

RHEUMATOLOGY PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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THE FULL VERSION STUDY GUIDE**

<https://rheumatology.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. What is the typical pattern and age distribution of juvenile idiopathic arthritis and how is it categorized?**
 - A. Onset before 16 years; oligoarticular, polyarticular (RF-positive/negative), systemic; persistent synovitis and growth-related issues.
 - B. Onset after 60 years; seropositive; bone erosions.
 - C. Onset in adulthood; osteoarthritis-like; single joint.
 - D. Onset in adolescence with only skin findings.
- 2. Which combination best describes Ehlers-Danlos Syndromes?**
 - A. Marfan syndrome
 - B. Scleroderma
 - C. Skin hyperextensibility, joint hypermobility, tissue fragility, vascular involvement
 - D. Osteogenesis imperfecta
- 3. Which imaging modality is most sensitive for detecting enthesitis?**
 - A. X-ray
 - B. Ultrasound with Doppler
 - C. MRI of the brain
 - D. CT scan of the joint
- 4. Which imaging modality is used to locate areas of inflammation before biopsy in suspected inflammatory myopathies?**
 - A. X-ray
 - B. MRI
 - C. Ultrasound
 - D. CT scan
- 5. What is systemic lupus erythematosus (SLE)?**
 - A. An autoimmune, multi-system inflammatory disorder with spontaneous relapses and remissions
 - B. A bacterial infection of the skin
 - C. A neurodegenerative disease
 - D. A purely metabolic disorder

- 6. What is a typical induction regimen for granulomatosis with polyangiitis?**
- A. NSAIDs only.
 - B. Glucocorticoids plus cyclophosphamide or rituximab, followed by maintenance.
 - C. Antimalarials only.
 - D. No treatment.
- 7. Which feature helps distinguish psoriatic arthritis from rheumatoid arthritis?**
- A. Symmetric MCP/PIP involvement with RF positivity.
 - B. Dactylitis, enthesitis, DIP involvement, and asymmetric oligoarthritis.
 - C. RA typically involves DIP joints earlier.
 - D. Psoriatic arthritis excludes axial involvement.
- 8. Which is a key safety monitoring parameter for JAK inhibitors?**
- A. Only monitoring blood glucose
 - B. Monitoring infections, lipid elevations, cytopenias, and liver enzymes
 - C. Only monitoring renal function
 - D. No monitoring needed
- 9. Retinal detachment is a potential concern in EDS presenting with which symptom?**
- A. Chest pain
 - B. Abdominal pain
 - C. Visual loss
 - D. Orthostatic dizziness
- 10. Which presentation in EDS most strongly suggests a vascular event causing hypovolemia?**
- A. Visual disturbance
 - B. Chest heaviness with exertion
 - C. Dizziness on standing
 - D. Orthostatic intolerance

Answers

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

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Explanations

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1. What is the typical pattern and age distribution of juvenile idiopathic arthritis and how is it categorized?

- A. Onset before 16 years; oligoarticular, polyarticular (RF-positive/negative), systemic; persistent synovitis and growth-related issues.**
- B. Onset after 60 years; seropositive; bone erosions.
- C. Onset in adulthood; osteoarthritis-like; single joint.
- D. Onset in adolescence with only skin findings.

Juvenile idiopathic arthritis is inflammatory arthritis that begins in childhood, specifically before 16 years of age. It is not one disease but a group of related conditions defined by pediatric classification. The main patterns are: oligoarticular, which involves four or fewer joints early on; polyarticular, which involves five or more joints and is further divided by rheumatoid factor status into RF-positive and RF-negative forms; and systemic onset, also called Still's disease, characterized by daily fevers, rash, and often systemic features in addition to arthritis. A common thread across these subtypes is persistent synovitis, meaning ongoing inflammation of the joint lining, which in turn can interfere with growth. Chronic joint inflammation near growth plates can lead to growth-related problems such as limb-length discrepancies or angular deformities if not well controlled. This pediatric-onset pattern and the distinct subtypes reflect how JIA is categorized, distinguishing it from adult-onset rheumatoid arthritis or osteoarthritis, which occur later in life and have different patterns (often older age at onset, more erosive disease, and usually different joint involvement).

