

PANCE PULMONOLOGY PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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THE FULL VERSION STUDY GUIDE**

<https://pancepulmonology.examzify.com>



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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. Asbestosis is classically associated with which exposure and finding?

- A. Coal mining with pleural plaques
- B. Sandblasting with dermatitis
- C. Welding with fibrosis
- D. Ships, insulation exposure with pleural plaques

2. Which statement about Homan's sign for DVT is most accurate?

- A. It is a highly reliable sign for DVT
- B. It is unreliable for DVT assessment
- C. It confirms DVT when positive
- D. It differentiates DVT from cellulitis

3. Which statement about TB IGRA interpretation is true?

- A. The IGRA can differentiate active TB from latent TB.
- B. IGRA results always require follow-up interpretation.
- C. IGRA results have false positives with BCG vaccination.
- D. IGRA interpretation cannot differentiate active from latent TB.

4. In sarcoidosis, which radiographic finding is NOT typical?

- A. Bilateral hilar lymphadenopathy
- B. Reticulonodular markings
- C. Cavitary lesions
- D. Noncaseating granulomas (histology)

5. Which finding is most indicative of asthma when evaluating airway reversibility?

- A. Reversibility with bronchodilators
- B. No response to bronchodilators
- C. Chronic dry cough without wheeze
- D. Age over 70

- 6. Which symptom is most commonly associated with acute pulmonary embolism?**
- A. Dyspnea at rest
 - B. Productive cough
 - C. Chest rash
 - D. Abdominal pain
- 7. During active TB treatment, how often should sputum AFB smear and culture be obtained until two consecutive cultures are negative?**
- A. Weekly until two negative cultures.
 - B. Monthly until two consecutive negative cultures.
 - C. End of intensive phase.
 - D. Annually.
- 8. Which of the following features best distinguishes asthma from COPD in a patient with dyspnea?**
- A. Onset in childhood, episodic symptoms, atopy, and reversibility with bronchodilators
 - B. Older age with smoking history and less reversibility
 - C. Rapid progression with constant symptoms
 - D. Fever and productive cough
- 9. Which asthma category best describes daytime symptoms more than 2 days per week and nighttime symptoms more than 2 nights per month?**
- A. Mild persistent
 - B. Intermittent
 - C. Moderate persistent
 - D. Severe persistent
- 10. In ARDS, plateau pressure should be limited to what value to minimize barotrauma during low tidal volume ventilation?**
- A. Plateau pressure ≤ 25 cm H₂O
 - B. Plateau pressure ≤ 40 cm H₂O
 - C. Plateau pressure ≤ 60 cm H₂O
 - D. Plateau pressure ≤ 30 cm H₂O

Answers

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

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Explanations

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1. Asbestosis is classically associated with which exposure and finding?

- A. Coal mining with pleural plaques
- B. Sandblasting with dermatitis
- C. Welding with fibrosis
- D. Ships, insulation exposure with pleural plaques**

Asbestos exposure causes chronic lung disease that often shows both interstitial fibrosis (asbestosis) and pleural involvement. The classic setting is work with ships and insulation, where asbestos was heavily used. Pleural plaques—calcified fibrous thickenings on the diaphragmatic or lateral pleura—are a hallmark imaging finding associated with prior asbestos exposure. They can occur with or without significant lung fibrosis and are strong evidence of past exposure. Coal mining causes coal workers' pneumoconiosis with nodules and progressive fibrosis, not the pleural plaques typical of asbestos. Sandblasting can expose to silica, leading to silicosis with upper-lobe nodules and eggshell calcifications, not the pleural plaques typical of asbestos. Welding fumes may cause metal-related lung changes but are not the classic source of pleural plaques. Therefore, exposure to ships and insulation with pleural plaques best fits as the asbestos-associated pattern.

