# LUNG CANCER PRACTICE TEST (SAMPLE)

## STUDY GUIDE



## SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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https://lungcancer.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.

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# 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!

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# Questions

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**1. What is the significance of malignant pleural effusion in lung cancer staging?**

A. Malignant pleural effusion is M1a (stage IV) and indicates disseminated disease

B. Malignant pleural effusion is M1b

C. Malignant pleural effusion does not affect staging

D. Pleural effusion is always benign

**2. Why is performance status important in lung cancer treatment decisions?**

A. It determines radiation dose alone

B. ECOG performance status predicts tolerance to therapy and prognosis; guides choice of surgery, chemotherapy, and immunotherapy.

C. It only indicates likelihood of metastasis

D. It only affects surgical decisions

**3. What is the goal of maintenance therapy in NSCLC?**

A. Prolong progression-free survival and potentially overall survival; can be continuation of a drug like pemetrexed or switch to a different agent.

B. Cure disease.

C. Achieve rapid tumor shrinkage.

D. Eliminate all mutations.

**4. How does bronchioalveolar cell carcinoma spread and invade?**

A. Spreads hematogenously early

B. Invades central bronchi extensively

C. Spreads along periphery and alveolar septa with no evidence of invasion into surrounding tissue

D. Does not spread at all

**5. What imaging is used for annual lung cancer screening in high-risk patients?**

A. Chest X-ray

B. PET-CT

C. Low-dose helical CT

D. MRI

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**6. What biopsy modality is commonly used to obtain tissue from a central lung lesion for diagnosis?**

A. Fine-needle aspiration from the chest wall

B. Sputum cytology

C. Excisional surgery

D. Bronchoscopy with transbronchial biopsy

**7. Where does lung cancer rank in cancer commonality?**

A. 1st

B. 2nd

C. 3rd

D. 4th

**8. Which histologic features best describe small cell lung cancer?**

A. Large cells with abundant cytoplasm

B. Adenocarcinoma with gland formation

C. Small cells with scant cytoplasm, high nuclear-to-cytoplasmic ratio, and neuroendocrine markers

D. Keratinizing squamous cells

**9. What term describes rare remote effects triggered by an abnormal immune response to a neoplasm, more common in SCLC?**

A. Paraneoplastic syndromes

B. Metastatic syndromes

C. Obstructive syndromes

D. Inflammatory syndromes

**10. The ADAURA trial demonstrated that adjuvant Osimertinib improves which outcome in resected EGFR-mutant NSCLC?**

A. Overall survival

B. Disease-free survival

C. Quality of life

D. Time to brain metastasis

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# Answers

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

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# Explanations

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## 1. What is the significance of malignant pleural effusion in lung cancer staging?

A. Malignant pleural effusion is M1a (stage IV) and indicates disseminated disease

B. Malignant pleural effusion is M1b

C. Malignant pleural effusion does not affect staging

D. Pleural effusion is always benign

*The key idea is that cancer in the pleural space is treated as metastatic disease. When malignant cells are found in the pleural fluid or there is malignant involvement of the pleura, this is classified as M1a. That makes the lung cancer stage IV, reflecting spread beyond the primary tumor within the chest. Even if there aren't distant metastases to organs outside the chest, malignant pleural effusion signifies disseminated disease within the thoracic cavity and upstages the cancer accordingly. This distinction matters because it guides prognosis and treatment toward systemic approaches rather than curative local therapy. Distant metastases outside the chest would be M1b, which is a different subset of stage IV. If the effusion were not malignant, it would not upstage the disease. And malignant pleural effusion is not always benign—the presence of malignant cells in the effusion is what changes the stage.*

## 2. Why is performance status important in lung cancer treatment decisions?

A. It determines radiation dose alone

B. ECOG performance status predicts tolerance to therapy and prognosis; guides choice of surgery, chemotherapy, and immunotherapy.

