PANCE ENDOCRINOLOGY 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. Which of the following is a symptom of Hyperosmolar Hyperglycemic Syndrome?

A. Shortness of Breath

B. Extreme Thirst

C. Jaundice

D. Rash

2. Which calcium-containing preparation is commonly used with active vitamin D for symptomatic hypocalcemia due to hypoparathyroidism?

A. Calcium carbonate

B. Calcium citrate

C. Calcitriol

D. Calcium carbonate or calcium citrate

3. Which pharmacologic agent is commonly used to stimulate growth hormone release during diagnostic testing?

A. Insulin-induced hypoglycemia

B. Dexamethasone

C. ACTH

D. Thyroid hormone

4. In MEN1, pancreatic neuroendocrine tumors commonly present as gastrinoma or insulinoma. Which symptom is most characteristic of gastrinoma?

A. Refractory peptic ulcers due to excess acid

B. Hypoglycemia after meals

C. Hypercalcemia

D. Weight gain without GI symptoms

5. In secondary (central) hypogonadism, what is the pattern of testosterone and LH/FSH?

A. Low testosterone with high LH/FSH

B. Low testosterone with low or normal LH/FSH

C. High testosterone with normal LH/FSH

D. Low testosterone with low LH/FSH

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6. Which of the following is a common adverse effect of long-term bisphosphonate therapy, and what administration practice helps mitigate it?

A. Esophagitis and osteonecrosis of the jaw; take with water and stay upright

B. Headache and nausea; take with food

C. Hypotension and flushing; avoid standing

D. Hyperglycemia and dehydration; take with juice

7. A patient develops hypocalcemia after total thyroidectomy. What is the most likely cause and initial management?

A. Autoimmune destruction of parathyroids with high PTH; treat with teriparatide

B. Vitamin D deficiency causing hypocalcemia; treat with high-dose ergocalciferol

C. Accidental removal or damage to the parathyroid glands causing hypoparathyroidism; treat with calcium supplementation and calcitriol; monitor magnesium

D. Hypermagnesemia causing hypocalcemia; treat with magnesium sulfate

8. Which laboratory pattern is typical of primary hypothyroidism?

A. Elevated TSH with low Free T4

B. Low TSH with high Free T4

C. Normal TSH with normal Free T4

D. Elevated TSH with high Free T4

9. Screening for gestational diabetes is performed at what gestational age and with what test?

A. 24–28 weeks with a 75 g oral glucose tolerance test

B. 12–16 weeks with a 50 g glucose challenge

C. 32–36 weeks with a 100 g OGTT

D. At delivery with random glucose

10. Which of the following is NOT a metabolic syndrome trait?

A. LDL Cholesterol ≥130 mg/dL

B. Abdominal Obesity

C. Triglycerides ≥150 mg/dL

D. Fasting Plasma Glucose ≥100 mg/dL

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Answers

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

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Explanations

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1. Which of the following is a symptom of Hyperosmolar Hyperglycemic Syndrome?

A. Shortness of Breath

B. Extreme Thirst

C. Jaundice

D. Rash

Hyperosmolar hyperglycemic syndrome boils down to extreme dehydration from profound hyperglycemia. The high blood glucose causes osmotic diuresis, so water is lost in the urine and the body signals thirst strongly. That makes extreme thirst the most characteristic symptom among the options. Shortness of breath is not a primary feature of HHS; it's more typical of conditions with acidosis like diabetic ketoacidosis. Jaundice and rash don't fit the pattern of HHS at all. In HHS you'd expect signs of dehydration, very high glucose with high serum osmolality, and often altered mental status, but little to no significant ketone production.

2. Which calcium-containing preparation is commonly used with active vitamin D for symptomatic hypocalcemia due to hypoparathyroidism?

