ACP Internal Medicine Board Review Questions and Answers -Wednesday, May 14, 2025

Why is reslizumab incorrect?

Omalizumab is indicated in situations with elevated IgE like the question stem. Reslizumab is a biologic that can be used if there is eosinophilia.

IgE vs eosinophilia? Explain?

Some phenotypes of asthma are characterized by elevated IgE or elevated eosinophils. These would require blood testing, but can be helpful in severe or refractory asthma to determine next steps in therapy with a biologic agent targeted towards one or the other.

How can Formoterol help during exercise if it's a long-acting beta agonist?

If this is in reference to question 2, the preferred regimen would be ICS +SABA or SABA. Formoterol can be used if needed, it is long acting, however has a rapid onset of action, which would make it acceptable for before exercise.

Both gold 1/2/3/4 and gold A/B/E were mentioned. Can you explain?

Good question. Numeric GOLD (1-4) classifications are in reference to airflow, so they describe the FEV1. The alphabetical (ABE) are in reference to disease severity, so they are based on symptoms and exacerbations.

I'm an ID doctor and concerned about long-term use of azithromycin to prevent cops what's the data about that, and I'm concerned about resistance, thanks.

Great point. It should be trialed for 1 year. Local resistance patterns may be taken into account in choosing between this and roflumilast.

Is the target SpO2 in COPD exacerbation 88-92% for all COPD patients, or only for those with CO2 retention?

There are differences in guidelines-- but in general, those are the targets for supplementation-- there are European and British guidelines that endorse oxygen target saturations of 88%-92%, with adjustment to 94%-98% if carbon dioxide levels are normal

Do they need pneumococcal vaccination every 5 years? Which pneumococcal vaccine is preferred?

We will cover this later in the course when we go through immunizations with ID.

Why don't you want to use azithromycin and roflumilast together?

Azithromycin and roflumilast should not be used together due to the potential for significant drug interactions that can increase the systemic exposure of roflumilast, leading to an elevated risk of adverse reactions.

Do patients have to be nonsmokers if using azithromycin?

Smoking significantly reduces the efficacy of daily azithromycin, although the choice to prescribe it still would likely be influenced by things beyond the scope of this exam such as prescription coverage and severity of symptoms

If we do low-dose steroid daily, then how long do you keep it on?

That is likely beyond the scope of this exam. Alternatives should be considered, and the lowest effective dose should be used.

What is the threshold to broaden abx beyond azithro (ie cephalosporin or anti-pseudomonal) in a hospitalized patient?

Your local antibiotic resistance information may influence this, as well as patient risk factors for MRSA or pseudomonas.

How can we improve compliance with CPAP for patients with OSA?

This specific question is likely beyond the scope of the exam. In clinical practice, there are alternatives such as nasal pillows or alternative devices, although patient factors greatly influence the ability of these to be used.

If on PFT, COPD is not reversible, why is bronchoconstriction the mainstay management for COPD?

LAMAs are the initial therapy indicated, they can improve bronchodilation but also can reduce mucus production. The data is good for their ability to reduce exacerbations and improve lung function in patients with COPD

Why is Prednisolone used for asthma while Prednisone is used for COPD? Is there a difference?

Prednisolone and Prednisone can be used for either, although in the US the latter is more commonly used for both Asthma and COPD

Can you comment on the device INSPIRE?

Hypoglossal nerve stimulator involves the implantation of a device that stimulates the hypoglossal nerve, which in turn activates the genioglossus muscle, leading to tongue protrusion and stiffening. This action helps to maintain airway patency during sleep, thereby reducing the frequency of apneic events.

Is there any role for the Trelogy machine in OSA associated with obesity hypoventilation syndrome with CO2 retention?

We are not able to endorse any specific brand, and specific brands are unlikely to appear on a high-stakes exam. The management for OHS does include positive pressure ventilation.

How can we differentiate between severe ecopd vs OHS, while both are chronic co2 retainers, with elevated Hco3 (as the kidney had time to compensate)?

