# MEDBRIDGE ORTHOPEDIC CLINICAL SPECIALIST (OCS) TEST 1 PRACTICE (SAMPLE)

## STUDY GUIDE



## SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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# Table of Contents


Copyright ..... 1

Table of Contents ..... 2

Introduction ..... 3

How to Use This Guide ..... 4

Questions ..... 5

Answers ..... 8

Explanations ..... 10

Next Steps ..... 15


SAMPLE

# 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. Which of the following is NOT one of the carpal tunnel CPR points?**

A. Shaking hands to relieve symptoms

B. Wrist ratio > 0.67

C. Symptom severity scale > 1.9

D. Phalen's test

**2. Claw hand (ulnar claw) deformity arises from damage to which nerve?**

A. Median nerve

B. Ulnar nerve

C. Radial nerve

D. Axillary nerve

**3. Which sign is associated with anterior interosseous nerve entrapment?**

A. Benedictine sign

B. Froment's sign

C. Tinel's sign

D. Phalen's sign

**4. Which statement is true about deep branch ulnar nerve injury?**

A. It causes intrinsic minus posture

B. It causes carpal tunnel syndrome

C. It causes radial deviation

D. It causes median nerve palsy

**5. The Scotty dog sign on oblique lumbar radiographs indicates fracture of which structure?**

A. Pars interarticularis

B. Pedicle

C. Lamina

D. Vertebral body

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**6. Six weeks of occipital headaches with occipital numbness and significant neck motion restriction accompanied by gait clumsiness best suggests which diagnosis?**

A. Atlas fracture

B. Upper cervical ligamentous instability

C. Cervical myelopathy

D. VBI

**7. What is a typical mechanism of ACL injuries?**

A. Direct blow to the knee

B. Hyperextension with axial load

C. Valgus loading with contact

D. Non-contact pivoting with sudden deceleration and change of direction

**8. How is a nondisplaced scaphoid fracture typically treated?**

A. Thumb spica cast immobilization for 6–12 weeks

B. Short-arm cast for 3 weeks

C. No immobilization needed

D. Wrist fusion

**9. Which nerve is at risk with a posterior dislocation of the hip?**

A. Femoral nerve

B. Sciatic nerve

C. Obturator nerve

D. Superior gluteal nerve

**10. Which feature is associated with Stage 2 Neer shoulder impingement?**

A. Calcific deposits and osteophyte formation

B. Tendon rupture

C. Fibrosis and tendinitis

D. Joint instability

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# Answers

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

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# Explanations

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## 1. Which of the following is NOT one of the carpal tunnel CPR points?

A. Shaking hands to relieve symptoms

B. Wrist ratio > 0.67

C. Symptom severity scale > 1.9

D. Phalen's test

*These carpal tunnel CPR points are a concise set of bedside clues that together help predict carpal tunnel syndrome without nerve testing. Shaking the hands to relieve symptoms is included because patients often report symptom relief with rest or movement, reflecting the intermittent nature of median nerve compression. A wrist ratio greater than 0.67 is included as an anatomical risk indicator—the ratio captures how the wrist's dimensions can predispose to tunnel crowding. A symptom severity scale above 1.9 provides a quantitative measure of how burdensome the symptoms are, which strengthens the prediction. Phalen's test, while a classic provocative maneuver for CTS, isn't part of this particular CPR. It's a diagnostic maneuver that can be positive in CTS but doesn't add independent predictive value within the multivariate rule used to derive the CPR, so it isn't included as one of the CPR points.*

