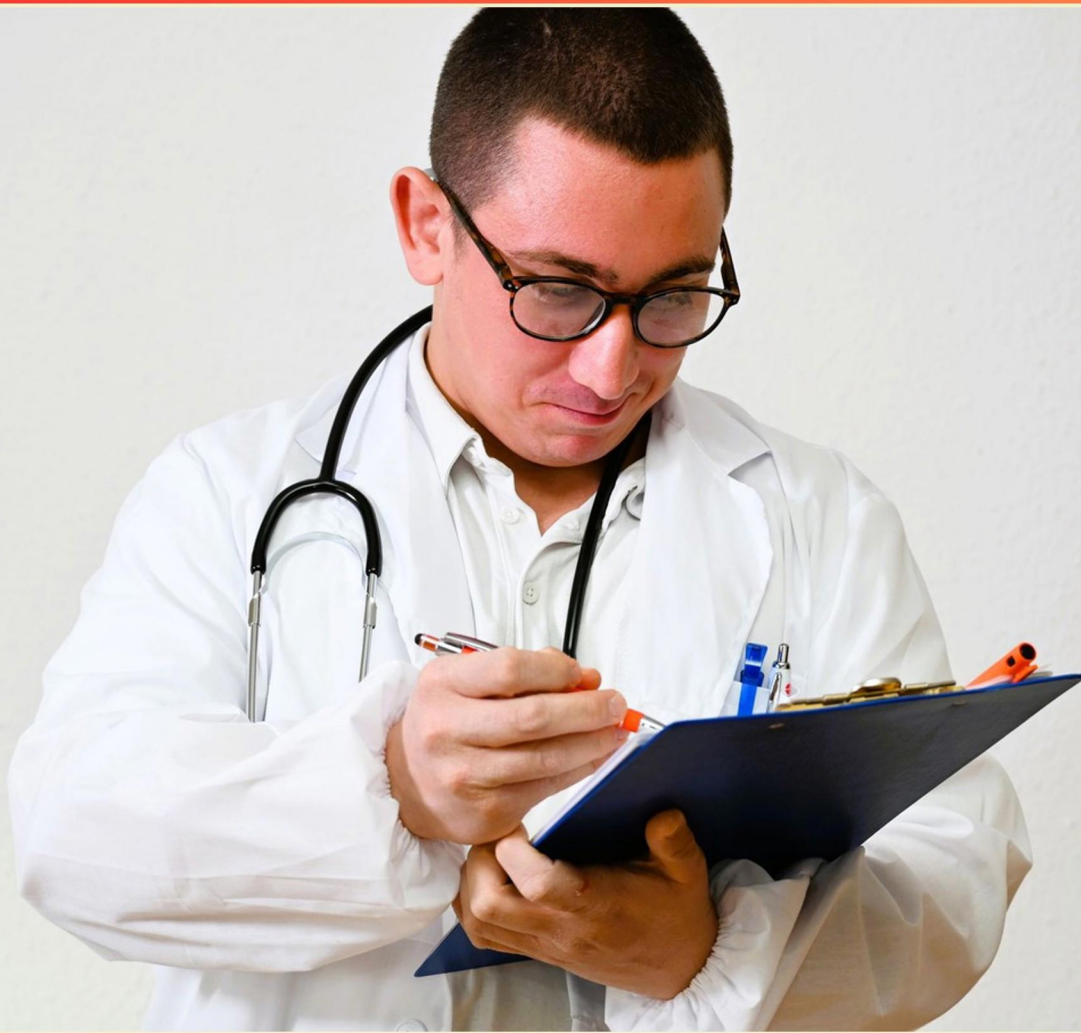


EXTREMITIES LIMITED SCOPE PRACTICE EXAM (SAMPLE)

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. Which of the following must be done to decrease the OID for a PA wrist projection?**
 - A. Fingers flexed
 - B. Fingers extended
 - C. Elbow flexed 90
 - D. Fingers separated
- 2. What is the leg position after a posterior hip dislocation?**
 - A. Flexion, adduction, internal rotation
 - B. Flexion, abduction, external rotation
 - C. Extension, adduction, internal rotation
 - D. Extension, abduction, external rotation
- 3. Which maneuver, besides McMurray, can aid in diagnosing a meniscal tear?**
 - A. Apley compression test
 - B. Thessaly test
 - C. Lachman test
 - D. McMurray test
- 4. For a lateral knee projection, which of the following flexion angles is correct?**
 - A. 90 degrees
 - B. 5 degrees
 - C. 45 degrees
 - D. 20 degrees
- 5. 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

