

ORTHOPEDIC CERTIFIED SPECIALIST (OCS) CLINICAL CASE PRACTICE EXAM (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

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- 1. In a patient with knee problems, which ligament is likely injured if Lachman and anterior drawer tests are positive?**
 - A. Lateral collateral ligament
 - B. Medial meniscus
 - C. Anterior cruciate ligament
 - D. Patella tendon
- 2. What symptom typically correlates with CTS that worsens at night?**
 - A. Loss of dexterity
 - B. Shoulder pain
 - C. Elbow stiffness
 - D. Knee swelling
- 3. What symptom is least likely to be associated with rheumatoid arthritis?**
 - A. Morning stiffness
 - B. Symmetrical joint swelling
 - C. Joint pain that improves with rest
 - D. Fatigue and malaise
- 4. Which nerve is primarily affected by cubital tunnel syndrome?**
 - A. Radial Nerve
 - B. Ulnar Nerve
 - C. Median Nerve
 - D. Musculocutaneous Nerve
- 5. Which of the following is NOT one of the "5 D's and 3 N's" indicative of potential vertebral artery dissection?**
 - A. Diplopia
 - B. Dysarthria
 - C. Vomiting
 - D. Nystagmus

6. For a 6 year old child who developed a septic joint, what is the most important diagnostic test?
- A. Plain radiograph
 - B. Complete blood count
 - C. Erythrocyte sedimentation rate
 - D. Joint aspiration
7. What is the minimum PROM knee flexion in degrees that indicates a consideration for hip mobilizations in knee OA?
- A. 135 degrees
 - B. 122 degrees
 - C. 90 degrees
 - D. 100 degrees
8. In CRPS presentation, how long must the severe pain persist past tissue damage?
- A. 1 month
 - B. 3 months
 - C. 6 months
 - D. 12 months
9. In Primary Subacromial Impingement Syndrome, which age group is primarily affected in Stage 2?
- A. 0-10 years
 - B. 11-24 years
 - C. 25-40 years
 - D. 41 years and older
10. Which of the following is a cluster of findings indicating ankylosing spondylitis?
- A. Morning stiffness lasting less than 10 minutes
 - B. Pain at rest that improves with exercise
 - C. Unilateral joint pain
 - D. Age of onset greater than 45 years

Answers

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

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Explanations

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1. In a patient with knee problems, which ligament is likely injured if Lachman and anterior drawer tests are positive?

- A. Lateral collateral ligament
- B. Medial meniscus
- C. Anterior cruciate ligament**
- D. Patella tendon

The anterior cruciate ligament (ACL) plays a crucial role in stabilizing the knee, particularly in preventing anterior translation of the tibia relative to the femur. When a patient presents with knee issues and both the Lachman test and the anterior drawer test yield positive results, it strongly indicates an ACL injury. The Lachman test specifically assesses the integrity of the ACL and is often considered more sensitive than the anterior drawer test, especially when performed on a flexed knee. A positive result demonstrates increased anterior translation of the tibia due to the laxity created by the compromised ligament. Similarly, the anterior drawer test evaluates the same mechanism by applying an anterior force on the proximal tibia. When both tests are positive, it strongly suggests that the ACL is damaged or ruptured. The other structures listed, such as the lateral collateral ligament, medial meniscus, and patellar tendon, have different roles in knee stability and would not typically cause positive results on both the Lachman and anterior drawer tests in the event of injury. Understanding the specific tests associated with each ligament or structure is critical in accurately diagnosing and treating knee injuries, highlighting the centrality of the ACL in this context.

2. What symptom typically correlates with CTS that worsens at night?

- A. Loss of dexterity**
- B. Shoulder pain
- C. Elbow stiffness
- D. Knee swelling

Carpal tunnel syndrome (CTS) is characterized by compression of the median nerve as it passes through the wrist, leading to a range of symptoms. One of the hallmark features of CTS is the presence of nocturnal symptoms, which often include tingling, numbness, or pain in the fingers. These symptoms tend to worsen at night, frequently disrupting sleep. Loss of dexterity is a significant symptom of CTS as well. As the condition progresses, individuals may find it increasingly difficult to perform fine motor tasks that require hand coordination, such as buttoning a shirt or typing. The deterioration of hand function is directly linked to the increased discomfort and neurological symptoms experienced during the night. In contrast, the other options—shoulder pain, elbow stiffness, and knee swelling—do not specifically correlate with carpal tunnel syndrome. Shoulder pain might be related to conditions affecting the shoulder girdle or cervical spine, elbow stiffness could be indicative of local issues within the elbow joint or surrounding tissues, and knee swelling typically pertains to lower limb pathology, none of which are characteristic of CTS.

