

# COMPREHENSIVE MOCK EXAM 10

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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 questions, single-best-answer, A-E format matching the parent book, domain-weighted to the official blueprint*

## Board-Review Questions

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1. During counseling on physical activity in obesity care, a 73-year-old with obesity and osteoarthritis wants to exercise but fears injury. What is the best recommendation?

- A. Use flexibility work initially and defer strengthening until pain is consistently minimal
- B. Start with high-impact interval exercise to build conditioning rapidly despite current joint symptoms
- C. Delay structured activity until meaningful weight loss reduces mechanical joint loading
- D. Begin with low-impact aerobic activity plus progressive strength and balance work tailored to function and pain
- E. Limit the program to walking because resistance and balance training add little benefit for older adults with osteoarthritis

2. At a multidisciplinary weight-management follow-up, the patient repeatedly misses follow-up because of transportation barriers but is benefiting from treatment. What is the best long-term adjustment?

- A. Assume missed visits indicate lack of interest in health as part of the current management plan
- B. Pause medication until transportation reliability improves enough to support routine monitoring
- C. Require more frequent in-person visits despite the same barrier when choosing the next management step
- D. Transfer care out of the program because repeated missed visits make safe longitudinal treatment difficult
- E. Use feasible alternatives such as telehealth, coordinated local monitoring, or less burdensome visit structures when clinically appropriate

3. During obesity care involving metabolic-bariatric treatment considerations, the patient years after gastric bypass has neuroglycopenic symptoms 2-3 hours after high-carbohydrate meals with documented low glucose. What is the most likely condition?

- A. Reactive hypertension caused by rapid gastric emptying
- B. Diabetic ketoacidosis caused by carbohydrate intake
- C. Early dumping syndrome occurring within minutes of eating, given the clinical details provided

- D.** Postbariatric hypoglycemia, within the treatment context described
- E.** Fasting hypoglycemia that excludes a relationship to surgery

**4.** At a visit focused on obesity-related health outcomes, a clinician wants to describe obesity without stigmatizing the patient. Which wording is preferred?

- A.** An obese patient who simply needs greater dietary discipline
- B.** A noncompliant individual whose weight reflects poor choices
- C.** A person with obesity who has a chronic disease requiring individualized treatment
- D.** A morbidly obese person defined primarily by body size
- E.** A failed dieter who has not tried hard enough

**5.** At a nutrition-focused weight-management visit, a patient with obesity has depression, food insecurity, knee pain, and uncontrolled diabetes. What is the best plan?

- A.** Require vigorous exercise despite untreated knee pain when choosing the next management step
- B.** Treat one problem at a time and postpone obesity care for years
- C.** Prioritize calorie restriction first and defer psychosocial, mobility, and food-access barriers until meaningful weight loss has begun
- D.** Use medication without assessing food access or mental health given the findings described
- E.** Build a multidisciplinary plan that addresses medical, psychological, functional, and social barriers in parallel

**6.** During a comprehensive obesity-medicine consultation, a patient with obesity has blood pressure readings of 148/92 mmHg and 146/90 mmHg on separate properly performed visits. What weight-related complication is present?

- A.** Orthostatic hypotension caused by excess adiposity
- B.** Hypertension requiring cardiovascular risk assessment and treatment
- C.** A measurement artifact that can be ignored if the patient is asymptomatic
- D.** Isolated white-coat hypertension proven without out-of-office data

E. Normal blood pressure because obesity raises the diagnostic threshold

**7.** During nutrition counseling in obesity care, why is adequate protein commonly emphasized during intentional weight loss?

**A.** It can support satiety and help preserve lean mass, especially when combined with resistance exercise

**B.** It guarantees fat loss regardless of total energy intake

**C.** Rely on higher protein intake instead of resistance training because both have the same effect on lean-mass preservation

**D.** Prioritize protein-rich foods while substantially reducing vegetables and whole grains to maximize satiety

**E.** Use very high protein intake to prevent most adaptive reductions in energy expenditure during weight loss

**8.** At a medication-management visit in obesity care, a patient with type 2 diabetes and obesity is using a sulfonylurea and has recurrent hypoglycemia while starting a potent incretin-based obesity medication. What should be considered?

**A.** Stop all glucose monitoring once weight treatment begins

**B.** Reduce or discontinue hypoglycemia-prone therapy as appropriate while monitoring glucose closely

**C.** Increase the sulfonylurea because weight loss raises insulin resistance

**D.** Add a second sulfonylurea to prevent weight recurrence

**E.** Ignore hypoglycemia because obesity medications cannot affect glucose

**9.** During adolescent obesity follow-up, a 13-year-old and parent are arguing about food at every meal. Which behavioral approach is most appropriate?

**A.** Ask the parent to monitor every bite while ignoring family routines

**B.** Make the child eat separate diet food while the family eats normally

**C.** Require public weigh-ins at home to increase accountability

**D.** Use family-based goals that change the home environment without singling out or shaming the child

**E.** Use food deprivation as punishment for missed activity goals

**10.** During an obesity visit discussing metabolic and bariatric procedures, a patient with obesity and gastroesophageal reflux has persistent symptoms despite lifestyle measures. Which obesity-treatment issue is especially important if surgery is being considered?

**A.** Choose between sleeve gastrectomy and gastric bypass without considering reflux because both procedures have similar reflux effects

**B.** Prefer sleeve gastrectomy because reducing stomach volume generally provides the most reliable reflux control

**C.** Endoscopic balloons are definitive surgical therapy for reflux

**D.** Base procedure selection on weight-loss efficacy alone because reflux can be managed separately after surgery

**E.** Procedure choice matters because Roux-en-Y gastric bypass often improves reflux while sleeve gastrectomy may worsen it

**11.** At a multidisciplinary visit addressing surgical and nonsurgical obesity options, which nutritional deficiency is especially important to monitor long term after Roux-en-Y gastric bypass?

**A.** Sodium deficiency caused by complete loss of intestinal sodium uptake

**B.** Hypervitaminosis A from universal overabsorption when choosing the next management step

**C.** Iron deficiency along with vitamin B12 and other micronutrient deficiencies, given the clinical details provided

**D.** Vitamin C excess caused by mandatory hyperabsorption

**E.** Copper excess from increased intestinal absorption given the findings described

**12.** At a multidisciplinary weight-management follow-up, a clinician hears a colleague describe a patient as "lazy and noncompliant because of her weight." What is the most appropriate response?

**A.** Agree because body size reliably measures motivation during longitudinal obesity care

- B.** Challenge the stigmatizing assumption and reframe obesity as a chronic multifactorial disease with barriers that should be assessed
- C.** Document the label in the medical record to improve continuity in this clinical setting
- D.** Avoid intervening because bias has no effect on care when counseling this patient
- E.** Withhold treatment until the patient demonstrates stronger willpower as part of the current management plan

**13.** During a pediatric obesity consultation, a 7-year-old has severe early-onset obesity, intense hyperphagia, developmental delay, hypotonia in infancy, and characteristic behavioral features. Which syndrome is most likely?

- A.** Alstrom syndrome with cone-rod dystrophy and hearing loss
- B.** Turner syndrome with short stature and gonadal dysgenesis
- C.** Marfan syndrome with tall stature and aortic root disease
- D.** Prader-Willi syndrome with neonatal hypotonia and later hyperphagia
- E.** Bardet-Biedl syndrome with retinal dystrophy and polydactyly

**14.** At a weight-management visit that includes preconception or pregnancy considerations, a patient with obesity and PCOS has irregular menses and insulin resistance. Which outcome can improve with weight reduction?

- A.** Expect menstrual irregularity to persist because weight reduction generally has little effect on the reproductive features of PCOS
- B.** Expect ovulation to improve only after a surgical weight-loss procedure produces large weight reduction
- C.** Normalize androgen levels pharmacologically before expecting any reproductive benefit from weight reduction
- D.** Focus on fertility treatment alone because weight reduction has little effect on insulin resistance in PCOS
- E.** Ovulatory function and metabolic risk can improve even with modest sustained weight loss

**15.** During shared decision-making for obesity treatment, the patient frequently snacks while watching television. Which behavioral strategy is most directly targeted to this cue?

- A.** Punitive exercise immediately after every snack episode
- B.** Exposure therapy to increase contact with snack foods during television
- C.** Stimulus control by separating eating from television and changing the food environment
- D.** Sleep restriction to reduce available evening eating time
- E.** Skipping breakfast to compensate for evening intake

**16.** During a pediatric obesity consultation, a 15-year-old with obesity has severe depression that is currently unstable. How should obesity treatment be tailored?

- A.** Coordinate obesity care with urgent mental-health treatment and choose interventions that protect safety and avoid worsening eating pathology
- B.** Ignore mood symptoms because weight treatment is independent of mental health
- C.** Select medication only by expected weight loss without psychiatric review when choosing the next management step
- D.** Postpone all medical care until body weight reaches an adult threshold as part of the current management plan
- E.** Use maximal dietary restriction because depression reduces adherence in this clinical setting

**17.** At a multidisciplinary weight-management follow-up, the patient asks whether alcohol matters for weight management. What is the best counseling point?

- A.** Only beer contributes calories; wine and spirits do not in this clinical setting
- B.** Alcohol needs to be counted in the nutrition history only when intake exceeds standard moderate-use thresholds
- C.** Alcohol provides calories, can lower dietary restraint, and should be included when assessing total intake and safety
- D.** Alcohol has no usable energy and therefore cannot affect weight
- E.** Alcohol improves satiety enough to substitute for meals safely as part of the current management plan

**18.** During integrated obesity and reproductive-health care, a pregnant patient with obesity asks for a weight-loss prescription because she is gaining more weight than expected. What is the best next step?

- A.** Focus on appropriate gestational weight gain, nutrition, activity, and obstetric risk management rather than intentional pharmacologic weight loss
- B.** Recommend a very-low-calorie diet to produce net weight loss in this clinical setting
- C.** Start a chronic obesity medication because pregnancy increases treatment urgency when choosing the next management step
- D.** Use phentermine because fetal risk is limited to late pregnancy as part of the current management plan
- E.** Advise fasting until prepregnancy weight is restored when counseling this patient

**19.** During an obesity visit focused on sleep-related complications, a patient with obesity and obstructive sleep apnea uses positive airway pressure successfully. Which treatment framing is most appropriate?

- A.** Assume PAP use prevents any benefit from weight reduction
- B.** Delay obesity treatment until PAP normalizes all cardiometabolic risk
- C.** Stop PAP once weight treatment begins because both therapies cannot be used together
- D.** Continue effective OSA therapy while treating obesity because the conditions should be managed concurrently
- E.** Use weight loss as a substitute for diagnosing residual sleep apnea

**20.** During shared decision-making for obesity treatment, the patient says, "I ate dessert at a party, so the whole week is ruined." Which cognitive pattern is most evident?

- A.** All-or-none thinking that can be reframed as a lapse rather than total failure
- B.** Loss of control proving the presence of bulimia nervosa
- C.** Classical conditioning that cannot be modified cognitively
- D.** A normal physiologic response that requires no behavioral work, within the treatment context described
- E.** Accurate prediction that one dessert causes a week of fat gain

**21.** During adolescent obesity follow-up, a 16-year-old has severe obesity with type 2 diabetes and obstructive sleep apnea despite intensive treatment. Which statement best reflects current obesity-medicine practice?

- A.** Continue nonsurgical therapy until every medication option has been exhausted before considering a surgical evaluation
- B.** Defer surgical referral because metabolic complications do not change candidacy during adolescence
- C.** Delay metabolic-surgery evaluation until adulthood because adolescent outcomes are insufficient to support referral
- D.** Referral to an experienced pediatric metabolic-bariatric surgery center is appropriate for evaluation
- E.** Use pubertal stage as the primary criterion for excluding an adolescent from metabolic-surgery evaluation

**22.** At a multidisciplinary weight-management follow-up, a patient with obesity is a cancer survivor taking a therapy associated with weight gain. What is the best obesity-medicine strategy?

- A.** Avoid resistance exercise because cancer survivors should not build muscle given the findings described
- B.** Use unregulated supplements to counter medication effects when choosing the next management step
- C.** Stop anticancer therapy solely because it promotes weight gain, given the clinical details provided
- D.** Coordinate with oncology, account for treatment effects and body-composition risk, and individualize nutrition, activity, and medication choices
- E.** Ignore obesity until all cancer follow-up has ended as part of the current management plan

**23.** At a medication-management visit in obesity care, the patient taking pregabalin for neuropathic pain reports increased appetite and edema with weight gain. What is the best interpretation?

- A.** The gain proves an endocrine disorder regardless of medication timing
- B.** Pregabalin can contribute to weight gain and should be included in the medication assessment

- C.** Edema excludes a medication contribution to measured body weight
- D.** The timing is more consistent with progression of neuropathic pain than with a medication effect on appetite or fluid balance
- E.** The medication should be stopped abruptly without evaluating pain control, given the clinical details provided

**24.** During adolescent obesity follow-up, a 10-year-old girl with obesity lives with her parents and two siblings. What is the best way to obtain a useful nutrition history?

- A.** Count only restaurant meals because home meals are not relevant when choosing the next management step
- B.** Assess the child and caregivers together, including meals, beverages, snacks, school food, and family routines
- C.** Focus exclusively on calories and avoid asking about meal structure
- D.** Interview only the caregiver and exclude the child from discussion
- E.** Interview only the child because caregiver reports are inherently biased

**25.** During an obesity pharmacotherapy review, a 60-year-old with established atherosclerotic cardiovascular disease and obesity wants pharmacotherapy that also has an FDA indication to reduce cardiovascular death, myocardial infarction, and stroke. Which medication fits this indication?

- A.** Semaglutide for chronic weight management
- B.** Phentermine used as short-term sympathomimetic therapy
- C.** Naltrexone-bupropion used for chronic weight management
- D.** Phentermine-topiramate extended release used for chronic treatment
- E.** Orlistat used as a gastrointestinal lipase inhibitor

**26.** At a follow-up focused on mobility, fitness, and function, why is resistance training particularly valuable during weight loss?

- A.** Use resistance training as the sole exercise mode because aerobic activity contributes little during weight reduction

- B.** Expect resistance training to prevent plateaus by maintaining a continuously increasing energy deficit
- C.** It helps preserve or improve muscle mass and function while weight is being reduced
- D.** Use resistance training in place of adequate protein intake because muscle loading alone preserves lean mass
- E.** Avoid resistance training during active fat loss because added muscle can obscure clinically meaningful weight change

**27.** During multidisciplinary management of obesity and behavioral health, a patient with depression attributes repeated overeating to low mood and anhedonia. Which assessment is most important before finalizing the obesity plan?

- A.** Focus solely on body mass index and omit functional symptoms when choosing the next management step
- B.** Avoid psychiatric history because it may stigmatize the patient
- C.** Assume depression will resolve once 5% weight loss is achieved
- D.** Clarify depression severity, suicidality, treatment status, and the relationship between mood and eating
- E.** Ask only whether the patient has ever joined a commercial diet

**28.** During a pediatric obesity consultation, a 16-year-old with severe obesity has right hip pain referred to the knee and walks with the foot externally rotated. Which complication requires urgent orthopedic evaluation?

- A.** Osgood-Schlatter disease confined to the tibial tubercle
- B.** Achilles tendinopathy presenting as referred knee pain
- C.** Growing pains that cause normal gait abnormalities
- D.** Slipped capital femoral epiphysis, given the clinical details provided
- E.** Patellofemoral pain syndrome without hip pathology

**29.** At a nutrition-focused weight-management visit, for an adult seeking weight reduction, which nutrition principle is most important across different evidence-based eating patterns?

- A.** Avoid dietary fat completely because it prevents weight loss
- B.** Create a sustainable energy deficit while maintaining nutritional adequacy and patient preference
- C.** Use one mandatory macronutrient ratio for every patient in this clinical setting
- D.** Require fasting every day to produce a metabolic advantage
- E.** Eliminate all carbohydrates regardless of medical context

**30.** During review of dietary treatment within a comprehensive obesity plan, which statement about meal replacements is most accurate?

- A.** Structured meal replacements can help some patients reduce decision burden and calorie intake when incorporated into a comprehensive plan
- B.** They are effective only when consumed in addition to usual meals as part of the current management plan
- C.** They eliminate the need to learn long-term eating strategies when counseling this patient
- D.** They permanently reset appetite regulation after several weeks in this clinical setting
- E.** Reserve meal replacements for short inpatient programs because outpatient use has not shown practical benefit

**31.** During an obesity visit discussing metabolic and bariatric procedures, what is the most important long-term follow-up principle after metabolic bariatric surgery?

- A.** Stop vitamin supplementation after weight stabilizes when counseling this patient
- B.** Monitor only body weight because laboratory testing is unnecessary
- C.** Avoid pharmacotherapy if weight recurrence later develops
- D.** Discharge from obesity care once the first postoperative year is complete, within the treatment context described
- E.** Lifelong monitoring for nutritional, metabolic, surgical, and behavioral complications, given the clinical details provided

**32.** At a family-centered pediatric weight-management visit, what is the preferred nutrition approach for a 10-year-old with obesity?

- A.** A family-based pattern emphasizing nutrient-dense foods, regular meals, and reduced sugar-sweetened beverages rather than a punitive restrictive diet
- B.** Eliminating all dietary fat during growth and development, given the clinical details provided
- C.** A separate very-low-calorie diet prepared only for the child when choosing the next management step
- D.** Using adult meal-replacement products without clinical supervision given the findings described
- E.** Skipping school lunch daily to accelerate weight loss as part of the current management plan

**33.** During review of medications that may affect obesity treatment, which factor should most directly guide selection among effective obesity medications?

- A.** Selecting the drug with the most advertising exposure during longitudinal obesity care
- B.** Expected benefit for the patient's goals and comorbidities balanced against contraindications, adverse effects, cost, access, and preference
- C.** Using the same medication first for every patient given the findings described
- D.** Choosing solely by the lowest monthly price regardless of efficacy when counseling this patient
- E.** Avoiding shared decision-making because it slows treatment, given the clinical details provided

**34.** At a visit focused on obesity-related health outcomes, a patient with obesity and metabolic dysfunction-associated steatohepatitis with fibrosis wants weight treatment. Which principle is most appropriate?

