

STEP 3 UWSA PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. A postmenopausal patient with a vertebral compression fracture. What class of drugs reduces vertebral fracture risk?**
 - A. Calcitonin
 - B. Bisphosphonates
 - C. HRT
 - D. Thiazide diuretics
- 2. A patient with atrial fibrillation starting warfarin therapy. What baseline tests should be obtained prior to starting therapy?**
 - A. CBC, kidney function, liver function, and baseline INR; assess drug interactions and bleeding risk.
 - B. Lipid panel
 - C. Electrolyte panel
 - D. Thyroid function
- 3. Hepatocellular carcinoma arises from which liver cell type?**
 - A. Cholangiocytes
 - B. Endothelial cells
 - C. Hepatocytes
 - D. Hepatic stellate cells
- 4. A child with a history of seizures has poor adherence to antiseizure meds. What is an important management step?**
 - A. Reassess and adjust the antiseizure regimen to improve adherence and seizure control; provide patient/caregiver education and safety planning.
 - B. Switch to a different class of antiseizure drugs without assessing adherence.
 - C. Refer for surgical epilepsy evaluation immediately.
 - D. No changes; rely on trial-and-error dosing.
- 5. Before starting warfarin for atrial fibrillation, which set of baseline tests is recommended?**
 - A. CBC, kidney function, liver function, and baseline INR.
 - B. Lipid panel
 - C. Serum potassium
 - D. Thyroid function

- 6. Anti-centromere antibodies are most characteristic of which form of systemic sclerosis?**
- A. Limited cutaneous systemic sclerosis (CREST)
 - B. Diffuse cutaneous systemic sclerosis
 - C. Systemic lupus erythematosus
 - D. Rheumatoid arthritis
- 7. Tetracyclines, NSAIDs, bisphosphonates, potassium chloride, and iron supplements can cause which condition?**
- A. Medication-induced esophagitis
 - B. Peptic ulcer disease
 - C. GERD
 - D. Esophagitis from smoking
- 8. What is the initial treatment for hypovolemic hyponatremia?**
- A. Normal saline to correct volume and suppress ADH release
 - B. Hypertonic saline
 - C. Fluid restriction
 - D. Diuretics
- 9. Atrial flutter: before cardiac ablation or pharmacologic or electrical conversion, what is recommended due to clot risk?**
- A. Antibiotics
 - B. Immediate cardioversion without anticoagulation
 - C. Antiplatelet therapy only
 - D. Anticoagulation
- 10. Polymyalgia rheumatica treatment is which of the following?**
- A. Steroids (low-dose)
 - B. NSAIDs alone
 - C. Methotrexate
 - D. Biologic therapy

Answers

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

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Explanations

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1. A postmenopausal patient with a vertebral compression fracture. What class of drugs reduces vertebral fracture risk?

- A. Calcitonin
- B. Bisphosphonates**
- C. HRT
- D. Thiazide diuretics

In postmenopausal osteoporosis, reducing osteoclast-driven bone loss lowers the risk of vertebral fractures. Bisphosphonates are potent antiresorptives that bind to bone and inhibit osteoclast activity, leading to decreased bone turnover and increased bone density. This direct suppression of bone resorption translates into a proven reduction in vertebral fracture risk, making them the preferred therapy for someone with a vertebral compression fracture. Other options have weaker or more context-specific effects: calcitonin has a less robust impact on fracture risk, hormone replacement therapy lowers fracture risk but carries significant risks (like thromboembolism and hormone-sensitive cancers), and thiazide diuretics may modestly influence calcium handling but do not address osteoporosis as effectively as bisphosphonates.

2. A patient with atrial fibrillation starting warfarin therapy. What baseline tests should be obtained prior to starting therapy?

- A. CBC, kidney function, liver function, and baseline INR; assess drug interactions and bleeding risk.**
- B. Lipid panel
- C. Electrolyte panel
- D. Thyroid function

When starting warfarin in atrial fibrillation, you need to establish the patient's baseline coagulation status and organ function because warfarin's effect depends on hepatic metabolism and vitamin K-dependent clotting. A CBC checks for thrombocytopenia or existing anemia that could raise bleeding risk. Kidney and liver function are important because warfarin is processed mainly by the liver, and liver disease can increase bleeding risk and alter metabolism; kidney function helps gauge overall health and potential medication interactions. A baseline INR is essential to know where the patient stands before therapy and to guide future dose adjustments and monitoring. Also, assessing potential drug interactions and overall bleeding risk informs safe initiation and management of therapy. Lipid panel, electrolyte panel, and thyroid function aren't required specifically to start warfarin, though they may be relevant for broader AF care.