## 2. Claw hand (ulnar claw) deformity arises from damage to which nerve?

A. Median nerve

B. Ulnar nerve

C. Radial nerve

D. Axillary nerve

*Claw hand appears when the intrinsic hand muscles that the ulnar nerve supplies are paralyzed. The ulnar nerve innervates the interossei and the medial two lumbricals, and these muscles normally flex the metacarpophalangeal joints while extending the interphalangeal joints. When they're weak or lost, the extensors pull the MCP joints into hyperextension while the IP joints remain flexed, especially in the ring and little fingers. This creates the characteristic clawing pattern. Other nerves produce different patterns of weakness (for example, median nerve injury can cause benediction or ape hand, radial nerve injury causes wrist drop, etc.), but claw hand specifically reflects loss of ulnar-innervated intrinsic hand muscles.*

## 3. Which sign is associated with anterior interosseous nerve entrapment?

A. Benedictine sign

B. Froment's sign

C. Tinel's sign

D. Phalen's sign

*Anterior interosseous nerve entrapment causes motor weakness of the muscles that flex the thumb's IP joint and the index finger's DIP joint (flexor pollicis longus and the lateral half of flexor digitorum profundus). When the patient tries to pinch, these joints can't flex properly, so the index finger and thumb don't come together as they should. The resulting posture is a benediction-like hand, known as Benedictine (or Benedict sign), which is the classic sign of this nerve entrapment. The other signs point to different nerves or conditions: Froment's sign tests ulnar nerve palsy with compensatory flexion of the thumb's IP joint due to loss of adductor pollicis; Tinel's sign indicates nerve irritation at a compression site; Phalen's sign is associated with carpal tunnel (median nerve).*

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## 4. Which statement is true about deep branch ulnar nerve injury?

A. It causes intrinsic minus posture

B. It causes carpal tunnel syndrome

C. It causes radial deviation

D. It causes median nerve palsy

*Deep branch injury of the ulnar nerve disrupts the intrinsic muscles of the hand—the interossei, the medial two lumbricals, the hypothenar group, and the adductor pollicis. When these muscles are paralyzed, the intrinsic balance that normally flexes the MCP joints and extends the IP joints is lost, so the extensor muscles pull the MCP joints into extension while the IP joints become flexed. This combination produces the intrinsic minus posture (often described as clawing) of the hand. Carpal tunnel syndrome is a problem of the median nerve at the wrist, not the ulnar intrinsic muscles. Radial deviation points to issues with the radial side nerves or extensors, not deep branch ulnar involvement, and does not reflect loss of intrinsic hand function. Median nerve palsy involves different muscles and patterns of weakness. Therefore, the true statement is that deep branch ulnar nerve injury causes intrinsic minus posture.*

## 5. The Scotty dog sign on oblique lumbar radiographs indicates fracture of which structure?

A. Pars interarticularis

B. Pedicle

C. Lamina

D. Vertebral body

*On oblique lumbar radiographs, the Scotty dog sign helps identify a fracture of the pars interarticularis. The neck of the Scotty dog represents this region, and when a pars interarticularis fracture occurs, it appears as a "collar" around that neck—the collar sign. This is the classic indicator of pars interarticularis fracture (spondylolysis). The other structures (pedicle, lamina, vertebral body) do not produce the collar sign on the oblique view, so they are not linked to this radiographic finding.*

## 6. Six weeks of occipital headaches with occipital numbness and significant neck motion restriction accompanied by gait clumsiness best suggests which diagnosis?

A. Atlas fracture

B. Upper cervical ligamentous instability

C. Cervical myelopathy

D. VBI

*Occipital headaches with numbness in the occipital region, along with marked neck motion restriction and a gait disturbance, point to instability at the atlas–axis region causing dynamic irritation of upper cervical structures. When the ligaments supporting the craniovertebral junction are lax or damaged, the atlas can move abnormally on the dens, especially with neck movement, leading to irritation of the suboccipital nerves and the cervicomedullary junction. This produces occipital headaches and occipital sensory changes, while the instability and pain limit neck motion and can yield gait clumsiness from cervical cord or brainstem involvement. An atlas fracture would be expected after a high-energy trauma with an acute, severe presentation, not a subacute six-week history. Cervical myelopathy from multilevel degeneration tends to present with broader UMN signs (hyperreflexia, hand dexterity issues) and would not as specifically explain occipital headaches and numbness. Vertebral basilar insufficiency typically presents with dizziness, vertigo, or syncope related to vertebrobasilar flow changes with head position, rather than the combination of occipital sensory symptoms plus neck stiffness and gait clumsiness.*

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## 7. What is a typical mechanism of ACL injuries?