- A.** Use alcohol to raise HDL cholesterol and reduce liver fat in this clinical setting
- B.** Avoid weight loss because it accelerates progression to cirrhosis
- C.** Treat only aminotransferase values and ignore adiposity, within the treatment context described
- D.** Assume normal bilirubin excludes clinically important fibrosis as part of the current management plan
- E.** Prioritize substantial sustained weight reduction and therapies with evidence for liver benefit while continuing fibrosis risk assessment

**35.** At a multidisciplinary visit addressing surgical and nonsurgical obesity options, which factor is most important when evaluating an adolescent for metabolic bariatric surgery?

- A.** Ability of the patient and family to participate in long-term nutritional, medical, and behavioral follow-up
- B.** Avoiding family involvement because surgery is an individual decision only
- C.** Requiring the adolescent to reach a specific adult age regardless of disease severity
- D.** Using body weight alone without assessing complications or maturity
- E.** Excluding all patients with treated mental-health conditions

**36.** During a comprehensive obesity-medicine consultation, a physician is speaking to a community group about obesity. Which message is most appropriate?

- A.** Emphasize a single standardized diet because public messaging should avoid presenting medication or surgery as routine treatment options
- B.** Describe medication and surgery as options only after many years of unsuccessful lifestyle treatment, regardless of disease severity
- C.** Obesity is a chronic, treatable disease shaped by biology and environment, and effective care includes multiple evidence-based options
- D.** Frame personal responsibility as the primary driver of obesity because stronger accountability is expected to improve engagement
- E.** Focus community education on obesity complications rather than presenting obesity itself as a chronic disease that warrants early treatment

**37.** During an obesity visit focused on sleep-related complications, a 58-year-old adult with obesity and moderate-to-severe obstructive sleep apnea asks whether any anti-obesity medication has an FDA indication specifically for OSA. Which medication is appropriate to discuss?

- A.** Orlistat used primarily through gastrointestinal lipase inhibition
- B.** Phentermine used as short-term sympathomimetic treatment
- C.** Naltrexone-bupropion used as chronic weight-management therapy
- D.** Liraglutide used as a GLP-1 receptor agonist for chronic weight management

E. Tirzepatide used with reduced-calorie nutrition and increased physical activity

**38.** At a follow-up focused on mobility, fitness, and function, a family wants to increase physical activity, but their neighborhood has no safe outdoor space. Which intervention best addresses the barrier?

- A. Delay treatment until the family moves to another neighborhood
- B. Identify safe, affordable alternatives such as school, community-center, or indoor activity options
- C. Set a step goal without discussing where activity can occur
- D. Tell the family that neighborhood safety is outside clinical care
- E. Recommend unsupervised outdoor exercise despite safety concerns

**39.** During review of medications that may affect obesity treatment, the patient seeking obesity pharmacotherapy has active suicidal ideation with a plan. What should the clinician do first?

- A. Begin obesity medication first because weight loss may improve mood
- B. Recommend unsupervised fasting to provide a sense of control
- C. Delay all discussion until the next routine follow-up visit during longitudinal obesity care
- D. Prescribe a stimulant because it may improve energy quickly
- E. Address the psychiatric emergency and ensure immediate safety before initiating weight-loss treatment

**40.** During shared decision-making for obesity treatment, a 47-year-old woman has weight gain, fatigue, constipation, cold intolerance, dry skin, and delayed reflex relaxation. Which test is most appropriate first?

- A. Plasma metanephrines without suggestive symptoms
- B. Serum insulin level after an overnight fast
- C. Random growth hormone concentration
- D. Serum thyroid-stimulating hormone when counseling this patient
- E. Twenty-four-hour urinary free cortisol as the initial test, given the clinical details provided

**41.** During a comprehensive obesity-medicine consultation, a 38-year-old woman presents 8 months after delivery with persistent weight gain. Which history is most important for understanding the postpartum trajectory?

- A.** The infant's birth order compared with extended family
- B.** Whether prenatal visits occurred in the morning or afternoon
- C.** Her prepregnancy shoe size and changes in foot width
- D.** The number of pregnancy books read during each trimester
- E.** Gestational weight gain, postpartum retention, sleep, lactation, and current medications

**42.** During adolescent obesity follow-up, a 16-year-old with obesity takes an atypical antipsychotic and has rapidly rising weight and triglycerides. What should be done next?

- A.** Use lifestyle counseling alone and reconsider the antipsychotic only if diabetes or severe dyslipidemia develops
- B.** Continue the current regimen unchanged because psychiatric efficacy should take priority over metabolic risk during adolescence
- C.** Coordinate with psychiatry to reassess metabolic risk and consider a lower-weight-risk regimen if clinically appropriate
- D.** Defer medication-focused metabolic intervention until adulthood because adolescent antipsychotic-associated weight gain is usually transient
- E.** Switch to a lower-weight-risk antipsychotic immediately on the basis of metabolic effects without first assessing psychiatric stability

**43.** During an obesity visit discussing metabolic and bariatric procedures, which statement correctly compares sleeve gastrectomy with Roux-en-Y gastric bypass?

- A.** Both are effective operations, but bypass creates an intestinal anastomosis and greater malabsorptive micronutrient considerations
- B.** Sleeve gastrectomy is a temporary endoscopic device removed after one year
- C.** Sleeve gastrectomy bypasses the proximal small intestine while Roux-en-Y does not
- D.** Neither procedure requires long-term vitamin and nutritional monitoring given the findings described

E. Roux-en-Y leaves the stomach and intestinal anatomy completely unchanged

**44.** At a medication-management visit in obesity care, a patient has a contraindication to the medication that would otherwise offer the greatest average weight loss. What should the clinician do?

A. Avoid all obesity treatment because the first choice cannot be used

B. Ignore the contraindication if the patient requests the medication

C. Combine the drug with a second medication to cancel the contraindication, given the clinical details provided

D. Use the contraindicated drug at a lower dose because efficacy is more important than safety

E. Choose another evidence-based therapy with a safer risk-benefit profile for this patient

**45.** During shared decision-making for obesity treatment, a patient with obesity and chronic venous insufficiency has leg edema and limited mobility. What is the best integrated plan?

A. Use diuretics solely to achieve a lower target body weight during longitudinal obesity care

B. Treat venous disease and edema while using feasible weight reduction and adapted physical activity to improve function

C. Avoid activity completely because edema makes movement unsafe when counseling this patient

D. Delay obesity care until venous symptoms disappear permanently

E. Assume all measured weight is adipose tissue and ignore fluid status

**46.** During a comprehensive obesity-medicine consultation, a patient with central adiposity has triglycerides 280 mg/dL and HDL cholesterol 34 mg/dL. Which obesity-related metabolic complication is most evident?

A. Familial hypercholesterolemia defined by isolated low LDL cholesterol, within the treatment context described

B. A normal lipid pattern expected in insulin resistance

C. Hypobetalipoproteinemia causing very low total cholesterol

D. Atherogenic dyslipidemia characterized by high triglycerides and low HDL cholesterol

E. Severe chylomicronemia proven by any triglyceride elevation

**47.** At a multidisciplinary weight-management follow-up, a night-shift worker sleeps about 5 hours on workdays and reports increased hunger and late-night snacking. Which sleep-history issue is most relevant to weight management?

A. Chronic sleep restriction and circadian disruption can increase appetite and impair weight regulation

B. Only sleep duration on weekends has clinical relevance to obesity

C. Short sleep reliably increases resting energy expenditure enough to cause weight loss

D. Sleep should be addressed only after all nutrition goals are achieved

E. Circadian timing has no relationship to eating behavior or metabolic health

**48.** During review of medications that may affect obesity treatment, the patient stops semaglutide after major weight loss and regains weight over the next year. Which interpretation is most accurate?

A. Interpret post-treatment regain as evidence that appetite regulation should remain suppressed after medication is stopped

B. Interpret regain as evidence that pharmacologic treatment has permanently reduced future treatment responsiveness

C. Weight recurrence after discontinuation is common and reflects the chronic biology of obesity rather than proof of personal failure

D. The original weight loss could not have been physiologic when choosing the next management step

E. Interpret regain as evidence that prior GLP-1 therapy caused lasting metabolic injury rather than recurrence of a chronic disease

**49.** During counseling on physical activity in obesity care, a patient is asked to record food intake, hunger, mood, and activity for two weeks. What behavioral technique is being used?

A. Cognitive avoidance

B. Response prevention

- C. Pharmacologic reinforcement
- D. Aversion conditioning
- E. Self-monitoring

**50.** During shared decision-making for obesity treatment, a patient with obesity and idiopathic intracranial hypertension is losing vision despite therapy. How does weight management fit into care?

- A. Delay weight treatment until vision has already stabilized as part of the current management plan
- B. Only cosmetic weight loss is relevant once papilledema occurs
- C. Substantial weight reduction is disease-modifying and should be pursued urgently alongside neuro-ophthalmologic management
- D. Use stimulants instead of addressing intracranial pressure in this clinical setting
- E. Weight has no relationship to intracranial pressure, within the treatment context described

**51.** During adolescent obesity follow-up, a 14-year-old with obesity has not improved sufficiently with intensive family-based treatment and has no contraindications. Which statement best reflects current obesity-medicine practice?

- A. All obesity medications are prohibited until age 21 as part of the current management plan
- B. Evidence-based obesity pharmacotherapy can be offered as an adjunct to lifestyle treatment in appropriately selected adolescents
- C. Medication should replace family-based lifestyle treatment entirely when choosing the next management step
- D. Pharmacotherapy is considered only after bariatric surgery has failed
- E. Adolescents should receive adult medications without attention to age-specific approval

**52.** During professional development in obesity medicine, which activity best supports ongoing competence in obesity medicine?

- A. Avoiding outcome review because it may reveal practice variation when counseling this patient
- B. Using patient testimonials as the main source of therapeutic evidence

- C. Regular continuing education and review of current peer-reviewed evidence, guidelines, safety communications, and clinical outcomes
- D. Selecting treatments primarily from promotional materials during longitudinal obesity care
- E. Relying only on knowledge acquired during residency given the findings described

53. At a family-centered pediatric weight-management visit, a 9-year-old with obesity and no severe complications is starting treatment. Which strategy is most appropriate?

- A. Use family-centered intensive health behavior and lifestyle treatment adapted to the child's developmental stage
- B. Set a rigid adult BMI target and ignore growth velocity during longitudinal obesity care
- C. Use shame-based counseling to increase personal responsibility
- D. Prescribe an adult crash diet without caregiver involvement
- E. Delay treatment until adolescence because younger children cannot change behavior

54. During evaluation of sleep-disordered breathing in obesity care, a patient with obesity snores loudly, has witnessed apneas, and has resistant hypertension. What diagnosis should be actively evaluated?

- A. Central sleep apnea caused solely by excess body weight
- B. Restless legs syndrome as the cause of nocturnal airway obstruction
- C. Primary insomnia as the explanation for witnessed breathing pauses
- D. Narcolepsy without cataplexy as the usual cause of loud snoring, given the clinical details provided
- E. Obstructive sleep apnea as part of the current management plan

55. During an obesity pharmacotherapy review, which history is a major contraindication to naltrexone-bupropion because bupropion lowers seizure threshold?

- A. Remote appendectomy without complications
- B. Seasonal allergic rhinitis, within the treatment context described
- C. Mild osteoarthritis treated with topical therapy

- D.** A seizure disorder when counseling this patient
- E.** Controlled hypothyroidism on stable levothyroxine

**56.** During a comprehensive obesity-medicine consultation, what feature of behavioral obesity treatment is most consistently associated with greater weight loss?

- A.** A single educational visit without follow-up in this clinical setting
- B.** Higher-intensity contact with repeated counseling, monitoring, and feedback, given the clinical details provided
- C.** Providing information without setting behavioral goals when choosing the next management step
- D.** Avoiding self-monitoring to reduce treatment burden as part of the current management plan
- E.** Using identical interventions regardless of patient preference

**57.** During review of medications that may affect obesity treatment, a patient with uncontrolled hypertension and coronary artery disease requests phentermine. What is the best next step?

- A.** Start phentermine and stop antihypertensive therapy to avoid interactions as part of the current management plan
- B.** Use a higher dose because cardiovascular disease reduces appetite response
- C.** Combine phentermine with another stimulant to minimize tachycardia in this clinical setting
- D.** Use phentermine only at bedtime because cardiovascular risk occurs during daytime
- E.** Avoid phentermine because sympathomimetic effects can increase heart rate and blood pressure and cardiovascular disease is a contraindication

**58.** During reassessment in a chronic obesity-care program, why is waist circumference clinically useful in many adults with overweight or obesity?

- A.** It determines the exact amount of visceral fat in kilograms
- B.** It is unaffected by measurement technique or body habitus
- C.** It directly measures total body fat percentage with laboratory precision, within the treatment context described

- D.** It provides information about central adiposity and cardiometabolic risk beyond BMI alone
- E.** It replaces the need to assess blood pressure and metabolic risk

**59.** At a visit focused on obesity-related health outcomes, a patient with obesity and MASLD has no advanced fibrosis. Which intervention has the strongest general role in disease management?

- A.** Using vitamin supplements alone without changing energy balance
- B.** Treating only the ALT value while ignoring metabolic risk
- C.** Routine liver transplantation before evidence of advanced disease
- D.** Sustained weight reduction through lifestyle, medication, and/or surgery as appropriate
- E.** Avoiding weight loss because hepatic fat protects against fibrosis

**60.** During shared decision-making for obesity treatment, a 41-year-old man has lost and regained weight several times. Before selecting a new treatment, which prior-history detail is most clinically informative?

- A.** The order in which previous clinicians discussed each diet
- B.** The magnitude, durability, and tolerability of responses to prior weight-loss treatments
- C.** Whether prior programs used printed or electronic handouts
- D.** The number of friends who attempted the same programs
- E.** His preferred day of the week for starting a plan when counseling this patient

**61.** During a comprehensive obesity-medicine consultation, a patient with obesity and urinary stress incontinence asks whether weight treatment can help. What is the best next step?

- A.** Weight reduction can decrease intra-abdominal pressure and improve stress incontinence symptoms in many patients
- B.** Fluid restriction is the primary obesity treatment for incontinence
- C.** Only surgical weight loss can affect urinary symptoms when choosing the next management step
- D.** Treat stress incontinence independently because expected symptom improvement from nonsurgical weight reduction is too small to influence obesity counseling

E. Weight loss usually worsens stress incontinence by reducing pelvic support

**62.** At a multidisciplinary visit addressing surgical and nonsurgical obesity options, which patient may reasonably be considered for metabolic surgery at BMI 30-34.9 kg/m<sup>2</sup>?

A. A patient with metabolic disease who has not achieved adequate durable benefit with nonsurgical treatment

B. A patient with BMI 29 kg/m<sup>2</sup> requesting surgery without clinical evaluation

C. A healthy patient with BMI 22 kg/m<sup>2</sup> who wants preventive surgery

D. A patient with BMI 27 kg/m<sup>2</sup> whose only goal is faster athletic performance

E. A patient with BMI 25 kg/m<sup>2</sup> and no obesity-related disease

**63.** During adolescent obesity follow-up, a 15-year-old girl with obesity reports secretive eating and loss of control but no vomiting. What should be done next?

A. Assume the behavior is expected in adolescence and defer discussion

B. Exclude caregivers from all safety-related assessment regardless of risk

C. Screen further for binge eating, mood symptoms, body-image distress, and compensatory behaviors

D. Recommend daily weighing without exploring emotional triggers

E. Prescribe a highly restrictive diet before assessing eating pathology

**64.** During an obesity visit discussing metabolic and bariatric procedures, a patient has obesity with BMI 36 kg/m<sup>2</sup> but is hesitant about surgery and cannot afford the preferred medication. What should be done next?

A. Use unregulated supplements as a substitute for evidence-based treatment

B. Create the most effective feasible plan now while addressing coverage, alternatives, and future treatment escalation

C. Prescribe the unaffordable medication and assume adherence when counseling this patient

D. Insist on surgery because medication access is limited during longitudinal obesity care

E. Delay all care until the preferred medication becomes affordable

**65.** During shared decision-making for obesity treatment, the patient says, "I lost 18 kg, but after a year my hunger increased and some weight returned. I must have failed." What is the best next step?

A. Advise that successful weight loss should permanently eliminate hunger signals

B. Explain that biologic adaptations after weight loss can increase hunger and favor weight regain, so long-term treatment is often needed

C. Recommend stopping follow-up because recurrence means treatment cannot work given the findings described

D. State that maintenance depends only on willpower once weight is lost when choosing the next management step

E. Explain that weight regain proves the original calorie deficit was imaginary

**66.** During a comprehensive obesity-medicine consultation, a patient has proximal muscle weakness, easy bruising, wide violaceous striae, hypertension, and rapid central weight gain. Which secondary cause should be evaluated?

A. Growth hormone deficiency established by a random level

B. Simple obesity without endocrine evaluation despite discriminatory features

C. Hyperaldosteronism as the usual cause of proximal myopathy and bruising, within the treatment context described

D. Primary hypothyroidism as the typical cause of violaceous striae, given the clinical details provided

E. Cushing syndrome when counseling this patient in this clinical setting

**67.** During an obesity pharmacotherapy review, the patient cannot afford the medication that would otherwise best fit the treatment plan. What is the most appropriate response?

A. Withhold all treatment until insurance coverage changes in this clinical setting

B. Discuss cost and coverage openly and select the most effective feasible alternative through shared decision-making

- C. Prescribe the unaffordable drug and assume the patient will find a way to pay
- D. Choose the cheapest option without discussing efficacy or safety
- E. Avoid asking about cost because finances are outside clinical decisions

**68.** During reassessment in a chronic obesity-care program, a patient with marked edema has gained 6 kg in two weeks without increased waist circumference. Which interpretation is most appropriate?

- A. Edema confirms that the patient has developed an eating disorder
- B. All short-term weight gain necessarily represents new body fat
- C. Rapid fluid gain is expected and requires no medical evaluation
- D. Some of the measured weight gain may reflect fluid rather than increased adipose tissue
- E. Body weight is unaffected by extracellular fluid volume

**69.** During obesity care involving metabolic-bariatric treatment considerations, the patient develops crampy abdominal pain, palpitations, flushing, and diarrhea shortly after a high-sugar meal following gastric bypass. Which diagnosis is most likely?