3. Hepatocellular carcinoma arises from which liver cell type?

- A. Cholangiocytes
- B. Endothelial cells
- C. Hepatocytes**
- D. Hepatic stellate cells

Hepatocellular carcinoma arises from hepatocytes, the liver's main parenchymal cells responsible for metabolism and detoxification. Chronic liver injury from hepatitis viruses, alcohol, or fatty liver leads to genetic mutations in hepatocytes and their clonal expansion into cancer. Other liver cell types have different tumor origins: cholangiocytes line the bile ducts and give rise to cholangiocarcinoma; endothelial cells line the blood vessels and can form other vascular tumors; hepatic stellate cells are involved in fibrosis and are not the source of hepatocellular carcinoma. Thus, the cancer originates from hepatocytes.

4. A child with a history of seizures has poor adherence to antiseizure meds. What is an important management step?

- A. Reassess and adjust the antiseizure regimen to improve adherence and seizure control; provide patient/caregiver education and safety planning.**
- B. Switch to a different class of antiseizure drugs without assessing adherence.
- C. Refer for surgical epilepsy evaluation immediately.
- D. No changes; rely on trial-and-error dosing.

When adherence to antiseizure medication is the main issue, the most important step is to assess and address barriers to taking the medicine and to optimize the regimen for easier, safer use while reinforcing safety plans. Work with the family to identify why doses are missed—cost, access, complicated schedules, side effects, or forgetfulness—and then simplify the plan: consider once-daily or longer-acting formulations if available, use reminders or pill organizers, and provide clear, practical instructions and education for both the child and caregivers. Pair this with safety planning so the patient has a clear plan for seizures and knows what to do at home or at school, including any rescue medications if prescribed. Changing to a different drug class without tackling adherence, pursuing immediate surgical evaluation, or doing nothing and trial-and-error dosing all fail to address the root issue and can lead to continued seizures and increased risk.

5. Before starting warfarin for atrial fibrillation, which set of baseline tests is recommended?

- A. CBC, kidney function, liver function, and baseline INR.**
- B. Lipid panel
- C. Serum potassium
- D. Thyroid function

Starting warfarin requires knowing how your blood clots now and whether your organs that influence drug handling are functioning properly. The liver synthesizes the vitamin K–dependent clotting factors that warfarin ultimately reduces, so checking liver function helps anticipate how strongly the INR may rise and how risky bleeding could be. A baseline INR is important because you'll be using INR to guide dosing once therapy begins, so knowing the current coagulation status provides a reference point for future monitoring. A complete blood count is needed to assess platelets and baseline anemia, both of which raise bleeding risk if you anticoagulate. Kidney function is checked because renal disease is common in patients with atrial fibrillation and can affect overall management and bleeding risk, even though warfarin itself is primarily metabolized by the liver. Lipid panel, potassium, and thyroid function aren't routinely required solely to start warfarin, as they don't directly determine initial dosing or immediate bleeding risk in the way the above tests do.

6. Anti-centromere antibodies are most characteristic of which form of systemic sclerosis?

- A. Limited cutaneous systemic sclerosis (CREST)**
- B. Diffuse cutaneous systemic sclerosis
- C. Systemic lupus erythematosus
- D. Rheumatoid arthritis

Anti-centromere antibodies are most closely associated with the limited cutaneous form of systemic sclerosis, the CREST subset. In this form, skin involvement is confined to the face and hands (often extending to forearms) and patients commonly have features of CREST: Calcinosis, Raynaud phenomenon, Esophageal dysmotility, Sclerodactyly, and Telangiectasias. The restricted distribution of skin and this serologic profile together define the limited form. In contrast, the diffuse form of systemic sclerosis is more often linked to anti-Scl-70 (topoisomerase I) antibodies and widespread skin involvement with greater risk of internal organ fibrosis. SLE and RA have their own characteristic autoantibodies and clinical patterns, not centered on anti-centromere antibodies. So, the presence of anti-centromere antibodies best points to the limited cutaneous (CREST) form.

