AMERICAN PODIATRIC MEDICAL LICENSING EXAMINATION (APMLE) PART 2 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.

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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!

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Questions

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1. **In Hardcastle classification for Lisfranc fracture-dislocations, a total incongruity injury is classified as which type?**

   A. Type A

   B. Type B1

   C. Type B2

   D. Type C

2. **Which of the following prophylactic interventions for diabetic neuropathic ulceration is NOT beneficial?**

   A. Optimization of glycemic control

   B. Compression stockings

   C. Intensive podiatric care

   D. Surgery

3. **Which radiographic view is best to evaluate pain at the posterior aspect of the ankle?**

   A. An Anteroposterior View of the Affected Ankle

   B. A Medial Oblique View of the Foot

   C. A Lateral View of the Foot and Ankle

   D. A Harris-Beath (Calcaneal Axial) View

4. **What is the first step in open reduction and internal fixation of an ankle pilon fracture?**

   A. Fixation of the fibular fracture

   B. Bone grafting of the metaphyseal defect

   C. Reconstruction of posterior malleolar fracture

   D. Fixation of the medial malleolar fracture

5. **The fifth toe can clearly be seen in all standard radiographic views except which?**

   A. lateral oblique

   B. dorsoplantar

   C. medial oblique

   D. lateral

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6. Which statement about gout is true?

A. Acute septic joint disease mimics gout.

B. Blood uric acid levels above 7 mg/dL are pathognomonic of gout.

C. Early acute gout is best treated by uricosuric agents.

D. Salicylates are administered to potentiate the effects of uricosuric agents.

7. After a flexor-to-extensor tendon transfer for stabilization, what position is required for healing?

A. Plantarflex the proximal phalanx at the metatarsophalangeal joint

B. Dorsiflex the proximal phalanx at the metatarsophalangeal joint

C. Allow the toe to seek its own level

D. Apply povidone-iodine to prevent infection

8. A reasonable intervention to prevent pulmonary emboli postoperatively after bunionectomy in an otherwise healthy patient would be which?

A. Elastic stockings

B. Warfarin

C. Subcutaneous heparin

D. Inferior vena cava filter

9. Which disease is associated with pes cavus due to increased spasticity of the fibularis (peroneus) longus?

A. Guillain-Barré syndrome

B. Multiple sclerosis

C. Amyotrophic lateral sclerosis

D. Charcot-Marie-Tooth disease

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10. List the steps of the McBride bunionectomy in the correct first-to-last order.

A. Medial capsulotomy, Exostectomy, Section of the deep transverse intermetatarsal ligament, Release of the conjoined adductor tendon, Removal of the fibular sesamoid

B. Medial capsulotomy, Exostectomy, Release of the conjoined adductor tendon, Section of the deep transverse intermetatarsal ligament, Removal of the fibular sesamoid

C. Removal of the fibular sesamoid, Medial capsulotomy, Exostectomy, Section of the deep transverse intermetatarsal ligament, Release of the conjoined adductor tendon

D. Medial capsulotomy, Exostectomy, Section of the deep transverse intermetatarsal ligament, Release of the conjoined adductor tendon, Removal of the fibular sesamoid

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Answers

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

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Explanations

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1. In Hardcastle classification for Lisfranc fracture-dislocations, a total incongruity injury is classified as which type?

A. Type A

B. Type B1

C. Type B2

D. Type C

Hardcastle classification uses the amount of incongruity at the tarsometatarsal joints to categorize Lisfranc injuries. A total incongruity injury means complete loss of alignment across the tarsometatarsal joints, with all metatarsal bases displaced relative to the tarsal bones. This is the most severe pattern in the scheme, reflecting a full dislocation of the Lisfranc complex. On imaging, you'd expect widespread misalignment of the metatarsals with the cuneiforms and cuboid, often with collapse of the arch. Therefore, the category that represents this complete loss of congruity is the one describing total incongruity.

2. Which of the following prophylactic interventions for diabetic neuropathic ulceration is NOT beneficial?

A. Optimization of glycemic control

B. Compression stockings

C. Intensive podiatric care

D. Surgery

Preventing diabetic neuropathic ulcers hinges on minimizing nerve damage and protecting the foot from excessive pressure, with good blood glucose control and proactive foot care playing central roles. Compression stockings are not helpful in this context because many patients with diabetic neuropathy have some degree of peripheral arterial disease; adding external compression can reduce blood flow to the already vulnerable tissues, increasing the risk of ischemia and skin breakdown. Ill-fitting stockings can also cause friction or pressure points on a numb foot, and deformities common in neuropathy can make proper fit difficult. In contrast, optimizing glycemic control helps slow neuropathy and vascular complications; intensive podiatric care reduces ulcer risk through regular foot exams, callus management, proper footwear, and patient education; and surgery can be considered to offload high-pressure areas or restore adequate perfusion in selected cases. Therefore, compression stockings do not provide a prophylactic benefit and may be harmful in this setting.

