MEDICAL SURGICAL NEUROSENSORY 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. Which CSF pattern is typical of bacterial meningitis?

A. High opening pressure, neutrophilic WBCs, low glucose, high protein.

B. Normal opening pressure, lymphocytic predominance, normal glucose.

C. Low opening pressure, eosinophilic predominance.

D. Normal pressure with elevated glucose and protein.

2. Which signs might indicate VP shunt malfunction in a child or adult?

A. Headache and vomiting

B. Lethargy or irritability; bulging fontanelles in infants.

C. Fever only.

D. Headache, vomiting, lethargy or irritability; in infants bulging fontanelles; fever may indicate infection.

3. What is the typical clinical triad for normal pressure hydrocephalus and the treatment approach?

A. Headache, papilledema, weight gain; treatment is radiotherapy.

B. Gait disturbance, urinary incontinence, cognitive impairment; treatment is CSF shunting.

C. Gait disturbance, autonomic dysfunction, short-term memory loss; treatment is diuretics.

D. Seizures, sensory loss, ataxia; treatment is chemotherapy.

4. Which of the following is a manifestation of a transient ischemic attack?

A. Loss of vision in one eye

B. Chronic dizziness lasting weeks

C. Permanent paraplegia

D. Continuous severe headache for days

5. Which imaging modality is commonly used to evaluate trigeminal neuralgia for vascular compression?

A. CT without contrast

B. Nuclear medicine scan

C. MRI with high-resolution sequences and MR angiography

D. Plain X-ray

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6. Which statement about autonomic dysreflexia triggers is true?

A. It can be triggered by bladder distention

B. It cannot be triggered by bladder distention

C. It only occurs with brain injuries

D. It resolves without intervention

7. Which posture is characteristic of decerebrate posturing?

A. Arms flexed and legs extended

B. Arms extended and legs extended

C. Arms adducted and hands clenched

D. Arms abducted and shoulders elevated

8. Which of the following is an early manifestation of amyotrophic lateral sclerosis (ALS)?

A. Tremor in the fingers

B. Visual disturbances

C. Hearing loss

D. Weakness of the distal extremities

9. Which cranial nerves control eye movements?

A. Oculomotor (CN III), Trochlear (CN IV), and Abducens (CN VI)

B. Trigeminal (CN V) and Facial (CN VII)

C. Optic (CN II)

D. Vestibulocochlear (CN VIII) and Glossopharyngeal (CN IX)

10. Which findings indicate optic nerve involvement when assessing cranial nerve II function?

A. Papilledema or pallor of the optic disc

B. Afferent pupillary defect

C. Visual acuity and visual fields

D. All of the above

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Answers

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

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Explanations

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1. Which CSF pattern is typical of bacterial meningitis?

A. High opening pressure, neutrophilic WBCs, low glucose, high protein.

B. Normal opening pressure, lymphocytic predominance, normal glucose.

C. Low opening pressure, eosinophilic predominance.

D. Normal pressure with elevated glucose and protein.

Bacterial meningitis typically produces an inflammatory exudate in the subarachnoid space that changes several CSF parameters. The opening pressure is usually elevated because of the inflammatory process and resulting brain swelling. The white blood cell count in the CSF shows neutrophilic predominance, reflecting an acute bacterial infection. Glucose in the CSF drops because bacteria consume glucose and inflammation disrupts transport of glucose from the blood into the CSF. Protein levels rise due to increased permeability of the blood-brain barrier and leakage of plasma proteins into the CSF. When you see a pattern described as high opening pressure, neutrophils dominating the WBCs, low glucose, and high protein, it best matches bacterial meningitis. In contrast, viral meningitis more commonly shows lymphocytic predominance with normal glucose, and other patterns (like eosinophils or very low glucose) point to different etiologies.

