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Question: 1

58-year-old male with obesity (BMI 38 kg/m2), hypertension, and hyperlipidemia has been on a medically supervised ketogenic diet for weeks. He reports good adherence and has lost 6% of his initial body weight. Pre-diet labs showed LDL-C 11 0 mg/dL and uric acid 6.0 g/dL. Current labs reveal LDL-C 160 mg/dL and uric acid 8.2 mg/dL. He also mentions mild constipation but no gout symptoms. He is otivated to continue the diet. What is the most appropriate next step in nutritional management?

A. Recommend discontinuing the ketogenic diet immediately due to the elevated LDL-C.
B. Initiate uric acid-lowering medication and advise increasing water intake-
C. Continue the ketogenic diet, increase dietary fiber for constipation, advise adequate hydration, and schedule lipid panel recheck in 4 weeks.
D. Transition the patient to a Mediterranean diet due to the combined lipid and uric acid changes.

Answer: C

Explanation:
The ketogenic diet is effective for weight loss (6% at 8 weeks), and the patient is adherent and motivated. Transient LDL-C elevation is common early in ketogenic diets due to lipid mobilization and often stabilizes; an immediate change is premature without evidence of sustained harm. Hyperuricemia is also a known, often transient, side effect managed by hydration; medication isn't indicated without gout symptoms- Constipation is addressed with fiber and hydration. Discontinuing (A) or transitioning (D) abandons a successful therapy prematurely. Initiating uric acid meds (B) is unnecessary for asymptomatic elevation and ignores the primary lipid concern. Continuing the diet (C) with symptom management and monitoring balances efficacy, safety, and patient adherence per guidelines acknowledging ketogenic diets' role under supervision.

Question: 2

32-year-old patient with severe obesity (BMI 48 kg/m2) since early childhood presents for genetic counseling following obesity gene panel testing ordered due to hyperphagia and developmental delay. The report identifies a heterozygous variant in the *MC4R* gene. One database classifies it as "Pathogenic," citing functional studies showing impaired signaling, while another classifies it as "Variant of Uncertain Significance (VI-JS)" due to its presence in a population database at low frequency. The patient expresses significant anxiety bout passing this to their future children. Which is the most appropriate initial counseling approach regarding this genetic finding?

A. Reassure the patient the variant is definitively pathogenic and discuss the 50% autosomal dominant inheritance risk, recommending preimplantation genetic diagnosis.
B. Explain the conflicting interpretations and VUS classification, emphasize that current obesity management is unchanged, and recommend referral to a clinical geneticist.

C. Disregard the result due to the conflicting classifications and focus solely on intensifying lifestyle and pharmacotherapy interventions.

D. Inform the patient the variant is likely tH1ign based on the population frequency and advise no further action or family discussion is needed-

Answer: B

Explanation:
The correct answer addresses the core principles of counseling for variants with conflicting or uncertain significance. It is essential to transparently explain the ambiguity (Pathogenic vs. WS) to the patient without over-interpreting the result. Current obesity management (lifestyle, pharmacotherapy, potential surgery) remains the priority regardless of this finding. Referring to a clinical geneticist ensures expert interpretation of the conflicting data, potential further testing (e.g., parental studies), accurate recurrence risk assessment, and specialized counseling regarding family implications, aligning with ACMG/ABOM guidelines. Option A incorrectly assumes pathogenicity is confirmed, leading to potentially unnecessary anxiety and premature reproductive planning. Option C inappropriately dismisses a potentially relevant result that warrants expert evaluation, especially given the clinical history. Option D incorrectly assumes benignity, disregarding the pathogenic evidence and failing to address the patient's concerns or need for geneticist evaluation.

Question: 3

58-year-old woman with a BMI of 42 kg/m2 presents with a 9-month history of progressive, bilateral knee pain worsening with weight-bearing activity and prolonged standing. She reports 15-20 minutes of morning stiffness that improves with movement. Examination reveals bilateral knee crepitus, mild effusions, and slight limitation in terminal extension. No erythema, warmth, or joint instability is noted. Recent labs show an elevated CRP (1.2 mg/dL) and ESR (35 mm/hr), but she is afebrile and has no history of acute attacks or other joint involvement. Based on this presentation, which weight-related musculoskeletal condition is the most likely primary diagnosis?

