

# Differential Diagnosis and Management of Common Acute Eye and Musculoskeletal Conditions Practice Test (Sample)

## Study Guide



**Everything you need from our exam experts!**

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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 eyelid lesion is described as a small yellowish pustule at the base of an eyelash?**
  - A. Stye.**
  - B. Chalazion.**
  - C. Hyphema.**
  - D. Retinal detachment.**
  
- 2. Chalazion most commonly occurs on which eyelid?**
  - A. Lower eyelid**
  - B. Upper eyelid**
  - C. Medial canthus**
  - D. Lateral canthus**
  
- 3. What should be assessed in a patient with red eye?**
  - A. Redness, discomfort, and vision loss.**
  - B. Redness only.**
  - C. Discharge color.**
  - D. Pupil size.**
  
- 4. Which of the following are risk factors for SCFE?**
  - A. Adolescents (10-15 years), obesity, and more common in males.**
  - B. Newborns**
  - C. Elderly with osteoarthritis**
  - D. Female athletes with knee pain**
  
- 5. What is the treatment for a Type 1 radial head fracture?**
  - A. Non-operative with splinting and orthopedic follow-up.**
  - B. Surgical fixation.**
  - C. Immediate aggressive ROM.**
  - D. Joint excision.**

- 6. Calcific tendonitis description**
- A. Bony overgrowth in the shoulder**
  - B. Calcium deposits in the knee**
  - C. Infection of the rotator cuff**
  - D. Formation of calcium deposits on rotator cuff tendons, causing chronic pain**
- 7. Barotrauma refers to ear injury caused by what circumstance?**
- A. Vision changes due to glare**
  - B. Ear barotrauma caused by rapid pressure changes, often during air travel or scuba diving**
  - C. Nasal congestion due to allergies**
  - D. Sinus infection from bacteria**
- 8. In a patient with suspected orbital involvement after trauma, which finding would most strongly suggest orbital cellulitis rather than a periocular infection?**
- A. Pain with eye movements and restricted extraocular movements.**
  - B. Crusting and itching of eyelid margins.**
  - C. Mucopurulent discharge without pain on movement.**
  - D. Normal vision with mild lid swelling.**
- 9. Which statement describes pain onset for a hip fracture?**
- A. Pain begins weeks after injury**
  - B. Pain is intermittent and unrelated to trauma**
  - C. Pain improves with rest**
  - D. Pain is typically acute immediately after trauma**
- 10. Ludwig's angina is best described as which of the following?**
- A. A viral upper respiratory infection**
  - B. A supraglottic swelling**
  - C. A parotid gland infection**
  - D. A rapidly progressive submandibular cellulitis often originating from dental infections**

## Answers

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

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## **Explanations**

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**1. What eyelid lesion is described as a small yellowish pustule at the base of an eyelash?**

- A. Stye.**
- B. Chalazion.**
- C. Hyphema.**
- D. Retinal detachment.**

A stye is an acute infection at the eyelid margin, usually involving a lash follicle or nearby gland, which classically presents as a tender, swollen lump with a small yellowish pus-filled point at the base of a lash. That yellow pustule precisely reflects purulent material accumulating where the lash attaches, which is the hallmark of an external hordeolum. This contrasts with a chalazion, which is a chronic, painless, firm nodule within the eyelid away from the lash line due to a blocked meibomian gland, not a pustule. Hyphema is blood collecting in the anterior chamber inside the eye, not a lid lesion, and retinal detachment involves the retina with symptoms like sudden vision changes, not a lump on the eyelid. So the described lesion fits an external stye best.

**2. Chalazion most commonly occurs on which eyelid?**

- A. Lower eyelid**
- B. Upper eyelid**
- C. Medial canthus**
- D. Lateral canthus**

Chalazion arises from blockage of a meibomian gland within the tarsal plate, leading to a painless, granulomatous inflammation. The upper eyelid has a larger number of meibomian glands, so obstruction is more likely there and the resulting lump tends to form in the upper lid. The lower lid has fewer glands, making chalazia less common there. Locations at the corners of the eye—medial or lateral canthus—are not typical sites for a chalazion, which develops within the eyelid tissue away from the canthi. So, the upper eyelid is the most frequent site because of the greater gland density and propensity for blockage.

