ACP Internal Medicine Board Review Questions and Answers -Thursday May 15, 2025

Can you explain impedance pH testing more?
Impedance pH testing is a procedure that evaluates GERD- it involves measuring both the acidity and the physical properties of refluxate in the esophagus. This technique combines pH monitoring with impedance measurement to detect reflux episodes regardless of their acidity-- this makes it particularly helpful in patients with GERD that is resistant to PPI therapy as it can detect reflux episodes that are nonacidic

If there is a partial PPI response after eight weeks, do you perform EGD to rule out other etiologies and then do PPI twice daily?
Yes, this would be a situation where looking for another etiology is important and EGD can be helpful.

Urea breath vs stool antigen test, which one to choose if provided in the question stem, as the best test?
It is unlikely they would have you choose between two options with similar efficacy in a high-stakes exam.

Can you use a urea breath test to demonstrate eradication of H. Pylori after treatment?
Yes, eradication testing can be done endoscopically, with a breath test, or a fecal antigen test

For H. Pylori treatment, should we use tetracycline or doxy as a first-line therapy?
Substituting doxycycline for tetracycline significantly reduces effectiveness. For example, a 14-day tetracycline-based achieves eradication rates of approx 87%, whereas doxycycline reduces this to 70% in one study I found.

Is H. pylori always symptomatic before complications arise? Is there discussion on screening asymptomatic, endemic populations for H. pylori?
There is not currently a lot of data on screening asymptomatic populations. There is some data to screen patients with other symptoms (unexplained iron def anemia, MALT lymphoma, hx of previous PUD)

You mentioned _____ gut syndrome. What was the word you used when discussing Q9 question stem?
Foregut

For Q9, if there wasn't vomiting, would option C be correct?
We look for structural lesions first-- and the variability of gastric scintigraphy study has limitations

Can you comment on h pylori treatment with rifabutin and amoxicillin duration dose etc?
14 days and in combo with a PPI

Your approach to H pylori treatment challenges - rx side effects preventing optimal rx course, drug-resistant H pylori?
As Dr Micic highlighted, drug resistance is a concern, which is why the quadruple therapy is now first line again as opposed to the clarithromycin-based triple therapy. Balancing optimal treatment with possible side effects is difficult and should involve a discussion with the patient, likely beyond the scope of this board review course.

Any role for Sennakot-s for constipation in patients with IBS-C? Or suppositories?
Good question, this is what I could find: evidence supporting its efficacy in IBS-C specifically is limited, with only 1 small RCT available, which mainly studied its use in chronic idiopathic constipation (CIC) rather than IBS-C. Senna-S is associated with potential side effects such as abdominal cramping, diarrhea, and the need for dose adjustments, and there is a lack of long-term safety data, making it less favorable compared to other option.

What does CIC 2 stand for on slide 5?
Sorry- for slide 10 it is actually the chloride channel that the medication acts on

How does functional hypersplenism occur with Celiac's dz?
This is not fully understood, but it occurs in about 1/3 of patients. It's thought to be related to the chronic inflammatory state and immune dysregulation

How do we screen for PSC in Crohn's disease on the previous slide?
This can be done with a combination of LFTs, GGT, and MRCP.

For Crohn's/ inflammatory disease, fecal calprotectin indicated. is there any use/recommendation for fecal lactoferrin? Is calprotectin superior to lactoferrin?
ACG indicates it can be used in conjunction with calprotectin for disease monitoring. I could not find data comparing the two.

Can you get away with monotherapy for Crohn's with budesonide?
Good question. For mild disease, monotherapy with budesonide can be used for induction but is generally not recommended for maintenance.

Can a patient have tenesmus with IBS?
yes

Would you recommend fiber during acute diverticulitis?
There is very low-quality evidence for comparing a liberalized and restricted fibre diet for inpatient management to improve hospital length of stay, recovery, gastrointestinal symptoms and reoccurrence so not part of current recommendations.

https://pubmed.ncbi.nlm.nih.gov/29382074/

If serology is pos for celiac disease, do you have to refer to GI for colonoscopy/biopsy for confirmation?
Yes, you want to pursue an (EGD) with duodenal biopsy i to confirm the diagnosis in pts with positive serology. Elevated tissue transglutaminase IgA is supportive but not definitive for diagnosis due to variability in test accuracy and the potential for false positives.