2. Which signs might indicate VP shunt malfunction in a child or adult?

A. Headache and vomiting

B. Lethargy or irritability; bulging fontanelles in infants.

C. Fever only.

D. Headache, vomiting, lethargy or irritability; in infants bulging fontanelles; fever may indicate infection.

Problems with a ventriculoperitoneal shunt typically lead to increased intracranial pressure because CSF drainage is blocked or the shunt malfunctions, so the signs you look for are those that reflect pressure changes in the brain. Headache and vomiting are classic ICP symptoms in adults and older children. In infants, they can't verbalize pain, so irritability or lethargy becomes a key sign, and the fontanelles can bulge because the skull bones haven't fused yet, allowing pressure to push outward. Fever is also important to consider because infection can accompany shunt problems and worsen outcomes; while fever alone isn't proof of malfunction, its presence with these neurological or developmental changes heightens concern for shunt infection and requires urgent evaluation. Together, these signs point to a possible VP shunt issue and prompt rapid assessment by a neurosurgeon with imaging to determine patency and need for revision or infection treatment.

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3. What is the typical clinical triad for normal pressure hydrocephalus and the treatment approach?

A. Headache, papilledema, weight gain; treatment is radiotherapy.

B. Gait disturbance, urinary incontinence, cognitive impairment; treatment is CSF shunting.

C. Gait disturbance, autonomic dysfunction, short-term memory loss; treatment is diuretics.

D. Seizures, sensory loss, ataxia; treatment is chemotherapy.

Normal pressure hydrocephalus presents with a distinct triad: gait disturbance, cognitive impairment, and urinary incontinence. The gait change is usually a broad-based, slow, magnetic or shuffling walk and often appears first. Cognitive problems resemble a subcortical dementia, with slowed processing and executive dysfunction. Urinary symptoms progress from urgency to incontinence as the condition advances. The underlying issue is impaired CSF absorption leading to ventriculomegaly, even though CSF pressure can read as normal on measurement. The treatment that fits this pattern is CSF diversion to remove excess fluid, most commonly a ventriculoperitoneal shunt, which can reduce ventricular size and improve gait and, to some extent, cognitive function and continence. A CSF tap test may help predict who will respond to shunting. Other approaches like diuretics or oncologic therapies (radiation, chemotherapy) do not address the root problem in NPH and are not standard treatments.

4. Which of the following is a manifestation of a transient ischemic attack?

A. Loss of vision in one eye

B. Chronic dizziness lasting weeks

C. Permanent paraplegia

D. Continuous severe headache for days

A transient ischemic attack is a brief episode of neurologic dysfunction caused by a temporary reduction in blood flow to a part of the brain or retina, with full recovery and no lasting damage. A classic sign is sudden, transient loss of vision in one eye, often described as a curtain or shade coming down over the eye. This occurs from temporary retinal ischemia (amaurosis fugax) due to an embolus or reduced blood flow in the ophthalmic circulation. The other scenarios describe problems that are not typical of a TIA: dizziness lasting weeks suggests a chronic vestibular issue, paraplegia would be a lasting deficit from a stroke or spinal injury, and a continuous headache for days points to a different diagnosis such as a migraine or other headache disorder. So, loss of vision in one eye best fits a transient ischemic attack.

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5. Which imaging modality is commonly used to evaluate trigeminal neuralgia for vascular compression?

A. CT without contrast

B. Nuclear medicine scan

C. MRI with high-resolution sequences and MR angiography

D. Plain X-ray

Evaluating trigeminal neuralgia caused by a blood vessel compressing the nerve requires imaging that shows both the nerve and adjacent vessels in detail. MRI with high-resolution 3D T2-weighted sequences (such as CISS or FIESTA) provides exceptional contrast between the trigeminal nerve and cerebrospinal fluid, making the nerve's course visible. When you add MR angiography, you can map the surrounding arteries and veins to see if a vessel is looping around or indenting the nerve—exactly what vascular compression means. This combination not only confirms a neurovascular conflict but also guides surgical planning, such as microvascular decompression. CT without contrast can't reliably visualize the soft tissues or the nerve-vessel relationship; nuclear medicine studies assess function rather than anatomy; plain X-ray provides little useful information about neural structures or vascular contacts.

