

COMPREHENSIVE MOCK EXAM 4

Supplemental to: Obesity Medicine Board Review 2026-2027

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American Board of Obesity Medicine (ABOM) Certification Examination for Obesity Medicine Physicians — 200 single-best-answer questions, five-option A-E format matching the parent book, domain-weighted to the current ABOM blueprint

Board-Review Questions

1. A 36-year-old woman who is breastfeeding asks to restart weight-loss medication immediately postpartum. What is the best approach?

- A. Use a marked calorie deficit now and reassess medication options after several months
- B. Delay anti-obesity medication through lactation and use nutrition and activity treatment in the meantime
- C. Restart her pre-pregnancy medication at the previous full dose because she tolerated it before conception
- D. Review lactation-specific medication safety, maternal recovery, nutrition, and potential infant exposure
- E. Choose an anti-obesity medication based on maternal efficacy without considering infant exposure

2. A 55-year-old woman rates the importance of weight-related behavior change as 9/10 but confidence as 3/10. Which motivational interviewing approach is most appropriate?

- A. Explore ways to increase confidence and identify a feasible first step
- B. Explore why the importance score is not lower and use that discussion to strengthen reasons for change
- C. Review the medical risks of obesity first, then ask her to choose among several recommended behavior targets
- D. Postpone goal setting until confidence rises because low self-efficacy predicts poor adherence
- E. Reflect the high importance score, then give a detailed clinician-directed plan for behavior change

3. A 33-year-old man gains 23 kg over 18 months after a traumatic brain injury involving the hypothalamus; his weight had been stable for a decade beforehand. Which feature most strongly changes the diagnostic approach?

- A. The absence of obesity during early childhood
- B. His current BMI category at this visit
- C. Abrupt weight gain after hypothalamic injury

- D.** The total magnitude of weight gained over 18 months
- E.** His adult sex and current age

4. A 58-year-old woman with obesity and painful knee osteoarthritis wants to exercise but walking worsens pain. What is the best integrated management strategy?

- A.** Continue weight-bearing walking at the same intensity and treat knee pain only if symptoms worsen
- B.** Treat osteoarthritis first and postpone structured activity until walking is nearly pain-free
- C.** Use upper-body exercise as the main activity strategy and avoid loading the lower extremities during weight treatment
- D.** Pursue dietary weight loss alone initially, then introduce strengthening after substantial weight reduction
- E.** Treat knee pain while using tolerable low-impact activity and strengthening so the comorbidity does not become an all-or-none barrier

5. A 48-year-old office worker does 40 minutes of brisk exercise five days weekly but sits for 11 hours on most workdays. Which interpretation is best?

- A.** Replace some structured exercise with standing time because occupational sitting is the dominant risk
- B.** Increase aerobic exercise duration but leave prolonged sitting unchanged
- C.** Prioritize sedentary-time counseling mainly when weekly aerobic activity is below recommended targets
- D.** Continue structured exercise while also reducing prolonged sedentary time during the workday
- E.** Consider his activity pattern adequate because he already meets an aerobic exercise target

6. A 37-year-old man with BMI 35 kg/m² has triglycerides 310 mg/dL, HDL cholesterol 31 mg/dL, and central adiposity. Which obesity-related metabolic pattern is most consistent with these findings?

- A.** Insulin-resistant atherogenic dyslipidemia with hypertriglyceridemia and low HDL cholesterol
- B.** Familial hypercholesterolemia characterized primarily by markedly elevated LDL cholesterol

C. Hypothyroid dyslipidemia characterized mainly by elevated LDL cholesterol and reduced metabolic rate

D. Nephrotic dyslipidemia associated with heavy proteinuria and secondary elevations in cholesterol

E. Cholestatic dyslipidemia associated with impaired bile flow and disproportionate cholesterol elevation

7. A patient who underwent sleeve gastrectomy 5 years ago feels well and asks whether vitamin monitoring can stop. What is the best answer?

A. Use complete blood count and routine chemistry as surveillance, adding micronutrient testing when abnormalities or symptoms appear

B. Continue routine supplements but stop laboratory surveillance if weight remains stable

C. Continue procedure-appropriate supplementation and long-term nutritional surveillance after sleeve gastrectomy

D. Use symptoms to determine when vitamin testing is needed rather than scheduled surveillance

E. Stop supplementation if the diet appears balanced and restart it if symptoms develop

8. A patient reports eating rapidly and routinely finishing restaurant portions before noticing fullness. Which skill is most appropriate?

A. Pre-portion restaurant meals before eating but continue the same rapid eating pace

B. Use a fixed eating window that ends several hours before bedtime

C. Drink water before meals as the main strategy for recognizing fullness

D. Slow the eating pace and deliberately attend to hunger, satiation, and fullness cues during meals

E. Reduce between-meal snacks to lower total intake while leaving the rapid pace of meals unchanged

9. A 41-year-old woman has recurrent postprandial neuroglycopenic symptoms 2 years after Roux-en-Y gastric bypass, with documented low glucose during episodes. Which complication should be considered?

- A.** Early dumping syndrome caused by rapid osmotic fluid shifts soon after eating
- B.** Insulinoma causing fasting and sometimes postprandial endogenous hyperinsulinemic hypoglycemia
- C.** Medication-associated hypoglycemia from an insulin or insulin-secretagogue regimen
- D.** Anastomotic stricture causing postprandial vomiting and progressive intolerance of solid food
- E.** Post-bariatric hypoglycemia after Roux-en-Y gastric bypass

10. A 28-year-old woman with lifelong severe obesity asks whether routine genetic testing is indicated solely because her current BMI is 43 kg/m². She had normal childhood weight and no hyperphagia, developmental abnormalities, or syndromic features. What is the best response?

- A.** Normal childhood weight confirms a monogenic disorder
- B.** Genetic obesity can be diagnosed from BMI without history
- C.** Genetic testing replaces evaluation for medications and comorbidities
- D.** Genetic testing guided by early onset, hyperphagia, and syndromic clues
- E.** All adults with BMI above 40 kg/m² require broad genetic sequencing

11. A 50-year-old woman has maintained substantial weight loss for 2 years. Which follow-up strategy is most appropriate?

- A.** Reduce follow-up to annual weight checks because the first 2 years of maintenance have been successful
- B.** Long-term follow-up helps sustain benefits and identify recurrence or complications early
- C.** Monitor cardiometabolic conditions but stop structured weight-maintenance follow-up
- D.** Continue current treatment but stop discussing relapse-prevention strategies unless regain begins
- E.** End active obesity treatment while advising her to return if she regains at least 10%

12. A 35-year-old single father says his food budget often runs out before payday and he relies on inexpensive shelf-stable foods. Which social determinant is most important to identify and address?

- A.** Limited nutrition knowledge despite stable access to adequate food throughout the month

- B.** Low readiness for behavior change despite having sufficient resources to follow the prescribed plan
- C.** A restrictive eating disorder characterized by avoidance of higher-cost fresh foods
- D.** Food insecurity that should shape the treatment plan and prompt connection to available resources
- E.** A preference for shelf-stable foods that can be addressed with nutrition education alone

13. A 37-year-old woman has twice-weekly episodes of eating an unusually large amount within 2 hours with loss of control and distress, without vomiting, laxatives, or compensatory exercise. Which diagnosis is most likely?

- A.** Avoidant/restrictive food intake disorder
- B.** Bulimia nervosa
- C.** Binge-eating disorder
- D.** Anorexia nervosa
- E.** Night eating syndrome

14. A patient has achieved 5% weight loss after 3 months of a comprehensive plan and reports improved blood pressure and energy. What is the best next step?

- A.** Escalate immediately to a substantially more restrictive plan because 5% loss is below a clinically meaningful response
- B.** End active treatment because the early blood-pressure improvement indicates the obesity treatment goal has been met
- C.** Continue and reinforce the effective plan, recognizing that 5% sustained loss can produce meaningful health benefits
- D.** Switch modalities now because remaining in the same BMI category means the current plan is ineffective
- E.** Reduce self-monitoring and follow-up intensity now that an early response has been demonstrated

15. A patient taking orlistat reports oily spotting and fecal urgency after high-fat meals. What is the best explanation?

- A.** Reduced intestinal triglyceride digestion and fat absorption from gastrointestinal lipase inhibition
- B.** Delayed gastric emptying from a central appetite-suppressing effect of orlistat
- C.** Increased bile-acid secretion that accelerates colonic transit after high-fat meals
- D.** Blockade of intestinal carbohydrate absorption causing osmotic diarrhea after mixed meals
- E.** Direct stimulation of colonic motility through enteric serotonin receptors

16. A patient asks whether 'ultra-processed' foods can matter in obesity treatment even when no single food is forbidden. Which counseling point is best?

- A.** Recommend complete avoidance of ultra-processed foods to prevent exposure to highly palatable foods
- B.** Focus on macronutrient percentages because processing level adds little beyond carbohydrate and fat content
- C.** Energy density, eating rate, palatability, fiber, and food form can influence spontaneous energy intake
- D.** Emphasize total calorie counting while treating food processing and eating rate as clinically unimportant
- E.** Prioritize vitamin supplementation rather than changing the proportion of highly processed foods

17. A patient says, 'I know walking would help, but I'm exhausted after work.' Which response best demonstrates reflective listening?

- A.** Reflect both her interest in activity and the fatigue barrier without judgment
- B.** It sounds as though evening walking should be straightforward once you decide to make it a priority
- C.** Would you like me to create a walking schedule that fits your workday?
- D.** You have good reasons to exercise, so the next step is to commit to a specific schedule
- E.** What keeps you from walking earlier in the day before you become tired?

18. A patient worries that a prescribed meal plan will isolate her from culturally important shared family meals. What is the best approach?

- A.** Adapt portions and preparation while preserving culturally meaningful foods and shared family meals
- B.** Keep the prescribed plan unchanged but allow traditional foods on occasional special events
- C.** Focus first on reducing culturally traditional foods because they are likely the major energy source
- D.** Recommend separate meal preparation so her portions can be measured independently from family meals
- E.** Replace traditional mixed meals with standardized meal-replacement products for easier calorie control

19. A 39-year-old woman with obesity asks about an intragastric balloon. Which description is most accurate?

- A.** A surgically implanted adjustable device that remains around the proximal stomach long term
- B.** An endoscopic suturing procedure that reduces gastric volume without leaving a space-occupying device
- C.** A temporary endoscopic balloon that occupies gastric space and is removed after a defined treatment period
- D.** A gastric device that can be placed without the need for structured nutrition or behavior follow-up
- E.** A temporary device that promotes weight loss mainly by creating intestinal malabsorption

20. A 45-year-old man gains 18 kg after a craniopharyngioma resection involving the hypothalamic region. He develops intense hunger and reduced energy expenditure. Which mechanism best explains the change?

- A.** Iatrogenic Cushing syndrome from perioperative glucocorticoid exposure
- B.** Hypogonadism related to pituitary dysfunction as the sole explanation for the rapid gain and hyperphagia
- C.** Primary hypothyroidism developing coincidentally after neurosurgery

- D.** Post-injury hypothalamic obesity from disruption of central appetite and energy-expenditure regulation
- E.** Growth hormone deficiency causing reduced lean mass without a major change in appetite regulation

21. A patient meets a weekly activity goal for four consecutive weeks. Which reinforcement strategy is most appropriate?

- A.** Use a favorite dessert as a reward after each week the activity goal is achieved
- B.** Increase the activity target immediately after each successful week to maintain pressure for progress
- C.** Give verbal praise without linking reinforcement to the specific behavior that was achieved
- D.** Withhold rewards until both activity and a predetermined weight-loss target are achieved
- E.** Use a non-food reward that is clearly linked to completion of the specific activity behavior

22. A 70-year-old woman with obesity and osteoporosis begins a weight-reduction program. Which issue deserves particular attention?

- A.** Emphasize aerobic calorie expenditure while allowing dietary calcium intake to fall during energy restriction
- B.** Avoid resistance and weight-bearing activity because osteoporosis makes mechanical loading unsafe
- C.** Use weight loss itself as the main bone-protective intervention because lower body weight reduces skeletal load
- D.** Older adults with osteoporosis require a plan that addresses bone and muscle preservation while treating obesity
- E.** Focus on calcium and vitamin D supplementation without addressing muscle strength or fall risk

23. A 61-year-old man has lost 20% of body weight and now has lower blood pressure and frequent dizziness. Which long-term management task is important?

- A.** Maintain all antihypertensive doses and increase sodium intake empirically to counter the dizziness

- B.** Reduce fluid intake because lower body weight generally lowers intravascular volume after weight loss
- C.** Reduce antihypertensive doses empirically before checking orthostatic blood pressure, volume status, or other causes of dizziness
- D.** Treat the dizziness as an expected adaptation and wait for persistent symptoms before reviewing the medication list
- E.** Reassess antihypertensive and other weight-sensitive medications after substantial weight loss

24. Two years after bariatric surgery, a patient develops paresthesias, gait difficulty, and macrocytic anemia. Which nutritional deficiency should be strongly considered?

- A.** Vitamin B12 deficiency, which can cause macrocytic anemia and posterior-column or peripheral neurologic dysfunction
- B.** Iron deficiency, which typically causes microcytic anemia and does not explain the neurologic findings well
- C.** Folate deficiency, which can cause macrocytosis but usually does not produce the characteristic neurologic syndrome
- D.** Thiamine deficiency, which can cause neurologic abnormalities but does not typically produce macrocytic anemia
- E.** Copper deficiency, which can cause anemia and myeloneuropathy but has a different typical hematologic pattern

25. A 29-year-old woman with previously stable weight gains 10 kg in 6 months after starting olanzapine. Thyroid testing is normal. What is the most likely contributor?

- A.** Primary hypothyroidism, which is less likely because thyroid testing is normal and the gain closely followed the medication change
- B.** Endogenous Cushing syndrome, which would usually require additional discriminatory clinical features
- C.** Polycystic ovary syndrome, which can coexist with obesity but is not suggested by the medication-linked time course
- D.** Olanzapine-associated weight gain temporally related to initiation of a weight-promoting antipsychotic

E. Major depressive disorder itself, which can affect weight but would not explain the strong temporal medication association as well

26. A 42-year-old woman has severe early-onset obesity due to a confirmed rare melanocortin-pathway genetic disorder. Which principle best distinguishes treatment from common polygenic obesity?

A. Use the genetic diagnosis mainly for prognosis while treating her exactly as common polygenic obesity

B. Use the confirmed pathway diagnosis to consider targeted therapy while continuing standard complication management

C. Focus on complication management because genetic obesity lacks pathway-directed pharmacologic options

D. Prioritize bariatric surgery because genetically mediated hyperphagia is unlikely to respond to medication

E. Choose treatment primarily from current BMI and comorbidity burden because the molecular diagnosis adds little therapeutic information

27. A 62-year-old man with knee osteoarthritis avoids walking because of pain but enjoys water exercise. Which history element is most important for an initial plan?

A. Set a standard step-count target and progress it weekly while using pain medication to maintain walking

B. Choose pain-tolerable, low-impact activity based on function, preference, and realistic access

C. Prescribe brisk land-based walking because weight-bearing exercise should be prioritized over aquatic activity

D. Use upper-body resistance exercise as the primary activity while deferring lower-extremity movement

E. Postpone structured activity until dietary treatment has produced enough weight loss to reduce knee pain

28. A 37-year-old woman with obesity has a seizure disorder controlled with medication. Which anti-obesity medication should generally be avoided because one component lowers the seizure threshold?

A. Orlistat (Xenical/Alli)

- B. Liraglutide (Saxenda)**
- C. Naltrexone/bupropion (Contrave)**
- D. Tirzepatide (Zepbound)**
- E. Semaglutide (Wegovy)**

29. A 40-year-old man with obesity has fatigue and low total testosterone measured once at 3 PM. Which interpretation is most appropriate before attributing his weight gain to hypogonadism?

- A. Diagnose hypogonadism from the low afternoon value if his BMI is above the obesity threshold**
- B. Measure free testosterone once in the afternoon and use that result as definitive confirmation**
- C. Start a therapeutic testosterone trial and use weight change to confirm whether hypogonadism was causal**
- D. Attribute the low total testosterone to obesity initially and repeat testing if sexual or reproductive symptoms persist**
- E. Confirm compatible symptoms and repeat testosterone with appropriately timed testing before diagnosing hypogonadism**

30. Three weeks after bariatric surgery, a patient has persistent vomiting and poor intake followed by confusion, ophthalmoplegia, and gait ataxia. What is the most urgent treatment?

- A. Give intravenous dextrose first, then replace thiamine after the neurologic symptoms begin to improve**
- B. Give prompt parenteral thiamine, ideally before carbohydrate administration, for suspected Wernicke encephalopathy**
- C. Use oral thiamine alone because neurologic manifestations imply a chronic rather than an acute deficiency**
- D. Wait for a serum thiamine level or neuroimaging result before giving vitamin replacement**
- E. Start parenteral vitamin B12 as the initial treatment because postoperative neurologic symptoms most often reflect cobalamin deficiency**

31. A 16-year-old girl with obesity is prescribed an anti-obesity medication. Which monitoring principle is most appropriate?

- A.** Monitor efficacy, adverse effects, growth, development, mental health, and medication-specific safety requirements
- B.** Use the standard adult titration schedule for any anti-obesity drug approved in adolescents
- C.** Track BMI response at each visit and review growth and development at routine age-based preventive intervals
- D.** Follow weight response and gastrointestinal adverse effects but use adult growth assumptions once puberty has begun
- E.** Monitor efficacy and common adverse effects but defer medication-specific laboratory or safety surveillance

32. A 41-year-old rotating-shift nurse has gained 9 kg, sleeps 5 to 6 hours on workdays, and eats at variable times overnight. Which sleep feature is most relevant?

- A.** Address chronic short sleep and circadian disruption because both can worsen appetite regulation and behavior change
- B.** Focus on total weekly sleep duration because circadian timing has little effect if hours are eventually recovered
- C.** Use caffeine strategically near the end of night shifts to normalize circadian alignment and appetite
- D.** Screen for obstructive sleep apnea but do not address shift-related sleep timing unless apnea is confirmed
- E.** Evaluate thyroid function first because rotating night work promotes weight gain primarily through hypothyroidism

33. A 54-year-old woman with BMI 42 kg/m² has no known diagnoses because she has not received medical care for 8 years. What is the best way to characterize her disease severity?

- A.** Use age and obesity class to estimate complication burden before ordering targeted tests
- B.** Classify her severity from BMI alone unless laboratory testing is already abnormal

C. Perform systematic screening for metabolic, mechanical, mental-health, and functional complications

D. Begin with symptom-directed testing and add broader cardiometabolic screening if the initial history suggests complications

E. Use waist circumference and BMI as sufficient measures of clinical severity at the initial visit

34. A 62-year-old man has BMI 34 kg/m² and a waist circumference well above the population-specific risk threshold. What additional information does waist circumference provide?

