Medbridge Orthopedic Clinical Specialist (OCS) Test 1 Practice (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. Which test is NOT part of the Park et al. trio for ruling in a full-thickness rotator cuff tear?

A. Painful arc sign

B. Drop-arm sign

C. Infraspinatus muscle test

D. Hawkins-Kennedy test

2. Which feature is associated with Stage 2 Neer shoulder impingement?

A. Calcific deposits and osteophyte formation

B. Tendon rupture

C. Fibrosis and tendinitis

D. Joint instability

3. Intrinsic minus hand posture occurs when which muscles are weak while extrinsic muscles remain intact?

A. Wrist flexion with MCP extension and PIP/DIP flexion

B. Wrist extension with MCP flexion

C. Full extension of all joints

D. Wrist flexion with MCP flexion

4. Which intervention has shown the most short-term benefit for calcific tendinitis of the shoulder?

A. Pulsed ultrasound

B. Isometric strengthening for shoulder flexors

C. PROM for shoulder flexion

D. Circling scapula exercises

5. During objective examination, atrophy is seen in the infraspinatus fossa. Which condition is most likely?

A. C7 radiculopathy

B. Subscapularis tear

C. Suprascapular nerve palsy

D. Dorsal scapular nerve palsy

6. Which finding is part of the cervical spine myelopathy cluster described by Cook et al.?

A. Ataxia

B. Numbness in fingertips

C. Decreased reflexes

D. Nocturnal neck pain

7. According to Park et al., which combination of tests yields the best post-test probability for full-thickness rotator cuff tear?

A. Painful arc sign, drop-arm sign, and infraspinatus muscle test

B. Empty can test, external rotation lag sign, and Hornblower sign

C. Painful arc sign, Hawkins-Kennedy test, and supraspinatus isolation test

D. Drop-arm sign, abdominal crunch test, and biceps provocation test

8. Which feature distinguishes tension-type headaches from migraine and cervicogenic headaches?

A. Unilateral headache

B. Bilateral headache

C. Radiation to the leg

D. Triggering by light exposure

9. Which findings predict a favorable response to mechanical traction in the traction subgroup?

A. Centralization with extension and a positive straight-leg raise

B. Centralization with extension and a negative straight-leg raise

C. Peripheralization with extension and a positive crossed straight-leg raise

D. Peripheralization with extension and a positive straight-leg raise

10. What is the action of the medial temporalis?

A. Move the mandible up, forward, and side-to-side

B. Elevate mandible and protrude

C. Depress mandible

D. Move mandible up, back, and side-to-side

Answers

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

Explanations

1. Which test is NOT part of the Park et al. trio for ruling in a full-thickness rotator cuff tear?

A. Painful arc sign

B. Drop-arm sign

C. Infraspinatus muscle test

D. Hawkins-Kennedy test

Park's trio are three signs that are specifically used to identify a full-thickness rotator cuff tear: the painful arc sign, the drop-arm sign, and the infraspinatus muscle test (resisted external rotation). The painful arc sign shows pain in a midrange of abduction, suggesting supraspinatus involvement. The drop-arm test demonstrates a failure to control the arm smoothly when lowering it, reflecting a tear. The infraspinatus muscle test assesses weakness or pain with resisted external rotation, again pointing toward a tear in the rotator cuff. Hawkins-Kennedy, by contrast, is a provocative impingement test that stresses the subacromial space to detect impingement syndrome. It's useful for impingement rather than specifically ruling in a full-thickness rotator cuff tear as defined by Park's trio. Therefore, Hawkins-Kennedy is not part of Park's trio.

