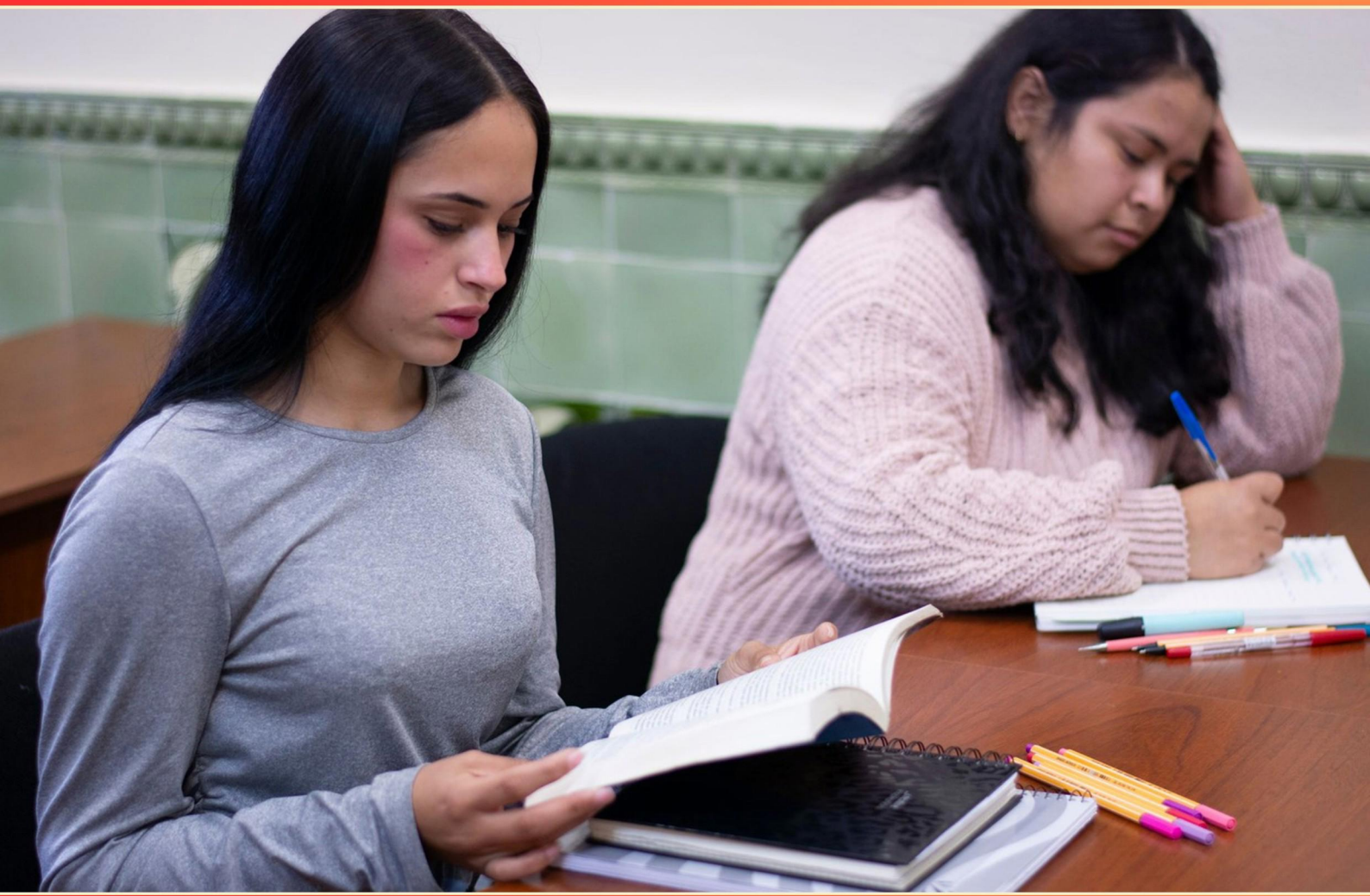
INTERNAL MEDICINE II PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR 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.

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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. In cirrhosis with acute variceal bleeding, what management strategy improves survival?

