AMSSM SPORTS MEDICINE 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.

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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. **What is the threshold for compartment pressure five minutes post-exercise in chronic exertional compartment syndrome?**

   A. 10 mmHg

   B. 15 mmHg

   C. 20 mmHg

   D. 30 mmHg

2. **Which type of femoral neck stress fracture carries a higher rate of complications?**

   A. Tension side (lateral)

   B. Compression side (medial)

   C. Either type equally

   D. Both types are benign

3. **Which type of decompression sickness involves musculoskeletal symptoms?**

   A. Type 2

   B. Type 1

   C. Type 3

   D. Type 4

4. **How does valgus extension overload differ from ulnar collateral ligament injury in terms of symptom location?**

   A. VEO pain occurs during acceleration; UCL injury during deceleration.

   B. VEO pain is in the anterior elbow; UCL injury is in the posterior elbow.

   C. VEO pain occurs during deceleration; UCL injury during acceleration.

   D. Both have the same pain location.

5. **Which muscle is NOT found in the first dorsal wrist extensor compartment?**

   A. Abductor pollicis longus

   B. Extensor pollicis brevis

   C. Extensor carpi radialis longus

   D. All are found in this compartment

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6. What is the primary treatment for proximal humeral epiphysiolysis?

A. Immediate surgery
B. Rest from throwing for 3 months
C. Physical therapy
D. Therapeutic injections

7. What is a common treatment option for an opened perilunate dislocation?

A. Rest and ice therapy
B. Open reduction and ligament repair
C. Corticosteroid injections
D. Complete immobilization

8. Which NSAIDs are associated with the highest cardiovascular risk?

A. Non-selective NSAIDs
B. COX-2 selective
C. COX-2 specific
D. Traditional NSAIDs

9. Which is a sign of a stinger injury related to nerve root damage?

A. Weakness in the arm
B. Loss of fine motor skills
C. Complete paralysis
D. Increased reflexes

10. What type of fracture is a Bennett fracture?

A. Fracture of the 2nd metacarpal
B. Fracture of the 3rd metacarpal
C. Fracture of the 1st metacarpal
D. Fracture of the 5th metacarpal

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Answers

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

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Explanations

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1. What is the threshold for compartment pressure five minutes post-exercise in chronic exertional compartment syndrome?

A. 10 mmHg

B. 15 mmHg

C. 20 mmHg

D. 30 mmHg

In chronic exertional compartment syndrome, the threshold for diagnosing increased compartment pressure post-exercise is commonly set at 20 mmHg. This measurement is significant because it reflects an elevated intramuscular pressure that can lead to impaired blood flow and muscle ischemia, causing the characteristic pain and dysfunction associated with this condition. After exertion, if the intramuscular pressure exceeds this threshold, it is indicative of the pathophysiological changes occurring within the compartment, and it supports the diagnosis of chronic exertional compartment syndrome. The 20 mmHg threshold is widely recognized in clinical practice, as it distinguishes normal post-exercise pressure from that indicative of the syndrome. Values significantly lower or higher suggest different conditions or normal physiological responses, making the understanding of this threshold crucial for clinicians evaluating athletes with exercise-induced leg pain.

2. Which type of femoral neck stress fracture carries a higher rate of complications?

A. Tension side (lateral)

B. Compression side (medial)

C. Either type equally

D. Both types are benign

A femoral neck stress fracture on the tension side, which is the lateral aspect, carries a higher rate of complications due to several factors. This type of fracture is particularly concerning because it is more prone to displacement. When a stress fracture occurs on the tension side, it may compromise the blood supply to the femoral head, which can lead to complications such as nonunion or avascular necrosis of the femoral head. In contrast, compression side fractures (on the medial side) typically have a better prognosis because they are less likely to displace, and the vascular supply to the femoral head tends to remain intact. The mechanical forces acting on the femoral neck can be managed more effectively when the fracture is on the compression side, thus reducing the likelihood of complications arising from displacement. The distinction between these two types of stress fractures is crucial for clinicians, as selecting the appropriate management strategy heavily depends on understanding the risks associated with each fracture type. This includes the potential for delayed healing or complications that can arise if the fracture worsens. The tension side fracture's increased risk underscores the importance of careful monitoring and potential surgical intervention in those cases.

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3. Which type of decompression sickness involves musculoskeletal symptoms?

