

FPSC 133

MCQS ON CHRONIC DISEASE MANAGEMENT 2026

SUBMISSION DEADLINE: 12 MAY 2026, 12 noon

INSTRUCTIONS

• To submit answers to the following multiple choice questions, you are required to log on to the College Online

Portal (<https://lms.wizlearn.com/cfps/>)

• Please contact sfp@cfps.org.sg if you have not received an email on the LMS account.

• Attempt ALL the following multiple-choice questions.

• There is only ONE correct answer for each question.

• The answers should be submitted to the College of Family Physicians Singapore via the College Online Portal

before the submission deadline stated above.

• There will be NO further extension of the submission deadline

S/N	30 MCQs
1	<p>The risk of antihypertensive drugs on rapid decline in eGFR in Japanese patients with Chronic Kidney Disease was studied by Kenta Fujimoto et al and their findings were published in Am J Hypertens, June 2025. Which of the following indicates a patient has rapid decline in eGFR?</p> <p>A. Annual reduction >10% B. Annual reduction >15% C. Annual reduction >20% D. Annual reduction >25% E. None of the above</p>
2	<p>In the 2024 European Society of Cardiology (ESC) hypertension clinical practice guidelines, which ONE of the following is the CORRECT definition of hypertension?</p> <p>A. BP \geq140/95 mmHg B. BP \geq140/90 mmHg C. BP \geq130/85 mmHg D. BP \geq130/80 mmHg E. BP \geq120/70 mmHg</p>
3	<p>Which ONE of the following organs can be damaged by prolonged elevated blood pressure?</p> <p>A. Eye B. Bone and joints C. Skin D. Hearing E. Hair and nails</p>
4	<p>A 50-year-old man presents with a blood pressure of 140/90 mmHg. In which ONE of the following is lowering of his blood pressure indicated?</p> <p>A. Heart failure B. Moderate CKD C. Severe CKD D. Type 2 diabetes mellitus E. All of the above</p>

5	<p>A 45-year-old woman is diagnosed with obstructive sleep apnoea. Which ONE of the following clinical features is likely to be ABSENT?</p> <ul style="list-style-type: none"> A. Day-time sleepiness B. Snoring when sleeping C. Renal bruit D. Atrial fibrillation E. Obesity
6	<p>The following statements are TRUE with regards to insulin initiation EXCEPT:</p> <ul style="list-style-type: none"> A. Insulin therapy should be initiated in patients with symptomatic hyperglycaemia B. Insulin therapy should be initiated in patients who have uncontrolled HbA1c despite optimising treatment with oral hypoglycaemic agents C. Common barriers to insulin therapy include stigma and inconvenience, fear of injection and pain, misconception that insulin use will result in greater complications of diabetes D. The doctor should be prepared to spend time to work with the patient to handle the challenges faced with insulin therapy E. Insulin therapy should be reserved as a last resort when there are no other medication options
7	<p>Which of the following is NOT a barrier to initiation of insulin therapy?</p> <ul style="list-style-type: none"> A. Cost of insulin therapy B. Fear of needle and pain C. Inconvenience and disruption of patient's lifestyle D. Limited access to diabetes nurse educators E. Patient denial and limited understanding of diabetes and complications
8	<p>When initiating patients on insulin therapy, the physician should advise the patients on the following EXCEPT:</p> <ul style="list-style-type: none"> A. Discontinue all oral hypoglycaemic agents B. Insulin administration and storage C. Safe driving D. Sick day management E. Effects of fasting and exercise and changes in insulin requirements
9	<p>The following strategies can be adopted to assist patients in overcoming the challenges to insulin therapy EXCEPT:</p> <ul style="list-style-type: none"> A. Demonstrate how insulin is administered and the convenience of insulin pens B. Offer measures to reduce weight gain—lifestyle advice, concomitant use of insulin with metformin, SGLT-2 inhibitors, GLP-1RA C. Attribute the patients' uncontrolled DM to their lifestyle and diet D. Education to raise awareness and understanding of glycaemic levels and desired targets through SMBG training and interpretation E. Empower patients with the knowledge on hypoglycaemia management
10	<p>If the patient has uncontrolled HbA1c and the basal insulin dose exceeds 0.5 units/kg/day, which of the following strategies will not be useful to further optimise their diabetes control?</p> <ul style="list-style-type: none"> A. Intensifying the insulin regime to a basal-plus regimen B. Intensifying the insulin regime to a basal-bolus regimen

