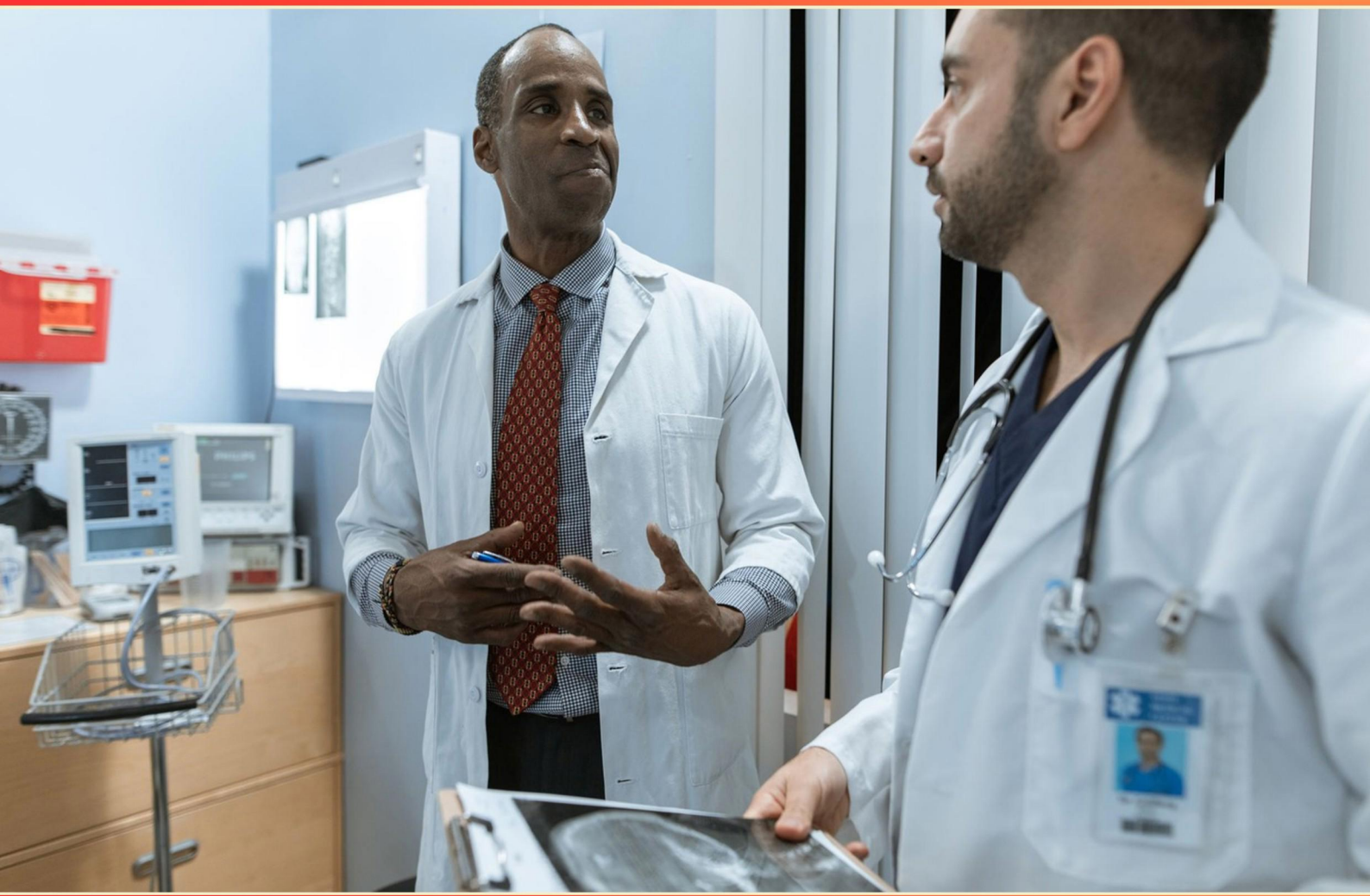
DYSPHAGIA AND REGURGITATION PRACTICE TEST (SAMPLE)

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.