A. Gout
B. Pseudogout
C. Rheumatoid Arthritis
D. Osteoarthritis

Answer: D

Explanation:
The bilateral knee pain exacerbated by weight-bearing and standing, coupled with crepitus and limited terminal extension on exam, strongly suggests osteoarthritis (OA), a common biomechanical complication of obesity due to increased joint loading- While the elevated CRP/ESR might suggest inflammation, the absence of fever, acute attacks (ruling out gout), prolonged morning stiffness (>1 hour typical for RA), or systemic symptoms makes inflammatory arthropathies less likely. The brief morning stiffness aligns with OA Gout (A) is incorrect as there's no history of acute monoarticular attacks (e.g., podagra) or tophi. Pseudogout (B) is unlikely without acute inflammatory flares or chondrocalcinosis evidence. Rheumatoid Arthritis (C) is incorrect due to the lack of prolonged morning

stiffness, symmetrical small joint involvement, or systemic features. Obesity is a major modifiable risk factor for knee OA progression.

Question: 4

42-year-old female presents for a 15-minute follow-up visit 18 months after Roux-en-Y gastric bypass. She reports a 12-pound weight regain over the past 6 months despite adhering to recommended protein intake and vitamin supplementation. She states she avoids liquid calories and sugary foods. During the nutrition history, she mentions increased work stress leading to frequent "grazing" on nuts and cheese in the evenings while watching TV, often not feeling physically hungry. She denies dumping syndrome or vomiting. Her food log shows consistent protein goals but frequent small, high-fat snacks outside planned meals. What is the MOST critical dietary behavior to address FIRST to support weight management in this patient?

A. Reducing sizes of protein sources at main meals
B. Implementing structured meal times and eliminating unscheduled grazing
C. Switching from high-fat nuts and cheese to lower-fat snack alternatives
D. Increasing daily water intake to improve satiety signals

Answer: B

Explanation:
The patient demonstrates classic non-hungry eating triggered by stress and environmental cues (TV), not physiological hunger, which is a primary driver of her weight regain despite adherence to core bariatric diet principles (protein, avoiding sugars/liquids). Addressing the unstructured grazing habit directly targets the behavioral dysregulation and context (stress, environment) promoting excess calorie intake. Option A is incorrect because her protein portions at meals are likely appropriate per guidelines and not identified as excessive; reducing them risks inadequate protein intake- Option C is incorrect because while nuts and cheese are calorie-dense, simply switching to lower-fat options doesn't address the underlying habit of unplanned, stress-induced eating; the behavior itself is the core issue. Option D is incorrect; while hydration is important, there's no indication of dehydration impairing satiety, and it doesn't address the behavioral trigger for eating. Structured eating is foundational for managing post-bariatric eating behaviors and disrupting the stress-grazing cycle.

Question: 5

45-year-old male with Class III obesity (BMI 43 kg/m2) requires significant weight loss within 3 months for elective knee replacement surgery. He has well-controlled hypertension (on hydrochlorothiazide 25mg daily) and a history of gout, with his last flare 8 months ago. His current eGFR is 58 mL/min/1.73m2. During nutritional counseling focused on achieving rapid, supervised weight loss, which dietary trategy is specifically contraindicated for this patient?

A. Low-carbohydrate/Ketogenic diet (less than 50g net carbs/day)
B. Protein-sparing modified fast (PSMF) (800 kcal/day, high protein, very low fat/carb)
C. Time-restricted eating (16:8 protocol, ad libitum intake within window)
D. Standard very-low-calorie diet (VLCD) (800 kcal/day, balanced macros, meal replacements)

Explanation:
PSMF is contraindicated here due to the patient's history of gout and borderline kidney function (eGFR 58 mL/min/I .73m2). PSMF induces significant ketosis and involves very high protein intake, which increases uric acid production and can precipitate gout flares. The reduced eGFR also raises concem for the renal solute load from high protein. Option A (Low-carb/Ketogenic) carries some gout risk but less than PSMF due to typically lower protein intake; its not absolutely contraindicated. Option C (Time-restricted eating) has no specific contraindications here and poses minimal added risk. Option D (Standard VLCD) uses balanced, lower-protein meal replacements and is less likely to provoke gout than PSMF; while caution is needed with eGFR, VLCD isn't absolutely contraindicated if closely monitored, unlike PSMF with gout. The urgency for weight loss doesn't override the specific risks PSMF poses to this patient.

