

COMPREHENSIVE MOCK EXAM 5

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, five options (A-E) to match the parent book, domain-weighted to the current ABOM blueprint

Board-Review Questions

1. A 52-year-old woman has gained weight since long-term prednisone was started for inflammatory disease. What is the best obesity-medicine response?

- A. Delay obesity treatment until glucocorticoids have been stopped permanently, as a relevant consideration in this case
- B. Add an unregulated stimulant supplement to offset steroid appetite, when considered with the rest of the presentation
- C. Ignore medication effects because lifestyle is the only modifiable factor, within an individualized obesity treatment plan
- D. Stop prednisone immediately without discussing the underlying disease, given the patient factors described above
- E. Coordinate with the treating specialist to minimize glucocorticoid exposure if clinically feasible

2. Which statement best reflects the modern clinical concept of obesity?

- A. Obesity is simply a voluntary behavior defined only by calorie choice, when considered with the rest of the presentation
- B. Obesity is diagnosed only when a patient develops type 2 diabetes, within an individualized obesity treatment plan
- C. Obesity severity is determined solely by a single scale measurement, given the patient factors described above
- D. Obesity is an acute condition that resolves permanently after short-term dieting, in the clinical context described
- E. Obesity is a chronic, relapsing disease in which excess or dysfunctional adiposity can impair health

3. A 17-year-old has obesity with type 2 diabetes, hypertension, and obstructive sleep apnea. What best characterizes disease severity?

- A. Severity should incorporate obesity-related complications, not BMI alone, within the treatment context described
- B. Only waist circumference determines treatment intensity, given the patient factors described above

- C.** Complications do not affect obesity staging in adolescents, in the clinical context described
- D.** The presence of diabetes excludes obesity as a diagnosis, as a relevant consideration in this case
- E.** BMI alone fully describes health risk and treatment urgency, when interpreted with the full presentation

4. A patient taking orlistat reports oily spotting, fecal urgency, and flatus with discharge. What is the best explanation?

- A.** They indicate systemic serotonin toxicity, given the patient factors described above, in the clinical setting described
- B.** They prove the patient has developed bowel obstruction, in the clinical setting described, as a relevant consideration in this case
- C.** These are expected gastrointestinal effects from reduced intestinal fat absorption and often worsen with high-fat meals
- D.** They are typical signs of thyroid C-cell tumors, when considered with the rest of the presentation, when interpreted with the full presentation
- E.** They result from increased pancreatic lipase activity, within an individualized obesity treatment plan

5. A patient with obesity has elevated ALT, hepatic steatosis on imaging, and fibrosis risk factors. What is the key next clinical concern?

- A.** Exclude metabolic liver disease because obesity makes viral hepatitis more likely, in the clinical setting described
- B.** Assess for steatohepatitis and clinically significant liver fibrosis rather than assuming simple steatosis
- C.** Assume all steatosis is benign and requires no further risk stratification, when considered with the rest of the presentation
- D.** Diagnose alcoholic liver disease without assessing alcohol exposure, within an individualized obesity treatment plan
- E.** Order liver biopsy in every patient regardless of noninvasive assessment, given the patient factors described above

- 6.** A patient asks about an intragastric balloon for obesity treatment. Which statement is most accurate?
- A.** It is an endoscopically placed temporary space-occupying device used with a comprehensive lifestyle program
 - B.** It eliminates the need for follow-up after placement, when considered with the rest of the presentation
 - C.** It works primarily by destroying gastric acid-producing cells, within an individualized obesity treatment plan
 - D.** It is implanted surgically and cannot be removed endoscopically, given the patient factors described above
 - E.** It is a permanent intestinal bypass that causes major malabsorption, in the clinical setting described
- 7.** A patient reports 30 minutes of brisk walking five days per week but sits at a desk for 10 hours daily. Which statement is most accurate?
- A.** Sedentary time matters only when no purposeful exercise is performed, when considered with the rest of the presentation
 - B.** Only resistance exercise can offset the effects of prolonged sitting, within an individualized obesity treatment plan
 - C.** Meeting an exercise goal eliminates any health effect of prolonged sitting, given the patient factors described above
 - D.** The activity is beneficial, but prolonged sedentary time remains a separate target for reduction
 - E.** Desk work should be replaced entirely by vigorous exercise breaks, as a relevant consideration in this case
- 8.** A 30-year-old woman taking phentermine-topiramate extended release wants to conceive. What is the most important counseling point?
- A.** The medication is preferred during pregnancy because it limits gestational weight gain, within an individualized obesity treatment plan
 - 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. Pregnancy testing is unnecessary once a stable dose has been reached, in the clinical setting described, in the clinical context described

D. Topiramate is safe in pregnancy when combined with phentermine, as a relevant consideration in this case, as a consideration for this patient

E. The medication should be continued through the first trimester and then stopped, when considered with the rest of the presentation, when interpreted with the full presentation

9. A 39-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 magnitude, durability, and tolerability of responses to prior weight-loss treatments

B. Whether prior programs used printed or electronic handouts, in the clinical setting described

C. The number of friends who attempted the same programs, as a relevant consideration in this case

D. The order in which previous clinicians discussed each diet, when considered with the rest of the presentation

E. His preferred day of the week for starting a plan, within an individualized obesity treatment plan

10. A patient with uncontrolled hypertension and coronary artery disease requests phentermine. What is the best response?

A. Combine phentermine with another stimulant to minimize tachycardia, in the clinical setting described, in the clinical context described

B. Avoid phentermine because sympathomimetic effects can increase heart rate and blood pressure and cardiovascular disease is a contraindication

C. Start phentermine and stop antihypertensive therapy to avoid interactions, when considered with the rest of the presentation

D. Use phentermine only at bedtime because cardiovascular risk occurs during daytime, within an individualized obesity treatment plan

E. Use a higher dose because cardiovascular disease reduces appetite response, given the patient factors described above

11. A patient with obesity has burning retrosternal discomfort after large evening meals and sour regurgitation when lying down. Which complication is most likely?

- A.** Biliary colic limited to right upper-quadrant postprandial pain
- B.** Pancreatitis causing persistent severe epigastric pain radiating to the back
- C.** Achalasia causing progressive dysphagia to solids and liquids
- D.** Peptic ulcer disease defined by nocturnal epigastric pain only
- E.** Gastroesophageal reflux disease, in the clinical setting described

12. A patient asks why weight-loss plateaus occur despite continued adherence. Which mechanism is most relevant?

- A.** As body weight falls, energy expenditure can decrease and appetite signals can rise, narrowing the energy deficit
- B.** Resting metabolism always rises substantially as weight decreases, within an individualized obesity treatment plan
- C.** Leptin concentrations increase and permanently suppress appetite after weight loss, given the patient factors described above
- D.** Calorie absorption from the intestine always doubles during weight loss, in the clinical setting described
- E.** Skeletal muscle becomes incapable of using fatty acids after dieting, as a relevant consideration in this case

13. A patient experiences clinically significant weight recurrence several years after metabolic surgery. What is the best approach?

- A.** Evaluate behavioral, medical, medication, and anatomic contributors and consider multimodal treatment including pharmacotherapy when appropriate
- B.** Assume surgery has failed permanently and no further treatment can help, given the patient factors described above
- C.** Blame the patient because biologic recurrence does not occur after surgery, in the clinical setting described, in the clinical context described

D. Avoid obesity medication because it cannot be used after bariatric procedures, as a relevant consideration in this case

E. Repeat surgery automatically without diagnostic evaluation, when considered with the rest of the presentation, when interpreted with the full presentation

14. A 44-year-old prefers an endoscopic procedure that reduces gastric volume by full-thickness suturing without surgical resection. Which procedure is being described?

A. Roux-en-Y gastric bypass, given the patient factors described above

B. Biliopancreatic diversion with duodenal switch, in the clinical setting described

C. Endoscopic sleeve gastropasty, as a relevant consideration in this case

D. Jejunioileal bypass, when considered with the rest of the presentation

E. Adjustable gastric band placement, within an individualized obesity treatment plan

15. A child has early-onset obesity, hyperphagia, retinal dystrophy, postaxial polydactyly, and renal abnormalities. What is the most likely diagnosis?

A. Turner syndrome with webbed neck and gonadal failure, in the clinical setting described

B. Beckwith-Wiedemann syndrome with fetal overgrowth and macroglossia, as a consideration for this patient

C. Monogenic MC4R deficiency without syndromic features, when considered with the rest of the presentation

D. Prader-Willi syndrome without retinal or limb abnormalities, within the treatment context described

E. Bardet-Biedl syndrome, given the patient factors described above, given the clinical details provided

16. What feature of behavioral obesity treatment is most consistently associated with greater weight loss?

A. Avoiding self-monitoring to reduce treatment burden, as a relevant consideration in this case

- B.** Providing information without setting behavioral goals, when considered with the rest of the presentation
- C.** A single educational visit without follow-up, within an individualized obesity treatment plan
- D.** Higher-intensity contact with repeated counseling, monitoring, and feedback, given the clinical details provided
- E.** Using identical interventions regardless of patient preference, in the clinical context described

17. A 72-year-old woman with obesity is beginning a calorie-reduced diet. Which nutrition concern deserves special attention?

- A.** Preserving protein intake and micronutrient adequacy to reduce loss of muscle and function
- B.** Avoiding all dairy and legumes because they contain calories, within an individualized obesity treatment plan
- C.** Maximizing calorie restriction even if protein intake falls very low, given the patient factors described above
- D.** Using prolonged fasting as the preferred way to prevent sarcopenia, in the clinical setting described
- E.** Eliminating resistance activity to avoid increasing appetite, as a relevant consideration in this case

18. A patient taking pregabalin for neuropathic pain reports increased appetite and edema with weight gain. What is the best interpretation?

- A.** Pregabalin is consistently weight-lowering and cannot explain the change, within the treatment context described
- B.** The medication should be stopped abruptly without evaluating pain control, given the clinical details provided
- C.** Pregabalin can contribute to weight gain and should be included in the medication assessment
- D.** The gain proves an endocrine disorder regardless of medication timing, as a relevant consideration in this case
- E.** Edema excludes a medication contribution to measured body weight, when considered with the rest of the presentation

19. A patient frequently snacks while watching television. Which behavioral strategy is most directly targeted to this cue?

- A.** Stimulus control by separating eating from television and changing the food environment
- B.** Sleep restriction to reduce available evening eating time, in the clinical setting described
- C.** Punitive exercise immediately after every snack episode, as a relevant consideration in this case
- D.** Exposure therapy to increase contact with snack foods during television, when interpreted with the full presentation
- E.** Skipping breakfast to compensate for evening intake, within an individualized obesity treatment plan

20. Which strategy is most useful for relapse prevention after successful weight loss?

- A.** Use rigid perfectionistic rules so no lapses occur, in the clinical setting described, in the clinical context described
- B.** Assume maintenance requires less support than initial weight loss, as a relevant consideration in this case
- C.** Avoid weighing or monitoring because feedback increases recurrence, when considered with the rest of the presentation
- D.** Identify high-risk situations in advance and create specific coping and recovery plans, within the treatment context described
- E.** Stop all treatment once the first goal weight is reached, given the patient factors described above

21. A patient has a contraindication to the medication that would otherwise offer the greatest average weight loss. What should the clinician do?

- A.** Choose another evidence-based therapy with a safer risk-benefit profile for this patient, as a consideration for this patient
- B.** Avoid all obesity treatment because the first choice cannot be used, when considered with the rest of the presentation
- C.** Ignore the contraindication if the patient requests the medication, within an individualized obesity treatment plan

- D.** Combine the drug with a second medication to cancel the contraindication, given the clinical details provided
- E.** Use the contraindicated drug at a lower dose because efficacy is more important than safety

22. What is the most appropriate overarching goal of obesity treatment?

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

23. A patient with obesity and hypertension begins losing weight and develops lightheadedness with lower home blood pressure readings. What is the best next step?

- A.** Add a sympathomimetic drug to raise blood pressure, within an individualized obesity treatment plan
- B.** Ignore symptoms because blood pressure never changes with weight loss, given the patient factors described above
- C.** Stop weight treatment because lower blood pressure is harmful, in the clinical setting described
- D.** Increase every antihypertensive dose because obesity is still present, as a relevant consideration in this case
- E.** Reassess antihypertensive doses because successful weight loss may reduce blood pressure medication requirements

24. A patient with chronic kidney disease and obesity is considering pharmacotherapy. What is the best general approach?

- A.** Use the same dose of every medication regardless of renal function, given the patient factors described above, given the clinical details provided
- B.** Choose therapy based on kidney function, comorbidities, labeling, hydration risk, and the potential renal and cardiovascular benefits of weight reduction
- C.** Treat kidney disease first and obesity only after renal function normalizes, as a relevant consideration in this case
- D.** Avoid monitoring volume status or kidney function during treatment, when considered with the rest of the presentation
- E.** Assume all obesity medications are contraindicated in any kidney disease, within an individualized obesity treatment plan

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

- A.** Early dumping syndrome, in the clinical setting described, in the clinical context described
- B.** Bile-acid diarrhea unrelated to meal composition, as a relevant consideration in this case
- C.** Acute pancreatitis from hypertriglyceridemia, when considered with the rest of the presentation
- D.** Postbariatric hypoglycemia occurring several hours after meals, within the treatment context described
- E.** Small-bowel obstruction caused by an internal hernia, given the patient factors described above

26. A physician is speaking to a community group about obesity. Which message is most appropriate?

- A.** Obesity is mainly a failure of personal discipline that requires public shame, as a relevant consideration in this case
- B.** People should wait for complications before seeking treatment, when considered with the rest of the presentation
- C.** Obesity is a chronic, treatable disease shaped by biology and environment, and effective care includes multiple evidence-based options
- D.** Only one diet works, so other treatments should not be discussed, given the patient factors described above

E. Medication and surgery are shortcuts and should be discouraged publicly, in the clinical setting described

27. A 67-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 prefers television dramas or documentaries, when considered with the rest of the presentation

B. Ask whether she owns more than one pair of walking shoes, within an individualized obesity treatment plan

C. Ask which season of the year she enjoys most, given the patient factors described above

D. Ask whether her neighborhood houses have stairs, in the clinical setting described, in the clinical context described

E. Ask about falls, mobility limits, cardiopulmonary symptoms, pain, and ability to perform daily activities

28. A 46-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. Her current clothing size compared with close relatives, within an individualized obesity treatment plan

B. The exact number of diets she has read about online, given the patient factors described above

C. A timeline linking weight changes to life events, illnesses, and medication starts

D. Whether she prefers morning or evening clinic visits, as a relevant consideration in this case

E. The brand of scale she uses for home measurements, when considered with the rest of the presentation

29. A 45-year-old woman has weight gain, fatigue, constipation, cold intolerance, dry skin, and delayed reflex relaxation. Which test is most appropriate first?