A. A practical surrogate for visceral fat that can stand in for more detailed anthropometric assessment

B. A surrogate for hepatic steatosis that can replace liver enzymes or imaging

C. Use waist circumference to estimate central adiposity and refine cardiometabolic risk beyond BMI

D. A measure of total body-fat percentage that is more precise than body-composition testing

E. An estimate of skeletal muscle mass that helps distinguish sarcopenia from obesity

35. A 65-year-old woman with obesity and heart failure is starting a weight-management program. Which outcome should be tracked in addition to body weight?

A. Daily calorie intake and sodium intake as the primary measures of whether the heart-failure syndrome is improving

B. Waist circumference and clothing size as the principal indicators of treatment response

C. Body-fat percentage at each visit so fluid-related weight changes can be separated from adipose loss

D. Symptoms, congestion or edema, blood pressure, medication tolerance, and functional capacity in addition to body weight

E. A fixed BMI target as the main endpoint, with heart-failure symptoms assessed only if weight loss stalls

36. A 56-year-old woman with obesity and hypertension wants a dietary pattern that also supports blood-pressure control. Which approach is most appropriate?

- A.** A DASH-style eating pattern emphasizing plant foods and lower sodium intake
- B.** A low-carbohydrate pattern centered on processed meats and cheese
- C.** A portion-controlled pattern built mainly around refined sweets and snack foods
- D.** An animal-food elimination pattern that excludes fruits, grains, and legumes
- E.** A high-sodium broth-based fasting pattern with minimal solid food

37. A patient says her primary goals are walking without knee pain and reducing diabetes medication, not reaching a particular scale number. How should the treatment plan respond?

- A.** Track functional, metabolic, and weight outcomes that directly reflect the patient's stated treatment goals
- B.** Use BMI category change as the primary endpoint and treat pain or glycemia as secondary outcomes
- C.** Focus on reducing diabetes medication and leave knee-related function outside the obesity-treatment plan
- D.** Set clinician-defined weight targets first, then revisit her preferred goals after initial treatment
- E.** Replace her functional goals with a target of at least 10% weight loss before judging treatment benefit

38. A 50-year-old man with obesity and gout is starting a weight-loss program. Which approach is most appropriate?

- A.** Temporarily stop urate-lowering therapy while caloric intake is reduced so medication effects do not obscure progress
- B.** Use a rapid very-low-calorie phase because faster loss is more likely to reduce urate immediately
- C.** Pursue gradual, well-hydrated weight loss while continuing gout-specific management
- D.** Use fluid restriction to accelerate early scale loss while monitoring gout symptoms
- E.** Prefer a very-high-protein ketogenic plan because gout risk is unrelated to the rate or composition of weight loss

39. A 15-year-old girl with obesity misses visits because her parent has unreliable transportation and cannot leave work easily. Which social determinant should be addressed?

- A.** Food insecurity that limits the family's ability to purchase the foods recommended in the treatment plan
- B.** Limited access to safe neighborhood spaces for outdoor physical activity
- C.** Limited health literacy that makes written nutrition instructions difficult for the family to use
- D.** Housing instability that prevents safe food storage and preparation in the home
- E.** Transportation and caregiver scheduling barriers that interfere with reliable attendance and continuity of care

40. A patient using a GLP-1–based obesity medication has persistent severe abdominal pain radiating to the back with vomiting. What is the best next action?

- A.** Treat presumptively for medication-related constipation and reassess if pain persists for several days
- B.** Severe persistent abdominal pain with vomiting warrants urgent assessment for pancreatitis
- C.** Evaluate first for uncomplicated dyspepsia because vomiting is common during dose escalation
- D.** Reduce the next dose but continue therapy while evaluating the pain at routine follow-up
- E.** Continue the medication and manage symptoms with antiemetics unless serum lipase is already elevated

41. A 63-year-old woman with obesity and type 2 diabetes loses 7% of baseline body weight and improves glycemia, blood pressure, and mobility. She is disappointed because she has not reached a 'normal' BMI. What is the best counseling point?

- A.** Continue the current plan if further weight loss toward a normal BMI appears achievable within the next year
- B.** Regard 7% loss as inadequate because cardiometabolic benefits generally require at least 15% loss
- C.** Shift the primary goal to BMI below 25 kg/m² despite improvement in diabetes and mobility
- D.** Escalate treatment because remaining in the obesity BMI range indicates residual risk despite improved health markers

E. Emphasize that modest sustained weight loss can improve glycemia, blood pressure, mobility, and other health outcomes

42. A 51-year-old man with BMI 39 kg/m² reports progressive daytime fatigue and morning headaches. His spouse notes loud snoring and witnessed pauses in breathing. Which historical feature most directly points to a weight-related complication that warrants diagnostic evaluation?

- A. Difficulty initiating sleep on stressful work nights without snoring or breathing pauses
- B. Witnessed apneas during sleep in the setting of loud snoring and daytime symptoms
- C. Intermittent nasal obstruction that varies with seasonal allergy exposure
- D. Restless sensations in the legs that improve with movement before sleep
- E. Frequent nocturia without reports of snoring, choking, or witnessed breathing pauses

43. A 43-year-old woman eats very little during the day and then has large, unplanned evening intake. She denies loss-of-control episodes. Which nutritional strategy is reasonable?

- A. Use a time-restricted eating window that omits breakfast and lunch so intake ends earlier in the day
- B. Prescribe a compensatory low-calorie day after each evening in which intake exceeds the plan
- C. Reduce breakfast carbohydrate and maintain the current daytime meal pattern to lower total energy intake
- D. Establish a more regular daytime meal pattern to reduce extreme hunger and unplanned evening intake
- E. Add a caloric evening beverage to reduce the size of the subsequent solid-food meal

44. A 50-year-old man asks whether obesity is entirely inherited because several relatives have severe obesity. Which statement is most accurate?

- A. Most familial clustering of severe obesity is explained by a single high-penetrance gene
- B. A strong family history means environmental exposures contribute little to the patient's current weight

C. Common obesity is typically polygenic and interacts with environmental and developmental exposures

D. High inherited risk predicts poor response to evidence-based obesity treatment

E. In the absence of a family history, biologic susceptibility is unlikely to contribute meaningfully

45. A 45-year-old man consumes about 30% of his daily food after dinner and wakes to eat several nights weekly, with full awareness and recall. He denies discrete large binges and purging. What is most likely?

A. Avoidant/restrictive food intake disorder

B. Night eating syndrome

C. Sleep-related eating disorder

D. Binge-eating disorder

E. Bulimia nervosa

46. A 40-year-old patient with class 2 obesity has repeatedly lost and regained weight after short-term programs. Which treatment model is most appropriate?

A. Repeat short-term programs whenever BMI rises substantially rather than maintaining continuous follow-up

B. Complete an intensive 4-week intervention, then transition to self-management without scheduled maintenance

C. Use repeated behavioral counseling alone because prior regain indicates escalation would add little

D. Reserve pharmacotherapy or surgery for a future episode after another structured lifestyle program fails

E. Use long-term chronic-disease management with monitoring, maintenance support, and treatment escalation when needed

47. A 39-year-old woman has BMI 31 kg/m², type 2 diabetes, obstructive sleep apnea, and substantial functional limitation from knee osteoarthritis. What best characterizes her obesity severity?

- A.** Use BMI class as the primary disease-severity measure because it standardizes risk across patients
- B.** Use waist circumference as the main severity measure because it better captures visceral adiposity
- C.** Define severity by the number of obesity treatments required rather than by current complications
- D.** Characterize severity by obesity-related complications and functional impairment, not BMI alone
- E.** Classify severity from percent body fat and treat comorbidities as separate diseases

48. A 60-year-old man with obesity and gastroesophageal reflux disease reports worse symptoms after large late-night meals. Which obesity-management recommendation also directly targets reflux?

- A.** Shift most daily calories to the evening but reduce the fat content of the late meal
- B.** Use vigorous exercise immediately after dinner to speed gastric emptying before bedtime
- C.** Replace the late solid meal with an equivalent-calorie liquid meal close to bedtime
- D.** Use smaller earlier meals and avoid recumbency soon after eating during weight management
- E.** Use a large high-fiber bedtime meal to reduce hunger during the night

49. A muscular 27-year-old athlete has BMI 31 kg/m², a small waist circumference, low body fat by validated assessment, and no metabolic abnormalities. What is the key limitation of BMI in this case?

- A.** Use a lower athlete-specific BMI threshold because high muscle mass increases metabolic risk at a given BMI
- B.** BMI is a useful population and screening measure but does not directly measure body composition
- C.** Use BMI as a direct estimate of visceral adiposity because waist circumference is already small
- D.** Interpret BMI normally until age 65, when loss of lean mass becomes the main source of error
- E.** Apply the same BMI value but subtract an adjustment factor based on sex

50. A 52-year-old man asks why two people with similar diets and activity can have very different body weights. Which explanation is most accurate?

- A.** Differences in reported calorie intake are usually sufficient to explain persistent weight differences between individuals
- B.** Genetic predisposition is the dominant determinant, with environmental exposures having little modifying effect
- C.** Variation in resting metabolism alone explains most between-person differences when activity is similar
- D.** Physical activity differences are the main explanation because appetite regulation is relatively uniform across people
- E.** Explain that body weight reflects interacting genetic, biologic, environmental, behavioral, medication, and social influences

51. A 50-year-old woman has BMI 32 kg/m² and inadequately controlled type 2 diabetes despite intensive lifestyle and medical therapy. Which statement is most accurate?

- A.** Continue intensive medical therapy for several more years before reconsidering surgery if diabetes remains inadequately controlled
- B.** Consider metabolic surgery at BMI 30–34.9 kg/m² when metabolic disease remains inadequately controlled despite nonsurgical treatment
- C.** Reserve metabolic surgery for BMI at least 35 kg/m² even when class I obesity is accompanied by uncontrolled diabetes
- D.** Recommend surgery now based on BMI and diabetes alone without assessing operative risk, preferences, or prior therapy
- E.** Consider endoscopic weight-loss procedures but not metabolic surgery because her BMI is below 35 kg/m²

52. A patient asks how endoscopic sleeve gastropasty differs from surgical sleeve gastrectomy. Which statement is correct?

- A.** It removes the entire stomach
- B.** It requires placement of an adjustable gastric band
- C.** Endoscopic suturing that reduces gastric volume without resection
- D.** It is simply another name for surgical sleeve gastrectomy

E. It creates a small bowel bypass

53. A 57-year-old man with obesity has exertional chest pressure relieved by rest. He has hypertension, dyslipidemia, and type 2 diabetes. What is the most important interpretation of this symptom?

A. Treat empirically for gastroesophageal reflux first because exertional discomfort is common in obesity

B. Attribute the symptom to obesity-related deconditioning unless resting electrocardiography is abnormal

C. Increase conditioning exercise and reassess the chest pressure after several weeks

D. Obesity care must identify urgent comorbid disease, not attribute symptoms automatically to weight

E. Use resting heart rate and blood pressure to determine whether cardiovascular evaluation is needed

54. A 67-year-old woman with obesity is losing weight but also losing strength and lean mass. Which nutrition principle is most important?

A. Increase the calorie deficit further because preserving scale-weight loss should take priority over lean mass

B. Adequate protein, resistance exercise, and attention to function help preserve muscle

C. Reduce protein to lower total energy intake while monitoring weight rather than strength

D. Use aerobic exercise alone and defer resistance training until the weight-loss phase is complete

E. Add micronutrient supplements but keep protein and resistance exercise unchanged

55. A patient repeatedly eats chips while watching television even when not hungry. Which behavioral technique most directly targets the environmental cue?

A. Pre-portion a planned serving of chips before television while keeping the snack visible and within reach

B. Replace chips with another highly palatable snack while keeping the same television-eating routine

- C.** Keep chips available but require self-weighing before eating them during television viewing
- D.** Move the same snack to a later evening time so eating is separated from the start of the television program
- E.** Remove chips from the television-viewing environment and create a different routine for that cue

56. A patient develops crampy abdominal pain, palpitations, flushing, and diarrhea soon after a high-sugar meal following Roux-en-Y gastric bypass. What is the most likely diagnosis?

- A.** Early dumping syndrome from rapid delivery of hyperosmolar carbohydrate into the small intestine
- B.** Post-bariatric hypoglycemia, which more often causes adrenergic or neuroglycopenic symptoms later after eating
- C.** Marginal ulcer, which more often causes persistent or meal-related epigastric pain rather than flushing and diarrhea
- D.** Internal hernia, which can cause intermittent severe abdominal pain and obstructive symptoms
- E.** Anastomotic stricture, which more often causes progressive intolerance of solid food and vomiting

57. A 7-year-old boy has severe obesity beginning before age 3, extreme hyperphagia, and a family history of similarly severe early-onset obesity. Which feature most strongly supports evaluation for a monogenic cause?

- A.** Severe obesity beginning before age 5 together with marked hyperphagia and a strong family pattern of similarly early disease
- B.** Obesity beginning during puberty with gradual weight gain and no hyperphagia or developmental abnormalities
- C.** A family history of common adult-onset obesity in several relatives without severe childhood disease
- D.** Acanthosis nigricans and hypertriglyceridemia developing after years of progressive obesity
- E.** Weight gain beginning after reduced activity following an orthopedic injury in later childhood

58. A 46-year-old man weighs 108 kg and is 1.80 m tall. What is his BMI, rounded to one decimal place?

- A.** 46.3 kg/m²
- B.** 36.7 kg/m²
- C.** 30.0 kg/m²
- D.** 33.3 kg/m²
- E.** 41.2 kg/m²

59. A 36-year-old woman with migraines asks which medication is more likely to favor weight loss rather than gain.

- A.** Pregabalin
- B.** Valproate
- C.** Olanzapine
- D.** Topiramate
- E.** Mirtazapine

60. A 42-year-old man uses daily self-weighing successfully and is not distressed by it. What is the best advice?

- A.** Change the treatment plan whenever weight rises on two consecutive daily measurements
- B.** Continue regular trend-focused self-weighing because it is useful and not causing psychological distress
- C.** Use symptom-triggered weighing when clothing fit, appetite, or edema suggests a meaningful change
- D.** Use scale trends as the principal outcome and reduce attention to metabolic or functional measures
- E.** Reduce weighing frequency because regular self-weighing generally undermines long-term maintenance

61. A 16-year-old girl with obesity sometimes eats a normal-sized snack but feels unable to stop and is distressed. Why does this history matter even if the amount is not objectively large?

- A.** Assess clinically important loss-of-control eating even when the amount consumed is not objectively large
- B.** Classify the episodes as night-eating syndrome because they tend to occur after school
- C.** Reassure her because the amount eaten is not objectively large enough to meet binge criteria
- D.** Treat the episodes as ordinary adolescent appetite variation unless body weight increases further
- E.** Diagnose bulimia nervosa from loss of control even without compensatory behaviors

62. A 63-year-old man with obesity is scheduled for total knee arthroplasty and is told he must lose a large amount of weight within 3 weeks or surgery will be canceled. What is the best obesity-medicine response?

- A.** Set a very-low-calorie target designed to achieve the requested amount before the operation
- B.** Use a commercially available fasting program without laboratory or nutritional monitoring
- C.** Use a safe, medically supervised perioperative plan that protects nutrition rather than chasing a short-term scale target
- D.** Prioritize the requested preoperative scale target while using short-term protein supplementation to limit nutritional compromise
- E.** Use short-term fluid and sodium restriction to meet the preoperative weight requirement

63. A 14-year-old with severe obesity has obstructive sleep apnea and hypertension despite intensive treatment. Which next step is appropriate?

- A.** Refer to a multidisciplinary pediatric metabolic and bariatric surgery center while continuing comprehensive obesity care
- B.** Delay referral until age 18 because pediatric surgery programs are intended mainly for older adolescents
- C.** Apply adult BMI thresholds directly without using pediatric severe-obesity criteria or developmental assessment
- D.** Complete nonsurgical treatment first and reconsider surgical referral after the adolescent reaches adult height

E. Discuss surgery after the adolescent identifies weight or appearance as a major personal treatment priority

64. A patient stops an effective GLP-1–based obesity medication because insurance coverage ends and begins regaining weight. What is the best next step?

- A. Pause structured obesity follow-up until insurance coverage for the original medication returns
- B. Continue intensive lifestyle treatment after coverage loss and reconsider medication when access to the original agent returns
- C. Interpret the regain as evidence that the prior medication response was not clinically meaningful
- D. Substitute a compounded GLP-1 product immediately without confirming formulation quality, indication, or access to approved therapy
- E. Address medication-access barriers and offer alternative evidence-based treatment while reinforcing maintenance behaviors

65. A 34-year-old woman has recurrent binges followed by self-induced vomiting and stimulant-laxative misuse and requests a very-low-calorie diet. What should the clinician do first?

- A. Aggressive restriction can worsen the binge-purge cycle, so eating-disorder treatment takes priority
- B. Use a short supervised fast to reduce binge triggers before starting eating-disorder treatment
- C. Begin calorie restriction now while monitoring purging frequency separately
- D. Start a very-low-calorie diet because higher BMI reduces the medical risk of restriction
- E. Address laxative misuse first but defer evaluation of binge-purge behavior until weight loss is underway

66. A patient with prior Roux-en-Y gastric bypass develops sudden severe intermittent abdominal pain with nausea. The examination is initially not dramatic. What serious late complication must remain high on the differential?

- A. Marginal ulcer causing more localized epigastric pain, often related to ulcer risk factors
- B. Internal hernia causing intermittent small-bowel obstruction after Roux-en-Y gastric bypass

- C. Anastomotic stricture causing progressive dysphagia or vomiting rather than intermittent severe pain
- D. Symptomatic cholelithiasis causing episodic right upper quadrant or epigastric pain after meals
- E. Post-bariatric hypoglycemia causing adrenergic or neuroglycopenic symptoms after carbohydrate intake

67. A 51-year-old man with BMI 41 kg/m² has moderate-to-severe obstructive sleep apnea. Which anti-obesity medication has an FDA indication for moderate-to-severe OSA in adults with obesity, together with reduced-calorie diet and increased physical activity?

- A. Orlistat
- B. Phentermine alone
- C. Tirzepatide
- D. Topiramate alone
- E. Naltrexone/bupropion

68. A 16-year-old girl wants to understand why she overeats most evenings after school. Which initial behavioral strategy is most useful?