A. Calcium carbonate

B. Calcium citrate

C. Calcitriol

D. Calcium carbonate or calcium citrate

In hypoparathyroidism, management of symptomatic hypocalcemia combines calcium supplementation with active vitamin D (such as calcitriol) to boost intestinal calcium absorption since PTH-driven Vitamin D activation is impaired. Both calcium carbonate and calcium citrate provide elemental calcium and are commonly used alongside calcitriol; the choice between them depends on factors like gastric acid status and tolerability. Calcium carbonate works well for many patients but relies on stomach acid for absorption, whereas calcium citrate is better in those with reduced acid or certain GI conditions. Calcitriol is the active vitamin D, not a calcium-containing preparation, so it isn't the answer here.

3. Which pharmacologic agent is commonly used to stimulate growth hormone release during diagnostic testing?

A. Insulin-induced hypoglycemia

B. Dexamethasone

C. ACTH

D. Thyroid hormone

The question tests understanding of how growth hormone release is provoked for diagnostic testing. Insulin-induced hypoglycemia is used because dropping blood glucose is a powerful, physiologic signal that strongly stimulates the hypothalamic-pituitary axis to release growth hormone. When hypoglycemia occurs, the body increases growth hormone–releasing hormone and suppresses somatostatin, producing a robust GH surge in individuals with normal pituitary function. In someone with growth hormone deficiency, the response is blunted or absent, making this a sensitive test for assessing GH reserve. This approach is why it's commonly used in diagnostic testing. The other agents listed do not serve as reliable GH secretagogues for this purpose. Dexamethasone modulates the glucocorticoid axis rather than directly provoking GH release; ACTH stimulates cortisol production to test adrenal function; thyroid hormone affects metabolic status but does not provide a strong, standardized stimulus for GH secretion.

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4. In MEN1, pancreatic neuroendocrine tumors commonly present as gastrinoma or insulinoma. Which symptom is most characteristic of gastrinoma?

A. Refractory peptic ulcers due to excess acid

B. Hypoglycemia after meals

C. Hypercalcemia

D. Weight gain without GI symptoms

Gastrin-secreting tumors drive Zollinger-Ellison syndrome, where excess gastrin causes marked gastric acid hypersecretion. This high acid load injures the upper GI tract and leads to multiple peptic ulcers that are often refractory to standard therapy and can appear in unusual locations, along with acid-related diarrhea. In MEN1, pancreatic neuroendocrine tumors frequently include gastrinomas, so the hallmark symptom is ulcers that fail to heal because of ongoing acid overproduction. The other options don't fit this pattern: hypoglycemia after meals suggests insulinoma; hypercalcemia points to concurrent parathyroid involvement in MEN1; weight gain without GI symptoms doesn't reflect acid-mediated pathology.

5. In secondary (central) hypogonadism, what is the pattern of testosterone and LH/FSH?

A. Low testosterone with high LH/FSH

B. Low testosterone with low or normal LH/FSH

C. High testosterone with normal LH/FSH

D. Low testosterone with low LH/FSH

Central (secondary) hypogonadism occurs when the hypothalamus or pituitary fails to provide enough GnRH and gonadotropins. With reduced LH and FSH signaling, the testes produce less testosterone, so testosterone is low. Because the pituitary isn't driving high LH/FSH in response to the low testosterone, those gonadotropins are low or inappropriately normal for the level of testosterone. This contrasts with primary hypogonadism, where testicular failure leads to low testosterone but compensatory high LH and FSH due to loss of negative feedback.

6. Which of the following is a common adverse effect of long-term bisphosphonate therapy, and what administration practice helps mitigate it?

A. Esophagitis and osteonecrosis of the jaw; take with water and stay upright

B. Headache and nausea; take with food

C. Hypotension and flushing; avoid standing

D. Hyperglycemia and dehydration; take with juice

Long-term bisphosphonate use can irritate the esophagus and, with prolonged therapy, is associated with osteonecrosis of the jaw. To reduce esophageal irritation, the medication is taken with a full glass of water and the patient remains upright for at least about 30 minutes after swallowing. This posture helps ensure the pill moves quickly into the stomach and minimizes contact with the esophageal lining. Taking bisphosphonates with food or other beverages can reduce absorption and isn't the recommended mitigation, and hyperglycemia isn't a typical adverse effect of these drugs.

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7. A patient develops hypocalcemia after total thyroidectomy. What is the most likely cause and initial management?