A. Twenty-four-hour urinary free cortisol as the initial test, given the clinical details provided

B. Serum insulin level after an overnight fast, in the clinical setting described

- C. Random growth hormone concentration, as a relevant consideration in this case
- D. Serum thyroid-stimulating hormone, when considered with the rest of the presentation
- E. Plasma metanephrines without suggestive symptoms, within an individualized obesity treatment plan

30. 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. Assess the child and caregivers together, including meals, beverages, snacks, school food, and family routines
- B. Interview only the child because caregiver reports are inherently biased, as a relevant consideration in this case
- C. Focus exclusively on calories and avoid asking about meal structure, when considered with the rest of the presentation
- D. Interview only the caregiver and exclude the child from discussion, within an individualized obesity treatment plan
- E. Count only restaurant meals because home meals are not relevant, given the patient factors described above

31. A patient regains 6% of body weight after an initially successful program. What is the most appropriate response?

- A. End treatment because recurrence proves the patient cannot respond, as a relevant consideration in this case
- B. Use shame to restore adherence rapidly, when considered with the rest of the presentation
- C. Repeat the identical plan without reviewing barriers or biology, within an individualized obesity treatment plan
- D. Assume the regain is entirely due to hidden eating, given the patient factors described above
- E. Reassess contributors and intensify or modify treatment rather than treating recurrence as personal failure

32. A patient misses obesity visits because the only available appointments conflict with hourly work and childcare. What is the best response?

- A.** Require weekly in-person visits before offering any treatment, when considered with the rest of the presentation
- B.** Intensify the diet because scheduling barriers reflect low motivation, within an individualized obesity treatment plan
- C.** Modify care delivery when possible, such as flexible scheduling or telehealth, while addressing practical barriers
- D.** Label the missed visits as nonadherence and discharge the patient, in the clinical setting described
- E.** Avoid discussing work or childcare because they are not medical issues, as a relevant consideration in this case

33. A 5-year-old with genetically confirmed LEPR deficiency has severe hyperphagic obesity. Which targeted medication acts through the melanocortin-4 receptor pathway?

- A.** Metformin, an insulin sensitizer without an obesity indication in this setting, within the treatment context described
- B.** Naltrexone-bupropion, which combines opioid and catecholamine pathways, given the clinical details provided
- C.** Setmelanotide, in the clinical setting described, as a relevant consideration in this case
- D.** Orlistat, which inhibits gastrointestinal lipase activity, as a relevant consideration in this case
- E.** Phentermine, a sympathomimetic approved for short-term use, when considered with the rest of the presentation

34. A 63-year-old man has difficulty remembering daily goals and medications. Which behavioral adaptation is most practical?

- A.** Use complex tracking tools because difficulty improves with challenge, given the patient factors described above
- B.** Assume forgetfulness reflects intentional nonadherence, in the clinical setting described

- C.** Increase the number of daily decisions to strengthen memory, as a relevant consideration in this case
- D.** Avoid involving support persons even with patient permission, when considered with the rest of the presentation
- E.** Simplify routines and use external cues such as pill organizers, reminders, and written action plans

35. 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/m², in the clinical setting described
- B.** Stop PAP as soon as any weight loss occurs, as a relevant consideration in this case
- C.** Use scale weight alone to determine whether apneas persist, when considered with the rest of the presentation
- D.** Continue PAP until the sleep disorder is reassessed objectively after weight change
- E.** Replace PAP with caffeine if daytime sleepiness improves, given the patient factors described above

36. A child with a high BMI also has marked edema from nephrotic syndrome. What limitation of BMI is most relevant?

- A.** Edema proves that obesity is absent in every child, as a relevant consideration in this case
- B.** Body weight can be inflated by fluid, so BMI may not accurately represent adiposity in this setting
- C.** BMI is unaffected by hydration or extracellular fluid, within an individualized obesity treatment plan
- D.** Fluid retention can be ignored when tracking weight change, given the patient factors described above
- E.** Pediatric BMI should always use adult fixed cutoffs, in the clinical setting described

37. A 48-year-old with obesity has fasting glucose 128 mg/dL on two separate mornings. What is the most likely diagnosis?

- A.** Type 1 diabetes established solely by the fasting value, when considered with the rest of the presentation
- B.** Type 2 diabetes mellitus, within an individualized obesity treatment plan, within the treatment context described
- C.** Prediabetes based only on impaired fasting glucose, given the patient factors described above
- D.** Normal glycemia because fasting values are below 140 mg/dL, in the clinical context described
- E.** Reactive hypoglycemia caused by excess insulin secretion, as a relevant consideration in this case

38. A 16-year-old with obesity frequently skips breakfast and then eats large amounts after school. What is a reasonable nutrition target?

- A.** Eliminate all snacks regardless of hunger or school schedule, within an individualized obesity treatment plan
- B.** Use caffeine instead of breakfast to suppress appetite, given the patient factors described above
- 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, as a relevant consideration in this case
- E.** Encourage longer fasting because adolescents need fewer meals, when considered with the rest of the presentation

39. A 9-year-old has rapid weight gain and a clear fall in height percentile over two years. Which principle is most important?

- A.** Primary obesity typically causes marked slowing of linear growth, given the patient factors described above
- B.** Reduced linear growth with weight gain raises suspicion for an endocrine or hypothalamic cause
- C.** Endocrine causes are likely whenever a child has a high BMI alone, as a relevant consideration in this case
- D.** Weight should be treated before investigating abnormal growth patterns, when considered with the rest of the presentation

E. Height velocity is unrelated to the evaluation of pediatric obesity, within an individualized obesity treatment plan

40. A patient asks whether alcohol matters for weight management. What is the best counseling point?

A. Alcohol intake is irrelevant unless liver enzymes are elevated, in the clinical setting described

B. Alcohol provides calories, can lower dietary restraint, and should be included when assessing total intake and safety

C. Only beer contributes calories; wine and spirits do not, when considered with the rest of the presentation

D. Alcohol has no usable energy and therefore cannot affect weight, within an individualized obesity treatment plan

E. Alcohol improves satiety enough to substitute for meals safely, given the patient factors described above

41. A 28-year-old woman using depot medroxyprogesterone acetate has gained weight and asks whether contraception could be contributing. What is the best response?

A. Injectable progestin can be weight promoting in some patients, so alternatives can be discussed if appropriate

B. All hormonal contraception causes the same degree of weight gain, when considered with the rest of the presentation

C. The injection must be stopped immediately regardless of pregnancy risk, within an individualized obesity treatment plan

D. Only estrogen-containing contraception has any potential weight effect, given the patient factors described above

E. Contraception never affects weight and should not be reviewed, in the clinical setting described

42. 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, when considered with the rest of the presentation

- B.** Achilles tendinopathy presenting as referred knee pain, within an individualized obesity treatment plan
- C.** Slipped capital femoral epiphysis, given the patient factors described above, given the clinical details provided
- D.** Patellofemoral pain syndrome without hip pathology, in the clinical setting described
- E.** Growing pains that cause normal gait abnormalities, as a relevant consideration in this case

43. 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 response?

- A.** Treatment should be delayed until adulthood because childhood obesity is usually transient, within an individualized obesity treatment plan
- B.** Only severe complications justify discussing weight-related health in childhood, given the patient factors described above
- C.** Obesity should be addressed as a chronic disease now, using family-centered treatment rather than watchful waiting alone
- D.** The child should be blamed directly so personal responsibility develops early, as a relevant consideration in this case
- E.** Rapid weight loss should be pursued with unsupervised fasting in all children, when considered with the rest of the presentation

44. Why is adequate protein commonly emphasized during intentional weight loss?

- A.** It prevents all adaptive changes in metabolic rate, given the patient factors described above
- B.** It can support satiety and help preserve lean mass, especially when combined with resistance exercise
- C.** It guarantees fat loss regardless of total energy intake, as a relevant consideration in this case
- D.** It should replace vegetables and whole grains completely, when considered with the rest of the presentation
- E.** It eliminates the need for resistance training during weight loss, within an individualized obesity treatment plan

45. A patient repeatedly overeats after stressful workdays. Which intervention best uses problem-solving therapy?

- A.** Tell the patient to avoid all stress because coping skills are ineffective, in the clinical setting described
- B.** Label each lapse as treatment failure and restart from the beginning, as a relevant consideration in this case
- C.** Prescribe a single solution without considering barriers, when considered with the rest of the presentation
- D.** Focus only on body weight rather than the behavior sequence, within an individualized obesity treatment plan
- E.** Identify the trigger, generate several coping alternatives, choose one, test it, and review the result

46. 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.** Repeat the claim until randomized trials are published, as a relevant consideration in this case, when considered with the rest of the presentation
- B.** Recommend the supplement because natural products are inherently safe, when considered with the rest of the presentation
- C.** Avoid public correction because misinformation cannot affect patient behavior, within an individualized obesity treatment plan
- D.** Provide clear evidence-based information about uncertain efficacy, potential harms, and the availability of regulated treatments
- E.** Dismiss everyone who asks about it as gullible, in the clinical setting described, as a relevant consideration in this case

47. A patient repeatedly misses follow-up because of transportation barriers but is benefiting from treatment. What is the best long-term adjustment?

- A.** Stop medication until transportation problems are permanently solved, when considered with the rest of the presentation
- B.** Terminate treatment because attendance is the sole measure of engagement, within an individualized obesity treatment plan

- C.** Require more frequent in-person visits despite the same barrier, given the patient factors described above
- D.** Assume missed visits indicate lack of interest in health, in the clinical setting described, as a relevant consideration in this case
- E.** Use feasible alternatives such as telehealth, coordinated local monitoring, or less burdensome visit structures when clinically appropriate

48. 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.** Severe chylomicronemia proven by any triglyceride elevation, given the patient factors described above
- C.** A normal lipid pattern expected in insulin resistance, in the clinical setting described
- D.** Hypobetalipoproteinemia causing very low total cholesterol, as a relevant consideration in this case
- E.** Atherogenic dyslipidemia characterized by high triglycerides and low HDL cholesterol

49. A 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.** Night eating syndrome, given the patient factors described above, given the clinical details provided
- B.** Sleep-related eating disorder with amnesia for episodes, in the clinical setting described
- C.** Binge-eating disorder requiring objectively large binges, as a relevant consideration in this case
- D.** Rumination disorder with repeated food regurgitation, when considered with the rest of the presentation
- E.** Bulimia nervosa with compensatory purging behaviors, within an individualized obesity treatment plan

50. 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, as a relevant consideration in this case
- C.** The balloon is a permanent implant intended to remain for life, when considered with the rest of the presentation
- D.** The balloon requires removal of most of the stomach, within an individualized obesity treatment plan
- E.** The balloon provides greater average weight loss than duodenal switch surgery, given the patient factors described above

51. 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, as a relevant consideration in this case, when considered with the rest of the presentation
- B.** Continue all anti-obesity medications through conception because fetal exposure is minimal, when considered with the rest of the presentation
- C.** Use preconception lifestyle and health optimization and discontinue medications that are contraindicated in pregnancy before conception as appropriate
- D.** Avoid discussing contraception or medication washout during preconception care, given the patient factors described above
- E.** Pursue rapid pharmacologic weight loss during pregnancy to reduce gestational gain, in the clinical setting described

52. A 55-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.** Orlistat, when considered with the rest of the presentation, when interpreted with the full presentation

- B.** Phentermine, within an individualized obesity treatment plan, within the treatment context described
- C.** Naltrexone-bupropion, given the patient factors described above, given the clinical details provided
- D.** Tirzepatide, in the clinical setting described, as a relevant consideration in this case
- E.** Liraglutide, as a relevant consideration in this case, when considered with the rest of the presentation

53. 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.** Add large amounts of oil because dietary fat has low energy density, given the clinical details provided
- C.** Replace water-rich vegetables with fried snack foods, in the clinical setting described
- D.** Add caloric sauces to every meal without changing portions, as a consideration for this patient
- E.** Replace whole fruit with sugar-sweetened juice, when considered with the rest of the presentation

54. A patient with obesity and MASLD has no advanced fibrosis. Which intervention has the strongest general role in disease management?

- A.** Treating only the ALT value while ignoring metabolic risk, given the patient factors described above
- B.** Avoiding weight loss because hepatic fat protects against fibrosis, in the clinical setting described
- C.** Using vitamin supplements alone without changing energy balance, as a relevant consideration in this case
- D.** Sustained weight reduction through lifestyle, medication, and/or surgery as appropriate
- E.** Routine liver transplantation before evidence of advanced disease, within an individualized obesity treatment plan

55. 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. Neither procedure requires long-term vitamin and nutritional monitoring, as a relevant consideration in this case
 - C. Sleeve gastrectomy is a temporary endoscopic device removed after one year, when considered with the rest of the presentation
 - D. Sleeve gastrectomy bypasses the proximal small intestine while Roux-en-Y does not, within an individualized obesity treatment plan
 - E. Roux-en-Y leaves the stomach and intestinal anatomy completely unchanged, given the patient factors described above
56. A patient with marked edema has gained 6 kg in two weeks without increased waist circumference. Which interpretation is most appropriate?
- A. Body weight is unaffected by extracellular fluid volume, as a relevant consideration in this case
 - B. Rapid fluid gain is expected and requires no medical evaluation, when considered with the rest of the presentation
 - C. All short-term weight gain necessarily represents new body fat, within an individualized obesity treatment plan
 - D. Some of the measured weight gain may reflect fluid rather than increased adipose tissue
 - E. Edema confirms that the patient has developed an eating disorder, in the clinical setting described
57. A patient with bipolar disorder is stable on treatment and wants obesity care. What principle should guide medication changes?
- A. Assume psychiatric stability makes future monitoring unnecessary, when considered with the rest of the presentation
 - B. Avoid all obesity pharmacotherapy in anyone with bipolar disorder, within an individualized obesity treatment plan

- C.** Choose treatment based only on expected kilograms lost, given the patient factors described above
- D.** Discontinue effective mood stabilizers whenever they promote weight gain, in the clinical setting described
- E.** Coordinate with psychiatry so any effort to reduce weight-promoting drugs does not destabilize mood

58. A 17-year-old with severe obesity and autism has sensory food aversions and limited communication. What is the best approach?