- A. Track intake together with hunger, mood, setting, sleep, and antecedents to identify the adolescent's evening triggers
- B. Start with a carbohydrate-elimination plan to test whether evening hunger improves
- C. Use weekly weighing as the main behavioral assessment before collecting eating-context data
- D. Avoid self-monitoring because tracking intake can be distressing in any adolescent
- E. Ask her to recall evening episodes at the next routine visit rather than collecting contemporaneous information

69. A 64-year-old man with obesity and chronic kidney disease starts a commercial high-protein weight-loss diet. What detail is most important before endorsing it?

- A. Whether the plan uses intermittent fasting, regardless of the patient's renal function or total protein prescription

- B.** Whether carbohydrate intake falls below a fixed percentage of total calories in the commercial program
- C.** Whether the diet relies on branded meal products rather than home-prepared foods
- D.** Whether fruit intake is limited enough to reduce potassium exposure before reviewing the patient's laboratory data
- E.** Whether the proposed protein target is appropriate for his kidney function, CKD stage, and renal nutrition plan

70. A 49-year-old man takes prednisone 20 mg daily for months and develops central weight gain, proximal weakness, and hypertension. What is the best interpretation?

- A.** Attribute the weight gain primarily to excess carbohydrate intake because prednisone itself is usually weight neutral
- B.** Interpret the proximal weakness and hypertension as consequences of obesity without considering medication effects
- C.** Consider glucocorticoid-related weight effects more strongly with parenteral exposure than with a stable oral dose
- D.** Systemic glucocorticoids can increase appetite, alter fat distribution, worsen insulin resistance, and produce Cushingoid features
- E.** Expect reduced appetite from prednisone and investigate a separate cause for the weight gain

71. A 52-year-old man has obesity, binge-eating disorder, uncontrolled hypertension, and chronic opioid therapy. What should guide medication selection?

- A.** Start two anti-obesity medications together at full doses to maximize early efficacy
- B.** Choose medication from BMI alone because comorbidities mainly affect follow-up rather than selection
- C.** Use comorbidities, contraindications, drug interactions, and safety factors to narrow medication choices before comparing efficacy
- D.** Choose the most effective agent first and modify therapy if opioid use or blood pressure creates treatment problems

E. Select the agent with the greatest average trial weight loss without first screening contraindications

72. A 47-year-old man with obesity and stage 4 chronic kidney disease seeks pharmacologic weight treatment. Which prescribing principle is most important?

A. Avoid pharmacologic obesity treatment because stage 4 CKD makes weight-loss medication inherently unsafe

B. Use standard maximal doses to avoid undertreatment caused by conservative renal prescribing

C. Assume renal clearance and adverse-effect risk are similar to those in patients with normal kidney function

D. Advanced kidney disease changes the suitability, dosing, and monitoring of several medications

E. Select therapy by expected efficacy and use standard dosing unless renal prescribing information specifies an adjustment

73. A 45-year-old man with obesity has a personal history of medullary thyroid carcinoma. Which medication class is generally contraindicated on this basis?

A. Avoid GLP-1–based obesity medications that carry a contraindication for medullary thyroid carcinoma or MEN2

B. Gastrointestinal lipase inhibitors because reduced fat absorption increases thyroid-cancer recurrence

C. Sympathomimetic obesity medications because thyroid C-cell tumors are linked to adrenergic stimulation

D. Bupropion-containing regimens because antidepressants are contraindicated after medullary thyroid carcinoma

E. Metformin-based regimens because prior thyroid malignancy precludes insulin-sensitizing therapy

74. A 17-year-old athlete with obesity wants an over-the-counter 'fat burner' containing multiple stimulants and proprietary ingredients. What is the most appropriate response?

A. Review the ingredients and allow a short trial if each stimulant is individually available over the counter

- B.** Recommend choosing a product with a proprietary blend because the exact stimulant doses are less likely to be excessive
- C.** Use the supplement only on training days to reduce cumulative stimulant exposure while preserving the desired effect
- D.** Recommend a lower-than-labeled dose while monitoring heart rate and blood pressure during athletic participation
- E.** Discourage use of an unregulated stimulant weight-loss supplement and review safer evidence-based options

75. A 74-year-old man with obesity, frailty, and sarcopenia wants aggressive weight loss. What is the most important modification to treatment?

- A.** Use an aggressive deficit first, then add strength-focused treatment after a substantial weight reduction
- B.** In older adults, weight loss can worsen sarcopenia unless treatment protects muscle and function
- C.** Prioritize maximal weekly weight loss because lower body mass will by itself reverse frailty
- D.** Emphasize low-impact aerobic exercise and avoid resistance loading because of his age
- E.** Use body weight as the principal outcome even if strength and walking capacity decline

76. A 52-year-old man with obesity and schizophrenia is stable only on clozapine after prior relapses. He wants help with weight gain. What is the best principle?

- A.** Ask psychiatry to switch clozapine primarily because weight gain is present, even though previous medication changes led to relapse
- B.** Treat obesity with evidence-based strategies while coordinating any psychotropic changes so psychiatric stability is protected
- C.** Add a stimulant-based weight-loss supplement to offset appetite effects while preserving the antipsychotic regimen
- D.** Continue clozapine and limit obesity care to lifestyle counseling because medication-associated weight gain is unavoidable
- E.** Delay obesity pharmacotherapy or metabolic treatment until schizophrenia has been in prolonged remission

77. An 11-year-old child has hyperphagia, developmental delay, hypotonia in infancy, short stature, and obesity. Which diagnosis should be considered?

- A.** Bardet-Biedl syndrome, in which retinal dystrophy and polydactyly are more characteristic clues
- B.** Melanocortin-4 receptor deficiency, which can cause severe hyperphagic obesity but not the classic infantile hypotonia-developmental phenotype
- C.** Prader-Willi syndrome, classically associated with infantile hypotonia followed by hyperphagia, developmental difficulties, short stature, and obesity
- D.** Leptin-receptor deficiency, which can cause severe early hyperphagic obesity but has a different syndromic profile
- E.** Hypothalamic obesity after acquired CNS injury, which would require a history of tumor, surgery, radiation, or other hypothalamic damage

78. A clinic has chairs with arms that do not accommodate many patients with severe obesity, gowns that do not fit, and scales located in a public hallway. What is the best systems-level response?

- A.** Keep the current equipment but offer private weighing only to patients who specifically request it
- B.** Obtain one high-capacity scale but continue using standard chairs and gowns unless a patient cannot use them
- C.** Provide appropriately sized seating, gowns, examination and weighing equipment, with private and respectful weighing procedures
- D.** Refer patients with very high body weight to another clinic whenever standard examination equipment is inadequate
- E.** Ask staff to improvise equipment accommodations case by case rather than changing the clinic environment

79. A 54-year-old man with poorly controlled hypertension and resting tachycardia asks for phentermine. Which concern is most important?

- A.** Phentermine's sympathomimetic effects can raise pulse and blood pressure in this patient
- B.** Concern for delayed gastric emptying because phentermine acts primarily through gastrointestinal motility

- C. Concern for recurrent hypoglycemia because sympathomimetics directly stimulate insulin secretion
- D. Concern for fat-soluble vitamin deficiency because phentermine inhibits intestinal lipases
- E. Concern for opioid withdrawal because phentermine has clinically important opioid-antagonist activity

80. A 61-year-old woman with obesity is referred solely because a random afternoon cortisol level was mildly elevated. She has no proximal weakness, bruising, facial plethora, or violaceous striae. What is the best next step?

- A. Reassess pretest probability before Cushing testing; testing should be guided by discriminatory clinical features
- B. Evaluate for adrenal insufficiency because a mildly elevated afternoon cortisol can reflect impaired adrenal reserve
- C. Proceed directly to formal Cushing syndrome testing because obesity plus any elevated cortisol creates high pretest probability
- D. Begin a glucocorticoid taper trial to determine whether the weight changes respond to lower cortisol exposure
- E. Diagnose endogenous Cushing syndrome if a repeat random cortisol is again above the laboratory reference range

81. A man with obesity, type 2 diabetes, and recurrent hypoglycemia is losing weight rapidly after starting intensive obesity treatment. What should be reassessed promptly?

- A. Continue current diabetes doses and treat each hypoglycemic episode with additional carbohydrate
- B. Reduce glucose monitoring because rapid weight loss makes capillary readings less representative
- C. Stop glucose monitoring first to determine whether symptoms persist without attention to numerical values
- D. Reassess insulin and insulin-secretagogue doses promptly as intake falls and glycemia improves
- E. Increase basal insulin because rapid weight loss can transiently raise hepatic glucose production

82. A clinician writes, 'morbidly obese, noncompliant patient refuses to lose weight' in the chart. Which revision is most appropriate?

- A.** Document 'poor adherence' as the primary problem because the patient has not achieved the recommended weight loss
- B.** Retain 'morbidly obese' but replace 'noncompliant' with 'declined treatment' to make the note more neutral
- C.** Describe the patient's motivation as low when recommended behaviors have not been implemented
- D.** Avoid documenting weight-related barriers so the chart does not reinforce stigma
- E.** Use person-first, neutral, behavior-specific documentation and record barriers or preferences without character judgments

83. A 49-year-old woman with obesity and hypertension loses 12% of her weight and develops lightheadedness with blood pressure 98/62 mm Hg while taking three antihypertensives. What is the best next step?

- A.** Use fluid restriction to determine whether the dizziness is due to residual obesity-related hypertension
- B.** Attribute the dizziness first to deconditioning or reduced caloric intake and keep antihypertensives unchanged pending follow-up
- C.** Reassess antihypertensives and volume status; antihypertensive regimens should be reassessed to prevent symptomatic hypotension
- D.** Keep the regimen unchanged and reassess at the next routine visit if systolic pressure remains below 100 mm Hg
- E.** Increase antihypertensive therapy to protect against rebound hypertension during continued weight loss

84. A public-health campaign wants to encourage healthier environments without stigmatizing people with obesity. Which approach is best?

- A.** Use images emphasizing severe health consequences to increase perceived personal responsibility

- B.** Center messaging on individual calorie choices because public campaigns should avoid structural explanations
- C.** Use before-and-after body images to motivate change even if the imagery may reinforce stereotypes
- D.** Design the campaign without input from people living with obesity to avoid normalizing higher body weight
- E.** Promote access to nutritious food, safe activity, and healthcare using nonstigmatizing public-health messaging

85. A 55-year-old man with obesity has biopsy-confirmed noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with F2-F3 fibrosis. Which obesity medication also has an FDA indication to treat this liver condition?

- A.** Tirzepatide (Zepbound), because its obesity indication automatically extends to fibrotic MASH
- B.** Orlistat (Xenical), because intestinal fat malabsorption directly reverses hepatic fibrosis
- C.** Semaglutide (Wegovy), which has an FDA indication for noncirrhotic MASH with moderate-to-advanced fibrosis
- D.** Naltrexone/bupropion (Contrave), because central appetite suppression is an approved antifibrotic therapy
- E.** Phentermine/topiramate extended release (Qsymia), because weight loss alone creates a labeled MASH indication

86. A patient asks which common operation both reduces gastric capacity and bypasses a segment of proximal small intestine. Which procedure is this?

- A.** Endoscopic intragastric balloon placement
- B.** Sleeve gastrectomy
- C.** Liposuction
- D.** Roux-en-Y gastric bypass
- E.** Adjustable gastric banding

87. A 43-year-old woman with obesity has major depressive disorder that is improving on treatment. How should depression influence obesity care?

- A.** Postpone obesity treatment until depression has been in full remission for a prolonged period
- B.** Stop the antidepressant first to see whether medication-associated weight effects are limiting progress
- C.** Defer structured behavioral treatment because depression makes adherence too unreliable
- D.** Focus early visits on weight treatment and intensify mood monitoring if adherence, function, or response worsens
- E.** Depression and obesity commonly coexist and can influence adherence, appetite, activity, and medication choice

88. A 5-year-old girl develops severe hyperphagic obesity after previously normal growth. Genetic testing shows biallelic loss-of-function variants affecting leptin signaling. Which broad mechanism is responsible?

- A.** Chronic catecholamine excess
- B.** Disruption of hypothalamic satiety signaling
- C.** Primary intestinal malabsorption
- D.** Excessive thyroid hormone production
- E.** Increased renal glucose loss

89. A 15-year-old adolescent has severe obesity with major comorbidities despite intensive multidisciplinary treatment. Which statement is most accurate?

- A.** Require evidence of irreversible organ damage before discussing surgery in an adolescent
- B.** Delay surgical evaluation until at least age 18 even when severe obesity and major comorbidities persist
- C.** Refer the adolescent to an experienced multidisciplinary metabolic and bariatric surgery program for evaluation
- D.** Base eligibility on chronologic age rather than obesity severity, development, comorbidities, and readiness

E. Use surgery as a replacement for family-based nutrition and behavioral follow-up

90. A 16-year-old girl with obesity lost 8% of body weight in a family-based program 3 years ago but regained it after follow-up ended. Which additional history is most useful for understanding her long-term weight trajectory?

A. The largest single-day weight change recorded during the prior program

B. Whether her prior program used calorie counting or portion-based meal planning

C. The exact clothing size she wore at the time of her lowest weight

D. Age at onset, growth trajectory, prior treatment response, and context surrounding weight regain

E. Whether the family used a home scale or clinic scale during the prior intervention

91. A woman using semaglutide for obesity develops recurrent postprandial right upper quadrant pain after rapid weight loss. Which complication should be considered?

A. Gallbladder disease such as cholelithiasis, which can emerge during substantial or rapid weight loss

B. Renal colic from nephrolithiasis as the most likely medication-associated cause of postprandial right upper quadrant pain

C. Acute appendicitis because rapid weight loss specifically increases appendiceal inflammation

D. Hyperthyroidism because GLP-1 therapy commonly causes thyroid hormone excess during rapid weight loss

E. Functional dyspepsia because gallstone disease is not associated with rapid pharmacologic weight loss

92. A woman plans pregnancy and is using an energy-restricted diet for obesity treatment. Which micronutrient issue deserves particular attention before conception?

A. Use a larger preconception calorie deficit even if dietary variety and micronutrient intake decrease

B. Reduce folate-rich foods to keep carbohydrate intake low during the preconception period

- C.** Focus preconception counseling on achieving a healthy energy intake, then intensify micronutrient planning once pregnancy is confirmed
- D.** Delay discussion of prenatal supplementation until weight loss is complete
- E.** Preconception care should support nutrient adequacy, including folate, while managing obesity safely

93. A 14-year-old adolescent has severe obesity since infancy, intense hyperphagia, and accelerated linear growth. There are no dysmorphic features or developmental delay. Which finding makes a melanocortin-4 receptor pathway defect more plausible than a syndromic obesity disorder?

- A.** Progressive retinal degeneration and polydactyly
- B.** New obesity beginning after corticosteroid therapy
- C.** Isolated severe early-onset hyperphagic obesity
- D.** Infantile hypotonia with developmental delay
- E.** Multiple congenital anomalies

94. A 44-year-old woman asks whether there is one macronutrient composition that is clearly best for long-term weight loss for every patient. Which answer is most accurate?

- A.** Choose a sustainable, nutritionally adequate energy-reduced pattern tailored to medical needs, culture, preferences, and adherence
- B.** Use a very-low-carbohydrate pattern because carbohydrate restriction has a metabolic advantage independent of adherence
- C.** Use a low-fat macronutrient target broadly because composition is a stronger predictor of long-term outcome than adherence
- D.** Use a high-protein target as the main determinant of success, with comorbidity-specific adjustments made later
- E.** Set dietary fat below 10% of energy because lower-fat patterns consistently outperform other energy-reduced diets

95. A 36-year-old woman gains 12 kg over 8 months and develops fatigue, constipation, cold intolerance, dry skin, and bradycardia. Which test is the most appropriate initial evaluation for a secondary contributor to weight gain?

- A.** Serum thyroid-stimulating hormone as the appropriate initial test for suspected primary hypothyroidism
- B.** Plasma free metanephrines because fatigue and weight gain are common presentations of catecholamine excess
- C.** Late-night salivary cortisol as the first test because rapid weight gain alone strongly suggests hypercortisolism
- D.** Insulin-like growth factor 1 because dry skin and bradycardia are typical manifestations of growth hormone excess
- E.** Morning serum cortisol because adrenal insufficiency is a common cause of rapid weight gain with constipation

96. A smoker who frequently uses nonsteroidal anti-inflammatory drugs develops epigastric pain after Roux-en-Y gastric bypass. Which complication is particularly concerning?

- A.** Symptomatic cholelithiasis, which more often causes episodic right upper quadrant or epigastric pain after meals
- B.** Marginal ulcer at the gastrojejunal anastomosis, for which smoking and NSAID exposure are important risk factors
- C.** Gastrojejunal anastomotic stricture, which more often presents with progressive postprandial vomiting or dysphagia
- D.** Acute pancreatitis, which usually causes persistent severe epigastric pain often radiating to the back
- E.** Internal hernia, which often causes intermittent or acute abdominal pain and obstructive symptoms

97. A 58-year-old man has limited literacy and becomes overwhelmed by a detailed 12-page behavior plan. What is the best adaptation?

- A.** Use numerical calorie and macronutrient targets because numbers reduce the need for written explanation

- B.** Keep the full plan unchanged and interpret missed steps as evidence that motivation is insufficient
- C.** Pause structured treatment until he can demonstrate understanding of the original written material
- D.** Add more technical education so he has complete information before simplifying the behavior goals
- E.** Use plain language, prioritized actions, teach-back, and simple tracking matched to the patient's health literacy

98. A sedentary 50-year-old woman with obesity wants to begin exercise but becomes discouraged by the goal of 150 minutes immediately. What is the best initial advice?

- A.** Start with a tolerable amount of activity, reduce sedentary time, and progress gradually toward guideline-based targets
- B.** Begin with resistance exercise because short bouts can feel more achievable than building aerobic duration
- C.** Start high-intensity intervals to achieve the target in less total exercise time
- D.** Delay activity counseling until she is ready to meet the full weekly aerobic target
- E.** Focus first on dietary weight loss and add activity after she can complete 150 minutes in a single week

99. A 47-year-old man sets a goal to 'exercise more.' Which revision best follows SMART goal principles?

- A.** Exercise on days when motivation feels high and increase duration when energy permits
- B.** Walk 20 minutes after dinner on Monday, Wednesday, Friday, and Saturday for the next two weeks
- C.** Increase weekly activity substantially before the next clinic visit
- D.** Schedule a daily workout for the next month and adjust duration according to fatigue
- E.** Lose 30 kg over the next several months by exercising more often

100. A 49-year-old man with BMI 38 kg/m² has blood pressure 148/92 mm Hg on two properly performed clinic visits, and home readings over the following week average 146/90 mm Hg. He is not taking antihypertensive medication. Which diagnosis is most appropriate?