3. Which radiographic view is best to evaluate pain at the posterior aspect of the ankle?

A. An Anteroposterior View of the Affected Ankle

B. A Medial Oblique View of the Foot

C. A Lateral View of the Foot and Ankle

D. A Harris-Beath (Calcaneal Axial) View

When there is pain at the back of the ankle, you need a view that shows the posterior structures in profile, so the lateral projection of the foot and ankle is the best choice. This view places the tibia, talus, and calcaneus in a true side view, allowing you to clearly see the posterior talar process, the posterior aspect of the tibia-tibial plafond, and the posterior subtalar joint. It's particularly useful for identifying fractures of the posterior talar process, os trigonum, and posterior impingement syndromes that may be hidden on other angles. The other views don't visualize the posterior anatomy as well: an anteroposterior view looks mainly at the front structures, a medial oblique shifts the view toward the medial column and still misses much of the posterior anatomy, and the Harris-Beath axial view emphasizes the calcaneus from an axial angle rather than the posterior ankle region.

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4. What is the first step in open reduction and internal fixation of an ankle pilon fracture?

A. Fixation of the fibular fracture

B. Bone grafting of the metaphyseal defect

C. Reconstruction of posterior malleolar fracture

D. Fixation of the medial malleolar fracture

Restoring the lateral column and ankle mortise by fixing the fibular fracture is the first maneuver because it reconstitutes the outer framework of the ankle. When the fibula is stabilized, the width of the tibial plafond relative to the talus becomes defined, giving a stable reference for any remaining tibial plafond fragments to be reduced accurately. This step also helps realign the syndesmosis and provides a stable scaffold for subsequent reconstruction of the medial and posterior malleoli and any metaphyseal defects. Bone grafting is typically reserved for filling voids after reduction rather than as the initial move, and addressing the posterior or medial malleoli is performed after establishing fibular fixation to ensure proper realignment within the restored mortise. In many high-energy pilon cases staged fixation is used if soft tissues are not ready, but within the open reduction and internal fixation sequence, fibular fixation comes first because it sets the foundation for a correct, stable reconstruction.

5. The fifth toe can clearly be seen in all standard radiographic views except which?

A. lateral oblique

B. dorsoplantar

C. medial oblique

D. lateral

The key idea is how projection affects what you can see on a foot radiograph. When the beam passes from a side view (lateral), the toes tend to stack in line with the beam, causing overlapping of the digits. This makes it hard to distinguish a single toe, especially the fifth toe on the far side, because its bones lie directly behind or in front of neighboring toes in that view. In contrast, the dorsoplantar view, and the oblique views (which rotate the foot to separate the toes), provide angles that reduce overlap and let you clearly visualize the fifth toe and its phalanges. That separation is why the fifth toe is clearly seen in those views but not in a true lateral view.

6. Which statement about gout is true?

A. Acute septic joint disease mimics gout.

B. Blood uric acid levels above 7 mg/dL are pathognomonic of gout.

C. Early acute gout is best treated by uricosuric agents.

D. Salicylates are administered to potentiate the effects of uricosuric agents.

Ruling out infection is essential in any acute monoarticular arthritis because septic joint disease can closely resemble gout. The true point is that acute septic arthritis can mimic a gout flare, so clinicians must perform joint aspiration to analyze crystals and obtain cultures. If bacteria are present, management is urgent antibiotics and drainage to prevent joint destruction. If crystals consistent with gout are found and cultures are negative, the picture fits gout and appropriate anti-inflammatory treatment is used. Understanding this helps distinguish gout from infection early. Uric acid levels above 7 mg/dL are not diagnostic of gout—many people with high uric acid never develop gout, and during an acute attack uric acid can be normal. Treating a new gout attack isn't about uricosuric agents; those are for long-term urate lowering and prevention, not immediate relief. And salicylates are not used to boost uricosurics; in fact, aspirin can interfere with urate excretion and is not a step to enhance urate-lowering therapy.

