Hereditary Cancer Risk, Diagnostics, and Treatment Strategies 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. MyRisk testing analyzes what type of genetic material?

A. Tumor DNA

B. Germline DNA

C. Mitochondrial DNA

D. RNA

2. MD-01 included patients with which disease stages?

A. Stage I-III, all subtypes

B. Stage IV only

C. Stage 0 only

D. All stages

3. In MRD surveillance, which interval is typical?

A. Every 1-2 weeks

B. Every 3-6 months

C. Every 2 years

D. Biweekly

4. In the EBLIS study, which MRD assay was employed?

A. Precise MRD

B. Signatera

C. Guardant360

D. CAPP-Seq

5. Does Medicare require patients to be affected for MyRisk coverage?

A. Yes

B. No

C. Only for some conditions

D. Depends on age

6. What types of samples can be used for MyRisk testing?

A. Blood

B. Saliva

C. Blood or saliva

D. Urine

7. Copy number variants in germline testing refer to which type of genetic change?

A. Single base substitutions.

B. Epigenetic changes.

C. Deletions or duplications that can be detected by methods like MLPA or microarray.

D. Balanced translocations.

8. What test definitively diagnoses cancer?

A. Blood test

B. MRI

C. Mammography

D. Biopsy

9. In which cancer is MyChoice CDx used?

A. Breast cancer

B. Prostate cancer

C. Pancreatic cancer

D. Ovarian cancer

10. What type of test is MyRisk?

A. A germline hereditary cancer test

B. A somatic tumor test

C. A pharmacogenomic test

D. A microbiome test

Answers

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

Explanations

1. MyRisk testing analyzes what type of genetic material?

A. Tumor DNA

B. Germline DNA

C. Mitochondrial DNA

D. RNA

MyRisk testing analyzes germline DNA, the inherited genetic material found in every cell and passed from parents to offspring. This type of DNA is typically obtained from blood or saliva and is used to identify pathogenic variants in cancer predisposition genes that can be inherited within a family. It's different from tumor DNA, which comes from cancer tissue and reflects somatic mutations specific to that tumor rather than inherited risk. Mitochondrial DNA is a separate genome with its own inheritance pattern and is not the target of this hereditary cancer risk panel. RNA isn't used for this DNA-based test, since the information the panel looks for is in the DNA sequence itself. So, the test is designed to assess inherited cancer risk by examining germline DNA.

2. MD-01 included patients with which disease stages?

A. Stage I-III, all subtypes

B. Stage IV only

C. Stage 0 only

D. All stages

In clinical trials, the stage of disease is a key factor for determining who can join and how outcomes are interpreted. MD-01 is described as including patients with Stage IV disease only, which means it enrolled individuals with metastatic cancer. This choice creates a homogeneous group where systemic therapy effects can be meaningfully evaluated, since all participants have advanced disease and typically measurable tumors. Why this matters: Stage IV patients often need systemic treatment rather than local, curative approaches, so the trial can assess the drug's activity, safety, and endpoints like objective response or progression-free survival in a consistent setting. Including earlier stages would mix populations with very different treatment goals and endpoints (for example, potential cure with surgery or radiation), making it harder to detect a true drug effect and potentially obscuring safety signals. Stage 0 (carcinoma in situ) and stages I–III represent localized disease with different management and prognosis, so they're not aligned with a trial designed to test a systemic therapy in metastatic disease. Enrolling all stages would dilute the findings and compromise the study's ability to evaluate efficacy in the intended population. Thus, Stage IV only is the best-fit inclusion for this study.

3. In MRD surveillance, which interval is typical?

A. Every 1-2 weeks

B. Every 3-6 months

C. Every 2 years

D. Biweekly

Minimal residual disease surveillance is all about catching relapse early while keeping testing practical for the patient. After achieving remission, relapse risk is highest in the near term, so monitoring needs to be frequent enough to detect rising MRD but not so often that it becomes burdensome or unnecessary given the test's cost and sensitivity. Checking MRD every 3 to 6 months provides a window to identify relapse early enough to intervene, without the strain of weekly or biweekly testing. It also fits common follow-up patterns in many hematologic trials and real-world practice. Testing more often than every few weeks adds little predictive value and increases burden, while spacing out to every two years risks missing a relapse for too long. Therefore, an interval of every 3–6 months is typically used for MRD surveillance in the post-remission period, with adjustments based on individual relapse risk and test characteristics.

4. In the EBLIS study, which MRD assay was employed?

A. Precise MRD

B. Signatera

C. Guardant360

D. CAPP-Seq

MRD detection in this context benefits from a tumor-informed approach that personalizes the assay to each patient's cancer mutations. The EBLIS study used Signatera, a tumor-informed ctDNA MRD test. It starts by sequencing the patient's tumor tissue to identify a set of patient-specific mutations. A personalized, targeted assay then monitors these exact mutations in serial blood samples, allowing highly sensitive detection of any residual disease after treatment and potentially identifying relapse earlier than imaging. This approach tends to be more sensitive for MRD than tumor-naïve panels that screen a fixed set of mutations across many patients, such as broad pretreatment profiling tests. While other methods like CAPP-Seq can be used for MRD, and broad panels like Guardant360 are useful for genomic profiling, they are not the tumor-informed, MRD-focused design used in this study. Precise MRD is not the platform employed here.