	<p>C. Switching the patient to a pre-mixed insulin regime</p> <p>D. Addition of GLP-1RA to the patient's treatment regimen</p> <p>E. Increase the dose of basal insulin by 4–6 units</p>
11	<p>A 42-year-old man with obesity reports that after dinner, despite feeling physically full, he often eats dessert when exposed to highly palatable foods. He notes that this behaviour is most pronounced when stressed or tired.</p> <p>Which of the following best explains this pattern of eating behaviour?</p> <p>A. Failure of hypothalamic homeostatic circuits to sense current energy stores</p> <p>B. Activation of reward-related corticolimbic circuits that can override homeostatic satiety signals</p> <p>C. Absence of a defended body-weight set point</p> <p>D. Increased conscious decision-making mediated by cortical control</p> <p>E. Reduced peripheral metabolic signalling from adipose tissue</p>
12	<p>A 52-year-old man is seen in primary care for weight management. His BMI is 33.8 kg/m². He has hypertension and dyslipidaemia, both optimally controlled. He is physically active at work and reports no functional limitations.</p> <p>Which of the following statements best reflects the most appropriate diagnostic and severity assessment approach for his obesity?</p> <p>A. BMI alone is sufficient to confirm obesity and guide treatment intensity</p> <p>B. Obesity diagnosis should be deferred until complications develop</p> <p>C. Excess adiposity should be confirmed using an additional anthropometric or body-fat measure</p> <p>D. Treatment should target a generic 5–10% weight loss regardless of comorbidities</p> <p>E. Aggressive treatment is indicated only if BMI is ≥40 kg/m²</p>
13	<p>A 48-year-old woman with obesity (BMI 35.5 kg/m²) has metabolic dysfunction-associated steatotic liver disease (MASLD) and moderate obstructive sleep apnoea. She is currently taking lifestyle measures and has lost 5% of her body weight over six months. Her liver enzymes and sleep symptoms have improved minimally.</p> <p>Which is the most appropriate next step in management?</p> <p>A. Escalate obesity treatment, as greater weight loss may be required to improve her complications</p> <p>B. Continue lifestyle therapy only, as 5% weight loss is adequate for most patients</p> <p>C. Focus on treating MASLD and OSA separately rather than targeting obesity</p> <p>D. Add medications for each complication before addressing obesity directly</p> <p>E. Avoid anti-obesity pharmacotherapy until BMI exceeds 40 kg/m²</p>
14	<p>A 50-year-old woman with obesity and impaired fasting glucose has struggled with weight regain after multiple diet attempts. She reports intense hunger when following low-calorie, high-carbohydrate meals. She</p>

	<p>asks whether a different dietary approach might help her maintain weight loss.</p> <p>What is the best next dietary recommendation to improve adherence and reduce hunger-related relapse?</p> <p>A. Advise her to “push through” the hunger as the key issue is compliance, since no specific diet is superior long-term</p> <p>B. A low-glycaemic index, higher-protein dietary pattern may improve weight-loss maintenance</p> <p>C. Time-restricted feeding should be routinely recommended due to strong long-term RCT evidence</p> <p>D. Very-low-energy diets are preferred for all patients because they overcome biological resistance</p> <p>E. Carbohydrate-restricted diets should be avoided in individuals with impaired glucose metabolism</p>
15	<p>A 54-year-old woman with obesity asks about newer weight-loss medications after reading about “incretin therapies” online. She is concerned about safety, durability and long-term value beyond weight loss.</p> <p>Which of the following statements best reflects the current evidence regarding GLP-1–based anti-obesity pharmacotherapy?</p> <p>A. Their primary mechanism of action is increasing basal metabolic rate</p> <p>B. Concerns about suicidality have led to strengthened regulatory warnings</p> <p>C. Lean-mass loss with these agents reflects predominantly functional muscle loss</p> <p>D. Weight regain after discontinuation suggests these drugs treat an ongoing pathophysiology</p> <p>E. Their clinical benefits are limited mainly to weight reduction</p>
16	<p>Mr X, a 40-year-old smoker with hypertension sees you for routine review. He reports two gout flares in the past two months, relieved with three days of Arcoxia for each episode. You perform some blood tests, which results in the following:</p> <p>Creatinine 95 $\mu\text{mol/L}$, eGFR $>90 \text{ mL/min}$ Uric acid 460 mmol/L HbA1c 5.4% Random hypo-count 7.5 mmol/L</p> <p>He is currently on Amlodipine 5 mg OM. He does not drink alcohol except one glass of wine once or twice a year on special occasions. His BMI is 25 kg/m^2.</p> <p>Which is the most appropriate next step?</p> <p>A. Offer dietary advice</p> <p>B. Offer dietary advice and advise regular exercise</p> <p>C. Discuss and offer to initiate urate lowering therapy, ideally with colchicine prophylaxis</p> <p>D. Prescribe NSAIDs standby for gout flare</p> <p>E. Prescribe prednisolone standby for gout flare</p>