A. Only antibiotics

B. Immediate liver transplant

C. Early vasoactive therapy, prophylactic antibiotics, urgent endoscopy

D. Delayed endoscopy

2. Gout classically presents with acute monoarthritis of which joint?

A. Knee

B. Wrist

C. Ankle

D. I.MTP joint

3. Which joint is most frequently involved in osteoarthritis?

A. Knee

B. Wrist

C. Ankle

D. Hand DIP joints

4. In acute kidney injury, prerenal azotemia due to hypoperfusion is best managed by:

A. Prerenal AKI due to hypoperfusion; treat with volume resuscitation and address the cause.

B. Intrinsic AKI management relies on nephrotoxin avoidance and dialysis.

C. Prerenal AKI requires immediate nephrology dialysis in all cases.

D. Prerenal AKI is best treated with diuretic therapy and no volume resuscitation.

5. Which regimen is appropriate for latent tuberculosis infection?

A. Isoniazid for 6-9 months

B. Rifapentine-isoniazid weekly for 12 weeks

C. Rifampin for 12 months

D. Ethambutol for 6 months

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6. Measurement of chest expansion is important in ..... disease?

A. AS (Bechterew disease)

B. Rheumatoid arthritis

C. Gout

D. Osteoporosis

7. In heart failure with reduced ejection fraction, which drug classes have proven mortality/morbidity benefit, and what is the role of ARNI?

A. ACE inhibitors or ARBs, beta-blockers, and mineralocorticoid receptor antagonists; ARNI can be used in eligible patients

B. Calcium channel blockers, loop diuretics, nitrates

C. Hydralazine alone

D. Digoxin only

8. Atopic dermatitis may be characterized by which statement?

A. A collection of exclusive concomitant skin symptoms along with bronchial asthma.

B. A disorder in which the exact diagnosis may be achieved by performing skin biopsy alone.

C. A disease where itch control is possible by the exclusive use of systemic antihistamines.

D. Having skin rehydration with emollients is inevitable in therapy.

9. In suspected acute pancreatitis, which test is typically performed to evaluate gallstone etiology?

A. CT scan

B. MRCP

C. Abdominal ultrasound

D. Barium swallow

10. Which feature is most characteristic of CREST syndrome?

A. Calcinosis

B. Raynaud phenomenon

C. Esophageal dysmotility

D. Sclerodactyly

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Answers

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

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Explanations

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1. In cirrhosis with acute variceal bleeding, what management strategy improves survival?

A. Only antibiotics

B. Immediate liver transplant

C. Early vasoactive therapy, prophylactic antibiotics, urgent endoscopy

D. Delayed endoscopy

In acute variceal bleeding on a cirrhotic liver, survival improves when you act fast with a bundled approach that stops the bleed, prevents infection, and provides definitive hemostasis. Starting a vasoactive agent right away lowers portal pressure and reduces ongoing bleeding, buying time and reducing transfusion needs. Prophylactic antibiotics are given because infections are common in cirrhotics with GI bleeding and worsen outcomes, including increasing rebleeding and mortality. Urgent endoscopy to perform variceal ligation (or other endoscopic therapy) achieves definitive control of the bleed and lowers the chance of rebleeding. Together, these measures address the main risks in the acute phase and have been shown to improve survival. Delaying endoscopy or relying on antibiotics alone misses the critical steps for hemostasis and infection prevention, and an immediate transplant is not an acute, broadly applicable management step.

2. Gout classically presents with acute monoarthritis of which joint?

A. Knee

B. Wrist

C. Ankle

D. I.MTP joint

Gout classicly presents as an acute attack in the first metatarsophalangeal joint (the big toe). This site is favored because peripheral joints in cooler areas of the body more readily allow monosodium urate crystals to precipitate, triggering a robust inflammatory response. The result is sudden, severe pain with swelling, redness, and warmth, often overnight. While gout can affect other joints such as the knee, ankle, or wrist, the big toe joint is the hallmark starting point and most strongly associated with the classic presentation. Understanding podagra helps distinguish gout from other causes of acute monoarthritis, such as septic arthritis or inflammatory arthritis, and guides appropriate management and urate-lowering considerations.

3. Which joint is most frequently involved in osteoarthritis?

A. Knee

B. Wrist

C. Ankle

D. Hand DIP joints

Osteoarthritis tends to affect joints that bear the most weight and undergo the most use. The knee fits this pattern best because it supports the body's weight and endures a lot of mechanical stress with daily activities and varied movements. Over time, cartilage degrades, and changes in the bone beneath the cartilage (subchondral sclerosis and osteophyte formation) develop, leading to pain, stiffness, and functional limitation. Although OA can involve other joints like the hands or hips, the knee is the most commonly affected overall, which is why it's the best answer here.

