Dysphagia and Regurgitation Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

Sample study guide. For the full version with hundreds of questions, visit:
https://dysphagiaregurgitation.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. In regurgitation management, which goal is to reduce tissue irritation and inflammation?

- **A. Decrease inflammation**
- **B. Protect the esophageal mucosa**
- **C. Pain management**
- **D. Change consistency of food and water**

2. Which condition is a esophageal diverticula differential for regurgitation?

- **A. Megaesophagus**
- **B. Esophageal Diverticula**
- **C. Esophagitis**
- **D. Gastroesophageal Reflux Disease**

3. Name three common neurogenic causes of oropharyngeal dysphagia.

- **A. Stroke, Parkinson disease, amyotrophic lateral sclerosis (ALS)**
- **B. GERD, peptic ulcer disease, gastritis**
- **C. Crohn disease, ulcerative colitis, diverticulitis**
- **D. Migraine, tension-type headache, cluster headache**

4. Which management strategy addresses patient comfort during regurgitation?

- **A. Pain management**
- **B. Protect the esophageal mucosa**
- **C. Place feeding tube**
- **D. Decrease inflammation**

5. In cricopharyngeal dysfunction, regurgitation occurs due to impairment of which structure?

- **A. Lower esophageal sphincter dysfunction.**
- **B. Esophageal motility disorder.**
- **C. Impaired relaxation of the upper esophageal sphincter leading to stasis and regurgitation.**
- **D. Pyloric sphincter spasm.**

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6. Which signs warrant endoscopy in suspected dysphagia?

- **A. Odynophagia alone.**
- **B. Weight loss alone.**
- **C. Iron-deficiency anemia alone.**
- **D. Odynophagia, weight loss, iron-deficiency anemia, GI bleeding, persistent vomiting, or progressive symptoms despite therapy.**

7. In peptic reflux-related esophageal strictures, dilation is favored over medical therapy when there is a truly narrowed lumen causing symptomatic dysphagia.

- **A. Mild reflux symptoms with no dysphagia.**
- **B. A truly narrowed lumen causing symptomatic dysphagia.**
- **C. Only regurgitation without dysphagia.**
- **D. Normal endoscopy with no narrowing.**

8. What does the 'bird beak' sign on a barium swallow indicate?

- **A. Achalasia**
- **B. Peptic stricture**
- **C. GERD**
- **D. Esophageal varices**

9. Which combination of signs would suggest a structural lesion such as cancer as the cause of dysphagia?

- **A. Intermittent dysphagia to liquids only**
- **B. Progressive solid-dysphagia with weight loss**
- **C. Sudden chest pain**
- **D. Recurrent heartburn**

10. Lip licking is a sign most closely associated with which swallowing phase?

- **A. Esophageal/Gastroesophageal phase**
- **B. Oral preparatory phase**
- **C. Cricopharyngeal-pharyngeal phase**
- **D. None of the above**

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Answers

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

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Explanations

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1. In regurgitation management, which goal is to reduce tissue irritation and inflammation?

A. Decrease inflammation

B. Protect the esophageal mucosa

C. Pain management

D. Change consistency of food and water

Reducing tissue irritation from regurgitation hinges on decreasing inflammation in the affected mucosa. When regurgitated contents and acid irritate the lining of the esophagus and throat, the body's inflammatory response causes swelling, redness, and sensitivity. By lowering this inflammatory process, you lessen edema and pain, promote healing, and break the cycle of ongoing irritation from refluxed material. Protective measures and texture modifications can help, but they don't address the inflammatory response as directly as reducing inflammation itself. Pain relief helps with comfort but doesn't tackle the underlying inflammation.

2. Which condition is a esophageal diverticula differential for regurgitation?

A. Megaesophagus

B. Esophageal Diverticula

C. Esophagitis

D. Gastroesophageal Reflux Disease

Regurgitation that comes from the esophagus is often due to a structural issue that can trap food and release it later. An esophageal diverticulum is exactly that kind of lesion—a pouch or outpouching in the esophageal wall that can collect undigested food and then regurgitate it, leading to the symptom. Among the options, the one that directly represents a diverticular lesion is esophageal diverticula, which is why it's the best fit. The other conditions can cause regurgitation as well, but they do so through different mechanisms: a dilated esophagus (megaesophagus) reflects a motility problem rather than a discrete pouch; esophagitis and GERD involve inflammation or reflux rather than a diverticular outpouching.

