CERVICAL SPINE ORTHOPEDICS II 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. Adjacent segment disease after cervical fusion results in degenerative changes at which levels?

A. The fused level only

B. Levels adjacent to the fused segment

C. All levels above the fusion

D. Only intervertebral discs without facet involvement

2. Which radiographic finding suggests instability after cervical fusion on postoperative flexion-extension films?

A. Decreased translational movement on flexion-extension

B. Increased motion or screw loosening

C. Normal alignment with no motion

D. New bone bridging across the fusion level

3. Neurogenic TOS accounts for approximately what percentage of cases?

A. 10-20%

B. 40-60%

C. 85-95%

D. 100%

4. What is the primary complaint with thoracic outlet syndrome?

A. Headache and neck stiffness

B. Numbness and weakness in the medial forearm and hand

C. Lumbar back pain

D. Dizziness

5. Ventral compressive pathology in multilevel cervical disease is best treated with which approach?

A. Anterior approach

B. Posterior approach

C. Lateral approach

D. Inferior approach

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6. Which sign is commonly associated with SJD?

A. Cervicogenic headache

B. Scleratogenous referral

C. Acute torticollis

D. Dizziness with neck movement

7. Which of the following is a sign commonly associated with SJD?

A. Scleratogenous referral

B. Dizziness with neck movement

C. Lower back pain

D. Vision changes

8. Which area is most effectively decompressed by an anterior approach in ventral cervical pathology without posterior compression?

A. Posterior elements

B. Vertebral canal

C. Lateral recess

D. Anterior vertebral column and ventral nerve roots

9. A unique form of arterial TOS where the axillary artery is compressed is common in

A. Cyclists

B. Swimmers

C. Weight lifters

D. Overhead throwing athletes

10. A soft disc injury refers to which of the following phenomena?

A. Bulge

B. Soft

C. Hard

D. Sequestration

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Answers

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

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Explanations

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1. Adjacent segment disease after cervical fusion results in degenerative changes at which levels?

A. The fused level only

B. Levels adjacent to the fused segment

C. All levels above the fusion

D. Only intervertebral discs without facet involvement

When a cervical segment is fused, the motion is eliminated at that level, but the neighboring segments must accommodate more movement. This shift concentrates biomechanical stress on the levels immediately above and below the fusion, accelerating degenerative changes there. That's why adjacent segment disease is defined by degenerative alterations at the levels adjacent to the fused segment, rather than at the fused level itself or at levels farther away. The affected adjacent levels can involve both the intervertebral discs and the facet joints, reflecting the combined impact of increased motion and load.

2. Which radiographic finding suggests instability after cervical fusion on postoperative flexion-extension films?

A. Decreased translational movement on flexion-extension

B. Increased motion or screw loosening

C. Normal alignment with no motion

D. New bone bridging across the fusion level

After cervical fusion, dynamic flexion-extension films are used to test whether the fused segment remains stable. The key sign of instability is movement that should not be present in a solid fusion. When the films show increased motion across the fusion level, or evidence that screws are loosening or migrating, it indicates the construct is not providing rigid stabilization—one possible reason is nonunion or hardware failure. In this context, increased motion or screw loosening is the clearest cue that instability is present. By contrast, decreased motion, normal alignment with no motion, or new bone bridging across the fusion level all point toward a stable, successful fusion.

3. Neurogenic TOS accounts for approximately what percentage of cases?

A. 10-20%

B. 40-60%

C. 85-95%

D. 100%

Neurogenic thoracic outlet syndrome is the most common form of TOS, because compression of the brachial plexus occurs more often than compression of the vascular structures. It typically accounts for about 85–95% of cases, which is why it dominates the overall distribution. The neurologic symptoms—numbness, tingling, and sometimes weakness in the arm—reflect this nerve involvement, whereas arterial or venous forms are much less common and represent the minority of cases.

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4. What is the primary complaint with thoracic outlet syndrome?

A. Headache and neck stiffness

B. Numbness and weakness in the medial forearm and hand

C. Lumbar back pain

D. Dizziness

Thoracic outlet syndrome mostly shows up as neurogenic symptoms in the arm from compression of the lower brachial plexus as it passes through the outlet. The most common and defining complaint is numbness and tingling, along with weakness, in the medial forearm and hand—this is the ulnar-nerve distribution and reflects involvement of the inferior trunk (C8–T1). Other symptoms can include hand fatigue or clumsiness, but the arm-centered sensory and motor changes in that specific inner forearm/hand area are what people typically notice first. Headache and neck stiffness are more consistent with cervical or musculoskeletal issues in the neck. Lumbar back pain involves the lower spine, not the upper limb. Dizziness suggests issues in the vestibular system or circulation of the head, not the brachial plexus. So the primary complaint tied to thoracic outlet syndrome is numbness and weakness in the medial forearm and hand.