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4. In acute kidney injury, prerenal azotemia due to hypoperfusion is best managed by:

A. Prerenal AKI due to hypoperfusion; treat with volume resuscitation and address the cause.

B. Intrinsic AKI management relies on nephrotoxin avoidance and dialysis.

C. Prerenal AKI requires immediate nephrology dialysis in all cases.

D. Prerenal AKI is best treated with diuretic therapy and no volume resuscitation.

When prerenal AKI is caused by hypoperfusion, the kidneys are structurally intact but not receiving enough blood flow. The priority is to restore renal perfusion and fix the underlying cause of the reduced forward flow. This is best achieved with volume repletion using appropriate IV fluids (often isotonic crystalloids) and by addressing factors driving the low effective circulating volume or low blood pressure (such as dehydration, hemorrhage, sepsis, or heart failure with poor forward flow). As kidney perfusion improves, GFR increases and creatinine and azotemia typically improve. Dialysis is not the first step in this scenario; it's reserved for situations where AKI persists despite restoration of perfusion or for life-threatening complications (severe hyperkalemia, acidosis, uremia, or refractory fluid overload). Diuretics do not correct the underlying perfusion problem and are not the primary treatment for prerenal azotemia, though they may be used later if volume overload becomes an issue after perfusion is restored. Helpful context: prerenal azotemia often shows a low urine sodium and a high BUN/creatinine ratio, reflecting preserved tubular function and avid reabsorption due to reduced perfusion. These signs typically improve with successful volume resuscitation and correction of the underlying cause.

5. Which regimen is appropriate for latent tuberculosis infection?

A. Isoniazid for 6-9 months

B. Rifapentine-isoniazid weekly for 12 weeks

C. Rifampin for 12 months

D. Ethambutol for 6 months

Treating latent tuberculosis infection aims to eliminate dormant bacilli to prevent progression to active TB. Isoniazid works by inhibiting mycolic acid synthesis in the bacteria, and when given for several months it effectively reduces the risk of reactivation. The traditional and widely used regimen is isoniazid taken daily for 6–9 months. This duration reliably lowers the chance of developing active TB and has a long track record of safety with proper monitoring for hepatotoxicity. The longer end of the range provides slightly better protection, especially in individuals at higher risk of reactivation, and remains a common choice when adherence and liver health are favorable. Other regimens exist, such as a weekly rifapentine–isoniazid combination for 12 weeks or rifampin alone for 4 months, which can be preferable for some patients due to shorter treatment, but ethambutol is not used for latent infection, and a 12-month rifampin course is not standard.

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6. Measurement of chest expansion is important in ..... disease?

A. AS (Bechterew disease)

B. Rheumatoid arthritis

C. Gout

D. Osteoporosis

Measuring chest expansion tests how well the rib cage moves during breathing, reflecting thoracic cage and spine mobility. It's especially informative when diseases involve the spine and costovertebral joints because these joints can stiffen and fuse, limiting how much the chest can expand. Ankylosing spondylitis commonly affects the spine and the joints that connect the ribs to the spine. This involvement reduces chest wall movement, so chest expansion is reduced in a characteristic way. Tracking this expansion over time helps assess disease progression and the impact on lung function, making it a useful clinical sign in this condition. To measure it, place a tape around the chest at the level of the nipples, have the patient inhale deeply, then exhale fully, and record the difference in chest circumference. Normal expansion is typically around 4–5 cm in adults; a markedly reduced expansion suggests restrictive chest wall movement, as seen in ankylosing spondylitis. Rheumatoid arthritis can affect the chest to some extent but is not as defining for chest expansion as ankylosing spondylitis. Gout and osteoporosis don't characteristically present with reduced chest expansion as a key diagnostic feature.

7. In heart failure with reduced ejection fraction, which drug classes have proven mortality/morbidity benefit, and what is the role of ARNI?