- A.** White-coat hypertension because the clinic readings are higher than the threshold for hypertension
- B.** Elevated blood pressure that does not yet meet criteria for hypertension because treatment has not started
- C.** Isolated systolic hypertension because the systolic pressure is elevated above the diagnostic threshold
- D.** Orthostatic intolerance because obesity can alter autonomic blood-pressure responses
- E.** Hypertension supported by repeated elevated clinic and out-of-office measurements

101. A physician is unfamiliar with the nutritional complications of a bariatric procedure performed at another center. What is the best next step?

- A.** Temporarily hold nonessential supplements while clarifying the procedure and expected deficiency profile
- B.** Continue the patient's existing supplements but defer surveillance because the operation was performed elsewhere
- C.** Use generic postoperative advice without obtaining the operative history or procedure-specific guidance
- D.** Seek current evidence or expert bariatric consultation and arrange procedure-specific nutritional monitoring
- E.** Make nutrition recommendations from personal experience before reviewing current bariatric guidance

102. A patient with obesity eats most meals from restaurants and estimates portions by eye. Which counseling tool is most useful for portion awareness?

- A.** Focus on food quality first and postpone portion-size counseling until weight loss plateaus
- B.** Track meal frequency and restaurant visits but leave portion size unmeasured

- C. Use standard restaurant serving assumptions rather than checking posted nutrition information or plate size
- D. Use fullness after the meal as the main estimate of how much energy the portion contained
- E. Teach practical portion guides and use restaurant nutrition information when available to improve portion awareness

103. A 40-year-old woman with obesity drinks four to five alcoholic beverages nightly and uses alcohol to cope with stress. What is the key next step?

- A. Start pharmacotherapy first and reassess alcohol use after early weight response is known
- B. Address alcohol after the first phase of weight treatment if it continues to interfere with calorie goals or adherence
- C. Fit the alcohol into a calorie target by reducing food intake earlier in the day
- D. Alcohol can add energy, worsen sleep, interact with medications, and represent a substance-use disorder requiring direct treatment
- E. Count the alcohol calories but defer assessment of coping, dependence, or alcohol-related harm

104. A resident describes obesity as simply the result of 'calories in exceeding calories out.' Which refinement is most appropriate?

- A. Use energy-balance arithmetic as the full explanation because biologic regulation does not materially alter intake or expenditure
- B. Discard energy balance as a model because obesity is determined by hormones rather than energy intake and expenditure
- C. Appetite, satiety, adaptive thermogenesis, sleep, medications, environment, and genetics influence both sides of the equation
- D. Treat macronutrient calories as physiologically distinct enough that a single energy-balance framework has limited clinical value
- E. Focus on exercise expenditure because resting metabolism and appetite regulation contribute little to long-term weight change

105. A 9-year-old child with severe early-onset obesity has hyperphagia, retinal dystrophy, and postaxial polydactyly. Which syndromic diagnosis is most likely?

- A.** Alström syndrome, which can cause retinal degeneration and obesity but is not typically characterized by postaxial polydactyly
- B.** Bardet-Biedl syndrome, characterized by retinal dystrophy, postaxial polydactyly, and obesity among its core features
- C.** Cohen syndrome, which can include developmental abnormalities and truncal obesity but has a different characteristic phenotype
- D.** Leptin-receptor deficiency, which can cause severe early hyperphagic obesity without the classic syndromic retinal and limb findings
- E.** Prader-Willi syndrome, which is associated with hyperphagia and developmental features but not the classic retinal dystrophy-polydactyly combination

106. A 53-year-old woman with obesity and type 2 diabetes needs intensification of glucose-lowering therapy. Which principle best aligns diabetes and obesity treatment?

- A.** Select diabetes therapy without considering weight effects because obesity can be managed independently afterward
- B.** Prioritize glucose lowering even if the selected medication commonly promotes weight gain and alternatives are appropriate
- C.** Choose a weight-promoting glucose-lowering agent to make subsequent obesity treatment easier to evaluate
- D.** When appropriate, glucose-lowering therapies with favorable weight effects can support both diabetes and obesity goals
- E.** Treat glycemia and body weight as separate targets even when one medication choice can influence both

107. A 39-year-old woman reports six prior attempts at weight loss, each producing 5% to 9% loss followed by regain after self-monitoring stopped. What is the most useful conclusion?

- A.** Document the single greatest prior loss because smaller responses add little to treatment planning
- B.** Avoid pharmacotherapy because repeated regain after behavioral treatment predicts poor medication response

- C.** Give greater weight to the largest and most durable prior response because shorter 5% to 9% losses offer limited planning value
- D.** Abandon lifestyle components because recurrence shows that behavior-based treatment has no future role
- E.** Recognize repeated initial response but inadequate long-term maintenance support after self-monitoring stopped

108. A 16-year-old girl with obesity has depressed mood, hypersomnia, low energy, increased appetite, and school withdrawal. Why is neuropsychiatric assessment important before intensifying obesity treatment?

- A.** Attribute the symptoms to obesity-related fatigue unless a separate psychiatric diagnosis was established before weight gain
- B.** Focus treatment on calorie intake first because mood symptoms are secondary to obesity in most adolescents
- C.** Delay obesity treatment until depression has fully resolved because concurrent treatment creates competing goals
- D.** Start obesity treatment while monitoring mood, then intensify depression treatment if symptoms persist despite improved routine and activity
- E.** Assess and treat depression concurrently because mood affects appetite, activity, adherence, safety, and obesity-treatment selection

109. A 16-year-old with obesity and depression wants treatment, and the parents are supportive. Which planning approach is best?

- A.** Start family-based obesity treatment and add formal mental-health treatment if depressive symptoms interfere with function or adherence
- B.** Have the parents make the major treatment decisions because adolescent involvement can reduce adherence
- C.** Use an adult obesity plan with standard targets because physiologic treatment principles do not differ in adolescence
- D.** Integrate family-based obesity care with adolescent mental-health treatment and developmentally appropriate shared decision-making

E. Set a rapid weight-loss target before treating depression so mood response can be judged against weight change

110. A 34-year-old woman with obesity has food insecurity and cannot afford the meal plan previously prescribed. What is the best revision?

A. Keep the prescribed foods but reduce portion sizes so the weekly cost falls without changing the plan's structure

B. Focus on adherence to the original plan first, then address food access if weight response remains inadequate

C. Redesign the plan around affordable, accessible foods and connect her with food-assistance resources because feasibility is part of effective care

D. Pause active obesity treatment until household food access is stable enough to support a standard meal plan

E. Replace meals with commercial supplements because standardized products simplify calorie control when food choices are limited

111. A 42-year-old man has rapid central weight gain, proximal muscle weakness, easy bruising, facial plethora, and wide violaceous striae. Which secondary cause should be evaluated?

A. Type 1 diabetes

B. Acromegaly

C. Cushing syndrome

D. Primary hyperparathyroidism

E. Addison disease

112. A 12-year-old with obesity is growing normally. The family asks for a very-low-calorie adult diet found online. What is the best recommendation?

A. Use intermittent fasting because shorter eating windows can reduce calories without altering food choice

B. Intensive family-based, nutritionally adequate treatment is preferred over unsupervised extreme restriction

- C. Apply the adult very-low-calorie plan with smaller portions but the same degree of restriction
- D. Set weight-loss goals without using the child's growth trajectory because current BMI percentile is sufficient
- E. Use a very-low-fat diet during puberty to create a larger energy deficit while preserving protein

113. A 16-year-old boy has BMI at the 97th percentile for age and sex. Which approach is appropriate for classifying adiposity in this patient?

- A. Classify risk with adult waist cut points because puberty makes BMI percentiles unreliable
- B. Use age- and sex-specific pediatric BMI percentiles and interpret them within normal growth and development
- C. Defer formal classification until late adolescence because BMI percentile changes rapidly during puberty
- D. Use the adult BMI threshold of 30 kg/m² once height velocity begins to slow
- E. Use weight-for-age alone because height contributes little to adolescent adiposity classification

114. A 44-year-old man has BMI 38 kg/m², type 2 diabetes, hypertension, and obstructive sleep apnea despite comprehensive medical treatment. Which statement best reflects contemporary indications for metabolic and bariatric surgery?

- A. Reserve surgery until diabetes has progressed despite evidence-based medical therapy to end-organ complications
- B. Use BMI 40 kg/m² as the surgical threshold because comorbidities do not lower the contemporary threshold
- C. Defer surgery until BMI exceeds 50 kg/m² because operative benefit is clearest in more severe obesity
- D. Recommend metabolic and bariatric surgery evaluation at BMI at least 35 kg/m² after appropriate multidisciplinary assessment
- E. Treat obstructive sleep apnea as a contraindication until positive-airway-pressure therapy has normalized symptoms

115. A 72-year-old with obesity, frailty, and diabetes wants to improve mobility. Which plan best fits his goals?

- A.** Keep diabetes medications unchanged during dietary treatment so glucose response can be compared with baseline therapy
- B.** Use body weight and glycemic markers as outcomes while leaving formal functional assessment out of the plan
- C.** Pursue a large initial calorie deficit to improve mobility rapidly, then address strength if it declines
- D.** Use calorie restriction with aerobic conditioning but defer resistance work because frailty increases exercise risk
- E.** In older adults, treatment should protect lean mass and function while accounting for medication changes and hypoglycemia risk

116. A 34-year-old woman with obesity has active bulimia nervosa with frequent purging. What is the best initial priority?

- A.** Begin weight-focused treatment while monitoring purging because a higher BMI lowers the urgency of eating-disorder care
- B.** Prioritize specialized eating-disorder treatment and stabilize active bulimia before initiating a routine restrictive weight-loss program
- C.** Use fasting to interrupt binge-purge cycles before referring for specialized eating-disorder treatment
- D.** Use frequent weight feedback as the main motivational tool because objective weight can challenge distorted eating beliefs
- E.** Start pharmacotherapy for obesity first and reassess the eating disorder if purging persists after weight loss

117. A 72-year-old man with obesity takes metoprolol for a remote indication that is no longer clear. Why review it rather than simply stop it?

- A.** Confirm the cardiovascular indication before changing a beta blocker that may affect weight or exercise tolerance

- B.** Assume the beta blocker is the main cause of severe obesity because weight gain is a class-defining adverse effect
- C.** Continue metoprolol specifically as an obesity treatment because reduced adrenergic tone improves appetite control
- D.** Stop metoprolol because beta-blocker effects on exercise capacity outweigh any prior cardiovascular indication
- E.** Change the medication based on weight effects before confirming why it was originally prescribed

118. A 38-year-old woman becomes pregnant 4 months after bariatric surgery. What is the most important management principle?

- A.** Use standard prenatal care alone because bariatric nutritional risks diminish once pregnancy begins
- B.** Coordinate high-risk obstetric follow-up with bariatric nutritional surveillance and micronutrient management
- C.** Use blood count and fetal growth as practical triggers for expanded micronutrient testing during pregnancy after bariatric surgery
- D.** Continue active postoperative weight-loss goals through pregnancy while monitoring fetal growth
- E.** Stop bariatric vitamin supplements during pregnancy to avoid fetal exposure to high nutrient doses

119. A 38-year-old man with obesity and HIV is gaining weight after an antiretroviral regimen change. What is the best approach?

- A.** Choose obesity medication without reviewing antiretroviral interactions because the treatments act through separate pathways
- B.** Change or stop the antiretroviral regimen independently to test whether weight gain reverses
- C.** Attribute the gain mainly to diet and activity unless the regimen has a recognized association with weight change
- D.** Avoid pharmacologic obesity treatment because HIV infection itself is a contraindication to weight-loss medication

E. Antiretroviral regimen effects, drug interactions, and cardiometabolic risk should be reviewed collaboratively

120. A man with obesity drinks three 20-ounce sugar-sweetened beverages daily. Which initial nutrition change is likely to reduce energy intake with minimal loss of satiety?

- A. Replace the beverages with an equal volume of 100% fruit juice to preserve micronutrient intake
- B. Replace them with sweetened sports drinks because these provide less concentrated carbohydrate than soda
- C. Reduce each beverage from 20 ounces to 16 ounces while keeping three servings per day
- D. Replace sugar-sweetened beverages with water or other noncaloric beverages
- E. Keep one beverage with each meal but compensate by reducing solid-food portions

121. A 60-year-old man with obesity and type 2 diabetes takes insulin and wants to sharply reduce carbohydrate intake. What is the most important safety step?

- A. Keep the insulin regimen unchanged until a substantial amount of weight has been lost
- B. Continue the current insulin doses during carbohydrate reduction and treat emerging hypoglycemia with snacks
- C. Reduce glucose monitoring because carbohydrate restriction makes glucose excursions more predictable
- D. Coordinate glucose monitoring and proactive insulin adjustment because sharp carbohydrate reduction can lower medication requirements
- E. Increase insulin modestly before carbohydrate restriction to cover anticipated hepatic glucose output, then titrate from glucose readings

122. A 35-year-old woman taking phentermine/topiramate extended release plans pregnancy. What is the most important counseling point?

- A. Use contraception during periods of regular ovulation and reassess pregnancy risk as weight and menstrual patterns change
- B. Avoid conception during phentermine/topiramate treatment because topiramate exposure is teratogenic and requires pregnancy prevention

- C.** Continue therapy through conception and increase the dose if pregnancy-related appetite rises
- D.** Continue phentermine/topiramate until pregnancy is confirmed because fetal risk begins later in gestation
- E.** Prefer phentermine/topiramate during pregnancy because limiting gestational weight gain improves maternal outcomes

123. A 32-year-old woman with obesity has irregular menses and hirsutism. She asks whether polycystic ovary syndrome is a 'secondary cause' that fully explains her obesity. Which response is most accurate?

- A.** Attribute irregular menses and hirsutism primarily to obesity-related insulin resistance before diagnosing a separate PCOS syndrome
- B.** Use BMI plus hirsutism as sufficient criteria for PCOS without evaluating ovulatory function or alternative causes
- C.** Treat PCOS as a single endocrine cause that independently explains the patient's obesity
- D.** Defer obesity treatment because weight loss can disrupt reproductive management of PCOS
- E.** Explain that PCOS and obesity often reinforce one another through insulin resistance and should be treated together

124. In 2026, the FDA approved Foundayo (orforglipron) for chronic weight management. Which statement correctly characterizes this medication?

- A.** It is a once-weekly injectable dual GIP/GLP-1 receptor agonist approved only for adults with type 2 diabetes
- B.** It is an over-the-counter intestinal lipase inhibitor taken with fat-containing meals for short-term weight loss
- C.** It is a once-daily oral GLP-1 receptor agonist for eligible adults with obesity or overweight plus a weight-related comorbidity
- D.** It is an injectable melanocortin-4 receptor agonist reserved for a small group of genetically confirmed obesity syndromes
- E.** It is a sympathomimetic tablet approved only for brief monotherapy because chronic use has not been studied

125. A 56-year-old woman with obesity and compensated cirrhosis requests weight-loss therapy. Which approach is best?

- A.** Defer obesity treatment because compensated cirrhosis makes intentional weight reduction more hazardous than beneficial
- B.** Use a very-low-protein energy deficit to reduce hepatic nitrogen load while pursuing weight loss
- C.** Pursue rapid weight loss to reduce liver fat even if lean mass and nutritional status worsen
- D.** Coordinate weight treatment with cirrhosis severity, nutritional status, medication safety, and the risk of sarcopenia
- E.** Choose the most effective medication without incorporating hepatic metabolism, cirrhosis severity, or nutrition status

126. A 53-year-old woman gained 9 kg after repeated courses of high-dose prednisone for inflammatory disease. She has facial rounding and proximal weakness. Which contributor is most likely?

- A.** Primary hypothyroidism, which can cause weight gain and fatigue but does not typically produce glucocorticoid-type facial rounding and proximal myopathy
- B.** Primary adrenal insufficiency, which more often causes weight loss and hypotension than central weight gain
- C.** Growth hormone deficiency, which may alter body composition but is less consistent with the temporal medication exposure and Cushingoid features
- D.** Polycystic ovary syndrome, which can be associated with obesity but would not explain the glucocorticoid-pattern physical findings
- E.** Glucocorticoid-associated weight gain with Cushingoid effects from repeated high-dose prednisone exposure

127. A 48-year-old woman says she becomes hungry soon after a breakfast of sweetened cereal and juice. Which change is most likely to improve satiety while supporting energy control?

- A.** Remove morning fluids so gastric volume comes primarily from solid food
- B.** Replace the cereal with an equal-calorie refined snack because total energy, not food composition, determines short-term satiety

- C. Protein and fiber can increase satiation and satiety and may support adherence to an energy-reduced eating pattern
- D. Add another serving of juice to increase breakfast volume without changing solid food
- E. Reduce breakfast protein so gastric emptying is faster and hunger cues are easier to interpret

128. A 29-year-old woman with obesity is planning pregnancy and uses semaglutide. What is the most important principle?

- A. Continue semaglutide through conception and pregnancy if maternal weight loss remains clinically beneficial
- B. Continue a previously tolerated anti-obesity medication through conception if the drug is not a sympathomimetic and maternal benefit is substantial
- C. Weight-loss pharmacotherapy is generally avoided during pregnancy, when intentional weight loss is not the therapeutic goal
- D. Prioritize rapid preconception loss and continue intentional weight reduction after pregnancy is established
- E. Stop structured nutrition counseling once pregnant because gestational weight goals replace obesity-related risk management

129. A 48-year-old woman with obesity asks about the higher-dose semaglutide formulation approved in 2026 for chronic weight management. Which statement is accurate?

- A. Wegovy HD provides a 7.2-mg once-weekly semaglutide dose for eligible adults after appropriate dose escalation
- B. The 7.2-mg dose is an oral semaglutide tablet that must be taken every morning on an empty stomach
- C. The higher dose is approved only for adolescents with severe obesity who did not respond to 2.4 mg weekly
- D. The 7.2-mg dose combines semaglutide with tirzepatide so that both GLP-1 and GIP receptors are activated
- E. The higher-dose product replaces standard semaglutide and should be started directly at 7.2 mg without titration

130. A parent asks how to support a 10-year-old child with obesity without increasing shame. Which strategy is best?

- A.** Use loss of privileges or food access after eating outside the family plan to reinforce adherence
- B.** Family-based treatment emphasizes supportive household changes, caregiver involvement, and reduced stigma
- C.** Comment openly on body-size changes at meals so the child recognizes the seriousness of obesity
- D.** Give the child a separate restrictive menu while the rest of the family keeps its usual foods
- E.** Use frequent school-based weigh-ins so the child and peers can see objective progress

131. A 58-year-old man with obesity and established atherosclerotic cardiovascular disease asks whether any obesity medication has an indication to reduce major cardiovascular events in adults with overweight or obesity and established cardiovascular disease. Which medication fits this description?