A. Direct blow to the knee

B. Hyperextension with axial load

C. Valgus loading with contact

D. Non-contact pivoting with sudden deceleration and change of direction

*The typical mechanism is a non-contact pivoting motion with sudden deceleration and a change of direction. In this scenario, the athlete plants the foot and rapidly twists the knee, generating large anterior tibial shear and rotational forces on the ACL as the body continues to move while the knee is trying to stop. The knee is often near full extension or in slight flexion with a valgus and rotational loading, which places the ACL under peak strain and can lead to tearing even without any direct blow to the knee. This pattern is common in sports that involve cutting, pivoting, and abrupt stops, such as basketball, soccer, and football. While direct impact or hyperextension can injure the ACL, the non-contact pivot-and-deceleration mechanism is the most typical.*

## 8. How is a nondisplaced scaphoid fracture typically treated?

A. Thumb spica cast immobilization for 6–12 weeks

B. Short-arm cast for 3 weeks

C. No immobilization needed

D. Wrist fusion

*Immobilize the wrist and thumb in a thumb spica cast for about 6–12 weeks. Nondisplaced scaphoid fractures heal best when movement at the fracture site is minimized because the scaphoid has a tenuous blood supply and is prone to delayed healing or nonunion if the bone is allowed to move. The thumb spica cast effectively restricts motion across the fracture, promoting proper alignment and ossification during the healing period. A short-arm cast that doesn't immobilize the thumb wouldn't control motion well enough, and no immobilization would prevent healing. Wrist fusion is not appropriate for a simple nondisplaced fracture, as it sacrifices wrist motion for a problem that can usually heal with proper immobilization.*

## 9. Which nerve is at risk with a posterior dislocation of the hip?

A. Femoral nerve

B. Sciatic nerve

C. Obturator nerve

D. Superior gluteal nerve

*When the hip is dislocated posteriorly, the femoral head is driven toward the back of the pelvis, placing structures behind the joint at risk. The sciatic nerve runs directly posterior to the hip joint in the gluteal region and then travels down the posterior thigh, making it the neural structure most susceptible to injury from a posterior dislocation. Injury to the sciatic nerve can affect the motor function of the hamstrings and all muscles below the knee, and produce sensory changes along the posterior thigh and leg to the foot, reflecting both tibial and common fibular components. The other nerves listed are less likely targets in this scenario because of their anatomical courses. The femoral nerve lies in front of the hip from the lumbar plexus; obturator nerve courses medially within the pelvis; and the superior gluteal nerve travels superior to the piriformis. Their paths are not as closely related to the posterior hip joint as the sciatic nerve, so they are less commonly affected by a posterior dislocation.*

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## 10. Which feature is associated with Stage 2 Neer shoulder impingement?

A. Calcific deposits and osteophyte formation

B. Tendon rupture

C. Fibrosis and tendinitis

D. Joint instability

*Stage 2 Neer shoulder impingement reflects fibrotic changes and tendinopathy of the rotator cuff. Over time, repetitive overhead activities cause microtrauma that leads to inflammation accompanied by fibrosis, thickening of the tendon, and degeneration of the tendinous tissue and bursal surface. This contrasts with the early stage, which is dominated by edema and hemorrhage, and with the later stage, where there are more advanced degenerative changes and tearing, sometimes with bone spur formation. That's why this option—fibrosis and tendinitis—best fits Stage 2. Calcific deposits and osteophytes are more aligned with advanced degenerative changes, tendon rupture suggests a more severe tear, and joint instability isn't a hallmark of this stage.*

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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.

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

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