- A. Small-bowel obstruction caused by an internal hernia
- B. Early dumping syndrome as part of the current management plan
- C. Postbariatric hypoglycemia occurring several hours after meals, within the treatment context described
- D. Bile-acid diarrhea, which would more typically cause watery stool without the prominent immediate vasomotor symptoms after a high-sugar meal
- E. Acute pancreatitis from hypertriglyceridemia

**70.** During shared decision-making for obesity treatment, which clinic change most directly reduces weight stigma and improves access for patients with obesity?

- A. Provide appropriately sized chairs, examination tables, gowns, and blood-pressure cuffs with privacy and respectful language
- B. Use stigmatizing terminology to emphasize disease severity, given the clinical details provided

- C.** Avoid asking permission before discussing weight because consent is unnecessary
- D.** Use small equipment so patients are reminded to lose weight
- E.** Require weighing in public areas to normalize discussion when choosing the next management step

**71.** At a medication-management visit in obesity care, the patient gained 11 kg during the year after starting treatment for schizophrenia. Which medication is most strongly associated with clinically important weight gain?

- A.** Lurasidone taken with the required food intake
- B.** Haloperidol used intermittently for acute agitation
- C.** Aripiprazole used at a low maintenance dose
- D.** Ziprasidone with routine metabolic monitoring
- E.** Olanzapine, within the treatment context described

**72.** During obesity care involving metabolic-bariatric treatment considerations, the patient prefers medication and strongly declines surgery after informed discussion. What is the best next step?

- A.** Coerce surgical referral because clinician preference overrides autonomy
- B.** Provide only educational handouts and no active treatment in this clinical setting
- C.** Refuse further care because the most effective option was declined as part of the current management plan
- D.** Document noncompliance and stop discussing obesity when counseling this patient
- E.** Respect the preference, provide effective nonsurgical treatment, and revisit options later if goals or circumstances change

**73.** During counseling on physical activity in obesity care, a patient with mobility impairment uses a wheelchair and has obesity. Which physical-activity counseling is most appropriate?

- A.** Delay obesity treatment until independent ambulation is achieved, given the clinical details provided

- B.** Adapt activity to ability, emphasizing accessible aerobic movement, upper-body or resistance work, and reduction of sedentary time where feasible
- C.** Exclude physical activity because walking is not possible given the findings described
- D.** Recommend only vigorous lower-extremity exercise regardless of function when counseling this patient
- E.** Use standard step-count goals as the only measure of success during longitudinal obesity care

**74.** At a visit focused on obesity-related health outcomes, which statement best reflects the modern clinical concept of obesity?

- A.** Obesity is diagnosed only when a patient develops type 2 diabetes
- B.** Obesity severity is determined solely by a single scale measurement
- C.** Obesity is a chronic, relapsing disease in which excess or dysfunctional adiposity can impair health
- D.** Obesity is an acute condition that resolves permanently after short-term dieting
- E.** Obesity is simply a voluntary behavior defined only by calorie choice

**75.** During shared decision-making for obesity treatment, a patient with obesity and chronic kidney disease has albuminuria and high cardiovascular risk. Which principle should guide treatment?

- A.** Assume kidney disease makes nutrition therapy impossible given the findings described
- B.** Treat obesity only after kidney disease reaches end-stage, given the clinical details provided
- C.** Ignore blood pressure and diabetes while pursuing weight loss during longitudinal obesity care
- D.** Manage kidney and cardiovascular risk factors while treating obesity because weight reduction can improve multiple interacting conditions
- E.** Use a single weight target as the only measure of renal improvement when counseling this patient

**76.** During nutrition counseling in obesity care, the patient wants to increase adherence to home-prepared meals. Which use of social support is most appropriate?

- A.** Encourage criticism when the patient deviates from the plan

- B.** Ask family members to police every food choice without consent
- C.** Keep goals secret so no one can influence behavior when choosing the next management step
- D.** Invite a supportive household member, with permission, to help plan shopping and meal preparation
- E.** Use competition with relatives as the primary treatment strategy

**77.** At a medication-management visit in obesity care, a 65-year-old man has difficulty remembering daily goals and medications. Which behavioral adaptation is most practical?

- A.** Avoid involving support persons even with patient permission
- B.** Increase the number of daily decisions to strengthen memory
- C.** Simplify routines and use external cues such as pill organizers, reminders, and written action plans
- D.** Use complex tracking tools because difficulty improves with challenge
- E.** Assume forgetfulness reflects intentional nonadherence in this clinical setting

**78.** During evaluation of sleep-disordered breathing in obesity care, a patient with obesity and OSA asks whether losing weight allows immediate discontinuation of positive airway pressure. What is the best advice?

- A.** Assume OSA is cured once BMI falls below 30 kg/m<sup>2</sup>
- B.** Stop PAP as soon as any weight loss occurs as part of the current management plan
- C.** Continue PAP until the sleep disorder is reassessed objectively after weight change
- D.** Replace PAP with caffeine if daytime sleepiness improves
- E.** Use scale weight alone to determine whether apneas persist

**79.** During a pediatric obesity consultation, a 4-year-old has severe obesity beginning in infancy and relentless hyperphagia. Several relatives have similar early-onset obesity. What should be done next?

- A.** Refer for evaluation of monogenic obesity, including melanocortin-pathway defects

- B.** Defer genetic evaluation until after puberty because results from early testing rarely change management of severe childhood obesity
- C.** Prioritize evaluation for cortisol excess because severe early-onset obesity with hyperphagia usually reflects Cushing syndrome
- D.** Begin a highly restrictive energy prescription first and reserve genetic evaluation for failure of conventional behavioral treatment
- E.** Attribute the familial pattern to shared environment unless developmental delay or dysmorphic features are also present

**80.** At integrated obesity and sleep-medicine follow-up, a patient with untreated obstructive sleep apnea has progressive fatigue and reduced activity with weight gain. How should the sleep disorder be conceptualized?

- A.** As a condition that is treated only with stimulant medication
- B.** As proof of a primary endocrine cause of obesity during longitudinal obesity care
- C.** Treat obstructive sleep apnea as a parallel comorbidity that has little effect on appetite, fatigue, or daytime activity once oxygen saturation is acceptable
- D.** As a weight-related condition that can worsen energy balance and should be treated concurrently
- E.** As a reason to postpone obesity treatment until PAP cures weight gain

**81.** During review of medications that may affect obesity treatment, the patient gains substantial weight after beginning a new medication. What feature most strongly supports a medication-induced contribution?

- A.** No change in appetite, fluid status, or activity over decades
- B.** A clear temporal relationship between drug initiation or dose escalation and the change in weight trajectory
- C.** Weight loss that began before the medication was prescribed when counseling this patient
- D.** A family history of obesity that excludes all medication effects
- E.** A stable weight trajectory for years after the medication was started

**82.** During an obesity visit addressing reproductive health, a 26-year-old woman using depot medroxyprogesterone acetate has gained weight and asks whether contraception could be contributing. What is the best next step?

- A.** Attribute the weight change to factors other than contraception because depot progestin has little relevance to medication review
- B.** Stop the injection promptly because weight gain outweighs contraceptive priorities in treatment selection
- C.** Assume each hormonal contraceptive method has a similar average effect on weight
- D.** Focus on estrogen-containing methods because progestin-only contraception is generally weight neutral
- E.** Injectable progestin can be weight promoting in some patients, so alternatives can be discussed if appropriate

**83.** At integrated obesity and sleep-medicine follow-up, a 59-year-old with obesity and moderate-to-severe obstructive sleep apnea asks whether any obesity medication has an FDA indication specifically for OSA. Which medication is appropriate to discuss?

- A.** Phentermine, within the treatment context described
- B.** Tirzepatide during longitudinal obesity care
- C.** Orlistat
- D.** Naltrexone-bupropion, given the clinical details provided
- E.** Liraglutide

**84.** During review of medications that may affect obesity treatment, an adult with obesity prefers an oral agent and asks about the small-molecule GLP-1 receptor agonist approved in 2026 for chronic weight management. Which medication is this?

- A.** Setmelanotide
- B.** Bremelanotide
- C.** Orforglipron
- D.** Pramlintide

E. Exenatide

**85.** During a pediatric obesity consultation, a 5-year-old with genetically confirmed LEPR deficiency has severe hyperphagic obesity. Which targeted medication acts through the melanocortin-4 receptor pathway?

- A. Orlistat, which inhibits gastrointestinal lipase activity
- B. Metformin, an insulin sensitizer without an obesity indication in this setting, within the treatment context described
- C. Phentermine, a sympathomimetic approved for short-term use
- D. Setmelanotide given the findings described during longitudinal obesity care
- E. Naltrexone-bupropion, which combines opioid and catecholamine pathways, given the clinical details provided

**86.** At a nutrition-focused weight-management visit, the patient reports eating "very little" but has continued to gain weight. Which nutrition-history question is most likely to uncover a commonly missed source of energy intake?

- A. Ask specifically about sugar-sweetened drinks, alcohol, coffee additives, and other caloric beverages
- B. Ask whether water is usually consumed cold or at room temperature
- C. Ask which grocery-store aisle is visited first each week
- D. Ask whether vegetables are usually eaten before or after the entree
- E. Ask whether meals are served on round or square plates in this clinical setting

**87.** During integrated obesity and reproductive-health care, a patient with polycystic ovary syndrome, obesity, and infertility wants to conceive. Which treatment focus is most appropriate?

- A. Use anti-obesity medication throughout pregnancy to maintain ovulation given the findings described
- B. Use a very-low-calorie diet during early pregnancy to improve insulin resistance
- C. Prescribe androgen therapy to promote ovulation when choosing the next management step

- D.** Defer weight-focused treatment until fertility therapy is complete because preconception weight reduction offers little metabolic or reproductive benefit
- E.** Improve metabolic health and weight before conception while coordinating fertility care and avoiding pregnancy-contraindicated weight-loss drugs

**88.** During nutrition counseling in obesity care, when is a very-low-calorie diet most appropriate?

- A.** As an unsupervised first-line plan for every person with overweight
- B.** For children without specialist oversight because growth is unaffected
- C.** In selected patients under close medical supervision with monitoring for contraindications, medications, and nutrient needs
- D.** During pregnancy to minimize gestational weight gain when choosing the next management step
- E.** In any patient with an active eating disorder to enforce structure given the findings described

**89.** At a medication-management visit in obesity care, the patient receiving chronic opioid therapy for severe pain asks about naltrexone-bupropion. What is the key concern?

- A.** Bupropion causes universal opioid toxicity when the drugs are combined
- B.** Naltrexone can block opioid analgesia and precipitate withdrawal, so the combination is inappropriate during ongoing opioid use
- C.** Because oral naltrexone has limited systemic exposure, chronic opioid therapy does not materially affect selection of this combination
- D.** Naltrexone increases the analgesic effect of opioid agonists when counseling this patient
- E.** The medication is preferred because it prevents all opioid adverse effects

**90.** During shared decision-making for obesity treatment, the patient regains 6% of body weight after an initially successful program. What is the most appropriate response?

- A.** Repeat the identical plan without reviewing barriers or biology
- B.** Assume the regain is entirely due to hidden eating during longitudinal obesity care
- C.** End treatment because recurrence proves the patient cannot respond

**D.** Use shame to restore adherence rapidly given the findings described

**E.** Reassess contributors and intensify or modify treatment rather than treating recurrence as personal failure

**91.** During a pediatric obesity consultation, a 17-year-old with severe obesity and autism has sensory food aversions and limited communication. What is the best approach?

**A.** Assume obesity treatment cannot be offered in neurodevelopmental disorders as part of the current management plan

**B.** Exclude caregivers from planning because autonomy requires no assistance in this clinical setting

**C.** Remove all preferred foods abruptly to force dietary flexibility, given the clinical details provided

**D.** Use the same counseling script used for every adolescent regardless of neurodevelopment

**E.** Individualize treatment with caregiver input, sensory-aware nutrition strategies, predictable routines, and appropriate multidisciplinary support

**92.** At a follow-up focused on mobility, fitness, and function, a patient has lost substantial weight and asks how much activity may help prevent regain. Which counseling point is most accurate?

**A.** Maintenance requires less activity than during sedentary baseline given the findings described

**B.** Exactly 60 minutes per week is sufficient for all long-term maintenance when counseling this patient

**C.** Only vigorous exercise affects long-term weight maintenance, given the clinical details provided

**D.** Weight-loss maintenance often requires more activity than the minimum needed for general health, commonly progressing toward 200-300 minutes weekly

**E.** After goal weight is reached, activity can return to general-health minimums because maintenance depends mainly on resting energy expenditure

**93.** During adolescent obesity follow-up, a 17-year-old has obesity with type 2 diabetes, hypertension, and obstructive sleep apnea. How should the severity of obesity be characterized?

**A.** Only waist circumference determines treatment intensity when counseling this patient

- B.** Complications do not affect obesity staging in adolescents
- C.** Severity should incorporate obesity-related complications, not BMI alone, within the treatment context described
- D.** BMI alone fully describes health risk and treatment urgency
- E.** The presence of diabetes excludes obesity as a diagnosis in this clinical setting

**94.** During nutrition counseling in obesity care, the patient asks how to interpret a nutrition label for weight management. Which comparison is most useful?

- A.** Ignore serving size because calories are listed for the whole package
- B.** Choose foods solely by whether they are labeled natural
- C.** Use only the front-of-package marketing claim in this clinical setting
- D.** Compare serving size, calories, protein, fiber, added sugars, and saturated fat in the context of the whole diet
- E.** Avoid any food containing more than one ingredient as part of the current management plan

**95.** At a medication-management visit in obesity care, an adult has BMI 31 kg/m<sup>2</sup> and no contraindications. Which statement about obesity pharmacotherapy eligibility is most accurate?

- A.** Medication eligibility requires type 2 diabetes in every patient
- B.** FDA-approved chronic obesity medication can be considered with lifestyle treatment at BMI at least 30 kg/m<sup>2</sup>
- C.** Pharmacotherapy is reserved only for patients who have already had surgery
- D.** Use medication only after lifestyle treatment has been discontinued so the independent drug effect can be assessed
- E.** Medication is appropriate only when BMI is at least 40 kg/m<sup>2</sup>

**96.** During review of medications that may affect obesity treatment, a patient with obesity takes antiretroviral therapy and has experienced weight gain. What is the best approach?

- A.** Avoid anti-obesity medication because treatment interactions make pharmacotherapy impractical in patients receiving antiretroviral therapy

- B.** Treat antiretroviral-associated weight change as unlikely because modern HIV regimens have little effect on body weight
- C.** Switch antiretroviral therapy primarily for weight control without first reviewing resistance history or virologic stability
- D.** Review the regimen with the HIV clinician, consider medication effects and alternatives, and treat obesity without jeopardizing viral suppression
- E.** Interrupt antiretroviral therapy temporarily so weight-management priorities can be addressed before viral suppression is resumed

**97.** During nutrition counseling in obesity care, the patient asks whether a low-carbohydrate diet is always superior to a low-fat diet for long-term weight loss. What is the best answer?

- A.** Either can be effective; long-term results depend largely on energy deficit, adherence, and individual metabolic needs
- B.** Low-fat diets are the only evidence-based approach to obesity during longitudinal obesity care
- C.** Low-carbohydrate diets cause greater long-term loss in every patient
- D.** All carbohydrate-containing foods should be avoided during weight treatment
- E.** Macronutrient composition should determine the diet regardless of adherence because metabolic effects dominate long-term weight outcomes

**98.** At a medication-management visit in obesity care, the patient on long-term obesity medication develops persistent severe adverse effects despite slower titration. What should be done next?

- A.** Add medications solely to mask every adverse effect without reassessment
- B.** Continue the same dose indefinitely because weight loss outweighs tolerability
- C.** Increase the dose because adverse effects indicate the medication is working
- D.** Reassess the risk-benefit balance and reduce, switch, or discontinue therapy while offering another effective treatment
- E.** Stop all obesity treatment permanently when counseling this patient in this clinical setting

**99.** At a visit focused on obesity-related health outcomes, the patient asks why weight-loss plateaus occur despite continued adherence. Which mechanism is most relevant?

- A.** Leptin concentrations increase and permanently suppress appetite after weight loss
- B.** Expect resting energy expenditure to increase as body mass decreases, thereby sustaining the initial calorie deficit
- C.** Attribute plateaus mainly to progressively greater intestinal calorie absorption during continued dieting
- D.** As body weight falls, energy expenditure can decrease and appetite signals can rise, narrowing the energy deficit
- E.** Skeletal muscle becomes incapable of using fatty acids after dieting

**100.** During shared decision-making for obesity treatment, a postmenopausal woman with obesity is losing weight and has osteoporosis risk. Which modification is most appropriate?

- A.** Avoid resistance exercise because it increases fracture risk in all patients
- B.** Include resistance and weight-bearing activity, adequate protein and bone nutrients, and monitor skeletal health
- C.** Bone-directed nutrition and resistance exercise are unnecessary during intentional weight loss if body mass index remains in the obesity range
- D.** Restrict calcium and vitamin D to accelerate fat loss given the findings described
- E.** Prefer rapid unsupervised weight loss to reduce skeletal loading

**101.** At a medication-management visit in obesity care, a patient with type 2 diabetes has progressive weight gain after escalation of glucose-lowering therapy. Which medication class is most likely contributing?

- A.** Insulin therapy, within the treatment context described
- B.** Glucagon-like peptide 1 receptor agonist therapy
- C.** Metformin therapy used as background treatment
- D.** Sodium-glucose cotransporter 2 inhibitor therapy
- E.** Dual GIP and GLP-1 receptor agonist therapy

**102.** During review of medications that may affect obesity treatment, a patient with chronic kidney disease and obesity is considering pharmacotherapy. What is the best general approach?

- A.** Assume all obesity medications are contraindicated in any kidney disease given the findings described
- B.** Treat kidney disease first and obesity only after renal function normalizes
- C.** Avoid monitoring volume status or kidney function during treatment when choosing the next management step
- D.** Choose therapy based on kidney function, comorbidities, labeling, hydration risk, and the potential renal and cardiovascular benefits of weight reduction
- E.** Use the same dose of every medication regardless of renal function, given the clinical details provided

**103.** During an obesity pharmacotherapy review, a 50-year-old woman has gained weight since long-term prednisone was started for inflammatory disease. What is the best next step?

