AAFM Boards Dermatology Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- **Practice answering questions under realistic conditions,**
- **Improve accuracy and speed,**
- **Review explanations to strengthen weak areas, and**
- **Approach the exam with greater confidence.**

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here’s how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don’t just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There’s no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

1. Tinea versicolor is caused by which type of organism?

A. Bacteria

B. Yeast-like fungus

C. Virus

D. Dermatophytes

2. Which condition is primarily treated with intravenous antibiotics and surgical intervention?

A. Infected diabetic foot ulcer

B. Flexor tenosynovitis

C. Acute appendicitis

D. Burn wound infection

3. What does the thickness (T) in the TNM classification of melanoma indicate?

A. The color of the melanoma

B. The percentage of ulceration

C. The depth of tumor invasion

D. The age of diagnosis

4. What is the common cause of folliculitis?

A. Staphylococcus aureus

B. E. coli

C. Fungal Infections

D. HSV-1

5. What are macules typically described as?

A. Raised lesions on the skin

B. Flat spots on the skin

C. Firm nodular spots

D. Thickened patches with scales

6. What type of cancer is Bowen's disease a precursor for?

A. Melanoma

B. Basal cell carcinoma

C. Squamous cell carcinoma

D. Kaposi's sarcoma

7. Which bacteria is the principal pathogen in nonbullous impetigo?

A. Streptococcus pneumoniae

B. Staphylococcus aureus

C. Escherichia coli

D. Propionibacterium acnes

8. What does atrophy look like on the skin?

A. Even skin texture

B. Areas that appear less "full" than normal

C. Inflamed and red areas

D. Uniformly thickened skin

9. What is a pyogenic granuloma?

A. A benign skin condition caused by UV exposure

B. A polypoid capillary hemangioma

C. A type of malignant melanoma

D. An ulcerative skin infection

10. How is Norweigan scabies treated?

A. Topical steroids

B. Ivermectin

C. Permethrin cream

D. Oral antihistamines

Answers

1. B
2. B
3. C
4. A
5. B
6. C
7. B
8. B
9. B
10. B

Explanations

1. Tinea versicolor is caused by which type of organism?

A. Bacteria

B. Yeast-like fungus

C. Virus

D. Dermatophytes

Tinea versicolor is caused by a yeast-like fungus, specifically a type of fungus known as Malassezia. This condition is characterized by the overgrowth of this particular organism on the skin, particularly in areas with high sebaceous (oil) gland activity. Malassezia is a normal inhabitant of human skin, but under certain conditions—such as hot and humid weather, excessive sweating, and oily skin—it can proliferate and lead to the characteristic skin changes seen in tinea versicolor. In contrast, bacteria are known to cause infections like impetigo or cellulitis, viruses are responsible for conditions like warts or herpes simplex lesions, and dermatophytes are fungi that cause infections such as athlete's foot and ringworm. Understanding the specific causative agent of tinea versicolor is crucial for appropriate treatment and management, often involving antifungal therapies aimed at reducing the yeast population on the skin.

2. Which condition is primarily treated with intravenous antibiotics and surgical intervention?

A. Infected diabetic foot ulcer

B. Flexor tenosynovitis

C. Acute appendicitis

D. Burn wound infection

Flexor tenosynovitis is primarily treated with intravenous antibiotics and surgical intervention due to the potential severity of the infection and the risk of complications if not addressed promptly. This condition usually results from infection of the flexor tendon sheath, often following a penetrating injury to the hand. The infection can lead to systemic effects and possible loss of function of the affected digit if not treated correctly. Intravenous antibiotics provide rapid and effective systemic treatment to control the infection, while surgical intervention is often necessary to relieve pressure, drain pus, and allow for proper healing of the tendon sheath. In contrast, the other conditions listed, while they may also require antibiotics and surgical intervention, do not primarily focus on these immediate treatment modalities in the same way that flexor tenosynovitis does. For example, infected diabetic foot ulcers can often be treated successfully with wound care and oral antibiotics in early stages, and acute appendicitis typically requires surgical removal of the appendix, but not necessarily intravenous antibiotics as a primary treatment. Burn wound infections may require a multifaceted approach including topical treatments and possibly surgical debridement but don't predominantly involve the same level of immediate surgical intervention as flexor tenosynovitis.