PFTs- COPD shows obstructive pattern (OHS often has a restrictive pattern), as well as the presence of sleep-disordered breathing on polysomnography, which is required for the diagnosis of OHS

If 6mm nodule seen on X-ray instead of ct like in the question, would the answer be to get CT now or to still get CT in 6-12 months for exam?

Lung nodule size cannot reliably be distinguished on CXR, so getting the CT to determine the size and then follow the ACR guidelines based on the size seen on CT would be best.

Can you explain the difference between parapneumonic effusion and empyema?

Both are fluid collections associated with pneumonia. Empyema is specifically pus/WBCs.

What is the role of large bore chest tube in loculated pleural effusion?

Large bore is typically reserved for blood, or if small bore does not work for parapneumonic or empyema.

O2 therapy for Pneumothorax - what dose, how long, when to stop?

There are not many studies/trials on this. Current guidelines from CHEST recommend conservative management, including observation WITHOUT oxygen supplementation, for stable patients with small pneumothoraces. Oxygen may be used in hypoxemia or significant symptoms, such as dyspnea or physiological instability

Is it wide splitting of S2 or fixed splitting can be seen with PHT??

This would depend on the severity of the PH, as both can occur (widened and fixed split - esp common in atrial septal defect with pulmonary hypertension-- or a single S2 in more severe cases

Do you use lytics for all empyema's or only difficult ones/ multiloculars?

Great questions. Typically, lytics should be used for empyema when loculations persist after initial tube drainage (small-bore chest tubes fail). Lytics improve pleural drainage, reduce the need for surgical intervention, and shorten hospital stays in these patients

Differentiating between post-CVA central sleep apnea clinically and on sleep study findings?

Differentiation between central and obstructive sleep apnea should be done with evaluation of respiratory effort on polysomnography

Thoughts on the use of capillary refill over lactic acid now being recommended by Survive Sepsis campaign?

Use of both should be considered. There is monitoring of lactate related to mortality, however, capillary refill is easy to use and less invasive. Although both are recommended, the campaign does not the CR should not be used alone.

How do you dose/manage steroids on someone with sepsis/septic shock if they are chronically on steroids?

"Typically, stress-dose steroids would be used, 200 mg of IV hydrocortisone per day for patients with septic shock, either as a continuous infusion or divided into doses given every 6 hours. The stress dose steroids would not replace the need for fluid resuscitation."

Utility of procalcitonin in septic shock or sepsis

The IDSA guidelines support the use of procalcitonin to determine if antibiotics can be stopped, as long as the optimal duration of therapy is unclear and procalcitonin testing is available

Can you explain the difference between active and passive cooling and warming in the ICU setting?

Active implies the use of external forces such as cooling blankets, warming machine, etc. Passive implies allowing the body to naturally acclimate to the surrounding temperature

Traditionally, we were taught that glucocorticoids should be administered for the biphasic reaction in anaphylaxis. Has this changed?

The use would be secondary to epinephrine, they should not be used in place of epinephrine

What is the difference between hyporeflexia and bradyreflexia?

Hyporeflexia refers to a decreased or diminished reflex response. Bradyreflexia is a slow or delayed response.

Zosyn with vancomycin is nephrotoxic. Could you please comment?

Yes. There are a few studies that highlight the combination of Vanc+Pip/Tazo results in more AKIs compared to Vanc+Cefepime or Vanc+Meropenem. It is thought to be a synergistic effect related to proximal tubule damage. So in that mentioned case, the patient can be on vancomycin, Tazobactam-piperacillin, and linezolid at the same time.

When de-escalating treatment for cellulitis, I use BID dosed cefuroxime or cefadroxil over Keflex when changing to PO abx, is this appropriate? or is there a coverage benefit to sticking with keflex?

Both Cephalexin and Cefadroxil are first generation cephalosporins with activity against MSSA which is acceptable, although Cephalexin is most commonly used. Cefuroxime is a second-generation cephalosporin, so it can also be used for MSSA/strep skin flora coverage. It is generally reserved for cases requiring broader gram-negative coverage or specific indications, such as infections with mixed bacterial flora

Sensitivity of probe-to-bone test 90% - why is it not 100% please? Is not every bone open to air inevitably infected?