When would abdominal CT angio be right answer in terms of test taking?
When what you are looking for is the vascular flow CTA is most helpful.

If the watershed is at the splenic flexure, why is the pain in lower quad instead of upper?
Visceral innervation is funny like that-- the gut doesn't follow the somatic nerve pattern-- and innervated in a way that pain in the midline bc it goes back using bilateral nerve fibers so the brain doesn't know which side it came from.

From embryology --- the foregut goes to the midepigastric, midgut to the periumbilical and then hindgut goes to suprapubic area. So because the splenic flexure is hindgut it typically goes to the midline lower quadrant.

Can fecal procalcitonin be elevated in C. Diff?
Yes, it is not specific. can be elevated in gastroenteritis.

Any good articles on afib and mesenteric ischemia to read?
https://www.nejm.org/doi/full/10.1056/NEJMra1503884?utm_source=openevidence

Any indication for cholecystectomy for multiple polyps more than or equal to 3 ??
The slides indicate cholecystectomy for high cancer risk, which is most associated with stones >3cm or polyp >1cm. There is not a lot of data on number of polyps. The guidelines do mentions serial US for polyps <1cm.

Any window period for cholecystectomy for acute cholecystitis
In most you want to think about within the first 72 hours-- decreased complications, shorter length of stay and decreased costs.

https://pubmed.ncbi.nlm.nih.gov/35258527/

Where is the radio labeled bile acid injected is that to come from small bowel through cystic duct to gall bladder or from gall bladder the other way
If asking about HIDA scan, it is administered through IV, then taken up by hepatocytes and excreted into bile. This is why liver disease can result in inaccurate results.

So for stone in CBD: we will start with US to dx than ERCP for treatment? When to do MRCP vs CT?
US will likely help you identify the biliary dilation -- and may show you a stone but may not. If you know there is a stone there, then moving to ERCP makes sense to try to intervene.... if you see bil dil but still are unsure the etiology then an MRCP could help to further define anatomy but often a decision made in collaboration with GI.
CT is often faster -- and may be an option if you don't have access to MRCP but it is not as sensitive.

Can you clarify when cholecystectomy, MRCP, versus ERCP would be a correct answer on a test question?
Stones in the gallbladder but without bil dil or you believe the stone has passed and you are worried about recurrence CCK.

If you worry that the ducts aren't clear -- and taking the gallbladder out will prevent more stones but not solve the problem then MRCP can helpful to answer that question.

If there a stone that is stuck, you need to clear that out, and in that case, you need ERCP often done prior to the CCK.

For testing purposes, do they use a typical pancreatitis risk strat such as ranson or bisap or generally just know high-risk features?
unlikely a high stakes exam will ask you to recall a formula and have a stem that asks you to give a score. -- so would think about it as knowing the risk factors.

How much alcohol related to acute pancreatitis?
This is likely beyond the scope of the board review course as it varies. However, I was able to find this-- large prospective cohort study highlighted that both frequent binge drinking and daily alcohol consumption significantly increase the risk of developing acute and chronic pancreatitis-- PMID: 36864550

Can you comment on any relationship between GLP1RA and pancreatitis risk?
It is not associated with an increased risk of pancreatitis.
https://pubmed.ncbi.nlm.nih.gov/40358430/

Role of opioid vs. non-opioid therapy in the management of acute pancreatitis?
This will likely depend heavily on patient co-morbidities, severity of pancreatitis, ability to tolerate po intake. Both are options.

Do we need to admit all patients with acute pancreatitis??? Maybe those with mild attack can be followed as outpatient?
In those with a mild case-- defined as no end organ damage or complications there is emerging evidence that they may be able to be managed as an outpatient--- but unlikely a high stakes exam will ask you for this decision.

Do we repeat CT abd for changes in 4-5 weeks after acute pancreatitis?
Currently there is no official recommendation for repeat imaging in the absence of symptoms. Imaging can often lag behind clinical improvement therefore in the absence of symptoms they may be misleading. There may be a role for imaging ~4 weeks later if symptoms persist or there is clinical suspicion for pseudocyst or infection.

Is there a role for abx in acute pancreatitis with walled off necrosis without an elevated WBC or other signs of infection?
The ACG pancreatitis guidelines state that sterile necrosis does not benefit from antibiotic therapy. Should be reserved for clinical indications of infection.