6. Which statement about autonomic dysreflexia triggers is true?

A. It can be triggered by bladder distention

B. It cannot be triggered by bladder distention

C. It only occurs with brain injuries

D. It resolves without intervention

Autonomic dysreflexia is triggered by a noxious stimulus below the level of spinal cord injury in people with injuries at or above the T6 level. A full bladder is a classic trigger because bladder distention sends signals that cannot be fully modulated by the disrupted pathways, leading to a sudden, widespread sympathetic response below the level of injury and a dangerous rise in blood pressure. Understanding the mechanism helps explain why this statement is true: bladder distention can provoke autonomic dysreflexia, so denying that it can be triggered is incorrect. It's also important to know that this condition is not limited to brain injuries; it occurs with high thoracic or cervical spinal cord injuries. And it requires prompt intervention rather than waiting for spontaneous resolution—the usual steps are to relieve the stimulus (check for bladder outlet obstruction or empty the bladder, ensure catheter function), position the patient upright to lower blood pressure, loosen restrictive clothing, and monitor blood pressure closely, with pharmacologic treatment if severe or persistent. So, the true point is that bladder distention is a recognized trigger for autonomic dysreflexia, not something that cannot trigger it, and it demands immediate management rather than expecting it to resolve on its own.

7. Which posture is characteristic of decerebrate posturing?

A. Arms flexed and legs extended

B. Arms extended and legs extended

C. Arms adducted and hands clenched

D. Arms abducted and shoulders elevated

Decerebrate posturing shows a brainstem injury with rigid extension of the body. The hallmark is that both the upper and lower limbs are extended: the arms are held straight with the hands often in a pronated position, and the legs remain extended with the feet plantarflexed. This contrasts with decorticate posturing, where the arms are flexed at the elbows and wrists while the legs extend. So the posture described as arms extended and legs extended best fits decerebrate posturing. The other descriptions involve flexion of the arms or different limb positions that do not reflect the characteristic extensor rigidity.

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8. Which of the following is an early manifestation of amyotrophic lateral sclerosis (ALS)?

A. Tremor in the fingers

B. Visual disturbances

C. Hearing loss

D. Weakness of the distal extremities

ALS starts with degeneration of motor neurons, so the first changes are in muscles you control voluntarily rather than in sensory or special senses. The hands and feet—the distal muscles—are typically the earliest affected, leading to weakness that makes fine motor tasks like gripping, buttoning, writing, or walking more difficult. Visual disturbances and hearing loss aren't caused by motor neuron degeneration and aren't expected in early ALS, and while some twitching can occur, a plain, early sign is the notable distal weakness. As the disease advances, weakness spreads to other muscles and upper motor neuron signs like increased tone and reflexes appear alongside continued muscle atrophy.

9. Which cranial nerves control eye movements?

A. Oculomotor (CN III), Trochlear (CN IV), and Abducens (CN VI)

B. Trigeminal (CN V) and Facial (CN VII)

C. Optic (CN II)

D. Vestibulocochlear (CN VIII) and Glossopharyngeal (CN IX)

Moving the eyes is controlled by three nerves that innervate the muscles that move the eyeball. The oculomotor nerve powers most of the extraocular muscles and also handles eyelid lifting and pupil constriction, the trochlear nerve drives the superior oblique muscle, and the abducens nerve controls the lateral rectus muscle. Together, these nerves allow the eye to rotate, tilt, and shift side to side for directed gaze and tracking. The optic nerve is for vision, not movement; the trigeminal and facial nerves deal with facial sensation and facial muscles; the vestibulocochlear and glossopharyngeal nerves are involved in balance/hearing and swallowing, not eye movements.

10. Which findings indicate optic nerve involvement when assessing cranial nerve II function?

A. Papilledema or pallor of the optic disc

B. Afferent pupillary defect

C. Visual acuity and visual fields

D. All of the above

Understanding optic nerve involvement starts with how CN II functions: the nerve carries visual information from the retina to the brain, and we assess both its structure and its function. Papilledema or pallor of the optic disc are direct signs at the optic nerve head. Papilledema indicates swelling of the optic disc from raised intracranial pressure, while pallor points to optic atrophy from chronic optic nerve damage. An afferent pupillary defect shows that the input from one eye is diminished or lost as it enters the brain, signaling optic nerve pathology or severe retinal disease along the afferent limb of the pupillary reflex. Visual acuity and visual fields test the end result of that transmission—how well central and peripheral vision are carried through the optic nerve to the brain. Taken together, these findings cover structural changes, reflex pathways, and functional vision, so they collectively indicate optic nerve involvement.

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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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