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7. After a flexor-to-extensor tendon transfer for stabilization, what position is required for healing?

A. Plantarflex the proximal phalanx at the metatarsophalangeal joint

B. Dorsiflex the proximal phalanx at the metatarsophalangeal joint

C. Allow the toe to seek its own level

D. Apply povidone-iodine to prevent infection

When a tendon transfer changes the direction of pull, the healing position must place the transferred tendon under the correct tension to maintain the new alignment and prevent relapse. For a flexor-to-extensor transfer aimed at stabilizing the toe, immobilizing the proximal phalanx in plantarflexion at the metatarsophalangeal joint keeps the toe in a flexed posture that supports the new line of pull of the transferred tendon as it heals. This position protects the repair from extension forces and helps preserve the correction as scar tissue forms. Placing the toe in dorsiflexion would stretch the repair and risk failure, letting the toe seek its own level would not protect the transfer, and antiseptic measures, while important for wound care, do not address the stabilization needed during healing.

8. A reasonable intervention to prevent pulmonary emboli postoperatively after bunionectomy in an otherwise healthy patient would be which?

A. Elastic stockings

B. Warfarin

C. Subcutaneous heparin

D. Inferior vena cava filter

Mechanical protection against venous clots is the idea here. Elastic compression stockings help prevent pulmonary embolism after surgery by applying graded pressure to the legs, which speeds venous return and reduces venous stasis in the calves and thighs. In a healthy patient undergoing bunionectomy, this low-risk, noninvasive approach is appropriate to lower the chance of deep vein thrombosis and subsequent PE. Pharmacologic options, like subcutaneous heparin or warfarin, offer greater anticoagulation but carry bleeding risks and require monitoring, so they're typically reserved for higher-risk situations. An inferior vena cava filter is an invasive measure used when anticoagulation can't be used or in cases of recurrent embolism despite therapy, not for routine prophylaxis after a minor procedure in a healthy patient.

9. Which disease is associated with pes cavus due to increased spasticity of the fibularis (peroneus) longus?

A. Guillain-Barré syndrome

B. Multiple sclerosis

C. Amyotrophic lateral sclerosis

D. Charcot-Marie-Tooth disease

High-arched feet with a tendency toward lateral instability (a cavovarus pattern) are classic in Charcot Marie Tooth disease. This hereditary neuropathy causes distal weakness and an imbalance between muscles that lift the foot and those that evert and plantarflex it. When the fibularis longus becomes relatively spastic, it pulls the foot into plantarflexion and eversion, contributing to the high arch and cavus deformity. The other conditions listed don't typically produce this characteristic pes cavus pattern through peroneal muscle spasticity; GBS is an acute polyradiculoneuropathy with ascending weakness, MS is a CNS demyelinating disease affecting gait patterns, and ALS causes progressive motor neuron loss without a fixed cavus deformity from peroneal overactivity.

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10. List the steps of the McBride bunionectomy in the correct first-to-last order.

A. Medial capsulotomy, Exostectomy, Section of the deep transverse intermetatarsal ligament, Release of the conjoined adductor tendon, Removal of the fibular sesamoid

B. Medial capsulotomy, Exostectomy, Release of the conjoined adductor tendon, Section of the deep transverse intermetatarsal ligament, Removal of the fibular sesamoid

C. Removal of the fibular sesamoid, Medial capsulotomy, Exostectomy, Section of the deep transverse intermetatarsal ligament, Release of the conjoined adductor tendon

D. Medial capsulotomy, Exostectomy, Section of the deep transverse intermetatarsal ligament, Release of the conjoined adductor tendon, Removal of the fibular sesamoid

Understanding the sequence of steps in a McBride bunionectomy helps restore alignment while maintaining joint stability. Start by releasing the medial structures—perform a medial capsulotomy to loosen the tight medial joint capsule and soft tissues, which allows the toe to realign smoothly. Next, remove the bony prominence with an exostectomy to address the medial metatarsal head bump that contributes to the deformity. Then divide the deep transverse intermetatarsal ligament to decrease the intermetatarsal angle, freeing the first and second metatarsals so they can sit properly. After that, release the conjoined tendon of the adductor hallucis to lessen the lateral pull on the toe and further correct sesamoid and joint alignment. Finally, remove the fibular (lateral) sesamoid if indicated, which is best done last to ensure prior corrections are in place before addressing the sesamoid; this step is contingent on intraoperative assessment of need.

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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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