Selected Cervical Pathologies, Dysfunctions, and Treatments 1 Practice Test (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 muscles are noted as having impaired relaxation in neck muscle dysfunction?

A. SCM, scalenes, upper trapezius

B. Biceps brachii

C. Rectus abdominis

D. Soleus

2. Which Quebec Task Force WAD level is defined by neck pain with musculoskeletal signs such as decreased ROM and point tenderness?

A. WAD 3

B. WAD 2

C. WAD 1

D. WAD 4

3. What is a key contraindication to performing manual cervical traction?

A. Instability, acute fracture, or inflammatory disease with ligamentous laxity (e.g., RA).

B. Traction is safe in all cervical spine conditions.

C. Traction is contraindicated only in elderly patients.

D. Traction is the preferred treatment for rheumatoid arthritis.

4. Which description best fits peripheral neuropathy?

A. Radiculopathy produces dermatomal pattern of weakness with reflex changes

B. Diffuse non-dermatomal sensory loss

C. Myotomal weakness with reflex changes

D. Nerve-specific deficits with sensory/motor involvement in a single peripheral nerve distribution

5. Which condition has altered sensory processing, altered motor performance, and altered NM control?

A. Dizziness

B. Migraine

C. Neck pain

D. Tendinopathy

6. Postoperative instruction includes not to 'push through' which symptom?

A. Pain

B. Numbness

C. Dizziness

D. Fatigue

7. Rupture of which ligaments may be encountered in WAD injuries?

A. Nuchal Ligaments

B. Transverse Atlantal Ligaments

C. Cruciates Ligaments

D. Alar Ligaments

8. In distinguishing cervical radiculopathy from a peripheral nerve lesion in the upper limb, which pattern is most characteristic of radiculopathy?

A. Dermatomal and myotomal patterns with reflex changes

B. Isolated nerve-specific sensory loss in a single nerve distribution

C. Symmetric distal weakness with normal reflexes

D. Proximal muscle weakness affecting many myotomes

9. When should exercise be modified after TOS surgery according to postoperative precautions?

A. If symptoms last more than 2 hours

B. Only if there is fever

C. After 6 weeks regardless

D. If symptoms last more than 24 hours

10. Which of the following is NOT a typical feature of postoperative rehabilitation after ACDF?

A. Heavy lifting early

B. Early gentle ROM

C. Progressive strengthening

D. Gradual return to activity

Answers

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

Explanations

1. Which muscles are noted as having impaired relaxation in neck muscle dysfunction?

A. SCM, scalenes, upper trapezius

B. Biceps brachii

C. Rectus abdominis

D. Soleus

When neck muscle dysfunction shows impaired relaxation, the muscles most often involved are those that directly control head and neck posture and are easily activated and held in a tense state. The sternocleidomastoid, scalenes, and upper trapezius fit this pattern because they are superficial, frequently recruited to stabilize the head and neck, and tend to develop chronic tightness with poor posture, stress, or overuse. After activity, these muscles may not fully relax, contributing to persistent stiffness, headaches, and restricted range of motion. The other muscles listed—biceps brachii, rectus abdominis, and soleus—are not neck muscles and are not typically described as having impaired relaxation in neck dysfunction, so they do not explain this pattern.

2. Which Quebec Task Force WAD level is defined by neck pain with musculoskeletal signs such as decreased ROM and point tenderness?

A. WAD 3

B. WAD 2

C. WAD 1

D. WAD 4

This question tests how the Quebec Task Force classifies whiplash injuries by the presence of objective signs. The level described—neck pain with musculoskeletal signs such as decreased range of motion and point tenderness—is the category where there is clear musculoskeletal involvement but no neurological deficits. That fits WAD II, where patients show reduced neck motion and local tenderness or muscle spasm, yet there are no nerve signs like numbness, weakness, or reflex changes. This differs from WAD I, which involves neck pain without objective physical signs; WAD III, which includes neurological signs; and WAD IV, which involves fracture or dislocation. Thus, the presence of decreased ROM and focal tenderness anchors the answer to WAD II.

3. What is a key contraindication to performing manual cervical traction?

A. Instability, acute fracture, or inflammatory disease with ligamentous laxity (e.g., RA).

B. Traction is safe in all cervical spine conditions.

C. Traction is contraindicated only in elderly patients.

D. Traction is the preferred treatment for rheumatoid arthritis.

Manual cervical traction should be avoided when the cervical spine is unstable, there is an acute fracture, or there is an inflammatory disease with ligamentous laxity, such as rheumatoid arthritis. These conditions mean the spine may move abnormally or already be compromised, so applying a traction force can worsen displacement, injure the spinal cord or nerve roots, or cause other serious complications. In instability or acute fracture, the goal is to protect the alignment of the spine, not to apply longitudinal stress. In diseases like RA, ligament laxity at the craniocervical junction increases the risk of dangerous motion or atlantoaxial instability under traction. Traction is not universally safe for all cervical conditions, age alone is not a contraindication, and rheumatoid arthritis is not a scenario where traction is preferred; rather, cervical involvement in RA is a red flag for potential instability and risk.

