone, growth hormone, and prolactin regulate other body functions and don't control water balance in the kidney. So the condition arises from low ADH, while the other hormones aren't responsible for central diabetes insipidus. To distinguish from nephrogenic diabetes insipidus, note that in central DI ADH is reduced, whereas in nephrogenic DI the kidneys don't respond to ADH despite its presence.

6. Which class of medications commonly causes hyperprolactinemia by blocking dopamine D2 receptors?

A. Dopamine antagonists (antipsychotics).

B. Serotonin reuptake inhibitors.

C. Beta blockers.

D. ACE inhibitors.

Dopamine normally keeps prolactin levels in check by acting on D2 receptors in the pituitary's tuberoinfundibular pathway. When these D2 receptors are blocked, the inhibitory influence on lactotrophs is removed, leading to increased prolactin release and hyperprolactinemia. This is a classic effect of dopamine antagonists, also known as antipsychotics, which block D2 receptors to provide their therapeutic CNS effects. That blockade in the pituitary explains the common side effects like galactorrhea, menstrual irregularities, and infertility. The other options don't explain hyperprolactinemia through direct D2 receptor blockade. Serotonin reuptake inhibitors can raise prolactin via serotonin pathways, but not by blocking D2 receptors. Beta blockers and ACE inhibitors don't influence prolactin through this mechanism.

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7. In MEN2A, what two additional endocrinopathies co-occur with medullary thyroid carcinoma?

A. Pheochromocytoma and primary hyperparathyroidism

B. Graves disease and Addison disease

C. Cushing syndrome and hypoparathyroidism

D. Hashimoto thyroiditis and diabetes mellitus type 1

In MEN2A, medullary thyroid carcinoma sits alongside two other endocrine tumors: pheochromocytoma and primary hyperparathyroidism. Pheochromocytomas are adrenal tumors that secrete excess catecholamines, which can cause headaches, sweating, palpitations, and high blood pressure; identifying them is crucial before any thyroid surgery to avoid dangerous catecholamine surges during manipulation. Primary hyperparathyroidism results from parathyroid overactivity, leading to elevated calcium levels. These three findings—medullary thyroid carcinoma, pheochromocytoma, and hyperparathyroidism—define the MEN2A pattern. Other autoimmune or metabolic conditions listed do not form part of this syndrome.

8. Which client complaint would indicate a hypoglycemic reaction?

A. Tremors and double vision

B. Anorexia and blurred vision

C. Hot, dry skin and weakness

D. Muscle cramps and elevated temperature

Hypoglycemia triggers both autonomic and neuroglycopenic signs as the brain and body try to cope with low glucose. Tremors reflect the autonomic counterregulatory response (epinephrine release) to low blood sugar, while double vision indicates neuroglycopenic effects on brain function, meaning the brain isn't getting enough fuel to coordinate vision properly. Together, these signs point to a hypoglycemic episode. The other pairings align more with hyperglycemia or non-specific issues (anorexia isn't a typical early autonomic cue of hypoglycemia, hot, dry skin fits dehydration or high glucose states, and muscle cramps with fever isn't characteristic of low blood sugar).

9. In a client with hypoparathyroidism, which dietary pattern is most appropriate?

A. High in phosphorus and low in calcium

B. Low in phosphorus and low in calcium

C. Low in phosphorus and high in calcium

D. High in phosphorus and high in calcium

Hypoparathyroidism causes low calcium and high phosphate because parathyroid hormone normally raises calcium and promotes phosphate excretion. With deficient PTH, the goal of the diet is to boost calcium while reducing phosphate, helping calcium stay available rather than becoming bound as phosphate. A pattern that is high in calcium and low in phosphorus best supports this balance, providing calcium to raise serum levels and limiting phosphate load to prevent further calcium binding. In contrast, high phosphate intake worsens the phosphate excess, and low calcium without addressing phosphate won't correct the calcium deficit; patterns with both high phosphate and high calcium don't reduce the phosphate burden, and patterns low in calcium don't raise calcium effectively. Practically, this means choosing calcium-rich foods but keeping phosphate-containing foods (like those with additives and excessive dairy or processed meats) in check to improve calcium availability.

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10. Postoperative hypophysectomy: thirst and polyuria; which parameter should be checked next to assess for the expected complication?

A. Serum glucose

B. Blood pressure

C. Respiratory rate

D. Urine specific gravity

After a hypophysectomy, the most feared complication is diabetes insipidus caused by loss of antidiuretic hormone. When DI occurs, the kidneys cannot concentrate urine, so patients produce large volumes of dilute urine despite thirst. The quickest way to detect this is to assess urine concentration, which is what urine specific gravity measures. A low urine specific gravity indicates dilute urine consistent with DI, signaling that the patient is not conserving water and may be developing this complication. Serum glucose, blood pressure, and respiratory rate aren't as directly informative about DI. Serum glucose would test for hyperglycemia (diabetes mellitus) but doesn't reflect ADH-dependent water handling. Blood pressure and respiratory rate can change with dehydration but don't specifically confirm the inability to concentrate urine. So measuring urine specific gravity provides the most direct and immediate insight into the expected postoperative complication.

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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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