

APEA MANAGEMENT ORTHOPEDICS PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

<https://apeamgmtortho.examzify.com>



Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	15

SAMPLE

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

SAMPLE

- 1. Suspected septic arthritis in an adult: immediate workup and initial management?**
 - A. Urgent joint aspiration with Gram stain, culture, cell count; imaging as needed; start IV antibiotics after aspiration and proceed to irrigation/debridement if purulent.
 - B. Start IV antibiotics before aspiration.
 - C. Observe and wait.
 - D. Joint aspiration is unnecessary.
- 2. Which test assesses hip abductor strength?**
 - A. Trendelenburg pelvic tilt test
 - B. Romberg balance test
 - C. Barlow test
 - D. Kernig sign
- 3. In suspected septic arthritis, when is MRI most appropriate?**
 - A. As the first-line imaging in all suspected cases.
 - B. To guide aspiration when ultrasound is clearly diagnostic.
 - C. Not needed if ultrasound shows a simple effusion.
 - D. For detailed assessment if ultrasound findings are inconclusive.
- 4. Which of the following factors is associated with prognosis after ACL reconstruction?**
 - A. Age, activity level, graft type, concomitant meniscal injuries, rehab compliance, smoking
 - B. Age and sex
 - C. Only graft type
 - D. Only rehabilitation duration
- 5. Which factor described below would most clearly increase osteoporosis risk in an older male?**
 - A. Low body weight, age 60 years
 - B. Regular exercise, age 60 years
 - C. Chronic glucocorticoid therapy, age 70 years
 - D. High calcium intake, age 70 years

- 6. Occipital pain and headache can occur with which injury?**
- A. Cervical whiplash injury
 - B. Low back strain
 - C. Elbow sprain
 - D. Ankle sprain
- 7. Which statement best describes the adolescent scoliosis finding?**
- A. There can be unequal rib prominences or shoulder heights.
 - B. It is more common in males and is idiopathic.
 - C. The diagnosis can be made when the curvature is 8 degrees or more.
 - D. There is a strong familial component to this condition.
- 8. In Osgood-Schlatter disease, what assessment finding is typical?**
- A. The pain is always bilateral.
 - B. Pain worsens with quadriceps contraction.
 - C. There will be an avulsion of the quadriceps tendon.
 - D. Assessments vary. An X-ray can be used for diagnosis.
- 9. In suspected septic arthritis, what is the next step if purulence is found during joint aspiration?**
- A. Proceed to irrigation and debridement.
 - B. Switch to oral antibiotics only.
 - C. Observe and discontinue treatment.
 - D. Ignore Purulence.
- 10. How are most acute AC separations managed in practice?**
- A. Nonoperative management with sling for Grades I-III; surgery for higher-grade injuries (IV-VI) or persistent symptoms
 - B. Immediate surgery for all
 - C. Physical therapy only
 - D. Casting for all

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. Suspected septic arthritis in an adult: immediate workup and initial management?

- A. Urgent joint aspiration with Gram stain, culture, cell count; imaging as needed; start IV antibiotics after aspiration and proceed to irrigation/debridement if purulent.
- B. Start IV antibiotics before aspiration.
- C. Observe and wait.
- D. Joint aspiration is unnecessary.

*In suspected septic arthritis, action focuses on rapid confirmation of infection and immediate source control to prevent joint destruction. The key step is urgent aspiration of the affected joint to obtain synovial fluid for Gram stain, cell count, and culture. The fluid analysis typically shows a markedly elevated white blood cell count with neutrophil predominance, and cultures (and Gram stain) help identify the culprit organism so therapy can be targeted. Imaging, such as ultrasound, can help guide aspiration or assess the extent of effusion, but it should not delay drainage. Once the sample is obtained, start intravenous antibiotics right away to cover the common pathogens (especially *Staphylococcus aureus*, including MRSA) and to begin treatment promptly. Tailor the regimen when culture results come back. If the fluid is purulent or there's evidence of ongoing infection, proceed to irrigation and debridement for definitive source control. Delaying drainage or waiting without action risks rapid joint damage and sepsis. Starting antibiotics before aspiration can reduce the diagnostic yield, so the preferred sequence is obtain synovial fluid first, then initiate empiric IV antibiotics, with escalation or de-escalation based on culture results.*

2. Which test assesses hip abductor strength?

- A. Trendelenburg pelvic tilt test
- B. Romberg balance test
- C. Barlow test
- D. Kernig sign

The test focuses on assessing the strength of the hip abductors, primarily the gluteus medius and minimus. When you stand on one leg, these muscles keep the pelvis level. If the hip abductors on the stance leg are weak, the pelvis drops on the side opposite the stance leg, producing a positive Trendelenburg sign. This makes it a direct way to gauge abductor strength and pelvic stability during unilateral stance, which is why it best fits the question. The other tests are for different purposes: balance/proprioception with Romberg, screening for developmental hip instability in infants with the Barlow test, and meningeal irritation with Kernig sign.

