

CERVICAL SPINE ORTHOPEDICS II PRACTICE EXAM (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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

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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 Bakody's sign and what does it indicate?

- A. Relief of radicular symptoms with arm elevation (shoulder abduction) indicating foraminal compression
- B. Worsening of radicular symptoms with arm elevation indicating central stenosis
- C. No change with arm movement
- D. Relief with neck extension indicating facet arthropathy

2. Which statement about TOS evaluation is true?

- A. A combination of clinical exam, imaging, EMG, and vascular studies is commonly used.
- B. Only imaging is necessary.
- C. Blood tests confirm the diagnosis.
- D. Surgical exploration is first-line.

3. Central canal stenosis typically presents with which type of clinical presentation compared to foraminal stenosis?

- A. Central canal stenosis presents with myelopathy (gait disturbance and brisk reflexes); foraminal stenosis presents with radicular pain and numbness
- B. Central canal stenosis presents with isolated neck pain; foraminal stenosis presents with myelopathy
- C. Central canal stenosis presents with radicular pain only; foraminal stenosis presents with gait disturbance
- D. Central canal stenosis presents with lower motor neuron signs; foraminal stenosis presents with upper motor neuron signs

4. Which statement describes reflexive SJD?

- A. It is defined by insidious onset
- B. It is caused by acute infection
- C. It involves sustained nociceptive irritation triggering reflexive muscle guarding, and altered mechanics
- D. It is identical to mechanical SJD

- 5. Which imaging modality is most informative for evaluating soft tissue and ligamentous injuries of the cervical spine?**
- A. MRI
 - B. CT scan
 - C. X-ray
 - D. Ultrasound
- 6. What is the typical time course for radiographic fusion to occur after ACDF?**
- A. 1-3 months
 - B. 3-12 months, with solid fusion by 6-12 months
 - C. 18-24 months
 - D. 6 weeks
- 7. Degenerative disc injuries/hard disc/spondylosis occur more in which demographic?**
- A. Younger men
 - B. Older men
 - C. Younger women
 - D. Older women
- 8. Which action is part of Bakody's sign?**
- A. Neck extension
 - B. Neck rotation
 - C. Shoulder depression
 - D. Arm elevation (shoulder abduction)
- 9. Which posterior decompression option is designed to expand the spinal canal for multilevel stenosis while aiming to preserve stability or minimize fusion?**
- A. Laminoplasty
 - B. Laminectomy with posterior fusion
 - C. Posterior fusion alone
 - D. Anterior corpectomy

10. Jefferson (C1 burst) fracture is described as what, and how is it typically managed?

- A. Burst fracture of C1; immobilization in a rigid collar or halo; surgery if instability or transverse ligament disruption
- B. Burst fracture of C2; immediate posterior fusion in all cases
- C. Compression fracture of C1 without instability; observation
- D. Dens fracture with angulation; halo immobilization only

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Answers

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

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Explanations

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1. What is Bakody's sign and what does it indicate?

- A. Relief of radicular symptoms with arm elevation (shoulder abduction) indicating foraminal compression
- B. Worsening of radicular symptoms with arm elevation indicating central stenosis
- C. No change with arm movement
- D. Relief with neck extension indicating facet arthropathy

Bakody's sign, or the shoulder abduction test, checks whether cervical radiculopathy is due to compression at the neural foramen. When the patient places the hand on top of the head, the arm is abducted, which reduces nerve root tension and can slightly widen the foraminal space. If the radicular pain or numbness decreases with this maneuver, it points to foraminal compression as the source of symptoms. If there's no relief or symptoms worsen, central canal stenosis or another non-foraminal source is more likely. So, relief with arm elevation specifically indicates foraminal compression.

2. Which statement about TOS evaluation is true?

- A. A combination of clinical exam, imaging, EMG, and vascular studies is commonly used.
- B. Only imaging is necessary.
- C. Blood tests confirm the diagnosis.
- D. Surgical exploration is first-line.