5. Ventral compressive pathology in multilevel cervical disease is best treated with which approach?

A. Anterior approach

B. Posterior approach

C. Lateral approach

D. Inferior approach

Ventral compression is best relieved by an anterior approach because it directly accesses the front of the cervical canal where the offending pathology lies, such as herniated discs, osteophytes, or ossified posterior longitudinal ligament. From the front you can safely remove these ventral elements and restore disc height and alignment, often with fusion across the involved levels (multilevel ACDF or corpectomy with fusion). A posterior approach decompresses from the back and may not adequately relieve ventral compression, potentially leaving the cord irritated and may require extensive bone removal with greater risk of instability. Lateral or inferior routes are not standard for addressing ventral cervical canal pathology.

6. Which sign is commonly associated with SJD?

A. Cervicogenic headache

B. Scleratogenous referral

C. Acute torticollis

D. Dizziness with neck movement

The key idea is how pain from spinal joints can refer in a non-dermatomal, deep pattern from the sclerotomes. Sclerotogenous joint dysfunction (SJD) produces pain that travels from cervical facet and related sclerotomal structures to areas that don't follow a single nerve root, giving a diffuse or oddly placed referral pattern rather than a clear dermatomal distribution. This sclerotogenous referral is the hallmark sign of SJD. The other signs describe different neck problems: cervicogenic headache refers to neck-origin pain felt as a headache; acute torticollis is a sudden neck muscle spasm causing abnormal head posture; dizziness with neck movement reflects neck-provoked vertigo or proprioceptive disturbance. While these can accompany neck issues, they do not define the sclerotogenous referral pattern characteristic of SJD.

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7. Which of the following is a sign commonly associated with SJD?

A. Scleratogenous referral

B. Dizziness with neck movement

C. Lower back pain

D. Vision changes

Sclerotogenous referral is the hallmark sign of sclerotogenous joint dysfunction. This means pain coming from spinal joints (like facet joints and surrounding structures) is felt in areas that share the same sclerotome, producing a deep, non-dermatomal, diffuse pattern rather than a sharp radicular or localized muscle pain. In practice, this referral pattern helps distinguish SJD from nerve-root–driven symptoms and from other neck-related signs, because the pain travels to regions not served by a single dermatome and often presents with focal joint tenderness. The other signs listed don't reflect this sclerotomal referral pattern. Dizziness with neck movement points more toward cervicogenic dizziness or vascular/oculomotor issues; lower back pain relates to the lumbar region rather than cervical joint dysfunction; vision changes are not typical of joints-based referral in the cervical spine.

8. Which area is most effectively decompressed by an anterior approach in ventral cervical pathology without posterior compression?

A. Posterior elements

B. Vertebral canal

C. Lateral recess

D. Anterior vertebral column and ventral nerve roots

When the compressive problem lies in front of the spinal cord, such as disc herniation or uncovertebral joint osteophytes, the most direct and effective relief comes from an anterior route. An anterior approach allows direct removal of ventral structures that crowd the ventral canal and ventral nerve roots, without disturbing the posterior elements. The lateral recess is the ventrolateral portion of the canal where the exiting nerve roots pass. Ventral degenerative changes often encroach on this region, so removing the offending ventral mass from the front directly decompresses the lateral recess. If there were posterior compression, a posterior approach would be more appropriate, but in this scenario—ventral pathology without posterior compression—the anterior route best targets the area most effectively decompressed.

9. A unique form of arterial TOS where the axillary artery is compressed is common in

A. Cyclists

B. Swimmers

C. Weight lifters

D. Overhead throwing athletes

Arterial thoracic outlet syndrome due to axillary artery compression occurs when the artery is pinched as it passes under the pectoralis minor during arm elevation. This is a dynamic, position-dependent compression that is most likely in athletes who repeatedly throw overhead. The throwing motion drives the shoulder into extreme abduction and external rotation, tightening the pectoralis minor and pressing the axillary artery against surrounding structures, leading to distal arm ischemia during those positions. Cyclists or swimmers tend to produce different, less consistent arterial compression patterns, and while weight lifters can have shoulder girdle crowding, the classic axillary artery compression linked to overhead throwing is most characteristic of overhead throwing athletes.

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10. A soft disc injury refers to which of the following phenomena?

A. Bulge

B. Soft

C. Hard

D. Sequestration

A soft disc injury refers to the soft, pliable material of the nucleus pulposus herniating through the annulus fibrosus. This descriptor focuses on the consistency of the herniated material, indicating it remains hydrated and non-calcified. It is contrasted with a hard disc (calcified/ossified material), a bulge (diffuse contour change without a focal rupture of the nucleus), and sequestration (a fragment that has broken off from the main disc). So the best interpretation is that the herniated material is soft, which aligns with the term itself. Imaging and clinical behavior of soft disc herniations often reflect their pliable nature, sometimes making them more likely to reabsorb.

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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://cervicalspineortho2.examzify.com

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

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