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

1. Which of the following are common swallow therapy exercises used for oropharyngeal dysphagia?

A. Effortful swallow, Mendelsohn maneuver, supraglottic swallow, Shaker (head-raising) exercise, and tongue-holding maneuver

B. Effortful swallow and Mendelsohn maneuver only

C. Supraglottic swallow and Shaker exercise

D. Tongue thrust exercises only

2. Which strategy is a recommended component of supportive treatment and nutritional management for dysphagia and regurgitation?

A. Change consistency of food and water

B. Let gravity help

C. Place feeding tube

D. Increase fiber intake

3. Esophageal muscle variability across species is true.

A. True

B. False

C. Not specified

D. Partially

4. In scleroderma, how is esophageal function typically affected?

A. Esophageal hypomotility with reduced peristalsis and decreased LES tone leading to GERD.

B. Esophageal hypermotility with increased peristalsis and increased LES tone.

C. Normal motility with normal LES tone.

D. Esophageal spasm without reflux.

5. IDDSI levels are used to categorize which of the following?

A. Liquids and foods to reduce aspiration risk

B. Severity of esophagitis

C. Stomach emptying rate

D. Gastric acid production

6. Which salivary gland inflammation is listed as a differential for regurgitation?

A. Sialocele

B. Sialodenitis

C. Megaesophagus

D. Cricopharyngeal Achalasia

7. In eosinophilic esophagitis, a positive endoscopic biopsy confirms eosinophilic infiltration and supports which type of treatment?

A. Confirms eosinophilic infiltration; supports dietary/anti-inflammatory treatment; monitor response with repeat endoscopy

B. Diagnoses cancer

C. Measures reflux

D. Cures EoE

8. What clinical clue is most associated with oropharyngeal dysphagia rather than esophageal dysphagia?

A. Trouble initiating a swallow and coughing on liquids

B. Dysphagia that begins with solids and progresses to liquids

C. Food sticking behind the sternum, mainly with solids

D. Chest pain after meals

9. What is the role of prokinetic agents in dysphagia management?

A. To cure GERD in all patients.

B. To reduce LES tone universally.

C. To enhance esophageal or gastric motility in select motility disorders; evidence varies and use is case-dependent.

D. To directly repair mucosal injuries.

10. What information does a videofluoroscopic swallow study provide?

A. Real-time imaging of oral, pharyngeal, and esophageal phases, showing transit, residue, and penetration/aspiration; assesses compensatory strategies

B. Static imaging of the esophagus only

C. Blood flow imaging during swallowing

D. Only radiographs without contrast during swallowing

Answers

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

Explanations

1. Which of the following are common swallow therapy exercises used for oropharyngeal dysphagia?

A. Effortful swallow, Mendelsohn maneuver, supraglottic swallow, Shaker (head-raising) exercise, and tongue-holding maneuver

B. Effortful swallow and Mendelsohn maneuver only

C. Supraglottic swallow and Shaker exercise

D. Tongue thrust exercises only

The idea behind swallow therapy for oropharyngeal dysphagia is to use a set of targeted maneuvers that address different parts of the swallow mechanism—strengthening pharyngeal constriction, improving airway protection, and enhancing hyolaryngeal elevation to aid swallowing safely. The best option includes all the commonly taught exercises: effortful swallow (increases posterior pharyngeal wall contraction and overall swallow effort), Mendelsohn maneuver (prolongs hyolaryngeal elevation to help keep the airway protected and widen the opening of the upper esophageal sphincter), supraglottic swallow (facilitates rapid glottic closure to reduce penetration or aspiration during swallow), Shaker (head-raising) exercise (improves anterior hyolaryngeal excursion and UES opening), and tongue-holding (Masako) maneuver (strengthens posterior pharyngeal wall squeeze). Together, these target multiple deficits seen in dysphagia and are commonly used in practice. Other options omit one or more of these key maneuvers or include items like tongue thrust exercises, which aren't standard swallow therapies for this condition.

2. Which strategy is a recommended component of supportive treatment and nutritional management for dysphagia and regurgitation?