3. In suspected septic arthritis, when is MRI most appropriate?

- A. As the first-line imaging in all suspected cases.
- B. To guide aspiration when ultrasound is clearly diagnostic.
- C. Not needed if ultrasound shows a simple effusion.
- D. For detailed assessment if ultrasound findings are inconclusive.

In suspected septic arthritis, ultrasound is used first to detect fluid and guide joint aspiration. MRI is most appropriate when ultrasound findings are inconclusive or when there is concern for more extensive disease that ultrasound cannot fully characterize. MRI provides superior soft-tissue contrast and can reveal bone marrow edema, occult osteomyelitis, synovitis, abscesses, and the precise extent of joint and surrounding tissue involvement, which is crucial for planning treatment. If ultrasound clearly shows a simple effusion with no signs suggesting deeper infection, MRI isn't needed. MRI isn't typically the first test in all suspected cases, and it isn't usually used to guide aspiration—that role belongs to ultrasound.

4. Which of the following factors is associated with prognosis after ACL reconstruction?

- A. Age, activity level, graft type, concomitant meniscal injuries, rehab compliance, smoking**
- B. Age and sex
- C. Only graft type
- D. Only rehabilitation duration

Prognosis after ACL reconstruction depends on multiple interacting factors that influence healing, graft incorporation, knee stability, and the ability to regain function. Age and activity level shape both the biology of healing and the demands the graft must withstand; younger, more active patients may push the graft harder and have different failure risks, while older patients may have slower healing but lower activity demands. Graft type matters because different graft sources (autograft vs allograft) have distinct healing timelines, strength properties, and donor-site effects that can influence early stability and long-term outcomes. Concomitant meniscal injuries affect knee mechanics, joint surface health, and the risk of later osteoarthritis, all of which impact prognosis. Rehabilitation compliance is crucial to restore range of motion, strength, and neuromuscular control and to enable a safe return to activity; poor adherence is a major predictor of poorer outcomes. Smoking impairs healing and graft maturation by reducing blood flow and tissue healing capacity, further affecting prognosis. Taken together, these factors provide a more accurate picture than any single element alone.

5. Which factor described below would most clearly increase osteoporosis risk in an older male?

- A. Low body weight, age 60 years
- B. Regular exercise, age 60 years
- C. Chronic glucocorticoid therapy, age 70 years**
- D. High calcium intake, age 70 years

Chronic glucocorticoid therapy is a major trigger for osteoporosis because it directly disrupts bone remodeling at multiple levels. These drugs suppress osteoblast formation and promote osteoblast and osteocyte death, leading to a sharp drop in bone formation. They also tilt the balance toward resorption by increasing RANKL and decreasing osteoprotegerin, so osteoclast activity rises. In addition, glucocorticoids reduce calcium absorption from the gut and increase calcium loss in the urine, lowering the calcium available for bone. This combination accelerates bone loss, especially in older individuals whose bone density is already declining with age. While low body weight, age, and lack of activity are risk factors, the effect of long-term glucocorticoid therapy is a direct and potent driver of osteoporosis, making it the factor most clearly increasing risk in an older male. Regular exercise and adequate calcium intake help reduce risk, whereas chronic steroid exposure drives it up.

6. Occipital pain and headache can occur with which injury?

A. Cervical whiplash injury

B. Low back strain

C. Elbow sprain

D. Ankle sprain

Occipital pain and headaches after a neck injury come from damage to the upper cervical structures and the surrounding soft tissues. In a whiplash event, the head is suddenly accelerated and decelerated, stressing the posterior neck muscles, ligaments, facet joints, and nearby nerves. This irritation can involve the suboccipital muscles and the greater occipital nerve, leading to pain at the back of the head and into the temples or neck. The other injuries listed affect different body regions and are not typically associated with occipital headaches; they involve the lower back, elbow, or ankle and don't commonly produce the characteristic head-and-neck pain pattern seen with cervical whiplash.

