

PRAXIS DYSPHAGIA 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

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- 1. What is NMES in dysphagia therapy, and what does evidence say about its use?**
 - A. Neuromuscular electrical stimulation aims to enhance swallowing muscle activity; evidence is mixed and it may be beneficial as an adjunct to traditional therapy in some cases.
 - B. NMES is an invasive surgical procedure to permanently strengthen the swallow muscles.
 - C. NMES is a pharmacologic agent used to increase saliva production during meals.
 - D. NMES is an imaging technique used to visualize swallow mechanics.
- 2. In the esophageal phase, what occurs to guide the bolus to the stomach?**
 - A. Relaxation/opening of the lower esophageal sphincter and esophageal peristalsis
 - B. Early initiation of the oral phase
 - C. Closure of the epiglottis
 - D. Relaxation/opening of the UES and esophageal peristalsis
- 3. Which statement best describes non-nutritive sucking in infants?**
 - A. It involves more swallowing than sucking.
 - B. It uses pacifiers and results in sustained sucking with frequent swallows.
 - C. It involves more sucking and less swallowing.
 - D. It is identical to nutritive sucking.
- 4. Louise is an 85-year-old with severe pharyngeal phase dysphagia and NPO; the surgeon is considering a more permanent non-oral feeding method. Louise is most likely receiving nutrition via which non-oral feeding method?**
 - A. Esophagostomy
 - B. Gastrostomy
 - C. Nasogastric
 - D. Pharyngostomy

- 5. How can you clinically distinguish oropharyngeal from esophageal dysphagia?**
- A. Oropharyngeal dysphagia presents with difficulty initiating swallow, coughing or choking during/after swallow, nasal regurgitation; esophageal dysphagia presents with a sensation of food sticking in the chest or back of the throat, often with reflux or regurgitation.
 - B. Oropharyngeal dysphagia is limited to elderly patients; esophageal dysphagia occurs only in younger patients.
 - C. Oropharyngeal dysphagia shows no coughing; esophageal dysphagia always includes coughing.
 - D. They are identical in presentation.
- 6. In videofluoroscopic swallowing, recording images in the AP view is best for which purpose?**
- A. Optimal visualization of epiglottic inversion
 - B. Optimal visualization of bilateral pharyngeal movement and stasis
 - C. Optimal visualization of aspiration
 - D. Optimal visualization of the base of the tongue and posterior pharyngeal wall movement
- 7. What considerations are essential when evaluating swallowing in a patient on mechanical ventilation?**
- A. Airway stability, cuff status, suctioning, coordination of respiration and swallow, readiness for instrumental assessment, and collaboration with respiratory therapy.
 - B. Only oxygen saturation and respiratory rate.
 - C. Swallow tests can be performed without coordination with respiratory therapy.
 - D. Ventilator settings do not affect swallowing.
- 8. Which type of sensation is most effective for eliciting the pharyngeal swallow?**
- A. Taste
 - B. Temperature
 - C. Pain
 - D. Touch

9. How do age-related changes (presbyphagia) influence assessment and treatment planning?

- A. They involve reduced laryngeal elevation, slower swallow, and diminished pharyngeal contraction; therapy emphasizes safety, gradual progression, and accommodating comorbidities and frailty.
- B. They imply improvement in swallow with age and require no therapy.
- C. They are identical to pediatric dysphagia features.
- D. They only affect saliva production and not swallowing mechanics.

10. Which of the following is a common contraindication for dysphagia therapy or instrumentation?

- A. Chronic stable hypertension
- B. Mild dehydration
- C. Adequate oxygen saturation
- D. Acute airway obstruction

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Answers

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

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Explanations

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1. What is NMES in dysphagia therapy, and what does evidence say about its use?

- A. Neuromuscular electrical stimulation aims to enhance swallowing muscle activity; evidence is mixed and it may be beneficial as an adjunct to traditional therapy in some cases.**
- B. NMES is an invasive surgical procedure to permanently strengthen the swallow muscles.
- C. NMES is a pharmacologic agent used to increase saliva production during meals.
- D. NMES is an imaging technique used to visualize swallow mechanics.

Neuromuscular electrical stimulation (NMES) is a noninvasive approach that uses surface electrodes placed over swallow muscles to deliver electrical currents with the aim of boosting their activity during therapy. In dysphagia rehab, it's typically used alongside traditional swallow exercises, with electrode placement targeting muscles involved in the oral and pharyngeal phases to help improve strength and coordination. The evidence is mixed: some studies show added benefit when NMES is combined with conventional therapy, while others find little to no extra improvement beyond standard treatment. Because this variability exists, NMES is viewed as a potential adjunct rather than a universal solution, and its use is best guided by clinical judgment, proper technique, and patient-specific considerations. It is not an invasive surgical procedure, a pharmacologic agent, or an imaging technique.