Diagnosing thoracic outlet syndrome relies on a broad, multimodal evaluation rather than a single test, because patients can have neurogenic, arterial, or venous compression and symptoms may mimic other conditions. The best approach combines thorough history and physical examination with targeted tests to uncover the type and location of compression and its functional impact. Clinical exam with provocative maneuvers helps reproduce symptoms and localize the suspected outlet. Nerve conduction studies and EMG can support neurogenic involvement, though they are not always definitive and may be normal in some cases. Imaging plays a critical role to identify anatomic causes and the presence of compression under dynamic conditions: X-rays can reveal bony abnormalities like cervical ribs; MRI can evaluate the brachial plexus and soft tissues; MR or CT angiography assesses arterial compromise, while duplex ultrasound can detect venous compression and flow changes. When vascular symptoms are present or suspected, dedicated vascular studies provide essential hemodynamic information to guide management. Blood tests do not confirm TOS and surgical exploration is not a first-line step; it's reserved for specific vascular findings or after conservative measures and diagnostic studies have clarified the problem. In short, a combination of clinical evaluation, imaging, EMG, and vascular studies is the comprehensive approach commonly used to evaluate TOS.

3. Central canal stenosis typically presents with which type of clinical presentation compared to foraminal stenosis?

- A. Central canal stenosis presents with myelopathy (gait disturbance and brisk reflexes); foraminal stenosis presents with radicular pain and numbness**
- B. Central canal stenosis presents with isolated neck pain; foraminal stenosis presents with myelopathy
- C. Central canal stenosis presents with radicular pain only; foraminal stenosis presents with gait disturbance
- D. Central canal stenosis presents with lower motor neuron signs; foraminal stenosis presents with upper motor neuron signs

Central canal stenosis in the cervical spine compresses the spinal cord, leading to myelopathy. That means signs of upper motor neuron impairment such as gait disturbance and brisk reflexes. In contrast, foraminal stenosis narrows the exit for a nerve root, producing radiculopathy with radicular pain and numbness in a dermatomal distribution. So the classic contrast is central canal stenosis causing myelopathy and foraminal stenosis causing radicular symptoms. The described pattern—central canal stenosis with myelopathy and foraminal stenosis with radicular pain and numbness—fits this distinction. The other patterns don't align with how cord versus nerve-root compression typically presents (central with UMN features; foraminal with radicular symptoms).

4. Which statement describes reflexive SJD?

- A. It is defined by insidious onset
- B. It is caused by acute infection
- C. It involves sustained nociceptive irritation triggering reflexive muscle guarding, and altered mechanics**
- D. It is identical to mechanical SJD

Reflexive SJD is driven by sustained nociceptive input that provokes a protective reflex contraction of the surrounding muscles, leading to guarding. That muscle guarding tightens the segment and alters its mechanics, so motion becomes limited and the joint appears dysfunctional even though there may not be a primary structural pathology. The key idea is that the dysfunction arises from a reflex protective response to pain, not from an intrinsic degenerative or infectious process. Because of this, it differs from a purely mechanical SJD, which implies a fixed structural problem in the joint. In short, ongoing nociception triggers reflex muscle guarding, which then changes the mechanics of the spine at that level.

5. Which imaging modality is most informative for evaluating soft tissue and ligamentous injuries of the cervical spine?

A. MRI

B. CT scan

C. X-ray

D. Ultrasound

When evaluating soft tissue and ligamentous injuries in the cervical spine, the emphasis is on visualizing ligaments, discs, and neural structures, including edema or tears. MRI provides superior soft tissue contrast and can directly show ligaments (such as facet joints and posterior ligaments), intervertebral discs, the spinal cord, and surrounding soft tissues in multiple planes. It can detect edema, contusions, and partial tears that CT or X-ray cannot see, making it the most informative choice for these injuries. CT excels at detailing bone and complex fractures, but it lacks the soft tissue sensitivity needed to assess ligaments and discs. X-rays reveal alignment and gross instability but miss most soft tissue injuries. Ultrasound has limited utility for the deep cervical spine due to bone and depth, so it cannot reliably evaluate cervical spine ligaments. So, MRI is the best option for comprehensive soft tissue and ligamentous assessment in the cervical region.