- A.** Use the same counseling script used for every adolescent regardless of neurodevelopment, within an individualized obesity treatment plan
- B.** Remove all preferred foods abruptly to force dietary flexibility, given the patient factors described above, given the clinical details provided
- C.** Individualize treatment with caregiver input, sensory-aware nutrition strategies, predictable routines, and appropriate multidisciplinary support
- D.** Exclude caregivers from planning because autonomy requires no assistance, as a relevant consideration in this case
- E.** Assume obesity treatment cannot be offered in neurodevelopmental disorders, when considered with the rest of the presentation

59. Which statement best explains why obesity often requires long-term treatment?

- A.** Long-term treatment is unnecessary once BMI falls below 30, given the patient factors described above
- B.** The disease is caused by a single reversible behavior in most patients, in the clinical setting described
- C.** Adipose tissue disappears permanently after any short-term diet, as a relevant consideration in this case
- D.** Metabolic adaptation always causes progressive weight loss after dieting, when considered with the rest of the presentation
- E.** Homeostatic and environmental pressures that promote weight regain persist even after successful weight reduction

60. A family wants to increase physical activity, but their neighborhood has no safe outdoor space. Which intervention best addresses the barrier?

- A.** Set a step goal without discussing where activity can occur, in the clinical setting described
- B.** Tell the family that neighborhood safety is outside clinical care, as a relevant consideration in this case
- C.** Recommend unsupervised outdoor exercise despite safety concerns, when considered with the rest of the presentation
- D.** Identify safe, affordable alternatives such as school, community-center, or indoor activity options
- E.** Delay treatment until the family moves to another neighborhood, given the patient factors described above

61. A 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.** Pramlintide, as a relevant consideration in this case, when considered with the rest of the presentation
- B.** Orforglipron, when considered with the rest of the presentation, when interpreted with the full presentation
- C.** Exenatide, within an individualized obesity treatment plan, within the treatment context described
- D.** Bremelanotide, given the patient factors described above, in the clinical setting described
- E.** Setmelanotide, in the clinical setting described, as a relevant consideration in this case

62. A patient has obesity with BMI 36 kg/m² but is hesitant about surgery and cannot afford the preferred medication. What is the best next step?

- A.** Delay all care until the preferred medication becomes affordable, when considered with the rest of the presentation
- B.** Use unregulated supplements as a substitute for evidence-based treatment, within an individualized obesity treatment plan

- C.** Prescribe the unaffordable medication and assume adherence, given the patient factors described above
- D.** Insist on surgery because medication access is limited, in the clinical setting described, as a relevant consideration in this case
- E.** Create the most effective feasible plan now while addressing coverage, alternatives, and future treatment escalation

63. A 24-year-old with lifelong severe obesity and hyperphagia is found to have a heterozygous MC4R variant. Which statement is most accurate?

- A.** MC4R deficiency is characterized primarily by progressive weight loss, within an individualized obesity treatment plan
- B.** All MC4R variants automatically qualify for setmelanotide treatment, given the patient factors described above
- C.** MC4R variants cause obesity only when accompanied by adrenal insufficiency, in the clinical context described
- D.** MC4R pathway defects are a recognized monogenic cause of early-onset obesity and hyperphagia
- E.** A genetic cause excludes any benefit from lifestyle or medical treatment, when interpreted with the full presentation

64. 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, given the patient factors described above
- B.** Avoid pharmacotherapy because language differences prevent shared decisions, in the clinical context described
- C.** Rely on a minor family member to interpret complex medical information, as a consideration for this patient
- D.** Provide only written English instructions and assume they are sufficient, when interpreted with the full presentation

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

65. What supplement counseling is appropriate for a patient taking orlistat long term?

A. Use a multivitamin containing fat-soluble vitamins separated in time from the medication, in the clinical context described

B. Avoid all vitamins because orlistat increases vitamin absorption, as a relevant consideration in this case

C. Take the multivitamin with every orlistat dose to maximize binding, when considered with the rest of the presentation

D. Take only vitamin C because fat-soluble vitamins are unaffected, within an individualized obesity treatment plan

E. Supplement iron only because vitamins A, D, E, and K are not affected, given the clinical details provided

66. A 62-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. Phentermine used as short-term sympathomimetic therapy, as a relevant consideration in this case

B. Orlistat used as a gastrointestinal lipase inhibitor, when considered with the rest of the presentation

C. Naltrexone-bupropion used for chronic weight management, within an individualized obesity treatment plan

D. Semaglutide for chronic weight management, given the patient factors described above

E. Phentermine-topiramate extended release used for chronic treatment, in the clinical context described

67. A 31-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. What is the most likely diagnosis?

- A.** Anorexia nervosa with persistent energy restriction, when considered with the rest of the presentation
- B.** Bulimia nervosa with recurrent compensatory behaviors, within an individualized obesity treatment plan
- C.** Avoidant restrictive food intake disorder with low intake, given the clinical details provided
- D.** Night eating syndrome limited to evening hyperphagia, in the clinical setting described
- E.** Binge-eating disorder, as a relevant consideration in this case, as a consideration for this patient

68. A 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.** Macronutrient composition is irrelevant to health or preference, within an individualized obesity treatment plan
- B.** All carbohydrate-containing foods should be avoided during weight treatment, given the patient factors described above
- C.** Low-fat diets are the only evidence-based approach to obesity, in the clinical setting described
- D.** Either can be effective; long-term results depend largely on energy deficit, adherence, and individual metabolic needs
- E.** Low-carbohydrate diets cause greater long-term loss in every patient, when considered with the rest of the presentation

69. A patient with obesity and knee osteoarthritis wants to avoid surgery. Which intervention can improve both obesity and joint symptoms?

- A.** Rapid dehydration to reduce scale weight before activity, given the patient factors described above
- B.** High-impact running despite severe pain, in the clinical setting described, as a relevant consideration in this case
- C.** Weight gain to increase cushioning around the knee joint, as a relevant consideration in this case
- D.** Clinically meaningful weight reduction combined with appropriate strengthening and low-impact activity

E. Complete avoidance of movement to prevent cartilage wear, within an individualized obesity treatment plan

70. A patient with obesity takes antiretroviral therapy and has experienced weight gain. What is the best approach?

A. Assume HIV medications never influence body weight, in the clinical setting described, as a relevant consideration in this case

B. Stop antiretroviral therapy because weight loss has greater priority, as a relevant consideration in this case, as a consideration for this patient

C. Avoid obesity pharmacotherapy in every person living with HIV, when considered with the rest of the presentation

D. Change the regimen without considering resistance history or virologic control, within an individualized obesity treatment plan

E. Review the regimen with the HIV clinician, consider medication effects and alternatives, and treat obesity without jeopardizing viral suppression

71. A 13-year-old with severe obesity asks which medications have established adolescent obesity indications. Which option is an example?

A. A compounded stimulant mixture with no approved indication, as a consideration for this patient

B. Chronic high-dose pseudoephedrine, when considered with the rest of the presentation

C. Semaglutide used for chronic weight management, within an individualized obesity treatment plan

D. A monoamine oxidase inhibitor used solely for appetite suppression, given the clinical details provided

E. An unregulated thyroid hormone supplement, in the clinical setting described

72. Which patient may reasonably be considered for metabolic surgery at BMI 30-34.9 kg/m²?

A. A patient with BMI 29 kg/m² requesting surgery without clinical evaluation, when considered with the rest of the presentation

- B.** A patient with metabolic disease who has not achieved adequate durable benefit with nonsurgical treatment
- C.** A patient with BMI 27 kg/m² whose only goal is faster athletic performance, given the patient factors described above
- D.** A healthy patient with BMI 22 kg/m² who wants preventive surgery, in the clinical setting described
- E.** A patient with BMI 25 kg/m² and no obesity-related disease, as a relevant consideration in this case

73. A 9-year-old has a BMI at the 96th percentile for age and sex. What is the appropriate classification?

- A.** Obesity, within an individualized obesity treatment plan, given the patient factors described above
- B.** Underweight because percentiles cannot be used for BMI, given the patient factors described above
- C.** Overweight only because pediatric obesity begins at the 99th percentile, in the clinical context described
- D.** Healthy weight because the BMI is below an adult threshold of 30, as a consideration for this patient
- E.** Severe obesity automatically at any value above the 95th percentile, when interpreted with the full presentation

74. A patient has reached a stable weight but cardiometabolic complications continue to improve. How should treatment success be viewed?

- A.** Cardiometabolic improvement cannot occur after weight plateaus, given the patient factors described above
- B.** Treatment should be withdrawn until weight begins rising again, in the clinical setting described
- C.** A stable scale weight means treatment has stopped working, as a relevant consideration in this case
- D.** Health benefits can continue even without further scale loss, so maintenance and complication management remain important

E. Further weight loss is mandatory regardless of health status, within an individualized obesity treatment plan

75. What is the most important long-term follow-up principle after metabolic bariatric surgery?

A. Avoid pharmacotherapy if weight recurrence later develops, in the clinical setting described

B. Stop vitamin supplementation after weight stabilizes, as a relevant consideration in this case

C. Monitor only body weight because laboratory testing is unnecessary, when considered with the rest of the presentation

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

76. A 15-year-old with obesity has severe depression that is currently unstable. How should obesity treatment be tailored?

A. Use maximal dietary restriction because depression reduces adherence, as a relevant consideration in this case

B. Select medication only by expected weight loss without psychiatric review, when considered with the rest of the presentation

C. Coordinate obesity care with urgent mental-health treatment and choose interventions that protect safety and avoid worsening eating pathology

D. Postpone all medical care until body weight reaches an adult threshold, given the patient factors described above

E. Ignore mood symptoms because weight treatment is independent of mental health, in the clinical setting described

77. Which factor best illustrates the multifactorial pathogenesis of obesity?

A. Excess calories alone without any biologic regulation of appetite, when considered with the rest of the presentation

- B.** One endocrine disorder that explains nearly every case of obesity, within an individualized obesity treatment plan
- C.** A fixed personality trait that is unaffected by environment or treatment, given the patient factors described above
- D.** A single universal defect in motivation shared by all affected individuals, in the clinical setting described
- E.** Genetic susceptibility interacting with neuroendocrine regulation, medications, environment, behavior, and social determinants

78. A woman becomes pregnant 5 months after sleeve gastrectomy. Which concern is most important?

- A.** Pregnancy eliminates the need for surgical follow-up, within an individualized obesity treatment plan, within the treatment context described
- B.** All vitamin supplementation should stop during pregnancy, given the patient factors described above, given the clinical details provided
- C.** Pregnancy always reverses the anatomic effects of sleeve gastrectomy, in the clinical setting described, in the clinical context described
- D.** Pregnancy soon after surgery occurs during rapid weight loss and may increase nutritional risk, so close obstetric and bariatric follow-up is needed
- E.** Rapid postoperative weight loss has no relevance to fetal nutrition, when considered with the rest of the presentation

79. A patient with obesity and chronic kidney disease has albuminuria and high cardiovascular risk. What is the best general treatment concept?

- A.** Treat obesity only after kidney disease reaches end-stage, given the patient factors described above, given the clinical details provided
- B.** Assume kidney disease makes nutrition therapy impossible, in the clinical setting described, as a relevant consideration in this case
- C.** Use a single weight target as the only measure of renal improvement, as a relevant consideration in this case
- D.** Ignore blood pressure and diabetes while pursuing weight loss, when considered with the rest of the presentation

E. Manage kidney and cardiovascular risk factors while treating obesity because weight reduction can improve multiple interacting conditions

80. A 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. Simple dietary indiscretion that can always be observed at home, in the clinical context described

B. Functional constipation as the only late surgical complication, as a consideration for this patient

C. Internal hernia with intermittent small-bowel obstruction, when interpreted with the full presentation

D. Peptic symptoms that exclude an anatomic emergency, within an individualized obesity treatment plan

E. Lactose intolerance that requires no urgent evaluation, given the patient factors described above

81. Which statement about meal replacements is most accurate?

A. They are inherently unsafe and should never be used in obesity treatment, as a relevant consideration in this case

B. They permanently reset appetite regulation after several weeks, when considered with the rest of the presentation

C. They eliminate the need to learn long-term eating strategies, within an individualized obesity treatment plan

D. Structured meal replacements can help some patients reduce decision burden and calorie intake when incorporated into a comprehensive plan

E. They are effective only when consumed in addition to usual meals, in the clinical setting described, in the clinical context described

82. A patient asks how to interpret a nutrition label for weight management. Which comparison is most useful?

A. Avoid any food containing more than one ingredient, when considered with the rest of the presentation

- B.** Compare serving size, calories, protein, fiber, added sugars, and saturated fat in the context of the whole diet
- C.** Choose foods solely by whether they are labeled natural, given the patient factors described above
- D.** Use only the front-of-package marketing claim, in the clinical setting described, as a relevant consideration in this case
- E.** Ignore serving size because calories are listed for the whole package, as a relevant consideration in this case

83. Which neuropsychiatric history is particularly relevant before using a sympathomimetic anti-obesity medication?

- A.** Seasonal allergy symptoms controlled with saline irrigation, within the treatment context described
- B.** History of uncomplicated myopia corrected with glasses, given the patient factors described above
- C.** Remote appendectomy without postoperative complications, in the clinical setting described
- D.** Anxiety, insomnia, substance-use history, and symptoms of mood activation, as a consideration for this patient
- E.** Preference for savory rather than sweet foods, when considered with the rest of the presentation

84. 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, given the patient factors described above
- B.** Use family-based goals that change the home environment without singling out or shaming the child
- C.** Use food deprivation as punishment for missed activity goals, as a relevant consideration in this case
- D.** Make the child eat separate diet food while the family eats normally, when considered with the rest of the presentation

E. Require public weigh-ins at home to increase accountability, within an individualized obesity treatment plan

85. A 70-year-old with obesity and osteoarthritis wants to exercise but fears injury. What is the best recommendation?

A. Begin with low-impact aerobic activity plus progressive strength and balance work tailored to function and pain

B. Avoid exercise because older age and osteoarthritis are absolute contraindications, as a relevant consideration in this case

C. Use high-impact jumping first to strengthen joints rapidly, when considered with the rest of the presentation

D. Perform only passive stretching because strength training is unsafe, within an individualized obesity treatment plan

E. Wait for normal BMI before beginning any physical activity, given the patient factors described above

86. A 4-year-old has severe obesity beginning in infancy and relentless hyperphagia. Several relatives have similar early-onset obesity. What is the best next step?