2. Which statement about Homan's sign for DVT is most accurate?

- A. It is a highly reliable sign for DVT
- B. It is unreliable for DVT assessment**
- C. It confirms DVT when positive
- D. It differentiates DVT from cellulitis

Homan's sign is not a reliable indicator for DVT. The test—holding the foot in dorsiflexion to elicit calf pain—has very limited sensitivity and specificity, so a positive or negative result does not meaningfully change the probability of DVT. Calf pain can arise from many other causes (muscle strain, cellulitis, irritation of the Achilles or soleus area, etc.), and some patients with DVT may not have this sign at all. Because of this poor diagnostic value, a positive Homan sign does not confirm DVT, and a negative sign does not rule it out. In practice, diagnosis relies on imaging with compression ultrasonography (and, in low-risk patients, D-dimer to help triage), rather than on Homan's sign.

3. Which statement about TB IGRA interpretation is true?

- A. The IGRA can differentiate active TB from latent TB.
- B. IGRA results always require follow-up interpretation.
- C. IGRA results have false positives with BCG vaccination.
- D. IGRA interpretation cannot differentiate active from latent TB.**

TB IGRA tests measure T-cell release of interferon-gamma in response to TB-specific antigens, which indicates infection with Mycobacterium tuberculosis but does not reveal whether the infection is active or latent. That limitation is why this statement is true: the test cannot differentiate active TB from latent TB based on IGRA results alone. IGRA's specificity is higher in BCG-vaccinated individuals because the antigens used are not present in BCG strains, so prior vaccination does not cause a false-positive IGRA. However, you still determine active disease through clinical evaluation, chest imaging, and microbiologic confirmation, since IGRA cannot distinguish disease activity.

4. In sarcoidosis, which radiographic finding is NOT typical?

- A. Bilateral hilar lymphadenopathy
- B. Reticulonodular markings
- C. Cavitory lesions
- D. Noncaseating granulomas (histology)**

The key idea is that chest imaging in sarcoidosis typically shows signs of lymph node involvement and interstitial lung changes—not tissue-level histology. On radiographs, you'd expect bilateral hilar lymphadenopathy and a reticulonodular pattern from granulomatous infiltration in the lungs. Cavitory lesions are not a typical radiographic feature of sarcoidosis, and when present they raise other possibilities. The histologic hallmark of sarcoidosis is noncaseating granulomas, which are a tissue finding seen on biopsy, not something seen on a chest X-ray. Because the question asks for a radiographic finding, the noncaseating granulomas described histologically are not a radiographic feature, making that option the correct choice.

5. Which finding is most indicative of asthma when evaluating airway reversibility?

- A. Reversibility with bronchodilators**
- B. No response to bronchodilators
- C. Chronic dry cough without wheeze
- D. Age over 70

Reversibility after a bronchodilator is the hallmark feature that points to asthma. In asthma, the airways are inflamed and hyperresponsive, so they often dilate noticeably after inhaled bronchodilators, which shows up as an improvement in spirometry, especially the FEV1. A common teaching threshold is an increase in FEV1 of about 12% and at least 200 mL from baseline within minutes after a short-acting bronchodilator. This pattern helps distinguish asthma from more fixed obstructive conditions, where the bronchodilator effect is minimal or absent. The other scenarios don't fit as well. No response to bronchodilators argues against asthma rather than for it, and a chronic dry cough without wheeze or being over 70 years old are nonspecific and can occur with many other conditions. So, observing a clear bronchodilator-induced improvement in airway function best indicates asthma.

6. Which symptom is most commonly associated with acute pulmonary embolism?

- A. Dyspnea at rest**
- B. Productive cough
- C. Chest rash
- D. Abdominal pain

Acute pulmonary embolism most commonly presents with dyspnea. When a clot blocks part of the pulmonary circulation, it creates a sudden ventilation–perfusion mismatch and reduced oxygenation. The lungs respond by increasing the respiratory drive, so many patients notice shortness of breath that can occur even at rest or with minimal activity. Tachypnea is also commonly seen on exam. The other symptoms listed are less typical: a productive cough might occur with infection or other lung processes, a chest rash points toward dermatologic or systemic conditions, and abdominal pain is not a typical feature of PE. While chest pain can occur if there's pleural irritation, the symptom most often reported by patients with PE is dyspnea.

7. During active TB treatment, how often should sputum AFB smear and culture be obtained until two consecutive cultures are negative?

- A. Weekly until two negative cultures.
- B. Monthly until two consecutive negative cultures.**
- C. End of intensive phase.
- D. Annually.