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3. Name three common neurogenic causes of oropharyngeal dysphagia.

A. Stroke, Parkinson disease, amyotrophic lateral sclerosis (ALS)

B. GERD, peptic ulcer disease, gastritis

C. Crohn disease, ulcerative colitis, diverticulitis

D. Migraine, tension-type headache, cluster headache

Oropharyngeal dysphagia comes from problems with the neural control of the mouth and pharynx. When the brain or the motor neurons that drive the bulbar muscles are damaged, the swallow plan or the muscle contractions needed to move a bolus from the mouth into the throat are impaired, leading to difficulty initiating swallowing and a higher risk of aspiration. Three classic neurogenic causes are those that disrupt this neural control: a stroke can injure the brain regions that coordinate the swallow, Parkinson disease causes slowed and poorly coordinated tongue and pharyngeal movements, and amyotrophic lateral sclerosis leads to progressive weakness of the bulbar muscles essential for the oral and pharyngeal phases of swallowing. The other options involve non-neurologic or non-dysphagia-related GI conditions (reflux and mucosal diseases; inflammatory bowel diseases; primarily headache disorders). While they can cause swallowing difficulties in rare circumstances, they are not recognized as common neurogenic causes of oropharyngeal dysphagia.

4. Which management strategy addresses patient comfort during regurgitation?

A. Pain management

B. Protect the esophageal mucosa

C. Place feeding tube

D. Decrease inflammation

Pain relief is the primary way to keep a patient comfortable during regurgitation because the immediate need is to lessen the throat and chest irritation and distress caused by refluxed contents. Analgesia and comfort measures directly reduce the discomfort of an episode, making it the most direct path to patient comfort. Protecting the esophageal mucosa helps prevent injury from regurgitated material and can contribute to comfort indirectly, but its focus is tissue protection rather than providing immediate relief during the episode. A feeding tube addresses nutrition and decompression rather than the sensation of regurgitation. Decreasing inflammation may reduce related pain over time, but it isn't the quickest or most direct method to improve comfort during regurgitation itself.

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5. In cricopharyngeal dysfunction, regurgitation occurs due to impairment of which structure?

A. Lower esophageal sphincter dysfunction.

B. Esophageal motility disorder.

C. Impaired relaxation of the upper esophageal sphincter leading to stasis and regurgitation.

D. Pyloric sphincter spasm.

The main concept is that regurgitation in cricopharyngeal dysfunction comes from the upper esophageal sphincter failing to relax. The cricopharyngeus muscle forms this sphincter, and it normally relaxes in coordination with swallowing to let the bolus pass from the pharynx into the esophagus. When relaxation is impaired or the sphincter is overly tight, material collects above the sphincter (stasis). That trapped content can then be expelled backward into the pharynx or mouth, producing regurgitation. This proximal mechanism is distinct from lower esophageal sphincter problems or gastric outlet issues like pyloric spasm. An esophageal motility disorder could affect swallowing, but the specific regurgitation in cricopharyngeal dysfunction is due to impaired relaxation of the upper esophageal sphincter.

6. Which signs warrant endoscopy in suspected dysphagia?

A. Odynophagia alone.

B. Weight loss alone.

C. Iron-deficiency anemia alone.

D. Odynophagia, weight loss, iron-deficiency anemia, GI bleeding, persistent vomiting, or progressive symptoms despite therapy.

Endoscopy is indicated in dysphagia when red flags or alarm features are present because they point to possible organic disease of the esophagus or upper GI tract that needs direct visualization and tissue sampling. The strongest trigger is a statement that includes multiple concerning signs—odynophagia, weight loss, iron-deficiency anemia, GI bleeding, persistent vomiting, or progressive symptoms despite therapy—since this combination elevates the suspicion for conditions such as cancer, ulcers, severe esophagitis, or other mucosal abnormalities. Each of these signs alone can be caused by a range of issues, but together they substantially raise the likelihood of a structural or malignant process, making endoscopy the appropriate diagnostic step. In contrast, single findings like odynophagia alone or weight loss alone are concerning but don’t by themselves mandate endoscopy without additional context or symptoms.