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

B. Use a restrictive diet without assessing developmental or genetic features, when interpreted with the full presentation

C. Assume the pattern is entirely behavioral because appetite is increased, within the treatment context described

D. Diagnose Cushing syndrome solely from the severity of obesity, given the patient factors described above

E. Wait until adulthood because genetic testing does not affect pediatric care, in the clinical context described

87. A patient with type 2 diabetes has progressive weight gain after escalation of glucose-lowering therapy. Which medication class is most likely contributing?

- A.** Glucagon-like peptide 1 receptor agonist therapy, when considered with the rest of the presentation
- B.** Insulin therapy, within an individualized obesity treatment plan, within the treatment context described
- C.** Sodium-glucose cotransporter 2 inhibitor therapy, given the patient factors described above
- D.** Dual GIP and GLP-1 receptor agonist therapy, in the clinical setting described
- E.** Metformin therapy used as background treatment, as a relevant consideration in this case

88. A 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.** Stop all oral intake until the medication reaches steady state, within an individualized obesity treatment plan
- B.** Slow or pause dose escalation, reinforce smaller lower-fat meals and hydration, and reassess tolerability
- C.** Ignore persistent vomiting because dehydration is not a concern, in the clinical setting described
- D.** Add another GLP-1 receptor agonist to improve gastrointestinal tolerance, as a relevant consideration in this case
- E.** Escalate immediately to the maximum dose to shorten the nausea period, when considered with the rest of the presentation

89. A patient has proximal muscle weakness, easy bruising, wide violaceous striae, hypertension, and rapid central weight gain. Which secondary cause should be evaluated?

- A.** Primary hypothyroidism as the typical cause of violaceous striae, given the clinical details provided
- B.** Growth hormone deficiency established by a random level, in the clinical setting described
- C.** Cushing syndrome, as a relevant consideration in this case, when considered with the rest of the presentation
- D.** Simple obesity without endocrine evaluation despite discriminatory features, when interpreted with the full presentation

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

90. A patient with polycystic ovary syndrome, obesity, and infertility wants to conceive. Which treatment focus is most appropriate?

A. Use a very-low-calorie diet during early pregnancy to improve insulin resistance, in the clinical setting described

B. Delay all metabolic treatment because fertility is unrelated to obesity, as a relevant consideration in this case

C. Use anti-obesity medication throughout pregnancy to maintain ovulation, when considered with the rest of the presentation

D. Improve metabolic health and weight before conception while coordinating fertility care and avoiding pregnancy-contraindicated weight-loss drugs

E. Prescribe androgen therapy to promote ovulation, given the patient factors described above, in the clinical setting described

91. A patient has lost substantial weight and asks how much activity may help prevent regain. Which counseling point is most accurate?

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

B. Maintenance requires less activity than during sedentary baseline, when considered with the rest of the presentation

C. Once weight is lost, physical activity has no role in preventing regain, within an individualized obesity treatment plan

D. Only vigorous exercise affects long-term weight maintenance, given the patient factors described above, given the clinical details provided

E. Exactly 60 minutes per week is sufficient for all long-term maintenance, in the clinical setting described, in the clinical context described

92. A patient with obesity reports worsening knee pain when climbing stairs and reduced walking tolerance. Which complication category is most likely contributing?

- A.** Inflammatory arthritis that is always independent of body weight, when interpreted with the full presentation
- B.** Peripheral neuropathy caused solely by vitamin C deficiency, within the treatment context described
- C.** Biomechanical osteoarthritis related to excess joint loading, given the clinical details provided
- D.** Septic arthritis occurring only with high body mass index, in the clinical context described
- E.** Autoimmune myositis causing proximal muscle inflammation, as a relevant consideration in this case

93. A patient receiving chronic opioid therapy for severe pain asks about naltrexone-bupropion. What is the key concern?

- A.** The medication is preferred because it prevents all opioid adverse effects, within an individualized obesity treatment plan
- B.** Naltrexone can block opioid analgesia and precipitate withdrawal, so the combination is inappropriate during ongoing opioid use
- C.** Naltrexone increases the analgesic effect of opioid agonists, in the clinical setting described, as a relevant consideration in this case
- D.** Chronic opioid use is irrelevant to selection of this medication, as a relevant consideration in this case
- E.** Bupropion causes universal opioid toxicity when the drugs are combined, when considered with the rest of the presentation

94. A patient with obesity and knee osteoarthritis asks whether the joint disease is related to weight. Which statement is most accurate?

- A.** Excess weight increases mechanical loading and inflammatory burden, and weight reduction can improve symptoms
- B.** Only underweight is associated with progression of knee osteoarthritis, in the clinical setting described
- C.** Osteoarthritis is unrelated to body weight once cartilage damage begins, as a relevant consideration in this case

D. Weight reduction worsens knee symptoms by reducing joint cushioning, when considered with the rest of the presentation

E. Exercise should be avoided because movement invariably accelerates cartilage loss, within an individualized obesity treatment plan

95. A muscular competitive athlete has BMI 31 kg/m² 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, in the clinical setting described

B. BMI may overestimate adiposity in very muscular individuals, so body composition and clinical risk should be considered

C. BMI proves excess adiposity regardless of body composition, when considered with the rest of the presentation

D. Waist circumference is never useful when BMI exceeds 30, within an individualized obesity treatment plan

E. Obesity can be diagnosed only by dual-energy x-ray absorptiometry, given the patient factors described above

96. A patient drinks three 20-ounce sugar-sweetened beverages daily. Which change is most likely to reduce energy intake without reducing solid-food portions?

A. Replace the beverages with water or other noncaloric drinks, as a relevant consideration in this case

B. Add fruit juice because naturally occurring sugar does not contribute calories

C. Drink the beverages only with meals while keeping the same volume, within the treatment context described

D. Switch to a beverage with the same sugar content but a different flavor, given the clinical details provided

E. Add a snack before each beverage to slow absorption, in the clinical setting described

97. A postmenopausal woman with obesity is losing weight and has osteoporosis risk. Which modification is most appropriate?

- A.** Restrict calcium and vitamin D to accelerate fat loss, when considered with the rest of the presentation
- B.** Avoid resistance exercise because it increases fracture risk in all patients, within an individualized obesity treatment plan
- C.** Prefer rapid unsupervised weight loss to reduce skeletal loading, given the patient factors described above
- D.** Include resistance and weight-bearing activity, adequate protein and bone nutrients, and monitor skeletal health
- E.** Use weight loss alone because bone health is unrelated to obesity treatment, as a relevant consideration in this case

98. A 14-year-old boy with severe obesity snores loudly, has witnessed apneas, morning headaches, and daytime sleepiness. What is the most appropriate next step?

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

99. A pregnant patient with obesity asks for a weight-loss prescription because she is gaining more weight than expected. What is the best response?

- A.** Focus on appropriate gestational weight gain, nutrition, activity, and obstetric risk management rather than intentional pharmacologic weight loss
- B.** Use phentermine because fetal risk is limited to late pregnancy, in the clinical setting described, in the clinical context described
- C.** Advise fasting until prepregnancy weight is restored, as a relevant consideration in this case, when considered with the rest of the presentation
- D.** Recommend a very-low-calorie diet to produce net weight loss, when considered with the rest of the presentation

E. Start a chronic obesity medication because pregnancy increases treatment urgency, within an individualized obesity treatment plan

100. A patient with obesity and idiopathic intracranial hypertension is losing vision despite therapy. How does weight management fit into care?

A. Use stimulants instead of addressing intracranial pressure, in the clinical setting described, as a relevant consideration in this case

B. Only cosmetic weight loss is relevant once papilledema occurs, as a relevant consideration in this case

C. Delay weight treatment until vision has already stabilized, when considered with the rest of the presentation

D. Weight has no relationship to intracranial pressure, within an individualized obesity treatment plan, within the treatment context described

E. Substantial weight reduction is disease-modifying and should be pursued urgently alongside neuro-ophthalmologic management

101. An Asian adult with metabolic disease has BMI 28 kg/m². Which modern surgery guidance is relevant?

A. Surgery is never considered below BMI 40 kg/m² in Asian adults, as a relevant consideration in this case

B. BMI thresholds are identical because body composition differences have no effect, when considered with the rest of the presentation

C. Lower BMI thresholds are used in Asian populations, and metabolic surgery may be considered from BMI about 27.5 kg/m²

D. Metabolic disease is irrelevant when BMI is below 35 kg/m², given the patient factors described above

E. Asian ancestry requires a higher BMI threshold than other populations, in the clinical setting described

102. A patient with obesity has depression, food insecurity, knee pain, and uncontrolled diabetes. What is the best plan?

- A.** Treat one problem at a time and postpone obesity care for years, when considered with the rest of the presentation
- B.** Require vigorous exercise despite untreated knee pain, within an individualized obesity treatment plan
- C.** Address only calorie intake because other problems are unrelated, given the patient factors described above
- D.** Build a multidisciplinary plan that addresses medical, psychological, functional, and social barriers in parallel
- E.** Use medication without assessing food access or mental health, as a relevant consideration in this case

103. Which factor should most directly guide selection among effective obesity medications?

- A.** Choosing solely by the lowest monthly price regardless of efficacy, within an individualized obesity treatment plan
- B.** Avoiding shared decision-making because it slows treatment, given the patient factors described above, given the clinical details provided
- C.** Using the same medication first for every patient, in the clinical setting described, as a relevant consideration in this case
- D.** Selecting the drug with the most advertising exposure, as a relevant consideration in this case, when considered with the rest of the presentation
- E.** Expected benefit for the patient's goals and comorbidities balanced against contraindications, adverse effects, cost, access, and preference

104. A patient with obesity drinks six alcoholic beverages nightly and wants a medication for weight loss. What is the best next step?

- A.** Recommend abrupt alcohol cessation without assessing withdrawal risk, given the patient factors described above
- B.** Assess alcohol use disorder and withdrawal risk and integrate treatment before selecting pharmacotherapy
- C.** Choose treatment solely from the patient's current body mass index, as a relevant consideration in this case

D. Ignore alcohol because beverage calories are the only relevant issue, when considered with the rest of the presentation

E. Start naltrexone-bupropion without clarifying alcohol use or seizure risk, within an individualized obesity treatment plan

105. 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, in the clinical setting described

B. Isolated white-coat hypertension proven without out-of-office data

C. A measurement artifact that can be ignored if the patient is asymptomatic

D. Normal blood pressure because obesity raises the diagnostic threshold

E. Hypertension requiring cardiovascular risk assessment and treatment

106. A 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, as a relevant consideration in this case

B. Avoid protein because it may slow the rate of weight loss, when considered with the rest of the presentation

C. Prioritize large high-volume meals to stretch the gastric pouch, within an individualized obesity treatment plan

D. Use small frequent intake with attention to protein, hydration, and prescribed vitamin-mineral supplementation

E. Drink most fluids with meals to maximize fullness, in the clinical setting described, as a relevant consideration in this case

107. 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, when interpreted with the full presentation
- B.** A family history of obesity in both biological parents, within an individualized obesity treatment plan
- C.** Increased appetite during a recent school sports season, given the patient factors described above
- D.** Preference for energy-dense snacks after afternoon classes, in the clinical setting described
- E.** Gradual weight gain while height continues along the same percentile, as a consideration for this patient

108. When is a very-low-calorie diet most appropriate?

- A.** During pregnancy to minimize gestational weight gain, within an individualized obesity treatment plan
- B.** In selected patients under close medical supervision with monitoring for contraindications, medications, and nutrient needs
- C.** For children without specialist oversight because growth is unaffected, in the clinical setting described
- D.** As an unsupervised first-line plan for every person with overweight, as a relevant consideration in this case
- E.** In any patient with an active eating disorder to enforce structure, when considered with the rest of the presentation

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

110. A 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.** Diabetic ketoacidosis caused by carbohydrate intake, in the clinical setting described
- B.** Fasting hypoglycemia that excludes a relationship to surgery, as a consideration for this patient
- C.** Reactive hypertension caused by rapid gastric emptying, when considered with the rest of the presentation
- D.** Postbariatric hypoglycemia, within an individualized obesity treatment plan, within the treatment context described
- E.** Early dumping syndrome occurring within minutes of eating, given the clinical details provided

111. A patient with obesity has active binge-eating disorder. Which treatment approach is most appropriate?

- A.** Treat the eating disorder concurrently and avoid overly restrictive strategies that may worsen binge-restrict cycles
- B.** Require daily punitive exercise after each episode, when considered with the rest of the presentation
- C.** Use fasting as the first-line intervention to suppress binge episodes, within an individualized obesity treatment plan
- D.** Ignore binge eating because weight loss alone will resolve it, given the patient factors described above
- E.** Delay psychiatric care until a target BMI is reached, in the clinical setting described, as a relevant consideration in this case

112. A woman with obesity has oligomenorrhea, biochemical hyperandrogenism, and polycystic ovaries after exclusion of mimicking disorders. What is the most likely diagnosis?

