ONCOLOGIC EMERGENCIES PRACTICE TEST (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.

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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. In patients with an anterior mediastinal mass, which anesthesia strategy helps minimize airway complications?

A. Maintain spontaneous ventilation

B. Avoid awake intubation

C. Use paralytics early to facilitate intubation

D. Proceed with immediate tracheostomy without airway planning

2. Which of the following is listed as other therapies for SVC syndrome?

A. Radiotherapy

B. Elevation of head, steroids, diuretics

C. Surgery

D. Anticoagulation

3. How does tumor lysis syndrome cause uric acid nephropathy?

A. Hydration and diuresis to flush crystals

B. Uric acid crystals precipitate in renal tubules causing obstruction and AKI

C. Biliary obstruction causing AKI

D. Immune complex deposition in glomeruli

4. What is the drainage limit typically recommended for thoracentesis?

A. 2-3 L

B. 0.5 L

C. 2-2.5 L

D. 1-1.5 L

5. Major blood vessel for venous blood flow from head, neck, upper extremities to heart and lungs and what happens when it is compressed by tumors

A. Aorta

B. Inferior vena cava

C. Pulmonary artery

D. Superior vena cava

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6. Which symptom is a hallmark of SVC syndrome related to venous drainage obstruction?

A. Edema with distended neck veins and facial edema

B. Cough with sputum production

C. Jaundice and dark urine

D. Headache and dizziness only

7. In febrile neutropenia, which statement best reflects the role of routine G-CSF according to guidelines?

A. Routine G-CSF is recommended for all patients with febrile neutropenia.

B. G-CSF is never used in febrile neutropenia.

C. May be used in high-risk patients to reduce duration of neutropenia.

D. Only used after neutrophil counts recover.

8. What is the most common first symptom of MSCC, and what are the other symptoms?

A. Most common: pain; other symptoms: motor deficit, sensory deficit, autonomic dysfunction

B. Most common: fever; other symptoms: cough

C. Most common: numbness; other symptoms: dizziness

D. Most common: swelling; other symptoms: fatigue

9. What is the initial management priority for suspected superior vena cava syndrome due to thoracic malignancy?

A. Maintain airway and hemodynamic stability; administer steroids for edema and plan urgent radiation therapy or endovascular relief as definitive treatment.

B. Wait and watch with supportive care only.

C. Begin anticoagulation immediately and defer radiation therapy.

D. Proceed directly to surgical bypass without steroids.

10. How is cancer-associated pulmonary embolism typically treated?

A. Anticoagulation with LMWH; DOACs may be used depending on tumor type and bleeding risk; consider IVC filter if anticoagulation contraindicated

B. Anticoagulation with aspirin only

C. Thrombolysis as first-line for all cases

D. No anticoagulation due to bleeding risk

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Answers

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

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Explanations

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1. In patients with an anterior mediastinal mass, which anesthesia strategy helps minimize airway complications?

A. Maintain spontaneous ventilation

B. Avoid awake intubation

C. Use paralytics early to facilitate intubation

D. Proceed with immediate tracheostomy without airway planning

Maintaining spontaneous ventilation is the safest approach when anesthesia is planned for an anterior mediastinal mass because the mass can compress the airway more as consciousness and muscle tone are lost. Keeping the patient breathing on their own preserves negative intrathoracic pressure and airway tone, helping keep the trachea and bronchi open during induction. It also buys time to manage the airway with the patient in a less collapsible state, rather than rushing to paralysis and positive-pressure ventilation that can worsen obstruction. Paralytics early would remove the patient's spontaneous breathing, increasing the risk of airway collapse or complete obstruction in the setting of external airway compression. Immediate tracheostomy without airway planning ignores the high likelihood of difficult airway management and may not provide a safe, controlled route to ventilation. Avoiding awake airway techniques misses a strategic option that maintains spontaneous respiration during airway assessment and intubation. By preserving the patient's own breathing during induction, you minimize the chance of sudden airway collapse and keep a safer path to definitive airway control.