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7. **In peptic reflux-related esophageal strictures, dilation is favored over medical therapy when there is a truly narrowed lumen causing symptomatic dysphagia.**

    A. Mild reflux symptoms with no dysphagia.

    B. A truly narrowed lumen causing symptomatic dysphagia.

    C. Only regurgitation without dysphagia.

    D. Normal endoscopy with no narrowing.

In peptic reflux-related esophageal strictures, the key decision is guided by whether there is a true mechanical narrowing that blocks passage of food. When the lumen is genuinely narrowed and this causes symptomatic dysphagia, dilation is the best option because it directly relieves the obstruction by widening the scarred segment, improving bolus transit. Medical therapy, like acid suppression, helps reduce ongoing reflux but does not fix a fixed narrowing. If the patient’s problem is a truly narrowed lumen with dysphagia, dilating the stricture addresses the root mechanical issue and provides symptomatic relief. If symptoms are mild and limited to reflux without any dysphagia, there isn’t a fixed obstruction to relieve, so dilation isn’t indicated. Regurgitation without dysphagia also suggests reflux symptoms rather than a structural narrowing. A normal endoscopy with no narrowing shows no lumen to dilate, so dilation isn’t appropriate there. So the best fit is a truly narrowed lumen causing symptomatic dysphagia, because it represents an actual mechanical obstruction that dilation can effectively treat.

8. **What does the 'bird beak' sign on a barium swallow indicate?**

    A. Achalasia

    B. Peptic stricture

    C. GERD

    D. Esophageal varices

The bird beak sign on a barium swallow points to a motility problem at the distal esophagus, specifically where the lower esophageal sphincter fails to relax and peristalsis is absent. This creates dilation above a sharp, tapered narrowing at the gastroesophageal junction—the classic appearance of Achalasia. Peptic stricture can narrow the esophagus from scarring due to reflux, but it usually presents as a more gradual, scarred narrowing rather than the abrupt, pointed taper seen with Achalasia. GERD itself is a reflux condition and may lead to strictures over time, but it does not produce this distinctive bird beak shape. Esophageal varices involve dilated veins and appear as vascular, serpentine structures rather than a tapered segment.

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9. Which combination of signs would suggest a structural lesion such as cancer as the cause of dysphagia?

A. Intermittent dysphagia to liquids only

B. Progressive solid-dysphagia with weight loss

C. Sudden chest pain

D. Recurrent heartburn

A structural lesion like cancer tends to produce a pattern where swallowing becomes progressively more difficult for solids, and over time this can extend to liquids as the narrowing grows. The solid-food persistence and progression point to a fixed obstruction, and weight loss adds a systemic red flag that malignancy may be involved. So, this combination—dysphagia that starts with solids and worsens over time, accompanied by weight loss—best signals a structural cause such as cancer. By contrast, dysphagia to liquids only suggests a motility problem, sudden chest pain could indicate an acute event rather than cancer, and recurrent heartburn is more typical of reflux, not an obstructing lesion.

10. Lip licking is a sign most closely associated with which swallowing phase?

A. Esophageal/Gastroesophageal phase

B. Oral preparatory phase

C. Cricopharyngeal-pharyngeal phase

D. None of the above

Lip licking reflects a response associated with the esophageal phase of swallowing. After the swallow, if esophageal events such as regurgitation, reflux, or lingering residue occur, a person may instinctively lick the lips to moisten and clear the mouth. This post-swallow, mouth-clearing action is best linked to the esophageal/gastroesophageal stage, where the bolus is moving through the esophagus and distal symptoms can prompt such oral–motor adjustments. It’s not a typical sign of the initial bolus formation and manipulation in the oral preparatory phase, nor is it specifically tied to the cricopharyngeal-pharyngeal phase of the swallow.

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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://dysphagiaregurgitation.examzify.com

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

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