This is likely outside the scope of the board exam review. However, 90% is considered high sensitivity, as few tests/exams have a higher/100% sensitivity.

What would prompt you to get LP in patients with minimal central signs/symptoms with positive blood culture for Listeria?

We would use the symptoms that we look for in meningoencephalitis (altered mental status, headache, neck stiffness, or focal neurological deficits).

Do u usually repeat MRI after you treat for osteomyelitis?

This is typically reserved in situations where there is a suspicion of treatment failure or delayed response.

What is the recommended antimicrobial coverage in cases concerning from aspiration pneumonia?

Great question. It is typically the same as CAP-- per IDSA, typically includes a β-lactam antibiotic combined with a macrolide or a respiratory fluoroquinolone. Notably, IDSA states anaerobic coverage should be added if there is a lung abscess or empyema.

Do you rely on mycoplasma serology or uGI died to mycoplasma pcr, Dr mycoplasma dx?

Is this question on the use of serology vs. PCR? Both have limitations-- IgM elevates in acute disease but can remain elevated so it lacks specificity for acute infection. PCR is specific but is less specific. The combination of the two may help improve diagnostic accuracy.

What are the possible indications to repeat CXR for radiological follow up following CAP??

Great question. Repeat imaging should be used in patients who do not improve with treatment, those with risk factors for malignancy (e.g., older age, smoking history), or recurrent pneumonia in the same area

What are the indications to treat latent TB? And how can we be sure it is treated, as IGRA will remain positive I guess.

Latent TB should be treated unless there is a strong contraindication to medications (that would be exceedingly rare). This is to prevent progression to active TB. No test needed after treatment.

Which patient does Not benefit from Latent Tuberculosis treatment? Would you treat patients who will frequently travel back to a high-prevalence region?

Treatment for latent TB is generally recommended as 5-10% of patients with LTBI will go on to have active TB without treatment

Add pseudomonal coverage ONLY for hx of Respiratory Pseudomonal isolation? Not for past hx of non-respiratory Pseudomonas infections? Is this Correct?

Pseudomonal coverage would be indicated if the patient had prior pseudomonal infection or colonization, not limited to just pneumonia.

Do you still tamiflu in hospitalized sick patients with symptoms over 48 hours?

IDSA states it could be considered in high-risk hospitalized patients after 48 hours

How long does one need to wait for a rash to come after burning pain?

This can vary and is likely beyond the scope of a board exam

How accurate is HSV PCR for HSV encephalitis in a patient in whom u have high suspicion for HSV encephalitis in the 1st week?

This would vary depending on the assay used. However, generally both sensitivity and specificity are above 85%

What are the recommended for precautions (airborne?) and isolation guidelines for Zoster?

If the patient is immunocompetent--contact isolation. If they are immunocompromised or have disseminated disease, airborne. Both are until all lesions are crusted over

How long do we limit contact sports after EBV infection?

American Medical Society for Sports Medicine recommends at least 3-4 weeks (from symptom onset)

Can you have a false positive EBV test? And if so, under what circumstances?

Monospot testing can be falsely positive in autoimmune disease, leukemia, and CMV infections

How do we tell if its Clostridioides colonization or infection with C. diff GDH/Toxin test?

This would be based on symptoms

What to do in a case of post-herpetic neuralgia where gabapentin/Lyrica and all other modalities, including opioids, are insufficient? Pain management referral?

There are some other therapies like TCA, capsaicin, or botulin injections that could be considered.

Do pt's with positive C. diff Ag but negative toxin, WITHOUT active diarrhea or other GI symptoms, require ongoing contact isolation?

Isolation is something used in hospitals and may vary depending on your local colonization/community C. diff rates and your institution's infection control policies. Asymptomatic cases with Ag positive but toxin negative do not require treatment

Do you use vancomycin oral prophylaxis for pts with a history of C. diff who need to be on long-term antibiotics or immunocompromised?

Oral vancomycin can be used as prophylaxis in patients with previous C. diff infection, although this should be balanced with the concern of promoting antibiotic resistance (ie VRE) and/or altering gut microbiome

Why specifically mention women when addressing Abx prophylaxis indications for recurrent UTI?