- A.** Coordinate with the treating specialist to minimize glucocorticoid exposure if clinically feasible
- B.** Postpone active obesity treatment until glucocorticoid therapy can be withdrawn from the underlying disease plan
- C.** Add an unregulated stimulant supplement to offset steroid appetite
- D.** Treat lifestyle behavior as the main modifiable factor and leave medication contributors unchanged unless toxicity develops
- E.** Discontinue prednisone to remove the weight-promoting exposure before coordinating with the treating specialist

**104.** At a medication-management visit in obesity care, what supplement counseling is appropriate for a patient taking orlistat long term?

- A.** Take the multivitamin with every orlistat dose to maximize binding
- B.** Use a multivitamin containing fat-soluble vitamins separated in time from the medication
- C.** Take only vitamin C because fat-soluble vitamins are unaffected
- D.** Supplement iron only because vitamins A, D, E, and K are not affected, given the clinical details provided

E. Avoid all vitamins because orlistat increases vitamin absorption

**105.** During shared decision-making for obesity treatment, a patient with BMI 42 kg/m<sup>2</sup>, type 2 diabetes, OSA, and prior unsuccessful lifestyle-only attempts wants the most effective plan. Which approach is best?

- A. Discuss combined evidence-based options, including intensive lifestyle treatment, pharmacotherapy, and metabolic surgery
- B. Choose treatment only by BMI and ignore diabetes or OSA when choosing the next management step
- C. Withhold pharmacotherapy until surgery has been attempted
- D. Repeat brief lifestyle advice alone indefinitely because escalation is inappropriate
- E. Require a fixed sequence of treatments regardless of patient preference

**106.** During a comprehensive obesity-medicine consultation, a patient with obesity and knee osteoarthritis asks whether the joint disease is related to weight. Which statement best reflects current obesity-medicine practice?

- A. Only underweight is associated with progression of knee osteoarthritis
- B. Exercise should be avoided because movement invariably accelerates cartilage loss
- C. Excess weight increases mechanical loading and inflammatory burden, and weight reduction can improve symptoms
- D. Weight reduction worsens knee symptoms by reducing joint cushioning
- E. Once structural osteoarthritis is established, weight reduction may improve cardiometabolic health but is unlikely to change knee symptoms

**107.** At a family-centered pediatric weight-management visit, a 9-year-old has rapid weight gain and a clear fall in height percentile over two years. Which principle is most important?

- A. Weight should be treated before investigating abnormal growth patterns
- B. The growth pattern is typical of common primary obesity because excess adiposity usually slows linear growth substantially

- C. Reduced linear growth with weight gain raises suspicion for an endocrine or hypothalamic cause
- D. Primary obesity typically causes marked slowing of linear growth
- E. Use excess BMI alone as sufficient evidence for an endocrine cause even when linear growth remains normal

**108.** During a weight-management visit emphasizing function in later life, a 74-year-old man with obesity, frailty, and low muscle mass wants aggressive weight loss. What is the most important treatment priority?

- A. Set a normal-BMI target before addressing mobility
- B. Balance fat loss with preservation of muscle, strength, nutrition, and physical function
- C. Avoid resistance exercise because it can increase body weight
- D. Maximize scale weight loss regardless of lean-mass loss
- E. Use prolonged fasting because frailty improves with lower body weight

**109.** During nutrition counseling in obesity care, a patient with obesity and hypertension wants an eating pattern that also supports cardiovascular health. Which eating pattern is a reasonable choice?

- A. A high-sodium processed-food pattern with no calorie target
- B. A plan emphasizing refined grains and processed meats when choosing the next management step
- C. A liquid-sugar diet because beverages reduce sodium intake
- D. A calorie-reduced DASH-style pattern rich in vegetables, fruits, legumes, whole grains, and lean proteins
- E. An all-meat diet that excludes plant foods indefinitely

**110.** During shared decision-making for obesity treatment, an adult has BMI 28 kg/m<sup>2</sup> and hypertension. Which statement best reflects current obesity-medicine practice?

- A. A chronic obesity medication may be considered because BMI is at least 27 kg/m<sup>2</sup> with a weight-related comorbidity
- B. Medication is contraindicated because BMI is below 30 kg/m<sup>2</sup>

- C. Hypertension does not count as a weight-related condition
- D. Only short-term sympathomimetics may be used at this BMI when choosing the next management step
- E. Medication requires prior failure of metabolic surgery as part of the current management plan

**111.** During a comprehensive obesity-medicine consultation, a 24-year-old with lifelong severe obesity and hyperphagia is found to have a heterozygous MC4R variant. Which statement best reflects current obesity-medicine practice?

- A. MC4R pathway defects are a recognized monogenic cause of early-onset obesity and hyperphagia
- B. MC4R variants cause obesity only when accompanied by adrenal insufficiency
- C. All MC4R variants automatically qualify for setmelanotide treatment
- D. MC4R deficiency is characterized primarily by progressive weight loss
- E. A genetic cause excludes any benefit from lifestyle or medical treatment

**112.** During an obesity visit discussing metabolic and bariatric procedures, the patient experiences clinically significant weight recurrence several years after metabolic surgery. What is the best approach?

- A. Assume surgery has failed permanently and no further treatment can help during longitudinal obesity care
- B. Blame the patient because biologic recurrence does not occur after surgery when counseling this patient
- C. Avoid obesity medication because it cannot be used after bariatric procedures
- D. Evaluate behavioral, medical, medication, and anatomic contributors and consider multimodal treatment including pharmacotherapy when appropriate
- E. Repeat surgery automatically without diagnostic evaluation given the findings described

**113.** At a family-centered pediatric weight-management visit, a 12-year-old boy with obesity avoids running because of knee pain but enjoys swimming. What is the best initial activity recommendation?

- A. Use punitive exercise after high-calorie meals to improve adherence

- B.** Prescribe maximal-intensity intervals despite current knee symptoms
- C.** Require running because only weight-bearing exercise affects health
- D.** Stop all activity until substantial weight loss has already occurred
- E.** Use enjoyable low-impact activity such as swimming while the knee pain is evaluated and treated

**114.** At a visit focused on obesity-related health outcomes, the patient misses obesity visits because the only available appointments conflict with hourly work and childcare. What is the best next step?

- A.** Intensify the diet because scheduling barriers reflect low motivation
- B.** Label the missed visits as nonadherence and discharge the patient
- C.** Avoid discussing work or childcare because they are not medical issues
- D.** Require weekly in-person visits before offering any treatment during longitudinal obesity care
- E.** Modify care delivery when possible, such as flexible scheduling or telehealth, while addressing practical barriers

**115.** During counseling on physical activity in obesity care, a patient with obesity and severe knee osteoarthritis cannot tolerate prolonged walking. What is the best treatment modification?

- A.** Recommend rest rather than structured exercise because loading an osteoarthritic joint is likely to accelerate symptoms
- B.** Defer intensive weight-management work until joint replacement has restored walking capacity
- C.** Use nutrition treatment alone because functional rehabilitation adds little when mechanical pain limits walking
- D.** Use low-impact activity, resistance exercise, pain management, and other obesity therapies rather than abandoning treatment
- E.** Require running because walking intolerance reflects insufficient effort

**116.** At a follow-up focused on mobility, fitness, and function, a 71-year-old woman with obesity reports 6 hours of television daily and no structured exercise. Which additional question is especially important before prescribing activity?

- A.** Ask whether she owns more than one pair of walking shoes as part of the current management plan
- B.** Ask about falls, mobility limits, cardiopulmonary symptoms, pain, and ability to perform daily activities
- C.** Ask whether her neighborhood houses have stairs in this clinical setting
- D.** Ask whether she prefers television dramas or documentaries
- E.** Ask which season of the year she enjoys most when counseling this patient

**117.** During adolescent obesity follow-up, a 13-year-old boy has crossed upward through several BMI percentiles over 18 months. Which historical feature would most strongly suggest that the recent weight acceleration deserves evaluation beyond routine primary obesity?

- A.** Rapid weight gain accompanied by a marked decline in linear growth velocity
- B.** Gradual weight gain while height continues along the same percentile
- C.** Preference for energy-dense snacks after afternoon classes
- D.** Increased appetite during a recent school sports season
- E.** A family history of obesity in both biological parents

**118.** During an obesity pharmacotherapy review, a patient with obesity drinks six alcoholic beverages nightly and wants a medication for weight loss. What should be done next?

- A.** Recommend abrupt alcohol cessation without assessing withdrawal risk
- B.** Choose treatment solely from the patient's current body mass index
- C.** Assess alcohol use disorder and withdrawal risk and integrate treatment before selecting pharmacotherapy
- D.** Ignore alcohol because beverage calories are the only relevant issue
- E.** Start naltrexone-bupropion without clarifying alcohol use or seizure risk

**119.** At a visit focused on obesity-related health outcomes, which goal is the best example of a SMART behavioral target?

- A.** Walk for 20 minutes after dinner on Monday, Wednesday, and Friday for the next two weeks
- B.** Eat healthier foods from now on given the findings described
- C.** Lose as much weight as possible this month
- D.** Exercise more whenever possible when choosing the next management step
- E.** Set a broad goal to eliminate sedentary time over the coming months without specifying when or how activity will change

**120.** During shared decision-making for obesity treatment, a patient with obesity and heart failure is losing weight rapidly after intensification of diuretics. What is the best interpretation?

- A.** Diuretic-induced weight loss should be counted as intentional fat loss
- B.** The change proves the obesity treatment is maximally effective
- C.** Fluid balance has no effect on measured body weight as part of the current management plan
- D.** All rapid loss after diuretics represents loss of fat mass when choosing the next management step
- E.** Some short-term weight change may reflect fluid loss, so adiposity change should be distinguished from decongestion

**121.** During a comprehensive obesity-medicine consultation, a child has early-onset obesity, hyperphagia, retinal dystrophy, postaxial polydactyly, and renal abnormalities. Which diagnosis is most likely?

- A.** Beckwith-Wiedemann syndrome with fetal overgrowth and macroglossia
- B.** Monogenic MC4R deficiency without syndromic features
- C.** Prader-Willi syndrome without retinal or limb abnormalities, within the treatment context described
- D.** Bardet-Biedl syndrome, given the clinical details provided
- E.** Turner syndrome with webbed neck and gonadal failure

**122.** At a nutrition-focused weight-management visit, a 35-year-old woman reports episodes twice weekly in which she eats an unusually large amount of food rapidly and feels unable to stop. She is distressed and does not purge or fast afterward. Which diagnosis is most likely?

- A.** Bulimia nervosa with recurrent compensatory behaviors
- B.** Night eating syndrome limited to evening hyperphagia
- C.** Anorexia nervosa with persistent energy restriction
- D.** Avoidant restrictive food intake disorder with low intake, given the clinical details provided
- E.** Binge-eating disorder as part of the current management plan

**123.** During obesity care involving metabolic-bariatric treatment considerations, the patient 18 months after Roux-en-Y gastric bypass develops sudden severe intermittent abdominal pain with nausea. The examination is initially not dramatic. What diagnosis must remain high on the differential?

- A.** Functional constipation as the only late surgical complication
- B.** Treat the episode as dietary intolerance if symptoms improve between pain episodes and arrange routine follow-up
- C.** Attribute symptoms to lactose intolerance because late anatomic complications usually produce continuous peritoneal findings
- D.** Internal hernia with intermittent small-bowel obstruction
- E.** Peptic symptoms that exclude an anatomic emergency

**124.** During an obesity visit discussing metabolic and bariatric procedures, a patient is comparing an intragastric balloon with metabolic bariatric surgery. Which distinction is most accurate?

- A.** The balloon is temporary and generally produces less weight loss than standard metabolic bariatric operations
- B.** The balloon causes more durable malabsorption than Roux-en-Y bypass
- C.** The balloon provides greater average weight loss than duodenal switch surgery
- D.** The balloon is a permanent implant intended to remain for life
- E.** The balloon requires removal of most of the stomach during longitudinal obesity care

**125.** During shared decision-making for obesity treatment, the patient asks about an intragastric balloon for obesity treatment. Which statement best reflects current obesity-medicine practice?

- A.** It works primarily by destroying gastric acid-producing cells
- B.** It is implanted surgically and cannot be removed endoscopically
- C.** Use balloon placement as a largely self-contained procedure because structured follow-up contributes little after deployment
- D.** It is a permanent intestinal bypass that causes major malabsorption
- E.** It is an endoscopically placed temporary space-occupying device used with a comprehensive lifestyle program

**126.** During review of medications that may affect obesity treatment, a 64-year-old adult with established atherosclerotic cardiovascular disease and obesity wants a medication with an FDA indication to reduce cardiovascular death, myocardial infarction, and stroke. Which medication fits that indication?

- A.** Phentermine used as short-term sympathomimetic therapy
- B.** Naltrexone-bupropion used for chronic weight management
- C.** Phentermine-topiramate extended release used for chronic treatment
- D.** Orlistat used as a gastrointestinal lipase inhibitor
- E.** Semaglutide used for chronic weight management

**127.** During counseling on physical activity in obesity care, which initial aerobic activity target is broadly appropriate for many adults who are currently inactive and medically stable?

- A.** Use only stretching because aerobic activity does not affect health
- B.** Progress gradually toward at least 150 minutes per week of moderate-intensity activity
- C.** Avoid activity until at least 10% of body weight has been lost
- D.** Begin immediately with daily maximal-intensity exercise for 90 minutes
- E.** Perform one long exercise session monthly instead of regular activity, given the clinical details provided

**128.** At a family-centered pediatric weight-management visit, a 13-year-old with severe obesity asks which medications have established adolescent obesity indications. Which option is an example?

- A.** Semaglutide used for chronic weight management
- B.** Chronic high-dose pseudoephedrine
- C.** An unregulated thyroid hormone supplement
- D.** A compounded stimulant mixture with no approved indication
- E.** A monoamine oxidase inhibitor used solely for appetite suppression, given the clinical details provided

**129.** At a visit focused on obesity-related health outcomes, which clinical pattern most strongly suggests a syndromic rather than common polygenic form of obesity?

- A.** Early severe obesity plus hyperphagia with developmental, sensory, renal, or dysmorphic abnormalities
- B.** Weight gain after starting a glucocorticoid medication
- C.** Postpartum weight retention after a high gestational gain
- D.** Central adiposity with family history of type 2 diabetes
- E.** Gradual adult weight gain during sedentary employment when choosing the next management step

**130.** During an obesity pharmacotherapy review, a patient with bipolar disorder is stable on treatment and wants obesity care. What principle should guide medication changes?

- A.** Replace an effective mood stabilizer primarily on the basis of its weight effect if another psychiatric drug is available
- B.** Avoid anti-obesity medication because bipolar disorder makes chronic pharmacotherapy too difficult to monitor safely
- C.** Choose treatment based only on expected kilograms lost
- D.** Coordinate with psychiatry so any effort to reduce weight-promoting drugs does not destabilize mood
- E.** Reduce psychiatric follow-up once mood has been stable long enough to begin an obesity-focused medication plan

**131.** At a family-centered pediatric weight-management visit, a 13-year-old with obesity has persistent ALT elevation after other common causes of liver injury are excluded. Which complication should be considered?

- A.** Acute viral hepatitis caused by excess adiposity
- B.** Wilson disease established solely by the presence of obesity, given the clinical details provided
- C.** Metabolic dysfunction-associated steatotic liver disease
- D.** Autoimmune hepatitis proven by an elevated ALT alone
- E.** Hemochromatosis as the most common pediatric obesity complication, within the treatment context described

**132.** At a multidisciplinary weight-management follow-up, a viral social-media post claims an unregulated supplement "melts fat without side effects." What is the best public-health response from an obesity specialist?

- A.** Provide clear evidence-based information about uncertain efficacy, potential harms, and the availability of regulated treatments
- B.** Repeat the claim until randomized trials are published as part of the current management plan
- C.** Avoid public correction because misinformation cannot affect patient behavior
- D.** Recommend the supplement because natural products are inherently safe when choosing the next management step
- E.** Dismiss everyone who asks about it as gullible in this clinical setting

**133.** During nutrition counseling in obesity care, the patient drinks three 20-ounce sugar-sweetened beverages daily. Which change is most likely to reduce energy intake without reducing solid-food portions?

- A.** Add a snack before each beverage to slow absorption
- B.** Drink the beverages only with meals while keeping the same volume, within the treatment context described
- C.** Add fruit juice because naturally occurring sugar does not contribute calories
- D.** Switch to a beverage with the same sugar content but a different flavor, given the clinical details provided

E. Replace the beverages with water or other noncaloric drinks

**134.** At a nutrition-focused weight-management visit, a patient with obesity has burning retrosternal discomfort after large evening meals and sour regurgitation when lying down. Which complication is most likely?

- A. Pancreatitis causing persistent severe epigastric pain radiating to the back
- B. Gastroesophageal reflux disease when counseling this patient
- C. Biliary colic limited to right upper-quadrant postprandial pain
- D. Achalasia causing progressive dysphagia to solids and liquids
- E. Peptic ulcer disease defined by nocturnal epigastric pain only

**135.** During adolescent obesity follow-up, a 14-year-old boy with severe obesity snores loudly, has witnessed apneas, morning headaches, and daytime sleepiness. Which next step is most appropriate?

- A. Assume weight loss must occur before sleep apnea can be diagnosed
- B. Recommend caffeine use and reassess only if grades decline
- C. Evaluate for obstructive sleep apnea with formal sleep assessment
- D. Attribute the sleepiness to adolescence without further evaluation
- E. Treat with a hypnotic medication before assessing airway obstruction

**136.** During a comprehensive obesity-medicine consultation, a 62-year-old man with obesity asks whether losing only 6% of body weight is worthwhile. What is the best answer?

- A. Weight loss below 10% has no measurable metabolic effect during longitudinal obesity care
- B. Small losses worsen metabolic risk by reducing lean mass inevitably
- C. Health benefits generally begin only after at least 25% weight loss
- D. Modest sustained weight loss can meaningfully improve glycemia, blood pressure, lipids, and other risk factors
- E. Only normalization of BMI produces clinically relevant benefit

**137.** At a multidisciplinary weight-management follow-up, a patient with type 2 diabetes and obesity needs better glycemic and weight control. Which treatment principle is preferred when clinically appropriate?