C. It only indicates likelihood of metastasis

D. It only affects surgical decisions

*A patient's functional status, as captured by ECOG performance status, is used to predict how well they'll tolerate treatment and what their overall outlook might be, which in turn guides what kinds of therapy are appropriate. If someone is fully active or has only mild symptoms (lower ECOG scores), they're more likely to handle aggressive approaches such as curative-intent surgery, platinum-based chemotherapy, or combinations, and they may be good candidates for newer therapies like immunotherapy. If the status is poorer (higher ECOG scores), the risk of serious side effects rises and the expected benefit from intensive treatment diminishes, so clinicians may opt for less intensive regimens, modify dosing, or focus on symptom management and quality of life. In short, performance status helps balance potential benefit against toxicity and directly shapes decisions about surgery, systemic therapy, and immunotherapy, while also informing prognosis. It does not determine radiation dose alone; radiation decisions depend on tumor stage, location, prior treatment, and overall organ function. It is not merely an indicator of metastasis likelihood, and it does not only affect surgical decisions—the status influences a broad range of treatment choices and overall management.*

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## 3. What is the goal of maintenance therapy in NSCLC?

A. Prolong progression-free survival and potentially overall survival; can be continuation of a drug like pemetrexed or switch to a different agent.

B. Cure disease.

C. Achieve rapid tumor shrinkage.

D. Eliminate all mutations.

*Maintenance therapy in NSCLC aims to keep the cancer under control after a response or stable disease from first-line treatment, with the goal of extending how long you stay progression-free and, if possible, overall survival. It works by either continuing at least one drug from the initial regimen (continuation maintenance) or switching to a different, non-cross-resistant agent after initial therapy (switch maintenance). This approach focuses on delaying progression and preserving quality of life rather than shrinking tumors quickly or curing the disease. So the best choice reflects prolonging disease control and potential survival, with options to continue the same drug or switch to another active one.*

## 4. How does bronchioalveolar cell carcinoma spread and invade?

A. Spreads hematogenously early

B. Invades central bronchi extensively

C. Spreads along periphery and alveolar septa with no evidence of invasion into surrounding tissue

D. Does not spread at all

*Bronchioloalveolar carcinoma tends to grow along the surfaces of the alveoli and along the alveolar septa, a pattern called lepidic spread. This means the tumor expands around the periphery of the lung and along the septal walls without breaking through into surrounding tissue early on. That preservation of lung architecture, with tumor cells lining the alveolar surfaces rather than invading the stroma, is why the description of spreading along the periphery and alveolar septa with no evidence of invasion into surrounding tissue is the best fit. If it were to spread hematogenously early, invade central bronchi, or be truly non-spreading, those descriptions wouldn't match the typical lepidic, surface-based growth pattern seen in this tumor.*

## 5. What imaging is used for annual lung cancer screening in high-risk patients?

A. Chest X-ray

B. PET-CT

C. Low-dose helical CT

D. MRI

*The main idea here is that screening asymptomatic, high risk individuals for lung cancer is done with a low dose chest CT. This imaging modality is sensitive enough to detect small nodules that could be early cancers, while the radiation dose is kept low so it can be repeated annually without excessive risk. Large screening trials showed a mortality benefit with low dose CT, which is why it's recommended for annual screening. Chest X ray, by contrast, does not reduce lung cancer mortality and can miss early, curable cancers, so it isn't used for routine screening. PET CT is valuable for staging known cancer or evaluating suspicious nodules after screening, but it's costly and exposes patients to more radiation, making it unsuitable as a first line screening tool for asymptomatic people. MRI doesn't play a role in standard screening either because it's less effective at detecting small lung nodules and is more technically challenging for chest imaging. So, the best choice for annual screening in high risk patients is low dose helical CT of the chest.*

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## 6. What biopsy modality is commonly used to obtain tissue from a central lung lesion for diagnosis?

