Extremities Limited Scope Practice Exam (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

1. To correct foreshortening of the femoral necks on a pelvis radiograph, how should the limb be rotated?

A. Lower limb 15-20 laterally

B. Lower limb 15-20 internally

C. Feet 15-20 externally

D. Feet axis equally in a relaxed lateral position

2. Moving a body part toward the body midline is called

A. Adduction

B. Abduction

C. Inversion

D. Rotation

3. Monteggia fracture involves fracture of which bone and dislocation of which structure?

A. Proximal ulna fracture with radial head dislocation

B. Distal ulna fracture with radial head dislocation

C. Proximal radius fracture with radial head dislocation

D. Distal radius fracture with radial head dislocation

4. Which test confirms an Achilles tendon rupture?

A. Thompson test (calf squeeze) indicating absence of plantar flexion

B. Dorsiflexion test

C. Lachman test

D. Tinel sign

5. Which imaging findings are most consistent with knee osteoarthritis?

A. Joint space narrowing, osteophyte formation, subchondral sclerosis

B. Joint effusion only

C. Subchondral cysts only

D. Increased joint space

6. What knee condition presents with snapping or intermittent pain due to thickened synovial folds?

A. Plica syndrome

B. IT band syndrome

C. Bursitis

D. Meniscal tear

7. Which of the following is necessary to demonstrate the knee joint space?

A. Fully flex the knee with the tube angled 5 cephalad

B. Central ray parallel to the patella

C. Direct the central ray superior to the patella

D. Direct the central ray perpendicular to the long axis of the tibia

8. Which condition presents with thickened palmar fascia and progressive flexion contractures of the digits?

A. Dupuytren contracture

B. Trigger finger

C. Carpal tunnel syndrome

D. Ganglion

9. What is the typical leg position after an anterior hip dislocation?

A. Flexion, abduction, external rotation

B. Flexion, adduction, internal rotation

C. Flexion, abduction, external rotation

D. Extension, adduction, external rotation

10. For a PA projection of the third digit, the central ray should target which joint?

A. Carpophalangeal

B. Metacarpophalangeal

C. Proximal interphalangeal

D. Distal interphalangeal

Answers

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

Explanations

1. To correct foreshortening of the femoral necks on a pelvis radiograph, how should the limb be rotated?

A. Lower limb 15-20 laterally

B. Lower limb 15-20 internally

C. Feet 15-20 externally

D. Feet axis equally in a relaxed lateral position

Foreshortening of the femoral necks happens when the leg isn't rotated so the necks lie close to the plane of the image receptor. Rotating the entire lower limb internally by about 15–20 degrees brings the femoral neck axis into a projection that is closer to parallel with the imaging plane, so the necks appear in true length rather than shortened. This internal rotation is standard for AP pelvis radiographs to ensure symmetric visualization of both hips and accurate assessment of the necks. External rotation would tilt the necks away from the film and worsen foreshortening, while a relaxed lateral position would not provide the desired AP pelvis view. So, internal rotation of the lower limb by about 15–20 degrees is the correct approach.

2. Moving a body part toward the body midline is called

A. Adduction

B. Abduction

C. Inversion

D. Rotation

Adduction describes moving a body part toward the body's midline. This brings the limb closer to the center of the body, such as lowering an arm from the side toward the torso or bringing the legs together. The opposite movement is abduction, which is moving away from the midline. Other terms refer to different motions: inversion is turning the sole of the foot inward, and rotation is turning a part around its axis. Those describe other directions or axes of motion and don't define movement toward the midline.

3. Monteggia fracture involves fracture of which bone and dislocation of which structure?

A. Proximal ulna fracture with radial head dislocation

B. Distal ulna fracture with radial head dislocation

C. Proximal radius fracture with radial head dislocation

D. Distal radius fracture with radial head dislocation

Monteggia fracture is defined by a fracture of the proximal ulna with dislocation of the radial head at the radiocapitellar joint. This pattern is what radiographs typically show: the ulna broken near the elbow and the radial head displaced relative to the capitulum, often anteriorly in children. The other scenarios involve fractures at the distal forearm or fractures of the radius itself, which do not match the classic Monteggia combination.

4. Which test confirms an Achilles tendon rupture?

A. Thompson test (calf squeeze) indicating absence of plantar flexion

B. Dorsiflexion test

C. Lachman test

D. Tinel sign

The test relies on the function of the gastrocnemius-soleus complex to plantarflex the foot. When you squeeze the calf, the normal tendon transmits that force to the heel and the foot plantarflexes. If the Achilles tendon is ruptured, there's no continuous connection to the heel, so squeezing the calf does not produce plantarflexion. This absence of movement in response to a calf squeeze makes the Thompson (calf squeeze) test a reliable bedside way to confirm an Achilles tendon rupture. The other tests target different structures or conditions and don't assess the Achilles tendon. The dorsiflexion test isn't a standard confirmatory test for rupture, Lachman tests the knee's ACL, and the Tinel sign is used to detect nerve irritation, not a tendon rupture.