- A.** Use a DPP-4 inhibitor together with a GLP-1 receptor agonist for additive weight loss
- B.** Prioritize glucose-lowering therapies that also promote meaningful weight reduction, such as semaglutide or tirzepatide
- C.** Avoid treating obesity until the A1C is normal in this clinical setting
- D.** Prefer medications that promote weight gain because glycemia is the only target
- E.** Use insulin secretagogues first solely because they are inexpensive

**138.** During reassessment in a chronic obesity-care program, a patient with obesity and hypertension begins losing weight and develops lightheadedness with lower home blood pressure readings. What should be done next?

- A.** Add a sympathomimetic drug to raise blood pressure as part of the current management plan
- B.** Continue current antihypertensive doses because treatment requirements usually remain stable during successful weight loss
- C.** Reassess antihypertensive doses because successful weight loss may reduce blood pressure medication requirements
- D.** Stop weight treatment because lower blood pressure is harmful
- E.** Increase every antihypertensive dose because obesity is still present

**139.** During an obesity pharmacotherapy review, which neuropsychiatric history is particularly relevant before using a sympathomimetic anti-obesity medication?

- A.** Preference for savory rather than sweet foods
- B.** Remote appendectomy without postoperative complications
- C.** History of uncomplicated myopia corrected with glasses
- D.** Seasonal allergy symptoms controlled with saline irrigation, within the treatment context described
- E.** Anxiety, insomnia, substance-use history, and symptoms of mood activation

**140.** During shared decision-making for obesity treatment, a child with a high BMI also has marked edema from nephrotic syndrome. What limitation of BMI is most relevant?

- A.** Interpret the high body weight as obesity because edema contributes little to pediatric BMI calculations
- B.** Apply adult BMI cut points because fluid-related weight gain makes age- and sex-specific percentiles less useful
- C.** Fluid retention can be ignored when tracking weight change
- D.** Body weight can be inflated by fluid, so BMI may not accurately represent adiposity in this setting
- E.** BMI is unaffected by hydration or extracellular fluid

**141.** During review of medications that may affect obesity treatment, the patient beginning a GLP-1-based obesity medication develops nausea during dose escalation. What is the most appropriate initial management when symptoms are mild and no red flags are present?

- A.** Slow or pause dose escalation, reinforce smaller lower-fat meals and hydration, and reassess tolerability
- B.** Add another GLP-1 receptor agonist to improve gastrointestinal tolerance
- C.** Ignore persistent vomiting because dehydration is not a concern
- D.** Escalate immediately to the maximum dose to shorten the nausea period
- E.** Stop all oral intake until the medication reaches steady state

**142.** During a pediatric obesity consultation, a 14-year-old has BMI 135% of the 95th percentile for age and sex. How should the severity be characterized?

- A.** Underweight due to rapid pubertal growth
- B.** Severe obesity when choosing the next management step
- C.** Overweight without obesity
- D.** Class 1 adult obesity using a fixed BMI cutoff only
- E.** Normal variation because adolescence invalidates BMI percentiles

**143.** During reassessment in a chronic obesity-care program, a 27-year-old woman with obesity has chronic headaches, pulsatile tinnitus, transient visual obscurations, and papilledema. Which complication is most likely?

- A.** Sinusitis causing sustained elevation of intracranial pressure
- B.** Migraine without aura causing papilledema as an expected finding
- C.** Idiopathic intracranial hypertension
- D.** Tension headache related only to neck muscle strain
- E.** Cluster headache causing bilateral optic-disc edema

**144.** During review of medications that may affect obesity treatment, the patient asks about a newly available oral small-molecule GLP-1 receptor agonist approved in 2026 for chronic weight management in adults. Which medication is this?

- A.** Orforglipron as part of the current management plan
- B.** Exenatide, within the treatment context described
- C.** Setmelanotide
- D.** Pramlintide during longitudinal obesity care
- E.** Bremelanotide when counseling this patient

**145.** During shared decision-making for obesity treatment, which factor best illustrates the multifactorial pathogenesis of obesity?

- A.** Genetic susceptibility interacting with neuroendocrine regulation, medications, environment, behavior, and social determinants
- B.** One endocrine disorder that explains nearly every case of obesity
- C.** A fixed personality trait that is unaffected by environment or treatment
- D.** A single universal defect in motivation shared by all affected individuals
- E.** Excess calories alone without any biologic regulation of appetite as part of the current management plan

**146.** During a comprehensive obesity-medicine consultation, a patient is ambivalent about changing evening eating habits. Which response best reflects motivational interviewing?

- A.** Confront resistance as evidence that the patient is unmotivated
- B.** List every health risk until the patient agrees with the clinician
- C.** Tell the patient what to do before asking about priorities
- D.** Ask permission to explore the pattern and elicit the patient's own reasons for considering change
- E.** Use shame to increase urgency and commitment when choosing the next management step

**147.** During obesity care involving metabolic-bariatric treatment considerations, the patient after gastric bypass is doing well and asks whether laboratory monitoring can stop. What is the best answer?

- A.** Monitor only if weight regain occurs, within the treatment context described
- B.** Stop supplements if the patient feels well when counseling this patient
- C.** Continue lifelong periodic nutritional and metabolic monitoring because deficiencies can develop years later
- D.** Stop laboratory follow-up after the first normal annual panel in this clinical setting
- E.** Use body weight as the only marker of postoperative nutrition

**148.** During reassessment in a chronic obesity-care program, the patient asks about an over-the-counter "fat burner" containing multiple stimulants and proprietary ingredients. What is the best counseling approach?

- A.** Use the supplement instead of evidence-based obesity treatment during longitudinal obesity care
- B.** Assume safety because the product is sold without a prescription
- C.** Review ingredients and risks, explain uncertain efficacy and regulation, and discourage potentially unsafe stimulant products
- D.** Recommend doubling the dose if appetite suppression is modest given the findings described
- E.** Avoid asking about supplements because they do not affect clinical care

**149.** At a visit focused on obesity-related health outcomes, which statement best explains why obesity often requires long-term treatment?

- A.** Long-term treatment is unnecessary once BMI falls below 30 as part of the current management plan
- B.** The disease is caused by a single reversible behavior in most patients
- C.** Expect homeostatic adaptation to reinforce continued weight loss after the initial diet-induced reduction in body mass
- D.** Homeostatic and environmental pressures that promote weight regain persist even after successful weight reduction
- E.** Adipose tissue disappears permanently after any short-term diet

**150.** During integrated obesity and reproductive-health care, a woman with obesity is planning pregnancy within the next few months and asks about anti-obesity medication. What is the best general approach?

- A.** Delay all obesity-related care until after delivery when counseling this patient as part of the current management plan
- B.** Pursue rapid pharmacologic weight loss during pregnancy to reduce gestational gain
- C.** Use preconception lifestyle and health optimization and discontinue medications that are contraindicated in pregnancy before conception as appropriate
- D.** Continue all anti-obesity medications through conception because fetal exposure is minimal
- E.** Avoid discussing contraception or medication washout during preconception care in this clinical setting

**151.** During a pediatric obesity consultation, a 9-year-old has a BMI at the 96th percentile for age and sex. What is the appropriate classification?

- A.** Severe obesity automatically at any value above the 95th percentile
- B.** Healthy weight because the BMI is below an adult threshold of 30
- C.** Underweight because percentiles cannot be used for BMI
- D.** Overweight only because pediatric obesity begins at the 99th percentile

E. Obesity as part of the current management plan

**152.** At a multidisciplinary weight-management follow-up, a patient has reached a weight plateau and is discouraged. Which counseling response is most helpful?

- A. Reduce follow-up because encouragement is no longer useful in this clinical setting
- B. Review non-scale benefits, adherence data, barriers, and options for intensifying treatment without framing the plateau as failure
- C. Set an extreme short-term target to restore motivation when counseling this patient
- D. Warn that a plateau proves the patient is secretly overeating as part of the current management plan
- E. Stop treatment because further progress is impossible during longitudinal obesity care

**153.** During review of medications that may affect obesity treatment, an obesity medicine physician learns that new evidence has changed the preferred use of a medication. What is the best professional response?

- A. Change treatment solely on the basis of manufacturer advertising
- B. Continue the old approach indefinitely because prior habits are sufficient
- C. Adopt every social-media claim before reviewing evidence as part of the current management plan
- D. Avoid continuing education once board certification is achieved
- E. Update practice using current evidence, labeling, and guidelines and communicate relevant changes to patients

**154.** At a visit focused on obesity-related health outcomes, which counseling point is important before any endoscopic obesity procedure?

- A. Follow-up is unnecessary unless immediate procedural complications occur
- B. The procedure is an adjunct, and durable results still require longitudinal nutrition, behavior, and medical follow-up

- C. Medication and lifestyle care should be stopped after the procedure during longitudinal obesity care
- D. All endoscopic procedures produce the same weight loss as metabolic surgery
- E. The procedure permanently cures obesity without additional treatment

**155.** During shared decision-making for obesity treatment, a 46-year-old prefers an endoscopic procedure that reduces gastric volume by full-thickness suturing without surgical resection. Which procedure is being described?

- A. Adjustable gastric band placement
- B. Biliopancreatic diversion with duodenal switch
- C. Endoscopic sleeve gastropasty
- D. Jejunioileal bypass
- E. Roux-en-Y gastric bypass

**156.** During an exercise-focused component of obesity treatment, a patient with obesity and heart failure with preserved ejection fraction has severe exercise limitation. Which treatment emphasis is reasonable?

- A. Use an individualized obesity plan that improves weight, symptoms, function, and cardiovascular risk while respecting heart-failure status
- B. Judge success only by BMI without functional outcomes given the findings described
- C. Stop heart-failure therapy while pursuing weight reduction during longitudinal obesity care
- D. Use high-dose sympathomimetics to improve exercise capacity when counseling this patient
- E. Avoid obesity treatment because heart failure makes weight change unsafe in this clinical setting

**157.** During nutrition counseling in obesity care, a 76-year-old woman with obesity is beginning a calorie-reduced diet. Which nutrition concern deserves special attention?

- A. Using prolonged fasting as the preferred way to prevent sarcopenia
- B. Eliminating resistance activity to avoid increasing appetite
- C. Avoiding all dairy and legumes because they contain calories

- D.** Preserving protein intake and micronutrient adequacy to reduce loss of muscle and function
- E.** Maximizing calorie restriction even if protein intake falls very low

**158.** At a weight-management visit that includes preconception or pregnancy considerations, a 27-year-old woman taking phentermine-topiramate extended release wants to conceive. Which counseling point is most important?

- A.** Pregnancy testing is unnecessary once a stable dose has been reached when counseling this patient
- B.** The medication is contraindicated in pregnancy because topiramate exposure increases risk of fetal oral clefts, so effective contraception and pregnancy testing are important
- C.** Topiramate is safe in pregnancy when combined with phentermine during longitudinal obesity care when choosing the next management step
- D.** The medication is preferred during pregnancy because it limits gestational weight gain as part of the current management plan
- E.** The medication should be continued through the first trimester and then stopped in this clinical setting

**159.** At a visit focused on obesity-related health outcomes, a patient with obesity has elevated ALT, hepatic steatosis on imaging, and fibrosis risk factors. Which issue should be prioritized next?

- A.** Assess for steatohepatitis and clinically significant liver fibrosis rather than assuming simple steatosis
- B.** Diagnose alcoholic liver disease without assessing alcohol exposure
- C.** Order liver biopsy in every patient regardless of noninvasive assessment
- D.** Assume all steatosis is benign and requires no further risk stratification
- E.** Exclude metabolic liver disease because obesity makes viral hepatitis more likely

**160.** During shared decision-making for obesity treatment, what is a reasonable way to define early treatment success in obesity?

- A.** Assess weight trajectory together with changes in comorbidities, function, quality of life, adherence, and treatment tolerability

- B.** Stop treatment if BMI remains in the obesity range despite major health improvement
- C.** Use only the number on the scale and ignore all health outcomes
- D.** Judge success after one week regardless of treatment mechanism when counseling this patient
- E.** Require the same percentage weight loss from every therapy, given the clinical details provided

**161.** At an obesity visit that includes mental-health assessment, a patient with obesity has active binge-eating disorder. Which treatment approach is most appropriate?

- A.** Delay psychiatric care until a target BMI is reached in this clinical setting
- B.** Treat the eating disorder concurrently and avoid overly restrictive strategies that may worsen binge-restrict cycles
- C.** Use fasting as the first-line intervention to suppress binge episodes
- D.** Ignore binge eating because weight loss alone will resolve it as part of the current management plan
- E.** Require daily punitive exercise after each episode when counseling this patient

**162.** During review of dietary treatment within a comprehensive obesity plan, the patient consumes at least one quarter of daily calories after the evening meal, has recurrent nocturnal awakenings to eat, and remembers the episodes. Which syndrome is most consistent with this pattern?

- A.** Binge-eating disorder requiring objectively large binges
- B.** Sleep-related eating disorder with amnesia for episodes
- C.** Night eating syndrome, given the clinical details provided
- D.** Bulimia nervosa with compensatory purging behaviors
- E.** Rumination disorder with repeated food regurgitation

**163.** During counseling on physical activity in obesity care, the patient reports 30 minutes of brisk walking five days per week but sits at a desk for 10 hours daily. Which statement best reflects current obesity-medicine practice?

- A.** Desk work should be replaced entirely by vigorous exercise breaks

- B.** The activity is beneficial, but prolonged sedentary time remains a separate target for reduction
- C.** Sedentary time matters only when no purposeful exercise is performed
- D.** Meeting an exercise goal eliminates any health effect of prolonged sitting
- E.** Only resistance exercise can offset the effects of prolonged sitting

**164.** At a visit focused on obesity-related health outcomes, the patient repeatedly overeats after stressful workdays. Which intervention best uses problem-solving therapy?

- A.** Identify the trigger, generate several coping alternatives, choose one, test it, and review the result
- B.** Prescribe a single solution without considering barriers
- C.** Tell the patient to avoid all stress because coping skills are ineffective
- D.** Focus only on body weight rather than the behavior sequence
- E.** Label each lapse as treatment failure and restart from the beginning

**165.** During a weight-management visit emphasizing function in later life, a 68-year-old has lost 18% of body weight but also reports weakness and reduced grip strength. What should be assessed?

- A.** Ignore function because percentage weight loss is the only outcome
- B.** Further restrict protein to accelerate scale-weight reduction
- C.** Lean-mass loss, protein intake, resistance activity, and other causes of functional decline
- D.** Assume weakness is desirable because it indicates rapid fat loss
- E.** Stop all resistance activity to conserve calories

**166.** During a comprehensive obesity-medicine consultation, a patient with obesity has high triglycerides, low HDL cholesterol, and elevated cardiovascular risk. Which management principle best applies?

- A.** Treat obesity and dyslipidemia concurrently with nutrition, activity, weight therapy, and lipid-lowering treatment based on overall risk
- B.** Treat lipids only because weight reduction cannot improve triglycerides

- C. Delay statin decisions until a normal BMI has been achieved as part of the current management plan
- D. Treat weight only because lipid therapy is unnecessary once obesity is addressed
- E. Use dietary cholesterol restriction as the sole determinant of therapy when choosing the next management step

**167.** At a multidisciplinary weight-management follow-up, an Asian American adult has a BMI of 24.5 kg/m<sup>2</sup> and central adiposity with type 2 diabetes. Which principle is most important?

- A. Standard BMI thresholds have identical risk meaning across all populations
- B. Cardiometabolic risk can occur at lower BMI in Asian populations, so ethnicity-sensitive thresholds and waist measures are useful
- C. Apply the same BMI risk interpretation across ethnic groups because adjusting thresholds may reduce consistency in diagnosis
- D. Once diabetes is present, waist circumference adds little clinically useful risk information beyond BMI and glycemic status
- E. A BMI below 25 excludes clinically important excess adiposity as part of the current management plan

**168.** During reassessment in a chronic obesity-care program, a patient has reached a stable weight but cardiometabolic complications continue to improve. How should treatment success be viewed?

- A. Treatment should be withdrawn until weight begins rising again
- B. Health benefits can continue even without further scale loss, so maintenance and complication management remain important
- C. Cardiometabolic improvement cannot occur after weight plateaus
- D. Further weight loss is mandatory regardless of health status when counseling this patient
- E. A stable scale weight means treatment has stopped working during longitudinal obesity care

**169.** At a visit focused on obesity-related health outcomes, a 41-year-old man with obesity asks for extensive endocrine testing despite normal growth history, no suggestive symptoms, and stable weight gain over many years. What is the best approach?

- A.** Delay obesity treatment until a rare endocrine disorder is excluded completely, within the treatment context described
- B.** Assume endocrine disease is the most common cause of adult obesity
- C.** Order every available pituitary and adrenal test in all patients with obesity
- D.** Use targeted testing guided by history and examination rather than broad endocrine screening
- E.** Limit laboratory assessment to routine metabolic testing because secondary endocrine causes are too uncommon to justify targeted evaluation

**170.** During shared decision-making for obesity treatment, an adult has a BMI of 32.4 kg/m<sup>2</sup>. Using standard adult BMI categories, how is this classified?

- A.** Normal-weight range
- B.** Class 1 obesity
- C.** Class 2 obesity
- D.** Overweight without obesity
- E.** Class 3 obesity

**171.** During obesity care involving metabolic-bariatric treatment considerations, according to modern metabolic-bariatric surgery indications, which adult clearly meets a recommended BMI criterion even without obesity-related comorbidities?

- A.** An adult with BMI 26 kg/m<sup>2</sup> who wants rapid cosmetic weight loss, within the treatment context described
- B.** An adult with BMI 24 kg/m<sup>2</sup> and no metabolic disease
- C.** An adult with BMI 28 kg/m<sup>2</sup> and no weight-related condition, given the clinical details provided
- D.** An adult with BMI above 35 kg/m<sup>2</sup> who is an appropriate surgical candidate
- E.** An adult with BMI 29 kg/m<sup>2</sup> whose only concern is clothing size

**172.** During an obesity pharmacotherapy review, the patient taking orlistat reports oily spotting, fecal urgency, and flatus with discharge. Which explanation best accounts for these findings?

- A.** They are typical signs of thyroid C-cell tumors as part of the current management plan
- B.** They result from increased pancreatic lipase activity when choosing the next management step
- C.** They prove the patient has developed bowel obstruction
- D.** These are expected gastrointestinal effects from reduced intestinal fat absorption and often worsen with high-fat meals
- E.** They indicate systemic serotonin toxicity in this clinical setting

**173.** At a medication-management visit in obesity care, a 52-year-old adult with obesity asks about the higher-dose semaglutide injection approved in 2026 for chronic weight management. Which statement is correct?