- A.** Functional hypothalamic amenorrhea from energy deficiency, when interpreted with the full presentation
- B.** Polycystic ovary syndrome, within an individualized obesity treatment plan, within the treatment context described

- C. Premature ovarian insufficiency with low ovarian reserve, given the patient factors described above
- D. Congenital adrenal hyperplasia assumed without testing, in the clinical setting described
- E. Hyperprolactinemia established without measuring prolactin, as a consideration for this patient

113. A patient gained 11 kg during the year after starting treatment for schizophrenia. Which medication is most strongly associated with clinically important weight gain?

- A. Olanzapine, within an individualized obesity treatment plan, within the treatment context described
- B. Haloperidol used intermittently for acute agitation, given the patient factors described above
- C. Lurasidone taken with the required food intake, in the clinical setting described
- D. Aripiprazole used at a low maintenance dose, as a relevant consideration in this case
- E. Ziprasidone with routine metabolic monitoring, when considered with the rest of the presentation

114. Which clinical pattern most strongly suggests a syndromic rather than common polygenic form of obesity?

- A. Gradual adult weight gain during sedentary employment, given the patient factors described above
- B. Weight gain after starting a glucocorticoid medication, in the clinical setting described
- C. Early severe obesity plus hyperphagia with developmental, sensory, renal, or dysmorphic abnormalities
- D. Postpartum weight retention after a high gestational gain, when considered with the rest of the presentation
- E. Central adiposity with family history of type 2 diabetes, within an individualized obesity treatment plan

115. A patient with obesity and severe knee osteoarthritis cannot tolerate prolonged walking. What is the best treatment modification?

- A.** Avoid all exercise because osteoarthritis always worsens with movement, in the clinical setting described
- B.** Use low-impact activity, resistance exercise, pain management, and other obesity therapies rather than abandoning treatment
- C.** Delay weight treatment until joint replacement has occurred, when considered with the rest of the presentation
- D.** Use only dietary restriction and ignore functional rehabilitation, within an individualized obesity treatment plan
- E.** Require running because walking intolerance reflects insufficient effort, given the patient factors described above

116. A patient with obesity and chronic venous insufficiency has leg edema and limited mobility. What is the best integrated plan?

- A.** Delay obesity care until venous symptoms disappear permanently, as a relevant consideration in this case
- B.** Use diuretics solely to achieve a lower target body weight, when considered with the rest of the presentation
- C.** Assume all measured weight is adipose tissue and ignore fluid status, within an individualized obesity treatment plan
- D.** Avoid activity completely because edema makes movement unsafe, given the patient factors described above
- E.** Treat venous disease and edema while using feasible weight reduction and adapted physical activity to improve function

117. Why is waist circumference clinically useful in many adults with overweight or obesity?

- A.** It provides information about central adiposity and cardiometabolic risk beyond BMI alone
- B.** It directly measures total body fat percentage with laboratory precision, within the treatment context described
- C.** It is unaffected by measurement technique or body habitus, given the patient factors described above

- D.** It replaces the need to assess blood pressure and metabolic risk, in the clinical setting described
- E.** It determines the exact amount of visceral fat in kilograms, as a relevant consideration in this case

118. A patient with obesity and metabolic dysfunction-associated steatohepatitis with fibrosis wants weight treatment. Which principle is most appropriate?

- A.** Treat only aminotransferase values and ignore adiposity, within an individualized obesity treatment plan, within the treatment context described
- B.** Avoid weight loss because it accelerates progression to cirrhosis, given the patient factors described above
- C.** Prioritize substantial sustained weight reduction and therapies with evidence for liver benefit while continuing fibrosis risk assessment
- D.** Use alcohol to raise HDL cholesterol and reduce liver fat, as a relevant consideration in this case, as a consideration for this patient
- E.** Assume normal bilirubin excludes clinically important fibrosis, when considered with the rest of the presentation

119. A patient with obesity is a cancer survivor taking a therapy associated with weight gain. What is the best obesity-medicine strategy?

- A.** Stop anticancer therapy solely because it promotes weight gain, given the patient factors described above, given the clinical details provided
- B.** Avoid resistance exercise because cancer survivors should not build muscle, in the clinical setting described, in the clinical context described
- C.** Use unregulated supplements to counter medication effects, as a relevant consideration in this case, as a consideration for this patient
- D.** Ignore obesity until all cancer follow-up has ended, when considered with the rest of the presentation, when interpreted with the full presentation
- E.** Coordinate with oncology, account for treatment effects and body-composition risk, and individualize nutrition, activity, and medication choices

120. Which clinic change most directly reduces weight stigma and improves access for patients with obesity?

- A.** Require weighing in public areas to normalize discussion, in the clinical setting described, as a relevant consideration in this case
- B.** Provide appropriately sized chairs, examination tables, gowns, and blood-pressure cuffs with privacy and respectful language
- C.** Use small equipment so patients are reminded to lose weight, when considered with the rest of the presentation
- D.** Avoid asking permission before discussing weight because consent is unnecessary, within an individualized obesity treatment plan
- E.** Use stigmatizing terminology to emphasize disease severity, given the patient factors described above, given the clinical details provided

121. Which activity best supports ongoing competence in obesity medicine?

- A.** Regular continuing education and review of current peer-reviewed evidence, guidelines, safety communications, and clinical outcomes
- B.** Using patient testimonials as the main source of therapeutic evidence, when considered with the rest of the presentation
- C.** Avoiding outcome review because it may reveal practice variation, within an individualized obesity treatment plan
- D.** Selecting treatments primarily from promotional materials, given the patient factors described above
- E.** Relying only on knowledge acquired during residency, in the clinical setting described, as a relevant consideration in this case

122. A 58-year-old man with obesity asks whether losing only 6% of body weight is worthwhile. What is the best answer?

- A.** Only normalization of BMI produces clinically relevant benefit, when considered with the rest of the presentation
- B.** Modest sustained weight loss can meaningfully improve glycemia, blood pressure, lipids, and other risk factors

- C. Weight loss below 10% has no measurable metabolic effect, given the patient factors described above
- D. Small losses worsen metabolic risk by reducing lean mass inevitably, in the clinical setting described
- E. Health benefits generally begin only after at least 25% weight loss, as a relevant consideration in this case

123. A 42-year-old man with BMI 48 kg/m² has daytime somnolence, resting oxygen saturation 90%, and elevated serum bicarbonate. Which diagnosis is most concerning?

- A. Panic disorder causing persistent bicarbonate elevation, within an individualized obesity treatment plan
- B. Isolated obstructive sleep apnea that cannot coexist with hypoventilation, given the clinical details provided
- C. Obesity hypoventilation syndrome with chronic daytime hypercapnia, in the clinical context described
- D. Exercise-induced bronchospasm limited to vigorous activity, as a consideration for this patient
- E. Simple deconditioning without ventilatory impairment, when considered with the rest of the presentation

124. 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, given the patient factors described above
- B. Use insulin secretagogues first solely because they are inexpensive, in the clinical setting described
- C. Prioritize glucose-lowering therapies that also promote meaningful weight reduction, such as semaglutide or tirzepatide
- D. Avoid treating obesity until the A1C is normal, when considered with the rest of the presentation, when interpreted with the full presentation
- E. Prefer medications that promote weight gain because glycemia is the only target, within an individualized obesity treatment plan

125. A 14-year-old with obesity has not improved sufficiently with intensive family-based treatment and has no contraindications. Which statement is most accurate?

- A.** All obesity medications are prohibited until age 21, in the clinical setting described, as a relevant consideration in this case
- B.** Adolescents should receive adult medications without attention to age-specific approval, as a relevant consideration in this case
- C.** Pharmacotherapy is considered only after bariatric surgery has failed, when considered with the rest of the presentation
- D.** Medication should replace family-based lifestyle treatment entirely, within an individualized obesity treatment plan
- E.** Evidence-based obesity pharmacotherapy can be offered as an adjunct to lifestyle treatment in appropriately selected adolescents

126. A patient with BMI 42 kg/m², type 2 diabetes, OSA, and prior unsuccessful lifestyle-only attempts wants the most effective plan. Which approach is best?

- A.** Withhold pharmacotherapy until surgery has been attempted, as a relevant consideration in this case
- B.** Discuss combined evidence-based options, including intensive lifestyle treatment, pharmacotherapy, and metabolic surgery
- C.** Choose treatment only by BMI and ignore diabetes or OSA, within an individualized obesity treatment plan
- D.** Require a fixed sequence of treatments regardless of patient preference, given the patient factors described above
- E.** Repeat brief lifestyle advice alone indefinitely because escalation is inappropriate, in the clinical setting described

127. A 16-year-old has severe obesity with type 2 diabetes and obstructive sleep apnea despite intensive treatment. Which statement is most accurate?

- A.** Metabolic surgery is never considered before age 25, when considered with the rest of the presentation

- B.** Severe comorbidities should not influence pediatric surgical referral, within an individualized obesity treatment plan
- C.** Adolescents must first fail every available obesity medication indefinitely, given the patient factors described above
- D.** Referral to an experienced pediatric metabolic-bariatric surgery center is appropriate for evaluation
- E.** Pubertal status alone makes surgery contraindicated, as a relevant consideration in this case

128. A clinician hears a colleague describe a patient as "lazy and noncompliant because of her weight." What is the most appropriate response?

- A.** Document the label in the medical record to improve continuity, within an individualized obesity treatment plan
- B.** Agree because body size reliably measures motivation, given the patient factors described above, in the clinical setting described
- C.** Challenge the stigmatizing assumption and reframe obesity as a chronic multifactorial disease with barriers that should be assessed
- D.** Withhold treatment until the patient demonstrates stronger willpower, as a relevant consideration in this case
- E.** Avoid intervening because bias has no effect on care, when considered with the rest of the presentation

129. Which factor is most important when evaluating an adolescent for metabolic bariatric surgery?

- A.** Using body weight alone without assessing complications or maturity, given the patient factors described above
- B.** Ability of the patient and family to participate in long-term nutritional, medical, and behavioral follow-up
- C.** Avoiding family involvement because surgery is an individual decision only, as a relevant consideration in this case
- D.** Requiring the adolescent to reach a specific adult age regardless of disease severity, when interpreted with the full presentation

E. Excluding all patients with treated mental-health conditions, within an individualized obesity treatment plan

130. 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, in the clinical setting described

B. Use only the patient's estimate of daily calorie intake, as a relevant consideration in this case

C. Exclude snacks because they are too variable to interpret, when considered with the rest of the presentation

D. Ask only about foods the patient already considers unhealthy, within an individualized obesity treatment plan

E. Use more than one method, such as a 24-hour recall plus questions about weekends and usual patterns

131. A patient maintains a 12% weight loss for two years on medication and lifestyle treatment. What is the best long-term strategy?

A. Reduce follow-up to none because maintenance is automatic, as a relevant consideration in this case

B. Continue effective treatment and periodic monitoring while adjusting only for goals, tolerability, safety, or preference

C. Discontinue medication solely because the current weight is lower, within an individualized obesity treatment plan

D. Encourage intentional weight cycling to prevent metabolic adaptation, given the patient factors described above

E. Stop all treatment because two years indicates the disease is cured, in the clinical setting described

132. A patient with obesity and hypertension wants an eating pattern that also supports cardiovascular health. Which pattern is a reasonable option?

- A.** A liquid-sugar diet because beverages reduce sodium intake, when considered with the rest of the presentation
- B.** A plan emphasizing refined grains and processed meats, within an individualized obesity treatment plan
- C.** A calorie-reduced DASH-style pattern rich in vegetables, fruits, legumes, whole grains, and lean proteins
- D.** An all-meat diet that excludes plant foods indefinitely, in the clinical setting described
- E.** A high-sodium processed-food pattern with no calorie target, as a relevant consideration in this case

133. Two adults have the same BMI of 36 kg/m². One has no detected complications; the other has diabetes, OSA, and severe knee osteoarthritis. What is the best interpretation?

- A.** Only age can explain differences in obesity-related health risk, within an individualized obesity treatment plan
- B.** Both patients have identical disease severity because BMI is identical, given the clinical details provided
- C.** The patient without complications has more severe obesity by definition, in the clinical context described
- D.** The second patient has greater obesity-related disease burden despite the same BMI, as a consideration for this patient
- E.** Complications should be ignored when selecting treatment intensity, when interpreted with the full presentation

134. A 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, in the clinical setting described
- C.** Classical conditioning that cannot be modified cognitively, as a relevant consideration in this case

D. Accurate prediction that one dessert causes a week of fat gain, when interpreted with the full presentation

E. A normal physiologic response that requires no behavioral work, within the treatment context described

135. A patient gains substantial weight after beginning a new medication. What feature most strongly supports a medication-induced contribution?

A. A clear temporal relationship between drug initiation or dose escalation and the change in weight trajectory

B. Weight loss that began before the medication was prescribed, as a relevant consideration in this case

C. A stable weight trajectory for years after the medication was started, when considered with the rest of the presentation

D. A family history of obesity that excludes all medication effects, within an individualized obesity treatment plan

E. No change in appetite, fluid status, or activity over decades, given the patient factors described above

136. 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 29 kg/m² whose only concern is clothing size, as a consideration for this patient

B. An adult with BMI 24 kg/m² and no metabolic disease, when considered with the rest of the presentation

C. An adult with BMI 26 kg/m² who wants rapid cosmetic weight loss, within the treatment context described

D. An adult with BMI 28 kg/m² and no weight-related condition, given the clinical details provided

E. An adult with BMI above 35 kg/m² who is an appropriate surgical candidate, in the clinical context described

137. A 32-year-old woman with obesity reports irregular menses, infertility, and increased terminal facial hair. Which weight-related condition should be specifically explored?

- A.** Central diabetes insipidus causing polyuria and polydipsia
- B.** Polycystic ovary syndrome, within an individualized obesity treatment plan
- C.** Primary ovarian insufficiency causing low androgen levels
- D.** Addison disease causing weight loss and hyperpigmentation
- E.** Hyperparathyroidism causing nephrolithiasis and hypercalcemia

138. 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, within an individualized obesity treatment plan
- B.** Assume depression will resolve once 5% weight loss is achieved, given the patient factors described above
- C.** Avoid psychiatric history because it may stigmatize the patient, in the clinical setting described
- 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, when considered with the rest of the presentation

139. A patient with obesity and heart failure with preserved ejection fraction has severe exercise limitation. Which treatment emphasis is reasonable?