In gastroenterology Q21, why is there no option for CT scan?
MRCP/MRI is going to have better sensitivity than CT and high stakes exams need a single right answer -- not one where limitations like access to an MR scanner to get an MRCP may be part of the decision making and complicate your answer selection.

What is the INR range acceptable to proceed with upper GI EGD for UGIB?
This will likely vary by institution (plus GI/anesthesia staff's comfort), however generally less than 2.5 INR is typically accepted

I think octreotide or Terlipressin can be used for bleeding esophageal varices
Both can be used, but due to side effects octreotide is preferred

In the setting of CAD with GIB in patient on aspirin and plavix, do you just hold plavix then and continue aspirin? Or vice versa?
this is often a clinical decision that depends on indication, timing from MI, stent and type and then if they can get endoscopy what is the risk stratification of what is or isn't found and recurrence risk for the bleed.

Acute severe upper GI bleed: IV PPI dose? Any benefit drip vs bolus?
Infusion is more pricey-- but the bolus data was done with the exclusion of ICU patients so important to note when considering the patient population.

If a CT scan shows no pancreatitis but the patient meets two of three criteria, is it still considered acute pancreatitis, and should it be treated?
Yes, pancreatitis is a clinical diagnosis with 2/3 criteria needed (symptoms, lipase, radiographic evidence). Radiologic disease can be delayed so patients with 2/3 criteria met should still be treated as pancreatitis.

Is there a new drug for mash and indications?
Yes, this is resmetirom

Any data of insulin resistance tests to predict mash?
MASH should be considered in patients with multiple metabolic disorders such as diabetes, hyperlipidemia, central obesity, and hypertension

But she would likely have been vaccinated against Hep B so why screen after that?
The CDC recommends once-in-a-lifetime screening for hep B (see slide 17)

Is there ever a need to test for Hep A IgG antibodies?
It may be helpful to check Hep A IgG if you are trying to ensure immunity, especially in the case of Hep C or other liver conditions, where you would want to vaccinate if not immunized

Any new recommendations on GLP-1 agonists for MASLD or MASH ?
Great question. Multiple studies are currently ongoing (semaglutide, tirzepatide) and may show promising results, although currently FDA approval is not specific for MASH/MASLD

Can you have liver damage caused by pure alcohol, which does not have 2:1 AST:ALT ratio. Or is Alcohol this unlikely cause in obesity and alcohol use?
More and more, we are seeing multifactorial liver damage. In patients with obesity and daily or consistent alcohol use, both likely contribute.

don't we check Maddrey score before prescribing prednisone for acute alcoholic hepa?
MELD >20 is the indication in the question. A Maddrey score >32 is also a tool used to calculate who may benefit from steroids.

Do I have to make sure I distinguish MASLD from MASH in my patients (e.g. via biopsy)? The only difference in management is for different Fib 4 Scores, no?
Good question. The treatment is similar initially, focusing on lifestyle changes (limit alcohol, weight loss, control of diabetes/lipids). If pursuing additional therapy such as resmetiron, would likely require hepatology referral and consideration of bx to solidify diagnosis of MASH

What would the second line be if prednisolone is contraindicated for AlcHep?
Pentoxifylline 400 mg orally three times daily for 4 weeks-- but important to note this is not recommended by the American College of Gastroenterology

Is there any concern for extended GLP-1 use leading to permanent gastroparesis? If so, how long should these agents be used before discontinuation?
There is not great data on this as these agents are still relatively new, so long-term data is lacking.

Could you expand a little more on chronic hepatitis B serology?
Chronic hepatitis B will have positive HBsAntigen but the surface antibody will be negative. The Core Ab will be positive as IgG.

Incidental finding of nodular liver c/w cirrhosis on CT - normal ALT/LFT, Albumin, Sodium, Cre, Plt 90K, no ascites, no sx - Do you add cirrhosis to prob list?
Imaging alone would not fit the diagnostic criteria of cirrhosis in the absence of physical findings or lab abnormalities.

Could we please get a comment on pmns correction in the ascitic fluid cell count?
There isn't a need to correct for a bloody tap. PMNs >250 is still the cutoff.

Is repeat paracentesis with fluid analysis routinely indicated after starting SBP treatment to document treatment response?
Yes, should be repeated at 48 hours and you are looking for a >25% drop in the PMNs -- If that has not happened you worry about treatment failure.
Clinically you may think about this differently if you have a patient who is getting better and you have the micro data and know the bug and susceptibilities to know the abx they are on are targeted.