2. Which combination best describes Ehlers-Danlos Syndromes?

- A. Marfan syndrome
- B. Scleroderma
- C. Skin hyperextensibility, joint hypermobility, tissue fragility, vascular involvement**
- D. Osteogenesis imperfecta

The main idea is recognizing the characteristic pattern of Ehlers-Danlos syndromes: a heritable connective tissue disorder where skin is unusually stretchable, joints move beyond normal range, and tissues are fragile, with vascular complications possible. This combination—skin that can be hyperextensible, joint hypermobility, tissue fragility, and potential vascular involvement—best fits EDS because it captures the hallmark cluster of manifestations seen across many EDS types. Other conditions describe different clusters. Marfan syndrome tends to show tall stature, long fingers, and aortic root widening rather than marked skin hyperextensibility and joint hypermobility. Scleroderma features skin thickening and tightness, not the easily stretchable skin and lax joints. Osteogenesis imperfecta focuses on bone fragility and fractures, sometimes blue sclera, but not prominent skin hyperextensibility or joint hypermobility.

3. Which imaging modality is most sensitive for detecting enthesitis?

- A. X-ray
- B. Ultrasound with Doppler**
- C. MRI of the brain
- D. CT scan of the joint

Enthesitis is inflammation at the insertion of tendons or ligaments into bone, so the best imaging to detect it is one that can visualize soft tissue changes at the enthesis and show active blood flow. Ultrasound with Doppler does exactly this: it directly images the enthesis, revealing thickening, hypoechogenicity, calcifications or erosions at the insertion, and, with Doppler, shows increased vascularity that indicates active inflammation. This combination makes it more sensitive for detecting enthesitis than X-ray or CT, which mainly reveal bone changes that appear later, and often more practical and accessible than MRI, which is great for deep or spine enthesitis but not as sensitive for superficial sites or as readily used for routine peripheral enthesitis assessment.

4. Which imaging modality is used to locate areas of inflammation before biopsy in suspected inflammatory myopathies?

- A. X-ray
- B. MRI**
- C. Ultrasound
- D. CT scan

Inflammatory myopathies produce active inflammation that shows up as edema in affected muscles. MRI is the most sensitive way to visualize this edema across multiple muscles because it provides excellent soft tissue contrast. Using fat-suppressed T2-weighted or STIR sequences, inflamed muscles appear bright, revealing the areas of active disease. This mapping lets you target the biopsy to the most inflamed region, improving the chance of a diagnostic specimen and reducing sampling of non-involved tissue. Contrast-enhanced imaging with gadolinium can further highlight inflamed areas by showing increased vascular permeability and enhancement. Other imaging options don't locate active inflammation as reliably. X-rays don't show soft tissue changes relevant to inflammatory myopathy. CT has limited soft tissue contrast for muscle and involves radiation. Ultrasound can detect some edema but is operator-dependent and less comprehensive for deep or multiple muscles. MRI's sensitivity and scope make it the best choice for guiding biopsy in suspected inflammatory myopathies.

5. What is systemic lupus erythematosus (SLE)?

- A. An autoimmune, multi-system inflammatory disorder with spontaneous relapses and remissions**
- B. A bacterial infection of the skin
- C. A neurodegenerative disease
- D. A purely metabolic disorder

SLE is an autoimmune disease where the immune system turns against the body, producing autoantibodies that trigger inflammation in many organ systems. This systemic immune activity can affect the skin, joints, kidneys, blood cells, brain, and other tissues, leading to a wide range of manifestations. A hallmark feature is a relapsing-remitting course, with periods of flares followed by quieter periods. This description—autoimmune, multi-system inflammatory disease with spontaneous relapses and remissions—best matches what SLE is. It is not a bacterial skin infection, not primarily a neurodegenerative condition, and not a purely metabolic disorder, which is why the other options don't fit.

6. What is a typical induction regimen for granulomatosis with polyangiitis?

- A. NSAIDs only.
- B. Glucocorticoids plus cyclophosphamide or rituximab, followed by maintenance.**
- C. Antimalarials only.
- D. No treatment.

Induction therapy for granulomatosis with polyangiitis is all about rapidly suppressing the systemic vasculitis to prevent organ damage, then locking in remission with maintenance. The standard approach combines high-dose glucocorticoids to quickly control inflammation with a cytotoxic or biologic agent to achieve durable immunosuppression. Specifically, high-dose steroids are given alongside either cyclophosphamide or rituximab, which target the underlying immune process. Once remission is reached, maintenance therapy is used to prevent relapse, typically with agents such as azathioprine or methotrexate, and sometimes rituximab in place of traditional maintenance. Other options like using NSAIDs or antimalarials alone do not suffice to induce remission in GPA, and doing nothing would allow the disease to progress.