- A.** The higher-dose product replaces the need for nutrition and physical-activity treatment in adults
- B.** The 7.2-mg formulation is limited to children younger than 12 years with monogenic obesity
- C.** The higher-dose product is tirzepatide rather than semaglutide and is dosed twice weekly
- D.** The 7.2-mg product is an oral daily formulation intended only for type 1 diabetes
- E.** Wegovy HD provides a 7.2-mg once-weekly semaglutide option for certain adults who meet chronic weight-management indications

**174.** At a visit focused on obesity-related health outcomes, two adults have the same BMI of 36 kg/m<sup>2</sup>. One has no detected complications; the other has diabetes, OSA, and severe knee osteoarthritis. What is the best interpretation?

- A.** The patient without complications has more severe obesity by definition
- B.** The second patient has greater obesity-related disease burden despite the same BMI
- C.** Complications should be ignored when selecting treatment intensity
- D.** Both patients have identical disease severity because BMI is identical, given the clinical details provided
- E.** Only age can explain differences in obesity-related health risk

**175.** During shared decision-making for obesity treatment, a muscular competitive athlete has BMI 31 kg/m<sup>2</sup> but low waist circumference and low measured body fat. What is the best interpretation?

- A.** The athlete automatically has class 3 obesity because of muscle mass
- B.** Obesity can be diagnosed only by dual-energy x-ray absorptiometry
- C.** Rely on BMI alone once it exceeds 30 kg/m<sup>2</sup> because waist measurement adds little when body weight is high
- D.** BMI may overestimate adiposity in very muscular individuals, so body composition and clinical risk should be considered
- E.** BMI proves excess adiposity regardless of body composition when choosing the next management step

**176.** During a comprehensive obesity-medicine consultation, the patient says, "I eat whenever I feel anxious, even if I am not physically hungry." Which behavioral construct is most directly being described?

- A.** Objective binge eating defined only by a specific calorie threshold
- B.** Food avoidance driven by fear of choking or sensory characteristics, given the clinical details provided
- C.** Compensatory purging intended to prevent weight gain after eating
- D.** Emotion-triggered eating in response to affect rather than homeostatic hunger, within the treatment context described
- E.** Night eating defined by awakening from sleep to consume food

**177.** At a multidisciplinary weight-management follow-up, a 39-year-old man with BMI 48 kg/m<sup>2</sup> has daytime somnolence, resting oxygen saturation 90%, and elevated serum bicarbonate. Which diagnosis is most concerning?

- A.** Obesity hypoventilation syndrome with chronic daytime hypercapnia
- B.** Isolated obstructive sleep apnea that cannot coexist with hypoventilation, given the clinical details provided
- C.** Exercise-induced bronchospasm limited to vigorous activity
- D.** Panic disorder causing persistent bicarbonate elevation
- E.** Simple deconditioning without ventilatory impairment

**178.** During an obesity visit discussing metabolic and bariatric procedures, an Asian adult with metabolic disease has BMI 28 kg/m<sup>2</sup>. Which modern surgery guidance is relevant?

- A.** BMI thresholds are identical because body composition differences have no effect
- B.** Asian-specific BMI thresholds apply to risk classification but not to metabolic-surgery consideration, which still begins at BMI 35 kg/m<sup>2</sup>
- C.** Use a BMI threshold of 40 kg/m<sup>2</sup> for surgery because lower thresholds are intended for medical therapy rather than procedures
- D.** Asian ancestry requires a higher BMI threshold than other populations
- E.** Lower BMI thresholds are used in Asian populations, and metabolic surgery may be considered from BMI about 27.5 kg/m<sup>2</sup>

**179.** At a family-centered pediatric weight-management visit, a 16-year-old with obesity frequently skips breakfast and then eats large amounts after school. What is a reasonable nutrition target?

- A.** Use caffeine instead of breakfast to suppress appetite during longitudinal obesity care
- B.** Encourage longer fasting because adolescents need fewer meals
- C.** Establish a regular meal pattern that reduces prolonged fasting and planned opportunities for uncontrolled eating
- D.** Require ketogenic eating without assessing preferences or medical context
- E.** Eliminate all snacks regardless of hunger or school schedule when counseling this patient

**180.** During an exercise-focused component of obesity treatment, which physical-activity history gives the most actionable information for obesity treatment planning?

- A.** Frequency, duration, intensity, type of activity, sedentary time, limitations, and prior injuries
- B.** Only the patient's preferred brand of exercise footwear
- C.** Only the number of gym memberships purchased in adulthood
- D.** Only whether activity occurs indoors or outdoors in this clinical setting
- E.** Only whether the patient considers themselves an active person

**181.** During a pediatric obesity consultation, a 15-year-old with obesity is being bullied about weight and now avoids school. Which issue should be assessed urgently?

- A.** Whether the child can tolerate a more restrictive diet
- B.** Whether classmates understand the child's exact BMI percentile
- C.** Depression, anxiety, self-harm risk, and the psychosocial impact of weight-based bullying
- D.** Whether sports participation should be withheld as a consequence
- E.** Whether daily public weigh-ins would increase motivation

**182.** At a multidisciplinary visit addressing surgical and nonsurgical obesity options, a patient with obesity and knee osteoarthritis wants to avoid surgery. Which intervention can improve both obesity and joint symptoms?

- A.** Clinically meaningful weight reduction combined with appropriate strengthening and low-impact activity
- B.** High-impact running despite severe pain when counseling this patient
- C.** Complete avoidance of movement to prevent cartilage wear in this clinical setting
- D.** Rapid dehydration to reduce scale weight before activity
- E.** Weight gain to increase cushioning around the knee joint

**183.** During an exercise-focused component of obesity treatment, a patient with obesity reports worsening knee pain when climbing stairs and reduced walking tolerance. Which complication category is most likely contributing?

- A.** Peripheral neuropathy caused solely by vitamin C deficiency, within the treatment context described
- B.** Attribute the knee pain to inflammatory arthritis because stair-related symptoms are less typical of mechanical loading
- C.** Autoimmune myositis causing proximal muscle inflammation
- D.** Biomechanical osteoarthritis related to excess joint loading, given the clinical details provided
- E.** Consider septic arthritis as a likely obesity-related explanation for chronic exertional knee pain without systemic symptoms

**184.** During nutrition counseling in obesity care, which dietary-assessment approach best reduces the chance that a clinician misses episodic high-calorie intake?

- A.** Rely on a single weekday breakfast as representative of total intake
- B.** Use more than one method, such as a 24-hour recall plus questions about weekends and usual patterns
- C.** Exclude snacks because they are too variable to interpret
- D.** Use only the patient's estimate of daily calorie intake in this clinical setting
- E.** Ask only about foods the patient already considers unhealthy

**185.** During shared decision-making for obesity treatment, a patient with obesity and gout wants a weight-loss plan. Which approach is most appropriate?

- A.** Use high alcohol intake to increase calorie expenditure in this clinical setting
- B.** Use repeated prolonged fasts because they reliably prevent gout attacks
- C.** Use gradual sustainable weight reduction and avoid dehydration or extreme fasting that can precipitate urate fluctuations
- D.** Avoid intentional weight reduction because urate levels commonly rise during dieting and offset the metabolic benefits
- E.** Use aggressive fluid restriction to accelerate early scale-weight loss while monitoring gout symptoms

**186.** During review of medications that may affect obesity treatment, the patient maintains a 12% weight loss for two years on medication and lifestyle treatment. What is the best long-term strategy?

- A.** Continue effective treatment and periodic monitoring while adjusting only for goals, tolerability, safety, or preference
- B.** Stop all treatment because two years indicates the disease is cured
- C.** Encourage intentional weight cycling to prevent metabolic adaptation
- D.** Reduce follow-up to none because maintenance is automatic as part of the current management plan

E. Discontinue medication solely because the current weight is lower when choosing the next management step

**187.** At a multidisciplinary weight-management follow-up, a 43-year-old woman seeks treatment for progressive weight gain. Which element of the weight history is most useful for identifying a potentially reversible trigger?

- A. The brand of scale she uses for home measurements
- B. The exact number of diets she has read about online
- C. Her current clothing size compared with close relatives
- D. A timeline linking weight changes to life events, illnesses, and medication starts
- E. Whether she prefers morning or evening clinic visits

**188.** At a nutrition-focused weight-management visit, which food substitution is most likely to reduce energy density while preserving meal volume?

- A. Replace part of a high-fat entree with vegetables and broth-based foods, within the treatment context described
- B. Replace whole fruit with sugar-sweetened juice as part of the current management plan
- C. Add caloric sauces to every meal without changing portions
- D. Replace water-rich vegetables with fried snack foods
- E. Add large amounts of oil because dietary fat has low energy density, given the clinical details provided

**189.** During review of medications that may affect obesity treatment, a patient has achieved substantial health improvement on chronic obesity pharmacotherapy and asks when the drug must be stopped. What is the best general principle?

- A. All obesity medications must be stopped after exactly 12 weeks
- B. Long-term pharmacotherapy is inappropriate because obesity becomes cured after weight loss
- C. Stopping therapy prevents biologic pressure toward weight regain

**D.** Obesity is chronic, so effective and tolerated pharmacotherapy is often continued long term to maintain benefits

**E.** Stop medication once the initial target is reached so long-term maintenance can be assessed without ongoing pharmacologic support

**190.** During an obesity visit discussing metabolic and bariatric procedures, the patient developed hyperphagia and rapid weight gain after surgery involving the hypothalamic region. What is the most likely mechanism?

**A.** Loss of pancreatic beta cells causing hyperphagia without hyperglycemia

**B.** Isolated thyroid hormone resistance caused by neurosurgery

**C.** Primary renal sodium retention without change in appetite

**D.** Peripheral neuropathy directly increasing intestinal calorie absorption, within the treatment context described

**E.** Hypothalamic injury disrupting appetite, satiety, and energy-regulation pathways

**191.** During a comprehensive obesity-medicine consultation, a 52-year-old with obesity has fasting glucose 128 mg/dL on two separate mornings. Which diagnosis is most likely?

**A.** Prediabetes based only on impaired fasting glucose

**B.** Reactive hypoglycemia caused by excess insulin secretion

**C.** Type 1 diabetes established solely by the fasting value

**D.** Normal glycemia because fasting values are below 140 mg/dL

**E.** Type 2 diabetes mellitus, within the treatment context described

**192.** During adolescent obesity follow-up, the parents of a 12-year-old with obesity ask whether the child should "grow out of it" before treatment begins. What is the best next step?

**A.** Obesity should be addressed as a chronic disease now, using family-centered treatment rather than watchful waiting alone

**B.** Rapid weight loss should be pursued with unsupervised fasting in all children

**C.** The child should be blamed directly so personal responsibility develops early

- D.** Only severe complications justify discussing weight-related health in childhood
- E.** Treatment should be delayed until adulthood because childhood obesity is usually transient

**193.** During nutrition counseling in obesity care, a patient with obesity says healthy food is unaffordable and often runs out before payday. Which nutrition-history finding should most directly alter the treatment plan?

- A.** A dislike of two specific nonstarchy vegetables when counseling this patient
- B.** Food insecurity causing cyclical restriction followed by reliance on inexpensive energy-dense foods
- C.** Using ceramic rather than disposable food containers
- D.** A preference for eating dinner at 7 rather than 6 PM
- E.** Buying groceries from more than one retail chain in this clinical setting

**194.** At a weight-management visit that includes preconception or pregnancy considerations, a woman with obesity has oligomenorrhea, biochemical hyperandrogenism, and polycystic ovaries after exclusion of mimicking disorders. Which diagnosis is most likely?

- A.** Premature ovarian insufficiency with low ovarian reserve
- B.** Functional hypothalamic amenorrhea from energy deficiency
- C.** Congenital adrenal hyperplasia assumed without testing
- D.** Hyperprolactinemia established without measuring prolactin
- E.** Polycystic ovary syndrome, within the treatment context described

**195.** During obesity care involving metabolic-bariatric treatment considerations, the patient after metabolic bariatric surgery struggles to meet protein and fluid goals. What is the most appropriate nutrition priority?

- A.** Stop supplements once early postoperative weight loss is established
- B.** Prioritize large high-volume meals to stretch the gastric pouch
- C.** Use small frequent intake with attention to protein, hydration, and prescribed vitamin-mineral supplementation

- D.** Drink most fluids with meals to maximize fullness in this clinical setting
- E.** Avoid protein because it may slow the rate of weight loss as part of the current management plan

**196.** During a comprehensive obesity-medicine consultation, what is the most appropriate overarching goal of obesity treatment?

- A.** Require identical calorie and activity targets for all patients
- B.** Normalize BMI in every patient before treating comorbid conditions
- C.** Improve health, function, quality of life, and durable weight-related outcomes through individualized care
- D.** Use weight change as the only meaningful measure of success in this clinical setting
- E.** Achieve the lowest possible body weight regardless of adverse effects

**197.** At a weight-management visit that includes preconception or pregnancy considerations, a 36-year-old woman with obesity reports irregular menses, infertility, and increased terminal facial hair. Which weight-related condition should be specifically explored?

- A.** Polycystic ovary syndrome when counseling this patient
- B.** Central diabetes insipidus causing polyuria and polydipsia
- C.** Primary ovarian insufficiency causing low androgen levels
- D.** Hyperparathyroidism causing nephrolithiasis and hypercalcemia
- E.** Addison disease causing weight loss and hyperpigmentation

**198.** During review of medications that may affect obesity treatment, a patient with limited English proficiency nods during counseling but later appears confused about medication dosing. What is the best practice?

- A.** Speak louder in English and repeat the same instructions faster in this clinical setting
- B.** Provide only written English instructions and assume they are sufficient
- C.** Avoid pharmacotherapy because language differences prevent shared decisions

**D.** Use a qualified medical interpreter and confirm understanding with teach-back, within the treatment context described

**E.** Rely on a minor family member to interpret complex medical information

**199.** During an obesity pharmacotherapy review, how often should active obesity pharmacotherapy be followed early after initiation according to contemporary standards?

**A.** At least monthly during the first several months to assess efficacy, adverse effects, and medication-taking behavior

**B.** Only once after one year unless the patient calls as part of the current management plan

**C.** Daily in-person visits for all patients regardless of risk

**D.** Follow-up should occur only after the maximum dose is reached

**E.** No follow-up is needed if the medication is FDA approved when choosing the next management step

**200.** At a medication-management visit in obesity care, which anticonvulsant is commonly associated with weight gain and should be recognized during medication review?

**A.** Zonisamide, which may be associated with weight loss

**B.** Felbamate, which is not a typical cause of major weight gain, within the treatment context described

**C.** Valproate during longitudinal obesity care

**D.** Topiramate, which often decreases appetite and weight

**E.** Lamotrigine, which is generally weight neutral

## **Answers**

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**1. D.** In this setting, exercise in older adults should be individualized to function and comorbidities. Low-impact aerobic, resistance, and balance activities can improve mobility and health while minimizing joint stress.

**2. E.** Clinically, long-term chronic-disease care should adapt to practical barriers when safe. Flexible delivery can preserve monitoring, reduce inequity, and support persistence with effective treatment.

- 3. D.** The best answer follows because postbariatric hypoglycemia typically presents with postprandial low glucose, often 1-3 hours after eating, and can cause neuroglycopenia. Management begins with careful evaluation and specialized medical nutrition therapy.
- 4. C.** Clinically, person-first, nonjudgmental language recognizes obesity as a disease rather than an identity or character flaw. This improves therapeutic alliance and reduces weight stigma.
- 5. E.** The best answer follows because obesity care is most effective when major barriers and complications are treated together. Integrated medical, behavioral, nutrition, social, and functional support can make the plan feasible and safer.
- 6. B.** In this setting, repeated elevated office measurements are consistent with hypertension and should trigger appropriate confirmation and management. Obesity is a major risk factor, but it does not change the diagnostic threshold upward.
- 7. A.** The central point is that protein supports satiety and lean-tissue preservation, particularly when paired with resistance training. Total energy balance and overall diet quality remain important.
- 8. B.** In this setting, gLP-1-based therapy can improve glycemia substantially. When combined with insulin or insulin secretagogues, doses may need reduction to prevent hypoglycemia while maintaining safe diabetes control.
- 9. D.** The central point is that pediatric treatment is most effective when the family environment supports healthy behaviors for everyone. Singling out the child or using shame can worsen conflict, stigma, and disordered eating risk.
- 10. E.** The central point is that reflux is an important factor in selecting an obesity procedure. Roux-en-Y gastric bypass commonly improves GERD, whereas sleeve gastrectomy can worsen symptoms in susceptible patients.
- 11. C.** The best answer follows because roux-en-Y gastric bypass alters intake and absorption, creating lifelong risk for iron, vitamin B12, folate, calcium, vitamin D, thiamine, and other deficiencies. Routine supplementation and laboratory monitoring are essential.
- 12. B.** The central point is that weight bias can harm communication, delay care, and worsen outcomes. Clinicians should model respectful language and challenge assumptions that reduce a complex chronic disease to character or motivation.
- 13. D.** In this setting, prader-Willi syndrome classically includes neonatal hypotonia and feeding difficulty followed later by hyperphagia, obesity, developmental and behavioral features, and hypogonadism. The early-life feeding transition is a useful clue.
- 14. E.** The best answer follows because weight reduction can improve insulin sensitivity, hyperandrogenism, menstrual regularity, and ovulatory function in many patients with PCOS, while

other targeted therapies may still be needed. The degree of benefit varies, and fertility-focused care may still require additional reproductive or metabolic therapy.

**15. C.** Clinically, stimulus control modifies environmental cues that trigger habitual eating. Creating a rule that food is eaten only in designated settings can weaken the learned television-snacking association.

**16. A.** The central point is that psychiatric instability affects safety, eating behavior, and treatment feasibility. Integrated care can address obesity while ensuring that depression and self-harm risk are treated appropriately.

**17. C.** The central point is that alcohol contributes meaningful energy and may also influence appetite, judgment, sleep, and metabolic health. Intake should be assessed explicitly rather than omitted from the nutrition history.