- A.** Judge success only by BMI without functional outcomes, given the patient factors described above, in the clinical setting described
- B.** Use an individualized obesity plan that improves weight, symptoms, function, and cardiovascular risk while respecting heart-failure status
- C.** Stop heart-failure therapy while pursuing weight reduction, as a relevant consideration in this case, as a consideration for this patient
- D.** Avoid obesity treatment because heart failure makes weight change unsafe, when considered with the rest of the presentation

E. Use high-dose sympathomimetics to improve exercise capacity, within an individualized obesity treatment plan

140. A 9-year-old with obesity and no severe complications is starting treatment. Which strategy is most appropriate?

A. Delay treatment until adolescence because younger children cannot change behavior, in the clinical setting described

B. Use shame-based counseling to increase personal responsibility, as a relevant consideration in this case

C. Set a rigid adult BMI target and ignore growth velocity, when considered with the rest of the presentation

D. Use family-centered intensive health behavior and lifestyle treatment adapted to the child's developmental stage

E. Prescribe an adult crash diet without caregiver involvement, given the patient factors described above

141. 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. Ignore hypoglycemia because obesity medications cannot affect glucose, as a relevant consideration in this case

B. Add a second sulfonylurea to prevent weight recurrence, when considered with the rest of the presentation

C. Stop all glucose monitoring once weight treatment begins, within an individualized obesity treatment plan

D. Increase the sulfonylurea because weight loss raises insulin resistance, given the patient factors described above

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

142. A 37-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.** Order every available pituitary and adrenal test in all patients with obesity, when interpreted with the full presentation
- B.** Delay obesity treatment until a rare endocrine disorder is excluded completely, within the treatment context described
- C.** Assume endocrine disease is the most common cause of adult obesity, given the patient factors described above
- D.** Refuse any laboratory evaluation because secondary causes never occur, in the clinical setting described
- E.** Use targeted testing guided by history and examination rather than broad endocrine screening

143. What is the preferred nutrition approach for a 10-year-old with obesity?

- A.** Using adult meal-replacement products without clinical supervision, within an individualized obesity treatment plan
- B.** Eliminating all dietary fat during growth and development, given the patient factors described above, given the clinical details provided
- C.** A family-based pattern emphasizing nutrient-dense foods, regular meals, and reduced sugar-sweetened beverages rather than a punitive restrictive diet
- D.** A separate very-low-calorie diet prepared only for the child, as a relevant consideration in this case, as a consideration for this patient
- E.** Skipping school lunch daily to accelerate weight loss, when considered with the rest of the presentation, when interpreted with the full presentation

144. 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.** Procedure choice matters because Roux-en-Y gastric bypass often improves reflux while sleeve gastrectomy may worsen it
- B.** Reflux should never influence obesity treatment selection, in the clinical setting described, as a relevant consideration in this case
- C.** Sleeve gastrectomy is always preferred for severe reflux, as a relevant consideration in this case, as a consideration for this patient

D. All bariatric operations have identical effects on reflux, when considered with the rest of the presentation

E. Endoscopic balloons are definitive surgical therapy for reflux, within an individualized obesity treatment plan

145. 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. Sleep should be addressed only after all nutrition goals are achieved, in the clinical setting described

B. Short sleep reliably increases resting energy expenditure enough to cause weight loss, as a consideration for this patient

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

D. Only sleep duration on weekends has clinical relevance to obesity, within an individualized obesity treatment plan

E. Circadian timing has no relationship to eating behavior or metabolic health, given the patient factors described above

146. Which counseling point is important before any endoscopic obesity procedure?

A. Follow-up is unnecessary unless immediate procedural complications occur, as a relevant consideration in this case

B. Medication and lifestyle care should be stopped after the procedure, when considered with the rest of the presentation

C. The procedure permanently cures obesity without additional treatment, within an individualized obesity treatment plan

D. The procedure is an adjunct, and durable results still require longitudinal nutrition, behavior, and medical follow-up

E. All endoscopic procedures produce the same weight loss as metabolic surgery, in the clinical setting described

147. A 34-year-old woman presents 8 months after delivery with persistent weight gain. Which history is most important for understanding the postpartum trajectory?

- A.** Gestational weight gain, postpartum retention, sleep, lactation, and current medications
- B.** Whether prenatal visits occurred in the morning or afternoon, within an individualized obesity treatment plan
- C.** The number of pregnancy books read during each trimester, given the patient factors described above
- D.** The infant's birth order compared with extended family, in the clinical setting described
- E.** Her prepregnancy shoe size and changes in foot width, as a relevant consideration in this case

148. A 15-year-old with obesity is being bullied about weight and now avoids school. Which issue should be assessed urgently?

- A.** Whether daily public weigh-ins would increase motivation, within an individualized obesity treatment plan
- B.** Whether sports participation should be withheld as a consequence, given the patient factors described above
- C.** Whether the child can tolerate a more restrictive diet, in the clinical setting described
- D.** Depression, anxiety, self-harm risk, and the psychosocial impact of weight-based bullying
- E.** Whether classmates understand the child's exact BMI percentile, when considered with the rest of the presentation

149. An obesity medicine physician learns that new evidence has changed the preferred use of a medication. What is the best professional response?

- A.** Update practice using current evidence, labeling, and guidelines and communicate relevant changes to patients
- B.** Change treatment solely on the basis of manufacturer advertising, in the clinical setting described
- C.** Continue the old approach indefinitely because prior habits are sufficient, as a relevant consideration in this case
- D.** Avoid continuing education once board certification is achieved, when considered with the rest of the presentation

E. Adopt every social-media claim before reviewing evidence, within an individualized obesity treatment plan

150. Which nutritional deficiency is especially important to monitor long term after Roux-en-Y gastric bypass?

A. Copper excess from increased intestinal absorption, in the clinical setting described

B. Hypervitaminosis A from universal overabsorption, as a relevant consideration in this case

C. Sodium deficiency caused by complete loss of intestinal sodium uptake, when interpreted with the full presentation

D. Vitamin C excess caused by mandatory hyperabsorption, within an individualized obesity treatment plan

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

151. An adult has BMI 31 kg/m² and no contraindications. Which statement about obesity pharmacotherapy eligibility is most accurate?

A. FDA-approved chronic obesity medication can be considered with lifestyle treatment at BMI at least 30 kg/m²

B. Medication eligibility requires type 2 diabetes in every patient, when considered with the rest of the presentation

C. Pharmacotherapy is reserved only for patients who have already had surgery, within an individualized obesity treatment plan

D. Medication is appropriate only when BMI is at least 40 kg/m², given the patient factors described above

E. Medication should never be combined with nutrition and activity treatment, in the clinical setting described

152. A patient with severe obesity and difficult gastroesophageal reflux is choosing between sleeve gastrectomy and Roux-en-Y gastric bypass. Which procedure often has an advantage for reflux control?

A. Sleeve gastrectomy because it reliably eliminates reflux, when considered with the rest of the presentation

- B.** Adjustable gastric band because it prevents esophageal obstruction, within the treatment context described
- C.** Intra gastric balloon because it is a permanent antireflux procedure, given the clinical details provided
- D.** Endoscopic sleeve gastropasty because it bypasses the duodenum, in the clinical context described
- E.** Roux-en-Y gastric bypass, as a relevant consideration in this case, as a consideration for this patient

153. A 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 an individualized obesity treatment plan, within the treatment context described
- B.** Stop laboratory follow-up after the first normal annual panel, given the patient factors described above
- C.** Continue lifelong periodic nutritional and metabolic monitoring because deficiencies can develop years later
- D.** Stop supplements if the patient feels well, as a relevant consideration in this case, when considered with the rest of the presentation
- E.** Use body weight as the only marker of postoperative nutrition, when considered with the rest of the presentation

154. A patient with obesity and obstructive sleep apnea uses positive airway pressure successfully. How should obesity treatment be framed?

- A.** Use weight loss as a substitute for diagnosing residual sleep apnea, given the patient factors described above
- B.** Stop PAP once weight treatment begins because both therapies cannot be used together, in the clinical context described
- C.** Assume PAP use prevents any benefit from weight reduction, as a relevant consideration in this case

D. Continue effective OSA therapy while treating obesity because the conditions should be managed concurrently

E. Delay obesity treatment until PAP normalizes all cardiometabolic risk, within an individualized obesity treatment plan

155. 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. No follow-up is needed if the medication is FDA approved, as a relevant consideration in this case

C. Follow-up should occur only after the maximum dose is reached, when considered with the rest of the presentation

D. Daily in-person visits for all patients regardless of risk, within an individualized obesity treatment plan

E. Only once after one year unless the patient calls, given the patient factors described above

156. A patient with obesity and urinary stress incontinence asks whether weight treatment can help. What is the best response?

A. Fluid restriction is the primary obesity treatment for incontinence, as a relevant consideration in this case

B. Incontinence is unrelated to obesity and should not be discussed, when considered with the rest of the presentation

C. Weight loss usually worsens stress incontinence by reducing pelvic support, within an individualized obesity treatment plan

D. Only surgical weight loss can affect urinary symptoms, given the patient factors described above

E. Weight reduction can decrease intra-abdominal pressure and improve stress incontinence symptoms in many patients

157. A 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, when considered with the rest of the presentation
- B.** Avoid asking about supplements because they do not affect clinical care, within an individualized obesity treatment plan
- C.** Recommend doubling the dose if appetite suppression is modest, given the patient factors described above
- D.** Review ingredients and risks, explain uncertain efficacy and regulation, and discourage potentially unsafe stimulant products
- E.** Assume safety because the product is sold without a prescription, as a relevant consideration in this case

158. A patient with obesity and PCOS has irregular menses and insulin resistance. Which outcome can improve with weight reduction?

- A.** Ovulation improves only after metabolic surgery, within an individualized obesity treatment plan
- B.** Ovulatory function and metabolic risk can improve even with modest sustained weight loss
- C.** Menstrual regularity is unrelated to metabolic health, in the clinical setting described
- D.** Weight loss has no effect on insulin resistance in PCOS, as a relevant consideration in this case
- E.** PCOS always worsens after any weight reduction, when considered with the rest of the presentation

159. A 76-year-old man with obesity, frailty, and low muscle mass wants aggressive weight loss. What is the most important treatment priority?

- A.** Balance fat loss with preservation of muscle, strength, nutrition, and physical function
- B.** Use prolonged fasting because frailty improves with lower body weight, in the clinical context described
- C.** Set a normal-BMI target before addressing mobility, as a relevant consideration in this case
- D.** Avoid resistance exercise because it can increase body weight, when considered with the rest of the presentation
- E.** Maximize scale weight loss regardless of lean-mass loss, within an individualized obesity treatment plan

160. A 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 which grocery-store aisle is visited first each week, in the clinical setting described
- B.** Ask whether water is usually consumed cold or at room temperature, as a relevant consideration in this case
- C.** Ask whether vegetables are usually eaten before or after the entree, when considered with the rest of the presentation
- D.** Ask specifically about sugar-sweetened drinks, alcohol, coffee additives, and other caloric beverages
- E.** Ask whether meals are served on round or square plates, given the patient factors described above

161. 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, as a relevant consideration in this case
- B.** All rapid loss after diuretics represents loss of fat mass, when considered with the rest of the presentation
- C.** Some short-term weight change may reflect fluid loss, so adiposity change should be distinguished from decongestion
- D.** Fluid balance has no effect on measured body weight, given the patient factors described above
- E.** The change proves the obesity treatment is maximally effective, in the clinical setting described

162. A patient stops semaglutide after major weight loss and regains weight over the next year. What is the most accurate interpretation?

- A.** Medication discontinuation should always cause continued weight loss, when considered with the rest of the presentation
- B.** The original weight loss could not have been physiologic, within an individualized obesity treatment plan

- C.** Weight recurrence means no future obesity treatment can be effective, given the patient factors described above
- D.** Weight recurrence after discontinuation is common and reflects the chronic biology of obesity rather than proof of personal failure
- E.** Regain proves that semaglutide permanently damaged metabolism, as a relevant consideration in this case

163. A 12-year-old boy with obesity avoids running because of knee pain but enjoys swimming. What is the best initial activity recommendation?

- A.** Prescribe maximal-intensity intervals despite current knee symptoms, within an individualized obesity treatment plan
- B.** Require running because only weight-bearing exercise affects health, given the patient factors described above
- C.** Use enjoyable low-impact activity such as swimming while the knee pain is evaluated and treated
- D.** Use punitive exercise after high-calorie meals to improve adherence, as a relevant consideration in this case
- E.** Stop all activity until substantial weight loss has already occurred, when considered with the rest of the presentation

164. A patient is asked to record food intake, hunger, mood, and activity for two weeks. What behavioral technique is being used?

- A.** Self-monitoring, given the patient factors described above
- B.** Pharmacologic reinforcement, in the clinical setting described
- C.** Cognitive avoidance, as a relevant consideration in this case
- D.** Response prevention, when considered with the rest of the presentation
- E.** Aversion conditioning, within an individualized obesity treatment plan

165. A patient with obesity and gout wants a weight-loss plan. Which approach is most appropriate?

- A.** Use repeated prolonged fasts because they reliably prevent gout attacks, in the clinical setting described
- B.** Use gradual sustainable weight reduction and avoid dehydration or extreme fasting that can precipitate urate fluctuations
- C.** Encourage dehydration to accelerate scale-weight loss, when considered with the rest of the presentation
- D.** Use high alcohol intake to increase calorie expenditure, within an individualized obesity treatment plan
- E.** Avoid all weight treatment because uric acid always rises permanently, given the patient factors described above

166. A 15-year-old girl with obesity reports secretive eating and loss of control but no vomiting. What is the best next step?

