Diabetic Wound Care Exam Prep

Free Practice Test — 30 Real Exam-Style Questions

with full answer key & explanations

Practice Questions

Try all 30 first, then check the answer key at the back.

1. A 78-year-old with mild dementia, diabetic foot ulcer, and poor glycemic control lives alone. What is the appropriate management?

A. Hospitalize for hyperglycemia management
B. Transition to intensive basal-bolus insulin
C. Provide large-print written education aids
D. Simplify regimen and order home health services

2. A referral involves a stable, shallow diabetic foot ulcer with good perfusion. What is the appropriate triage decision?

A. Admit directly to vascular surgery service
B. Accept transfer to tertiary limb salvage unit
C. Redirect to local outpatient wound care clinic
D. Schedule urgent emergency department visit

3. An obese patient with a non-healing DFU reports good intake. Which finding best identifies a risk for occult malnutrition?

A. Body Mass Index calculated above 30
B. Serum prealbumin level of 12 mg/dL
C. Patient report of three daily meals
D. Serum albumin level of 3.8 g/dL

4. A hospital system implements a multidisciplinary limb salvage team. Which primary metric indicates the clinical effectiveness of this care model?

A. Decreased rate of major amputations
B. Increased patient referral volume
C. Reduced cost per wound dressing
D. Shorter wait for initial appointments

5. A patient with a DFU and type 2 diabetes starts high-dose prednisone. What is the priority management step?

A. Monitor fasting glucose levels weekly
B. Maintain current oral hypoglycemic agents
C. Discontinue corticosteroid therapy rapidly
D. Proactively increase insulin therapy dosage

6. A patient with no structural foot deformities has a third recurrence of a plantar ulcer despite previous healing. Which referral addresses the likely root cause?

A. Infectious disease for suppression
B. Vascular surgery for revascularization
C. Case management and social work
D. Plastic surgery for flap reconstruction

7. Triage the following patients: Patient A has stable dry gangrene of the toe (no systemic signs); Patient B has crepitus and fever.

A. Both patients to emergency department
B. A to vascular clinic; B to emergency
C. A to emergency; B to vascular clinic
D. Both patients to the outpatient wound care center

8. An 80 kg patient has a large, draining sacral ulcer. Using standard injury factors for chronic wounds (30-35 kcal/kg), what is the estimated daily energy requirement?

A. Approximately 2400 to 2800 kcal per day
B. Approximately 1600 to 2000 kcal per day
C. Approximately 1200 to 1500 kcal per day
D. Approximately 3500 to 4000 kcal per day

9. A patient with a non-healing diabetic foot ulcer has an Ankle-Brachial Index (ABI) of 0.45. Which intervention is indicated?

A. Referral for physical therapy
B. Routine wound care follow-up
C. Application of compression wraps
D. Urgent vascular referral, same day

10. An alert, non-critically ill inpatient with a diabetic foot infection has fasting blood glucose levels consistently between 145–160 mg/dL. What is the best management approach?

A. Relax targets to >200 mg/dL
B. Tighten control to 80–110 mg/dL
C. Maintain current glucose targets
D. Administer insulin for <100 mg/dL

11. An 80-kg patient with a large, draining diabetic foot ulcer requires nutritional support. What is the estimated daily protein requirement?

A. 64 g based on RDA standards
B. 100–120 g to meet demands
C. 40–50 g to spare renal function
D. 200 g for maximum anabolism

12. A patient presents with a deep, infected, neuroischemic ulcer. Which referral strategy optimizes limb salvage?

A. Concurrent vascular and infectious consults
B. Treat infection first, then refer to vascular
C. Revascularize first, then treat infection
D. Sequential referral starting with podiatry

13. A diabetic foot ulcer probes to bone. Superficial swab cultures are positive for Staphylococcus aureus. What is the most appropriate next step?

A. Apply topical antimicrobial dressings
B. Treat based on superficial swab results
C. Initiate empiric oral antibiotics
D. Obtain imaging and bone biopsy

14. A patient with a diabetic foot ulcer repeatedly misses appointments, citing a lack of transportation. Which action addresses the primary barrier?

A. Discontinuation from practice
B. Intensive patient education
C. Social work consultation
D. Prescription of home health

15. A patient with a diabetic ulcer and Stage 4 chronic kidney disease requires nutritional intervention. How should protein goals be determined?

