

MSK EQUINE DEVELOPMENTAL ORTHOPEDIC DISEASES 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.

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!

Questions

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- 1. In what plane do flexural deformities occur?**
 - A. frontal plane
 - B. transverse plane
 - C. oblique plane
 - D. sagittal plane
- 2. A limb deformity of 12 degrees would be categorized as which type?**
 - A. Normal (0-5 degrees)
 - B. Moderate (11-20 degrees)
 - C. Mild (5-10 degrees)
 - D. Severe (>20 degrees)
- 3. Cartilage at the articular side of the epiphysis forms which structure?**
 - A. Epiphyseal growth plate
 - B. Articular cartilage
 - C. Perichondrium
 - D. Synovial membrane
- 4. Which tendons are involved with MCPJ flexural deformity?**
 - A. Deep or superficial digital flexor tendon or both
 - B. Deep digital flexor tendon only
 - C. Suspensory ligament
 - D. Extensor tendons
- 5. What are the surgical options for treatment of moderate to severe flexural deformity of the MCPJ?**
 - A. Desmotomy of the inferior accessory ligament of the DDFT
 - B. Superior and inferior check ligament desmotomies
 - C. Deep digital flexor tenotomy
 - D. Rasps down the heel

- 6. Which of the following is a nonsurgical treatment option for flexural deformity of the MCPJ?**
- A. Deep digital flexor tenotomy
 - B. Desmotomy of the superior accessory ligament of the SDFT
 - C. Inferior check ligament desmotomy
 - D. NUTRITION dietary modification, wedge shoes, exercise restriction, analgesics, splints
- 7. Flexural deformities affect which structures?**
- A. soft tissue structures
 - B. bone tissues
 - C. nerves
 - D. blood vessels
- 8. Why does OC not tend to present with lameness as the primary clinical sign?**
- A. Lesions are on weight-bearing surfaces
 - B. OC occurs on gliding surfaces and not weight bearing surfaces
 - C. It is always painful
 - D. It is due to infection
- 9. Which joint is most commonly affected by angular limb deformity?**
- A. Carpus
 - B. Fetlock
 - C. Hock
 - D. Stifle
- 10. What surgical treatment is used to cause growth retardation for the treatment of angular limb deformity?**
- A. implants placed to bridge the physis on the convex aspect of bone
 - B. periosteal transection on concave aspect
 - C. hoof manipulation
 - D. bone shortening

Answers

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

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Explanations

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1. In what plane do flexural deformities occur?

- A. frontal plane
- B. transverse plane
- C. oblique plane
- D. sagittal plane**

Flexural deformities involve abnormal bending due to tight or shortened soft tissues, so they manifest as a limb held in a more flexed position at the joints. Flexion and extension occur in the sagittal plane, the plane that divides the body into left and right halves. That's why these deformities are described in the sagittal plane—it's the plane governing forward-backward bending at the joints (like fetlock, pastern, or coffin joints in horses). The other planes describe different directions of deformity: the frontal plane involves side-to-side (varus/valgus) deviation, and the transverse plane involves rotation. An example is a foal with a flexural deformity where the limb sits in excessive flexion at the fetlock or pastern, observable in the sagittal orientation.

2. A limb deformity of 12 degrees would be categorized as which type?

- A. Normal (0-5 degrees)
- B. Moderate (11-20 degrees)**
- C. Mild (5-10 degrees)
- D. Severe (>20 degrees)

The idea here is scoring the severity of an angular limb deformity by how many degrees the limb deviates from normal alignment. The ranges given define the categories: 0–5 normal, 5–10 mild, 11–20 moderate, and over 20 severe. A measurement of 12 degrees sits in the 11–20 window, so it is classified as moderate. It's not mild (which tops out at 10), not normal (0–5), and not severe (over 20). This level of deformity typically signals a need for more than routine monitoring but not as extensive as what might be required for a severe case.

3. Cartilage at the articular side of the epiphysis forms which structure?

- A. Epiphyseal growth plate**
- B. Articular cartilage
- C. Perichondrium
- D. Synovial membrane

The surface of the epiphysis that faces the joint is covered by articular cartilage, a thin layer of hyaline cartilage that provides a smooth, durable, low-friction surface for articulation. This cartilage remains at the joint surface as the bone grows and functions, helping distribute loads across the joint. The epiphyseal growth plate, in contrast, sits at the boundary between the epiphysis and metaphysis and is the site of longitudinal bone growth; it ossifies into the epiphyseal line as growth ends. The perichondrium is the outer covering of cartilage, not the joint surface itself, and the synovial membrane lines the joint capsule and secretes synovial fluid rather than forming cartilage. So the cartilage on the articular side forms articular cartilage.

4. Which tendons are involved with MCPJ flexural deformity?

- A. Deep or superficial digital flexor tendon or both
- B. Deep digital flexor tendon only
- C. Suspensory ligament
- D. Extensor tendons

Flexural deformity at the fetlock (MCP joint) happens when the flexor apparatus crossing the joint is shortened or overly tight, pulling the fetlock into flexion. The tendons that cross and influence this joint are the deep digital flexor tendon and the superficial digital flexor tendon; either one being tight can cause the fetlock to flex, and both together can contribute if more severe. The suspensory ligament primarily stabilizes the fetlock and does not cause flexural deformity, and the extensor tendons would tend to extend the joint rather than flex it. So the deformity can arise from involvement of the deep digital flexor, the superficial digital flexor, or both.