Good question. Currently, there are only guidelines for recurrent UTI in women (American Urologic Association)

What antibiotic would you use for daily prophylaxis in the prevention of recurrent UTIs?

Nitrofurantoin, cephalexin, and tmp depending on co-morbidities and prior cultures

What is the treatment for culture-negative prostatitis?

Maintenance of empiric therapy (often levo or cipro, outpatient)

Would you still treat a pregnant patient with less than 100,000 CFU bacteria and asymptomatic?

No, that technically would not meet the criteria for asymptomatic bacteriuria, so per IDSA, there is insufficient evidence to treat

Do you use aminoglycosides for gonorrhea in case of severe penicillin or cephalosporin allergy?

Treatment of gonorrhea in case of allergy would be 240 mg IM gentamicin once, plus a single 2 g oral dose of azithromycin

For STI testing, GC/CT annual testing < 25 years, is there a low end to the age recommendation or just start testing once sexually active?

Yes, CDC recommends annual chlamydia testing once sexually active through age 25 in women.

How would you treat ocular syphilis with LP-positive syphilis?

Ocular syphilis is a form of neurosyphilis, which requires 10-14 days of IV penicillin infusion.

The other non-treponemal test that you do if treponema's test and RPR test are both positive would be EIA or other?

If treponemal and RPR are both positive, proceed to treatment

To clarify, for testing purposes, which is the recommended diagnostic algorithm for syphilis currently: classic or reverse?

This depends on your lab and the assays available

Guidance on duration of Prep or just during risk?

This is likely beyond the scope of the board review course, however, the need for PrEP should be based on risk and reassessed at each visit

Also, I do prefer descovy for prep rather than truvada comments

Provider preference is beyond the scope of the board review course, although it is worth noting that TAF/FTC is not approved for prevention in receptive vaginal sex, which may limit its use in certain populations

For the treatment of recurrent genital herpes, what is the number of reinfection episodes considered the threshold to qualify as recurrent?

CDC recommends considering suppressive therapy if someone has experienced 4-6 episodes in a year

For prep are injectable medications for prep might a topic to test because lots of data about injectable meds for prep and also treatment.

The only injectable medication currently approved for PrEP is Cabotegravir. We do not have information on the specific content of questions for the board exam.

How about Mycoplasma genitalia for chronic prostatic, when to test or think about it?

MG is more often a cause of urethritis. It could be suspected in prostatitis in cases that do not respond to traditional antibiotics, or if an organism is not identified

How soon a >50 year old patient can get the shingles vaccine after a flare?

As soon as acute illness is over (generally 2-4 weeks after)

Ok that's not what MKSAP says, thanks for clarifying!

"Thanks for bringing this up-- both are correct, but in saying that totally understand that presenting it this way is confusing. At the core, with comorbidities the intent was to demonstrate that you want two agents to be sure that we are double covering S. pneumo-- in most cases we talk about it in the way that is described in the table in MKSAP== a beta lactam paired with either doxy or a macrolide.

If someone were to have a severe beta lactam allergy, then you may not want to use a PCN or cephalosporin agent, and in that case, you could use doxy paired with Macrolides.... That degree of nuance is unlikely to show up on a high-stakes exam.

Hope that helps."

For splenectomized pts do we need to consider the meningococcal vaccine?

Yes

Why isn’t the HPV vaccine routinely recommended after 26?

The data isn't as strong in this age group, so people aged 27-45 years, the recommendation is shared decision making.

How about Hep B vaccine series even if received as young adult/teenager? Are there any new recommendations about it?

The ACIP specifies that persons who have completed a HepB vaccination series at any point should not receive additional HepB vaccination, although there is no evidence that receiving extra doses is harmful.

Do family members of the pregnant woman need Tdap with each of their family members pregnancy, even if they have had it within 10 years as well?

No-- if they have been vaccinated in the past 10 years, then just the pregnant person needs to be vaccinated.

Any benefit to giving pcp 21 after pcp 20 has been given in the past given different given the unique serotypes in 21?

