

NBEO PART III PATIENT ENCOUNTERS AND PERFORMANCE SKILLS (PEPS) PRACTICE TEST (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE**

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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

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- 1. RAO follow-up: What is the recommended follow-up interval for CRAO to monitor neovascularization?**
 - A. Every 3-4 weeks for 6 months
 - B. Every 2-3 weeks for 3 months
 - C. Every 6-12 months
 - D. Every 12 weeks for 6 months
- 2. What is the purpose of a laser peripheral iridotomy in AACG management?**
 - A. To permanently reduce aqueous production
 - B. To prevent blockage of the drainage system by creating an alternate pathway
 - C. To remove the iris
 - D. To perform cataract extraction
- 3. Which tests are used for ERM testing?**
 - A. Mac OCT, Fundus photo, Amsler
 - B. Optical coherence tomography angiography, fluorescein angiography, cone dystrophy testing
 - C. Fluorescein angiography, OCT, and Amsler grid
 - D. Visual acuity testing alone
- 4. For follow up after retinal vein occlusion (RVO) treatment, what interval is recommended to monitor for neovascularization over the next six months?**
 - A. Every Two Weeks
 - B. Every 3-4 Weeks
 - C. Every 6 Months
 - D. Annually
- 5. Hypertensive retinopathy stage 4 features include which of the following?**
 - A. Attenuation with AV crossing
 - B. Cotton-wool spots with hemorrhages
 - C. ONH edema, macular star, venous engorgement
 - D. Retinal detachment

- 6. AREDS II supplementation is shown to slow progression in which AMD category?**
- A. Moderate AMD
 - B. Early AMD
 - C. Advanced wet AMD
 - D. Dry AMD
- 7. In blepharitis management when demodex is suspected, which treatment is specifically recommended?**
- A. XDEM VY bid for 6 weeks
 - B. Lid scrubs bid, hot compresses for 10-15 min qd, PFATs, hypochlorous acid spray, omega-3 diet
 - C. Omega-3 diet only
 - D. Hypochlorous acid spray only
- 8. Adenoviral Conjunctivitis follow-up timing: which statement is correct?**
- A. If a steroid is used, follow-up is in 3-4 days; otherwise 2-3 weeks
 - B. Follow-up is always in 1 month
 - C. Follow-up is required daily for a week
 - D. Follow-up is not necessary at all
- 9. There is a surgical option to treat CSR, but what is a potential downside?**
- A. No downsides
 - B. It can lead to other complications down the line
 - C. It always cures CSR
 - D. It causes immediate CNV in all patients
- 10. Which statement best describes the pathophysiology of diabetic retinopathy?**
- A. When blood sugar is high, small retinal vessels leak fluid and protein, potentially affecting the macula and causing blurry vision
 - B. It is caused by increased intraocular pressure damaging the optic nerve
 - C. It results from retinal detachment due to high blood pressure
 - D. It is due to abnormal corneal swelling from diabetes

Answers

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

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Explanations

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1. RAO follow-up: What is the recommended follow-up interval for CRAO to monitor neovascularization?

- A. Every 3-4 weeks for 6 months**
- B. Every 2-3 weeks for 3 months
- C. Every 6-12 months
- D. Every 12 weeks for 6 months

After CRAO, retinal ischemia can trigger neovascularization over the ensuing weeks to months. The risk period extends through about six months, so close surveillance during that time is essential. Following a cadence of every 3–4 weeks for six months allows for timely detection of iris or retinal neovascularization as it first appears, enabling prompt treatment to prevent neovascular glaucoma and preserve vision. If neovascular changes are found, treatment options such as panretinal photocoagulation or anti-VEGF therapy are considered to control the neovascular process. Less frequent follow-up or shorter monitoring periods risk missing early neovascularization during the critical window.

2. What is the purpose of a laser peripheral iridotomy in AACG management?

- A. To permanently reduce aqueous production
- B. To prevent blockage of the drainage system by creating an alternate pathway**
- C. To remove the iris
- D. To perform cataract extraction

Relieving pupillary block by creating a passage in the iris. A laser peripheral iridotomy makes a small hole in the peripheral iris so aqueous humor can move from the posterior chamber to the anterior chamber, bypassing the block that causes angle closure. This equalizes pressures, reduces iris bombe, widens the iridocorneal angle, and lowers intraocular pressure. It's not about reducing aqueous production, removing the iris, or cataract extraction—those are different approaches. The result is an alternate drainage route that helps prevent future angle-closure attacks.

