Submission Date	Submission Time	Question
05/24/2022	09:10:47	How is 24 hour BP monitoring done? Are the patients attached to a BP cuff all day?
		You order a 24 home (amb) BP machine -- its set up in office (our cardiology nurses for example are trained to set them up) and yes, the machine cycles at various intervals throughout day and night for 24 hours and then they turn the machine back in and a cardiologist reads it and gives you the assessment.
05/24/2022	09:14:22	Would you have a patient complete ambulatory BP monitoring prior to treatment if SBP >160 or DBP > 100?
		I think you are getting at here whether or not its 'safe' to wait to get a home assessment or if you are concerned about HTN urgency etc. We've all seen patients with very elevated blood pressures that are secondary to white coat syndrome and so the degree itself isn't that helpful. but, if you are concerned, you should ask questions to see if you might truly be dealing with something more concerning (asking about headache, chest pain, SOB) and look for end organ damage (EKG, eye exam, UA, renal panel) but if all that is negative, it would be very prudent to make sure you know what you are dealing with (true vs white coat HTN) by getting data outside of the office with home readings before potentially over medicating someone or starting someone on what is likely going to be a long term med.
05/24/2022	09:15:08	For the boards, would they give us a primary Aldo patient with a normal potassium?
		I would think this would be very very unlikely.
05/24/2022	09:17:02	At one point there was a higher BP allowance for elderly patients (>140/>90) before calling it HTN. Is this no longer a thing?
		Yes, there was at one point an 'allowance' for letting older folks ride higher, but studies like HYVET and SPRINT came out and we found that tighter control even in older folks was beneficial and so the guidelines were changed
05/24/2022	09:22:37	are there any correlations found with those with "white coat" hypertension?

		data regarding CV risk in white coat HTN are conflicting, but some data seems to show an association between increased CV risk and white coat HTN. there is literature to suggest that those with white coat hypertension have a 3-4 fold increased risk of developing sustained HTN at 7-10 years compared with normotensive patients. So, be careful of those folks who carry the label 'white coat HTN" and then their BP is just always assumed forever going forward to be white coat effect and they are never assessed in the future for true HTN.
05/24/2022	09:25:54	For screening for fibromuscular dysplasia, one should jump to screening angiography first? Not even start with renal ultrasound / arterial duplex?
		If one suspects FMD, it is most appropriate to diagnose using non invasive imaging tests --- CTA, MRA or duplex ultrasonograhy -- probably depends on local resources, or contraindications to certain tests, patient preference, expertise of the institution reading the study. for example duplex u/s should only be used as the first choice in high volume centers with expertise in this technique.
05/24/2022	09:28:59	preferred rx for fibromuscular dysplasia?
		the initial antihypertensive drug class of choice in FMD is an ACE or ARB. in patients with FMD and HTN, there are some folks who should be considered for renal artery revascularization -- those indications are for those with recent onset HTN particularly in younger patients who are less likely to have atherosclerotic disease, in whom the goal is to cure HTN and reduce med burden, or those with resistent HTN despite med adherence, those who are unable to tolerate antihypertensive meds, those with bilateral FMD or unilateral FMD and a single functioning kidney.
05/24/2022	09:31:41	would there ever be a time in HTN (such as if the BP is >20 pts above goal) when lifestyle modifications would NOT be the answer?
		I would say that lifestyle modification (DASH diet, weight loss, alcohol, reduction in alcohol/smoking) should always be part of the regimen to manage HTN, but might not be appropriate as the sole/only treatment in those with end organ damage (in those folks, medications are also going to be part of the picture).
05/24/2022	09:35:57	what is the physiology of how weight impacts BP?

		likely multifactorial, but losing weight for example causes a reduction in plasma renin activity and a decrease in sympathetic tone may also be involved.
05/24/2022	09:43:47	A lot of radiology guidelines have started saying iv contrast does not cause AKI. Have IM guidelines reflected this?
		As the contrast agents have evolved there is conversation that risk for contrast induced nephropathy -- however, for the purposes of the board would still consider this in the differential in the appropriate question stem.
05/24/2022	09:45:34	What's a normal kidney size on US?
		This varies a bit based the size of the patient/gender. A number that is out there is ~ 11 cm +/- 1 cm..... but that is a frame of reference.
05/24/2022	09:47:07	will they test us based on retina pictures do you think?
		If you are given a picture it will likely be in the context of a clinical scenario and often they can be used together to answer the question.
05/24/2022	09:50:30	What is the normal range for ARR (PAC/PRA = ARR) ?
		This may vary a bit based on the labs and for the boards normal ranges are provided-- using MKSAP 19 as a reference the range offered is a PAC/PRA greater than 20 with a PAC of at least 15 ng/dL is considered a positive result-- using a midmorning seated sample from the patient.
05/24/2022	09:57:35	in the outpatient setting, how can we determine end-organ damage to assess if BP is too high for them (some are chronically high)?
		You would rely more on clinical judgement which for sure would also incorporate symptoms.
05/24/2022	10:02:38	Why is urine cytology not good to do?
		It has a relatively low sensitivity and high cost so not a well suited test to screen for bladder cancer
05/24/2022	10:05:00	Could you explain again how increasing oral calcium could be helpful in a patient with recurrent stones?