- A.** Prescribe a highly restrictive diet before assessing eating pathology, as a relevant consideration in this case
- B.** Screen further for binge eating, mood symptoms, body-image distress, and compensatory behaviors
- C.** Recommend daily weighing without exploring emotional triggers, within an individualized obesity treatment plan
- D.** Assume the behavior is expected in adolescence and defer discussion, given the patient factors described above
- E.** Exclude caregivers from all safety-related assessment regardless of risk, in the clinical setting described

167. Which history is a major contraindication to naltrexone-bupropion because bupropion lowers seizure threshold?

- A.** Mild osteoarthritis treated with topical therapy, when considered with the rest of the presentation
- B.** Seasonal allergic rhinitis, within an individualized obesity treatment plan, within the treatment context described
- C.** Controlled hypothyroidism on stable levothyroxine, given the patient factors described above

- D.** Remote appendectomy without complications, in the clinical setting described
- E.** A seizure disorder, as a relevant consideration in this case, as a consideration for this patient

168. A patient is ambivalent about changing evening eating habits. Which response best reflects motivational interviewing?

- A.** List every health risk until the patient agrees with the clinician, within an individualized obesity treatment plan
- B.** Confront resistance as evidence that the patient is unmotivated, given the patient factors described above
- C.** Use shame to increase urgency and commitment, in the clinical setting described, in the clinical context described
- D.** Ask permission to explore the pattern and elicit the patient's own reasons for considering change
- E.** Tell the patient what to do before asking about priorities, when considered with the rest of the presentation

169. A patient with obesity snores loudly, has witnessed apneas, and has resistant hypertension. What diagnosis should be actively evaluated?

- A.** Narcolepsy without cataplexy as the usual cause of loud snoring, given the clinical details provided
- B.** Obstructive sleep apnea, in the clinical setting described, in the clinical context described
- C.** Primary insomnia as the explanation for witnessed breathing pauses, as a consideration for this patient
- D.** Restless legs syndrome as the cause of nocturnal airway obstruction, when interpreted with the full presentation
- E.** Central sleep apnea caused solely by excess body weight, within an individualized obesity treatment plan

170. 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 weight-related condition that can worsen energy balance and should be treated concurrently

- B.** As a reason to postpone obesity treatment until PAP cures weight gain, as a relevant consideration in this case
- C.** As a condition that is treated only with stimulant medication, when considered with the rest of the presentation
- D.** As unrelated to appetite, activity, or cardiometabolic risk, within an individualized obesity treatment plan
- E.** As proof of a primary endocrine cause of obesity, given the patient factors described above

171. A 29-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, as a consideration for this patient
- B.** Migraine without aura causing papilledema as an expected finding, when interpreted with the full presentation
- C.** Cluster headache causing bilateral optic-disc edema, within an individualized obesity treatment plan
- D.** Tension headache related only to neck muscle strain, given the patient factors described above
- E.** Idiopathic intracranial hypertension, in the clinical setting described, in the clinical context described

172. Which anticonvulsant is commonly associated with weight gain and should be recognized during medication review?

- A.** Valproate, when considered with the rest of the presentation, when interpreted with the full presentation
- B.** Felbamate, which is not a typical cause of major weight gain, within the treatment context described
- C.** Topiramate, which often decreases appetite and weight, given the patient factors described above
- D.** Lamotrigine, which is generally weight neutral, in the clinical setting described
- E.** Zonisamide, which may be associated with weight loss, as a relevant consideration in this case

173. 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.** Hemochromatosis as the most common pediatric obesity complication, within the treatment context described
- B.** Wilson disease established solely by the presence of obesity, given the clinical details provided
- C.** Metabolic dysfunction-associated steatotic liver disease, in the clinical setting described
- D.** Acute viral hepatitis caused by excess adiposity, as a relevant consideration in this case
- E.** Autoimmune hepatitis proven by an elevated ALT alone, when considered with the rest of the presentation

174. An adult has a BMI of 32.4 kg/m². Using standard adult BMI categories, how is this classified?

- A.** Class 2 obesity, given the patient factors described above
- B.** Overweight without obesity, in the clinical setting described
- C.** Normal-weight range, as a relevant consideration in this case
- D.** Class 3 obesity, when considered with the rest of the presentation
- E.** Class 1 obesity, within an individualized obesity treatment plan

175. A clinician wants to describe obesity without stigmatizing the patient. Which wording is preferred?

- A.** A person with obesity who has a chronic disease requiring individualized treatment, in the clinical context described
- B.** A noncompliant individual whose weight reflects poor choices, as a relevant consideration in this case
- C.** An obese patient who simply needs greater dietary discipline, when considered with the rest of the presentation
- D.** A failed dieter who has not tried hard enough, within an individualized obesity treatment plan
- E.** A morbidly obese person defined primarily by body size, given the patient factors described above

176. A patient has reached a weight plateau and is discouraged. Which counseling response is most helpful?

- A.** Review non-scale benefits, adherence data, barriers, and options for intensifying treatment without framing the plateau as failure
- B.** Stop treatment because further progress is impossible, when considered with the rest of the presentation
- C.** Warn that a plateau proves the patient is secretly overeating, within an individualized obesity treatment plan
- D.** Set an extreme short-term target to restore motivation, given the patient factors described above, in the clinical setting described
- E.** Reduce follow-up because encouragement is no longer useful, in the clinical setting described, as a relevant consideration in this case

177. A patient on long-term obesity medication develops persistent severe adverse effects despite slower titration. What is the best next step?

- A.** Stop all obesity treatment permanently, when considered with the rest of the presentation, within an individualized obesity treatment plan
- B.** Continue the same dose indefinitely because weight loss outweighs tolerability, within an individualized obesity treatment plan
- C.** Reassess the risk-benefit balance and reduce, switch, or discontinue therapy while offering another effective treatment
- D.** Increase the dose because adverse effects indicate the medication is working, in the clinical setting described
- E.** Add medications solely to mask every adverse effect without reassessment, as a relevant consideration in this case

178. Which physical-activity history gives the most actionable information for obesity treatment planning?

- A.** Only whether activity occurs indoors or outdoors, within an individualized obesity treatment plan

- B.** Only the number of gym memberships purchased in adulthood, given the patient factors described above
- C.** Only the patient's preferred brand of exercise footwear, in the clinical setting described
- D.** Frequency, duration, intensity, type of activity, sedentary time, limitations, and prior injuries
- E.** Only whether the patient considers themselves an active person, when considered with the rest of the presentation

179. An Asian American adult has a BMI of 24.5 kg/m² and central adiposity with type 2 diabetes. Which principle is most important?

- A.** A BMI below 25 excludes clinically important excess adiposity, given the patient factors described above
- B.** Ethnicity should never influence interpretation of anthropometric risk, in the clinical setting described
- C.** Cardiometabolic risk can occur at lower BMI in Asian populations, so ethnicity-sensitive thresholds and waist measures are useful
- D.** Waist circumference has no role when diabetes is already present, when considered with the rest of the presentation
- E.** Standard BMI thresholds have identical risk meaning across all populations, within an individualized obesity treatment plan

180. A 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 response?

- A.** State that maintenance depends only on willpower once weight is lost, in the clinical setting described
- B.** Explain that weight regain proves the original calorie deficit was imaginary, as a relevant consideration in this case
- C.** Advise that successful weight loss should permanently eliminate hunger signals, when considered with the rest of the presentation
- D.** Explain that biologic adaptations after weight loss can increase hunger and favor weight regain, so long-term treatment is often needed

E. Recommend stopping follow-up because recurrence means treatment cannot work, given the patient factors described above

181. A patient with mobility impairment uses a wheelchair and has obesity. Which physical-activity counseling is most appropriate?

A. Use standard step-count goals as the only measure of success, as a relevant consideration in this case, as a consideration for this patient

B. Exclude physical activity because walking is not possible, when considered with the rest of the presentation, when interpreted with the full presentation

C. Adapt activity to ability, emphasizing accessible aerobic movement, upper-body or resistance work, and reduction of sedentary time where feasible

D. Delay obesity treatment until independent ambulation is achieved, given the patient factors described above, given the clinical details provided

E. Recommend only vigorous lower-extremity exercise regardless of function, in the clinical setting described, in the clinical context described

182. A patient seeking obesity pharmacotherapy has active suicidal ideation with a plan. What should the clinician do first?

A. Prescribe a stimulant because it may improve energy quickly, when considered with the rest of the presentation

B. Delay all discussion until the next routine follow-up visit, within an individualized obesity treatment plan

C. Recommend unsupervised fasting to provide a sense of control, given the patient factors described above

D. Begin obesity medication first because weight loss may improve mood, in the clinical setting described

E. Address the psychiatric emergency and ensure immediate safety before initiating weight-loss treatment

183. A patient prefers medication and strongly declines surgery after informed discussion. What is the best response?

- A.** Refuse further care because the most effective option was declined, within an individualized obesity treatment plan
- B.** Respect the preference, provide effective nonsurgical treatment, and revisit options later if goals or circumstances change
- C.** Coerce surgical referral because clinician preference overrides autonomy, in the clinical setting described, in the clinical context described
- D.** Document noncompliance and stop discussing obesity, as a relevant consideration in this case, when considered with the rest of the presentation
- E.** Provide only educational handouts and no active treatment, when considered with the rest of the presentation, when interpreted with the full presentation

184. A 66-year-old has lost 18% of body weight but also reports weakness and reduced grip strength. What should be assessed?

- A.** Stop all resistance activity to conserve calories, given the patient factors described above
- B.** Further restrict protein to accelerate scale-weight reduction, in the clinical setting described
- C.** Lean-mass loss, protein intake, resistance activity, and other causes of functional decline
- D.** Ignore function because percentage weight loss is the only outcome, when considered with the rest of the presentation
- E.** Assume weakness is desirable because it indicates rapid fat loss, within an individualized obesity treatment plan

185. An adult has BMI 28 kg/m² and hypertension. Which statement is most accurate?

- A.** Medication requires prior failure of metabolic surgery, in the clinical setting described
- B.** Hypertension does not count as a weight-related condition, as a relevant consideration in this case
- C.** Only short-term sympathomimetics may be used at this BMI, when considered with the rest of the presentation
- D.** A chronic obesity medication may be considered because BMI is at least 27 kg/m² with a weight-related comorbidity

E. Medication is contraindicated because BMI is below 30 kg/m², given the patient factors described above

186. A 16-year-old with obesity takes an atypical antipsychotic and has rapidly rising weight and triglycerides. What is the best next step?

A. Wait until adulthood before addressing medication-related metabolic effects, as a relevant consideration in this case

B. Prescribe a crash diet while leaving the medication review unchanged, when considered with the rest of the presentation

C. Tell the family that medication-associated weight gain cannot be treated, within an individualized obesity treatment plan

D. Stop the antipsychotic without psychiatric input because weight takes priority, given the patient factors described above

E. Coordinate with psychiatry to reassess metabolic risk and consider a lower-weight-risk regimen if clinically appropriate

187. 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. Long-term pharmacotherapy is inappropriate because obesity becomes cured after weight loss

B. Stopping therapy prevents biologic pressure toward weight regain, within an individualized obesity treatment plan

C. Medication should always stop as soon as the first weight goal is reached, given the patient factors described above

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

E. All obesity medications must be stopped after exactly 12 weeks, as a relevant consideration in this case

188. A 14-year-old has BMI 135% of the 95th percentile for age and sex. How should the severity be characterized?

- A.** Class 1 adult obesity using a fixed BMI cutoff only, within an individualized obesity treatment plan
- B.** Underweight due to rapid pubertal growth, given the patient factors described above
- C.** Normal variation because adolescence invalidates BMI percentiles, in the clinical context described
- D.** Severe obesity, as a relevant consideration in this case, when considered with the rest of the presentation
- E.** Overweight without obesity, when considered with the rest of the presentation, when interpreted with the full presentation

189. What is a reasonable way to define early treatment success in obesity?

- A.** Require the same percentage weight loss from every therapy, given the patient factors described above, given the clinical details provided
- B.** Judge success after one week regardless of treatment mechanism, in the clinical setting described, as a relevant consideration in this case
- C.** Assess weight trajectory together with changes in comorbidities, function, quality of life, adherence, and treatment tolerability
- D.** Stop treatment if BMI remains in the obesity range despite major health improvement, when considered with the rest of the presentation
- E.** Use only the number on the scale and ignore all health outcomes, within an individualized obesity treatment plan

190. 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, in the clinical setting described
- B.** Eliminate all carbohydrates regardless of medical context, as a relevant consideration in this case
- C.** Require fasting every day to produce a metabolic advantage, when considered with the rest of the presentation
- D.** Use one mandatory macronutrient ratio for every patient, within an individualized obesity treatment plan

E. Create a sustainable energy deficit while maintaining nutritional adequacy and patient preference

191. A patient with obesity has high triglycerides, low HDL cholesterol, and elevated cardiovascular risk. Which management principle is most appropriate?

A. Treat obesity and dyslipidemia concurrently with nutrition, activity, weight therapy, and lipid-lowering treatment based on overall risk

B. Treat weight only because lipid therapy is unnecessary once obesity is addressed, when considered with the rest of the presentation

C. Treat lipids only because weight reduction cannot improve triglycerides, within an individualized obesity treatment plan

D. Use dietary cholesterol restriction as the sole determinant of therapy, given the patient factors described above

E. Delay statin decisions until a normal BMI has been achieved, in the clinical setting described, as a relevant consideration in this case

192. Which goal is the best example of a SMART behavioral target?

A. Lose as much weight as possible this month, when considered with the rest of the presentation

B. Stop being sedentary permanently, within an individualized obesity treatment plan, within the treatment context described

C. Walk for 20 minutes after dinner on Monday, Wednesday, and Friday for the next two weeks

D. Exercise more whenever possible, in the clinical setting described, as a relevant consideration in this case

E. Eat healthier foods from now on, as a relevant consideration in this case, as a consideration for this patient

193. A 68-year-old with obesity, sarcopenia, and diabetes is choosing between aggressive calorie restriction and a more moderate plan with resistance training. Which is preferable?

A. Set a rapid normal-BMI target before considering function, within an individualized obesity treatment plan

- B.** Use a moderate individualized energy deficit with adequate protein and resistance exercise to protect lean mass
- C.** Choose the most aggressive calorie restriction regardless of muscle loss, in the clinical setting described
- D.** Avoid protein because it interferes with fat loss, as a relevant consideration in this case
- E.** Avoid resistance training because it raises scale weight, when considered with the rest of the presentation

194. A patient developed hyperphagia and rapid weight gain after surgery involving the hypothalamic region. What is the most likely mechanism?