- A.** Orlistat for chronic weight management
- B.** Naltrexone used alone for weight management
- C.** Semaglutide for chronic weight management
- D.** Metformin prescribed for weight management in an adult with established cardiovascular disease
- E.** Short-term phentermine monotherapy

132. A 49-year-old woman has good weekday adherence but repeatedly overeats at unplanned social events. What is the best behavioral intervention?

- A.** Develop a specific coping and implementation plan for predictable high-risk social situations
- B.** Avoid social events during active weight loss, then reintroduce them after maintenance begins
- C.** Stop weekend self-monitoring so attention to food does not interfere with social participation
- D.** Treat unplanned social events as a relatively fixed exposure and focus behavior change on the more controllable weekday routine
- E.** Use guilt after overeating as a cue to increase restraint at the next social event

133. A 47-year-old woman with obesity and stress urinary incontinence asks whether weight management can be part of treatment. Which response is best?

- A.** Use aggressive fluid restriction to decrease urinary leakage while pursuing weight loss
- B.** Use weight loss as sole therapy and postpone pelvic-floor treatment until the weight goal is reached
- C.** Refer directly for incontinence surgery and defer weight-management treatment until after recovery
- D.** Treat urinary symptoms independently because stress incontinence is not meaningfully influenced by body weight
- E.** Use weight reduction together with pelvic-floor and other condition-specific therapy for stress urinary incontinence

134. A 41-year-old woman with BMI 34 kg/m² reports stress urinary leakage when coughing, laughing, and exercising. Urinalysis is normal. Which diagnosis is most likely?

- A.** Acute cystitis
- B.** Ureteral obstruction
- C.** Diabetes insipidus
- D.** Overflow incontinence from neurogenic bladder
- E.** Stress urinary incontinence

135. A 63-year-old man with type 2 diabetes gained weight after therapy intensification. Which regimen is most likely to contribute directly?

- A.** Basal-bolus insulin therapy
- B.** A GLP-1 receptor agonist
- C.** An SGLT2 inhibitor
- D.** Carbohydrate-counting education alone
- E.** Metformin

136. A patient avoids gyms because exercise-induced tachycardia triggers panic attacks. What is the best interpretation?

- A.** Treat panic symptoms and adapt the activity plan so exercise-related sensations do not become a persistent barrier
- B.** Interpret the avoidance as evidence of exercise-related cardiac risk because tachycardia reliably signals unsafe exertion
- C.** Treat the panic disorder separately because fear of bodily sensations has little effect on activity adherence
- D.** Use high-intensity exercise to promote habituation to tachycardia without concurrent anxiety-focused treatment
- E.** Focus on weight reduction first because panic symptoms usually remit after body weight decreases

137. A patient with BMI 44 kg/m² reports exertional dyspnea and years of inactivity but no chest pain. What should be clarified before prescribing exercise intensity?

- A.** Use resting symptoms and baseline vital signs as the principal safety screen before choosing an exercise intensity
- B.** Assume deconditioning from inactivity and begin vigorous interval training to establish baseline capacity
- C.** Avoid prescribing any exercise because BMI above 40 kg/m² makes exertional dyspnea a contraindication
- D.** Exertional dyspnea may reflect deconditioning, mechanical load, cardiopulmonary disease, or a combination
- E.** Use BMI to calculate a safe maximum heart rate without assessing functional capacity or associated symptoms

138. A 51-year-old man with obesity and obstructive sleep apnea loses substantial weight and reports less snoring. What should happen to his positive-airway-pressure therapy?

- A.** Treatment should not be discontinued solely because symptoms improve; objective reassessment is appropriate
- B.** Treat symptom improvement as evidence that OSA has resolved after substantial weight loss

- C.** Increase airway pressure empirically because weight loss can alter upper-airway mechanics unpredictably
- D.** Continue the current settings indefinitely without considering repeat sleep testing after major weight change
- E.** Stop positive-airway-pressure therapy now and restart it if snoring or daytime sleepiness returns

139. A 32-year-old woman with obesity is 18 weeks pregnant. Which weight-management goal is most appropriate?

- A.** Defer nutrition and activity counseling until postpartum because gestational gain is physiologic
- B.** Support appropriate gestational weight gain, nutrition, and safe activity rather than pursuing intentional weight loss during pregnancy
- C.** Use a supervised intentional weight-loss target during the second trimester if prepregnancy BMI was in the obesity range
- D.** Use anti-obesity medication to keep gestational weight gain below guideline ranges
- E.** Use a very-low-calorie diet under obstetric observation to minimize gestational gain

140. A 31-year-old woman with obesity and epilepsy takes valproate and plans pregnancy next year. What is most appropriate?

- A.** Switch valproate primarily to reduce weight risk even if the alternative has not been evaluated for seizure control or pregnancy planning
- B.** Continue the current regimen through conception and address medication safety only after pregnancy is confirmed
- C.** Add a stimulant-containing supplement to offset appetite effects while preserving the current antiseizure regimen
- D.** Change to a more weight-neutral antiseizure medication solely for obesity benefit without coordinated neurologic and preconception review
- E.** Medication optimization must balance obesity effects with control of the primary disease and reproductive safety

141. Several weeks after an endoscopic bariatric procedure, a patient develops severe persistent abdominal pain, fever, tachycardia, and inability to tolerate oral intake. What is the best response?

- A.** Increase light activity and oral intake gradually to see whether symptoms reflect routine postprocedure recovery
- B.** Observe symptoms for several months because delayed abdominal discomfort is common after endoscopic procedures
- C.** Arrange urgent evaluation for a possible procedure-related complication because systemic signs and poor intake are concerning
- D.** Manage fever, tachycardia, and poor intake as postprocedure inflammatory symptoms while watching for peritoneal findings
- E.** Start fiber and oral hydration first because constipation is the most common explanation for postprocedure pain

142. A 35-year-old man has BMI 29 kg/m² but marked visceral adiposity, hypertension, prediabetes, and dyslipidemia. Which statement is most accurate?

- A.** Use BMI as the primary adiposity measure and treat waist and metabolic abnormalities as separate risk factors
- B.** Avoid obesity-focused treatment because BMI below 30 kg/m² places him outside clinically important adiposity
- C.** Treat hypertension and dyslipidemia separately and consider the visceral adiposity incidental at this BMI
- D.** Recognize clinically important visceral adiposity and cardiometabolic disease even though BMI remains below 30 kg/m²
- E.** Attribute the metabolic findings to nonadiposity causes because BMI is below the conventional obesity threshold

143. A 15-year-old with obesity and hypertension begins intensive obesity treatment. Which management principle is most appropriate?

- A.** Treat pediatric hypertension by age-appropriate standards while continuing comprehensive obesity treatment and monitoring
- B.** Pause obesity treatment until blood pressure is controlled so treatment effects can be separated

- C.** Monitor blood pressure without treatment because weight reduction usually normalizes pediatric obesity-related hypertension
- D.** Use adult blood-pressure thresholds because obesity accelerates cardiovascular maturation in adolescents
- E.** Defer antihypertensive management until adulthood unless symptoms or end-organ damage develop

144. A 35-year-old vegetarian patient with obesity wants a higher-protein energy-reduced diet. Which recommendation best respects her dietary pattern?

- A.** Use protein supplements as the primary source because vegetarian whole foods contain too much carbohydrate for weight loss
- B.** Add a small amount of lean animal protein because achieving a higher protein target is difficult with plant foods during energy restriction
- C.** Avoid legumes because their carbohydrate content offsets the satiety benefit of their protein and fiber
- D.** Use sweetened protein beverages because liquid plant protein is more effective for weight loss than whole foods
- E.** Nutrition plans should be individualized to culture and preference while meeting protein, micronutrient, and energy needs

145. A 15-year-old boy says he 'hardly eats anything.' His recall shows modest meals but several sugar-sweetened beverages and sports drinks daily. What is the key nutritional insight?

- A.** Focus on dietary fat because beverage energy contributes little if solid meals are modest
- B.** Treat the small meals as evidence of low habitual intake without quantifying beverages or snacks
- C.** Beverage intake should be assessed explicitly in adolescents as part of a complete nutrition history
- D.** Count sports drinks separately from habitual beverage intake because they are consumed primarily around planned activity
- E.** Treat beverage calories as negligible compared with solid food when assessing adolescent energy intake

146. A 58-year-old man with BMI 35 kg/m² had stable weight for years, then gained 14 kg after smoking cessation and initiation of an antipsychotic. Which interpretation is best?

- A.** Use current BMI as the main explanation because temporal weight trajectory adds little after obesity is established
- B.** Attribute the gain primarily to aging because both smoking cessation and medication use occurred in midlife
- C.** Temporal links between weight change and medications, smoking cessation, illness, pregnancy, sleep, or life events are clinically useful
- D.** Treat post-cessation weight gain as a fixed biologic change that makes future obesity treatment ineffective
- E.** Give greatest weight to early antipsychotic-associated gain because medication effects tend to attenuate after the initial treatment period

147. A 48-year-old woman of Asian ancestry has BMI 24.8 kg/m² but increased central adiposity and type 2 diabetes. Which principle is most important?

- A.** Central adiposity and metabolic disease can occur at lower BMI, so clinical context and fat distribution remain important
- B.** Treat diabetes as unrelated to adiposity because BMI is below the conventional overweight threshold for some populations
- C.** Use the conventional BMI threshold as the main adiposity criterion and treat diabetes as a separate risk factor at this BMI
- D.** Disregard waist distribution because BMI is the preferred measure across all ancestry groups
- E.** Use total body weight without considering central adiposity or population differences in metabolic risk

148. A 51-year-old man follows a highly restrictive diet that excludes entire food groups despite no allergy or medical indication. He repeatedly abandons it after 2 weeks. What is the best adjustment?

- A.** A nutritionally adequate, culturally acceptable plan is usually preferable to unnecessary rigid restriction
- B.** Use a fasting period after dietary deviations to restore the weekly calorie target

- C. Add more prohibited foods to reduce decision-making and make the diet easier to follow
- D. Keep the restrictive pattern and focus on strengthening adherence rather than changing its food exclusions
- E. Interpret repeated 2-week adherence as evidence that dietary approaches are unlikely to work for this patient

149. A 50-year-old man with BMI 36 kg/m² has fasting triglycerides 180 mg/dL, blood pressure 138/88 mm Hg, fasting glucose 112 mg/dL, and waist circumference 116 cm. Which finding most strongly indicates cardiometabolic risk related to central adiposity?

- A. Mildly elevated fasting triglycerides considered in isolation from the other metabolic findings
- B. BMI alone, without incorporating waist circumference or the accompanying metabolic abnormalities
- C. Fasting glucose elevation considered separately from waist circumference and blood pressure
- D. Blood pressure elevation considered independently from the patient's central fat distribution
- E. Central adiposity accompanied by hypertension, dysglycemia, and dyslipidemia as a clustered cardiometabolic-risk pattern

150. A patient loses 12% of body weight with treatment, then reports increasing hunger and reduced satiety during maintenance. Which physiologic concept best explains this experience?

- A. Expect the strongest adaptive appetite and energy-expenditure responses after bariatric surgery, with smaller effects after nonsurgical loss
- B. Expect hunger to remain suppressed during maintenance once a double-digit weight loss has been achieved
- C. Expect resting energy expenditure to increase relative to body size after weight loss, making maintenance easier
- D. Treat appetite regulation as largely independent of prior weight loss when planning maintenance
- E. Weight loss can trigger adaptive increases in hunger and reductions in energy expenditure that favor regain

151. A 13-year-old girl has BMI equal to 125% of the 95th percentile for age and sex. How should this finding be interpreted?

- A.** Interpret 125% of the 95th BMI percentile as meeting a commonly used definition of severe pediatric obesity
- B.** Treat the percentile as a reason to defer comorbidity screening until additional weight gain occurs
- C.** Convert the percentile to an adult BMI category before deciding whether obesity is severe
- D.** Interpret severe obesity at this age as sufficient evidence of a monogenic obesity syndrome
- E.** Classify the value as ordinary obesity because severe-obesity thresholds begin above 140% of the 95th percentile

152. A 16-year-old boy with obesity has loud snoring, witnessed apneas, morning headaches, and daytime sleepiness. What is the most important next step in the sleep evaluation?

- A.** Attribute the daytime sleepiness to adolescent sleep habits unless school performance declines
- B.** Focus first on total sleep duration and sleep hygiene before evaluating the reported breathing pauses
- C.** Use caffeine for daytime sleepiness and reassess snoring after sleep duration improves
- D.** Monitor symptoms through adolescence because pediatric sleep-disordered breathing often resolves with growth
- E.** Obtain appropriate sleep testing for suspected obstructive sleep apnea based on snoring, apneas, and daytime symptoms

153. A 68-year-old woman is losing weight and wants to preserve function. Which exercise component is especially important for maintaining lean mass and strength?

- A.** Resistance training helps preserve or improve muscle strength and lean mass during weight loss, especially in older adults
- B.** Prioritize low-intensity aerobic exercise and postpone resistance work until weight stabilizes
- C.** Use breathing and balance exercises as substitutes for progressive muscle loading
- D.** Avoid load-bearing exercise because intentional weight loss already reduces musculoskeletal stress

E. Use flexibility and stretching as the main exercise strategy because resistance work adds little during weight loss

154. A 9-year-old with obesity is being teased at school and has begun avoiding physical education. What is the best treatment priority in addition to weight-related care?

A. Temporarily remove the child from preferred activities so weight reduction can become the main focus

B. Treat the bullying as a school issue and continue the obesity plan without direct psychosocial assessment

C. Use the teasing as a cue to set a more aggressive weight-loss target with the family

D. Address weight-based bullying and psychosocial distress while creating a supportive, nonstigmatizing activity plan

E. Increase frequency of school-based weight checks to document progress and reassure peers and staff

155. Six months after Roux-en-Y gastric bypass, a patient has microcytic anemia with low ferritin. Which deficiency is most likely?

A. Vitamin B12 deficiency, which more often produces macrocytosis and neurologic findings

B. Folate deficiency, which more often produces macrocytic rather than microcytic anemia

C. Iron deficiency, which commonly produces low ferritin and microcytic anemia after Roux-en-Y gastric bypass

D. Copper deficiency, which can cause anemia and neurologic abnormalities but is not suggested by low ferritin

E. Thiamine deficiency, which is important after prolonged vomiting but does not typically cause low-ferritin microcytic anemia

156. A patient maintained a 12% weight loss for 3 years, then regained 6% after a job change and sleep disruption. What is the most appropriate interpretation?

A. Reassess and intensify chronic obesity care when weight recurs after major life and sleep changes

- B.** Treat the prior 12% loss as clinically unimportant because part of it has been regained
- C.** Continue the same plan unchanged because prior recurrence predicts limited benefit from further intervention
- D.** Stop structured treatment because weight regain after several years indicates failure of chronic management
- E.** Interpret the regain as evidence that the original obesity diagnosis did not reflect a chronic disease

157. A physician is interviewed about obesity for a community program. Which message is most appropriate?

- A.** Lead with severe complication risks and alarming imagery to increase motivation for weight loss
- B.** Emphasize a single standardized diet-and-exercise prescription as the main solution for most people
- C.** Frame obesity primarily as a consequence of individual lifestyle choices to emphasize personal responsibility
- D.** Describe obesity as a complex chronic disease and emphasize evidence-based prevention and treatment without stigma
- E.** Focus public messaging on prevention and lifestyle change while giving little attention to medical treatment options

158. A clinician plans to discuss obesity with a patient whose BMI is 36 kg/m². What is the best opening approach?

- A.** Begin by explaining the medical risks of obesity so the patient understands why weight loss should be prioritized
- B.** Ask permission to discuss weight and connect the conversation to the patient's own health priorities and goals
- C.** Use the BMI result to introduce treatment because objective measurements reduce the need to ask permission
- D.** Ask about recent weight change and immediately propose a target before discussing the patient's reason for the visit

E. Defer discussion unless the patient independently raises weight because clinicians should not initiate obesity conversations

159. A patient with chronic kidney disease and obesity requests a very-high-protein weight-loss diet. What is the best approach?

A. Use liquid protein supplements to reach a high target while minimizing total food volume

B. Avoid dietary intervention until kidney function improves because renal disease makes nutrition treatment too complex

C. Use a standard high-protein obesity plan because adiposity-related goals take priority over renal considerations

D. Set protein intake by weight-loss goals without adjusting for kidney disease stage or nephrology recommendations

E. Protein targets should be individualized in chronic kidney disease with appropriate renal guidance

160. A man with BMI 41 kg/m² and severe OSA has tried several evidence-based medications with inadequate response and is interested in surgery. What is the best plan?

A. Frame surgery as a last-resort option only after all nonsurgical therapies have been permanently exhausted

B. Continue the current medication regimen unchanged because failure of several agents predicts poor surgical response

C. Delay referral until a further medication trial produces at least modest weight loss, demonstrating treatment adherence

D. Stop positive-airway-pressure therapy during the surgical evaluation so postoperative OSA improvement can be measured from baseline

E. Refer for metabolic and bariatric surgery evaluation while continuing evidence-based treatment of obstructive sleep apnea

161. An adolescent successfully completes a year of family-based treatment. Which transition strategy best supports long-term success?

- A.** Discharge from structured care after the final family-based visit and advise follow-up only if substantial regain occurs
- B.** Continue pediatric follow-up but postpone discussion of adult-care transfer until after the eighteenth birthday
- C.** Plan ongoing follow-up and a gradual, coordinated transition to adult obesity care with increasing adolescent autonomy
- D.** Continue monitoring weight but stop comorbidity surveillance once early metabolic improvement has been documented
- E.** Transfer self-management responsibility abruptly to the adolescent to encourage independence before adult care begins

162. A 32-year-old man with untreated ADHD repeatedly forgets meal plans, visits, and self-monitoring. Why does this matter?

- A.** Recognize that executive dysfunction can impair planning, self-monitoring, visit attendance, and treatment follow-through
- B.** Interpret missed visits as intentional nonadherence unless he reports memory problems during the encounter
- C.** Assume untreated ADHD increases energy expenditure enough to offset its effects on planning and self-monitoring
- D.** Treat executive-function problems as relevant mainly to academic performance rather than health-behavior implementation
- E.** Use BMI response to determine whether ADHD symptoms are clinically important for the treatment plan

163. A 43-year-old warehouse worker has alternating day and night shifts and brief meal breaks. Which social-history detail should most influence the dietary plan?

- A.** Use cafeteria calorie labeling as the main determinant of whether his work environment supports the plan
- B.** Choose a preferred dietary philosophy first and adapt the shift schedule to fit its meal timing
- C.** Design the diet around shift timing, meal breaks, food access, and other workplace constraints

- D.** Use childhood meal patterns to predict which current workplace foods will be easiest to sustain
- E.** Use coworkers' body sizes as a proxy for whether the workplace environment promotes excess energy intake

164. A 36-year-old woman with obesity and PCOS has irregular menses and prediabetes. Which treatment goal is appropriate?