The key idea is that monitoring response to therapy in active pulmonary TB relies on microbiologic conversion, with culture conversion being the most reliable sign that viable bacilli are no longer present. Sputum cultures are used because they detect living bacteria, whereas smear results can stay positive for a while even after the bacilli are dead. Because a single negative culture could be a fluke or influenced by sampling, two consecutive negative cultures on separate days provide greater confidence that the patient is truly converting and less likely to remain contagious. Monthly testing strikes the right balance between timely confirmation and practicality. Weekly testing would be unnecessarily frequent, and waiting only until the end of the intensive phase could miss ongoing positivity and ongoing infectiousness. Annual testing would be far too infrequent to detect conversion early. Therefore, continuing monthly sputum AFB smear and culture until two consecutive cultures are negative best aligns with how clinicians assess when a patient has achieved microbiologic convertibility and can safely reduce isolation measures while completing the course of therapy.

8. Which of the following features best distinguishes asthma from COPD in a patient with dyspnea?

- A. Onset in childhood, episodic symptoms, atopy, and reversibility with bronchodilators**
- B. Older age with smoking history and less reversibility
- C. Rapid progression with constant symptoms
- D. Fever and productive cough

The feature that best distinguishes asthma from COPD in a dyspneic patient is a history consistent with onset in childhood, episodic symptoms that vary with triggers, and atopy, paired with airflow obstruction that is reversible after bronchodilators. Asthma reflects bronchial hyperreactivity and inflammatory changes that respond well to bronchodilators or anti-inflammatory therapy, so lung function tests often show a noticeable improvement after a bronchodilator challenge (for example, a significant rise in FEV1). In contrast, COPD usually emerges later in life, often after many years of smoking, with a gradual, persistent course and airflow limitation that is less reversible with bronchodilators. Fever and productive cough point to infection or another acute process rather than the typical chronic, reversible pattern of asthma, and rapid progression with constant symptoms is more aligned with COPD than with asthma.

9. Which asthma category best describes daytime symptoms more than 2 days per week and nighttime symptoms more than 2 nights per month?

A. Mild persistent

B. Intermittent

C. Moderate persistent

D. Severe persistent

Asthma severity is defined by how often symptoms occur during the day and how often they wake you at night. Intermittent asthma has daytime symptoms no more than twice weekly and nighttime awakenings no more than twice a month. If daytime symptoms occur more than twice weekly but not daily, and nighttime awakenings occur more than twice a month but not weekly, the category is mild persistent. The described pattern—daytime symptoms more than 2 days per week but not daily, with nighttime awakenings more than 2 nights per month but not many per week—fits this profile. If daytime symptoms were daily or nighttime awakenings were weekly or more, it would be pushed toward moderate or severe persistent. So this scenario best describes mild persistent asthma.

10. In ARDS, plateau pressure should be limited to what value to minimize barotrauma during low tidal volume ventilation?

A. Plateau pressure $\leq$ 25 cm H₂O

B. Plateau pressure $\leq$ 40 cm H₂O

C. Plateau pressure $\leq$ 60 cm H₂O

D. Plateau pressure $\leq$ 30 cm H₂O

In ARDS, the goal of ventilation is to prevent alveolar overdistension by using lung-protective strategies, including low tidal volumes and limiting the pressure applied to the lungs. Plateau pressure is the pressure in the small airways and alveoli during an inspiratory hold when airflow is zero, so it reflects the elastic recoil and distending pressure of the lung itself rather than airway resistance. Keeping this plateau pressure at 30 cm H₂O or lower reduces the risk of barotrauma and further lung injury in the fragile ARDS lung, especially when delivering low tidal volumes of about 4–6 mL/kg predicted body weight. If plateau pressure tends to rise above this threshold, adjust by lowering tidal volume or optimizing PEEP while monitoring to stay under 30 cm H₂O. The other values are not the accepted target for minimizing barotrauma in this setting: pressures higher than 30 cm H₂O increase risk, and a value like 25 cm H₂O, while very protective, is not the standard target and may not be feasible with typical lung-protective settings; 40 cm H₂O or 60 cm H₂O would markedly raise the risk of barotrauma.

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://pancepulmonology.examzify.com>

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

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