A. Change consistency of food and water

B. Let gravity help

C. Place feeding tube

D. Increase fiber intake

Modifying how food and fluids are prepared is a foundational approach to supporting safe swallowing in dysphagia. By changing the consistency and texture, you directly influence how the bolus moves through the mouth, pharynx, and esophagus. Thicker liquids and softer or puréed foods travel more slowly and require less oral-motor effort, giving the swallow more time to coordinate and protect the airway. This reduces the likelihood of aspiration and can also lessen regurgitation episodes during meals by preventing large, poorly controlled bolus movements. The choice of texture is individualized and often tested by a clinician to find the safest level, sometimes using a progression from thin to thicker consistencies as needed, while also pairing with other supportive measures like proper seating, small bites, and paced eating to maintain nutrition and hydration. Letting gravity do the work isn't a reliable primary strategy for safety during swallowing, and placing a feeding tube is used only when oral intake cannot meet nutritional needs. Increasing fiber targets digestion rather than swallowing mechanics, so it doesn't address the core issue in dysphagia management.

3. Esophageal muscle variability across species is true.

A. True

B. False

C. Not specified

D. Partially

The key idea is that esophageal muscle composition is not the same in every species. In many animals, the esophagus contains both skeletal (striated) and smooth muscle, with the proximal portion often under voluntary control (skeletal muscle) and the distal portion under involuntary control (smooth muscle). The boundary between these muscle types—the length of the transition zone—varies from species to species, and some species show different patterns of distribution altogether. This reflects differences in swallowing mechanics and neural control across species. So, stating that esophageal muscle variability across species is true aligns with observed anatomical diversity. It's not universally constant, nor is it unspecified or limited to only some aspects; the variation exists across species, which is why the statement is the best choice.

4. In scleroderma, how is esophageal function typically affected?

A. Esophageal hypomotility with reduced peristalsis and decreased LES tone leading to GERD.

B. Esophageal hypermotility with increased peristalsis and increased LES tone.

C. Normal motility with normal LES tone.

D. Esophageal spasm without reflux.

In scleroderma, the smooth muscle of the distal esophagus becomes fibrotic, leading to weak contractions and poor peristalsis. At the same time, the lower esophageal sphincter tends to be hypotensive. This combination means the esophagus doesn't move food down effectively and the barrier to reflux is weakened, so gastric contents reflux into the esophagus more easily, causing GERD. The pattern described—reduced peristalsis with a decreased LES tone—is the typical esophageal change in this condition. The other options don't fit because they imply either increased or normal motility or lack the reflux-prone pattern seen with scleroderma.

5. IDDSI levels are used to categorize which of the following?

A. Liquids and foods to reduce aspiration risk

B. Severity of esophagitis

C. Stomach emptying rate

D. Gastric acid production

IDDSI levels describe the texture and thickness of liquids and foods to standardize swallowing safety. By classifying how thick a liquid is or how textured a food is, clinicians can tailor what a patient can safely swallow, aiming to reduce aspiration risk and related complications. This system is specifically about swallowing safety and consistency, not about disease severity or GI physiology. The other options relate to esophageal inflammation, gastric emptying, or acid production—factors that don't pertain to texture or thickness classifications.

6. Which salivary gland inflammation is listed as a differential for regurgitation?

A. Sialocele

B. Sialodenitis

C. Megaesophagus

D. Cricopharyngeal Achalasia

Regurgitation is often thought of in relation to esophageal or pharyngeal dysfunction, but inflammatory processes of the salivary glands can also appear on the differential. Sialadenitis is inflammation of a salivary gland, which can alter saliva flow, cause oral discomfort, and affect swallowing in a way that mimics or contributes to regurgitation. In contrast, a sialocele is a saliva collection from a ruptured duct (not inflammation), and the other two options describe esophageal motor problems—megaesophagus and cricopharyngeal achalasia—that cause regurgitation through different mechanisms. So the salivary gland inflammation considered in the differential is sialadenitis.