2. In the esophageal phase, what occurs to guide the bolus to the stomach?

- A. Relaxation/opening of the lower esophageal sphincter and esophageal peristalsis
- B. Early initiation of the oral phase
- C. Closure of the epiglottis
- D. Relaxation/opening of the UES and esophageal peristalsis**

During the esophageal phase, propulsion of the bolus relies on coordinated esophageal peristalsis—wave-like contractions that push the bolus downward. Before this movement can begin, the upper esophageal sphincter must relax to admit the bolus into the esophagus. Once inside, the peristaltic waves carry the bolus toward the stomach, and at the distal end the lower esophageal sphincter relaxes to allow entry into the stomach. The key idea captured here is the opening of the upper sphincter to enter the esophagus plus the esophageal peristaltic motion that moves the bolus downward toward the stomach.

3. Which statement best describes non-nutritive sucking in infants?

- A. It involves more swallowing than sucking.
- B. It uses pacifiers and results in sustained sucking with frequent swallows.
- C. It involves more sucking and less swallowing.**
- D. It is identical to nutritive sucking.

Non-nutritive sucking is sucking without milk flow. Because there's no liquid to swallow, infants tend to suck in longer bursts with few or no swallows, so you see more sucking actions and less swallowing overall. Pacifiers are commonly used for this pattern, but the key feature is the lack of liquid intake and the low swallowing rate. That's why the description of more sucking with less swallowing best fits non-nutritive sucking, whereas patterns that emphasize frequent swallows or equate it with nutritive sucking don't align with the absence of milk flow.

4. Louise is an 85-year-old with severe pharyngeal phase dysphagia and NPO; the surgeon is considering a more permanent non-oral feeding method. Louise is most likely receiving nutrition via which non-oral feeding method?

- A. Esophagostomy
- B. Gastrostomy
- C. Nasogastric**
- D. Pharyngostomy

Non-oral feeding routes are used when swallowing safety is compromised, so nutrition can reach the stomach without going through the mouth or pharynx. In severe pharyngeal phase dysphagia, the risk of aspiration is high, and a tube that bypasses the swallowing process is needed. A nasogastric tube enters through the nose into the stomach, delivering calories directly into the gastrointestinal tract with minimal invasiveness and without surgery. It's typically used in the short to intermediate term while clinicians assess prognosis and plan for a longer-term solution. More permanent options like gastrostomy, pharyngostomy, or esophagostomy require surgical or endoscopic procedures and are considered when longer-term feeding is anticipated. So, Louise would most commonly be receiving nutrition via a nasogastric tube, especially as a bridging method or when a quick, non-surgical route is appropriate.

5. How can you clinically distinguish oropharyngeal from esophageal dysphagia?

- A. Oropharyngeal dysphagia presents with difficulty initiating swallow, coughing or choking during/after swallow, nasal regurgitation; esophageal dysphagia presents with a sensation of food sticking in the chest or back of the throat, often with reflux or regurgitation.**
- B. Oropharyngeal dysphagia is limited to elderly patients; esophageal dysphagia occurs only in younger patients.
- C. Oropharyngeal dysphagia shows no coughing; esophageal dysphagia always includes coughing.
- D. They are identical in presentation.

The key idea is that the problem location and when symptoms appear during swallowing determine the distinction. Oropharyngeal dysphagia is a transfer problem at the mouth or pharynx, so difficulty starts with initiating the swallow and is often accompanied by coughing or choking during or right after swallowing, sometimes with nasal regurgitation when the bolus escapes into the nasal cavity. Esophageal dysphagia, on the other hand, stems from the esophagus itself; patients typically feel that food "sticks" in the chest or back of the throat, and this picture is often associated with reflux or regurgitation of undigested material. It's not about age, and coughing is not an obligatory feature of esophageal dysphagia, nor are the two conditions identical. Evaluating the timing of symptoms and signs like nasal regurgitation versus a sticking sensation helps distinguish the two clinically.

6. In videofluoroscopic swallowing, recording images in the AP view is best for which purpose?

- A. Optimal visualization of epiglottic inversion
- B. Optimal visualization of bilateral pharyngeal movement and stasis**
- C. Optimal visualization of aspiration
- D. Optimal visualization of the base of the tongue and posterior pharyngeal wall movement

AP view in videofluoroscopy is used to compare the left and right sides of the pharynx at once, making it the best way to assess whether pharyngeal constrictor movement is symmetric and whether residual material is present on both sides. This bilateral perspective helps detect unilateral weakness or asymmetry that could be missed on a single-sided view. Other aspects of swallowing, like epiglottic inversion, aspiration, and the movement of the base of the tongue with the posterior pharyngeal wall, rely more on depth and front-to-back relationships that are more clearly seen in the lateral view. So while you can glean some information about those components, the AP view is most informative for evaluating bilateral pharyngeal movement and stasis.

7. What considerations are essential when evaluating swallowing in a patient on mechanical ventilation?

- A. Airway stability, cuff status, suctioning, coordination of respiration and swallow, readiness for instrumental assessment, and collaboration with respiratory therapy.**
- B. Only oxygen saturation and respiratory rate.
- C. Swallow tests can be performed without coordination with respiratory therapy.
- D. Ventilator settings do not affect swallowing.