		This depends a bit about the type of stones-- in general even in calcium containing stones calcium may not be the driving problem. As an example, calcium in the diet binds with other agents (like oxalate) and in doing that prevents the oxalate from being absorbed--> less oxalate in the circulation then results in less oxalate excreted in the urine so it can't precipitate into a calcium oxalate stone in the kidney.
05/24/2022	10:05:54	is there any preferred med for renovascular hypertension in the older atherosclerotic group?
		In these cases would follow the guidelines for management of JNC guidelines for management of HTN.
05/24/2022	10:08:00	What are the new trials that finally proved that there is no benefit for starting different antihypertensives based on race, I would love to show my clinic attending.
		There is increased awareness that "race" is a construct that has been created-- and not based on biology. Hence, the need for medicine to move away from "race" when considering decisions for our patients.
05/24/2022	10:09:29	is cal PAC/PRA is direct calculation or requires unit conversion or done directly by the lab?
		Normal ranges are provided for the boards-- in clinical medicine it is important to understand the measurement that is done in your individual labs. There can be times when you need to standardize the measurements before you look at the ratio.
05/24/2022	10:10:52	a pt that comes to the office with a headache and bp>180/100 Should the pt be given a bp med and monitored in the office for 1 hour and if not ,<25% then sent for admission?
		This can be a challenging question and depends a bit on the description of the headache, frequency, etc. There may be times when if it is the worse HA they have ever had when you may not want to treat/wait in the office.
05/24/2022	10:13:15	Why would it be kidney U/S and not bladder?

		At our hospital we do have the ability to do a bladder scan at the bedside which can give you a quick assessment of bladder volume-- that is a reasonable first step but wasn't an option in the stem. A formal renal US will also give you an assessment of bladder volume for us-- if at patient has hydro they will also comment on bladder distension.
05/24/2022	10:19:52	How long before an obstructive uropathy results in permanent renal damage? Is there a typical timeframe for critical catheter placement?
		Like most things, this depends on several factors. Complete or prolonged partial obstruction can lead to tubular atrophy, interstitial fibrosis and eventually irreversible renal injury and the prognosis is dependant on the severity and duration of the obstruction. With total ureteral obstruction, there is evidence that relatively complete recovery of GFR can be achieved if obstruction is relieved within one week, while little or no recovery occurs after 12 weeks. so, the sooner this can be discovered/relieved the better. the course of partial obstruction is less predictable and dependent on pre existing renal disease or other complicating factors.
05/24/2022	10:22:16	can you explain the physiology of postobstructive diuresis
		post obstructive diuresis is primarily a problem with chronic, not acute urinary retention and usually represents an appropriate attempt to excrete excess fluid retained during the period of obstruction.
05/24/2022	10:26:14	how do we treat with contrast induced nephropathy
		Supportive care-- work to keep them euvoluemic, dose meds based on GFR and work to minimize the risk of a second insult-- and if develop indications for dialysis you may need to support the patient in this way.
05/24/2022	10:28:47	Is there anything you can do to treat ATN? Diuresis?
		ATN often requires time and supportive care-- we work to avoid a second insult and to keep the patient euvolemic. Use of diruetics can be tried in the setting of volume overload to help with volume management while you wait for the tubular cells/kidney to recover.
05/24/2022	10:32:12	are there questions with FeNa for diagnosis

		There may be questions that offer a FeNa on the boards-- in those settings though it will be important to also look at the clinical data presented around it. As an example, a FeNa <1% is commonly thought to be prerenal-- but can also occur in the setting of hepatorenal or CIN-- and in those setting IVF may worsen the patient't status.
05/24/2022	10:40:45	for boards Empagliflozin also is an answer??
		that specific med wasn't an option for that question -- the med class here would be most important to consider
05/24/2022	10:41:35	NS and statins; Do you routinely start statins in NS or you follow the guidelines?
		for a board exam, remember, the answers they are looking for would be to follow guidelines
05/24/2022	10:43:22	can you restate why the albumin-creatinine ratio can "improve" later in diabetic kidney disease?
		Improvement in the pressure gradient across the glomeruli with treatment.
05/24/2022	10:46:49	For ABIM, which target do we use for BP control in diabetics?
		ABIM won't ask you a question where you have to decide between multiple sets of guidelines-- high stakes exams like this offer question where there is a single best answer and have done testing on those questions before they use them for scoring purposes.
05/24/2022	10:55:07	What is the magic gfr number for renal transplant referral?
		Qualify if <20 -- Dr. Mariani suggested as an example though that she will refer prior to that threshold to get the "to do" list started.
05/24/2022	11:02:00	are there lot of questions on the different glomerulonephritis, or we need know about biopsy findings or path findings on boards?
		We don't know the specific questions that will be used on the boards.
05/24/2022	11:16:47	What's the reasoning for diaylsis in Malnutrition?