4. Which description best fits peripheral neuropathy?

A. Radiculopathy produces dermatomal pattern of weakness with reflex changes

B. Diffuse non-dermatomal sensory loss

C. Myotomal weakness with reflex changes

D. Nerve-specific deficits with sensory/motor involvement in a single peripheral nerve distribution

Focus on how a lesion localizes: peripheral neuropathy means disease of the peripheral nerves themselves. When a single nerve is involved, you get deficits confined to that nerve's territory, affecting both sensation and motor function in the areas that nerve supplies, often with reflex changes limited to those muscles. This nerve-specific pattern matches a peripheral nerve lesion rather than a nerve root problem. In contrast, radiculopathy follows a dermatomal distribution because it involves a nerve root, and myotomal weakness follows a myotome with corresponding reflex changes. A diffuse, non-dermatomal sensory loss doesn't fit a single peripheral nerve distribution and points away from a focal peripheral neuropathy. So the description of deficits localized to a single peripheral nerve's sensory and motor territory best fits peripheral neuropathy.

5. Which condition has altered sensory processing, altered motor performance, and altered NM control?

A. Dizziness

B. Migraine

C. Neck pain

D. Tendinopathy

Sensorimotor dysfunction in neck pain involves changes across three domains: how sensory information from the neck is processed, how neck-related movements are performed, and how the nervous system coordinates muscle activity around the neck. Pain and altered afferent input from cervical tissues can disrupt proprioception, leading to impaired neck position sense and altered sensory processing. This often goes hand in hand with motor performance changes, such as reduced activation or timing of deep neck stabilizers and compensatory co-activation of superficial muscles, which can shift movement patterns and endurance. Neuromuscular control is affected as the CNS adapts its feedforward and corrective strategies for head and neck movements, influencing postural control and coordination with eye and head movements. Because neck pain commonly produces this triad of sensory, motor, and neuromuscular alterations, it best fits the description. Dizziness, migraine, and tendinopathy involve other primary mechanisms and don't consistently present all three domains together in the same way.

6. Postoperative instruction includes not to 'push through' which symptom?

A. Pain

B. Numbness

C. Dizziness

D. Fatigue

Pain is the signal to protect healing after neck surgery. Pushing through it can overtax healing tissues, disrupt the surgical repair, increase swelling, or irritate nerves, risking setbacks in recovery. That's why postoperative guidelines emphasize stopping or modifying activity when pain arises beyond what is tolerable. Numbness, dizziness, and fatigue can occur for various reasons during the recovery period and aren't the primary cue to halt activity, though new or worsening numbness should prompt medical attention. In short, pain is the symptom that most clearly indicates you should back off and reassess.

7. Rupture of which ligaments may be encountered in WAD injuries?

A. Nuchal Ligaments

B. Transverse Atlantal Ligaments

C. Cruciates Ligaments

D. Alar Ligaments

Whiplash injuries stretch the ligaments that stabilize the craniocervical junction, with the alar ligaments being a key target. These ligaments run from the dens of the axis to the occipital condyles and mainly restrict rotation and side-bending of the head on the atlas. A sudden, violent acceleration–deceleration can tear or sprain them, leading to rotational instability at the upper neck, which fits how whiplash often presents. The transverse (cruciform) ligament is crucial for dens stability and its rupture would cause severe instability not typically seen in a standard whiplash pattern. The nuchal ligaments are posterior and robust, and ruptures there are not characteristic of WAD. The term cruciate is more commonly used for knee ligaments, not cervical ones. So the alar ligaments are the most likely to be involved in whiplash injuries.

8. In distinguishing cervical radiculopathy from a peripheral nerve lesion in the upper limb, which pattern is most characteristic of radiculopathy?

A. Dermatomal and myotomal patterns with reflex changes

B. Isolated nerve-specific sensory loss in a single nerve distribution

C. Symmetric distal weakness with normal reflexes

D. Proximal muscle weakness affecting many myotomes

Radiculopathy is a problem at a spinal nerve root, so the deficits it produces follow a dermatomal pattern for sensation and a myotomal pattern for movement, often with reflex changes tied to the affected root. This means you'll see sensory loss and weakness that map to the same spinal level (for example, a C6 pattern with lateral forearm/thumb sensation and specific elbow/wrist movements) and a diminished reflex corresponding to that root. A peripheral nerve lesion, by contrast, follows the distribution of a specific nerve, which can cut across multiple dermatomes or myotomes, and may spare the root-level reflex pattern. The hallmark then is a dermatomal and myotomal pattern with reflex changes, rather than a localized nerve distribution.

9. When should exercise be modified after TOS surgery according to postoperative precautions?

A. If symptoms last more than 2 hours

B. Only if there is fever

C. After 6 weeks regardless

D. If symptoms last more than 24 hours

In postoperative rehab after thoracic outlet syndrome surgery, the signal to adjust exercise is based on how long symptoms last after activity. If symptoms persist for more than about two hours, that indicates the exercise is provoking neurovascular irritation and should be modified or paused to protect healing tissues. This symptom-driven approach lets you progress safely while avoiding prolonged nerve or vascular strain. Fever would suggest an infection and isn't the criterion for adjusting exercise; a rigid rule like "never change anything for six weeks" ignores individual healing, and waiting a full day (24 hours) before modifying could allow ongoing irritation to worsen.

10. Which of the following is NOT a typical feature of postoperative rehabilitation after ACDF?

A. Heavy lifting early

B. Early gentle ROM

C. Progressive strengthening

D. Gradual return to activity

Postoperative rehab after ACDF focuses on protecting the fusion while gradually restoring motion and strength. Early on, gentle range of motion is encouraged to prevent stiffness, with a careful progression to strengthening of the neck and scapular muscles, and then a gradual return to activities as healing allows. Heavy lifting early would place excessive load on the fusion and hardware, risking implant failure, compromised fusion, or other complications, so it isn't a typical part of the rehabilitation plan.

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://selectedcervicalpathdysfunctreatments1.examzify.com

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