**3. What should be assessed in a patient with red eye?**

- A. Redness, discomfort, and vision loss.**
- B. Redness only.**
- C. Discharge color.**
- D. Pupil size.**

Assessing how the red eye relates to vision and comfort is the crucial first step. Redness is a nonspecific sign that can come from many causes, but whether vision is affected and how much pain or discomfort the patient has help distinguish benign surface issues from sight-threatening problems. If vision is preserved and discomfort is mild, conditions like simple conjunctivitis or dry eye are more likely. If vision is altered or there is significant pain, photophobia, or other urgent symptoms, this points to more serious etiologies such as corneal involvement, anterior chamber inflammation, or acute pressure-raising conditions, all of which require prompt evaluation. Context matters too: discharge color, trauma, contact lens use, and light sensitivity can guide the differential, but the most actionable assessment is vision status and the level of discomfort. Early recognition of any vision change is the key to deciding urgency and referral.

#### 4. Which of the following are risk factors for SCFE?

- A. Adolescents (10-15 years), obesity, and more common in males.**
- B. Newborns**
- C. Elderly with osteoarthritis**
- D. Female athletes with knee pain**

SCFE most commonly occurs during adolescence when the growth plate at the hip is vulnerable, and two of the strongest risk factors are being in that age range and carrying excess weight. Obesity increases the shear forces across the proximal femoral physis, making a slip more likely, and boys are affected somewhat more than girls, reflecting a higher incidence in males. Newborns and elderly individuals with osteoarthritis involve hip problems with very different mechanisms and timing, so they're not typical risk groups for SCFE. Female athletes with knee pain would more likely have conditions related to the knee or overuse injuries, not a slip of the femoral head. Thus, the combination of adolescence (roughly 10-15 years), obesity, and male predominance best matches the known risk profile for SCFE.

#### 5. What is the treatment for a Type 1 radial head fracture?

- A. Non-operative with splinting and orthopedic follow-up.**
- B. Surgical fixation.**
- C. Immediate aggressive ROM.**
- D. Joint excision.**

Nondisplaced radial head fractures are treated nonoperatively because the fracture fragments are still aligned and the joint remains stable. Immobilization with a splint or short cast provides pain relief and allows healing without the risks of surgery. After a brief immobilization period, structured, gradual range-of-motion exercises are introduced to prevent stiffness and restore function. Surgical fixation is reserved for fractures that are displaced or unstable, where anatomy cannot be maintained by splinting. Immediate aggressive ROM is inappropriate in the acute phase because it can disrupt a healing nondisplaced fracture. Joint excision is not first-line for isolated Type I fractures due to potential instability and loss of forearm rotation, and is generally considered only in more complex or elderly-demand scenarios.

## 6. Calcific tendonitis description

- A. Bony overgrowth in the shoulder
- B. Calcium deposits in the knee
- C. Infection of the rotator cuff
- D. Formation of calcium deposits on rotator cuff tendons, causing chronic pain**

Calcific tendonitis is the deposition of calcium crystals, most commonly hydroxyapatite, within a tendon of the shoulder's rotator cuff, leading to chronic shoulder pain and sometimes acute flares when the deposits irritate surrounding tissues. The option describing the formation of calcium deposits on rotator cuff tendons, causing chronic pain, best fits this entity. The other ideas describe different problems: a bone spur is a bony overgrowth, not calcium in a tendon; calcium in the knee points to calcium deposition but in a different location and context; an infection of the rotator cuff is a septic process without calcium deposition. In calcific tendonitis, imaging often shows calcifications within the rotator cuff tendons, most commonly the supraspinatus, aligning with the described description.