3. Which tests are used for ERM testing?

- A. Mac OCT, Fundus photo, Amsler**
- B. Optical coherence tomography angiography, fluorescein angiography, cone dystrophy testing
- C. Fluorescein angiography, OCT, and Amsler grid
- D. Visual acuity testing alone

For ERM testing you want a combination of structural visualization, documentation, and functional assessment. Macular OCT provides high-resolution cross-sectional images that show the epiretinal membrane on the inner retina, any traction on the fovea, and distortion of retinal layers—this is the primary tool to confirm the membrane and gauge its severity. Fundus photography gives a clear surface image to document the membrane's appearance and extent over time. The Amsler grid evaluates functional impact by revealing metamorphopsia or scotomas that patients notice in daily vision, helping track progression or treatment response. Visual acuity testing alone can show reduced vision but cannot reveal the membrane or quantify distortion. Fluorescein angiography or OCT angiography focus on retinal vasculature and are not routinely required for diagnosing ERM unless another vascular condition is suspected; cone dystrophy testing targets a different disorder. Therefore, the combination of macular OCT, fundus photography, and an Amsler grid best covers ERM testing.

4. For follow up after retinal vein occlusion (RVO) treatment, what interval is recommended to monitor for neovascularization over the next six months?

- A. Every Two Weeks
- B. Every 3-4 Weeks**
- C. Every 6 Months
- D. Annually

Neovascularization after retinal vein occlusion can develop even after initial treatment, driven by persistent retinal ischemia and VEGF. Because these abnormal vessels can form within weeks, close surveillance in the first six months is essential to detect iris or angle neovascularization early and treat promptly before complications like neovascular glaucoma or recurrent edema occur. Monitoring about every 3-4 weeks aligns with the typical treatment cadence and allows timely assessment for new vessels and the need for additional therapy. Longer intervals (six months or annually) risk missing early neovascular changes, while overly frequent visits (every two weeks) are usually not necessary unless progression is evident. Regular dilated exams focusing on the iris and angle (with imaging as needed) complete the monitoring strategy.

5. Hypertensive retinopathy stage 4 features include which of the following?

- A. Attenuation with AV crossing
- B. Cotton-wool spots with hemorrhages
- C. ONH edema, macular star, venous engorgement**
- D. Retinal detachment

Recognize the hallmark features of malignant hypertensive retinopathy (stage 4): optic nerve head edema (papilledema) with leakage signs such as a macular star from hard exudates and venous engorgement due to severe vascular congestion. The optic disc swelling is the defining feature that elevates this to stage 4, with the macular star indicating macular involvement from leakage around the swollen disc. Previous signs like hemorrhages and cotton-wool spots are typical of earlier stages, but without disc edema you'd be in a lower stage. Retinal detachment is not a characteristic part of hypertensive retinopathy stages.

6. AREDS II supplementation is shown to slow progression in which AMD category?

- A. Moderate AMD**
- B. Early AMD
- C. Advanced wet AMD
- D. Dry AMD

AREDS2 is aimed at people with moderate (intermediate) AMD in one or both eyes and looks at whether adding antioxidants and minerals can slow the eye's progression to the advanced forms of AMD. The study found that this supplementation reduces the chance of progressing to advanced AMD (the neovascular or geographic atrophy forms) in those with moderate disease, helping to delay vision decline. It does not apply to early AMD, and once AMD is already in an advanced stage, this supplementation isn't shown to reverse or substantially slow progression. So the best match is moderate AMD.