		Uremia can lead to changes in taste and appetite suppression which then leads to weight loss and malnutrition. Initiation of dialysis in this setting can be tried to improve intake-- it doesn't always work but can be worth a conversation with the patient and nephro re: a trial.
05/24/2022	11:22:45	can you comment on PPI dose in CKI
		In general, PPI do not require dose adjustment- there have been cases where PPIs have been associated with acute interstitial nephritis which is not dose dependent. And there have been cases where PPI use has been associated with CKD-- in this setting though it is an association and has not clearly been determined to be a causation of the CKD.
05/24/2022	11:28:49	why avoid erythropoiesis agents if history of CVA?
		The mechanism of increased CV risk, including stroke with the use of epo is not well understood.
05/24/2022	12:14:21	In respiratory acid base how do you account for an abnormal baseline PCO2.
		And on that note how do you figure out Acute vs chronic if you don't have a baseline CO2? Just based on PH?
05/24/2022	12:17:46	What about the role of vitamin D deficiency and any increased risk of renal stones?
		Usually I worry about high vitamin D (causing increased urine calcium) as a risk factor for stones.
05/24/2022	12:21:48	What are your thoughts on Renal Denervation for patients with resistant hypertension without a secondary cause?
		This is still under study at this point. Trials have been mixed. So, I am not recommending at this time.
05/24/2022	12:22:54	How much nephron get injured in a regular single kidney biopsy ? How many kidney biopsies can a person get from single kidney during a lifetime??
		biopsy typically only samples about 15 glomeruli. Each kidney has about 1 million glomeruli. So, not really a risk to kidney function.
05/24/2022	12:23:40	is there any benefit in IV hydration before contrast load to decrease contrast induce nephropathy

		making sure euvolemic is probably all you need. IV hydration probably not needed. Just don't want people hypovolemic
05/24/2022	12:24:13	what age range is considered as "young women" for fibromuscular dysplasia?
		It's a good question! Probably <30, but I think pre-menopausal is worth considering.
05/24/2022	12:24:52	treatment for type 2 HRS??
		Largely supportive - avoiding AKI, optimizing volume status, Transplant!
05/24/2022	12:26:39	what would be a good reason to do 24 hr urine collection for protein
		Good to do if UPCR seems inaccurate - fluctuating a lot between measurements, extremes of muscle mass making the ratio incorrect. Or, if on the threshold of a treatment decision and need a really accurate measurement
05/24/2022	12:27:36	do you think we will see SGLT2 inhibitors for renal protection without HTN, ie in solitary kidney, post transplant?
		it does seem to be protective despite cause of CKD. Data in IgA is pretty convincing. So, I think it may be helpful in these other settings. Data on transplant is lacking currently.
05/24/2022	12:28:32	So what is the target Hgb for Hx of CVA is it less then 10?
		If history of stroke, I would avoid ESA. Instead use iron and intermittent transfusion first. If end up using it, I would aim for 9-10
05/24/2022	12:29:04	How does thiazide help DI?
		forces urine osm to be higher (and excrete less water). And, also cause mild volume depletion which will decrease total urine volume (decrease delivery of salt and water to distal nephron)
05/24/2022	12:33:10	Is SIADH dx by urine osm > serum osm or by just urine osm > 100? Assuming all other labs also fit (high urine sodium)

		you are right that you need all the data - serum Na, urine Osm and serum Osm. I usually also get urine Na and K to calculate fraction of urine which is water. Then you can prove that the urine is inappropriately concentrated. You are right though, that urine osm high in the setting of hyponatremia, it's in appropriate whether it's higher than serum osm or not.
05/24/2022	12:33:53	What about oral urea for treatment of SIADH?
		It is potentially effective by causing an osmotic diuresis and water loss. Just unpredictable to titrate and hard to obtain.
05/24/2022	12:34:41	For cirrhosis and hyponatremia, when do you stop diuresis and worry about HRS and give albumin bolus?
		I decide based on eGFR. So, if creatinine is rising, I would worry about HRS. Otherwise if just hyponatremic, then you can continue diuresis and water restriction.
05/24/2022	12:36:24	referring Q16, does shifting potassium intra-cellularly before emergent dialysis impede your ability to definitively correct potassium?
		Great point! Potentially yes! This could make the rebound after dialysis worse and limit our ability to remove the potassium (if we dialyze against a normal serum potassium due to the shift then we will remove less total potassium). But, if EKG changes, you really have no choice. "Emergent dialysis" won't work within minutes. Takes time to get the machine ready and will take a couple hours to normalize potassium.
05/24/2022	12:38:13	Can you go over trans tubular potassium gradient and when it’s used
		Potassium to creatinine ratio in the urine is pretty good. TTKG can be used in hyperkalemia, but didn't validate well after initial studies.
05/24/2022	12:38:55	why should Kayexalate be avoided in o ut patient?
		You can use kayexalate, but will be too slow to address EKG changes. So, need something faster. And, if getting dialysis, that will be much better (and less side effects) for removing potassium.