## 7. Barotrauma refers to ear injury caused by what circumstance?

- A. Vision changes due to glare
- B. Ear barotrauma caused by rapid pressure changes, often during air travel or scuba diving**
- C. Nasal congestion due to allergies
- D. Sinus infection from bacteria

Barotrauma is ear injury from rapid changes in surrounding air pressure that the ear can't equalize across the eardrum. When you experience a quick drop or rise in ambient pressure—such as during airplane ascent or descent or while scuba diving—the Eustachian tube must equalize the pressure between the middle ear and the outside environment. If it can't equalize promptly, the pressure difference strains or damages the tympanic membrane and middle-ear structures, causing pain, fullness, and sometimes hearing changes. That's why the correct option fits best: it explicitly links ear injury to rapid pressure changes and common situations like air travel or scuba diving. The other choices describe unrelated issues—glare affecting vision, nasal congestion from allergies, or bacterial sinus infection—and do not describe pressure-driven ear injury.

**8. In a patient with suspected orbital involvement after trauma, which finding would most strongly suggest orbital cellulitis rather than a periocular infection?**

**A. Pain with eye movements and restricted extraocular movements.**

**B. Crusting and itching of eyelid margins.**

**C. Mucopurulent discharge without pain on movement.**

**D. Normal vision with mild lid swelling.**

The distinguishing sign is involvement of the orbit itself, which makes eye movements painful and limited. When the infection extends behind the orbital septum to affect the extraocular muscles and orbital tissues, moving the eye becomes painful and the range of motion can be restricted. This contrasts with periocular (preseptal) infections that are confined to the eyelids and surrounding skin, where eye movements remain full and pain on movement is absent. In practice, this sign points to orbital cellulitis, a medical emergency requiring urgent imaging to assess extent and prompt IV antibiotics to prevent vision loss or intracranial spread. Crusting and itching of the eyelid margins point to blepharitis or conjunctival irritation rather than orbital involvement. Mucopurulent discharge without pain on movement suggests conjunctivitis rather than orbital cellulitis, and normal vision with mild lid swelling is more compatible with superficial eyelid/skin involvement or uncomplicated conjunctival irritation rather than orbital disease.

**9. Which statement describes pain onset for a hip fracture?**

**A. Pain begins weeks after injury**

**B. Pain is intermittent and unrelated to trauma**

**C. Pain improves with rest**

**D. Pain is typically acute immediately after trauma**

Pain onset for a hip fracture is typically acute and immediate. The fracture happens at the moment of injury (often a fall or direct blow), tearing bone and surrounding tissues and producing sudden, severe hip or groin pain. This pain is usually constant and worsens with movement or weight-bearing, and the patient often cannot lift or bear weight on the affected leg. This pattern helps distinguish it from conditions where pain starts later, occurs intermittently, or improves noticeably with rest. In addition to the abrupt onset, you'll often see the leg held in a shortened, externally rotated position due to muscle spasm and the fracture itself, which reinforces the need for urgent evaluation and imaging.

**10. Ludwig's angina is best described as which of the following?**

- A. A viral upper respiratory infection**
- B. A supraglottic swelling**
- C. A parotid gland infection**
- D. A rapidly progressive submandibular cellulitis often originating from dental infections**

Ludwig's angina is a rapidly progressive bacterial cellulitis of the submandibular space, typically originating from a dental infection. This causes bilateral swelling under the jaw and floor of the mouth, which can push the tongue upward and threaten the airway. That combination of a dental-origin infection with diffuse submandibular space involvement and potential airway compromise is what sets it apart from the other options. It is not a viral upper respiratory infection, which would lack the focal submandibular space involvement and airway-threatening swelling. It is not a supraglottic swelling condition like epiglottitis, which centers on the laryngeal supraglottic structures and presents with drooling and acute airway symptoms but without the characteristic submandibular cellulitis. It also isn't a parotid gland infection, which would present primarily as parotid region swelling rather than the floor-of-mouth/submandibular space involvement. Key point: rapid submandibular space infection from dental sources, with potential airway obstruction, requiring prompt airway assessment, broad-spectrum antibiotics covering oral flora including anaerobes, and surgical drainage if an abscess forms.

## 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](mailto: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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