7. In blepharitis management when demodex is suspected, which treatment is specifically recommended?

- A. XDEMVI bid for 6 weeks
- B. Lid scrubs bid, hot compresses for 10-15 min qd, PFATs, hypochlorous acid spray, omega-3 diet**
- C. Omega-3 diet only
- D. Hypochlorous acid spray only

When demodex is suspected in blepharitis, the treatment that targets both the mites and the resulting lid margin inflammation with a practical, multi-pronged approach is most effective. Regular lid hygiene with scrubs helps physically remove debris and lash-margin crusts where Demodex mites and their byproducts accumulate, making it harder for mites to thrive. Pairing this with warm compresses for several minutes each day loosens meibum, improves gland expressibility, and supports a healthier tear film. Providing lubrication with preservative-free artificial tears keeps the ocular surface comfortable as the lid margin heals. Adding a hypochlorous acid spray at the lid margin gives antimicrobial action directly where mites reside, helping reduce microbial load that can accompany Demodex-related inflammation. Omega-3 fatty acids support meibomian gland function and have anti-inflammatory benefits, which complements both the mechanical cleaning and the glandular treatment. This combination addresses cleaning, heating, tear film support, antimicrobial control, and gland function, making it the most comprehensive and appropriate strategy when Demodex is suspected. Relying on a single therapy, such as omega-3s alone or an antiseptic spray alone, misses key aspects of Demodex blepharitis, so the full regimen provides the best chance for symptom relief and lid-margin health.

8. Adenoviral Conjunctivitis follow-up timing: which statement is correct?

- A. If a steroid is used, follow-up is in 3-4 days; otherwise 2-3 weeks**
- B. Follow-up is always in 1 month
- C. Follow-up is required daily for a week
- D. Follow-up is not necessary at all

The key idea is how the use of a topical steroid changes how soon you recheck a patient with adenoviral conjunctivitis. Adenoviral conjunctivitis is typically self-limiting over a couple of weeks, so if you're not using steroids, you follow the course and reassess after about 2–3 weeks to confirm resolution and watch for any complications. If a steroid is used, you need closer monitoring because steroids can alter healing, mask worsening disease, raise intraocular pressure, or promote steroid-related side effects. For this reason, the patient is rechecked much sooner—typically within 3–4 days—to ensure the infection is improving and to catch any adverse reactions early. The option reflecting this approach is the best, because it aligns follow-up timing with the safety considerations and healing trajectory when steroids are involved. The other timings—daily follow-up for a week, follow-up only at 1 month, or no follow-up at all—don't fit the expected monitoring needs for this condition, especially when steroids are used.

9. There is a surgical option to treat CSR, but what is a potential downside?

- A. No downsides
- B. It can lead to other complications down the line**
- C. It always cures CSR
- D. It causes immediate CNV in all patients

When treating CSR with a surgical option, the idea to focus on is that the intervention may address the current issue but can bring new risks that show up later. Intraocular surgery carries a range of potential complications—such as cataract progression in phakic eyes, infection inside the eye, pressure changes, inflammatory responses, or iatrogenic retinal tears or detachments—that could affect vision even after an initial improvement. Because of these possible downstream issues, a downside of the surgical approach is that it can lead to other complications down the line. The other statements aren't accurate: there isn't no downside, it doesn't always cure CSR, and it doesn't cause immediate choroidal neovascularization in all patients.

10. Which statement best describes the pathophysiology of diabetic retinopathy?

- A. When blood sugar is high, small retinal vessels leak fluid and protein, potentially affecting the macula and causing blurry vision**
- B. It is caused by increased intraocular pressure damaging the optic nerve
- C. It results from retinal detachment due to high blood pressure
- D. It is due to abnormal corneal swelling from diabetes

Chronic high blood sugar damages the retinal microvasculature, leading to breakdown of the blood-retinal barrier. This causes leakage of fluid and plasma proteins from the small retinal vessels, especially around the macula, producing macular edema and blurred vision. Over time, capillary nonperfusion and ischemia promote VEGF-driven neovascularization in proliferative diabetic retinopathy, which increases the risk of hemorrhage and tractional retinal detachment. This description specifically captures the vascular leakage and edema central to diabetic retinopathy. Other statements describe conditions that are not this disease process: increased intraocular pressure affects the optic nerve in glaucoma, retinal detachment is not caused by hypertension in this context, and corneal swelling is a front-of-eye issue unrelated to the retinal microvasculature.

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://nbeopart3peps.examzify.com>

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

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