05/24/2022	12:40:15	Is there any truth in this practice— in the facility where I work I have been cautioned by our pharmacist to give glucose and amp of D50 in patient's whose serum glucose is low— like less or equal to 100– when correcting hypoerK. Is there any truth in this?
		you are right, that this is prophylactic and absolute use of glucose may vary by patient.
05/24/2022	12:41:15	Would a urine sodium of 45 mEq/L after vomiting/orthostasis contradict the expected physiologic response? Metabolic Alkalosis question.
		you are right, in volume depletion, you typically have low urine sodium. Vomiting is a special case - non-absorbable bicarbonate drags so sodium with it.
05/24/2022	12:41:47	in Q17 why the urine sodiumlevel was given, is that a clue/
		pretty classic range for vomiting
05/24/2022	12:43:43	Can you explain urine potassium/Cr ratio again
		similar to fractional excretion of sodium. Tells you whether the kidney is excreting potassium appropriately. So, high urine potassium/creatinine means kidney is excreting potassium (appropriate in hyperkalemia, inappropriate in hypokalemia). So, low potassium/creatinine ratio in setting of hypokalemia means it is not renal wasting.
05/24/2022	12:48:27	What is the typical range for normal urine anion gap?
		Depends on diet, but typically -20 to -50
05/24/2022	12:52:09	so which guidelines we follow for board exams purposes
		Where there are competing guidelines a high stakes exam like the boards needs to write questions where there is a single best answer and because of that will not offer/be able to ask you to choose between two options that are in conflict.
05/24/2022	12:52:25	so for board exam purpose do we pick 45years for average risk as its changed now?
		yes
05/24/2022	12:54:56	How do you do HPV testing alone? Doesnt it still need a Pap smear? Or is it a blood test?

		Why would you ever do HPV+pap testing if you can just do HPV alone for people above 30?
05/24/2022	12:56:27	For the boards- in the average risk- will the age group be 45 or 50 for colon cancer screening?
		this is a fairly newer recommendation, so not sure if the boards will have incorporated this new recommendation into its questions or even ask about this because of that, and I don't have knowledge of what is or is not on the exam, so I can't comment on this one way or the other. if you are asked, would give the current recommendations.
05/24/2022	13:00:02	How do you do HPV testing alone? Doesnt it still need a Pap smear? Or is it a blood test?
		you can do the HPV testing during the pelvic exam and there have some papers that suggest that the most helpful test in folks over 30 is the HPV test to be able to triage risk etc.
05/24/2022	13:00:24	I thought we are starting PAP smears at age 25 now (rather than 21yo)?
		the current recommendation is still to start at 21
05/24/2022	13:02:14	As African Americans are considered higher risk in general, is the recommendation to be screened at age 40?
		is this for CRC screening? the recommendation is that 45 is for all folx except those with the risks that Dr. James mentioned (personal, fhx, h/o XRT to abdomen etc)
05/24/2022	13:03:32	What is the risk of cervical cancer if the couple is in monogamous relationship throughout the life (HPV risk is low)?
		HPV is considered an STI, but there are factors that one might know about in relationships that might cause someone to be exposed to HPV (unknown issues with fidelity of partner etc) and to err on the side of safety etc, would still recommend screening every five years for folx 30-65.
05/24/2022	13:04:00	why is is average age of incidence of CRC decreasing?
		likely related to environmental factors
05/24/2022	13:04:51	Any screening recommendation for pancreatic cancer?
		not for average risk people

05/24/2022	13:06:31	Do we also employ annual lose dose CT scan for lung cancer screening in people who vape within the last 15 years?
		the current protocol/recommendations apply only for those who have smoked 'regular' cigarettes
05/24/2022	13:09:00	When would you consider Breast MRI??
		there are no data from RCTS that show a benefit of screening by MRI in women at average risk for breast cancer. sometimes your genetics consult team will recommend in an alternating fashion with mammography for certain folks at high risk
05/24/2022	13:10:35	Which guidelines will ABIM Board exam use for cervical cancer screening? Because ACS states starting at 25 years of age (and what we use in my practice as well). (sorry to duplicate this question, but previous answer still confusing to me - Thangs in advance!)
		Where there are competing guidelines a high stakes exam like this the boards needs to write questions where there is a single best answer and because of that will not offer/be able to ask you to choose between two options that are in conflict.
05/24/2022	13:12:36	Are Guidelines for ABIM boards based on USPSTF recommendations or ACS/ or other organization's recommendations
		Where there are competing guidelines a high stakes exam like the boards needs to write questions where there is a single best answer and because of that will not offer/be able to ask you to choose between two options that are in conflict.
05/24/2022	13:20:45	Should that slide say all patients above 65? (slide 311 regarding pneumococcal vaccination)
		Thanks for pointing this out-- you are correct. We will correct for the audience after the break!
05/24/2022	13:23:48	Is prevnar 13 no longer used? What about someone who got prevnar 13 before- do they need revaccination with the 15?
		This correct. Prevnar is no longer used. Note that Prevnar has 13 components, compared to the 20 in PCV 20. Therefore, you are getting broader coverage with PCV20. Yes. They should be vaccinated with either the PCV20, or PCV15 and PPSV23 vaccination schedules.