- A.** Delay fertility planning until BMI is in the normal range because conception is unlikely before then
- B.** Obesity treatment should be integrated with glycemic, reproductive, and cardiovascular risk management
- C.** Use any effective obesity medication while pursuing pregnancy because PCOS-related infertility reduces conception risk
- D.** Treat the endocrine diagnosis separately and avoid weight-focused treatment because PCOS is the primary disorder
- E.** Address menstrual irregularity but defer metabolic risk management until reproductive goals are completed

165. A 46-year-old man with obesity has severe hypertriglyceridemia and asks whether weight loss alone is enough. Which answer is best?

- A.** Treat the triglycerides through weight loss alone unless pancreatitis has already occurred
- B.** Start lipid-specific therapy and stop dietary counseling so the response can be attributed to medication
- C.** Treat pancreatitis risk as unrelated to triglyceride severity when the patient also has obesity
- D.** Use exercise as the primary therapy even when triglyceride levels require more immediate risk reduction
- E.** Combine weight management with specific treatment of severe hypertriglyceridemia and evaluation of secondary causes

166. A 15-year-old adolescent with obesity spends most of the day sedentary and dislikes organized sports. What is the best counseling approach?

- A.** Pediatric activity counseling should be developmentally appropriate, enjoyable, and family-supported
- B.** Require organized competitive sports so activity can be measured and progressed consistently
- C.** Use exercise as a consequence for sedentary behavior to increase total weekly energy expenditure
- D.** Delay formal activity goals until later adolescence when preferences and schedules are more stable
- E.** Select activities by estimated calorie expenditure rather than enjoyment because adherence can be addressed later

167. A patient with type 2 diabetes takes insulin and a sulfonylurea before metabolic surgery. What is the key immediate postoperative medication issue?

- A.** Rapidly reassess and reduce insulin or sulfonylurea therapy as oral intake and glycemia change after metabolic surgery
- B.** Keep the sulfonylurea unchanged until substantial weight loss occurs because early glycemic effects are small
- C.** Increase insulin doses immediately because postoperative stress predictably raises glucose requirements
- D.** Reduce glucose monitoring once oral intake falls because hypoglycemia risk is lower after surgery
- E.** Keep preoperative diabetes doses initially because major glycemic improvement usually follows substantial postoperative weight loss

168. A 44-year-old woman with BMI 36 kg/m² reports worsening knee pain when climbing stairs and difficulty walking more than two blocks. Which additional history best characterizes a biomechanical complication of obesity?

- A.** Ask about exercise preferences without separately assessing pain-related limitations in routine mobility
- B.** Clarify whether the pain is worse in cold weather because weather sensitivity is a more specific measure of biomechanical severity

- C.** Measure current step count as the main functional assessment and infer pain-related limitation from total daily steps
- D.** Assess how knee pain affects walking distance, stair use, work, self-care, and other daily activities
- E.** Focus on radiographic severity because imaging grade is more informative than the patient's functional limitations

169. A 59-year-old woman with BMI 39 kg/m² has chronic bilateral knee pain, crepitus, and pain worse with weight-bearing. Which diagnosis best explains this biomechanical complication?

- A.** Polymyalgia rheumatica with shoulder and hip-girdle stiffness
- B.** Gouty arthritis with episodic inflammatory monoarthritis
- C.** Knee osteoarthritis with chronic weight-bearing pain and crepitus
- D.** Acute septic arthritis with a hot swollen joint and systemic features
- E.** Lumbar radiculopathy with neurologic pain referred toward the knee

170. A 10-year-old with obesity is referred for treatment. Which intervention has the strongest role as foundational therapy?

- A.** A brief primary-care counseling program with monthly weight checks and general advice on diet and activity
- B.** A school-only activity program without coordinated nutrition or caregiver involvement
- C.** An individually prescribed calorie-restricted diet delivered to the child without changing the household environment
- D.** Anti-obesity pharmacotherapy as stand-alone first-line treatment without a structured family-based intervention
- E.** Intensive family-based multicomponent behavioral treatment addressing nutrition, activity, and behavior change

171. A 46-year-old woman with BMI 37 kg/m², hypertension, and knee osteoarthritis wants treatment. Which plan is most appropriate?

- A.** Start with a standardized calorie-restricted diet and add medication or procedural treatment if early response is inadequate
- B.** Use a patient-centered multimodal plan that addresses complications, function, preferences, and treatment escalation
- C.** Refer for surgery now because BMI above 35 kg/m² plus complications makes operative therapy the most definitive option
- D.** Set a cosmetic target weight as the primary outcome and address blood pressure or knee function afterward
- E.** Treat body weight as the main disease target while managing hypertension and osteoarthritis outside the obesity plan

172. A 38-year-old woman uses depot medroxyprogesterone and reports weight gain since starting it. Which conclusion is best?

- A.** Stop contraception before discussing pregnancy risk, alternative methods, or the patient's reproductive priorities
- B.** Treat the temporal association as coincidental because injectable contraception has no meaningful relationship to weight change
- C.** Attribute the entire weight gain to depot medroxyprogesterone from the history alone
- D.** Use exposure to the contraceptive as sufficient evidence that medication-induced obesity is the primary diagnosis
- E.** Assess timing, contraceptive priorities, and alternatives before changing the medication

173. A 28-year-old woman has intrusive memories, hypervigilance, emotional eating, and poor sleep after trauma. Which approach is best?

- A.** Use trauma-informed care that addresses post-traumatic symptoms, sleep, and emotional eating alongside obesity treatment
- B.** Use strict dietary rules first and defer trauma-focused care until eating patterns are stabilized
- C.** Treat the trauma history as unrelated to appetite, sleep, or treatment engagement unless PTSD was diagnosed before weight gain

D. Interpret emotional eating after trauma mainly as a motivation problem rather than a symptom linked to distress

E. Require a detailed trauma narrative before beginning obesity treatment so triggers can be fully mapped

174. Which description best characterizes sleeve gastrectomy?

A. An endoscopic procedure that narrows the stomach without removing gastric tissue

B. A body-contouring operation that removes subcutaneous abdominal fat but leaves the stomach unchanged

C. An adjustable gastric band placed around the proximal stomach to create restriction

D. A gastric pouch with a jejunal anastomosis that bypasses the duodenum

E. Sleeve gastrectomy uses longitudinal gastric resection to create a tubular stomach without an intestinal bypass

175. A 42-year-old man with obesity and chronic opioid therapy for severe pain asks about naltrexone/bupropion. What is the major problem with this choice?

A. Concern that the combination lacks central nervous system activity and therefore will not affect appetite

B. Concern that naltrexone acts as a GLP-1 receptor agonist and could duplicate incretin therapy

C. Avoid naltrexone/bupropion because naltrexone can block opioid analgesia and precipitate withdrawal

D. Concern that bupropion routinely causes clinically important hypoglycemia in patients without diabetes

E. Concern that the combination is contraindicated primarily because opioid-treated patients are usually older

176. A 48-year-old man with BMI 45 kg/m² has dyspnea, daytime hypercapnia, and sleep-disordered breathing without another explanation for hypoventilation. Which diagnosis is most likely?

A. Obstructive sleep apnea without awake hypoventilation, which can cause sleep-disordered breathing but not persistent daytime hypercapnia by itself

B. Obesity hypoventilation syndrome, defined by obesity with sleep-disordered breathing and awake alveolar hypoventilation after other causes are excluded

C. Medication-induced hypoventilation from opioids or sedatives, which must be excluded before attributing hypercapnia to obesity

D. Chronic obstructive pulmonary disease causing hypercapnia, which would require supportive pulmonary history or testing rather than obesity alone

E. Neuromuscular hypoventilation from respiratory-muscle weakness, which would require evidence of an alternative neuromuscular disorder

177. A 27-year-old woman gained 12 kg after a bipolar-disorder medication change. Which medication is most likely to have contributed substantially to the weight gain?

A. Bupropion

B. Lamotrigine

C. Topiramate

D. Olanzapine

E. Metformin

178. A 13-year-old with obesity and prediabetes is participating in intensive health behavior and lifestyle treatment. The family asks about medication. What is the best general approach?

A. Defer pharmacotherapy until adulthood because lifestyle treatment remains the sole recommended modality during adolescence

B. Replace intensive lifestyle treatment with medication once an adolescent meets pharmacotherapy criteria

C. For eligible adolescents, pharmacotherapy can be offered as an adjunct to intensive lifestyle treatment

D. Use prediabetes as an indication for bariatric surgery without first considering obesity severity, readiness, or other treatment options

E. Select from adult anti-obesity medications without checking pediatric age indications, dosing, or safety requirements

179. A 43-year-old woman loses 18% of body weight on a well-tolerated anti-obesity medication and reaches major health goals. She asks to stop it because she thinks medication should only be temporary. What is the best counseling principle?

- A.** Obesity pharmacotherapy is often chronic, and stopping an effective medication can lead to weight regain
- B.** Stop the medication after a fixed short treatment course even if response is substantial and adverse effects are minimal
- C.** Expect much of the achieved loss to persist after withdrawal because long-term appetite behavior has been retrained during treatment
- D.** Avoid long-term pharmacotherapy because chronic medication use conflicts with lifestyle-based obesity care
- E.** Stop therapy once BMI is lower than baseline even if weight-related complications are still improving

180. A 17-year-old boy who regained weight after a successful family-based program says, 'I failed because I lack willpower.' Which response best reflects modern obesity care?

- A.** Interpret regain as evidence that the prior family-based treatment did not produce a real clinical response
- B.** Obesity is a heterogeneous chronic disease shaped by biological, environmental, behavioral, developmental, and social determinants
- C.** Explain that sustained behavior change should substantially reduce biologic pressure for regain after a successful family program
- D.** Transition toward self-management in late adolescence because family-based chronic care becomes less central as autonomy increases
- E.** Frame body weight primarily as the result of repeated conscious choices about eating and activity

181. A 46-year-old woman with BMI 40 kg/m² has chronically elevated alanine aminotransferase, hepatic steatosis on ultrasound, minimal alcohol intake, and no viral hepatitis. Which diagnosis is most likely?

- A.** Metabolic dysfunction-associated steatotic liver disease

- B.** Alcohol-associated steatotic liver disease despite minimal alcohol exposure
- C.** Wilson disease causing chronic hepatic steatosis
- D.** Primary biliary cholangitis with cholestatic liver injury
- E.** Acute viral hepatitis causing hepatocellular injury

182. A patient loses 15% of body weight with medication and lifestyle treatment. At 18 months, weight begins to rise by 3%. What is the best response?

- A.** Keep the current plan unchanged until the full 15% loss has been regained so normal fluctuation is not overtreated
- B.** Use a more confrontational counseling style to restore adherence after the first sign of recurrence
- C.** Stop the current treatment because any regain indicates that the original strategy has failed
- D.** Address early weight recurrence by reassessing adherence, appetite, medications, sleep, life changes, and treatment intensity
- E.** Document nonadherence as the likely cause before reassessing appetite, sleep, medications, or life changes

183. A 14-year-old girl says she 'exercises every day' because she walks between classes and does household chores. Which follow-up best clarifies her physical activity pattern?

- A.** Assess school-day activity in detail first because structured weekdays provide the most reproducible estimate of her routine
- B.** Use current body weight as a proxy for whether her activity level is adequate
- C.** Count routine household chores as vigorous exercise without asking about duration or intensity
- D.** Clarify frequency, duration, intensity, activity type, and sedentary time across both school days and weekends
- E.** Use participation in organized sports as the main measure of whether the adolescent is physically active

184. A clinician wants to update an obesity medication protocol after hearing about a new indication. What is the best professional approach?

- A.** Change the protocol after reviewing promotional materials because a newly marketed indication has already undergone regulatory review
- B.** Use professional social-media summaries as the principal source because they synthesize new evidence more quickly
- C.** Continue the older protocol despite new evidence to maintain consistency across previously treated patients
- D.** Keep the existing protocol until a major specialty guideline changes because product indications rarely change first
- E.** Verify the new indication using current authoritative evidence, labeling, and safety information before changing the protocol

185. A 52-year-old man with obesity and heart failure has marked edema and gains 5 kg in 1 week. What is the most important interpretation of the scale change?

- A.** Interpret a 5-kg weekly increase as fat gain because edema is common at baseline in patients with obesity and heart failure
- B.** Treat the 5-kg increase primarily as excess energy storage and reduce calorie intake before changing heart-failure therapy
- C.** Treat rapid 5-kg gain with edema as possible fluid retention and assess promptly for heart-failure decompensation
- D.** Increase exercise to mobilize fluid before evaluating congestion or other signs of decompensation
- E.** Stop using body weight in follow-up because edema prevents scale changes from providing any useful clinical information

186. A 43-year-old man with BMI 42 kg/m² has loud snoring, witnessed apneas, and excessive daytime sleepiness. Which test is most appropriate to establish the suspected obesity-related diagnosis?

- A.** Overnight pulse oximetry alone, which can detect desaturation but does not fully establish obstructive sleep apnea in many patients
- B.** Spirometry to evaluate airflow limitation as the primary test for the witnessed apneas
- C.** Arterial blood gas testing as the primary diagnostic test for obstructive sleep apnea

- D.** Appropriate sleep apnea testing, such as polysomnography when clinically indicated, to establish the diagnosis
- E.** Echocardiography to assess pulmonary pressures before performing any sleep-specific diagnostic testing

187. A 70-year-old woman has BMI 30 kg/m², sarcopenia, reduced mobility, and high visceral fat. Which body-composition issue is especially important when interpreting BMI?

- A.** Use sarcopenia as evidence that visceral adiposity is unlikely because loss of muscle generally accompanies loss of fat
- B.** Similar BMI values can conceal very different proportions of fat and lean mass
- C.** Interpret BMI as a direct marker of metabolic health in older age because comorbidity prevalence is higher
- D.** Use BMI without functional assessment because age-related changes in body composition do not alter its interpretation
- E.** Estimate skeletal muscle mass directly from BMI once age and sex are known

188. A 49-year-old patient using orlistat develops new flank pain and hematuria. Which 2026 safety update is most relevant?

- A.** Orlistat is now known to cause immune-mediated glomerulonephritis, so treatment should continue while complement levels are checked
- B.** Orlistat labeling warns about hyperoxaluria, calcium oxalate nephrolithiasis or oxalate nephropathy, and rare acute kidney injury
- C.** Orlistat commonly causes uric-acid stones by increasing purine absorption, so all patients require prophylactic allopurinol
- D.** Orlistat causes renal injury mainly through direct tubular toxicity, making routine serum drug-level monitoring necessary
- E.** Orlistat-associated flank pain is usually benign steatorrhea referred to the back and does not require renal evaluation

189. A 45-year-old man with schizophrenia is stable on olanzapine but has gained 18 kg and developed prediabetes. What is the best obesity-treatment approach?

- A.** Prioritize changing the antipsychotic even if psychiatric stability is threatened because prediabetes indicates urgent weight risk
- B.** Continue the effective antipsychotic unchanged and manage weight primarily through lifestyle treatment and metabolic monitoring
- C.** Stop olanzapine before psychiatric consultation to determine how much of the weight is medication related
- D.** Serious mental illness and psychotropic medications can affect weight, but patients should receive evidence-based obesity care
- E.** Defer obesity treatment because serious mental illness makes adherence to weight-management therapy unreliable

190. A 62-year-old man with obesity and knee osteoarthritis cannot tolerate jogging. Which activity plan is most appropriate?

- A.** Use relative rest during painful periods, then add low-impact aerobic activity after symptoms improve
- B.** Postpone physical activity until weight loss lowers knee load enough to tolerate jogging
- C.** Prioritize running because weight-bearing activity is required for meaningful cardiometabolic benefit
- D.** Use aerobic activity but avoid lower-extremity strengthening because it can increase joint compression
- E.** Use low-impact aerobic activity such as cycling or aquatic exercise plus strengthening as tolerated

191. A 44-year-old woman with obesity and polycystic ovary syndrome wants to conceive. Which treatment focus is most appropriate?

- A.** Delay obesity treatment until fertility therapy has failed because weight management can interfere with ovulation induction
- B.** Optimize metabolic health before conception and review obesity-medication safety and discontinuation planning with reproductive goals
- C.** Prioritize fertility treatment alone and reassess metabolic risk after pregnancy is achieved

- D.** Pursue maximal short-term weight loss with pharmacotherapy until pregnancy is confirmed, then stop treatment
- E.** Continue anti-obesity medication during pregnancy if it previously improved insulin resistance and menstrual regularity

192. A patient is considering an endoscopic obesity procedure and asks whether follow-up is necessary if the procedure is technically successful. What is the best answer?

- A.** Continue nutrition, behavior, medical monitoring, and weight-recurrence follow-up after the procedure
- B.** Stop anti-obesity medication after the procedure because endoscopic treatment precludes future pharmacotherapy
- C.** Use early weight response to determine the intensity of later follow-up rather than scheduling the same chronic-care cadence for everyone
- D.** Schedule a technical postprocedure check and shift longer-term follow-up back to routine primary care
- E.** Treat a technically successful procedure as definitive therapy that removes the need for nutrition and behavioral follow-up

193. A 34-year-old woman with BMI 37 kg/m² has irregular menses, hirsutism, and biochemical hyperandrogenism. Pregnancy and other major endocrine mimics have been excluded. Which obesity-associated diagnosis is most likely?

- A.** Primary ovarian insufficiency
- B.** Sheehan syndrome
- C.** Polycystic ovary syndrome
- D.** Turner syndrome
- E.** Complete androgen insensitivity syndrome

194. A 45-year-old woman has maintained weight loss but becomes distressed by daily weighing and begins obsessive checking. What is the best response?

- A.** Continue daily weighing unchanged because objective monitoring should take priority over emerging psychological distress
- B.** Stop the entire obesity-treatment program because self-monitoring has become psychologically difficult
- C.** Increase weighing frequency temporarily to reduce uncertainty about normal day-to-day fluctuations
- D.** Modify the self-monitoring strategy so it preserves useful feedback without worsening obsessive checking or psychological distress
- E.** Use weighing as a behavioral consequence after dietary lapses so it remains linked to accountability

195. A 51-year-old woman reports eating 'healthy foods' but uses large portions of nuts, olive oil, and whole-grain dishes. Which assessment is most useful?

- A.** High-quality foods can still be energy dense, so portions, cooking fats, and second servings matter
- B.** Focus on added sugar because nuts and unsaturated oils have limited impact on total energy intake
- C.** Estimate habitual energy intake from current BMI rather than quantifying portions of calorie-dense foods
- D.** Count unsaturated fats as metabolically favorable enough that portion size need not be measured
- E.** Treat portion size as less important when the foods are minimally processed and nutrient dense

196. A 55-year-old woman with BMI 41 kg/m² has fasting glucose 132 mg/dL on two separate mornings. She is asymptomatic. Which diagnosis is most appropriate?