5. Does Medicare require patients to be affected for MyRisk coverage?

A. Yes

B. No

C. Only for some conditions

D. Depends on age

Medicare coverage for tests like MyRisk is driven by medical necessity, not just being at risk. In practice, coverage is typically limited to situations where the test will influence management—usually when the patient has a cancer diagnosis or a qualifying clinical indication based on personal history or family history. If someone is asymptomatic and only has a general risk concern, Medicare often does not cover the test. Age isn't the deciding factor; the key is whether testing will change treatment, surveillance, or prevention decisions. So the best answer is that Medicare generally requires the patient to have an affected condition or a qualifying indication for coverage.

6. What types of samples can be used for MyRisk testing?

A. Blood

B. Saliva

C. Blood or saliva

D. Urine

The main concept here is that MyRisk testing accepts more than one specimen type because it analyzes germline DNA and has been validated to work with DNA from both sources. Blood provides high-quality, high-quantity genomic DNA that's routinely used for sequencing panels. Saliva offers a convenient, non-invasive collection method and, with proper stabilization, yields DNA suitable for the same kind of sequencing and analysis. Both options are considered valid because the lab has demonstrated that DNA from either source meets the necessary quality and quantity for the multi-gene hereditary cancer panel. Urine isn't used for this test because it doesn't reliably provide the germline DNA required for comprehensive panel analysis; it usually isn't validated for this purpose, and the DNA obtained is not consistently adequate for accurate sequencing.

7. Copy number variants in germline testing refer to which type of genetic change?

A. Single base substitutions.

B. Epigenetic changes.

C. Deletions or duplications that can be detected by methods like MLPA or microarray.

D. Balanced translocations.

Copy number variants are deletions or duplications of DNA segments that change the number of copies of a genomic region. In germline testing, these structural changes alter gene dosage rather than just the sequence, and they're detected by methods that measure copy number across the genome or targeted genes, such as MLPA or microarray. This distinguishes them from single base substitutions, which are small sequence changes, and from epigenetic changes, which modify gene expression without changing the DNA sequence, or from balanced translocations, which rearrange material between chromosomes without changing the overall copy number. CNVs are important in hereditary cancer because they can underlie pathogenic variants that sequencing alone might miss.

8. What test definitively diagnoses cancer?

A. Blood test

B. MRI

C. Mammography

D. Biopsy

Definitive cancer diagnosis comes from tissue examined under a microscope. A biopsy collects cells from the suspicious area so a pathologist can assess cellular features, pattern, and invasion to confirm malignancy and determine the cancer type. This histopathologic confirmation is the gold standard for diagnosis. Blood tests can reveal abnormalities or tumor markers that raise suspicion or monitor disease, but they don't prove cancer because markers can be false positives or false negatives and are not specific to cancer. Imaging tests like MRI or mammography reveal where a lesion is and guide further testing, but they cannot definitively distinguish cancer from benign conditions without tissue evidence. Biopsy can be performed in several ways depending on location—core needle, incisional, excisional, or fine-needle aspiration—yet the essential idea is obtaining a tissue specimen for microscopic analysis to confirm cancer.

9. In which cancer is MyChoice CDx used?

A. Breast cancer

B. Prostate cancer

C. Pancreatic cancer

D. Ovarian cancer

The main idea is how a companion diagnostic like MyChoice CDx is used to identify tumors that may respond to targeted therapy. MyChoice CDx is designed to assess homologous recombination deficiency (HRD) and BRCA1/2 mutation status in tumor tissue. In ovarian cancer—especially high-grade serous cases—HRD is common and predicts sensitivity to PARP inhibitors. Because of this, MyChoice CDx is used to select ovarian cancer patients who are likely to benefit from PARP inhibitor therapy, guiding treatment decisions such as maintenance after platinum-based chemotherapy. While PARP inhibitors are also used in breast, prostate, and pancreatic cancers, those settings rely on different testing approaches (often BRCA1/2 mutation testing or other HRD assessments specific to those contexts). The MyChoice CDx test is specifically aligned with guiding PARP inhibitor use in ovarian cancer.

10. What type of test is MyRisk?

A. A germline hereditary cancer test

B. A somatic tumor test

C. A pharmacogenomic test

D. A microbiome test

MyRisk is a germline hereditary cancer risk assessment test. It analyzes inherited DNA from normal cells (such as blood or saliva) to identify pathogenic variants in cancer predisposition genes. This information helps estimate an individual's lifetime cancer risk and guide appropriate screening, risk-reduction strategies, and cascade testing for family members. It is not analyzing tumor DNA, which would be a somatic tumor test used to guide treatment; it is not pharmacogenomic testing, which looks at how genes affect drug metabolism and response; and it is not a microbiome test, which examines gut microbial composition.

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://heredirtarycancerrisktreatmentstrat.examzify.com

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