05/24/2022	13:26:57	Are patients on HD considered immunocompromised needing PCV?
		I suggest considering patients receiving HD within the category of CKD. Therefore, patients with a history of chronic kidney disease. Because they are included in the individuals that should be vaccinated, I would recommend PCV.
05/24/2022	13:28:09	Acip recomendation for pneumococcal vaccination still seems to be 65 years of age, not 60.
		You are absolutely correct. This is a mistake in the packet, and an oversight on my part. My apologies. I will address this during the next session.
05/24/2022	13:55:31	for known dense breasts undergoing breast cancer screening, do we always order the digital mammo (rather than the screening)?
		yes, for women with dense breast tissue digital mammo would be preferred when available.
05/24/2022	13:57:26	did I hear correctly? Birads 4 or greater OR palpable mass get automatic breast biospy?
		If palpable mass even if not visible on imaging you want to biopsy to be sure you aren't missing something. And then BIRADS 4 is the category that radiology uses to signal that the finding is suspicious for malignancy and biopsy should be considered.
05/24/2022	13:59:03	for known dense breasts undergoing breast cancer screening, do we always order the digital mammo (rather than the screening)?
		It's still screening--not diagnostic
05/24/2022	14:04:27	If pt meets criteria for lynch syndrome but has neg genetic test, do still do scope every 2 years starting at age 20?
		This is a bit nuanced-- the presence of the pathogenic genetic defect is part of the diagnosis of Lynch syndrome-- a patient may fulfill Amsterdam criteria for clinical suspicion for Lynch syndrome--> which then leads to genetic testing--> but if negative do not have the diagnosis. At that point would have a conversation with the genetic counseling and oncology teams re: how best to screen.

05/24/2022	14:05:58	for known dense breasts undergoing breast cancer screening, do we always order the digital mammo (rather than the screening)?
		correct-- would be screening with digital mammo rather than film screening.
05/24/2022	14:18:34	Why is the average age of the incidence of CRC decreasing?
		Likely related to environmental factors
05/24/2022	14:19:34	What was the error the speaker just mentioned?
		Pneumoncoccal vaccine for all patients starting at 65-- rather than the slide that states for all patients start at 60 (the line about 19-64 for immuncompromised is correct)
05/24/2022	14:31:25	should immunocompromised patients be getting high dose flu vaccine?
		high dose influenza vaccine is preferred given then increased likelihood of developing a more robust immune response, however using the standard dose is also reasonable
05/24/2022	14:32:58	Did Pfizer stopped production of Chantix
		They recalled it due to potential increased risk of cancer
05/24/2022	14:34:34	For CRC screening, the FH of tubular adenoma <60 is equivalent to CRC for screening?
		The US multi society task force on CRC recommends that if there is documentation that a first degree relative had an advanced adenoma (greater than 1 cm, or with high grade dysplasia, or with villous elements or required surgical excision) that this should be weighed the same as a first degree relative having CRC when suggesting screening programs
05/24/2022	14:38:41	if patient had Varicella vaccine and never had chicken pox, does he still need shingles vaccine after age 50?
		The ACIP states that shingrex may be used in patients who received the chicken pox vaccine since herpes zoster due to the vaccine strain of the virus has been reported, however there are no data on the efficacy of shingrex in reducing vaccine strain herpes zoster
05/24/2022	14:42:00	Why should buproprion not be used with eating disorders?

		for some reason, people with a h/o anorexia nervosa or bulimia seem to be more likely to experience seizures on this med
05/24/2022	14:43:08	dont prescribe buproprion for ANY kind of eating disorder? what about binge eating disorder?
		for some reason, this med is associated with increased risk of seizures in patients with a h/o anorexia nervosa and or bulimia. the labeling only lists those two eating disorders
05/24/2022	14:44:29	Did Pfizer stopped production of Chantix
		yes --- they stopped the global production of chantix due to higher levels of nitrosamines
05/24/2022	14:46:42	Do you think they will ask about specific SSRIs that are approved for conditions or just be able to pick the right class of medication for the question? For example, for PMDD I believe Fluoxetine, Paroxetine, & Sertraline are the main SSRIs that are FDA approved. Thanks
		I don't know for sure what will be/will not be asked, however would be aware of contraindications for certain meds or when you wouldn't choose a certain med (like avoiding paroxetine in people who could be pregnant) or avoiding buproprion in patients with h/o seizure d/o for example. I think this is more likely to be tested than asking about specific prescribing which is more of an art in a certain class of drugs.
05/24/2022	14:48:39	Is mirtazapine safe for geriatric patients?
		mirtazapine might be appropriate for an older adult --- for example we use it in our older adults who need help with appetite stimulation who also may be depressed with weight loss. often in older adults we start at lower dose like 7.5 mg/day.
05/24/2022	14:52:14	Since Verinicline is no longer available, does the boards want you to recommend it?