7. In eosinophilic esophagitis, a positive endoscopic biopsy confirms eosinophilic infiltration and supports which type of treatment?

A. Confirms eosinophilic infiltration; supports dietary/anti-inflammatory treatment; monitor response with repeat endoscopy

B. Diagnoses cancer

C. Measures reflux

D. Cures EoE

A positive biopsy showing eosinophilic infiltration confirms eosinophilic esophagitis and points to a management approach that targets reducing esophageal inflammation and removing triggers. The mainstay of treatment is dietary modification to identify and avoid offending foods plus anti-inflammatory therapy, typically with topical corticosteroids, to lessen eosinophilic inflammation. Because EoE is a chronic condition that can recur, clinicians monitor progress with repeat endoscopy and biopsies to verify histologic remission and mucosal healing. Cancer diagnosis is not the purpose of this biopsy, and measuring reflux is not what this histology directly guides. While treatment can control symptoms and inflammation, EoE is not universally cured; ongoing management and follow-up are common.

8. What clinical clue is most associated with oropharyngeal dysphagia rather than esophageal dysphagia?

A. Trouble initiating a swallow and coughing on liquids

B. Dysphagia that begins with solids and progresses to liquids

C. Food sticking behind the sternum, mainly with solids

D. Chest pain after meals

The key idea is where the problem shows up in the swallowing process. Oropharyngeal dysphagia involves trouble with the oral to pharyngeal phase, so the airway protection during the swallow is often impaired. Trouble initiating a swallow and coughing on liquids is the strongest clue because it reflects an inability to propel material from the mouth into the pharynx and then protect the airway. When the swallow doesn't start smoothly, thin liquids are more likely to misroute into the airway, triggering coughing or choking. This pattern points to a problem with the neuromuscular coordination of the oropharyngeal phase. In contrast, symptoms that begin with solids and progress to liquids usually indicate a problem within the esophagus itself, such as a structural narrowing or a motility issue. Food sticking behind the sternum, especially with solids, is classic for an esophageal obstruction. Chest pain after meals also fits esophageal etiologies like reflux or spasm. So the presence of coughing or choking on liquids during attempted swallowing best differentiates oropharyngeal dysphagia from esophageal dysphagia.

9. What is the role of prokinetic agents in dysphagia management?

A. To cure GERD in all patients.

B. To reduce LES tone universally.

C. To enhance esophageal or gastric motility in select motility disorders; evidence varies and use is case-dependent.

D. To directly repair mucosal injuries.

Prokinetic agents are used when swallowing difficulty is tied to slowed or poorly coordinated movement of the esophagus or stomach. They work by boosting esophageal peristalsis and/or speeding gastric emptying, which helps propel the swallowed bolus more effectively and reduces stasis that can worsen dysphagia. Because motility disorders vary widely from person to person, the benefit of prokinetics is not universal and must be considered on a case-by-case basis; the evidence supporting their use differs depending on the specific motility issue and patient response. They are not a cure for GERD in all patients, they do not universally decrease LES tone, and they do not directly repair mucosal injuries. Their role is to enhance propulsion when the primary problem is impaired motility.

10. What information does a videofluoroscopic swallow study provide?

A. Real-time imaging of oral, pharyngeal, and esophageal phases, showing transit, residue, and penetration/aspiration; assesses compensatory strategies

B. Static imaging of the esophagus only

C. Blood flow imaging during swallowing

D. Only radiographs without contrast during swallowing

VFSS provides real-time visualization of the entire swallow pathway—from the oral phase through the pharyngeal phase and into the esophagus—while a contrast bolus moves through. This dynamic view shows how quickly the bolus transits, where residue remains, and whether material enters the airway (penetration or aspiration). It also lets clinicians test compensatory strategies, such as changing bolus thickness or size or using postural adjustments and swallowing maneuvers, to see how these changes impact safety and efficiency. Unlike static imaging of the esophagus, or imaging focused on blood flow, or radiographs without contrast, this study captures the complete, coordinated process of swallowing with the ability to assess airway protection and functional adjustments in real time.

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!