**18. A.** Clinically, pregnancy is not a time for intentional pharmacologic weight loss. Care focuses on appropriate gestational gain, nutrient adequacy, safe activity, and management of obesity-related obstetric risks.

**19. D.** The best answer follows because pAP treats airway obstruction directly, while obesity treatment addresses an important upstream risk factor. Both can be continued together, and OSA should be reassessed as weight changes.

**20. A.** The best answer follows because all-or-none thinking turns a small lapse into abandonment of the plan. Cognitive restructuring helps the patient view a single event as limited and return to the next planned behavior.

**21. D.** Clinically, appropriately selected adolescents with severe obesity and significant complications can benefit from metabolic-bariatric surgery. Evaluation should occur in an experienced multidisciplinary pediatric program.

**22. D.** Clinically, cancer treatment can affect weight, muscle mass, endocrine function, and fatigue. Obesity care should be coordinated with oncology to preserve cancer outcomes while improving metabolic and functional health.

**23. B.** The best answer follows because pregabalin and gabapentin can be weight promoting. The temporal relationship, appetite change, and edema make the medication relevant, but changes should be coordinated to preserve safe pain management.

**24. B.** The best answer follows because pediatric nutrition occurs within a family and school environment. Combining the child's perspective with caregiver information better captures intake, routines, access, and opportunities for family-based change.

- 25. A.** The best answer follows because semaglutide used for chronic weight management has an FDA cardiovascular risk-reduction indication in adults with established cardiovascular disease and overweight or obesity. This is distinct from weight loss alone.
- 26. C.** In this setting, resistance exercise supports lean mass, strength, physical function, and metabolic health. It complements rather than replaces aerobic activity and adequate nutrition.
- 27. D.** The best answer follows because mood symptoms can affect appetite, self-care, adherence, and safety. Understanding severity and treatment allows coordinated care and helps distinguish emotional eating from other eating disorders.
- 28. D.** The best answer follows because slipped capital femoral epiphysis is associated with obesity and may present with hip, thigh, or referred knee pain plus altered gait. Delay can worsen displacement and complications, so urgent evaluation is warranted.
- 29. B.** The best answer follows because different eating patterns can produce weight loss when they create a sustained energy deficit. Adherence, nutritional adequacy, comorbidities, culture, and preference are central to long-term success.
- 30. A.** In this setting, portion-controlled meal replacements can be effective tools for some individuals, especially when they simplify choices. Long-term planning still requires attention to nutrition quality, behavior, and maintenance.
- 31. E.** Clinically, metabolic surgery is powerful but requires lifelong care. Micronutrient deficiencies, weight recurrence, bone health, hypoglycemia, gastrointestinal complications, and psychosocial issues can emerge years later.
- 32. A.** Clinically, children need adequate nutrition for growth and development. Family-based changes in food quality, structure, beverages, and portions are safer and more sustainable than isolating the child with severe restriction.
- 33. B.** Clinically, medication choice is person centered. Expected weight and health benefits should be balanced with safety, comorbidities, tolerability, affordability, availability, and the patient's preferences.
- 34. E.** The best answer follows because weight reduction can improve steatosis and steatohepatitis, and newer obesity therapies may offer specific liver benefit. Fibrosis risk still requires appropriate assessment because liver enzymes alone do not stage disease.
- 35. A.** In this setting, adolescent surgery requires careful multidisciplinary assessment of medical severity, psychosocial readiness, family support, and capacity for lifelong follow-up and supplementation. Treated mental-health conditions are not automatically disqualifying.
- 36. C.** The best answer follows because public education should reduce stigma and communicate that obesity is a chronic disease with behavioral, pharmacologic, procedural, and surgical treatments. Accurate framing encourages earlier and more equitable care.

- 37. E.** Tirzepatide has an FDA indication for moderate-to-severe obstructive sleep apnea in adults with obesity, used together with reduced-calorie nutrition and increased physical activity. OSA still requires individualized sleep-medicine management; the obesity medication indication does not make every other OSA therapy unnecessary.
- 38. B.** The central point is that the environment can constrain physical activity. Effective obesity care recognizes these barriers and helps the family identify realistic, safe alternatives rather than prescribing an inaccessible plan.
- 39. E.** The best answer follows because active suicidal ideation with plan is an immediate safety priority. Obesity treatment can continue after stabilization, but it should never supersede urgent psychiatric assessment and protection.
- 40. D.** In this setting, the symptoms suggest hypothyroidism, and serum TSH is the standard initial screening test for primary thyroid dysfunction. Hypothyroidism can contribute modestly to weight gain but usually does not explain severe obesity by itself.
- 41. E.** Clinically, postpartum weight is influenced by gestational gain, retained weight, sleep disruption, lactation, mood, and medications. These factors can be modified or incorporated into treatment planning.
- 42. C.** The best answer follows because metabolic adverse effects of antipsychotics should be recognized early in youth. Obesity care should be coordinated with mental-health treatment so psychiatric stability and metabolic health are both protected.
- 43. A.** Clinically, sleeve gastrectomy primarily reduces stomach volume, while Roux-en-Y also reroutes the proximal intestine. Both require long-term follow-up, with bypass carrying particular risks related to altered absorption and anatomy.
- 44. E.** In this setting, the most effective treatment is not the one with the highest average weight loss if it is unsafe for the individual. Obesity care requires selecting among multiple effective options based on personalized risk and benefit.
- 45. B.** The central point is that edema can affect scale weight and mobility, and venous disease needs direct treatment. Obesity care can proceed concurrently with adapted movement and attention to fluid-related changes in measured weight.
- 46. D.** The central point is that insulin resistance commonly produces elevated triglycerides and low HDL cholesterol. This pattern increases cardiometabolic risk and should be managed alongside weight treatment.
- 47. A.** In this setting, insufficient sleep and circadian misalignment can worsen appetite regulation, eating behavior, and cardiometabolic risk. Sleep is therefore a treatment target alongside nutrition, activity, and other therapies.

- 48. C.** The best answer follows because trials and clinical experience show substantial weight recurrence after stopping effective incretin-based therapy. This supports viewing obesity treatment similarly to other chronic-disease therapies that may need continuation.
- 49. E.** The central point is that self-monitoring increases awareness of patterns, triggers, and progress. It is a foundational behavioral technique that provides data for problem solving and feedback.
- 50. C.** The central point is that weight reduction can lower intracranial pressure and improve idiopathic intracranial hypertension. Threatened vision still requires urgent specialty management; obesity treatment is an important concurrent disease-modifying strategy.
- 51. B.** In this setting, current pediatric obesity care allows pharmacotherapy for appropriately selected adolescents as an adjunct to intensive health behavior and lifestyle treatment. Drug selection must respect age-specific indications and safety.
- 52. C.** In this setting, competence requires continuous learning and critical appraisal. Reviewing guidelines, trials, safety updates, and one's own outcomes helps keep practice current and evidence based.
- 53. A.** The central point is that pediatric obesity treatment should be developmentally appropriate and family centered. The goal is healthier growth, behaviors, and complication risk rather than simply imposing an adult weight-loss model.
- 54. E.** In this setting, obesity is a major risk factor for obstructive sleep apnea, and loud snoring plus witnessed apneas is a classic presentation. Untreated OSA can worsen blood pressure and cardiometabolic risk.
- 55. D.** Clinically, bupropion can lower seizure threshold, making a seizure disorder a major contraindication. Other important concerns include uncontrolled hypertension and situations involving opioid use or abrupt withdrawal from certain substances.
- 56. B.** The central point is that more intensive, repeated behavioral contact generally produces greater weight loss than one-time advice. Ongoing feedback and problem solving help translate knowledge into sustained behavior change.
- 57. E.** The best answer follows because phentermine is a sympathomimetic and is not appropriate in patients with cardiovascular disease or uncontrolled hypertension. A non-sympathomimetic option should be selected instead.
- 58. D.** In this setting, waist circumference is an accessible proxy for central adiposity and adds risk information in many patients. It does not directly quantify visceral fat or replace evaluation of obesity-related complications.

- 59. D.** The best answer follows because weight reduction can improve hepatic steatosis, inflammation, and metabolic risk. The required magnitude and treatment modality depend on disease severity, fibrosis risk, and the patient's overall obesity treatment plan.
- 60. B.** In this setting, prior response and tolerability help estimate what previously worked, why it stopped working, and what barriers or adverse effects should shape the next plan. Administrative details about prior programs are much less relevant.
- 61. A.** The central point is that obesity increases intra-abdominal pressure and is associated with urinary incontinence. Weight reduction can improve symptoms and should be combined with appropriate pelvic-floor or urologic care as needed.
- 62. A.** The central point is that modern guidance supports considering metabolic surgery for selected individuals with BMI 30-34.9 kg/m<sup>2</sup> and metabolic disease, particularly when nonsurgical approaches have not produced adequate durable improvement. This threshold is not an automatic mandate; candidacy still depends on metabolic disease severity, prior treatment response, operative risk, and informed patient preference.
- 63. C.** The best answer follows because loss-of-control and secretive eating warrant assessment for eating disorders and associated psychiatric symptoms. Treatment planning should avoid intensifying restriction before the eating pathology and safety issues are clarified.
- 64. B.** The best answer follows because treatment should begin with feasible evidence-based options rather than waiting for ideal access. Cost barriers can be addressed through alternative medications, intensive behavioral care, coverage appeals, or later escalation.
- 65. B.** The central point is that weight loss triggers adaptive changes in appetite and energy expenditure that can promote recurrence. Framing obesity as a chronic relapsing disease supports maintenance therapy rather than assigning blame.
- 66. E.** In this setting, proximal weakness, easy bruising, wide violaceous striae, and rapid central weight gain are discriminatory features for hypercortisolism. Routine screening for Cushing syndrome is not needed in all obesity, but these findings justify testing.
- 67. B.** The central point is that cost and coverage directly affect treatment access and persistence. A feasible plan should balance evidence, comorbidities, adverse effects, preferences, and financial realities.
- 68. D.** The central point is that scale weight reflects fat, lean tissue, glycogen, gut contents, and fluid. Rapid gain with edema should prompt evaluation for fluid retention and underlying medical disease rather than being labeled as adipose gain alone.

- 69. B.** In this setting, early dumping occurs soon after ingestion of hyperosmolar, often high-sugar foods and causes gastrointestinal and vasomotor symptoms. Postbariatric hypoglycemia generally occurs later after eating.
- 70. A.** The central point is that a respectful physical environment is part of clinical quality. Appropriate equipment, privacy, person-first language, and permission-based discussion reduce stigma and improve the safety and dignity of care.
- 71. E.** In this setting, olanzapine has a high propensity for weight gain and metabolic adverse effects. When clinically feasible, coordination with psychiatry to consider lower-risk alternatives can be part of obesity treatment.
- 72. E.** Clinically, shared decision-making respects informed patient preferences while still offering evidence-based alternatives. Treatment plans can evolve as benefits, risks, access, and goals change.
- 73. B.** In this setting, activity prescriptions should be functional and inclusive. People with mobility impairment can benefit from adapted aerobic and resistance activity, and treatment should not depend on walking-based goals.
- 74. C.** The best answer follows because obesity is a chronic, heterogeneous disease influenced by biology, environment, behavior, medications, and social context. Framing it this way supports long-term treatment and reduces blame and stigma.
- 75. D.** Clinically, obesity, diabetes, hypertension, and kidney disease commonly reinforce one another. Integrated risk-factor management and individualized obesity treatment are more effective than treating each condition in isolation.
- 76. D.** The best answer follows because supportive involvement can improve practical implementation when it is collaborative and consented to. Surveillance, criticism, and coercion can damage autonomy and the therapeutic environment.
- 77. C.** The best answer follows because behavioral plans should match cognitive and practical capacity. Simplifying routines and using environmental cues can improve adherence without blaming the patient.
- 78. C.** Clinically, weight reduction can improve OSA, but residual disease may remain. PAP should generally continue until repeat clinical or sleep evaluation confirms that therapy can be modified safely.
- 79. A.** The best answer follows because severe obesity beginning very early in life with marked hyperphagia and a strong family pattern suggests monogenic obesity. Identification may affect counseling, prognosis, and eligibility for targeted therapy in specific genetic conditions.
- 80. D.** The best answer follows because sleep apnea can worsen fatigue, activity tolerance, and cardiometabolic health and may interact bidirectionally with obesity. Treating OSA and obesity concurrently is preferable to a delayed sequential approach.

- 81. B.** Clinically, temporal association is central to recognizing medication-induced weight gain. Family susceptibility and other factors can coexist, so the medication should be considered when the trajectory changes after exposure.
- 82. E.** In this setting, depot medroxyprogesterone is among medications that may promote weight gain. A person-centered discussion can weigh contraceptive priorities against potential metabolic effects and consider alternatives when appropriate.
- 83. B.** The central point is that tirzepatide is FDA approved to treat moderate-to-severe obstructive sleep apnea in adults with obesity in conjunction with reduced-calorie nutrition and increased physical activity. Weight reduction contributes importantly to the improvement in OSA.
- 84. C.** Orforglipron is an orally administered small-molecule GLP-1 receptor agonist approved in 2026 for long-term weight reduction in adults with obesity or overweight plus at least one weight-related comorbidity, together with reduced-calorie nutrition and increased physical activity.
- 85. D.** In this setting, setmelanotide is an MC4 receptor agonist approved for certain genetically confirmed melanocortin-pathway disorders, including LEPR, POMC, and PCSK1 deficiency, and for Bardet-Biedl syndrome. It is not a general treatment for common polygenic obesity.
- 86. A.** The central point is that liquid calories are easily underrecognized and may contribute substantial energy without the satiety of solid foods. A beverage inventory is therefore a high-yield component of nutrition assessment.
- 87. E.** The best answer follows because weight reduction before pregnancy can improve metabolic and reproductive outcomes in many patients with PCOS. Preconception medication review and coordination with reproductive care are essential.
- 88. C.** The central point is that very-low-calorie diets can produce rapid weight loss but require careful selection and medical monitoring. They are not routine unsupervised plans and are inappropriate in several high-risk settings.
- 89. B.** In this setting, naltrexone is an opioid antagonist. Using naltrexone-bupropion in a patient dependent on opioid agonists can precipitate withdrawal and interfere with pain control.
- 90. E.** Clinically, weight recurrence is common and can reflect biologic adaptation, medication changes, stress, sleep, environment, or waning treatment intensity. A chronic-care model calls for reassessment and escalation when needed.
- 91. E.** The best answer follows because neurodevelopmental differences can affect communication, sensory tolerance, routines, and food repertoire. Treatment should adapt to these needs rather than withholding care or using inflexible strategies.

- 92. D.** Clinically, higher volumes of regular activity are commonly associated with successful weight-loss maintenance. The specific target should be individualized, but many patients benefit from progressing beyond the basic 150-minute health target.
- 93. C.** Clinically, obesity severity is not captured by body size alone. The presence and severity of metabolic, mechanical, and psychological complications should inform staging and treatment intensity.
- 94. D.** The best answer follows because label reading is most useful when it focuses on serving size and nutrients relevant to energy intake, satiety, and cardiometabolic health. Marketing terms alone can be misleading.
- 95. B.** Clinically, chronic obesity pharmacotherapy is generally indicated for adults with BMI at least 30 kg/m<sup>2</sup>, or at least 27 kg/m<sup>2</sup> with a weight-related condition, when used as part of comprehensive treatment. Eligibility alone does not determine the drug choice; comorbidities, contraindications, expected efficacy, tolerability, cost, and preference remain essential.
- 96. D.** The best answer follows because some antiretroviral regimens can influence weight, but maintaining effective HIV therapy is essential. Coordinated medication review can identify alternatives while preserving virologic suppression and enabling obesity treatment.
- 97. A.** The central point is that multiple dietary patterns can support weight loss. The most useful plan is one that is safe, nutritionally sound, creates an energy deficit, and can be sustained by the individual.
- 98. D.** In this setting, long-term treatment should be effective and tolerable. Persistent adverse effects warrant adjustment or a different modality rather than abandoning obesity care or forcing an unsafe regimen.
- 99. D.** The central point is that adaptive thermogenesis and appetite changes can reduce the effective energy deficit as weight falls. A plateau is therefore biologically expected and does not necessarily indicate lack of adherence.
- 100. B.** In this setting, weight loss can reduce bone mass, especially in older and postmenopausal adults. Resistance and weight-bearing exercise plus adequate protein, calcium, vitamin D, and appropriate osteoporosis care help mitigate risk.
- 101. A.** Clinically, insulin is effective for glycemia but commonly promotes weight gain, particularly as doses increase. Weight effects should be considered when optimizing diabetes therapy in a patient with obesity.
- 102. D.** The central point is that chronic kidney disease changes medication selection, dosing, and monitoring, but does not eliminate obesity treatment. Individualization should incorporate renal function, adverse-effect risk, and the benefits of weight reduction.

- 103. A.** In this setting, systemic glucocorticoids can promote appetite, adiposity, and metabolic complications. The safest strategy is coordinated minimization or substitution when the underlying condition permits, while treating obesity concurrently.
- 104. B.** In this setting, by reducing fat absorption, orlistat can also reduce absorption of fat-soluble vitamins. A multivitamin containing vitamins A, D, E, and K is commonly recommended at a separate time from dosing.
- 105. A.** The best answer follows because severe obesity with major complications warrants discussion of the full treatment spectrum. Lifestyle, medication, and surgery can be combined or sequenced based on effectiveness, safety, preferences, and access.
- 106. C.** The best answer follows because obesity contributes to osteoarthritis through mechanical loading and systemic inflammatory pathways. Clinically meaningful weight reduction and appropriate activity can improve pain and function.
- 107. C.** Clinically, children with common primary obesity usually maintain or accelerate linear growth. A decline in height velocity is a red flag for endocrine, genetic, or hypothalamic pathology and warrants targeted evaluation.
- 108. B.** Clinically, in older adults, obesity treatment must avoid worsening sarcopenia and frailty. Protein adequacy, resistance exercise, functional goals, and moderate individualized weight reduction are often more important than maximal scale loss.
- 109. D.** The central point is that a DASH-style dietary pattern can support blood-pressure control and can be adapted to create an energy deficit for weight loss. Treatment should address both obesity and cardiovascular risk.
- 110. A.** In this setting, adults with BMI at least 27 kg/m<sup>2</sup> plus a weight-related condition such as hypertension may meet labeling criteria for chronic obesity pharmacotherapy. Selection still depends on safety, preferences, and access.
- 111. A.** Clinically, mC4R signaling is central to appetite regulation, and pathogenic variants can produce early-onset hyperphagic obesity. Treatment remains comprehensive, and targeted-drug eligibility depends on the specific approved genetic indication rather than any MC4R variant.
- 112. D.** In this setting, weight recurrence can occur after surgery and has multiple potential causes. Evaluation should be systematic, and treatment may include behavioral support, anti-obesity medication, endoscopic therapy, or revision in selected patients.
- 113. E.** Clinically, activity should be feasible, enjoyable, and safe. Low-impact exercise can preserve participation while a musculoskeletal problem is addressed, reducing the risk that pain becomes a long-term barrier.