2. Which feature is associated with Stage 2 Neer shoulder impingement?

A. Calcific deposits and osteophyte formation

B. Tendon rupture

C. Fibrosis and tendinitis

D. Joint instability

Stage 2 Neer shoulder impingement reflects fibrotic changes and tendinopathy of the rotator cuff. Over time, repetitive overhead activities cause microtrauma that leads to inflammation accompanied by fibrosis, thickening of the tendon, and degeneration of the tendinous tissue and bursal surface. This contrasts with the early stage, which is dominated by edema and hemorrhage, and with the later stage, where there are more advanced degenerative changes and tearing, sometimes with bone spur formation. That's why this option—fibrosis and tendinitis—best fits Stage 2. Calcific deposits and osteophytes are more aligned with advanced degenerative changes, tendon rupture suggests a more severe tear, and joint instability isn't a hallmark of this stage.

3. Intrinsic minus hand posture occurs when which muscles are weak while extrinsic muscles remain intact?

A. Wrist flexion with MCP extension and PIP/DIP flexion

B. Wrist extension with MCP flexion

C. Full extension of all joints

D. Wrist flexion with MCP flexion

Intrinsic minus occurs when the intrinsic hand muscles are weak while the extrinsic muscles remain intact. The intrinsic muscles normally flex the metacarpophalangeal joints and help extend the PIP and DIP joints through the extensor mechanism. When they're weak, the extrinsic extensors pull the MCP joints into extension, and the flexors continue to pull the PIP and DIP joints into flexion because there is no intrinsic force to extend them. This creates the characteristic posture of MCP extension with PIP/DIP flexion, often accompanied by wrist flexion. The described pattern—wrist flexion with MCP extension and PIP/DIP flexion—best matches this mechanism and is the classic presentation of intrinsic minus.

4. Which intervention has shown the most short-term benefit for calcific tendinitis of the shoulder?

A. Pulsed ultrasound

B. Isometric strengthening for shoulder flexors

C. PROM for shoulder flexion

D. Circling scapula exercises

Short-term relief in calcific tendinitis is driven by interventions that quickly decrease pain and inflammation and improve tissue gliding around the painful area. Pulsed ultrasound provides rapid, noninvasive modulation of the inflammatory environment and can improve tissue vitality and microcirculation without adding load to the joint. These non-thermal effects—such as mechanical stimulation that enhances healing processes and reduces sensitivity—often translate into noticeable pain reduction and better ROM in the early weeks of treatment. In contrast, strengthening and scapular/ROM-focused activities build long-term function and stability, but their benefits typically unfold over a longer time frame and rely on patient effort and progress with exercise. While maintaining mobility and improving mechanics are essential, they don't generally offer the same immediate symptomatic relief that pulsed ultrasound can provide in the short term.

5. During objective examination, atrophy is seen in the infraspinatus fossa. Which condition is most likely?

A. C7 radiculopathy

B. Subscapularis tear

C. Suprascapular nerve palsy

D. Dorsal scapular nerve palsy

The infraspinatus sits in the infraspinous fossa and is innervated by the suprascapular nerve. When this nerve is compromised, the infraspinatus (and often the supraspinatus) wastes away, which you'd see as atrophy in the area where the infraspinatus resides. That pattern points to suprascapular nerve palsy rather than issues with other nerves or roots. Dorsal scapular nerve palsy would affect rhomboids and levator scapulae, not the infraspinatus region. A subscapularis tear would mainly affect internal rotation and adduction, not cause isolated infraspinatus atrophy. C7 radiculopathy could weaken multiple shoulder muscles, not show a selective wasting in the infraspinatus fossa. So the most likely condition is suprascapular nerve palsy.

6. Which finding is part of the cervical spine myelopathy cluster described by Cook et al.?

A. Ataxia

B. Numbness in fingertips

C. Decreased reflexes

D. Nocturnal neck pain

Cervical myelopathy involves the spinal cord and produces upper motor neuron–type signs that affect gait and coordination. In the Cook et al. cluster, gait disturbance or ataxia reflects disruption of proprioception and corticospinal pathways from cord compression, making ataxia the finding that best fits a cord-based process. Numbness in the fingertips can occur with peripheral nerve or dermatomal issues rather than a cord syndrome, and decreased reflexes are more typical of lower motor neuron or radicular problems (or early spinal shock) rather than the classic UMN pattern seen with myelopathy. Nocturnal neck pain is non-specific and not a defining feature of the cord-based cluster.