Can you expand how you remember SAAG?
HIGH SAAG indicates portal(HIGH)pertension (this was the best I could come up with!)

Do you use polyethylene glycol instead of lactulose to prevent HE when poor adherence to lactulose?
The quality of evidence is low for this, but clinically yes that would be an option

How does the agitated saline echo help diagnose HPS?
Delayed bubbles indicate a pulmonary shunting (immediate bubbles would indicate a cardiac shunt/PFO)

Does ischemic liver vs shock liver same as acute liver injury?
yes

Do you feel confident in stopping hepatitis B treatment in some patients?
There are criteria for discontinuing therapy that are beyond the scope of the course-- stopping therapy does come with the risk of relapse.

What does a direct anisoglobulin test - neg hemolysis mean?
We will discuss this more in hematology

Dr. Dejan discussed ischemic shock under acute liver failure, I would appreciate help with the differentiation of terms.
The cause of shock matters less-- any hypotension can lead to acute liver injury from low flow and ischemia to the liver.

Role of Vitamin E in <MASH
The AGA comments that natural vitamin E may be considered if patients are not diabetic and do not have cirrhosis

Any comments on DILI?
This was lower importance on the ABIM blueprint so not included in the content.

Could you please summarize at the end of section 4, which GI-related conditions need CT with contrast besides acute appendicitis?
This would be a fairly extensive list and would depend significantly on the symptoms, patient appearance/physical exam, and differential diagnosis

Any role for a short course of oral steroids for postinfectious cough?
In the absence of asthma, no.

Any indication for doing CT chest in a chronic cough?
If you were going to image chronic cough (cough lasting more than 8 weeks) would start with a chest x-ray and then, if that is abnormal, consider a CT.

How would you differentiate between upper respiratory cough and lPR (throat clearing, globus sensation, etc)
Upper respiratory cough is common in the setting of a URI and may be associated with nasal congestion, rhinorrhea, sore throat etc.

Laryngopharyngeal reflux has the symptoms you included and the diagnosis between the two can be challenge but may be best sorted out by a trial of a PPI and if question remains then use of laryngoscopy or 24 hour pH monitoring could be used.

For acute brochitis, why not suspect pneumonia, and why not to proceed with CXR as physical exam could be normal?
Pneumonia is a clinical diagnosis and not made solely on imaging. There should typically be changes in lung sounds, fever.

Cardiopulmonary exercise testing is not the same as stress testing for cardiac issues, correct? DOE is a rarely CAD
Correct-- is not the same. Cardiopulmonary exercise testing measures O2, CO2, HR, EKG and BP.

How often do we see cervicogenic angina, esp in older pts w cervical radic/myelop and presentation can look like cardiac, often relieved with NTG?
Prevalence has not been well defined in a quick lit review-- there is a SR that found 95 cases in 1100 suggesting it is rare. The reference is here https://pubmed.ncbi.nlm.nih.gov/33276331/

What is postprandial orthostatic hypotension physiology?
This is typically the result of diversion of blood flow to the splanchnic system (stimulated by eating, to aid in digestion), which results in reduced circulating blood volume

What does mixed upbeat torsional look like?
Combination of vertical (upbeat) and torsional (rotational) eye movements.

Please explain catch-up saccades for vertigo testing?
These are quick eye movements that occur during smooth pursuit eye movements to correct for discrepancies between the target's position and the eye's position

Any role of betahistine in BPPV?
Positional treatments are recommended first line before pharmacologic

Can you clarify bidirectional vs torsional nystagmus? how would that look different on the exam?
Bidirectional means changes direction with gaze change, whereas torsional is rotational movements

When we say chronic insomnia, is there a specific duration such as 2 weeks or 4 weeks or months?
3 months

Any recommendations for acute insomnia for hospitalized patients other than environmental measures?
Melatonin can be a good starting place for these patients as well.

What about trazodone for insomnia?
It is an off-label use for sleep, but for patients with depression and insomnia, it can be helpful for treating the depression

The maneuvers for hilt maneuvers are done only when the patient has the vertigo, or are they okay do when the patient is asymptomatic?
Dix-Hallpike would be for diagnosis, Epley is for treatment (ie when symptomatic)

In the introductory question stem, the most likely diagnosis is BPH; not acute cystitis. Therefore, what is the use/value of the U/A?
UA is recommended by AUA on initial diagnosis of BPH to ensure no other causes, including acute cystitis or interstitial cystitis

How much can we trust the patient's self-exam if the provider is not able to palpate the mass on exam?
That's a tough question and likely beyond the scope of the board review. In general, breast mass should be evaluated with imaging regardless of whether found by patient or the clinician. Similar to mammography not detecting all cancers, physical exam does not detect all masses/cancers.