6. What is the typical time course for radiographic fusion to occur after ACDF?

A. 1-3 months

B. 3-12 months, with solid fusion by 6-12 months

C. 18-24 months

D. 6 weeks

Radiographic fusion after ACDF is a months-long process. The graft and adjacent endplates need time to form a continuous bony bridge and achieve stable continuity across the fused segment, which is not evident right away on X rays. In most patients, signs of fusion begin to appear around 3 months, and the fusion progresses toward maturity over the next several months. By about 6–12 months, a solid, mature fusion is typically evident on radiographs (and CT can confirm when there's any doubt). If fusion isn't evident around a year, nonunion becomes a consideration. Short timeframes like a few weeks or a few months are usually too early for radiographic fusion to be established, and waiting 18–24 months exceeds the common timeframe for typical fusion.

7. Degenerative disc injuries/hard disc/spondylosis occur more in which demographic?

A. Younger men

B. Older men

C. Younger women

D. Older women

Degenerative disc disease and spondylosis are driven by aging. As people get older, discs lose water content and height, the annulus can develop fissures, and there is progressive wear at the facet joints with osteophyte formation. These changes accumulate over time, so they are far more common in older individuals than in the young. Among older adults, women tend to show a higher prevalence of these degenerative changes, partly related to hormonal and bone-density factors after menopause. Therefore, the demographic most affected is older women.

8. Which action is part of Bakody's sign?

- A. Neck extension
- B. Neck rotation
- C. Shoulder depression
- D. Arm elevation (shoulder abduction)**

Bakody's sign assesses relief of cervical radicular symptoms by lifting the arm. When the arm is elevated (shoulder abduction) the load and tension on the affected cervical nerve root are reduced, often opening the intervertebral foramina enough to lessen compression and relieve pain or numbness. A positive sign—symptoms improving with arm elevation—supports radiculopathy from cervical nerve root compression rather than a peripheral, non-spinal issue. The other actions don't produce this unloading of the nerve root in the same way, so they aren't part of Bakody's sign.

9. Which posterior decompression option is designed to expand the spinal canal for multilevel stenosis while aiming to preserve stability or minimize fusion?

- A. Laminoplasty**
- B. Laminectomy with posterior fusion
- C. Posterior fusion alone
- D. Anterior corpectomy

Laminoplasty enlarges the spinal canal from a posterior approach by splitting and hinging the lamina on one side and opening it like a door on the other. This widens the canal across multiple levels while preserving the posterior elements and the stability provided by the posterior tension band, so fusion is often unnecessary. In multilevel stenosis, this decompresses the neural elements across levels without sacrificing as much stability as removing the lamina or fusing would. Laminectomy with posterior fusion decompresses but relies on fusion to maintain stability, which can limit motion and add risk; posterior fusion alone does not decompress the canal; and anterior corpectomy decompresses from the front and is not a posterior approach designed to widen the canal while preserving posterior stability.

10. Jefferson (C1 burst) fracture is described as what, and how is it typically managed?

- A. Burst fracture of C1; immobilization in a rigid collar or halo; surgery if instability or transverse ligament disruption**
- B. Burst fracture of C2; immediate posterior fusion in all cases
- C. Compression fracture of C1 without instability; observation
- D. Dens fracture with angulation; halo immobilization only

A Jefferson fracture is a burst injury of the atlas (C1) from axial loading, where the ring breaks and the lateral masses can widen. The key determinant is the transverse ligament: if it remains intact, the instability is limited and nonoperative management with immobilization in a rigid cervical collar or a halo vest is typically adequate. If the transverse ligament is disrupted or there is atlantoaxial instability, surgical stabilization is indicated, usually via posterior fusion. This pattern explains why the best answer describes a burst fracture of C1 managed with immobilization unless there is instability or transverse ligament disruption that requires surgery.

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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