- A.** Fasting plasma glucose at or above the diagnostic threshold on repeat testing establishes diabetes in an asymptomatic patient
- B.** Treat the values as normal for severe obesity unless hemoglobin A1c is also above the diagnostic threshold
- C.** Consider diabetes insipidus because fasting hyperglycemia can reflect osmotic water loss
- D.** Classify the fasting values as prediabetes because she has no hyperglycemic symptoms

E. Consider reactive hypoglycemia because repeated fasting elevations can follow overnight counterregulatory hormone release

197. A 52-year-old woman with BMI 38 kg/m² has burning retrosternal discomfort and acidic regurgitation that worsen after large evening meals and when supine. Which diagnosis is most likely?

- A. Acute pancreatitis with persistent severe epigastric pain and vomiting
- B. Gastroesophageal reflux disease with postprandial, positional regurgitation
- C. Peptic ulcer disease with localized epigastric pain unrelated to posture
- D. Biliary colic with episodic right upper quadrant pain after meals
- E. Achalasia with progressive dysphagia and retained esophageal contents

198. A patient has a lapse during a holiday weekend and says, 'I've ruined everything, so I may as well stop treatment.' Which counseling response is best?

- A. Tighten dietary rules for the next week so the lapse is offset by greater restraint
- B. Pause self-monitoring temporarily because discussing the lapse may reinforce guilt and discouragement
- C. Treat the lapse as information, identify triggers, and resume the planned behaviors promptly rather than abandoning treatment
- D. Use a brief compensatory fast to restore the prior weight trajectory before resuming the usual plan
- E. Wait until the next scheduled visit to revisit goals so the patient has time to regain motivation independently

199. A 17-year-old adolescent with obesity has not achieved sufficient improvement with intensive health behavior and lifestyle treatment. Which general principle is consistent with contemporary pediatric obesity care?

- A. Offer an age-appropriate anti-obesity medication as an adjunct to intensive health behavior and lifestyle treatment in an eligible adolescent
- B. Use any adult anti-obesity medication because efficacy is more important than pediatric labeling once puberty has begun

- C. Replace family-based lifestyle treatment with medication once an adolescent has had inadequate response
- D. Determine medication eligibility from body weight alone rather than age, BMI classification, comorbidities, and labeling
- E. Delay pharmacotherapy until age 21 because adolescent obesity should be treated behaviorally even when intensive treatment is insufficient

200. A 29-year-old resident physician eats most of her calories from 9 PM to midnight after long shifts and denies nocturnal awakenings or loss of control. What should be documented before changing the plan?

- A. Exact calorie intake during the late-night period before asking about occupational constraints
- B. Supplement and caffeine use as the primary explanation for the late eating pattern before assessing meal timing
- C. Macronutrient distribution at night before clarifying how work hours and meal breaks affect when food is available
- D. Meal timing, shift schedule, food access, hunger, and situational triggers that shape the late-night eating pattern
- E. The glycemic index of individual late-night foods before documenting the broader work and eating context

Answers

- 1. D.** Postpartum treatment must consider lactation exposure, maternal recovery, nutritional needs, and product-specific prescribing information. Medication choices should not be assumed safe during breastfeeding.
- 2. A.** Motivational interviewing elicits a patient's own reasons and strategies for change. Low confidence suggests focusing on self-efficacy and a manageable first step.
- 3. C.** A sudden change after hypothalamic injury is a red flag for secondary obesity. The trajectory and precipitating event are more diagnostic than the current BMI alone.
- 4. E.** Knee osteoarthritis should be managed in parallel with obesity rather than used as a reason to avoid activity. Pain-tolerable low-impact aerobic activity and strengthening, together with condition-specific osteoarthritis care and weight management, can improve function.

- 5. D.** A person can meet exercise targets and still have prolonged sedentary time. Obesity care should preserve planned exercise while also increasing daily movement and breaking up sitting.
- 6. A.** Insulin resistance commonly produces hypertriglyceridemia, low HDL cholesterol, and central adiposity. This pattern is a frequent cardiometabolic complication of obesity.
- 7. C.** Micronutrient deficiencies can emerge years after bariatric surgery. Long-term surveillance and procedure-appropriate supplementation are part of lifelong postoperative care.
- 8. D.** Slowing eating and increasing awareness of internal cues can reduce automatic intake and improve recognition of satiation. The intervention targets the identified behavior directly.
- 9. E.** Post-bariatric hypoglycemia can present with postprandial adrenergic or neuroglycopenic symptoms, often after Roux-en-Y gastric bypass. The diagnosis requires careful correlation with documented hypoglycemia.
- 10. D.** Genetic testing has highest yield when severe obesity begins very early or is accompanied by hyperphagia, a strong family pattern, or syndromic findings. Adult BMI alone is not sufficient.
- 11. B.** Obesity is chronic, and maintenance remains an active treatment phase. Long-term follow-up helps sustain benefits and identify recurrence or complications early.
- 12. D.** Running out of food money before payday is a classic clue to food insecurity. Screening for food insecurity helps the clinician build a feasible nutrition plan and connect the family with appropriate community or public resources.
- 13. C.** Recurrent objective binges with loss of control and distress, without regular compensatory behavior, are characteristic of binge-eating disorder.
- 14. C.** A 5% weight loss can produce clinically meaningful improvements in cardiometabolic health and function. When the patient is responding and tolerating treatment, the plan should be reinforced and continued while longer-term goals and maintenance are addressed.
- 15. A.** Orlistat inhibits gastric and pancreatic lipases, reducing hydrolysis and absorption of dietary triglycerides. High-fat meals therefore increase unabsorbed intestinal fat, which can cause oily spotting, steatorrhea, and fecal urgency.
- 16. C.** Energy density, eating rate, palatability, fiber, and food form can influence spontaneous energy intake. Counseling can emphasize substitutions rather than moralizing individual foods.
- 17. A.** Reflective listening accurately captures ambivalence without judgment and supports collaborative problem solving, a core motivational interviewing skill.
- 18. A.** Culturally responsive care adapts portions, preparation, frequency, and meal composition while preserving meaningful social and cultural practices.

- 19. C.** Intra-gastric balloons are temporary endoscopic devices that occupy gastric volume and are used as part of a broader obesity-treatment program, not as standalone permanent surgery.
- 20. D.** Damage to hypothalamic pathways after craniopharyngioma treatment can produce severe hyperphagia, reduced energy expenditure, autonomic changes, and rapid weight gain. The abrupt onset after hypothalamic injury strongly supports hypothalamic obesity.
- 21. E.** Positive reinforcement can strengthen desired behaviors. Non-food rewards avoid pairing energy-dense foods with behavioral success.
- 22. D.** Older adults with osteoporosis require a plan that addresses bone and muscle preservation while treating obesity. Nutritional adequacy and appropriate exercise are important safeguards.
- 23. E.** Substantial weight loss can lower blood pressure and alter requirements for antihypertensive and other weight-sensitive medications. New dizziness should prompt reassessment of blood pressure, volume status, and the medication regimen rather than automatic continuation or empiric changes without evaluation.
- 24. A.** Vitamin B12 deficiency can occur after bariatric surgery and can produce macrocytic anemia together with paresthesias, gait impairment, and posterior-column or peripheral neurologic dysfunction. The combined hematologic and neurologic findings make B12 deficiency a leading concern.
- 25. D.** Olanzapine is among the antipsychotic medications with substantial potential for weight gain. The previously stable weight followed by a 10-kg increase soon after starting olanzapine, with normal thyroid testing, strongly supports medication-associated weight gain.
- 26. B.** Some rare genetic obesity disorders have targeted therapies directed at the melanocortin pathway. Even then, comprehensive management of nutrition, function, and complications remains necessary.
- 27. B.** Activity prescriptions should account for pain, function, preference, and access. Low-impact alternatives can improve fitness while reducing joint loading.
- 28. C.** Bupropion lowers the seizure threshold, making naltrexone/bupropion contraindicated in patients with seizure disorders.
- 29. E.** Obesity can alter sex hormone measurements, and testosterone diagnosis requires compatible symptoms and properly obtained confirmatory testing. A single afternoon value is insufficient.
- 30. B.** Persistent vomiting after bariatric surgery can rapidly deplete thiamine and precipitate Wernicke encephalopathy. When the classic neurologic syndrome is suspected, parenteral thiamine should be given promptly and should not be delayed for testing; thiamine should precede or accompany carbohydrate administration.
- 31. A.** Pediatric pharmacotherapy requires the same attention to efficacy and adverse effects as adult treatment plus developmental considerations and age-specific prescribing requirements.

- 32. A.** Sleep duration, sleep quality, and circadian timing are part of obesity assessment. Shift work can disrupt both sleep and meal timing.
- 33. C.** Absence of documented disease is not equivalent to absence of complications. Comprehensive evaluation is needed to determine the clinical burden and severity of obesity.
- 34. C.** Waist circumference is a practical marker of abdominal adiposity and can refine cardiometabolic risk assessment, particularly when interpreted alongside BMI and clinical risk factors.
- 35. D.** In heart failure, scale weight can change because of both adipose loss and fluid shifts. Obesity treatment should therefore track symptoms, congestion, blood pressure, medication tolerance, and functional status along with weight.
- 36. A.** A DASH-style pattern is nutrient-dense and evidence-based for blood-pressure reduction. Nutrition therapy should address obesity and comorbid conditions simultaneously.
- 37. A.** Patient-centered obesity care tracks outcomes that matter clinically and personally, including mobility, glycemia, sleep, quality of life, and complications, not just kilograms lost.
- 38. C.** Rapid catabolism and dehydration can precipitate gout flares. Sustainable weight reduction and management of urate-lowering therapy are preferable.
- 39. E.** The vignette directly identifies transportation problems and a caregiver work-schedule conflict as barriers to attendance. These are social determinants that can disrupt continuity of pediatric obesity care and should be addressed with practical access solutions.
- 40. B.** Severe persistent abdominal pain with vomiting warrants urgent assessment for pancreatitis. GLP-1–based agents carry precautions related to pancreatitis and should not simply be continued through such symptoms.
- 41. E.** Obesity treatment focuses on health, function, complications, and sustainable weight reduction rather than attainment of a single 'ideal' BMI. Modest sustained loss can produce substantial clinical benefit.
- 42. B.** Witnessed apneas, loud snoring, and daytime symptoms raise concern for obstructive sleep apnea, a common obesity-related complication. The history should actively screen for complications rather than focus only on body size.
- 43. D.** For some patients, regular eating can reduce excessive hunger and vulnerability to unplanned intake. The plan should be individualized and distinguished from treatment of binge-eating disorder.
- 44. C.** Common obesity is typically polygenic and interacts with environmental and developmental exposures. Genetic susceptibility does not make effective treatment impossible.

- 45. B.** Night eating syndrome involves evening hyperphagia and/or nocturnal ingestions with awareness and recall. Sleep-related eating disorder more often occurs with reduced awareness.
- 46. E.** Relapsing weight gain is best approached through chronic-disease care, including longitudinal monitoring, multimodal treatment, maintenance, and escalation when needed.
- 47. D.** Obesity is a chronic disease whose clinical severity depends on the presence and impact of metabolic, mechanical, and functional complications in addition to anthropometric measures.
- 48. D.** Meal timing and portion modification can reduce reflux symptoms, while weight reduction can improve GERD in many patients.
- 49. B.** BMI is a useful population and screening measure but does not directly measure body composition. High lean mass can elevate BMI without excess adiposity.
- 50. E.** Energy balance is biologically regulated and influenced by multiple interacting determinants. A multifactorial model is more accurate and less stigmatizing than a single-cause explanation.
- 51. B.** Contemporary guidance allows consideration of metabolic surgery in selected patients with class I obesity and metabolic disease who have not achieved adequate benefit from nonsurgical treatment.
- 52. C.** Endoscopic sleeve gastropasty uses endoluminal suturing to reduce gastric volume and alter gastric geometry without removing stomach tissue.
- 53. D.** Exertional pressure relieved by rest is concerning for myocardial ischemia, particularly in a patient with multiple cardiometabolic risk factors. Obesity care must identify urgent comorbid disease, not attribute symptoms automatically to weight.
- 54. B.** Older adults are vulnerable to loss of lean mass during weight reduction. Adequate protein, resistance exercise, and attention to function help preserve muscle.
- 55. E.** Stimulus control changes environmental cues that reliably trigger eating. Removing the chips from the television-viewing context and building a different routine directly targets the learned cue-behavior association.
- 56. A.** Early dumping syndrome occurs soon after eating, especially after high-sugar meals, and can cause crampy abdominal symptoms, diarrhea, palpitations, and vasomotor symptoms such as flushing. The timing and symptom cluster distinguish it from later post-bariatric hypoglycemia.
- 57. A.** Severe obesity beginning very early in life, especially before age 5, with pronounced hyperphagia and a strong familial pattern raises concern for a monogenic obesity disorder and supports targeted genetic evaluation.
- 58. D.** BMI is weight in kilograms divided by height in meters squared: $108/(1.80^2) = 108/3.24 = 33.3$ kg/m².

- 59. D.** Topiramate commonly reduces appetite and body weight, whereas valproate, pregabalin, mirtazapine, and olanzapine can promote gain.
- 60. B.** For patients who tolerate it well, regular self-weighing can support self-monitoring and early recognition of regain. Trends are more informative than day-to-day variation.
- 61. A.** Loss of control is clinically meaningful even when the amount is not objectively large and can be associated with distress and disordered eating in adolescents.
- 62. C.** Preoperative weight management should focus on safe, achievable risk reduction and adequate nutrition. Extreme short-term weight-loss demands can cause harm and rarely represent true adipose loss.
- 63. A.** Adolescents with severe obesity should be considered for referral to experienced multidisciplinary surgery programs when clinically appropriate, while comprehensive medical and behavioral care continues.
- 64. E.** Loss of access is a real treatment barrier. Chronic care requires contingency planning, alternatives, and ongoing support rather than blaming the patient for recurrence.
- 65. A.** Bingeing with recurrent compensatory behaviors is concerning for bulimia nervosa. Aggressive restriction can worsen the binge-purge cycle, so eating-disorder treatment takes priority.
- 66. B.** Internal hernia is a potentially dangerous late complication after Roux-en-Y gastric bypass. It can present with severe intermittent abdominal pain and nausea despite initially subtle examination findings, so a low threshold for urgent evaluation is warranted.
- 67. C.** Tirzepatide has an FDA indication for moderate-to-severe obstructive sleep apnea in adults with obesity, reflecting improvement associated with pharmacologic weight reduction and related mechanisms.
- 68. A.** Developmentally appropriate self-monitoring can identify triggers and contexts for eating behavior and support targeted family-based behavioral interventions.
- 69. E.** High-protein diets may be inappropriate or require modification in chronic kidney disease depending on disease stage, nutritional status, and renal management goals. The protein target should be coordinated with the patient's kidney care rather than adopted from a generic commercial plan.
- 70. D.** Systemic glucocorticoids can increase appetite, alter fat distribution, worsen insulin resistance, and produce Cushingoid features.
- 71. C.** Obesity pharmacotherapy should be individualized to contraindications, drug interactions, comorbidities, patient goals, and expected benefit. Safety screens come before preference for maximal weight loss.

- 72. D.** Advanced kidney disease changes the suitability, dosing, and monitoring of several medications. Obesity treatment remains appropriate but requires individualized renal safety assessment.
- 73. A.** Several GLP-1–based weight-management products carry a boxed warning and contraindication for patients with a personal or family history of medullary thyroid carcinoma or MEN2.
- 74. E.** Multi-ingredient stimulant supplements can contain uncertain doses, undeclared ingredients, or clinically important cardiovascular and drug-interaction risks. Adolescents should be steered away from unregulated weight-loss supplements and toward evidence-based, age-appropriate care.
- 75. B.** In older adults, weight loss can worsen sarcopenia unless treatment protects muscle and function. Goals should emphasize mobility, strength, comorbidity benefit, and nutritional adequacy.
- 76. B.** Psychiatric stability is a major treatment priority, especially when clozapine is uniquely effective. Obesity should still be treated actively, with coordination between obesity and psychiatric care rather than abrupt or destabilizing psychotropic changes.
- 77. C.** Prader-Willi syndrome classically evolves from hypotonia and feeding difficulty in infancy to hyperphagia and obesity later in childhood, often with developmental delay and short stature. The combined phenotype is highly characteristic.
- 78. C.** A weight-inclusive clinical environment requires equipment that safely accommodates patients across body sizes and preserves privacy and dignity. Appropriately sized seating, gowns, examination equipment, and private weighing reduce barriers and stigma.
- 79. A.** Phentermine is a sympathomimetic and can increase pulse and blood pressure. Cardiovascular status and contraindications should be assessed before use.
- 80. A.** Random serum cortisol is not a diagnostic screening test for Cushing syndrome, and indiscriminate endocrine testing in uncomplicated obesity produces false positives. Testing should be guided by discriminatory clinical features.
- 81. D.** Reduced energy intake and improved insulin sensitivity can lower medication requirements. Agents that directly cause hypoglycemia often need dose reduction and close monitoring.
- 82. E.** Clinical documentation should use person-first, nonstigmatizing language and describe observable behaviors, preferences, and barriers rather than assigning character judgments such as 'noncompliant' or implying moral failure.
- 83. C.** Clinically meaningful weight loss can reduce blood pressure. Antihypertensive regimens should be reassessed to prevent symptomatic hypotension.
- 84. E.** Effective public communication can address environmental and structural determinants while avoiding stereotypes and blame. This supports prevention and treatment without reinforcing stigma.