A. Autoimmune destruction of parathyroids with high PTH; treat with teriparatide

B. Vitamin D deficiency causing hypocalcemia; treat with high-dose ergocalciferol

C. Accidental removal or damage to the parathyroid glands causing hypoparathyroidism; treat with calcium supplementation and calcitriol; monitor magnesium

D. Hypermagnesemia causing hypocalcemia; treat with magnesium sulfate

Postoperative hypocalcemia after total thyroidectomy is most often due to accidental removal or damage to the parathyroid glands, causing hypoparathyroidism and a drop in PTH. PTH is the hormone that maintains calcium by increasing bone resorption, boosting kidney calcium reabsorption, and stimulating active vitamin D production, which in turn increases gut calcium absorption. When parathyroids are disrupted, calcium falls because these pathways are blunted. Initial management focuses on replacing calcium and providing active vitamin D to enhance calcium absorption independent of PTH. This means starting calcium supplementation and giving calcitriol (the active form of vitamin D). Calcitriol helps raise serum calcium without relying on PTH-mediated activation of vitamin D. Because magnesium is essential for PTH secretion and action, it's important to check and correct magnesium if it's low, since hypomagnesemia can prevent correction of hypocalcemia and prolong dependence on calcium therapy. The other scenarios don't fit this immediate postoperative setting: autoimmune destruction would not present with high PTH, a vitamin D deficiency would be less likely right after surgery, and hypermagnesemia is not the typical cause here and would be addressed by correcting magnesium levels.

8. Which laboratory pattern is typical of primary hypothyroidism?

A. Elevated TSH with low Free T4

B. Low TSH with high Free T4

C. Normal TSH with normal Free T4

D. Elevated TSH with high Free T4

In primary hypothyroidism, the thyroid gland isn't producing enough thyroid hormone. That drop in circulating Free T4 loses the normal negative feedback on the pituitary, so the pituitary ramps up TSH production to try to stimulate the thyroid. The result is a high TSH level with a low Free T4 level—the classic lab pattern for primary hypothyroidism. This contrasts with hyperthyroidism, where TSH tends to be suppressed even if Free T4 is high, or with central (pituitary/hypothalamic) causes where TSH may be low or inappropriately normal with a low Free T4.

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9. Screening for gestational diabetes is performed at what gestational age and with what test?

A. 24–28 weeks with a 75 g oral glucose tolerance test

B. 12–16 weeks with a 50 g glucose challenge

C. 32–36 weeks with a 100 g OGTT

D. At delivery with random glucose

Screening for gestational diabetes is timed to detect impaired glucose handling when insulin resistance from placental hormones typically peaks—mid-pregnancy. Around 24–28 weeks, all pregnant patients are screened so that any abnormal glucose tolerance can be identified and managed before complications arise. Using a 75 g oral glucose tolerance test in a one-step approach, you fast, drink the glucose solution, and measure fasting, 1-hour, and 2-hour glucose values. If any of these exceed the guideline thresholds, gestational diabetes is diagnosed. This timing and test choice balance catching cases that develop in the second trimester with practical testing logistics. Screening earlier in pregnancy would miss cases that emerge later, while screening or diagnosing at delivery is irrelevant for prenatal management. A 32–36 weeks assessment with a 100 g OGTT reflects a different diagnostic pathway used in some two-step strategies, not the standard screening approach described here.

10. Which of the following is NOT a metabolic syndrome trait?

A. LDL Cholesterol ≥130 mg/dL

B. Abdominal Obesity

C. Triglycerides ≥150 mg/dL

D. Fasting Plasma Glucose ≥100 mg/dL

Metabolic syndrome is defined by a cluster of risk factors that track together: abdominal obesity, high triglycerides, low HDL cholesterol, high blood pressure, and elevated fasting glucose. LDL cholesterol is not part of this cluster, so an LDL level of 130 mg/dL or higher does not count as a metabolic syndrome trait. The other choices fit the criteria: abdominal obesity is one of the traits, triglycerides at or above 150 mg/dL is another, and fasting plasma glucose at or above 100 mg/dL is another. A diagnosis typically requires at least three of these factors present.

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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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