We don't have data that this offers an incremental benefit at this time.

How about hepatitis b vaccination on pts with rituximab?

"HBV vaccination should ideally be administered prior to rituximab initiation, as rituximab significantly blunts vaccine responses. Delaying rituximab for at least 2 weeks after vaccination is conditionally recommended to improve vaccine immunogenicity, assuming disease activity allows for this delay.

And this is a population that we sorry about Hep B reactivation in when on rituximab as well."

Do we need any type of isolation for hospitalized acute hepatitis A infection??

No, standard precautions/hand hygiene are recommended

Botox / onabotulinum toxin A) injections for spasticity, how high is the potential risk of full-blown Botulism toxicity?

Low, but we aren't able to find rates in our quick lit search

Hospital Infection Control frowns on urine cultures obtained while pt has indwelling catheter. Any evidence-based exception to this rule?

"*This is about quality markers-- if they have a positive culture off a catheter then that is counted as a cauti in the world of infection prevention (they start with the assumption that the clinician wouldn't sent it if there were not a clinical indication)-- that then has implications for how your hospital is looked at compared to peers for quality of care, etc.*

So there is data that cultures in the absence of symptoms lead to over-treatment, but particularly in the setting of a catheter, there are additional concerns."

When do we need to get 2 sets of cultures vs 3 sets for IE?

ACC does recommend at least 3 sets from different sites for IE diagnosis, although this is not always done in clinical practice (often 2 used)

Can IUDs also help with PMDD?

No.

Is there a difference in treatment for a patient addicted to cigar smoking?

Treatment for cigar addiction is similar to cigarette smoking cessation, focusing on a combination of pharmacotherapy and behavioral interventions to address nicotine dependence. First-line pharmacotherapies include varenicline, nicotine replacement therapy (NRT) in combination (e.g., patch with gum or lozenge), and bupropion, with varenicline showing superior efficacy in some populations, including those with substance-use disorders.

Could we please learn about the guidelines for AAA screening in smokers?

"AHA recommends screening men who are ≥65 years of age who have ever smoked

We will cover it in the cardiology content on Friday morning."

Can we please get a comment on DEXA scan screening?

This session is on cancer screening. Bone mineral density screening will be covered in endocrinology

Are we discussing polyp monitoring frequency in the GI section?

Good question, that is not part of this lecture. There is a helpful table in MKSAP19 if you have it (GI section, table# 26). The table is based off this: https://pubmed.ncbi.nlm.nih.gov/32044092/

If one had to pick one test out of the three different stool-based crc screening tests, which one would be preferred?

This is often a decision that is based on patient preference and weighs the frequency that it is repeated with the specificity and sensitivity of the test-- and probably has a factor of what your lab offers.

If we are doing yearly FIT in Avg risk patient, is q 10 y Colonoscopy is required or optional.

If the FIT test is positive then they will need a colonoscopy for diagnostic purposes-- if the FIT is negative, then you repeat it annually without the need for a colonoscopy for screening.

Do we start screening at 21 years old even if not sexually active?

Yes, USPSTF recommends starting at 21 regardless of sexual activity

How long do you HPV test if a woman has a new partner at age 55 or 60?

New partners do not directly impact the screening recommendations/guidelines. The addition of HPV testing with cytology (co-testing) is utilized to decrease frequency of testing

On an exam is shared decision making always going to be the answer even in the recommended screening window?

For something like prostate cancer, it may…. but that is a hard concept to test on a high-stakes exam where they have to have a single right answer to the question.

Which Education Study body are we going to be tested on since there are multiple different guidelines?

For high-stakes exams, they have to have a single right answer to the question stem so where there are guidelines with conflicting recommendations that is a hard concept to test.

Any guidelines for AAA in smokers?

We will cover this content in the cardiology section on Friday.

How would the screening change if a patient had a hysterectomy for malignant reasons? Also, how would it change for those with a diagnosis of HIV?

In patients with hysterectomy (with cervix removal) for endometrial cancer, screening can typically be discontinued as long as no previous high-risk CIN on screening