- 85. C.** Semaglutide (Wegovy) received an FDA indication for adults with noncirrhotic MASH and moderate-to-advanced fibrosis (F2-F3). Obesity treatment and management of cardiometabolic and liver risk remain important, but the other listed anti-obesity medications do not have this specific labeled MASH indication.
- 86. D.** Roux-en-Y gastric bypass creates a small gastric pouch and reroutes food through a Roux limb, producing restrictive and metabolic effects with partial intestinal bypass.
- 87. E.** Depression and obesity commonly coexist and can influence adherence, appetite, activity, and medication choice. Integrated care is preferable to treating either condition in isolation.
- 88. B.** Leptin-melanocortin pathway defects impair hypothalamic sensing of energy stores and satiety, producing severe early-onset hyperphagic obesity.
- 89. C.** Current pediatric and surgical guidance supports referral of appropriately selected adolescents with severe obesity for evaluation at experienced multidisciplinary metabolic and bariatric surgery centers.
- 90. D.** A useful pediatric weight history includes age at onset, longitudinal growth trajectory, previous interventions, degree and durability of response, and the context in which regain occurred. These details are more informative than isolated measurements.
- 91. A.** Gallbladder disease can occur during substantial or rapid weight loss and is a recognized adverse-event concern with GLP-1–based obesity treatment.
- 92. E.** Preconception care should support nutrient adequacy, including folate, while managing obesity safely. Aggressive nutritionally inadequate diets are inappropriate.
- 93. C.** Monogenic leptin-melanocortin pathway disorders can present as isolated severe early-onset hyperphagic obesity without the multisystem features typical of syndromic obesity.
- 94. A.** Multiple dietary patterns can produce weight loss when they reduce energy intake and are sustainable. Individualization improves adherence and allows accommodation of comorbidities and preferences.
- 95. A.** Fatigue, constipation, cold intolerance, dry skin, bradycardia, and weight gain are classic clues to hypothyroidism. Serum TSH is the appropriate initial test for suspected primary hypothyroidism in most patients.
- 96. B.** After Roux-en-Y gastric bypass, smoking and NSAID exposure increase concern for marginal ulceration at the gastrojejunal anastomosis. Epigastric pain in this setting warrants evaluation for this complication.
- 97. E.** Behavioral plans should be tailored to health literacy, cognitive load, and patient capacity. Teach-back and simplified priorities improve understanding and implementation.

- 98. A.** Physical activity can be accumulated and progressed gradually. Starting below the ultimate target improves safety and adherence while still building fitness and function.
- 99. B.** Specific, measurable, achievable, relevant, and time-bound goals are easier to implement and review than broad intentions.
- 100. E.** Repeated blood pressures in the hypertensive range, supported by elevated home measurements, establish persistent hypertension rather than a white-coat pattern. Obesity increases cardiovascular risk but does not change the basic need to diagnose and treat hypertension appropriately.
- 101. D.** Professional competence includes recognizing limits, seeking authoritative information or consultation, and ensuring continuity of evidence-based care.
- 102. E.** Restaurant portions can be large and energy-dense. Practical portion estimation and available nutrition information can improve awareness without requiring perfect measurement.
- 103. D.** Alcohol can add energy, worsen sleep, interact with medications, and represent a substance-use disorder requiring direct treatment.
- 104. C.** The energy-balance equation is true but incomplete as an explanatory model. Appetite, satiety, adaptive thermogenesis, sleep, medications, environment, and genetics influence both sides of the equation.
- 105. B.** The combination of early obesity, retinal dystrophy, and postaxial polydactyly is highly characteristic of Bardet-Biedl syndrome. Other genetic obesity disorders can cause hyperphagia or retinal disease, but this phenotypic cluster is particularly suggestive of Bardet-Biedl syndrome.
- 106. D.** Medication selection can address multiple chronic conditions simultaneously. When appropriate, glucose-lowering therapies with favorable weight effects can support both diabetes and obesity goals.
- 107. E.** Past response shows what has worked and where treatment failed. Repeated initial loss followed by regain suggests that maintenance and chronic treatment deserve greater emphasis.
- 108. E.** Mental health symptoms can influence obesity and its treatment. Adolescents should be assessed and treated for depression and safety concerns in parallel with obesity care.
- 109. D.** Adolescent care should integrate family support, autonomy development, mental health, and age-appropriate treatment options.
- 110. C.** A treatment plan that the patient cannot afford is not clinically feasible. Effective obesity care should adapt recommendations to available foods and resources and address food insecurity through appropriate assistance and referrals.
- 111. C.** Discriminatory features such as proximal weakness, easy bruising, facial plethora, and broad violaceous striae raise suspicion for hypercortisolism beyond common obesity.

- 112. B.** Pediatric obesity treatment must support normal growth and development. Intensive family-based, nutritionally adequate treatment is preferred over unsupervised extreme restriction.
- 113. B.** Children and adolescents are classified using age- and sex-specific BMI percentiles because expected BMI changes with growth and development.
- 114. D.** Modern metabolic and bariatric surgery guidance recommends surgery for patients with BMI at least 35 kg/m², with or without obesity-related comorbidities, after appropriate evaluation.
- 115. E.** In older adults, treatment should protect lean mass and function while accounting for medication changes and hypoglycemia risk.
- 116. B.** Active eating disorders require specialized treatment. Standard restrictive weight-loss strategies can aggravate pathology and should not proceed without appropriate multidisciplinary management.
- 117. A.** Some beta blockers can modestly affect weight and exercise tolerance, but they may be essential for cardiovascular disease; indication review comes first.
- 118. B.** Pregnancy soon after bariatric surgery requires multidisciplinary management with careful nutritional monitoring. Rapid postoperative weight loss and micronutrient deficiencies can complicate pregnancy.
- 119. E.** People living with HIV should receive comprehensive obesity care. Antiretroviral regimen effects, drug interactions, and cardiometabolic risk should be reviewed collaboratively.
- 120. D.** Sugar-sweetened beverages can contribute substantial energy with relatively low satiety. Replacing them with water or other noncaloric beverages can reduce energy intake without requiring a reduction in solid-food volume.
- 121. D.** Substantial carbohydrate reduction can lower glucose and insulin requirements. In patients using insulin or insulin secretagogues, medication and monitoring plans should be adjusted to prevent hypoglycemia.
- 122. B.** Topiramate is associated with fetal harm, including oral clefts. Pregnancy should be avoided while using phentermine/topiramate, with appropriate testing and contraception according to prescribing requirements.
- 123. E.** PCOS and obesity have bidirectional metabolic interactions. PCOS does not provide a single deterministic explanation for obesity, but identifying it matters for reproductive and metabolic management.
- 124. C.** Orforglipron (Foundayo) is an oral GLP-1 receptor agonist approved in 2026 for chronic weight management in adults with obesity or adults with overweight and at least one weight-related comorbidity, together with a reduced-calorie diet and increased physical activity. It is taken once daily and is not an injectable dual GIP/GLP-1 agonist.

- 125. D.** Chronic liver disease requires individualized obesity care because medication handling, malnutrition, and sarcopenia may alter risk. Weight treatment should be integrated with hepatology management.
- 126. E.** Repeated high-dose systemic glucocorticoid exposure can increase appetite, promote central adiposity, and cause Cushingoid features such as facial rounding and proximal muscle weakness. The medication history and phenotype strongly support glucocorticoid-associated weight gain.
- 127. C.** Protein and fiber can increase satiation and satiety and may support adherence to an energy-reduced eating pattern.
- 128. C.** Weight-loss pharmacotherapy is generally avoided during pregnancy, when intentional weight loss is not the therapeutic goal. Medication discontinuation timing and preconception health should be addressed before conception.
- 129. A.** In March 2026, the FDA approved Wegovy HD, a higher 7.2-mg once-weekly semaglutide dose for chronic weight management in eligible adults. The product uses dose escalation rather than immediate initiation at the highest dose; it is not an oral formulation or a semaglutide-tirzepatide combination.
- 130. B.** Family-based treatment emphasizes supportive household changes, caregiver involvement, and reduced stigma. Singling out a child can worsen shame and disordered eating risk.
- 131. C.** Semaglutide for weight management has an FDA cardiovascular risk-reduction indication in adults with established cardiovascular disease and overweight or obesity, in addition to its chronic weight-management indication.
- 132. A.** Implementation intentions and coping plans link predictable high-risk situations to specific responses, improving adherence and relapse prevention.
- 133. E.** Obesity is a modifiable contributor to stress incontinence. Weight management can be integrated with pelvic-floor and urogynecologic care.
- 134. E.** Leakage with increases in intra-abdominal pressure is characteristic of stress urinary incontinence. Obesity is an important modifiable risk factor.
- 135. A.** Insulin can promote weight gain through anabolic effects, reduced glycosuria, and defensive eating around hypoglycemia.
- 136. A.** Anxiety can directly interfere with treatment behaviors. A graded plan and appropriate anxiety treatment can address the barrier.
- 137. D.** Exertional dyspnea may reflect deconditioning, mechanical load, cardiopulmonary disease, or a combination. The symptom should be characterized before setting intensity.

- 138. A.** Weight loss can improve OSA but does not guarantee resolution. Treatment should not be discontinued solely because symptoms improve; objective reassessment is appropriate.
- 139. B.** During pregnancy, care focuses on appropriate gestational gain, nutrient adequacy, safe activity, and management of complications rather than active weight-loss treatment.
- 140. E.** Valproate can contribute to weight gain and has important reproductive safety concerns, but antiseizure therapy cannot be changed based on weight effects alone. Preconception planning should be coordinated with neurology and obstetric care to preserve seizure control while addressing fetal risk and metabolic health.
- 141. C.** Severe pain with systemic signs and inability to tolerate intake after an endoscopic procedure may indicate a serious complication and requires urgent clinical evaluation.
- 142. D.** BMI is a screening measure, not a complete disease-severity assessment. Central adiposity and related complications can identify clinically important excess adiposity even when BMI is below a conventional obesity threshold.
- 143. A.** Pediatric obesity-related comorbidities require active diagnosis and treatment in parallel with obesity care; weight management does not replace condition-specific management.
- 144. E.** Nutrition plans should be individualized to culture and preference while meeting protein, micronutrient, and energy needs.
- 145. C.** Caloric beverages can add substantial energy while providing limited satiety. Beverage intake should be assessed explicitly in adolescents as part of a complete nutrition history.
- 146. C.** Temporal links between weight change and medications, smoking cessation, illness, pregnancy, sleep, or life events are clinically useful. The clustered timing here points to modifiable contributors rather than BMI alone.
- 147. A.** BMI-risk relationships vary across populations. Central adiposity and metabolic disease can occur at lower BMI, so clinical context and fat distribution remain important.
- 148. A.** Long-term adherence is a major determinant of dietary effectiveness. A nutritionally adequate, culturally acceptable plan is usually preferable to unnecessary rigid restriction.
- 149. E.** Marked central adiposity together with elevated triglycerides, blood pressure, and fasting glucose represents a cluster of cardiometabolic risk. Waist circumference adds clinically useful information about fat distribution beyond BMI alone.
- 150. E.** Weight loss can produce adaptive changes in appetite and energy expenditure that promote regain. This helps explain why long-term maintenance commonly requires continued treatment.

- 151. A.** Severe pediatric obesity is commonly defined using a percentage of the age- and sex-specific 95th BMI percentile; 120% or more of that percentile is an important threshold.
- 152. E.** Snoring, witnessed apneas, and daytime symptoms in an adolescent with obesity raise concern for obstructive sleep apnea and warrant objective evaluation.
- 153. A.** Resistance training helps preserve or improve muscle strength and lean mass during weight loss, especially in older adults.
- 154. D.** Weight stigma can worsen mental health, avoidance, and engagement in care. Pediatric obesity treatment should explicitly assess and address bullying while supporting enjoyable, safe activity.
- 155. C.** Iron deficiency is common after Roux-en-Y gastric bypass because of reduced intake and altered absorption. Microcytic anemia with low ferritin strongly supports iron deficiency.
- 156. A.** Obesity often relapses when physiologic, environmental, or life circumstances change. Long-term care should respond with renewed assessment and treatment adjustment.
- 157. D.** Public communication should be accurate, evidence-based, and nonstigmatizing. Emphasizing complexity, prevention, treatment options, and health rather than blame supports informed awareness.
- 158. B.** A respectful obesity conversation begins by asking permission and using person-centered, nonstigmatizing language. Linking treatment to the patient's own health priorities supports shared decision-making and engagement.
- 159. E.** Comorbid disease can change the safety and appropriateness of a dietary pattern. Protein targets should be individualized in chronic kidney disease with appropriate renal guidance.
- 160. E.** BMI 41 kg/m² with severe obesity-related OSA and inadequate response to evidence-based medical therapy is an appropriate setting to discuss and refer for metabolic and bariatric surgery evaluation. OSA treatment should continue during evaluation and perioperative planning.
- 161. C.** Obesity is chronic, and successful pediatric treatment should transition rather than abruptly stop. Planned follow-up, gradual transfer of responsibility, and coordinated movement to adult care reduce gaps in treatment and comorbidity monitoring.
- 162. A.** Obesity treatment often requires planning, cue management, monitoring, and repeated follow-through, all of which can be affected by executive dysfunction.
- 163. C.** A plan must fit the environment in which eating occurs. Shift timing, break length, storage, and food availability strongly affect feasibility.
- 164. B.** PCOS is a multisystem metabolic and reproductive condition. Obesity treatment should be integrated with glycemic, reproductive, and cardiovascular risk management.

- 165. E.** Obesity treatment often improves dyslipidemia but does not replace urgent management of severe hypertriglyceridemia or evaluation for secondary causes.
- 166. A.** Pediatric activity counseling should be developmentally appropriate, enjoyable, and family-supported. Reducing sedentary time and increasing routine movement can be meaningful even without organized sports.
- 167. A.** Glycemia can improve rapidly after metabolic surgery while caloric intake falls sharply. Insulin and insulin-secretagogue doses therefore require close postoperative reassessment.
- 168. D.** Biomechanical complications should be characterized by their impact on function. Asking how knee pain limits walking, stairs, work, and activities of daily living helps define clinical severity and guides a tolerable activity plan.
- 169. C.** Chronic weight-bearing pain with crepitus is typical of knee osteoarthritis. Excess adiposity increases mechanical loading and is associated with this common obesity-related complication.
- 170. E.** For a 10-year-old with obesity, intensive family-based multicomponent behavioral treatment is foundational. Effective programs integrate nutrition, physical activity, behavior-change strategies, and caregiver involvement rather than relying on brief advice or a single modality.
- 171. B.** Effective obesity treatment is individualized and multimodal, incorporating health goals, complications, preferences, prior response, contraindications, and available therapies.
- 172. E.** Medication-related weight change is probabilistic. The timeline, competing contributors, reproductive goals, and acceptable alternatives should be reviewed.
- 173. A.** Trauma can affect eating, sleep, stress, trust, and engagement. Trauma-informed care emphasizes safety, choice, collaboration, and appropriate referral.
- 174. E.** Sleeve gastrectomy removes much of the greater-curvature stomach to create a tubular gastric sleeve; it does not create an intestinal bypass.
- 175. C.** Because naltrexone is an opioid antagonist, naltrexone/bupropion is contraindicated with chronic opioid use and can precipitate withdrawal or interfere with analgesia.
- 176. B.** Obesity hypoventilation syndrome is characterized by obesity, sleep-disordered breathing, and awake alveolar hypoventilation after other causes of hypoventilation have been excluded. Daytime hypercapnia is the key feature distinguishing it from uncomplicated obstructive sleep apnea.
- 177. D.** Several second-generation antipsychotics, especially olanzapine and clozapine, can produce substantial weight gain and metabolic adverse effects.

- 178. C.** For eligible adolescents, pharmacotherapy can be offered as an adjunct to intensive lifestyle treatment. Selection must follow age-specific indications, contraindications, and shared decision-making.
- 179. A.** For chronic obesity, effective and tolerated pharmacotherapy may be continued long term when benefits outweigh risks. Withdrawal can be followed by increased appetite and weight regain.
- 180. B.** Obesity is a heterogeneous chronic disease shaped by biological, environmental, behavioral, developmental, and social determinants. Weight regain does not imply moral failure.
- 181. A.** Hepatic steatosis in the setting of obesity and metabolic risk, after excluding major competing causes, is consistent with metabolic dysfunction-associated steatotic liver disease.
- 182. D.** Weight recurrence is common in chronic obesity and should trigger early, nonjudgmental reassessment and treatment adjustment rather than abandonment of care.
- 183. D.** A useful activity history describes frequency, intensity, time, type, and sedentary behavior rather than relying on a vague statement that the adolescent is active.
- 184. E.** Maintaining competence requires ongoing review of current evidence, labeling, guidelines, and safety information, especially in a rapidly evolving therapeutic area.
- 185. C.** Short-term weight changes in heart failure can reflect fluid shifts. Obesity management must distinguish adipose change from disease-related volume changes and address decompensation promptly.
- 186. D.** Loud snoring, witnessed apneas, and excessive daytime sleepiness strongly suggest obstructive sleep apnea. The diagnosis is established with appropriate sleep apnea testing, including polysomnography when indicated, rather than by nonspecific cardiopulmonary tests alone.
- 187. B.** Aging can alter body composition through loss of muscle and redistribution of fat. BMI alone may therefore obscure sarcopenic obesity and functional risk.
- 188. B.** FDA labeling for orlistat products now highlights rare acute kidney injury associated with hyperoxaluria, calcium oxalate nephrolithiasis, and oxalate nephropathy. New flank or groin pain, hematuria, reduced urination, or edema warrants stopping the OTC product and appropriate clinical evaluation.
- 189. D.** Serious mental illness and psychotropic medications can affect weight, but patients should receive evidence-based obesity care. Medication changes require coordination to protect psychiatric stability.
- 190. E.** Activity should be adapted to pain, function, and comorbidities. Low-impact aerobic options and progressive strengthening can improve fitness without requiring jogging.

- 191. B.** Preconception care in a patient with obesity and PCOS should integrate metabolic optimization, reproductive goals, and medication-safety planning. Anti-obesity medications generally require review and discontinuation planning before pregnancy rather than continuation into pregnancy.
- 192. A.** Endoscopic procedures are components of chronic obesity treatment. Long-term outcomes depend on multidisciplinary follow-up, behavior and nutrition support, and management of weight recurrence and adverse events.
- 193. C.** Irregular ovulation plus clinical or biochemical hyperandrogenism, after exclusion of alternative causes, supports polycystic ovary syndrome, which is strongly associated with insulin resistance and obesity.
- 194. D.** Self-monitoring should be individualized. A tool that worsens anxiety or compulsive behavior should be modified while maintaining other forms of supportive follow-up.
- 195. A.** Diet quality and energy intake are related but not identical. High-quality foods can still be energy dense, so portions, cooking fats, and second servings matter.
- 196. A.** Fasting plasma glucose at or above the diagnostic threshold on repeat testing establishes diabetes in an asymptomatic patient. Obesity markedly increases risk for type 2 diabetes.
- 197. B.** Typical heartburn and regurgitation that worsen after meals and recumbency support gastroesophageal reflux disease, a condition whose risk is increased by obesity.
- 198. C.** Lapses are expected in long-term behavior change and do not equal treatment failure. A useful response is to analyze triggers, use problem-solving and relapse-prevention skills, and resume the plan promptly without punitive compensation.
- 199. A.** Contemporary pediatric guidance supports offering appropriately indicated anti-obesity pharmacotherapy to eligible adolescents as an adjunct to intensive health behavior and lifestyle treatment, not as a replacement.
- 200. D.** A useful nutrition history includes not only what is eaten but also when, where, and under what constraints. Shift timing, meal breaks, food access, hunger, and triggers can explain a late eating pattern and help identify feasible changes.