3. What does the thickness (T) in the TNM classification of melanoma indicate?

A. The color of the melanoma

B. The percentage of ulceration

C. The depth of tumor invasion

D. The age of diagnosis

The thickness (T) in the TNM classification of melanoma specifically refers to the depth of tumor invasion into the skin. This measurement is crucial as it helps determine the staging of melanoma, which can influence prognosis and treatment options. The thickness is usually measured in millimeters and indicates how deeply the melanoma has penetrated into the skin layers. Understanding the T classification is essential for evaluating the extent of the disease and for making clinical decisions regarding management and therapy for melanoma patients. The other aspects mentioned in the options do not pertain to the TNM classification of melanoma; the color of the melanoma, percentage of ulceration, and the age of diagnosis do not reflect the depth of the tumor invasion, which is why those options do not apply to the thickness categorization.

4. What is the common cause of folliculitis?

A. Staphylococcus aureus

B. E. coli

C. Fungal Infections

D. HSV-1

Folliculitis is commonly caused by Staphylococcus aureus, a bacterium that is often found on the skin and in the nasal passages. This pathogen can invade hair follicles, leading to inflammation and the characteristic pustules or red bumps associated with folliculitis. Staphylococcus aureus is particularly notorious for causing skin infections, making it a primary consideration for folliculitis. The infectious process typically occurs when there is a disruption in the normal skin barrier, which can happen due to shaving, friction from clothing, or other irritative factors. Once the hair follicle is compromised, Staphylococcus aureus can proliferate, resulting in the clinical presentation of folliculitis. In contrast, while there are other microbes that can cause similar conditions, such as E. coli or fungi, they are less commonly associated with folliculitis specifically. E. coli is more often linked to gastrointestinal infections, and fungal infections usually cause different kinds of skin conditions rather than isolated folliculitis. HSV-1 primarily causes viral infections associated with oral herpes and is not typically involved in folliculitis. Thus, Staphylococcus aureus is recognized as the most prevalent organism responsible for this skin condition.

5. What are macules typically described as?

A. Raised lesions on the skin

B. Flat spots on the skin

C. Firm nodular spots

D. Thickened patches with scales

Macules are typically described as flat spots on the skin that are less than 1 centimeter in diameter. They are not raised above the surrounding skin, which differentiates them from other types of skin lesions. Due to their flat nature, macules can be of various colors, including red, brown, or white, and they can be indicative of various conditions, such as freckles, lentigines, or certain inflammatory conditions. Understanding the characteristics of macules is crucial for skin assessment and diagnosis, as they can provide information about underlying dermatological issues. The flatness of macules is key; they remain at the same level as the surrounding skin, allowing for differentiation from raised lesions or nodules, which would involve other types of dermatological terminology and classifications.

6. What type of cancer is Bowen's disease a precursor for?

A. Melanoma

B. Basal cell carcinoma

C. Squamous cell carcinoma

D. Kaposi's sarcoma

Bowen's disease is considered a precursor to squamous cell carcinoma (SCC). It presents as a localized form of intraepithelial carcinoma, characterized by the proliferation of atypical keratinocytes within the epidermis. If left untreated, Bowen's disease has the potential to progress to invasive squamous cell carcinoma, making it important for early detection and intervention. Understanding the different types of skin cancers is crucial in dermatology. While melanoma, basal cell carcinoma, and Kaposi's sarcoma are significant skin cancers, Bowen's disease specifically arises from the keratinocytes and is directly linked to the development of squamous cell carcinoma. Recognition of Bowen's disease and its potential for progression to SCC underscores the importance of vigilance in monitoring and addressing atypical skin lesions.