Assessing swallowing in a patient on mechanical ventilation focuses on safety and the ability to protect the airway while you assess swallow function. Start with airway stability and cuff status because the airway needs to be protected during swallowing, yet the presence and condition of the endotracheal tube and its cuff can influence how the larynx moves and how secretions are managed. An inflated cuff improves protection but can alter laryngeal mechanics, whereas deflating the cuff temporarily may change swallow physiology and risk, so decisions are individualized and coordinated with the care team. Suctioning also plays a key role. Secretions and the need for suctioning can disrupt swallow timing and increase the risk of aspiration, so you plan around when suctioning is performed and ensure secretions are adequately cleared before or after a swallow. Coordination of respiration and swallow is essential in this setting. Swallowing naturally aligns with specific phases of the breathing cycle, but mechanical ventilation imposes a respiratory pattern that can disrupt this timing. Evaluations should consider whether the patient can coordinate swallow with the exhalatory phase or whether pauses or adjustments to the ventilator cycle are needed to minimize aspiration risk. Readiness for instrumental assessment matters. When deciding to pursue videofluoroscopic swallow study or FEES, the patient must be hemodynamically stable, tolerating the transfer or test environment, and able to participate without excessive sedation. Instrumental assessment provides direct visualization of bolus flow and airway protection, guiding safer feeding decisions. Collaboration with respiratory therapy is vital. Respiratory therapists help optimize ventilator settings, manage airway care, and time procedures to protect the airway during swallow testing. Their involvement ensures that oxygenation and ventilation are maintained and that the evaluation fits safely within the patient's respiratory plan. These collective considerations—airway protection and cuff management, suctioning and secretions, synchronized respiration and swallow, readiness for instrumental testing, and multidisciplinary collaboration—are what make a swallowing evaluation on mechanical ventilation safe and informative.

8. Which type of sensation is most effective for eliciting the pharyngeal swallow?

- A. Taste
- B. Temperature
- C. Pain
- D. Touch**

Pharyngeal swallow initiation relies on tactile, mechanical input from the oropharynx. The most potent cue is touch on areas like the faucial arches or posterior pharyngeal wall, where mucosal mechanoreceptors detect contact as the bolus arrives. This sensory signal travels to the brainstem swallowing center and rapidly triggers the coordinated pharyngeal constriction and airway protection that define the swallow. Taste and temperature can modulate swallow timing or salience, and cold stimulation is sometimes used in therapy to help the response, but they are not as reliable as touch for triggering the reflex. Pain typically hinders swallowing rather than promoting it. Thus, touch is the sensation that most effectively elicits the pharyngeal swallow.

9. How do age-related changes (presbyphagia) influence assessment and treatment planning?

- A. They involve reduced laryngeal elevation, slower swallow, and diminished pharyngeal contraction; therapy emphasizes safety, gradual progression, and accommodating comorbidities and frailty.**
- B. They imply improvement in swallow with age and require no therapy.
- C. They are identical to pediatric dysphagia features.
- D. They only affect saliva production and not swallowing mechanics.

Presbyphagia reflects aging-related changes in swallowing that reduce efficiency and airway protection, such as less laryngeal elevation, slower swallow timing, and weaker pharyngeal contraction. These changes shape how we assess and plan treatment because older adults often have less physiologic reserve and more medical complexity, so safety during swallowing becomes the priority and the approach must be tailored to a slower pace and to any comorbidities or frailty. In assessment, we vigilantly look for signs of airway invasion, residue after swallowing, and how meal dynamics are affected, using instrumental tools as needed to accurately gauge timing, bolus flow, and safety. In treatment planning, the emphasis is on safety, gradual progression of diet texture and volume, and strategies that accommodate frailty and other health issues—such as postural adjustments, pacing, cueing, and carefully chosen therapeutic exercises or strategies that fit the individual's overall health status. This isn't about swallowing improving with age or being identical to pediatric dysphagia, and it isn't limited to saliva production; the focus is on the age-related changes to the swallow mechanism and how those changes guide careful, individualized management.

10. Which of the following is a common contraindication for dysphagia therapy or instrumentation?

- A. Chronic stable hypertension
- B. Mild dehydration
- C. Adequate oxygen saturation
- D. Acute airway obstruction**

Airway safety during dysphagia therapy or instrumentation is essential. Acute airway obstruction means the airway is blocked or at imminent risk; in this state, swallowing maneuvers or introducing a scope could trigger further obstruction, coughing, or laryngospasm and markedly increase the risk of aspiration or respiratory failure. Because safety must come first, this is a contraindication until the obstruction is relieved and the patient is stabilized. The other conditions don't automatically preclude therapy: chronic stable hypertension and mild dehydration can be managed with precautions, and adequate oxygen saturation indicates the patient is currently stable enough to participate with monitoring.

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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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