2. Which of the following is listed as other therapies for SVC syndrome?

A. Radiotherapy

B. Elevation of head, steroids, diuretics

C. Surgery

D. Anticoagulation

The main idea is how to provide immediate, non-definitive relief for SVC syndrome while cancer-directed treatment is arranged. Elevating the head improves venous drainage from the upper body by gravity, helping reduce facial and neck edema. Steroids can shrink surrounding edema and inflammation around the tumor or lymph nodes, often producing rapid relief of symptoms. Diuretics help lower circulating volume and venous congestion, contributing to decreased edema. Together, these are supportive, non-surgical measures aimed at symptom relief and stabilization, distinct from definitive cancer treatments like radiotherapy or chemotherapy. Radiotherapy is a primary treatment to target the obstruction itself, so it isn't grouped with these supportive measures. Anticoagulation would only be appropriate if a thrombus is contributing to the obstruction, not as a general therapy for SVC syndrome. Surgery is not typically a first-line or routine management for this condition.

3. How does tumor lysis syndrome cause uric acid nephropathy?

A. Hydration and diuresis to flush crystals

B. Uric acid crystals precipitate in renal tubules causing obstruction and AKI

C. Biliary obstruction causing AKI

D. Immune complex deposition in glomeruli

Tumor lysis syndrome causes uric acid nephropathy because rapid breakdown of malignant cells dumps a huge load of purines into the bloodstream, which are metabolized to uric acid. The resulting hyperuricemia, with very high urinary uric acid, leads to crystallization within the renal tubules. Those uric acid crystals obstruct tubular flow and injure tubular cells, impairing kidney function and causing acute kidney injury. Hydration and diuresis help by increasing urine flow to flush out crystals and reduce their precipitation. The other mechanisms described don't fit this scenario: biliary obstruction affects the liver, immune complex deposition causes glomerulonephritis, and neither explains uric acid crystal–induced tubular obstruction seen in TLS.

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4. What is the drainage limit typically recommended for thoracentesis?

A. 2-3 L

B. 0.5 L

C. 2-2.5 L

D. 1-1.5 L

The main idea is safety in fluid removal. Draining pleural fluid too quickly or in large amounts can cause re-expansion pulmonary edema and hemodynamic instability from sudden shifts in intrathoracic pressure and venous return. To balance relief with risk, the typical drainage limit in one thoracentesis is about 1 to 1.5 liters. Draining more than this in a single session increases the risk of complications, while draining too little (like 0.5 L) may not provide meaningful relief or diagnostic value. If more fluid is needed, the procedure can be staged or a catheter can be placed for gradual drainage over time.

5. Major blood vessel for venous blood flow from head, neck, upper extremities to heart and lungs and what happens when it is compressed by tumors

A. Aorta

B. Inferior vena cava

C. Pulmonary artery

D. Superior vena cava

The major venous channel that returns blood from the head, neck, and upper limbs to the heart is the superior vena cava. It collects blood from the brain, face, neck, and arms via the brachiocephalic veins and drains directly into the right atrium. If a tumor in the mediastinum compresses this vessel, venous drainage from the upper body is obstructed, raising upstream venous pressure. That produces upper-body venous congestion—swelling of the face and neck, distended neck veins, and often edema of the arms. It can also cause shortness of breath, coughing, and headaches from increased intracranial venous pressure. The aorta is arterial and exits the heart to the body; the inferior vena cava drains the lower body; the pulmonary artery carries blood to the lungs. The scenario described points to compression of the superior vena cava and the resulting SVC syndrome.

6. Which symptom is a hallmark of SVC syndrome related to venous drainage obstruction?

A. Edema with distended neck veins and facial edema

B. Cough with sputum production

C. Jaundice and dark urine

D. Headache and dizziness only

Obstruction of the superior vena cava blocks venous drainage from the head, neck, and upper extremities, leading to venous congestion in those areas. The best clue is edema of the face with swelling of the upper body and distended neck veins, which directly reflects the elevated venous pressure above the blockage. Other listed symptoms point to other problems—productive cough suggests airway disease, jaundice/dark urine indicates liver or biliary issues, and headaches or dizziness can occur with raised intracranial pressure but aren't the defining feature of SVC obstruction. So the combination of facial edema plus distended neck veins is the hallmark sign.

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7. In febrile neutropenia, which statement best reflects the role of routine G-CSF according to guidelines?