17	<p>Mr Y, a 45-year-old man, reports three recent gout attacks involving the ankle and knee. His BP is 144/94 mmHg. On examination, there is a small tophus over the left elbow.</p> <p>He volunteers that two years ago he had taken allopurinol 100 mg daily for one month, then 200 mg daily for three months, but stopped as it “did not help his gout and there was no improvement.” He did not follow up with his GP.</p> <p>Two weeks ago, he was admitted for a gout flare. Blood tests showed:</p> <ul style="list-style-type: none"> • Uric acid: 620 $\mu\text{mol/L}$ • Creatinine: 95 $\mu\text{mol/L}$ • eGFR: 65 mL/min <p>Which is the CORRECT advice?</p> <p>A. Reassure him that urate-lowering therapy is unnecessary unless he develops more than five attacks per year</p> <p>B. Advise that allopurinol should not be restarted since it previously failed, and initiate febuxostat or probenecid instead</p> <p>C. Advise that urate-lowering therapy should be restarted with gradual dose titration to achieve a serum urate target of $<300 \mu\text{mol/L}$, with regular monitoring, and consider colchicine prophylaxis during titration</p> <p>D. Advise that urate-lowering therapy should only be started after complete resolution of tophi with target of uric acid $<360 \mu\text{mol/L}$</p> <p>E. Start allopurinol immediately at 300 mg daily without prophylaxis, as renal function is acceptable</p>
18	<p>You are seeing Mr Y TWO months later. At your last visit, he declined colchicine prophylaxis as he did not want to take “too many tablets”. He has since started and is adherent to his urate-lowering therapy. Last month, his serum uric acid had decreased to 390 mmol/L.</p> <p>He experienced a gout flare last week and has come today to ask about colchicine prophylaxis.</p> <p>Which is the CORRECT advice regarding colchicine prophylaxis?</p> <p>A. Colchicine prophylaxis is not useful once urate-lowering therapy has already been started</p> <p>B. Colchicine prophylaxis can reduce the risk of gout flares, particularly during the first 3–6 months after initiating urate-lowering therapy</p> <p>C. Colchicine prophylaxis should be stopped permanently after any episode of diarrhoea</p> <p>D. Colchicine prophylaxis inevitably causes renal impairment even in patients with normal renal function</p> <p>E. Colchicine prophylaxis should only be started if serum uric acid is above 600 mmol/L</p>
19	<p>Mr Y, a 60-year-old mechanic, was recently started on allopurinol 100 mg two months ago and increased to 200 mg three weeks ago in your clinic.</p> <p>He came down with flu four days ago and developed rashes after being given Klacid, flumucil, and loratidine by another GP. Today, he returns to your clinic.</p>

	<p>Which is the most appropriate next step?</p> <p>A. Stop Klacid and continue the chronic medications</p> <p>B. Prescribe paracetamol for pain relief and switch to Levofloxacin 500 mg bd instead</p> <p>C. Continue medications and check for Dengue serology</p> <p>D. Stop Klacid, flumucil, and loratidine</p> <p>E. Stop all medications and refer for possible SJS</p>
20	<p>A 40-year-old accountant on allopurinol 100 mg OM for the past one year reports two recent gout attacks in the last one year. He has no other known past medical history.</p> <p>His BMI 25 kg/m², BP 144/94 mm Hg.</p> <p>He is having a gout attack now. He tells you that his gout attacks are usually aborted with colchicine TDS for two days. Whilst on colchicine, he does not experience diarrhoea except perhaps one episode of loose stools after which he stops colchicine.</p> <p>Which is the most appropriate next step?</p> <p>A. Continue allopurinol at 100 mg OM despite the attack and start colchicine. Consider checking a baseline creatinine if not recently done</p> <p>B. Stop Allopurinol during this acute gout attack and start colchicine. Consider checking a baseline creatinine if not recently available</p> <p>C. Increase the allopurinol to 200 mg OM today and start colchicine. Consider checking a baseline creatinine if not recently done</p> <p>D. Start hydrochlorothiazide for hypertension</p> <p>E. Start Losartan for hypertension</p>
21	<p>Which of the following factors is NOT associated with metabolic dysfunction associated fatty liver disease (MAFLD)?</p> <p>A. Smoking</p> <p>B. Elevated uric acid</p> <p>C. Overweight status</p> <p>D. Hypertension</p> <p>E. Elevated triglycerides</p>
22	<p>Proven and recommended 1st-line treatment for patients with compensated cirrhosis from MAFLD is:</p> <p>A. Liver transplant</p> <p>B. Bariatric surgery</p> <p>C. Vitamin E</p> <p>D. Weight loss</p> <p>E. Metformin</p>
23	<p>Assessment of MAFLD at primary care clinic includes all of the following except:</p> <p>A. Fibroscan</p> <p>B. FIB-4 assessment</p> <p>C. Liver biopsy</p> <p>D. Liver function test</p> <p>E. Fasting lipids</p>