7. Which statement best describes the adolescent scoliosis finding?

A. There can be unequal rib prominences or shoulder heights.

B. It is more common in males and is idiopathic.

C. The diagnosis can be made when the curvature is 8 degrees or more.

D. There is a strong familial component to this condition.

Adolescent scoliosis shows up as asymmetry of the trunk from a lateral spinal curve with rotation of the vertebrae. On exam you'll commonly see unequal rib prominences and uneven shoulder heights, signs that become especially evident when the patient bends forward to reveal a rib hump. These visual and palpable clues are the most useful clinical indicators in teens, which is why this statement is the best description. While scoliosis can run in families and many cases are idiopathic, it is more common in females, not males. The diagnosis is made radiographically by a Cobb angle of 10 degrees or more; an 8-degree curvature isn't the standard diagnostic threshold. The key point is the visible trunk asymmetry due to rib cage rotation, which the chosen statement captures.

8. In Osgood-Schlatter disease, what assessment finding is typical?

A. The pain is always bilateral.

B. Pain worsens with quadriceps contraction.

C. There will be an avulsion of the quadriceps tendon.

D. Assessments vary. An X-ray can be used for diagnosis.

Osgood-Schlatter disease is a traction injury of the tibial tubercle caused by repetitive pulling of the patellar tendon through the growing knee in adolescents. The hallmark assessment finding is pain and tenderness at the tibial tubercle that gets worse with activities that contract the quadriceps, because bending the knee and forcing the quadriceps to contract increases tension on the patellar tendon and strains the developing tibial tubercle. This explains why resisted knee extension or activities like running and jumping provoke the pain. It's common for the pain to be localized to the tibial tubercle and to fluctuate with activity, and it can be unilateral or, less frequently, bilateral. Imaging, such as an X-ray, can show fragmentation or irregularity of the tibial tubercle in some cases, but the diagnosis is largely clinical and based on the activity-related pain and tenderness. The idea that the problem always presents bilaterally, or that it involves an avulsion of the quadriceps tendon, doesn't fit the typical mechanism or presentation.

9. In suspected septic arthritis, what is the next step if purulence is found during joint aspiration?

- A. Proceed to irrigation and debridement.**
- B. Switch to oral antibiotics only.
- C. Observe and discontinue treatment.
- D. Ignore Purulence.

Purulence in a suspected septic joint signals established infection that must be controlled immediately. The best next step is urgent irrigation and debridement of the joint to physically remove purulent material and infected tissue, reduce the bacterial load, and allow antibiotics to work effectively. This is typically done with rapid arthroscopic irrigation/debridement (or open debridement if needed), with cultures obtained at the time of the procedure. Start broad-spectrum intravenous antibiotics right away after obtaining cultures and tailor them once results return. Purulent drainage cannot be reliably treated with antibiotics alone taken by mouth, and delaying drainage risks rapid cartilage destruction and systemic spread.

10. How are most acute AC separations managed in practice?

- A. Nonoperative management with sling for Grades I-III; surgery for higher-grade injuries (IV-VI) or persistent symptoms**
- B. Immediate surgery for all
- C. Physical therapy only
- D. Casting for all

In acute AC separations, treatment is guided by how severely the ligaments are torn and how much the clavicle is displaced. For most injuries that are mild to moderate (grades I–III), nonoperative management with a sling provides comfortable immobilization while the ligaments heal, followed by structured rehabilitation to restore range of motion and strength. This approach works well because the damage is often limited to the AC ligaments, with the coracoclavicular (CC) ligaments intact or only minimally involved, allowing functional recovery without the risks of surgery. Surgery is reserved for more severe injuries (grades IV–VI) where there is marked displacement and substantial disruption of both the AC and CC ligaments, as well as for cases with persistent symptoms or instability after an initial trial of nonoperative care. In these high-grade injuries, operative stabilization aims to anatomically reconstruct the ligaments and restore AC/CC stability, which improves pain, function, and the ability to return to high-demand activities. So, the best approach in practice is nonoperative for less severe injuries (with a sling) and surgical intervention for higher-grade injuries or when symptoms persist despite nonoperative treatment.

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://apeamgmtortho.examzify.com>

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

SAMPLE