3. What symptom is least likely to be associated with rheumatoid arthritis?

- A. Morning stiffness
- B. Symmetrical joint swelling
- C. Joint pain that improves with rest**
- D. Fatigue and malaise

Joint pain that improves with rest is least likely to be associated with rheumatoid arthritis due to the characteristic nature of the disease. In rheumatoid arthritis, patients typically experience joint pain that tends to worsen with inactivity or during periods of rest. This is often due to the inflammatory processes that are exacerbated with prolonged immobility, leading to stiffness and increased discomfort when the person starts moving again after rest. In contrast, the other symptoms mentioned are commonly associated with rheumatoid arthritis. Morning stiffness is a hallmark sign, often lasting for more than an hour, as the joints may feel tight and painful after being immobile overnight. Symmetrical joint swelling is another key symptom, as this condition usually affects joints on both sides of the body simultaneously. Fatigue and malaise are also frequent complaints among individuals with rheumatoid arthritis, stemming from the overall impact of chronic inflammation and disease activity. Understanding these distinctions is critical for recognizing the nature of rheumatoid arthritis, which primarily involves persistent inflammation leading to symptoms that typically do not improve with rest.

4. Which nerve is primarily affected by cubital tunnel syndrome?

- A. Radial Nerve
- B. Ulnar Nerve**
- C. Median Nerve
- D. Musculocutaneous Nerve

Cubital tunnel syndrome primarily affects the ulnar nerve. This condition occurs when the ulnar nerve becomes compressed or irritated at the elbow, specifically as it passes through the cubital tunnel. The cubital tunnel is located on the inner part of the elbow, and the ulnar nerve can be subjected to pressure in this area due to various factors such as direct trauma, prolonged elbow flexion, or repetitive stress. As the ulnar nerve travels through the forearm into the hand, it innervates several muscles responsible for fine motor control and sensation, particularly in the ring and little fingers. Symptoms of cubital tunnel syndrome can include numbness and tingling in these fingers, weakness in grip strength, and pain on the inner side of the elbow. This specific pathology emphasizes the role of the ulnar nerve as being critical in this condition, distinguishing it from the other nerves listed, which do not have the same association with cubital tunnel syndrome.

5. Which of the following is NOT one of the "5 D's and 3 N's" indicative of potential vertebral artery dissection?

- A. Diplopia
- B. Dysarthria
- C. Vomiting**
- D. Nystagmus

In the context of vertebral artery dissection, the "5 D's and 3 N's" represent a specific set of clinical signs and symptoms that suggest potential involvement of the vertebrobasilar system. The "5 D's" refer to Diplopia (double vision), Dysarthria (difficulty articulating words), Dysphagia (difficulty swallowing), Dizziness (specific types such as vertigo), and Drop attacks (sudden loss of strength). The "3 N's" involve Nystagmus (involuntary eye movements), Nausea, and Neck pain. Among the choices provided, vomiting does not fit into this established clinical classification. While nausea is included in the "3 N's," vomiting is generally considered a symptom that can arise from a variety of conditions, including but not limited to vestibular disturbances or increased intracranial pressure. Thus, vomiting is not specifically indicative of vertebral artery dissection as per the "5 D's and 3 N's," making it the correct answer in identifying which symptom is not associated with this condition.

6. For a 6 year old child who developed a septic joint, what is the most important diagnostic test?

- A. Plain radiograph
- B. Complete blood count
- C. Erythrocyte sedimentation rate
- D. Joint aspiration**

In cases of septic joint, particularly in children, joint aspiration is paramount as it allows for the direct assessment of the joint fluid. This test not only helps in diagnosing the presence of infection by evaluating the color, clarity, and viscosity of the fluid, but it also enables the clinician to perform a cell count and potentially culture the fluid for microbial growth. The results from joint aspiration can provide critical information, such as the white blood cell count and differential, which helps establish whether there is an infection and its likely etiology. By isolating the organism responsible for the joint infection, appropriate antibiotic treatment can be initiated. Additionally, aspiration can be therapeutic, helping to relieve pressure through fluid removal, which alleviates pain and improves function. This procedure is thus considered essential in the management of septic joints, especially in pediatric patients where prompt treatment is necessary to prevent complications. While other tests like a complete blood count or an erythrocyte sedimentation rate can provide supportive information about overall inflammation or infection in the body, they do not offer the specific insights that joint aspiration provides regarding the joint itself. Likewise, plain radiographs have limited ability to diagnose septic arthritis in its early stages, as bone changes may not be evident immediately.