A. Type 2

B. Type 1

C. Type 3

D. Type 4

Decompression sickness (DCS), often referred to as "the bends," can be categorized into different types based on the symptoms and systems affected. Type 1 decompression sickness, also known as "mild DCS," primarily manifests with musculoskeletal symptoms. These symptoms typically include joint and muscle pain, often resembling arthritis or other musculoskeletal disorders, and are frequently described as a deep, aching pain. This occurs when nitrogen gas that has dissolved in the body's tissues during a period of high pressure (such as when diving) begins to form bubbles as pressure decreases rapidly during ascent. The formation of these bubbles can cause irritation and inflammation in joints and muscles, leading to significant discomfort and pain. In comparison, Type 2 decompression sickness involves more severe systemic symptoms and primarily affects the neurological, cardiovascular, and pulmonary systems. This can include symptoms such as confusion, dizziness, weakness, and in severe cases, can lead to respiratory distress or neurologic impairments. Type 3 and Type 4 decompression sickness are less commonly referenced and may not align with the typical presentations of DCS categorized under the first two types. Thus, Type 1 is recognized specifically for its association with musculoskeletal symptoms and is the most accurate answer in this context.

4. How does valgus extension overload differ from ulnar collateral ligament injury in terms of symptom location?

A. VEO pain occurs during acceleration; UCL injury during deceleration.

B. VEO pain is in the anterior elbow; UCL injury is in the posterior elbow.

C. VEO pain occurs during deceleration; UCL injury during acceleration.

D. Both have the same pain location.

Valgus extension overload (VEO) and ulnar collateral ligament (UCL) injuries are both common conditions affecting the elbow, particularly in throwing athletes, but they manifest distinctly in terms of symptomatology and the activities that exacerbate or alleviate the pain. In the case of valgus extension overload, the pain is typically associated with the deceleration phase of throwing. This phase occurs when the arm transitions from the acceleration phase to follow-through, resulting in significant stress across the elbow joint, particularly at the anterior aspect where structures experience compression. Consequently, athletes often report pain located at the anterior aspect of the elbow due to this overload, especially when attempting to throw or during rapid deceleration of the arm. On the other hand, an ulnar collateral ligament injury tends to present pain during the acceleration phase of throwing. This is when the medial side of the elbow is under significant stress from the high torque and stress applied while the arm accelerates through the delivery of the pitch. The pain associated with a UCL injury typically manifests on the inner (medial) aspect of the elbow, reflecting the site of the ligament's attachment and the stress it incurs during this phase of throwing. Thus, understanding the timing of the pain relative to the phases

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5. Which muscle is NOT found in the first dorsal wrist extensor compartment?

A. Abductor pollicis longus

B. Extensor pollicis brevis

C. Extensor carpi radialis longus

D. All are found in this compartment

The first dorsal wrist extensor compartment is a specific anatomical space in the wrist that contains certain muscles responsible for the extension and abduction of the wrist and thumb. The muscles typically found in this compartment are the abductor pollicis longus and the extensor pollicis brevis. These muscles are crucial for thumb movements, including abduction and extension. The extensor carpi radialis longus, however, is primarily associated with the second dorsal compartment of the wrist. This muscle plays a significant role in wrist extension and radial deviation but is not contained within the first compartment. Understanding these anatomical relationships helps clarify the specific roles and locations of these muscles during wrist and hand movements. Overall, the presence of the abductor pollicis longus and extensor pollicis brevis in the first dorsal compartment contrasts with the function and location of the extensor carpi radialis longus, validating the selection of this muscle as the one not found in the first dorsal wrist extensor compartment.

6. What is the primary treatment for proximal humeral epiphysiolysis?

A. Immediate surgery

B. Rest from throwing for 3 months

C. Physical therapy

D. Therapeutic injections

The primary treatment for proximal humeral epiphysiolysis, which is often seen in young athletes, particularly baseball players, involves rest from throwing for an appropriate duration, typically around three months. This condition arises due to repetitive stress on the growing epiphyseal plate, leading to its separation or injury. The initial management focuses on allowing the bone and surrounding soft tissues to heal naturally without the added stress of throwing activities. Resting from throwing enables the epiphyseal plate to recover and reduces inflammation and pain associated with the condition. During this period, it is essential to avoid exacerbating the injury through continued stress from activities that involve overhead movements. While options like physical therapy can be beneficial for rehabilitation after the initial healing phase, they are not the primary treatment for the condition itself at the onset. Immediate surgery is typically reserved for cases with significant displacement or associated complications, which are less common. Therapeutic injections may provide relief in certain scenarios, but they are not a first-line treatment for proximal humeral epiphysiolysis, especially in a growing athlete. Therefore, the emphasis on rest from throwing for three months serves as the most effective primary treatment to facilitate proper healing of the injury.

