CMS II Rheumatology E1 Practice Exam (Sample)

Study Guide

Everything you need from our exam experts!

Table of Contents

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. What is the first-line treatment for Tietze syndrome and Costochondritis?

A. Antibiotics

B. Corticosteroid injections

C. NSAIDs

D. Opioid analgesics

2. Which option is listed as an association with pseudogout in the provided material?

A. Osteoarthritis (MC)

B. Hyperparathyroidism

C. Hemochromatosis and Hyperthyroidism

D. All of the above

3. A 10-year FRAX probability above what percent indicates high risk for a hip fracture?

A. 1%

B. 5%

C. 10%

D. 3%

4. Which type of collagen is associated with blood vessels and parenchymal cells?

A. Type I

B. Type IV

C. Type II

D. Type III

5. True or False: Systemic corticosteroids are a standard treatment for osteoarthritis.

A. True

B. False

C. Not recommended

D. Not applicable

6. Which therapeutic approach is indicated for enteropathic arthritis according to the source?

A. IL-23 and TNF inhibitors are used

B. Only NSAIDs are used

C. Surgery is the only treatment

D. Antibiotics are first-line

7. Which knee-related finding is commonly described in rheumatoid arthritis?

A. Gout crystals

B. Baker cyst

C. Osteophytes

D. Chondromalacia

8. Which auto-antibody pair is used to monitor disease activity in vasculitis?

A. p-ANCA & c-ANCA

B. ANA

C. RF

D. Anti-CCP

9. In TOS, which structure is most commonly compressed?

A. Subclavian artery

B. Subclavian vein

C. Brachial plexus

D. Axillary artery

10. What is the recommended first-line treatment for chronic gout flares occurring two or more times per year?

A. Xanthine oxidase inhibitors

B. Colchicine

C. Probenecid

D. Pegloticase

Answers

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

Explanations

1. What is the first-line treatment for Tietze syndrome and Costochondritis?

A. Antibiotics

B. Corticosteroid injections

C. NSAIDs

D. Opioid analgesics

NSAIDs are the first-line approach because Tietze syndrome and costochondritis involve inflammatory pain of the chest wall joints, and NSAIDs directly reduce inflammation and provide analgesia by blocking prostaglandin synthesis. This helps relieve tenderness and swelling with relatively safe, short-term use. Rest and gentle activity modification, plus local heat or ice, can support this treatment. Antibiotics aren't useful since these conditions aren't caused by infection. Corticosteroid injections may help if pain is localized and persistent despite NSAIDs, but they're not the initial choice due to risks and the general effectiveness of NSAIDs. Opioid analgesics are reserved for severe, refractory pain after NSAIDs have been tried, because of their higher risk of adverse effects and dependence.

2. Which option is listed as an association with pseudogout in the provided material?

A. Osteoarthritis (MC)

B. Hyperparathyroidism

C. Hemochromatosis and Hyperthyroidism

D. All of the above

Pseudogout is calcium pyrophosphate deposition disease, so it often sits alongside other joint and metabolic issues. The joints most commonly affected with CPPD can coincide with osteoarthritis, and imaging may show chondrocalcinosis. Beyond OA, several systemic or metabolic conditions predispose to CPPD crystal formation. Hyperparathyroidism disrupts calcium and phosphate balance, increasing deposition risk. Hemochromatosis can damage joints and promote CPPD crystal formation. Some sources also note thyroid disorders, including hyperthyroidism, as associated with CPPD, reflecting broader metabolic links. Because each of these conditions can accompany pseudogout, all of the listed associations are considered valid.

3. A 10-year FRAX probability above what percent indicates high risk for a hip fracture?

A. 1%

B. 5%

C. 10%

D. 3%

FRAX estimates the chance of a hip fracture over the next 10 years using age, sex, and various risk factors. When deciding who might benefit from treatment, guidelines use a threshold to label someone as high risk. For hip fracture, a 10-year probability of about three percent is commonly used as the cutoff for high risk. Crossing this threshold means the likelihood of a hip fracture is sufficient to consider starting preventive therapy, given the substantial impact a hip fracture can have on health and independence in older adults. Keep in mind that exact thresholds can vary by country and guideline updates, but three percent is the typical benchmark used in many contexts.

4. Which type of collagen is associated with blood vessels and parenchymal cells?

A. Type I

B. Type IV

C. Type II

D. Type III

Collagen that lines basement membranes around vessels and supports the surfaces where parenchymal cells sit is type IV. This form forms a flexible, sheet-like network rather than thick fibers, creating the basement membrane that endothelial and epithelial cells rest on and that surrounds blood vessels. Because it forms these non-fibrillar networks, it provides a stable yet permeable foundation for the cells in organs and vessels. In contrast, fibrillar collagens like type I and type II build strong fibers in bone, skin, and cartilage, while type III forms reticular, delicate scaffolds in soft tissues. The basement membrane–associated type IV collagen specifically underpins the structural interface between vessels and the parenchymal cells they service.