		i wouldn't recommend anything on a board exam answer that you wouldn't also recommend in real life. I think that is the best bet. the FDA made an update on 5/5 of this month saying that the FDA is now confident in manufacturer's ability to supply patients with this med with levels of the impurity at or below the agency's acceptable intake limit. they say that 'any newly manufactured vareniciline for the US market should have levels of N-nitroso-vareniciline impurity at or below that limit."
05/24/2022	14:53:39	Do you check GeneSight test if pt is not responding to many antidepressants . ?
		This would be out of scope for something ABIM would ask.
05/24/2022	14:54:48	Which patient would get ECT vs Esketamine? How would we differentiate those patients on the test?
		On a high stakes exam like the ABIM the questions need to have a single best answer-- you would likely not be asked to choose between these two.
05/24/2022	14:56:01	Is phenobarbital considered 1st line therapy for acute alcohol withdrawal, or are only benzos considered 1st line?
		Would consider benzos first line and the answer for ABIM purposes.
05/24/2022	14:58:53	what are key differences between naloxone and naltrexone?
		Naloxone=acute overdose and reversal. Natrexone=slower onset, longer action and for treatment of alcohol use disorder or opioid dependence.
05/24/2022	15:04:06	Do you think they will ask about specific SSRIs that are approved for conditions or just be able to pick the right class of medication for the question? For example, for PMDD I believe Fluoxetine, Paroxetine, & Sertraline are the main SSRIs that are FDA approved. Thanks
		Thanks!
05/24/2022	15:18:26	What is the main differences btn pcv 20 vs the olders ones
		For the PC13 we have fewer strains covered compared to the PCV20. For the PPSV 23 you are only targeting capsular components of the bacterium. However, for the PCV20 you are targeting both capsular and surface protein components which will provide a stronger immune response.

05/24/2022	15:30:18	Is prednisone not given for hyperthyroidism? I remember mnemonic of 3Ps: propranolol, PTU and prednisone
		Pred is sometimes used for treatment of Graves orbitopathy-- not necessarily for the hyperthyroidism piece.
05/24/2022	15:38:12	increaseing 30% of levo in pregnancy in 1st trimester, correct? And what about the following trimesters?
		Further adjustment based on lab follow up of TSH and free T4 which should be followed throughout pregnancy
05/24/2022	15:39:16	**For central hypothyroidism you cannot monitor treatment with TSH correct? Check T3 and Free T4 instead?**
		Correct-- central hypothyroid will have a low TSH and therefore not able to follow to determine.
05/24/2022	15:40:10	What is euthyroid sick syndrome? Is that same as nonthyroidal Illness syndrome?
		Yes
05/24/2022	15:42:21	when defining as sublclinical hypo- or hyperthyroidism, is there TSH cutoff? or is it low normal or high normal levels?
		TSH that is up/down and normal T4
05/24/2022	15:44:17	how long does a subclinical hypothyroid typically take to normalize?
		Risk of overt hypothyroidism is 2-4% per year. TSH will normalize in 1/3 of patients.
05/24/2022	15:46:10	Fatigue is nonspecific but does not qualify as symptomatic for treatment of sub clinical hypothyroidism?
		In this question stem the patient had fatigue and elevation in TSH which was unchanged from 2 month which is why the answer was to continue to follow TSH levels.
05/24/2022	15:54:27	Is prednisone not given for hyperthyroidism? I remember mnemonic of 3Ps: propranolol, PTU and prednisone
		For thyroid storm. Not all hyperthyroidism
05/24/2022	15:58:31	Is there a reason why propranolol is used in thyroid storm over atenolol/metoprolol?
		Decreased conversion of T4->T3