A. ACE inhibitors or ARBs, beta-blockers, and mineralocorticoid receptor antagonists; ARNI can be used in eligible patients

B. Calcium channel blockers, loop diuretics, nitrates

C. Hydralazine alone

D. Digoxin only

In heart failure with reduced ejection fraction, the treatments that have consistently shown to reduce death and hospitalization are renin–angiotensin system blockade, beta-blockade, and mineralocorticoid receptor antagonism. ACE inhibitors or ARBs slow adverse remodeling and improve survival; beta-blockers reduce sudden death and improve outcomes by dampening chronic sympathetic stimulation; and mineralocorticoid receptor antagonists like spironolactone or eplerenone further decrease mortality and HF admissions by reducing fibrosis and fluid retention. The role of the ARNI is to provide at least as good if not better outcomes than an ACE inhibitor in eligible patients, by combining neprilysin inhibition with angiotensin receptor blockade. In practice, eligible patients can switch to or start an ARNI in place of an ACE inhibitor/ARB to achieve additional mortality and morbidity benefit, while monitoring for effects like hypotension, hyperkalemia, and angioedema (and observing a washout period when switching from an ACE inhibitor). Other drugs listed mainly relieve symptoms without proven mortality benefit in this setting, such as calcium channel blockers, traditional nitrates with diuretics, and digoxin, which improves symptoms and exercise tolerance but does not reduce mortality. Hydralazine alone also lacks mortality benefit, though hydralazine with nitrates adds benefit in specific populations when used with standard therapy.

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8. Atopic dermatitis may be characterized by which statement?

A. A collection of exclusive concomitant skin symptoms along with bronchial asthma.

B. A disorder in which the exact diagnosis may be achieved by performing skin biopsy alone.

C. A disease where itch control is possible by the exclusive use of systemic antihistamines.

D. Having skin rehydration with emollients is inevitable in therapy.

A fundamental concept here is that atopic dermatitis involves skin barrier dysfunction and dry skin, making hydration with emollients a central part of treatment. Rehydrating the skin helps restore the lipid barrier, reduces transepidermal water loss, and dampens the itch-scratch cycle, which in turn improves overall control and enhances the effectiveness of other therapies. Because of this barrier-focused approach, using regular emollients is basically a baseline, universal step in managing the condition. The other statements don't fit as well. Atopic dermatitis is not defined by an exclusive set of skin symptoms with bronchial asthma, since atopy can involve multiple conditions but isn't limited to a fixed triad. Diagnosis isn't made by skin biopsy alone—histology is not specific and the diagnosis is clinical. And itch control is not achieved solely with systemic antihistamines; they may help modestly, but effective management usually requires barrier repair with emollients plus anti-inflammatory therapies and other measures, not reliance on antihistamines alone.

9. In suspected acute pancreatitis, which test is typically performed to evaluate gallstone etiology?

A. CT scan

B. MRCP

C. Abdominal ultrasound

D. Barium swallow

When pancreatitis might be caused by gallstones, the imaging test of choice is abdominal ultrasound because it directly visualizes gallstones and assesses the biliary tract. It's noninvasive, quick, inexpensive, and widely available, and it can show gallstones, sludge, gallbladder wall changes, and dilation of the common bile duct suggesting obstruction. If gallstones or biliary obstruction are found, that guides management, such as pursuing interventions for ductal stones if needed. CT scans are excellent for evaluating pancreatic tissue and complications but are less sensitive for detecting gallstones themselves. MRCP provides a detailed view of the biliary tree and ducts and is used if ultrasound is inconclusive or if ductal stones are suspected without intervention, but it's not the first-line test due to cost and availability. Barium swallow is unrelated to biliary pathology.

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10. Which feature is most characteristic of CREST syndrome?

A. Calcinosis

B. Raynaud phenomenon

C. Esophageal dysmotility

D. Sclerodactyly

CREST syndrome is the limited form of systemic sclerosis, where vascular and fibrotic features overlap. The feature that best captures its hallmark presentation is Raynaud phenomenon. Digital arteries spasm in response to cold or stress, causing the characteristic triphasic color change (white from ischemia, blue from deoxygenation, red from reperfusion) and often painful fingers. This vascular abnormality is very common and typically appears early, serving as a key clue to CREST. Calcinosis, esophageal dysmotility, and sclerodactyly are indeed part of CREST, but they tend to appear later or vary more among patients. Raynaud phenomenon stands out because of its high prevalence and its position as an early, defining vascular manifestation of the syndrome.

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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:

https://internalmedicine2.examzify.com

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

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