7. Tetracyclines, NSAIDs, bisphosphonates, potassium chloride, and iron supplements can cause which condition?

- A. Medication-induced esophagitis**
- B. Peptic ulcer disease
- C. GERD
- D. Esophagitis from smoking

Pill-induced esophagitis occurs when certain oral medications irritate or injure the esophageal mucosa if the pill lingers in the esophagus. Tetracyclines, NSAIDs, bisphosphonates, potassium chloride tablets, and iron supplements are classic culprits because they are relatively caustic to mucosa and can get stuck or dissolve where contact is prolonged. The injury presents with odynophagia and chest pain and can mimic reflux, but it's specifically caused by the pill's local mucosal damage rather than general acid exposure. This differs from peptic ulcer disease or GERD, where the primary problem is acid injury to the stomach or distal esophagus from reflux, not a localized reaction to a swallowed pill. Smoking-related esophagitis isn't a recognized standard cause of a discrete pill-induced injury, though smoking can worsen reflux symptoms in general. To prevent this, pills should be taken with plenty of water and the patient should stay upright for at least 30 minutes after taking them. If symptoms occur, stopping the offending medication and evaluating with endoscopy if needed are typical steps.

8. What is the initial treatment for hypovolemic hyponatremia?

- A. Normal saline to correct volume and suppress ADH release**
- B. Hypertonic saline
- C. Fluid restriction
- D. Diuretics

When volume is depleted, the body lowers effective arterial blood volume and releases ADH, which increases water reabsorption and dilutes serum sodium. The best initial treatment is isotonic saline (normal saline) to restore intravascular volume, improve perfusion, and suppress ADH. As volume status improves, ADH decreases, and the kidneys can excrete free water, allowing serum sodium to rise gradually. Hypertonic saline is reserved for severe, life threatening symptoms like seizures or coma, not routine initial management of hypovolemic hyponatremia. Fluid restriction won't help here because the problem is volume depletion, and diuretics would worsen the volume deficit and hyponatremia.

9. Atrial flutter: before cardiac ablation or pharmacologic or electrical conversion, what is recommended due to clot risk?

- A. Antibiotics
- B. Immediate cardioversion without anticoagulation
- C. Antiplatelet therapy only

D. Anticoagulation

In atrial flutter, blood can pool in the atria and form thrombi because the atrial contractions are ineffective. If you move to rhythm control with ablation or electrical or pharmacologic conversion, a formed clot can be dislodged and travel to the brain, causing a stroke or systemic embolism. Because of this embolic risk, anticoagulation is recommended before attempting rhythm control. Therapeutic anticoagulation—using a DOAC or warfarin with appropriate INR targets—is typically given for at least about three weeks before cardioversion or ablation if the flutter has been present for more than 48 hours or its duration is unknown. If the duration is uncertain or the clot risk is high, a transesophageal echocardiogram can be done to exclude a thrombus; if none is found, the procedure can proceed with ongoing anticoagulation. After successful rhythm restoration, continuing anticoagulation for several weeks helps prevent thromboembolism while the atria recover and regain function. Antibiotics are not indicated for this issue, and antiplatelet therapy alone does not provide sufficient protection against stroke risk from atrial thrombi.

10. Polymyalgia rheumatica treatment is which of the following?

- A. Steroids (low-dose)
- B. NSAIDs alone
- C. Methotrexate

D. Biologic therapy

Polymyalgia rheumatica involves systemic inflammation driven in part by interleukin-6 signaling, so therapies that directly block this inflammatory pathway can be highly effective and offer steroid-sparing benefits. Biologic therapy, particularly IL-6 inhibitors, provides targeted control of the inflammatory process, which can lead to rapid symptom relief and allow tapering or avoiding long-term glucocorticoids in patients where steroids pose risks or are not well tolerated. That targeted mechanism makes it the best choice among the options when considering disease control with a focus on reducing steroid exposure. In practice, low-dose steroids remain the standard first-line approach for most patients, while NSAIDs alone are insufficient and methotrexate may help some as an adjunct, but biologics offer a direct anti-inflammatory strategy that can be especially valuable in refractory or steroid-sparing scenarios.

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://step3uwsa.examzify.com>

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

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