5. True or False: Systemic corticosteroids are a standard treatment for osteoarthritis.

A. True

B. False

C. Not recommended

D. Not applicable

Systemic corticosteroids are not a standard treatment for osteoarthritis. Osteoarthritis is mainly a degenerative joint condition where the goal is to relieve pain and improve function with NSAIDs or acetaminophen (and non-pharmacologic measures), rather than dampening a systemic inflammatory process. Systemic steroids carry risks with long-term use—osteoporosis, hyperglycemia, hypertension, weight gain, increased infection risk—and they don't modify the underlying degenerative changes of OA. In contrast, if steroids are used for osteoarthritis, they are typically given as injections directly into the affected joint to provide local anti-inflammatory relief with fewer systemic effects. So the statement is false because systemic corticosteroids are not considered a standard, routine treatment for OA.

6. Which therapeutic approach is indicated for enteropathic arthritis according to the source?

A. IL-23 and TNF inhibitors are used

B. Only NSAIDs are used

C. Surgery is the only treatment

D. Antibiotics are first-line

Enteropathic arthritis responds best to systemic immunomodulation that targets the inflammatory pathways shared by the gut and joints. Blocking TNF-alpha has strong evidence for improving both intestinal inflammation (inflammatory bowel disease) and joint symptoms, making anti-TNF therapies a mainstay. Adding IL-23 pathway inhibition is also effective because IL-23 drives the Th17 inflammatory axis involved in mucosal and joint disease; IL-12/23 inhibitors used in IBD can help with arthritis as well. Together, therapies that inhibit TNF and IL-23 address the underlying inflammatory processes driving the condition. NSAIDs alone often fail to control the arthritis and can worsen gut disease, surgery is not a primary treatment for the inflammatory arthritis, and antibiotics are not a first-line strategy for this condition.

7. Which knee-related finding is commonly described in rheumatoid arthritis?

A. Gout crystals

B. Baker cyst

C. Osteophytes

D. Chondromalacia

Rheumatoid arthritis causes chronic inflammation of the knee joint lining, leading to persistent joint effusions from synovitis. The excess fluid and inflammatory process can extend into the popliteal area, distending the gastrocnemio-semimembranosus bursa and forming a Baker's cyst (popliteal cyst). This behind-the-knee swelling is a classic finding described with inflammatory arthritis like RA. Gout crystals describe urate crystal deposition and are more typical of acute gouty arthritis, not a hallmark knee finding in RA. Osteophytes are bony growths associated with osteoarthritis and degenerative changes rather than RA. Chondromalacia refers to cartilage softening under the patella and is more aligned with patellofemoral pain rather than the inflammatory knee manifestations of RA.

8. Which auto-antibody pair is used to monitor disease activity in vasculitis?

A. p-ANCA & c-ANCA

B. ANA

C. RF

D. Anti-CCP

Autoimmune vasculitis associated with neutrophil cytoplasmic antibodies uses ANCA testing to gauge disease activity. The main antibodies are c-ANCA (usually PR3-ANCA) and p-ANCA (usually MPO-ANCA). In ANCA-associated vasculitis, rising ANCA titers often align with active disease or relapse, while falling levels tend to accompany response to treatment. Clinicians monitor these titers over time together with symptoms, imaging, and inflammatory markers to manage therapy. Other antibodies like ANA, RF, and anti-CCP are associated with different diseases (ANA with lupus spectrum, RF/anti-CCP with rheumatoid arthritis) and aren't used to track vasculitis activity.

9. In TOS, which structure is most commonly compressed?

A. Subclavian artery

B. Subclavian vein

C. Brachial plexus

D. Axillary artery

The structure most commonly compressed in thoracic outlet syndrome is the brachial plexus. Why this is best: the brachial plexus traverses the thoracic outlet and is susceptible to compression in the narrow spaces formed by the first rib, clavicle, and surrounding scalene muscles. When the plexus is compressed, patients typically present with neurogenic symptoms in the arm—numbness, tingling, and weakness—often in the distribution of the ulnar nerves and intrinsic hand muscles. This neurogenic presentation accounts for the vast majority of TOS cases, making the brachial plexus the most frequent structure affected. Compression of the subclavian artery or subclavian vein can occur, but they are less common and lead to vascular signs such as claudication or edema, respectively. The axillary artery is not the usual site of primary compression in TOS.

10. What is the recommended first-line treatment for chronic gout flares occurring two or more times per year?

A. Xanthine oxidase inhibitors

B. Colchicine

C. Probenecid

D. Pegloticase

When gout flares happen repeatedly, the goal is to prevent further attacks by lowering the level of uric acid in the blood. The best first-line approach is a xanthine oxidase inhibitor, such as allopurinol or febuxostat. These drugs reduce the production of uric acid in the liver, steadily lowering serum urate and decreasing crystal formation over time, which translates into fewer flares. Starting urate-lowering therapy often needs a careful plan because lowering uric acid can transiently trigger more flares. To counter this, clinicians commonly give low-dose colchicine or a nonsteroidal anti-inflammatory drug for several months while the uric acid target is reached. The target is usually a serum urate below around 6 mg/dL (lower if tophi are present). Colchicine is effective for treating acute flares and can be used to prevent initiation flares, but it isn't used as the primary long-term strategy to prevent chronic gout by itself. Probenecid, a uricosuric agent, and pegloticase, used for refractory cases, are not considered first-line options.

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://cms2rheumatologue1.examzify.com

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