- A.** Primary renal sodium retention without change in appetite, given the patient factors described above
- B.** Hypothalamic injury disrupting appetite, satiety, and energy-regulation pathways
- C.** Isolated thyroid hormone resistance caused by neurosurgery, as a relevant consideration in this case
- D.** Loss of pancreatic beta cells causing hyperphagia without hyperglycemia, when interpreted with the full presentation
- E.** Peripheral neuropathy directly increasing intestinal calorie absorption, within the treatment context described

195. 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.** Food insecurity causing cyclical restriction followed by reliance on inexpensive energy-dense foods
- B.** Buying groceries from more than one retail chain, as a relevant consideration in this case
- C.** A dislike of two specific nonstarchy vegetables, when considered with the rest of the presentation
- D.** Using ceramic rather than disposable food containers, within an individualized obesity treatment plan
- E.** A preference for eating dinner at 7 rather than 6 PM, given the patient factors described above

196. A patient cannot afford the medication that would otherwise best fit the treatment plan. What is the most appropriate response?

- A.** Avoid asking about cost because finances are outside clinical decisions, as a relevant consideration in this case
- B.** Choose the cheapest option without discussing efficacy or safety, when considered with the rest of the presentation
- C.** Prescribe the unaffordable drug and assume the patient will find a way to pay, within an individualized obesity treatment plan
- D.** Discuss cost and coverage openly and select the most effective feasible alternative through shared decision-making
- E.** Withhold all treatment until insurance coverage changes, in the clinical setting described, in the clinical context described

197. Why is resistance training particularly valuable during weight loss?

- A.** It eliminates the need for adequate dietary protein, when considered with the rest of the presentation
- B.** It prevents any loss of body fat by increasing muscle weight, within an individualized obesity treatment plan
- C.** It should replace all aerobic activity in every patient, given the patient factors described above
- D.** It helps preserve or improve muscle mass and function while weight is being reduced
- E.** It guarantees continued weight loss after a plateau, as a relevant consideration in this case

198. A patient wants to increase adherence to home-prepared meals. Which use of social support is most appropriate?

- A.** Use competition with relatives as the primary treatment strategy, within an individualized obesity treatment plan
- B.** Invite a supportive household member, with permission, to help plan shopping and meal preparation
- C.** Encourage criticism when the patient deviates from the plan, in the clinical setting described

D. Ask family members to police every food choice without consent, as a relevant consideration in this case

E. Keep goals secret so no one can influence behavior, when considered with the rest of the presentation

199. A patient says, "I eat whenever I feel anxious, even if I am not physically hungry." Which behavioral construct is most directly being described?

A. Food avoidance driven by fear of choking or sensory characteristics, given the clinical details provided

B. Objective binge eating defined only by a specific calorie threshold, in the clinical context described

C. Compensatory purging intended to prevent weight gain after eating, as a consideration for this patient

D. Night eating defined by awakening from sleep to consume food, when considered with the rest of the presentation

E. Emotion-triggered eating in response to affect rather than homeostatic hunger, within the treatment context described

200. Which initial aerobic activity target is broadly appropriate for many adults who are currently inactive and medically stable?

A. Avoid activity until at least 10% of body weight has been lost, in the clinical setting described

B. Use only stretching because aerobic activity does not affect health, as a relevant consideration in this case

C. Begin immediately with daily maximal-intensity exercise for 90 minutes, when interpreted with the full presentation

D. Progress gradually toward at least 150 minutes per week of moderate-intensity activity

E. Perform one long exercise session monthly instead of regular activity, given the clinical details provided

Answers

- 1. E.** 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.
- 2. E.** 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.
- 3. A.** 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.
- 4. C.** 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.
- 5. B.** 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.
- 6. A.** Intra-gastric 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.
- 7. D.** 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.
- 8. B.** Phentermine-topiramate is contraindicated in pregnancy because of teratogenic risk from topiramate. Patients who can become pregnant need effective contraception and appropriate pregnancy testing.
- 9. A.** 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.
- 10. B.** Phentermine is a sympathomimetic and is not appropriate in patients with cardiovascular disease or uncontrolled hypertension. A non-sympathomimetic option should be selected instead.
- 11. E.** 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.
- 12. A.** 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.

- 13. A.** 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.
- 14. C.** 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.
- 15. E.** 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.
- 16. D.** 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.
- 17. A.** Older adults are vulnerable to sarcopenia during weight loss. Adequate protein, nutrient density, and resistance activity help protect muscle, function, and bone health.
- 18. C.** 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.
- 19. A.** 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.
- 20. D.** Relapse prevention anticipates predictable challenges and plans how to respond to them. Continued monitoring and rapid recovery from lapses are more realistic than expecting perfect adherence.
- 21. A.** 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.
- 22. A.** Obesity treatment is health-centered and individualized. Weight reduction is important, but improvements in complications, function, well-being, and sustainability are also core outcomes.
- 23. E.** Weight reduction can improve blood pressure and may lower medication needs. Ongoing monitoring allows antihypertensive therapy to be adjusted to avoid symptomatic hypotension.
- 24. B.** 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.

- 25. A.** 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.
- 26. C.** 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.
- 27. E.** 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.
- 28. C.** 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.
- 29. D.** 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.
- 30. A.** 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.
- 31. E.** 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.
- 32. C.** 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.
- 33. C.** 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.
- 34. E.** Behavioral plans should match cognitive and practical capacity. Simplifying routines and using environmental cues can improve adherence without blaming the patient.
- 35. D.** 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.
- 36. B.** 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.

- 37. B.** 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.
- 38. C.** 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.
- 39. B.** 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.
- 40. B.** 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.
- 41. A.** 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.
- 42. C.** 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.
- 43. C.** Pediatric obesity commonly persists and can produce early complications. Current care emphasizes prompt, family-centered, nonstigmatizing treatment rather than passive delay.
- 44. B.** Protein supports satiety and lean-tissue preservation, particularly when paired with resistance training. Total energy balance and overall diet quality remain important.
- 45. E.** 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.
- 46. D.** 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.
- 47. E.** 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.
- 48. E.** Insulin resistance commonly produces elevated triglycerides and low HDL cholesterol. This pattern increases cardiometabolic risk and should be managed alongside weight treatment.
- 49. A.** 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.

- 50. A.** Intra-gastric 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.
- 51. C.** 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.
- 52. D.** 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.
- 53. A.** 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.
- 54. D.** 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.
- 55. A.** 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.
- 56. D.** 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.
- 57. E.** 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.
- 58. C.** 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.
- 59. E.** 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.
- 60. D.** 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.
- 61. B.** 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.

- 62. E.** 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.
- 63. D.** 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.
- 64. E.** Qualified interpretation and teach-back improve informed decision-making and medication safety. Language access is a core component of equitable, person-centered obesity care.
- 65. A.** 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.
- 66. D.** 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.
- 67. E.** 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.
- 68. D.** 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.
- 69. D.** 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.
- 70. E.** 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.
- 71. C.** 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.
- 72. B.** Modern guidance supports considering metabolic surgery for selected individuals with BMI 30-34.9 kg/m² 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.
- 73. A.** 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.

- 74. D.** 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.
- 75. E.** Metabolic surgery is powerful but requires lifelong care. Micronutrient deficiencies, weight recurrence, bone health, hypoglycemia, gastrointestinal complications, and psychosocial issues can emerge years later.
- 76. C.** 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.
- 77. E.** Obesity arises from interacting biologic, behavioral, environmental, medication, and social influences. Recognizing this complexity supports comprehensive treatment rather than simplistic blame.
- 78. D.** Pregnancy is usually advised to be delayed until the rapid weight-loss phase has passed, often about 12-18 months. If conception occurs earlier, careful monitoring of maternal weight, nutrition, and micronutrients is essential.
- 79. E.** 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.
- 80. C.** 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.
- 81. D.** 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.
- 82. B.** 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.
- 83. D.** 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.
- 84. B.** 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.
- 85. A.** 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.
- 86. A.** 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.

- 87. B.** 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.
- 88. B.** 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.
- 89. C.** 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.
- 90. D.** 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.
- 91. A.** 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.
- 92. C.** 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.
- 93. B.** Naltrexone is an opioid antagonist. Using naltrexone-bupropion in a patient dependent on opioid agonists can precipitate withdrawal and interfere with pain control.
- 94. A.** Obesity contributes to osteoarthritis through mechanical loading and systemic inflammatory pathways. Clinically meaningful weight reduction and appropriate activity can improve pain and function.
- 95. B.** 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.
- 96. A.** 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.
- 97. D.** 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.
- 98. E.** 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.

- 99. A.** 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.
- 100. E.** 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.
- 101. C.** 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/m² 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.
- 102. D.** 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.
- 103. E.** Medication choice is person centered. Expected weight and health benefits should be balanced with safety, comorbidities, tolerability, affordability, availability, and the patient's preferences.
- 104. B.** 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.
- 105. E.** 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.
- 106. D.** 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.
- 107. A.** 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.
- 108. B.** 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.
- 109. B.** 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.
- 110. D.** 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.

- 111. A.** 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.
- 112. B.** 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.
- 113. A.** 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.
- 114. C.** 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 dysmorphology. Common obesity is typically not accompanied by that constellation.
- 115. B.** 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. E.** 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.
- 117. A.** 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.
- 118. C.** 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.
- 119. E.** 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.
- 120. B.** 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.
- 121. A.** Competence requires continuous learning and critical appraisal. Reviewing guidelines, trials, safety updates, and one's own outcomes helps keep practice current and evidence based.
- 122. B.** 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.

- 123. C.** 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.
- 124. C.** 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.
- 125. E.** 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.
- 126. B.** 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.
- 127. D.** Appropriately selected adolescents with severe obesity and significant complications can benefit from metabolic-bariatric surgery. Evaluation should occur in an experienced multidisciplinary pediatric program.
- 128. C.** 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.
- 129. B.** 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.
- 130. E.** 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.
- 131. B.** 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.
- 132. C.** 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.
- 133. D.** 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.
- 134. A.** 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.

- 135. A.** 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.
- 136. E.** Current ASMBS/IFSO guidance recommends metabolic-bariatric surgery for individuals with BMI above 35 kg/m² 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/m² is not accompanied by a traditionally qualifying comorbidity.
- 137. B.** Irregular ovulation, hyperandrogenic features, infertility, and obesity are common in polycystic ovary syndrome. Recognizing the pattern prompts appropriate reproductive and metabolic evaluation.
- 138. D.** 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.
- 139. B.** 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.
- 140. D.** 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.
- 141. E.** 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.
- 142. E.** 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.
- 143. C.** 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.
- 144. A.** 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.
- 145. C.** 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.

- 146. D.** 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.
- 147. A.** 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.
- 148. D.** 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.
- 149. A.** Obesity medicine evolves rapidly. Professional competence requires ongoing learning, appraisal of evidence, awareness of labeling changes, and incorporation of new information into patient care.
- 150. E.** 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.
- 151. A.** Chronic obesity pharmacotherapy is generally indicated for adults with BMI at least 30 kg/m², or at least 27 kg/m² 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.
- 152. E.** Roux-en-Y gastric bypass often improves reflux, whereas sleeve gastrectomy can worsen or provoke gastroesophageal reflux in some patients. Procedure selection should incorporate reflux severity and other clinical factors.
- 153. C.** 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.
- 154. D.** 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.
- 155. A.** 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.
- 156. E.** 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.
- 157. D.** 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.

- 158. B.** 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.
- 159. A.** 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.
- 160. D.** 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.
- 161. C.** 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.
- 162. D.** 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.
- 163. C.** 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.
- 164. A.** Self-monitoring increases awareness of patterns, triggers, and progress. It is a foundational behavioral technique that provides data for problem solving and feedback.
- 165. B.** 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.
- 166. B.** 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.
- 167. E.** 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.
- 168. D.** 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.
- 169. B.** 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.

- 170. A.** 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 sequential wait-and-see approach.
- 171. E.** 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.
- 172. A.** 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.
- 173. C.** 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.
- 174. E.** Standard adult BMI classification defines class 1 obesity as 30.0-34.9 kg/m², class 2 as 35.0-39.9, and class 3 as at least 40. BMI should still be interpreted alongside complications and body composition.
- 175. A.** Person-first, nonjudgmental language recognizes obesity as a disease rather than an identity or character flaw. This improves therapeutic alliance and reduces weight stigma.
- 176. A.** Plateaus are expected and should prompt collaborative reassessment. Recognizing health improvements and using objective data supports persistence and informs safe treatment intensification.
- 177. C.** 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.
- 178. D.** 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.
- 179. C.** 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.
- 180. D.** 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.
- 181. C.** 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.

- 182. E.** 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.
- 183. B.** Shared decision-making respects informed patient preferences while still offering evidence-based alternatives. Treatment plans can evolve as benefits, risks, access, and goals change.
- 184. C.** 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.
- 185. D.** Adults with BMI at least 27 kg/m² plus a weight-related condition such as hypertension may meet labeling criteria for chronic obesity pharmacotherapy. Selection still depends on safety, preferences, and access.
- 186. E.** 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.
- 187. D.** 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.
- 188. D.** 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.
- 189. C.** 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.
- 190. E.** 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.
- 191. A.** 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.
- 192. C.** SMART goals are specific, measurable, achievable, relevant, and time-bound. A defined walking plan can be tracked and adjusted, unlike vague outcome statements.
- 193. B.** Older adults with sarcopenia need treatment that protects muscle and physical function. Moderate energy restriction, adequate protein, and resistance exercise can improve adiposity without worsening frailty.
- 194. B.** 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.

- 195. A.** 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.
- 196. D.** Cost and coverage directly affect treatment access and persistence. A feasible plan should balance evidence, comorbidities, adverse effects, preferences, and financial realities.
- 197. D.** Resistance exercise supports lean mass, strength, physical function, and metabolic health. It complements rather than replaces aerobic activity and adequate nutrition.
- 198. B.** Supportive involvement can improve practical implementation when it is collaborative and consented to. Surveillance, criticism, and coercion can damage autonomy and the therapeutic environment.
- 199. E.** 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.
- 200. D.** 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.