5. What are the surgical options for treatment of moderate to severe flexural deformity of the MCPJ?

- A. Desmotomy of the inferior accessory ligament of the DDFT
- B. Superior and inferior check ligament desmotomies
- C. Deep digital flexor tenotomy
- D. Rasps down the heel

In moderate to severe flexural deformity of the fetlock, the problem is a tight flexor-tendon system restrained by the check ligaments crossing the fetlock. Cutting those ligaments relieves the abnormal pull and lets the fetlock extend more normally as the limb bears weight. Releasing both the superior (proximal) and inferior (distal) check ligaments directly addresses the tensions from the tendons on both ends of the fetlock, providing the most reliable correction while preserving tendon function. Desmotomy of just the inferior accessory ligament of the deep digital flexor tendon targets only one part of the system and may not yield adequate correction in a moderate to severe deformity. Deep digital flexor tenotomy cuts the tendon itself, which is a more drastic measure with greater rehabilitation demands and potential hoof or gait issues, and is generally reserved for refractory cases. Rasps down the heel would not address the underlying joint contracture and thus does not correct the fetlock flexion.

6. Which of the following is a nonsurgical treatment option for flexural deformity of the MCPJ?

- A. Deep digital flexor tenotomy
- B. Desmotomy of the superior accessory ligament of the SDFT
- C. Inferior check ligament desmotomy
- D. NUTRITION dietary modification, wedge shoes, exercise restriction, analgesics, splints

Non-surgical management can be effective for mild flexural deformities at the fetlock because the goal is to slow growth, reduce tendon tension, and support the limb as it remodels, rather than to immediately release contracted structures. Controlling nutrition and overall feeding slows rapid growth that often drives soft-tissue contracture in young horses. Limiting exercise decreases repetitive loading that can aggravate the deformity. Wedge shoes help alter the hoof-pastern axis and load distribution to encourage gradual extension at the fetlock as the limb bears weight. Analgesics manage discomfort that might limit movement and rehab, while splints provide external support to maintain a favorable posture during healing. Surgical options, by contrast, involve cutting or releasing tendons or ligaments to achieve rapid correction and are typically reserved for more severe cases or when conservative management fails.

7. Flexural deformities affect which structures?

A. soft tissue structures

B. bone tissues

C. nerves

D. blood vessels

Flexural deformities arise from changes in soft tissues crossing the affected joints, not the bones. When contracture or shortening occurs in these soft tissues, the limb is pulled into an abnormal bend. The structures most involved are the flexor tendons that run along the back of the leg—the superficial and deep digital flexor tendons—and their supporting ligaments, such as the check ligaments. This soft-tissue imbalance tightens the joint surfaces (fetlock, pastern, or coffin), producing the characteristic abnormal flexion. Bones, nerves, and blood vessels aren't the primary drivers of this condition. They can be affected secondarily if the deformity persists or becomes severe, but the initiating problem is soft-tissue contracture, making soft tissue structures the best answer.

8. Why does OC not tend to present with lameness as the primary clinical sign?

A. Lesions are on weight-bearing surfaces

B. OC occurs on gliding surfaces and not weight bearing surfaces

C. It is always painful

D. It is due to infection

OC lesions in horses most often affect cartilage on surfaces that glide within the joint rather than the main weight-bearing areas. Because these gliding surfaces are not the primary load-bearing zones, early cartilage disruption often causes little or no pain during normal activity. As a result, lameness may be mild or absent at first. Lameness tends to appear later if the lesion becomes fissured or detaches, leading to cartilage flaps, joint effusion, or synovitis that provoke pain during movement. If the lesion were on a true weight-bearing surface, mechanical pain and lameness would be more evident from the outset.

9. Which joint is most commonly affected by angular limb deformity?

A. Carpus

B. Fetlock

C. Hock

D. Stifle

Angular limb deformity comes from an imbalance in growth at the limb's physes combined with how the limb bears weight. In young horses, the stifle joint is a common target because the growth areas near the distal femur and proximal tibia have a major influence on the overall limb axis, and even small differences in growth rate there translate into visible angular deviation as the foal starts to bear weight and move. This makes deformities at the stifle appear more frequently and be readily observable early in development. Other joints like the carpus and fetlock can be involved as well, but the stifle often shows the deformity first and most prominently due to the substantial contribution of its growth plates to limb alignment. Understanding this helps explain why the stifle is the joint most commonly affected in angular limb deformities.

10. What surgical treatment is used to cause growth retardation for the treatment of angular limb deformity?

A. implants placed to bridge the physis on the convex aspect of bone

B. periosteal transection on concave aspect

C. hoof manipulation

D. bone shortening

In a growing limb with angular deformity, correction is achieved by modulating growth so the limb straightens as growth proceeds. The best approach is to slow growth on the convex side by placing implants that bridge the growth plate (physis) on that side. This transphyseal bridging temporarily retards growth on the convex aspect while the opposite (concave) side continues to grow, allowing gradual realignment as the animal matures. The implants are typically removed later to resume normal growth once the desired alignment is reached. Periosteal transection on the concave side would stimulate growth there, not retard it, which would not achieve this corrective pattern. Hoof manipulation is not a surgical method for correcting angular limb deformities, and bone shortening does not address growth at the physis in the same guided-growth way.

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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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