A. Default to high-protein wound protocols
B. Collaboration with nephrology and dietetics
C. Strict protein restriction to 0.6 g/kg
D. Unrestricted high-protein supplementation

16. A patient with a diabetic foot ulcer presents with extending cellulitis, fever of 38.9°C (102°F), and tachycardia. What is the correct triage decision?

A. Immediate emergency department referral
B. Urgent vascular referral within 48 hours
C. Outpatient intramuscular antibiotics
D. Next-day follow-up in the clinic

17. For an 84-year-old patient with a diabetic ulcer, history of falls, and cognitive impairment, what is the primary glycemic management goal?

A. Aggressive insulin therapy
B. Strict normalization of HbA1c
C. Maintenance of HbA1c < 6.5%
D. Avoidance of hypoglycemia

18. A patient with a non-healing ulcer has monophasic pulses and an ABI of 0.6. What is the specific role of the vascular surgeon in this case?

A. Prescribe orthotic offloading
B. Manage local wound debridement
C. Perform revascularization
D. Oversee antibiotic management

19. In the physiological sequence of diabetic wound healing, which phase is most characteristically prolonged and fails to progress?

A. Proliferative phase
B. Inflammatory phase
C. Remodeling phase
D. Hemostasis phase

20. Which complication of autonomic neuropathy most directly predisposes the diabetic foot to bacterial invasion and infection?

A. Cutaneous anhidrosis
B. Charcot neuroarthropathy
C. Motor neuropathy
D. Venous insufficiency

21. A clinician debrides a plantar diabetic foot ulcer but fails to implement an offloading plan. What is the likely clinical outcome?

A. Excessive granulation
B. Immediate osteomyelitis
C. Rapid ulcer expansion
D. Recalcitrant healing

22. Which physiological process is the primary hallmark of the remodeling phase of wound healing?

A. Granulation tissue formation
B. Rapid capillary angiogenesis
C. Collagen Type I synthesis
D. Neutrophil infiltration

23. A diabetic patient with a non-healing foot ulcer has an Ankle-Brachial Index (ABI) of 1.4. Which test is indicated next?

A. Repeat Ankle-Brachial Index
B. Toe-Brachial Index (TBI)
C. Venous Duplex Ultrasound
D. Computed Tomography Angiogram

24. A patient demonstrates loss of vibratory sensation and proprioception. Which clinical risk is primarily associated with this large-fiber deficit?

A. Unperceived repetitive trauma
B. Severe burning paresthesia
C. Temperature hypersensitivity
D. Autonomic sudomotor dysfunction

25. A diabetic patient presents with a red, hot, swollen foot but no open wound or systemic fever. What is the priority intervention?

A. Therapeutic compression wrapping
B. Intravenous antibiotic therapy
C. Surgical debridement of bone
D. Strict total non-weight bearing

26. Which growth factor is critically deficient in diabetic wounds, directly leading to impaired angiogenesis and capillary sprouting?

A. TNF-alpha
B. MMP-9
C. VEGF
D. Interleukin-1

27. How does the accumulation of advanced glycation end-products (AGEs) structurally alter the skin in patients with diabetes?

A. Increases tissue flexibility
B. Decreases collagen turnover
C. Enhances capillary perfusion
D. Accelerates re-epithelialization

28. A patient perceives a sharp pinprick but cannot feel the 10g Semmes-Weinstein monofilament. What is the correct interpretation?

A. Loss of protective sensation
B. Intact protective sensation
C. Small fiber neuropathy only
D. Normal somatosensory function

29. What cellular dysfunction primarily drives the transition of a diabetic foot ulcer into a chronic, non-healing state?

A. Premature endothelial progenitor differentiation
B. Senescence of dermal fibroblasts and keratinocytes
C. Excess tissue inhibitors of metalloproteinases
D. Persistent pro-inflammatory macrophage phenotype

30. A diabetic patient has palpable pulses, normal ABI, but a non-healing ulcer and atrophy. Which pathology is indicated?

A. Deep venous thrombosis with reflux
B. Significant proximal arterial occlusion
C. Microvascular disease (microangiopathy)
D. Acute bacterial soft tissue infection

Answer Key & Explanations

1. D — Simplify regimen and order home health services
Simplifying treatment and ordering home health supervision ensures adherence in patients with cognitive impairment and limited support.