Question: 6

42-year-old male patient of South Asian descent presents for a routine health evaluation. He reports no significant medical history but admits to a sedentary lifestyle. Physical exam reveals a weight of 82 kg and height of 1.72 meters (BMI 27.7 kg/m2). His blood pressure is 142/88 mmHg. When characterizing the severity of his weight status using appropriate classifications, what is his obesity category?

A. Overweight
B. Class I Obesity
C. Class II Obesity
D. Not obese

Explanation:
This patient's BMI of 27.7 kg/m2 falls within the Class I Obesity range (BMI 227.5 kg/m2) for individuals of South Asian descent, per consensus guidelines from the WHO and ADA which lower thresholds due to higher adiposity and cardiometabolic risk at lower BMIs in this Option A (Oveweight) is incorrect as it applies the standard CDC cutoff (BMI kg/m2) but ignores race-specific adjustments. Option C (Class II Obesity) is incorrect as it misapplies the standard cutoff (BMI 235 kg/m2) without accounting for ethnicity Option D (Not obese) is incorrect because, despite being below the standard obesity threshold, his BMI exceeds the race-adjusted threshold and is clinically significant given his elevated blood pressure. The correct classification guides appropriate intervention intensity.

Question: 7

42-year-old woman with Class II obesity (BMI 37 kg/m2) presents for obesity management. She reports worsening depressive symptoms over the past 6 months, including low mood, anhedonia, and low energy, significantly impacting her daily function. Her primary are physician started paroxetine 20 mg daily 8 months ago for anxiety, coinciding with a 15 kg weight gain. She expresses significant distress about this weight gain and fears trying another antidepressant that might cause further gain. She also

mentions she "doesn't like stimulating medications." What is the MOST appropriate next step regarding her antidepressant medication during this initial obesity medicine evaluation?

A. Continue paroxetine and focus solely on lifestyle intervention for weight loss.
B. Switch antidepressant medication to bupropion XL 150 mg daily.
C. Switch antidepressant medication to duloxetine 30 mg daily.
D. Switch antidepressant medication to mirtazapine 1 5 mg nightly.

Answer: B

Explanation:
Bupropion is the most appropriate choice as it is associated with weight neutrality or modest weight loss, directly addressing the patient's primary concern about medication-induced weight gain. It is also less likely to cause sedation or fatigue compared to other options and is not typically considered 'stimulating" in an unpleasant way at standard doses, aligning with her preference. Continuing paroxetine (A) ignores her distress about its contribution to significant weight gain and may hinder weight loss efforts. Duloxetine (C), an SNRI, can cause weight gain or loss variably but is less predictable than bupropion for weight neutrality and may have activating effects she dislikes. Mirtazapine (D) is strongly associated with significant weight gain and sedation, making it contraindicated given her history and concerns. The key is prioritizing an antidepressant effective for depression/anxiety that minimizes weight impact per obesity medicine principles

Question: 8

58-year-old patient with class Ill obesity (BMI 44 kg/m2) and severe osteoarthritis limiting ambulation presents for initial obesity management. During the social history, they report living alone in a rural town 25 miles from the nearest city. Their sole local food source is a small convenience store with limited fresh produce. While they qualify for SNAP benefits and have a neighbor who occasionally provides vegetables from a community garden, they struggle to afford regular transportation to supermarkets in the city. Which environmental/geographic characteristic represents the *most significant* barrier to accessing healthy food for this patient, requiring prioritization in the care plan?