05/24/2022	16:48:04	Why not OGTT for Q7?
		It may add more confusion to the situation-- in the setting of two tests where one is normal and the other is abnormal the rule of thumb is to repeat the abnormal test in order to clarify.
05/24/2022	16:53:58	You can give metformin for prediabetes?
		yes. metformin was found in the diabetes prevention program trail to reduce the rate of progression to type 2 DM compared with placebo and was most helpful in those who were more overweight/obese and younger
05/24/2022	16:57:12	Is it okay to start a GLP1 instead of metformin as a first line agent for T2DM?
		most of us (and this is supported by labeling/guidelines) would use GLP1 agonists as an adjunctive agent or alternative monotherapy for patients in whom initial therapy with lifestyle intervention and metformin failed or who cannot take metformin. metformin, given its safety profile, low cost, and benefits should be first line unless otherwise contraindicated or can't be tolerated.
05/24/2022	17:01:24	is it a good rule of thumb to say A1c% targets coincide by decade of life? eg, 7% for 70s, 8% for 80s
		a1c targets should be determined based on patient characteristics -- you may have a younger patient who has limited life expectancy and severe comorbidities and then you may want to have a goal only of avoiding hypoglycemia and severe hyperglycemia and have a target therefore of less than 8.5%. Or you may have a healthy older adult who is doing really well and has life expectancy of greater than 10 years and you may target a a1c of less than 7.5 percent.
05/24/2022	17:03:58	q9 what about gabapentin?
		this would have been reasonable but it wasn't offered as an answer choice
05/24/2022	17:04:36	Q9 ,METFORMIN CAN GIVE DEFECIENCY OF B12 ETC
		yes, but as Dr Sandouk just said, you are more likely to see that after years of metformin and in this case the patient hadn't been on metformin that long
05/24/2022	17:08:39	Q9 ,METFORMIN CAN GIVE DEFECIENCY OF B12 ETC

		Point well taken, it's just a different logic than many Qs where you diagnose before treating.
05/24/2022	17:22:54	can to take dd4 and glp1 together
		combination therapy with GLP1 receptor agonists and DPP4 inhibitors does not provide additive glucose lowering effects and thus the combination should be avoided.
05/24/2022	17:33:15	In practical sense when do you stop insulin drip? When AG normalizes or after ketones are cleared? Because i have had pts who still have remain sick even after AG is closed
		From the purposes of managing DKA when the gap closes you can give long acting and stop the drip/let them eat. However, in clinical practice if they are still feeling unwell and you are concerned they are not able to tolerate PO you may want to continue the insulin gtt and decide based on clinical course when to make the conversion.
05/24/2022	17:35:02	will we ever be tested on HHS patients and what to do when their serum glucose and osms drops too fast putting them at high risk of cerebral edema?
		One can imagine this is testable in the vignette scenario where you are given a patient with HHS--- note that the glucose falls quickly and the patient becomes altered and you may need to be able to identify the risk of cerebral edema in a setting like this.
05/24/2022	17:38:31	Can you explain pseudo hypercalcemia again
		Serum calcium is high-- but ionized calcium normal. 50-60% of calcium is protein bound-- so in the setting when proteins are up you may get a higher total reading. It is the calcium that is ionized that is the physiologically active component and in this setting testing the ionized calcium is the number that you want to know.
05/24/2022	17:39:21	Q10 in multiple myeloma is the circulating calcium bound to the extra immunoglobulins, hence high Ca an normal ionized. Is bone destruction from plasmacytomas a factor in this case?
		Lytic lesions lead to true hypercalcemia-- high serium Ca and high ionized calcium.
05/24/2022	17:41:53	If total calcium is high and ionized is normal, what does that mean?

		This is the clinical scenario where you think about elevated protein (in the question stem immunoglobulins)
05/24/2022	17:46:34	Can you clarify the statement that aspirin is no longer recommended for secondary prevention of CVD in Diabetic patients
		sorry -- I think that slide had an error. asa for secondary prevention still makes sense and would be recommended.
05/24/2022	17:47:47	How about Gestational diabetes? do you treat as life long dm
		would not consider gestational DM as a lifelong diabetes diagnosis -- but recognize that those folx have a higher lifetime risk of developing type II DM than people who don't have this history, so should be counseled and monitored appropriately.
05/24/2022	17:51:17	Question 11 - she has some SIRS criteria, wouldn't you get a CBC as well? Could be i.e., a perfed appy in addition to DKA accounting for some of the symptoms.
		If there had been an answer choice that included both a CBC and an ABG and electrolytes that would have been preferred, but that answer didn't exist here. the main thing was recognizing that this pt could have DKA and you will need to calculate her anion gap and check an ABG. neither choice C or D (which contained a cbc option) had an ABG or full electrolytes to be able to calculate her gap etc.
05/24/2022	17:52:12	Can you please clarify your last statement about the role of ASA for secondary prevention?
		I think that was an error. using aspirin for secondary prevention still is recommended.
05/24/2022	17:55:47	is there a serum level of PTH that would indicate parathyroidectomy (for primary PTH)?
		the decision to pursue surgical treatment for hyperparathyroidism depends not on total level of PTH but other indications -- like age less than 50 (if asymptomatic), decreased GFR, total calcium 1 mg/dl above reference range, osteoporosis, hypercaluria (24 hour urine calcium greater than 400 mg/dl, h/o stone etc
05/24/2022	18:00:33	I though monofilament test = pinprick test for small nerve fiber testing -- what am I getting wrong here?