7. Which feature helps distinguish psoriatic arthritis from rheumatoid arthritis?

- A. Symmetric MCP/PIP involvement with RF positivity.
- B. Dactylitis, enthesitis, DIP involvement, and asymmetric oligoarthritis.**
- C. RA typically involves DIP joints earlier.
- D. Psoriatic arthritis excludes axial involvement.

Distinguishing features of psoriatic arthritis include dactylitis, enthesitis, distal interphalangeal (DIP) joint involvement, and an asymmetric oligoarthritis pattern. Dactylitis—uniform swelling of an entire digit—is a classic clue for PsA and is not typical of rheumatoid arthritis. Enthesitis, inflammation at tendon and ligament insertions (such as the Achilles tendon or plantar fascia), is another hallmark more commonly seen in PsA than in RA. DIP joint involvement is also more typical of PsA, whereas rheumatoid arthritis classically affects the MCP and PIP joints and spares the DIP joints. The arthritis pattern in PsA is often asymmetric and oligoarticular rather than the typically symmetric polyarthritis seen in RA. In contrast, rheumatoid arthritis usually presents as symmetric polyarthritis involving MCP and PIP joints and is often seropositive for rheumatoid factor or anti-CCP antibodies, with less emphasis on enthesitis, dactylitis, or DIP involvement. Psoriatic arthritis can involve the spine and sacroiliac joints (axial disease), so a statement that PsA excludes axial involvement isn't accurate.

8. Which is a key safety monitoring parameter for JAK inhibitors?

- A. Only monitoring blood glucose
- B. Monitoring infections, lipid elevations, cytopenias, and liver enzymes**
- C. Only monitoring renal function
- D. No monitoring needed

JAK inhibitors affect immune signaling, blood cell production, and liver metabolism, so safe use requires broad safety monitoring across several areas. The most important monitoring includes tracking for infections (due to immune suppression) and regular blood counts to detect cytopenias like anemia or thrombocytopenia, since the drug can blunt hematopoiesis. They can also cause lipid elevations, so periodic lipid panels are needed. Liver enzymes can rise with JAK inhibitors, making routine liver function tests essential. Taken together, monitoring infections, lipids, cytopenias, and liver enzymes covers the main safety risks and guides timely dose adjustments or discontinuation if issues arise. Options focusing only on glucose or renal function, or suggesting no monitoring at all, don't address these broad, simultaneous risks.

9. Retinal detachment is a potential concern in EDS presenting with which symptom?

- A. Chest pain
- B. Abdominal pain
- C. Visual loss**
- D. Orthostatic dizziness

In Ehlers-Danlos syndrome, abnormal collagen in ocular tissues like the sclera makes the retina more vulnerable to tears and detachment. The hallmark sign of retinal detachment is sudden, painless loss of vision in one eye, often with flashes of light or floaters and sometimes a curtain-like shadow as the detachment progresses. Because of this tissue fragility, retinal detachment tends to present primarily with visual disturbance. The other symptoms listed—chest pain, abdominal pain, or orthostatic dizziness—reflect problems in other organ systems and are not typical indicators of retinal detachment.

10. Which presentation in EDS most strongly suggests a vascular event causing hypovolemia?

- A. Visual disturbance
- B. Chest heaviness with exertion
- C. Dizziness on standing
- D. Orthostatic intolerance**

Orthostatic intolerance points to a hemodynamic problem where the body struggles to maintain blood pressure and cerebral perfusion when moving to an upright position. In EDS with vascular involvement, a vascular event can cause acute loss of circulating volume. When standing, gravity further reduces venous return, and if the remaining blood volume isn't enough or the autonomic response can't compensate, brain perfusion drops, producing symptoms like dizziness, lightheadedness, or near-syncope. This pattern directly signals a vascular-related hypovolemia rather than a transient or unrelated issue. Visual disturbances can arise from many causes, chest heaviness with exertion suggests cardiac or pulmonary stress, and dizziness on standing alone can occur with various conditions; but orthostatic intolerance specifically mirrors the volume depletion and impaired upright hemodynamics expected after a vascular event in this setting.

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:

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

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