A. Limited mobility due to osteoarthritis
B. Residence in a rural area classified as a food desert
C. Dependence on SNAP benefits for food purchasing
D. Distance to affordable supermarkets with diverse healthy options

Answer: D

Explanation:
While all factors contribute, the distance requiring costly transportation is the primary environmental barrier directly limiting access to affordable, healthy food despite other resources (SNAP, garden)- Option A (mobility) is a health condition, not an environmental characteristic, though it exacerbates the distance challenge. Option B (rural food desert) describes the area but doesn't capture the specific *access barrier* of distance/transportation cost highlighted in the scenario; the food desert status is the context, not the actionable barrier. Option C (SNAP dependence) relates to financial resources, not

geography/environment; SNAP helps affordability but doesn't overcome the physical access problem-The core environmental barrier preventing utilization of SNAP benefits or access to diverse healthy food is the significant distance to affordable supermarkets, compounded by transportation limitations.

Question: 9

52-year-old woman with obesity (BMI 34 kg/m2) and well-controlled type 2 diabetes (HbA1c 6.8% on stable metformin dose) presents or initial weight management evaluation. She reports diligently following a reduced-calorie diet and increasing physical activity for 3 months but has gained 2 kg. During the medication and supplement history, she lists: daily multivitamin, calcium 600 mg, vitamin D 2000 IU, chromium picolinate 200 mcg, ginseng 400 mg, and fish oil capsules (takes 4 capsules daily providing 1200 mg EPA/DHA each). Her diet recall is consistent with her prescribed plan. Which supplement is most likely contributing to her unexpected weight gain?

A. Chromium picolinate
B. Fish oil capsules
C. Ginseng
D. Vitamin D

Answer: B

Explanation:
The fish oil capsules are the most likely contributor to weight gain due to their significant caloric density. Each gram of fat provides 9 kcal; 4 capsules delivering 4800 mg (4.8 g) of fish oil contribute approximately 43 kcal daily, which can impede calorie deficit efforts over time. Chromium picolinate (A) is often used for potential glucose control and weight *loss*, but evidence for significant weight gain is lacking. Ginseng (C) shows mixed evidence, with some studies suggesting potential modest weight *loss* effects, not gain. While vitamin D deficiency (D) is associated with obesity, supplementation itself does not cause weight gain; correcting deficiency might modestly aid weight management The patient's stable diabetes and consistent diet highlight the caloric impact of the fish oil as the key factor.

Question: 10

52-year-old male with obesity (BMI 38 kg/m2, stable for 6 months), moderate obstructive sleep apnea (OSA) diagnosed 3 months prior, and hypertension presents for follow-up. He reports poor adherence to CPAP (<2 hours/night 4x/week) due to discomfort and difficulty falling asleep. He works rotating shifts (days/nights alternating weekly) and experiences daytime fatigue and increased evening snacking. During counseling on behavioral modifications to support weight management and OSA management, which sleep hygiene recommendation should be prioritized *first* to address his specific barriers?

A. Strictly enforce a consistent bedtime and wake-up time 7 days per week, regardless of shift schedule.
B. Implement a 1-hour pre-bed 'Wind-down' routine involving relaxation techniques in a dimly lit room.
C. Remove all electronic devices (TV, phone) from the bedroom and use the bed only for sleep and intimacy.
D. Gradually restrict time in bed to match current average sleep duration to increase sleep drive.

Explanation:

Stimulus control (Option C) is the priority- His primary sleep barrier is difficulty falling asleep, exacerbated by potential pre-sleep arousal from electronics and poor sleep environment association, directly hindering CPAP use- While consistency (A) is ideal, it's impractical and potentially harmful with rotating shifts, likely increasing frustration. Relaxation techniques (B) are beneficial but secondary to establishing a strong bed-sleep association first. Sleep restriction (D) is contraindicated due to existing severe daytime fatigue and OSA reducing time in bed could worsen sleepiness and cardiovascular risk without addressing the core stimulus control issue. Focusing on strengthening the bed-sleep link (C) addresses the immediate barrier to falling asleep, which is critical for improving CPAP tolerance and overall sleep quality, foundational for weight management efforts impacted by fatigue-related snacking.

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