- 6. Which injury is defined by tearing of the ulnar collateral ligament at the MCP joint of the thumb?**
- A. Jersey finger
 - B. Mallet finger
 - C. Gamekeeper's (skier's) thumb
 - D. Boutonnière deformity
- 7. Why are supracondylar humerus fractures in children clinically important?**
- A. They can injure the brachial artery and median nerve; require urgent evaluation and reduction if displaced.
 - B. They can injure the radial nerve and ulnar nerve; observation is enough if displaced.
 - C. They commonly cause shoulder dislocation.
 - D. They are always non-displaced and do not require urgent treatment.
- 8. Which condition presents with tenderness at the medial elbow and pain with resisted wrist flexion?**
- A. Lateral epicondylitis
 - B. Cubital tunnel syndrome
 - C. Radial tunnel syndrome
 - D. Medial epicondylitis
- 9. For oblique hand radiographs, how can you prevent foreshortening of the phalanges and obscuring of the interphalangeal joints?**
- A. Use a block to place digits parallel to the image receptor
 - B. Rotate the hand from 45-55 degrees
 - C. Rest the thumb and fingertips on the image receptor
 - D. Align the central ray to be perpendicular to the fingers
- 10. According to the Ottawa ankle rules, which finding prompts radiographs after an ankle injury?**
- A. Inability to weight-bear for four steps with focal bone tenderness at the malleoli or midfoot.
 - B. Severe swelling alone.
 - C. Pain with ankle dorsiflexion.
 - D. Numbness in the foot.

Answers

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

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Explanations

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1. Which of the following must be done to decrease the OID for a PA wrist projection?

- A. Fingers flexed**
- B. Fingers extended
- C. Elbow flexed 90
- D. Fingers separated

To decrease the object-to-image distance, place the hand so the wrist sits as close to the image receptor as possible. Curling the fingers into a fist makes the hand more compact, bringing the wrist nearer to the IR and thus reducing OID. Extending the fingers would lift the hand away from the receptor, increasing OID, and spreading the fingers would also add distance between the wrist and the IR. The elbow position doesn't by itself change how close the wrist is to the IR when the forearm is supported, so it's not the primary way to reduce OID. So, flexing the fingers is the best way to minimize OID in a PA wrist projection.

2. What is the leg position after a posterior hip dislocation?

- A. Flexion, adduction, internal rotation**
- B. Flexion, abduction, external rotation
- C. Extension, adduction, internal rotation
- D. Extension, abduction, external rotation

Posterior hip dislocations cause the leg to be flexed at the hip, adducted toward the midline, and internally rotated. This happens because the femoral head is displaced backward out of the acetabulum, often after a force to the knee or dashboard-type injury, pulling the leg into that flexed, cross-legged position. The limb is usually shortened as well, reflecting the displacement of the hip joint. This pattern differs from anterior dislocations, where the leg tends to be extended (or flexed), abducted, and externally rotated. So the description of flexion, adduction, and internal rotation best matches the post-dislocation position.

3. Which maneuver, besides McMurray, can aid in diagnosing a meniscal tear?

- A. Apley compression test
- B. Thessaly test**
- C. Lachman test
- D. McMurray test

The key idea is using a dynamic, weight-bearing maneuver that specifically stresses the meniscus to reproduce symptoms. The Thessaly test does this by having the patient stand on one leg and slowly rotate the knee while it's flexed at about 5 degrees and then at 20 degrees. If there's a meniscal tear, the twisting under load often causes joint-line pain, a sense of catching, or locking. It's a quick, simple way to assess meniscal integrity in a clinic setting. Other maneuvers can test meniscal pathology too, but they're less direct or not focused on the meniscus. The Apley compression test also targets the meniscus but is performed with the patient lying face down and can be less specific. The Lachman test evaluates the anterior cruciate ligament rather than the meniscus, and McMurray is the classic test already noted. Thus, the Thessaly test stands out as the best additional maneuver for diagnosing a meniscal tear.

4. For a lateral knee projection, which of the following flexion angles is correct?

- A. 90 degrees
- B. 5 degrees
- C. 45 degrees
- D. 20 degrees**

For a lateral knee projection, you want the knee to be flexed only lightly so the femoral condyles can be superimposed and the tibia aligned under the femur. This position keeps the femorotibial joint space open and the patella in profile, producing a true lateral view. About 20 degrees of knee flexion achieves this balance: it places the knee in proper alignment without excessive rotation, giving a clean lateral image with accurate joint visualization. Very little flexion (around 5 degrees) wouldn't allow true lateral superimposition, and too much flexion (like 45 or more) would alter the relationships and obscure the joint details. A 20-degree bend is the standard that yields the best lateral knee image.

5. 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.

6. Which injury is defined by tearing of the ulnar collateral ligament at the MCP joint of the thumb?

- A. Jersey finger
- B. Mallet finger
- C. Gamekeeper's (skier's) thumb**
- D. Boutonnière deformity

The injury described is a tear of the ulnar collateral ligament at the metacarpophalangeal joint of the thumb, which is known as Gamekeeper's thumb (also called skier's thumb). The ulnar collateral ligament stabilizes the thumb's MCP joint during pinching, and an abnormal force—such as forced abduction or a fall onto an outstretched thumb—can stretch or rupture this ligament. This injury specifically affects the thumb at its base joint (MCP), not the fingers, and presents with pain and instability when trying to pinch or grip. The other conditions involve different structures: Jersey finger is a rupture/avulsion of the flexor digitorum profundus tendon at the fingertip; Mallet finger is an extensor tendon avulsion at the distal interphalangeal joint; Boutonnière deformity is a central slip injury at the proximal interphalangeal joint. Thus, tearing of the UCL at the thumb's MCP joint fits Gamekeeper's thumb best.