A. Routine G-CSF is recommended for all patients with febrile neutropenia.

B. G-CSF is never used in febrile neutropenia.

C. May be used in high-risk patients to reduce duration of neutropenia.

D. Only used after neutrophil counts recover.

The question tests how G-CSF is used in febrile neutropenia. Guidelines do not endorse giving G-CSF routinely to every patient with febrile neutropenia. Instead, G-CSF may be considered in patients who are at high risk for complications, with the goal of shortening the duration of neutropenia (and potentially reducing hospital stay), rather than treating the fever itself. It's used during the neutropenic phase to hasten neutrophil recovery, not after neutrophil counts have already recovered. So the best statement is that G-CSF may be used in high risk patients to reduce the duration of neutropenia.

8. What is the most common first symptom of MSCC, and what are the other symptoms?

A. Most common: pain; other symptoms: motor deficit, sensory deficit, autonomic dysfunction

B. Most common: fever; other symptoms: cough

C. Most common: numbness; other symptoms: dizziness

D. Most common: swelling; other symptoms: fatigue

In malignant spinal cord compression, the earliest clue is pain caused by the tumor and surrounding edema pressing on the spinal structures. This pain is typically localized to the level of compression and often worsens with movement or at night, signaling that the spinal canal is being affected. As the compression progresses, neurological deficits appear. You'd then see weakness or motor problems, sensory changes such as numbness or decreased sensation, and autonomic dysfunction like bladder or bowel problems. This sequence—pain first, then motor and sensory changes, with autonomic issues—is why the correct explanation lists pain as the most common initial symptom along with motor deficit, sensory deficit, and autonomic dysfunction as the subsequent problems. Fever isn't a hallmark feature of MSCC at presentation, dizziness isn't typical, and swelling isn't a defining symptom of this emergency. Recognizing pain as the first sign helps prompt urgent imaging and treatment to prevent further neurological injury.

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9. What is the initial management priority for suspected superior vena cava syndrome due to thoracic malignancy?

A. Maintain airway and hemodynamic stability; administer steroids for edema and plan urgent radiation therapy or endovascular relief as definitive treatment.

B. Wait and watch with supportive care only.

C. Begin anticoagulation immediately and defer radiation therapy.

D. Proceed directly to surgical bypass without steroids.

The key idea is that this is an oncologic emergency, so the first priority is to secure the patient's airway and hemodynamics. Obstruction in the superior vena cava from a thoracic malignancy can cause rapid facial and neck swelling, dyspnea, and potential airway compromise. Stabilizing breathing and circulation is essential before pursuing definitive tumor-directed therapy. Steroids are given promptly because they reduce inflammatory edema around the tumor and the compressed vessels, which can improve venous return and airway patency quickly. After stabilization, definitive relief of the obstruction should be pursued urgently with radiation therapy or endovascular decompression (such as stenting) to decompress the SVC and alleviate symptoms. Anticoagulation is not the immediate priority unless there is a clear thrombotic component, and proceeding to surgical bypass without addressing the edema and obstruction is not appropriate as a first move. Waiting or providing only supportive care without addressing the edema and obstruction risks rapid deterioration.

10. How is cancer-associated pulmonary embolism typically treated?

A. Anticoagulation with LMWH; DOACs may be used depending on tumor type and bleeding risk; consider IVC filter if anticoagulation contraindicated

B. Anticoagulation with aspirin only

C. Thrombolysis as first-line for all cases

D. No anticoagulation due to bleeding risk

Treating cancer-associated pulmonary embolism centers on anticoagulation to prevent clot propagation and recurrence, since cancer patients have a higher risk of thrombosis and recurrence after a PE. Historically the preferred agent has been low molecular weight heparin, which has shown better outcomes in cancer patients than some other anticoagulants. Direct oral anticoagulants can be used in many patients today, but choice depends on the tumor type and bleeding risk (GI cancers, for example, may pose higher bleeding risk with DOACs). If anticoagulation is truly contraindicated because of active bleeding or other high bleeding risks, an inferior vena cava filter may be considered to prevent further emboli. Thrombolysis is not the routine first-line treatment for all cancer-associated PE and is reserved for patients with massive, life-threatening PE or certain high-risk situations, due to the substantial bleeding risk. Aspirin alone does not provide adequate treatment for a PE, and no anticoagulation is not typical unless there is an absolute contraindication.

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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://oncologicem.examzify.com

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

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