24	<p>Which of the following is NOT a major cause of death among patients with MAFLD over the long term?</p> <ul style="list-style-type: none"> A. Pancreatic cancer B. Hepatitis flares C. Cerebrovascular accident D. Acute myocardial infarct E. Heart failure
25	<p>Which of the following is NOT a common abnormal laboratory marker in patients with MAFLD?</p> <ul style="list-style-type: none"> A. Elevated uric acid B. Elevated triglycerides C. Elevated MCV D. Elevated GGT E. Elevated fasting glucose
26	<p>The following are first-line tests in the assessment of suspected heart failure, EXCEPT:</p> <ul style="list-style-type: none"> A. Electrocardiogram (ECG): important for identifying evidence of acute or prior myocardial infarction or acute ischaemia, as well as rhythm abnormalities such as atrial fibrillation B. Chest x-ray: characteristic findings are cardiac-to-thoracic width ratio above 50%, cephalisation of the pulmonary vessels, Kerley B-lines, and pleural effusions C. Blood test: Cardiac troponin (T or I), complete blood count, serum electrolytes, blood urea nitrogen, creatinine, liver function test and brain natriuretic peptide (BNP). BNP (or NT-proBNP) level adds greater diagnostic value to the history and physical examination than other initial tests mentioned above D. Ambulatory blood pressure: to determine overall mean blood pressure control and diurnal variability E. Transthoracic Echocardiogram: to determine ventricular function and haemodynamics
27	<p>A 65-year-old gentleman with known chronic heart failure presents to your clinic with worsening shortness of breath. His current medication regimen comprises an ACE-inhibitor, beta blocker, and a loop diuretic. He has mild ankle oedema, an elevated jugular venous pressure, and bibasal crepitations. His blood pressure is 145/82 mmHg. Which of the following would be the next appropriate management?</p> <ul style="list-style-type: none"> A. Add digoxin B. Add spironolactone C. Discontinue the beta blocker D. Discontinue the ACE-inhibitor E. Add rosuvastatin
28	<p>A 67-year-old lady with stable reduced ejection fraction chronic heart failure presents to your clinic requesting a review of her medications. She has a history of ischaemic heart disease as a cause of her heart failure. She wants to reduce her pill burden. Which of the following medications has no proven mortality benefit?</p> <ul style="list-style-type: none"> A. Entresto (sacubutril/valsartan)

	<p>B. Nitrates and hydralazine C. Digoxin D. Spironolactone E. Bisoprolol</p>
29	<p>As a primary care physician, you refer your patient with suspected heart failure for a direct access transthoracic echo to determine the left ventricular ejection fraction (EF). Which of the following is the correct formula for calculating the EF?</p> <p>A. $EF = [\text{end systolic volume (ESV)} - \text{end diastolic volume (EDV)}] \div \text{EDV}$ B. $EF = [\text{Heart rate (HR)} \times \text{end diastolic volume (EDV)}] \div \text{end systolic volume (ESV)}$ C. $EF = [\text{Heart rate (HR)} \times \text{end systolic volume (ESV)}] \div \text{end diastolic volume (EDV)}$ D. $EF = [\text{end diastolic volume (EDV)} - \text{end systolic volume (ESV)}] \div \text{EDV}$ E. $EF = [\text{end diastolic volume (EDV)} - \text{end systolic volume (ESV)}] \div \text{Heart rate (HR)}$</p>
30	<p>Very common causes of decompensation in a stable patient with heart failure include all of the following except:</p> <p>A. Excess intake of sodium in the diet B. Inappropriate reduction in medications C. Lack of physical activity D. Lack of medication compliance E. Reduced intake of water</p>