7. Why are supracondylar humerus fractures in children clinically important?

- A. They can injure the brachial artery and median nerve; require urgent evaluation and reduction if displaced.**
- B. They can injure the radial nerve and ulnar nerve; observation is enough if displaced.
- C. They commonly cause shoulder dislocation.
- D. They are always non-displaced and do not require urgent treatment.

Displaced supracondylar fractures in children are clinically important because the distal fragment can compromise the neurovascular bundle in the elbow, especially the brachial artery and the median nerve. These structures sit in front of the elbow, so a displaced fracture can stretch, compress, or injure them, leading to signs of poor hand perfusion (pale, cool hand, weak or absent pulse) and motor or sensory deficits in the median nerve distribution (such as trouble with thumb opposition and sensation over the lateral palm and first three fingers). Because loss of blood flow or neural function can quickly become permanent, urgent evaluation and reduction are needed when the fracture is displaced to restore alignment and perfusion. After reduction, reassessing circulation and nerve function is crucial, and persistent issues may require surgical management. While nerve injuries to the radial or ulnar nerves can occur, they are not the primary, immediate concern in this scenario, and shoulder dislocation is not a typical result of a supracondylar fracture. Non-displaced fractures may be managed nonoperatively, but displaced ones demand prompt action to protect the limb.

8. Which condition presents with tenderness at the medial elbow and pain with resisted wrist flexion?

- A. Lateral epicondylitis
- B. Cubital tunnel syndrome
- C. Radial tunnel syndrome
- D. Medial epicondylitis**

The main idea is that tenderness at the medial elbow with pain produced by resisted wrist flexion points to medial epicondylitis, also known as golfer's elbow. This condition is a tendinopathy at the origin of the wrist flexor-pronator muscles—the common flexor tendon—where they attach to the medial epicondyle. Repetitive wrist flexion (and forearm pronation) strains these tendons, so when you try to actively flex the wrist against resistance, the irritated tendon fiber is stressed and painful. Palpation over the medial epicondyle is typically tender as well. That pattern helps distinguish it from other elbow conditions. Lateral epicondylitis would show tenderness at the outer elbow and pain with resisted wrist extension. Cubital tunnel syndrome involves ulnar nerve symptoms—numbness or tingling in the ring and little fingers, often with elbow flexion. Radial tunnel syndrome usually causes pain around the radial (lateral) elbow, occasionally with pain on resisted forearm rotation or middle finger extension, rather than focal tenderness at the medial epicondyle. So the described signs fit medial epicondylitis, reflecting overuse of the wrist flexor origin at the medial elbow.

9. For oblique hand radiographs, how can you prevent foreshortening of the phalanges and obscuring of the interphalangeal joints?

- A. Use a block to place digits parallel to the image receptor**
- B. Rotate the hand from 45-55 degrees
- C. Rest the thumb and fingertips on the image receptor
- D. Align the central ray to be perpendicular to the fingers

Foreshortening happens when the bones aren't parallel to the image receptor, making the phalanges look shorter and the interphalangeal joints harder to assess. Placing a block so the digits lie parallel to the image receptor keeps the phalanges in the same plane as the IR, preserving their true length and letting the joints be clearly visualized. Simply rotating the hand to a standard oblique angle can still misalign the phalanges with the receptor if individual digits aren't kept parallel, and resting the thumb and fingertips on the receptor helps stability but doesn't guarantee the needed parallel orientation. While directing the central ray perpendicular to the fingers helps reduce overall distortion, it can't compensate for bones that aren't parallel to the receptor.

10. According to the Ottawa ankle rules, which finding prompts radiographs after an ankle injury?

- A. Inability to weight-bear for four steps with focal bone tenderness at the malleoli or midfoot.**
- B. Severe swelling alone.
- C. Pain with ankle dorsiflexion.
- D. Numbness in the foot.

Ottawa ankle rules guide when X-rays are needed after an ankle injury by focusing on two things: specific focal bone tenderness and the ability to bear weight. If there is tenderness at key bony landmarks (the malleolar area at the tips or posterior edges of the distal tibia or fibula, or in the midfoot at the navicular or the base of the fifth metatarsal) or the patient cannot bear weight for four steps immediately and in the emergency department, radiographs are recommended because fracture is more likely. The described finding—inability to weight-bear for four steps combined with focal bone tenderness at the malleoli or midfoot—fits these criteria perfectly. It signals a real possibility of fracture, so imaging helps confirm and guide treatment. Severe swelling alone, pain with ankle dorsiflexion, or numbness in the foot do not by themselves meet the Ottawa criteria for radiographs, so they don't mandate imaging under these rules.

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!

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