7. What is the minimum PROM knee flexion in degrees that indicates a consideration for hip mobilizations in knee OA?

- A. 135 degrees
- B. 122 degrees**
- C. 90 degrees
- D. 100 degrees

In the context of knee osteoarthritis (OA), assessing passive range of motion (PROM) is crucial for understanding joint function and planning appropriate interventions. The minimum PROM knee flexion that may indicate a need for hip mobilizations is 122 degrees. This threshold is significant because it reflects a level of knee flexion that, if not achieved, suggests limitations that may impact functional mobility. In cases of knee OA, individuals often experience decreased range of motion, which can affect their ability to perform activities of daily living and maintain independence. When knee flexion is limited to around 122 degrees, it may be necessary to consider addressing hip mobility, as the hip joint plays an integral role in overall lower extremity mechanics and can influence knee function. Furthermore, addressing adjoined joints like the hip can help improve overall lower extremity mobility and potentially alleviate some of the stresses placed on the knee joint. Consequently, when individuals with knee OA exhibit this particular limitation in knee flexion, practitioners should give careful consideration to interventions that may involve hip mobilizations to enhance overall joint functionality and reduce pain.

8. In CRPS presentation, how long must the severe pain persist past tissue damage?

- A. 1 month
- B. 3 months
- C. 6 months**
- D. 12 months

In Complex Regional Pain Syndrome (CRPS), the defining characteristic is the persistence of severe pain that is disproportionate to the extent of tissue injury. The current understanding and diagnostic criteria indicate that for a diagnosis of CRPS to be considered valid, symptoms must persist for at least 6 months beyond the initial tissue damage or injury. This timeframe is critical because it helps distinguish CRPS from other acute pain syndromes that may resolve more quickly. Long-term pain post-injury, such as exceeding the 6-month threshold, supports the diagnosis of CRPS, as the pain mechanism alters, creating a complex interaction involving both the nervous and immune systems. Recognizing this 6-month duration is essential in clinical practice for appropriate diagnosis and treatment planning. Thus, 6 months serves as a critical marker for practitioners to identify and manage CRPS effectively.

9. In Primary Subacromial Impingement Syndrome, which age group is primarily affected in Stage 2?

- A. 0-10 years
- B. 11-24 years
- C. 25-40 years**
- D. 41 years and older

In Stage 2 of Primary Subacromial Impingement Syndrome, the most affected age group is typically between 25 and 40 years. This demographic is often involved in activities that require repetitive overhead motions, which can lead to the development of impingement pathology. In this stage, the condition primarily features progressive changes in the rotator cuff, and individuals in this age group may begin to experience chronic shoulder pain, often exacerbated by specific activities or postures. The combination of dynamic shoulder use and the natural aging process, which can include degenerative changes in the shoulder joint and surrounding structures, makes this age group particularly susceptible to developing symptoms associated with impingement. As individuals age beyond 40 years, they may start to present with more chronic conditions or have different clinical findings, such as cuff tears or other degenerative changes that would categorize their shoulder issues differently. Additionally, younger age groups (0-10 and 11-24 years) generally experience fewer shoulder impingement problems as they are less engaged in the repetitive overhead activities that often lead to such conditions. Thus, they are less likely to be categorized under Stage 2 of impingement syndrome. This developmental understanding highlights why the 25-40 age range is

10. Which of the following is a cluster of findings indicating ankylosing spondylitis?

- A. Morning stiffness lasting less than 10 minutes
- B. Pain at rest that improves with exercise**
- C. Unilateral joint pain
- D. Age of onset greater than 45 years

The selection of the finding that indicates ankylosing spondylitis is particularly relevant due to the characteristic features of the condition. Pain at rest that improves with exercise is a hallmark symptom of ankylosing spondylitis. Patients typically experience stiffness and pain during periods of inactivity, especially in the morning or after prolonged sitting, which can directly improve with movement and exercise. This phenomenon is a key differentiator in terms of inflammatory back pain associated with ankylosing spondylitis compared to mechanical causes. The other findings are less indicative of ankylosing spondylitis. For instance, morning stiffness lasting less than 10 minutes suggests a more mechanical, non-inflammatory problem as it contrasts significantly with the lengthy morning stiffness commonly seen in ankylosing spondylitis. Similarly, unilateral joint pain is not typical of ankylosing spondylitis, as this condition generally presents with bilateral symptoms and involves the sacroiliac joints early on. Finally, an age of onset greater than 45 years contradicts the usual demographic for ankylosing spondylitis, which often begins in younger adults, typically in their late teens to early 30s. Thus, the proper identification of each of these characteristics is crucial in diagnosing ank

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:

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

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