A. Fine-needle aspiration from the chest wall

B. Sputum cytology

C. Excisional surgery

D. Bronchoscopy with transbronchial biopsy

*Central lung lesions are best sampled through the airways, so bronchoscopy with transbronchial biopsy is the standard approach for diagnosis. By using a flexible bronchoscope, the clinician can directly visualize the central lesion or endobronchial mass and obtain targeted tissue from within or around the bronchial walls. This method yields histology and can be augmented with brushings, washings, or biopsies to increase diagnostic accuracy, all without the need for open surgery. Fine-needle aspiration from the chest wall is more suited to peripheral nodules that abut the chest wall, since central lesions are not easily reached this way and the approach carries additional risks like pneumothorax. Sputum cytology can detect tumor cells but generally has limited sensitivity for central lesions compared with tissue obtained via bronchoscopy. Excisional surgery is much more invasive and reserved for cases where less invasive methods have failed or resection is planned, not for routine diagnostic sampling of a central lesion.*

## 7. Where does lung cancer rank in cancer commonality?

A. 1st

B. 2nd

C. 3rd

D. 4th

*Incidence ranking shows how often new cancer cases are diagnosed. Globally, breast cancer is the most commonly diagnosed cancer, with lung cancer as the second most common. So lung cancer ranks second in cancer commonality. It's helpful to keep in mind that lung cancer has the highest mortality among cancers, even though it isn't the most commonly diagnosed. If it were first, third, or fourth, that would contradict the global incidence data.*

## 8. Which histologic features best describe small cell lung cancer?

A. Large cells with abundant cytoplasm

B. Adenocarcinoma with gland formation

C. Small cells with scant cytoplasm, high nuclear-to-cytoplasmic ratio, and neuroendocrine markers

D. Keratinizing squamous cells

*Small cell lung cancer is a high-grade neuroendocrine carcinoma defined by small cells with scant cytoplasm and a high nuclear-to-cytoplasmic ratio. The nuclei are typically finely granular with inconspicuous nucleoli, and the cells often appear in clusters with frequent mitoses and areas of necrosis. A hallmark is neuroendocrine differentiation, demonstrated by markers such as synaptophysin, chromogranin A, and CD56. This combination distinguishes it from other lung cancers: large cells with abundant cytoplasm point to large cell carcinoma, gland formation indicates adenocarcinoma, and keratinizing cells indicate squamous cell carcinoma. The neuroendocrine features and the characteristic small, compact cells are what make the description fit small cell lung cancer.*

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**9. What term describes rare remote effects triggered by an abnormal immune response to a neoplasm, more common in SCLC?**

A. Paraneoplastic syndromes

B. Metastatic syndromes

C. Obstructive syndromes

D. Inflammatory syndromes

*Paraneoplastic syndromes are remote effects caused by a tumor that arise not from direct invasion but from immune cross-reactivity or ectopic hormone or protein production by the cancer cells. Small cell lung cancer, with its neuroendocrine nature, is especially prone to these. This explains why a patient with SCLC might develop problems like SIADH with hyponatremia, ectopic ACTH production leading to Cushing syndrome, or Lambert-Eaton myasthenic syndrome—issues that occur even when the tumor isn't directly invading the affected tissues. These phenomena are distinct from metastasis, which is the spread of cancer to distant sites and causes symptoms through tumor burden in those sites, or from local obstructive effects caused by a tumor blocking airways or ducts. In short, the remote, immune- or hormone-mediated effects in SCLC are classic examples of paraneoplastic syndromes.*

**10. The ADAURA trial demonstrated that adjuvant Osimertinib improves which outcome in resected EGFR-mutant NSCLC?**

A. Overall survival

B. Disease-free survival

C. Quality of life

D. Time to brain metastasis

*The central measure here is disease-free survival, which tracks how long patients remain free from cancer after surgery and initial treatment. In the ADAURA trial, adding osimertinib after resection significantly extended the time before recurrence or death compared with placebo. This shows the drug's ability to delay cancer return in EGFR-mutant NSCLC after surgery, a primary goal of adjuvant therapy. Overall survival data were not yet mature in the initial reports, and while brain metastases were reduced as a meaningful secondary finding, the most robust and widely reported result was the improvement in disease-free survival.*

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# 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://lungcancer.examzify.com

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

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