

01	☐ A	☐ B	☐ C	☐ D	☐ E
02	☐ A	☐ B	☐ C	☐ D	☐ E
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35	☐ A	☐ B	☐ C	☐ D	☐ E
36	☐ A	☐ B	☐ C	☐ D	☐ E
37	☐ A	☐ B	☐ C	☐ D	☐ E
38	☐ A	☐ B	☐ C	☐ D	☐ E
39	☐ A	☐ B	☐ C	☐ D	☐ E

PRACTICE QUESTIONS

American Physical Therapy Association (APTA)

FMB969TE

Specialist Certification Examination In Orthopaedic Physical Therapy

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for American Physical Therapy Association (APTA) FMB969TE , each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, FMB969TE
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

QUESTION 1

SINGLE CHOICE

A patient presents with anterolateral hip pain and tenderness over the greater trochanter that is reproduced with resisted hip abduction in sidelying. Which of the following conditions is the MOST likely diagnosis?

- ☐ A Iliopsoas tendinopathy
- ☒ B Trochanteric bursitis / gluteal tendinopathy
- ☐ C Femoroacetabular impingement
- ☐ D Piriformis syndrome

ANSWER B

WHY Tenderness over the greater trochanter with pain reproduced by resisted hip abduction in sidelying is classic for gluteal tendinopathy (often historically labeled trochanteric bursitis). Iliopsoas tendinopathy is reproduced by resisted hip flexion, FAI by hip flexion/adduction/internal rotation (FADIR), and piriformis syndrome by resisted external rotation in seated position.

QUESTION 2

SINGLE CHOICE

During lumbar spine examination, a patient reports pain that radiates into the buttock and posterior thigh but stops above the knee. There is no sensory deficit, no myotomal weakness, and straight leg raise is limited by hamstring tightness at 70 degrees. Which classification best fits this presentation?

- ☐ A Lumbar radiculopathy
- ☐ B Lumbar spinal stenosis
- ☒ C Lumbar referred pain / somatic dysfunction
- ☐ D Cauda equina syndrome

ANSWER C

WHY Pain radiating to the buttock/posterior thigh that does not cross the knee, without neurological deficit, is consistent with somatic referred pain rather than true radiculopathy (which typically extends below the knee in a dermatomal pattern with possible sensory/motor loss). Cauda equina would involve saddle anesthesia and bowel/bladder changes.

QUESTION 3

SINGLE CHOICE

A 58-year-old patient reports low back pain that is unrelieved by rest, is worse at night, and has caused an unintended 10-pound weight loss over the past three months. Which of the following is the MOST appropriate next action?

- ☐ A Initiate a core stabilization program and re-evaluate in 4 weeks
- ☒ B Refer the patient back to the physician for further medical workup
- ☐ C Apply lumbar traction and moist heat
- ☐ D Perform repeated end-range extension exercises in prone

ANSWER B

WHY Red flags such as night pain, unexplained weight loss, and age over 50 raise concern for serious pathology (e.g., malignancy, infection). The appropriate response is medical referral, not initiation of conservative orthopaedic intervention.

QUESTION 4

SINGLE CHOICE

A patient demonstrates a positive painful arc between 60 and 120 degrees of shoulder abduction and reports pain on resisted isometric abduction with the arm at 90 degrees. Which structure is MOST likely involved?

- ☒ A Subacromial bursa / supraspinatus tendon
- ☐ B Acromioclavicular joint
- ☐ C Long head of the biceps tendon
- ☐ D Glenohumeral joint capsule

ANSWER A

WHY A painful arc between 60 and 120 degrees of abduction corresponds to impingement of the supraspinatus tendon and subacromial bursa beneath the coracoacromial arch. Resisted abduction at 90 degrees further implicates the supraspinatus. AC joint pathology typically localizes pain at end-range (above 120 degrees).

QUESTION 5

SINGLE CHOICE

For a patient with patellofemoral pain syndrome, which exercise prescription is MOST supported by current evidence for short-term pain reduction?

- ☐ A Open chain knee extension from 90 to 40 degrees of flexion
- ☐ B Isometric quad sets in full extension only
- ☒ C Hip abduction and external rotation strengthening combined with knee exercises
- ☐ D Stretching of the iliotibial band alone

ANSWER C

WHY Current evidence supports combined hip (abduction/external rotation) and knee strengthening for patellofemoral pain. Open chain knee extension through a small arc can be used selectively but is not the most evidence-based primary intervention. Isolated quad sets and IT band stretching alone are not best supported.

QUESTION 6

SINGLE CHOICE

Which of the following BEST describes the mechanism by which thrust manipulation is theorized to produce immediate hypoalgesia and improved mobility?

- ☐ A Permanent lengthening of capsular collagen fibers
- ☒ B Restoration of normal accessory motion and modulation of central pain processing via mechanoreceptor input
- ☐ C Elimination of intra-articular adhesions through mechanical disruption
- ☐ D Direct decompression of the spinal nerve root

ANSWER B

WHY Manipulation is theorized to restore accessory motion and modulate pain through neurophysiologic mechanisms including mechanoreceptor-mediated changes in central pain processing. Collagen is not permanently lengthened, adhesions are not directly eliminated by thrust, and thrust manipulation does not directly decompress neural structures.

QUESTION 7

SINGLE CHOICE

Which outcome measure is MOST appropriate to capture both pain and disability in a patient with neck pain?

- ☐ A Numeric Pain Rating Scale alone
- ☒ B Neck Disability Index (NDI)
- ☐ C Timed Up and Go (TUG)
- ☐ D Berg Balance Scale (BBS)

ANSWER B

WHY The Neck Disability Index is a region-specific, self-report measure that captures both pain and disability for patients with neck dysfunction. The NPRS captures only pain intensity, while the TUG and BBS are measures of mobility and balance respectively and do not specifically address neck-related disability.

QUESTION 8

SINGLE CHOICE

A patient taking warfarin for atrial fibrillation asks whether it is safe to use topical diclofenac gel for knee osteoarthritis. Which response is MOST appropriate?

- ☒ A Yes, topical NSAIDs have minimal systemic absorption and are generally safe with warfarin.
- ☐ B No, all NSAIDs including topical forms are absolutely contraindicated with warfarin.
- ☐ C Yes, but the patient should double the warfarin dose.
- ☐ D No, the patient should switch to oral ibuprofen instead.

ANSWER A

WHY Topical NSAIDs have low systemic absorption and are generally considered safer than oral NSAIDs in patients on anticoagulants such as warfarin, although clinician consultation is still appropriate. Oral NSAIDs carry a well-documented bleeding risk with warfarin and are not a safer substitute.

QUESTION 9

TRUE FALSE

Magnetic resonance imaging (MRI) is the imaging modality of choice for evaluating acute fractures of long bones in most clinical scenarios.

☐ **A** True☒ **B** False

ANSWER B

WHY False. Plain radiographs (X-ray) are typically the imaging modality of choice for acute fractures of long bones because they are fast, inexpensive, and highly sensitive for bony injury. MRI is more useful for soft tissue, ligamentous, or stress-related injuries and is generally not first-line for acute fractures.

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