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7. What is a common treatment option for an opened perilunate dislocation?

A. Rest and ice therapy

B. Open reduction and ligament repair

C. Corticosteroid injections

D. Complete immobilization

In the case of an opened perilunate dislocation, open reduction and ligament repair are indeed the most common treatment options. This type of injury involves the dislocation of the carpal bones in the wrist, often resulting in significant instability and potential compromise of the surrounding ligaments. The primary goal of treatment is to restore the normal anatomy of the wrist and ensure that the joint surfaces are aligned properly. Open reduction allows the surgeon to directly visualize and correct the dislocation, and any damaged ligaments can be repaired during the procedure to restore stability to the wrist. Additionally, addressing an opened perilunate dislocation surgically is important to prevent long-term complications such as chronic pain, arthritis, and loss of function, which can arise if the injury is treated conservatively or not addressed adequately. Other treatments like rest and ice therapy, corticosteroid injections, or complete immobilization do not address the underlying dislocation and can lead to poorer functional outcomes if employed alone.

8. Which NSAIDs are associated with the highest cardiovascular risk?

A. Non-selective NSAIDs

B. COX-2 selective

C. COX-2 specific

D. Traditional NSAIDs

COX-2 selective NSAIDs are associated with higher cardiovascular risks primarily because of their mechanism of action. While COX-2 inhibitors were developed to minimize gastrointestinal side effects by selectively inhibiting the COX-2 enzyme—responsible for inflammation and pain—they also impact cardiovascular function. This selectivity can lead to an imbalance in the production of prostaglandins, favoring those that promote vasoconstriction and platelet aggregation, thereby increasing the risk of cardiovascular events such as heart attacks and strokes. Clinical trials, particularly those assessing drugs like rofecoxib and valdecoxib, highlighted these risks, leading to significant concerns regarding their usage, especially in individuals with pre-existing cardiovascular conditions or risk factors. The understanding that while all NSAIDs can carry cardiovascular risks, COX-2 selective inhibitors have a notably higher association with adverse cardiovascular outcomes is crucial for clinical decisions regarding pain management in patients at risk.

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9. Which is a sign of a stinger injury related to nerve root damage?

A. Weakness in the arm

B. Loss of fine motor skills

C. Complete paralysis

D. Increased reflexes

A stinger injury, often referred to as a burner, typically occurs due to a stretch or compression of the brachial plexus nerves, which can lead to various neurological symptoms. Weakness in the arm is a common manifestation of this type of nerve root damage. This weakness is often localized to specific muscles innervated by the affected nerves and is usually temporary, resolving as the nerve function returns. In cases of stinger injuries, while some individuals may experience other symptoms such as numbness or tingling, the presence of weakness directly indicates involvement of the motor nerves affected by the injury. This makes it a primary sign of nerve root damage. The other choices may relate to neurological issues but are not specifically characteristic of a stinger injury. Loss of fine motor skills might suggest more extensive central nervous system involvement beyond the acute injury stage. Complete paralysis indicates a more severe nerve injury or damage and is usually not associated with the transient nature of a typical stinger injury. Increased reflexes generally suggest heightened nerve function rather than damage. Thus, weakness in the arm stands out as the most relevant sign associated with a stinger injury.

10. What type of fracture is a Bennett fracture?

A. Fracture of the 2nd metacarpal

B. Fracture of the 3rd metacarpal

C. Fracture of the 1st metacarpal

D. Fracture of the 5th metacarpal

A Bennett fracture specifically refers to an intra-articular fracture of the base of the first metacarpal bone, which is the bone that supports the thumb. This type of fracture is typically caused by axial loading on a partially flexed thumb, resulting in a fracture that can lead to joint instability due to the involvement of the carpometacarpal joint. Recognizing the location and mechanics of the Bennett fracture is crucial in sports medicine, especially given the significant role the thumb plays in grip and hand function. Accurate identification is essential for appropriate management and treatment, as surgical intervention may be necessary to restore function and stability in the affected area. A deeper understanding of this fracture helps differentiate it from those affecting other metacarpals, which have different implications for function and treatment.

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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:

https://amssmsportsmed.examzify.com

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

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