5. Which imaging findings are most consistent with knee osteoarthritis?

A. Joint space narrowing, osteophyte formation, subchondral sclerosis

B. Joint effusion only

C. Subchondral cysts only

D. Increased joint space

Imaging findings in knee osteoarthritis reflect cartilage loss with bone changes at the joint. The most characteristic pattern includes joint space narrowing from cartilage thinning, marginal osteophyte formation as the bone responds to instability, and subchondral sclerosis where the bone just beneath the cartilage becomes denser due to altered loading. This combination best captures the typical radiographic appearance of OA. Joint effusion can occur but isn't the defining feature and appears in many knee conditions. Subchondral cysts can appear in OA but are not the core pattern by themselves. Increased joint space would imply preserved or widened cartilage, which is not what OA shows.

6. What knee condition presents with snapping or intermittent pain due to thickened synovial folds?

A. Plica syndrome

B. IT band syndrome

C. Bursitis

D. Meniscal tear

Thickened synovial folds in the knee can irritate the joint during bending and straightening, producing a snapping sensation and intermittent pain. This is plica syndrome, where a residual synovial fold (often on the medial side) becomes inflamed or enlarged and catches between the femur and patella as the knee moves. Clinically, patients often feel a snap on the inner knee with flexion-extension and have intermittent anterior knee pain, sometimes with focal tenderness along the medial plica. Imaging isn't usually needed, though MRI can show a thickened plica if surgery is being considered. This differs from IT band syndrome, which causes lateral knee pain without a snap; bursitis, which presents with swelling and warmth rather than a distinct snapping; and meniscal tears, which cause joint line pain, catching, or locking rather than snapping from a synovial fold. Most cases improve with activity modification and physical therapy; surgery to remove the plica is reserved for persistent symptoms.

7. Which of the following is necessary to demonstrate the knee joint space?

A. Fully flex the knee with the tube angled 5 cephalad

B. Central ray parallel to the patella

C. Direct the central ray superior to the patella

D. Direct the central ray perpendicular to the long axis of the tibia

To show the knee joint space clearly, you want the projection to preserve the true relationship of the femur and tibia surfaces. Directing the central ray perpendicular to the long axis of the tibia achieves this by aligning the beam with the knee in its natural frontal plane, minimizing distortion and preventing the joint space from appearing artificially narrowed or widened. If you angle the beam differently—such as tilting cephalad with a fully flexed knee or directing the beam parallel to the patella or superior to it—the projection can misrepresent the tibiofemoral joint space, making it harder to assess. So, perpendicular to the tibia's long axis best preserves and demonstrates the joint space.

8. Which condition presents with thickened palmar fascia and progressive flexion contractures of the digits?

A. Dupuytren contracture

B. Trigger finger

C. Carpal tunnel syndrome

D. Ganglion

Dupuytren contracture is a fibrous thickening of the palmar fascia that forms nodules and cords in the palm, pulling the digits into flexion progressively. This results in a fixed flexion of the fingers, most commonly the ring and pinky, as the cords shorten and contract the joints, typically at the metacarpophalangeal joints. It often develops slowly and may be painless, with risk factors including male sex, Northern European ancestry, and associated conditions like diabetes or heavy alcohol use. This differs from other hand conditions you might see. Trigger finger involves thickening of the flexor tendon sheath (A1 pulley) leading to locking or catching of the finger, not a thickened palmar fascia forming cords. Carpal tunnel syndrome causes numbness, tingling, and weakness from median nerve compression rather than a structural cord pulling the finger into a contracture. A ganglion is a fluid-filled cyst that presents as a lump, not a progressive fixed finger flexion deformity.

9. What is the typical leg position after an anterior hip dislocation?

A. Flexion, abduction, external rotation

B. Flexion, adduction, internal rotation

C. Flexion, abduction, external rotation

D. Extension, adduction, external rotation

An anterior hip dislocation typically causes the leg to be in flexion, abduction, and external rotation. This posture arises because the femoral head has moved anteriorly from the acetabulum, and the surrounding muscles pull the limb into a flexed position with the thigh spread outward (abduction) and rotated outward (external rotation). In contrast, a posterior hip dislocation usually presents with flexion, adduction, and internal rotation, reflecting posterior displacement of the head. A variation called superior (pubic) anterior dislocation can show extension, but the common pattern asked about is flexion, abduction, and external rotation.

10. For a PA projection of the third digit, the central ray should target which joint?

A. Carpophalangeal

B. Metacarpophalangeal

C. Proximal interphalangeal

D. Distal interphalangeal

For a PA view of a finger, center the central ray to the proximal interphalangeal joint. Placing the CR at the PIP joint puts that joint in the middle of the image and keeps the entire finger length—proximal to distal phalanges—well demonstrated with good sharpness and minimal distortion. This positioning best shows the anatomy of the finger joints, which is essential for evaluating fractures or other joint issues. Centering at a joint at the base (carpometacarpal/metacarpophalangeal area) would not optimally capture the mid and distal portions, and centering at the distal interphalangeal joint would shift the image away from the PIP joint, potentially clipping parts of the proximal phalanx and reducing detail where injuries commonly occur. So the proximal interphalangeal joint is the correct target.

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://extremitieslimscope.examzify.com

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