Are there pregnancy management questions on IM boards?
3% of the content is Ob/GYN per the blueprint that ABIM provides-- and one of the areas that they highlight as high importance is nutritional def in pregnancy.

Are we significantly undertreating/working up perimenopausal women if endometrial biopsy is answer? (I feel like I hardly ever see this done.)
Agreed! Commonly in clinical practice I see TVUS used, however in this case because she is NOT yet post-menopausal, you really do need the endometrial bx.

What is Cowden Syndrome?
A PTEN hamartoma tumor syndrome with increased risk for some malignancies

I am under the impression that we have to do an endometrial bx in every perimenopausal woman? Doesn't every woman have abnormal bleeding around menopause?
Not every perimenopausal woman, however, the workup of abnormal uterine bleeding especially if >45 and/or risk factors for endometrial cancer

Also, no estrogen therapy for migraines with aura?
Good question. It should be taken into consideration when considering risks especially due to the concern for stroke, however there are some options with lower dose, such as patch that may be used with shared decision making.

Any recommendations for treatment of chronic UTI or the use of estrogen creams for chronic UTIs in older women?
Yes, this should be considered for use if no contraindications as they do reduce UTI

Any guidelines for hormonal contraception in transgender population?
Important topic, but beyond the scope of the ABIM blueprint and not something we are able to cover.

Use of testosterone in postmenopausal females? if yes, how much and how long?
This is likely beyond the scope of the board exam review

Can you combine Fezolintant with vaginal estrogen in pts with hx of MI or stroke
There is limited data in this space. Fezolintant itself does not carry known cardiovascular risks, the safety of combining it with vaginal estrogen in patients with prior cardiovascular events remains unstudied.

To clarify, for the first time fall in geriatric patients, should do a home safety eval, which may include PT evaluation?
Yes, who conducts the home safety eval may vary; however, it is often a physical therapist.

Is there any role for high-dose aspirin after hip fracture replacement/surgery for VTE prophylaxis?
There is some data that would support this, however LMWH has better data for DVT prevention specifically, so it is typically preferred. Could consider ASA if there was a contraindication to heparin.

Is there any role/studies/information regarding long-term AC for elderly patients who are not mobile (due to fractures, or deconditioning/frailty)?
Good question. There are unfortunately not a lot of studies on this, so currently, guidelines recommend against this, although individual patient factors such as previous provoked VTE or malignancy may influence this on a case-by-case basis

Any studies on cervical myelopathy as the underlying cause of falls, as abnormal gait occurs with long tract signs long before the patient falls and fractures something,
I could not find any studies on this specifically.

Why is docusate wrong?
Not very effective alone

Can you expand on situations where we should not be satisfied with normal Vit B12 and B9 levels? E.g. is it MCV > 100 that should always prompt MMA level?
Good question. If patients clinically are having symptoms such as neuropathy or have risk factors like diet or medication (metformin, diuretic) use or previous gastric surgery, consider further evaluation with MMA if B12 is normal. I will also note that "normal" B12 levels vary depending on who you ask and your assay, at my institution we treat before the level gets to the actual limit of normal for the assay

What is the starting dose for oral morphine for dyspnea?
In the literature I found data for everything from 8-30mg per day. Likely varies depending on previous opiate exposure, co-morbidities like malignancy, dementia, renal failure etc.

Geri Q10 says "switch to sustained," which suggests that they are stopping IR morphine. Is that not how we should think about it?
Good point. The issue is that the relief is not lasting long enough, not necessarily that it's not effective so A and C do not make the most sense. B is reasonable as morphine is working but not lasting, however, this is cancer-related pain and there is good data for switching to long-acting therapy to aid in reduction of pain between doses
In clinical practice you may switch to XR and also have an IR agent, but the question did not give you that option

What if the patient has a positive PHQ 9 consistent with mild depression? Still appropriate to help in medical aid in dying?
This is likely beyond the scope of the board review course and likely strongly influenced by state laws