- 114. E.** The central point is that treatment success depends on access and feasibility. Work schedules, childcare, transportation, and similar social determinants should shape how care is delivered rather than being misinterpreted as lack of motivation.
- 115. D.** Clinically, mechanical limitations should modify rather than prevent treatment. Low-impact movement, strength training, pain management, and medical or surgical obesity therapies can improve both weight and function.
- 116. B.** Clinically, older adults may have mobility, balance, pain, or cardiopulmonary limitations that should shape the exercise plan. Functional assessment helps select safe aerobic and resistance activities and prevent injury.
- 117. A.** Clinically, primary obesity in children is usually associated with preserved or accelerated linear growth. Rapid weight gain plus reduced height velocity raises concern for endocrine or other secondary causes and warrants targeted evaluation.
- 118. C.** The central point is that heavy alcohol use affects energy intake, liver health, medication selection, and withdrawal risk. Substance-use assessment and treatment are part of safe obesity care and may change which pharmacotherapy is appropriate.
- 119. A.** The central point is that sSMART goals are specific, measurable, achievable, relevant, and time-bound. A defined walking plan can be tracked and adjusted, unlike vague outcome statements.
- 120. E.** In this setting, in heart failure, rapid scale changes often reflect fluid shifts. Obesity treatment outcomes should distinguish decongestion from fat loss and track symptoms, function, and body composition when useful.
- 121. D.** Clinically, bardet-Biedl syndrome is a ciliopathy characterized by obesity, retinal degeneration, polydactyly, renal disease, and variable developmental or hypogonadal features. This syndromic pattern should prompt genetic evaluation.
- 122. E.** Clinically, recurrent objectively large binges with loss of control, distress, and no regular compensatory behavior are characteristic of binge-eating disorder. Bulimia requires compensatory behaviors, while the other conditions have different eating-pattern features.
- 123. D.** The central point is that internal hernia is a potentially serious late complication after Roux-en-Y gastric bypass and can present with episodic severe pain despite a relatively benign early examination. Prompt surgical evaluation may be necessary.
- 124. A.** The best answer follows because intragastric balloons are temporary devices and typically produce less weight loss than operations such as sleeve gastrectomy or Roux-en-Y gastric bypass. Choice depends on goals, risk, eligibility, and patient preference.

**125. E.** The best answer follows because intragastric balloons are temporary endoscopic devices that occupy gastric volume and can promote weight loss when combined with behavioral treatment. They require planned removal and structured follow-up.

**126. E.** Semaglutide used for chronic weight management has an FDA indication to reduce the risk of cardiovascular death, myocardial infarction, and stroke in adults with established cardiovascular disease and overweight or obesity. This cardiovascular indication is distinct from weight loss alone.

**127. B.** The central point is that a gradual progression toward about 150 minutes of moderate activity weekly is a common health target. Starting below that level is appropriate for deconditioned patients, with progression based on tolerance and goals.

**128. A.** Clinically, semaglutide for chronic weight management has an adolescent obesity indication beginning at age 12 years. Several other agents also have pediatric indications, but treatment should be comprehensive and individualized.

**129. A.** The best answer follows because syndromic obesity is suggested by early severe obesity combined with findings outside weight regulation, such as developmental delay, retinal disease, polydactyly, renal anomalies, or distinctive dysmorphism. Common obesity is typically not accompanied by that constellation.

**130. D.** In this setting, weight-promoting psychiatric medications are important contributors, but psychiatric stability is essential. Shared management can explore alternatives or adjuncts without abrupt changes that risk relapse.

**131. C.** In this setting, persistent aminotransferase elevation in youth with obesity can reflect metabolic dysfunction-associated steatotic liver disease. Evaluation should still consider other causes rather than attributing all liver abnormalities to weight.

**132. A.** The best answer follows because obesity specialists can improve public awareness by correcting misinformation without shaming people who encounter it. Communication should distinguish evidence-based regulated treatments from products with uncertain benefit and safety.

**133. E.** The central point is that sugar-sweetened beverages provide substantial calories with limited satiety. Replacing them with noncaloric beverages can reduce total energy intake without requiring smaller solid-food portions.

**134. B.** Clinically, typical heartburn and acid regurgitation, especially after large meals and when supine, are characteristic of gastroesophageal reflux disease. Obesity increases reflux risk through several mechanical and metabolic pathways.

**135. C.** The best answer follows because loud snoring, witnessed apneas, morning headaches, and daytime sleepiness are classic features of obstructive sleep apnea. Obesity increases risk, but OSA should be diagnosed and treated directly rather than waiting for weight loss.

**136. D.** The best answer follows because even 5-7% weight loss can improve glycemia and cardiovascular risk factors, while larger losses often produce greater benefits. Treatment goals should include health outcomes, not only a target BMI.

**137. B.** The central point is that weight management is a primary treatment goal in type 2 diabetes with obesity. GLP-1-based therapies with high weight efficacy can improve both glycemia and weight and may offer additional cardiometabolic benefits.

**138. C.** Clinically, weight reduction can improve blood pressure and may lower medication needs. Ongoing monitoring allows antihypertensive therapy to be adjusted to avoid symptomatic hypotension.

**139. E.** Clinically, sympathomimetic drugs can worsen insomnia, anxiety, palpitations, and misuse risk. A focused neuropsychiatric and substance-use history helps identify patients in whom another therapy may be safer.

**140. D.** The central point is that BMI depends on measured body weight and cannot distinguish fat from excess fluid. In major edema, the clinician should interpret weight and BMI cautiously and use the broader clinical context.

**141. A.** The central point is that gastrointestinal adverse effects are common during titration of GLP-1-based therapies. Slower dose escalation and dietary adjustments can improve tolerability, while severe or persistent symptoms require evaluation.

**142. B.** The central point is that severe pediatric obesity can be defined using BMI relative to the 95th percentile, commonly at least 120% of that percentile. The degree of severity helps guide evaluation and treatment intensity.

**143. C.** Clinically, idiopathic intracranial hypertension is strongly associated with obesity, particularly in women of reproductive age. Papilledema with headache and pulsatile tinnitus requires urgent evaluation to protect vision.

**144. A.** In this setting, orforglipron became an FDA-approved oral small-molecule GLP-1 receptor agonist for chronic weight management in adults in 2026. It represents a nonpeptide oral incretin-based option distinct from injectable GLP-1 therapies.

**145. A.** In this setting, obesity arises from interacting biologic, behavioral, environmental, medication, and social influences. Recognizing this complexity supports comprehensive treatment rather than simplistic blame.

**146. D.** The central point is that motivational interviewing emphasizes autonomy, collaboration, and eliciting change talk. Asking permission and exploring the patient's own values is more effective than confrontation or coercion.

- 147. C.** In this setting, micronutrient deficiencies and metabolic complications can occur long after surgery, sometimes without early symptoms. Lifelong supplementation and periodic laboratory assessment are therefore standard parts of follow-up.
- 148. C.** In this setting, dietary supplements may contain stimulants, interacting ingredients, or inconsistent doses, and efficacy is often unproven. A medication history should explicitly include supplements and support safer evidence-based choices.
- 149. D.** Clinically, obesity is biologically defended and influenced by persistent environmental and social factors. Continued behavioral, pharmacologic, or surgical support may therefore be needed to maintain benefits.
- 150. C.** Clinically, weight management before pregnancy can improve health, but anti-obesity medications are generally not used during pregnancy and several require discontinuation before conception. Preconception planning should include medication review and nutrition.
- 151. E.** In this setting, for children and adolescents, BMI is interpreted by age- and sex-specific percentiles. A BMI at or above the 95th percentile meets the standard definition of obesity.
- 152. B.** The central point is that plateaus are expected and should prompt collaborative reassessment. Recognizing health improvements and using objective data supports persistence and informs safe treatment intensification.
- 153. E.** In this setting, obesity medicine evolves rapidly. Professional competence requires ongoing learning, appraisal of evidence, awareness of labeling changes, and incorporation of new information into patient care.
- 154. B.** The best answer follows because endoscopic procedures can be effective components of treatment, but obesity remains chronic. Long-term outcomes depend on appropriate selection, follow-up, behavioral care, and management of recurrence or complications.
- 155. C.** The best answer follows because endoscopic sleeve gastropasty uses endoscopic suturing to reduce gastric volume and alter gastric geometry without surgical removal of stomach. It is less invasive than operative sleeve gastrectomy.
- 156. A.** Clinically, obesity contributes to symptoms and functional limitation in HFpEF. Treatment should be coordinated with cardiovascular care and should consider symptom burden, function, medication safety, and cardiometabolic benefit.
- 157. D.** In this setting, older adults are vulnerable to sarcopenia during weight loss. Adequate protein, nutrient density, and resistance activity help protect muscle, function, and bone health.
- 158. B.** The central point is that phentermine-topiramate is contraindicated in pregnancy because of teratogenic risk from topiramate. Patients who can become pregnant need effective contraception and appropriate pregnancy testing.

- 159. A.** In this setting, the prognostic issue in metabolic liver disease is progression to steatohepatitis and fibrosis. Noninvasive risk stratification and appropriate referral help identify patients at risk for advanced disease.
- 160. A.** In this setting, obesity treatment aims to improve health as well as weight. Early assessment should consider expected response, disease complications, function, tolerability, and whether intensification or modification is needed.
- 161. B.** Clinically, binge-eating disorder is clinically important and should be addressed directly. Excessively restrictive plans can worsen loss-of-control eating, so integrated behavioral and, when indicated, pharmacologic treatment is preferred.
- 162. C.** In this setting, night eating syndrome features evening hyperphagia and/or nocturnal eating with awareness and recall. Sleep-related eating disorder is generally associated with reduced awareness or amnesia.
- 163. B.** Clinically, purposeful exercise and sedentary behavior are related but distinct targets. A patient can meet an activity goal and still benefit from breaking up prolonged sitting and increasing overall movement.
- 164. A.** In this setting, structured problem solving identifies a specific barrier, generates options, tests a feasible plan, and learns from the outcome. This builds self-efficacy and reduces all-or-none responses to setbacks.
- 165. C.** The central point is that large weight loss can include loss of lean tissue, especially in older adults. Monitoring function, nutrition, and resistance activity helps preserve muscle and identify other causes of weakness.
- 166. A.** Clinically, obesity treatment can improve triglycerides and other metabolic factors, but lipid-lowering therapy should still follow cardiovascular-risk indications. Comorbid conditions are treated in parallel, not sequentially.
- 167. B.** Clinically, body composition and metabolic risk differ across populations. Asian populations can develop cardiometabolic disease at lower BMI, so lower screening thresholds and central adiposity measures can improve risk identification.
- 168. B.** The best answer follows because a weight plateau does not negate improvements in glycemia, blood pressure, sleep, mobility, or cardiovascular risk. Maintenance of achieved loss and health gains is a major therapeutic success.
- 169. D.** The best answer follows because secondary endocrine causes of obesity are uncommon and usually have additional clinical clues. Targeted evaluation avoids low-value testing while allowing treatment of obesity to begin promptly.

**170. B.** The best answer follows because standard adult BMI classification defines class 1 obesity as 30.0-34.9 kg/m<sup>2</sup>, class 2 as 35.0-39.9, and class 3 as at least 40. BMI should still be interpreted alongside complications and body composition.

**171. D.** The central point is that current ASMBS/IFSO guidance recommends metabolic-bariatric surgery for individuals with BMI above 35 kg/m<sup>2</sup> regardless of the presence or severity of comorbidities, assuming appropriate evaluation and candidacy. The recommendation reflects evidence that surgery can provide durable health benefit even when a BMI above 35 kg/m<sup>2</sup> is not accompanied by a traditionally qualifying comorbidity.

**172. D.** The central point is that orlistat inhibits gastrointestinal lipases, causing some dietary fat to remain unabsorbed. Gastrointestinal adverse effects are therefore common and can be reduced by limiting excessive fat intake.

**173. E.** In 2026 the FDA approved a higher 7.2-mg once-weekly semaglutide injection, Wegovy HD, for long-term weight reduction in certain adults with obesity or overweight plus a weight-related condition. It remains an adjunct to reduced-calorie nutrition and increased physical activity rather than a replacement for comprehensive care.

**174. B.** In this setting, BMI describes body size but not the full health impact of obesity. Complications and functional impairment are critical for staging and for choosing the intensity and goals of treatment.

**175. D.** Clinically, BMI is a useful screening tool but does not directly measure adipose tissue. In highly muscular individuals, additional anthropometric or body-composition information can prevent misclassification.

**176. D.** Clinically, the patient is describing eating cued by emotional state rather than physiologic hunger. This pattern can be targeted with awareness, coping skills, stimulus control, and treatment of underlying anxiety when appropriate.

**177. A.** Clinically, severe obesity, daytime hypoxemia, and elevated bicarbonate suggest chronic hypoventilation and possible hypercapnia. Obesity hypoventilation syndrome requires targeted evaluation and ventilatory management, often alongside OSA treatment.

**178. E.** In this setting, ASMBS/IFSO guidance recognizes higher metabolic risk at lower BMI in Asian populations and uses lower thresholds, including consideration of surgery at BMI above about 27.5 kg/m<sup>2</sup> in appropriate patients. The lower threshold reflects the greater metabolic risk observed at lower BMI in many Asian populations and should still be applied with individualized surgical assessment.

**179. C.** The best answer follows because irregular eating can contribute to excessive hunger and loss-of-control eating later in the day. A structured, nutritionally adequate meal pattern can reduce vulnerability to large unplanned intake.

- 180. A.** The best answer follows because a useful activity history characterizes dose, sedentary behavior, functional limitations, and barriers. This allows a safe, individualized prescription rather than relying on a global self-label such as "active." This information allows the clinician to prescribe activity that is safe, feasible, measurable, and matched to the patient's functional capacity.
- 181. C.** The central point is that weight-based bullying is associated with substantial psychological harm. The clinician should assess mood, anxiety, safety, school functioning, and support systems while explicitly avoiding further stigmatization.
- 182. A.** In this setting, weight reduction decreases joint load and can reduce osteoarthritis pain, while appropriately designed exercise improves strength and function. These interventions complement standard pain and orthopedic care.
- 183. D.** The central point is that excess body mass increases mechanical load across weight-bearing joints and is strongly associated with osteoarthritis symptoms. Functional limitation from pain can then further reduce activity and should be addressed in the treatment plan.
- 184. B.** The best answer follows because intake varies by day and context, and self-estimated calories are often inaccurate. Combining structured recall with questions about usual and weekend patterns improves the clinical picture.
- 185. C.** In this setting, gradual weight reduction can improve hyperuricemia and metabolic health, whereas dehydration and crash dieting may precipitate gout. The plan should also address standard urate-lowering and dietary measures when indicated.
- 186. A.** Clinically, successful maintenance generally requires continued support because obesity is chronic and biologic pressure toward regain persists. Long-term therapy can be adjusted, but stopping an effective regimen often leads to recurrence.
- 187. D.** The central point is that a longitudinal weight timeline can reveal inflection points associated with pregnancy, injury, sleep disruption, endocrine disease, or weight-promoting medications. Current size or isolated preferences do not establish when or why the trajectory changed.
- 188. A.** In this setting, foods high in water and fiber generally have lower energy density, allowing larger portions for fewer calories. This can improve satiety while maintaining an energy deficit.
- 189. D.** Clinically, chronic obesity medications are generally intended for long-term treatment when effective, safe, and acceptable. Discontinuation commonly leads to weight recurrence because the underlying disease biology persists.
- 190. E.** The best answer follows because hypothalamic injury can produce severe hyperphagia, reduced energy expenditure, autonomic changes, and rapid weight gain. The timing after surgery near appetite-regulating nuclei is highly suggestive.

- 191. E.** In this setting, a fasting plasma glucose of at least 126 mg/dL on repeat testing meets a diagnostic criterion for diabetes in the appropriate clinical setting. Obesity substantially increases risk for type 2 diabetes.
- 192. A.** Clinically, pediatric obesity commonly persists and can produce early complications. Current care emphasizes prompt, family-centered, nonstigmatizing treatment rather than passive delay.
- 193. B.** Clinically, food insecurity is a major social determinant that can drive irregular intake and reliance on inexpensive calorie-dense foods. The plan should address access and resources rather than simply prescribe foods the patient cannot reliably obtain.
- 194. E.** The central point is that the combination of ovulatory dysfunction and hyperandrogenism, with exclusion of alternative causes, supports polycystic ovary syndrome. Obesity and insulin resistance commonly worsen its metabolic and reproductive manifestations.
- 195. C.** The best answer follows because after bariatric surgery, limited gastric capacity and altered absorption make protein, hydration, and lifelong micronutrient supplementation important. Small, structured intake helps meet needs while reducing intolerance.
- 196. C.** The best answer follows because obesity treatment is health-centered and individualized. Weight reduction is important, but improvements in complications, function, well-being, and sustainability are also core outcomes.
- 197. A.** In this setting, irregular ovulation, hyperandrogenic features, infertility, and obesity are common in polycystic ovary syndrome. Recognizing the pattern prompts appropriate reproductive and metabolic evaluation.
- 198. D.** The central point is that qualified interpretation and teach-back improve informed decision-making and medication safety. Language access is a core component of equitable, person-centered obesity care.
- 199. A.** Clinically, early follow-up supports dose titration, adverse-effect management, adherence, and assessment of response. Contemporary standards recommend relatively frequent contact initially, often at least monthly for the first three months.
- 200. C.** The central point is that valproate is a recognized weight-promoting anticonvulsant. Medication review should identify such contributors and, when clinically appropriate, prompt discussion of alternatives with the prescribing clinician.