		monofilaments are fibers that are calibrated so that if a force of 10 grams is applied to the extent that the monofilament is bent but the patient does not feel it, then that point is considered insensate. this is a different tool that just using a safety pin for example.
05/24/2022	18:01:53	What is difference between T score and Z score again?
		The T score is a comparison of a person's bone density with that of a healthy 30 year old of the same sex. the z score is a comparison of a person's bone density with that of an average person of the same age and sex.
05/24/2022	18:08:34	Can you touch on the risk of PPI associated osteoporosis?
		an association between PPIs and fracture is plausible, however many observational studies do not prove causality. further studies investigating the relationship between PPIs and fracture are required.
05/24/2022	18:09:35	If z score less than-2, do you do treat as osteoporosis?
		if using Z score alone to diagnose osteoporosis, the criteria is to have a z score less than 2.5.
05/24/2022	18:12:49	After how long do you repeat DEXA when you start bisphosphonates to evaluate response to therapy?
		there are several published guidelines for monitoring the response to osteoporosis therapy and all recommend f/u BMD (dexa) testing, however there is no consensus on the optimal frequency of monitoring and preferred site to monitor, so given this, would not expect a question like this to appear on the boards.
05/24/2022	18:16:38	is treatment different for proliferative or non proliferative for sake of board testing?
		in my opinion, this type of question would be unlikely to appear on an IM board given it seems out of scope (we wouldn't expect an internist to make a decision on a case like this). as you know, non proliferative DR often doesn't get treated unless there also is DME. proliferative DR is treated with the anti VEGF meds
05/24/2022	18:22:47	z score of less than 2 is the criteria for osteoporosis treatment?

		treatment can be based on using FRAX score, or Z score (Z less than 2.5), or the diagnosis of clinical osteoporosis (osteopenia plus a fragility fracture should be considered then clinical osteoporosis) and be treated
05/24/2022	18:27:20	to confirm: Osteopenia can be diagnosed (without DEXA) for (1) fragility fracture (2) vertebral compression fx or (3) hip fracture (from falling?)?
		osteoporosis can be diagnosed either with a score of less than 2.5 at any site on BMD on DEXA, OR fragility fracture (particularly at the spine, hip, wrist, humerus, rib and pelvis)
05/24/2022	18:32:08	so how would that change our management with the 2hour postprandial glucose levels, increase determir, add short acting or add exenatide?
		The question stem here is suggesting by the glucose reading you have that the A1c should be fine.... but it isn't so we need to figure out why the A1c is tracking higher. This higher A1c suggests that we are missing those higher numbers-- if we can confirm high postprandial then treatement would be either that the patient needs to have less carbs with meals or they need something added that will help with the spike postprandial.
05/24/2022	18:33:09	how do you handle dosing of those on SGLT2 or GLP1 that continues to lose weight (& thus improve their A1c)? do you incrementally wean down? do you stop when A1c normal?
		This is partially dependent on other comorbitities-- if the patient has CKD or HFrEF then they have indications to continue this medication and in those settings would not plan to stop them.
05/24/2022	18:34:17	How common is euglycemic DKA on SGLT2 inhibitors
		It can happen and should be considered in the clinical setting when the patient has an anion gap metabolic acidosis even when the glucose is normal.
05/24/2022	18:37:49	Would you give bicarb even if it’s only AGMA and there is no delta gap? Also is normal saline given over LR in setting of metabolic acidosis?

		Additional bicarb can lead to metabolic alkalosis as the acid leading to the gap is metabolized. In the setting of extreme pH suppression (and often the patient may tell you they feel short of breath as they are breathing fast in the attempt to compensate) may be a reason to try bicarb in the short term. NS vs. LR are both colloids and fine to use-- in this setting they are used for volume resuscitation.
05/24/2022	18:40:02	Can you speak a little bit to testing for adrenal insufficiency for people in icu for example septic shock
		AI is important to remember in patients who are critically ill-- particularly in the setting of a patient who has been given fluids and/or pressors and not having an improvement in clinical response. Often in this setting stress dose steroids are initiated as a diagnosis that you don't want to miss and testing can be done at a later time.
05/24/2022	18:45:37	Would you get a prolactin level as well for gynecomastia?
		this test isn't recommended for the first line workup of gynecomastia unless you find hypogonadism in your workup
05/24/2022	18:50:50	FOr Q16, why would you test for plasma metaneprhine if person is asymptomatic and electrolyte normal?
		the indication to do biochemical testing for pheo is that the adrenal lesion has an attentuation value of greater than 10 Hounsfield units
05/24/2022	18:52:36	What level of TG was associated with pancreatitis?
		progressively increases after 500 however in reality it is rare to see TG associated pancreatitis unless TG are over 1000
05/24/2022	19:03:33	U ORDERED FENOFIBRATE AND THEN DID U STOP STATIN OR NOT?
		No you do not stop the statin-- fenofibrate added for the TGs
05/24/2022	19:12:47	if this is functional wouldn't we have other symptoms or signs of pheochromocytoma?
		It may but the question was targeting the testing the concept of evaluation of an incidental adrenal nodule with high Houndsfield units.