2. C — Redirect to local outpatient wound care clinic
Low-risk, stable chronic wounds should be managed in community outpatient settings to prevent resource mismanagement at tertiary centers.

3. B — Serum prealbumin level of 12 mg/dL
Prealbumin is a sensitive indicator of recent protein status; levels below 15 mg/dL suggest malnutrition despite obesity.

4. A — Decreased rate of major amputations
The primary measure of success for a multidisciplinary team is the reduction of major amputations through coordinated intervention.

5. D — Proactively increase insulin therapy dosage
Corticosteroids cause significant insulin resistance; management must include proactively increasing insulin to prevent hyperglycemia and impaired healing.

6. C — Case management and social work
Psychosocial factors cause recurrence; refer to case management and social work.

7. B — A to vascular clinic; B to emergency
A to vascular clinic; B to emergency for suspected gas gangrene and sepsis.

8. A — Approximately 2400 to 2800 kcal per day
Use 30–35 kcal/kg: 80 kg × 30–35 = 2400–2800 kcal/day.

9. D — Urgent vascular referral, same day
ABI 0.45 indicates severe ischemia; urgent vascular referral required.

10. C — Maintain current glucose targets
Target glucose 140–180 mg/dL in noncritically ill inpatients to reduce hypoglycemia risk.

11. B — 100–120 g to meet demands
Catabolic wounds require 1.25–1.5 g/kg/day. For 80 kg, this equals 100–120 g daily.

12. A — Concurrent vascular and infectious consults
Simultaneous care addresses ischemia and infection in parallel, preventing delays inherent in sequential referrals.

13. D — Obtain imaging and bone biopsy
Positive probe-to-bone suggests osteomyelitis. Superficial swabs are unreliable; imaging and bone biopsy

confirm diagnosis.

14. C — Social work consultation
The barrier is structural (transportation). Social work assists with logistical resources to resolve this.

15. B — Collaboration with nephrology and dietetics
Balancing CKD protein restrictions with wound healing requirements necessitates multidisciplinary collaboration.

16. A — Immediate emergency department referral
Fever and tachycardia indicate severe infection requiring immediate inpatient management; outpatient referral is unsafe.

17. D — Avoidance of hypoglycemia
In frail elderly patients, hypoglycemia risks outweigh tight control benefits; prioritizing safety is essential.

18. C — Perform revascularization
The vascular surgeon's primary role is assessing for and performing revascularization to restore pulsatile flow.

19. B — Inflammatory phase
Chronic hyperglycemia arrests wounds in the inflammatory phase, preventing progression to proliferation and remodeling.

20. A — Cutaneous anhidrosis
Anhidrosis causes dry, cracked skin, creating portals for bacterial entry and increasing infection risk.

21. D — Recalcitrant healing
Without offloading to relieve mechanical stress, the wound stimulus persists, leading to recalcitrant healing.

22. C — Collagen Type I synthesis
Remodeling replaces immature Type III collagen with Type I collagen to increase wound tensile strength.

23. B — Toe-Brachial Index (TBI)
An ABI > 1.4 indicates calcified arteries; TBI is reliable as toe vessels rarely calcify.

24. A — Unperceived repetitive trauma
Large-fiber neuropathy causes loss of protective sensation, leading to unperceived repetitive trauma and subsequent ulceration during ambulation.

25. D — Strict total non-weight bearing
These signs suggest acute Charcot neuroarthropathy. Immediate total non-weight bearing prevents bone collapse and permanent foot deformity.

26. C — VEGF
VEGF drives angiogenesis. In diabetic wounds, blunted VEGF expression leads to poor capillary growth and insufficient granulation tissue.

27. B — Decreases collagen turnover
AGEs cross-link collagen, making it resistant to enzymatic degradation. This reduces collagen turnover, causing stiff, non-compliant skin.

28. A — Loss of protective sensation
Inability to feel the 10g monofilament indicates loss of protective sensation, reflecting large-fiber dysfunction.

29. D — Persistent pro-inflammatory macrophage phenotype
Persistent pro-inflammatory M1 macrophages prevent transition to the proliferative repair phase.

30. C — Microvascular disease (microangiopathy)
Atrophic skin and poor healing with normal macrovascular exams suggest capillary-level microangiopathy.

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