7. According to Park et al., which combination of tests yields the best post-test probability for full-thickness rotator cuff tear?

A. Painful arc sign, drop-arm sign, and infraspinatus muscle test

B. Empty can test, external rotation lag sign, and Hornblower sign

C. Painful arc sign, Hawkins-Kennedy test, and supraspinatus isolation test

D. Drop-arm sign, abdominal crunch test, and biceps provocation test

Combining signs that reflect a large rotator cuff tear increases the likelihood of confirming the tear after testing. The painful arc sign points to subacromial pain during mid-range elevation, which is common with rotator cuff involvement. The drop-arm sign shows an inability to control the arm during lowering after abduction, a classic indicator of a full-thickness supraspinatus tear and related cuff pathology. The infraspinatus muscle test assesses external rotation strength; weakness here suggests infraspinatus involvement, reinforcing the suspicion of a significant tear when paired with the other signs. Taken together, these three findings provide a stronger post-test probability for a full-thickness rotator cuff tear than any single test alone, because they cover both tear presence and the functional impact on the cuff. Other test sets may include signs that focus more on impingement or isolating a single muscle rather than indicating a full-thickness tear, or they combine with tests that assess unrelated structures (like the biceps or abdominal maneuvers). While those can be informative for broader shoulder pathology, they don't yield as high a post-test probability for a full-thickness tear when used together.

8. Which feature distinguishes tension-type headaches from migraine and cervicogenic headaches?

A. Unilateral headache

B. Bilateral headache

C. Radiation to the leg

D. Triggering by light exposure

Tension-type headaches are typically felt on both sides of the head as a pressing or tightening sensation. This bilateral distribution sets them apart from migraine, which is usually unilateral and pulsating, and from cervicogenic headaches, which are often unilateral with neck involvement. Radiation to the leg isn't a feature of tension-type headaches, and light sensitivity is more characteristic of migraine. So the hallmark distinguishing feature is the bilateral pattern of pain.

9. Which findings predict a favorable response to mechanical traction in the traction subgroup?

A. Centralization with extension and a positive straight-leg raise

B. Centralization with extension and a negative straight-leg raise

C. Peripheralization with extension and a positive crossed straight-leg raise

D. Peripheralization with extension and a positive straight-leg raise

Traction tends to help when there is nerve root irritation from a disc problem that can be relieved by unloading the spine. If extension worsens symptoms and they peripheralize—moving further down the leg—this pattern signals ongoing nerve tension from a disc source that may respond to decompression. A positive crossed straight-leg raise adds evidence of significant disc-related nerve root compression affecting the opposite side, which is particularly responsive to traction's unloading effect. In this context, that combination best predicts a favorable response to mechanical traction. Centralization with extension suggests a different direction of symptom change and isn't as strongly predictive here, and a negative straight-leg raise or a non-crossed positive SLR provides less corroborating evidence of a disc-related radiculopathy amenable to traction.

10. What is the action of the medial temporalis?

A. Move the mandible up, forward, and side-to-side

B. Elevate mandible and protrude

C. Depress mandible

D. Move mandible up, back, and side-to-side

The medial temporalis is a jaw closing muscle that helps elevate the mandible. In addition to lifting the jaw, its posterior fibers pull the mandible back (retrude). When one side contracts alone, it can contribute to a slight side-to-side (grinding) movement as the mandible is guided toward the opposite side. This combination of elevating, retruding, and aiding lateral movement fits the described action. Depression of the mandible is carried out by other muscles, not the temporalis, and protrusion is mainly achieved by other muscles working with the anterior temporalis and medial pterygoid.

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://medbridgeocs1.examzify.com

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