7. Which bacteria is the principal pathogen in nonbullous impetigo?

A. Streptococcus pneumoniae

B. Staphylococcus aureus

C. Escherichia coli

D. Propionibacterium acnes

Staphylococcus aureus is the principal pathogen in nonbullous impetigo. This type of skin infection is characterized by superficial vesicles that rupture and form crusted lesions, typically occurring in children. Staphylococcus aureus is particularly adept at colonizing the skin and mucous membranes, which is crucial in the development of impetigo. The bacteria can invade areas of broken skin, whether from scratches, insect bites, or other traumas, leading to infection. The production of exoenzymes and toxins by Staphylococcus aureus contributes to its virulence, allowing it to effectively spread and cause skin lesions. Nonbullous impetigo often presents as honey-colored crusts, which are a result of stagnant serum that becomes colonized by this specific bacterium. The nature of Staphylococcus aureus to cause localized skin infections and its common presence on the skin makes it the leading cause of nonbullous impetigo, setting it apart from other bacteria that are involved in different types of infections or are more prevalent in other conditions.

8. What does atrophy look like on the skin?

A. Even skin texture

B. Areas that appear less "full" than normal

C. Inflamed and red areas

D. Uniformly thickened skin

Atrophy in the context of dermatology refers to a thinning or decrease in skin volume, which leads to areas of the skin appearing less "full" than normal. This can result in a variety of visual changes including a shiny appearance, a decrease in skin elasticity, and often, a more pronounced visibility of underlying structures such as blood vessels or muscle. Atrophy may occur due to various factors including aging, prolonged use of topical corticosteroids, or certain skin conditions. It is characterized by a distinct change in texture; therefore, the visual impression of skin areas being less full is a clear indicator of atrophy. The other related options describe different conditions or characteristics of skin but do not align with the definition of atrophy. For example, even skin texture indicates a healthy state, inflamed and red areas suggest irritation or infection, and uniformly thickened skin often relates to other dermatological conditions such as keratosis or scleroderma, rather than atrophy.

9. What is a pyogenic granuloma?

A. A benign skin condition caused by UV exposure

B. A polypoid capillary hemangioma

C. A type of malignant melanoma

D. An ulcerative skin infection

A pyogenic granuloma is classified as a polypoid capillary hemangioma, which means it is a benign growth of blood vessels that appears as a raised, red lesion on the skin. These lesions are typically small but can vary in size and are characterized by their rapid growth and tendency to bleed easily due to their vascular nature. They often arise in response to trauma, irritation, or hormonal changes, although the exact cause is not always clear. In contrast to the other options, a pyogenic granuloma is not related to UV exposure, does not represent a malignant condition such as melanoma, nor is it an ulcerative infection. While some benign skin conditions may arise from sun damage, pyogenic granulomas are specifically vascular in origin and are not caused by sun exposure. The term "ulcerative skin infection" suggests an inflammatory or infectious process, which is not applicable to pyogenic granuloma as it is not inherently infectious and typically does not cause ulceration unless it is traumatized. Thus, understanding the nature of a pyogenic granuloma as a benign vascular lesion helps clarify its proper classification.

10. How is Norweigan scabies treated?

A. Topical steroids

B. Ivermectin

C. Permethrin cream

D. Oral antihistamines

Norwegian scabies, also known as crusted scabies, is a severe form of scabies characterized by the presence of thick crusts of skin infested with a large number of mites. The treatment for Norwegian scabies requires a more aggressive approach compared to typical scabies due to the extensive infestation and the accompanying immune response. Ivermectin is effective because it is an oral medication that works systemically to kill scabies mites. It is particularly important in the treatment of crusted scabies because it can penetrate the thick crusts, reaching the mites that may be buried within the skin. This systemic action makes it superior for cases that are difficult to manage through topical treatments alone. Other treatments, such as permethrin cream, while commonly used for typical scabies, may not be as effective on their own for Norwegian scabies, necessitating the use of ivermectin to ensure complete eradication of the infestation. Topical steroids and oral antihistamines do not target the scabies mites directly, and thus are not effective treatment options for scabies infestations.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://aafmboardsdermatology.examzify.com

We wish you the very best on your exam journey. You've got this!