Utilize this workbook to test your clinical knowledge—on your own time. Feel free to print this workbook so that you can write your answers on a hard copy. Or, if you have Adobe® Acrobat® Pro, electronically highlight your answers and save this PDF to your computer.

This portion of the workbook contains questions for the 2012 Self-Assessment Examination for Practitioners (SAE-P): Pain Management, which you can use to assess your knowledge on the topic.

Earn up to 8 AMA PRA Category 1 Credits™ and help fulfill the self assessment requirement for Part II of Maintenance of Certification (MOC) by going online to www.me.aapmr.org and completing this activity.
1. Which symptom is NOT needed to make the diagnosis of Post-Traumatic Stress Disorder?
   (a) Hyper arousal
   (b) Severe depression
   (c) Event flashbacks
   (d) Activity avoidance

2. Which area of the brain is involved in the development of Post-Traumatic Stress Disorder?
   (a) Frontal Cortex
   (b) Cerebellum
   (c) Corpus Callosum
   (d) Amygdala

3. What symptom or sign cannot be detected by the Minnesota Multiphasic Personality Inventory 2 test?
   (a) Accuracy of self-reported symptoms
   (b) Level of cooperation with testing
   (c) Falsified symptoms/malingering
   (d) Degree of psychological distress

4. Which is NOT a key feature of a conversion disorder?
   (a) Abnormal neurologic symptoms
   (b) Absence of identifiable pathology
   (c) Presence of conscious simulation
   (d) Associated psychological stressor

5. Which phenomenon is most consistent with the formation of opioid-induced hyperalgesia?
   (a) Reduction in number of opioid receptors
   (b) Progression of painful disease process
   (c) Diminished pain with reduced opioid dose
   (d) Opioid medication induced neurotoxicity

6. Symptoms of opioid withdrawal include:
   (a) eye watering, runny nose, sweating, piloerection, bone and joint pain.
   (b) coughing, dry mouth, emesis, incontinence.
   (c) dizziness, dry eyes, hunger, fatigue.
   (d) dysphagia, palpitations, muscle cramps, paresthesias.

7. Which of the cervical spinal nerves are the primary peripheral nerve structures that can refer pain to the head?
   (a) C4-C5
   (b) C1-C3
   (c) C4-C6
   (d) C2-C7

8. What is the most common presentation of a patient suffering with lumbar spinal stenosis?
   (a) Axial low back pain
   (b) Isolated leg numbness
   (c) Neurogenic claudication
   (d) Lower extremity weakness

9. Which of the following is the “gold standard" for diagnosing facet mediated pain?
   (a) Pain diagram outlining established Z-joint referral pain
   (b) Computed tomography (CT) of the spine
   (c) Plain radiographs of the spine
   (d) Fluoroscopically guided medial branch blocks
10. Adhesive capsulitis is associated with a fibrotic capsule adhering to itself and the neck of the humerus. The joint capsule volume capacity is subsequently:
   (a) Increased
   (b) No change
   (c) Fluctuates
   (d) Decreased

11. When evaluating patellar tracking in a patient with Patellofemoral Syndrome, you are looking for:
   (a) the Q angle.
   (b) the J-sign.
   (c) femoral anteversion.
   (d) genu recurvatum.

12. What is the most common cause of Trigeminal Neuralgia?
   (a) Herpes Zoster
   (b) Vascular Anomaly
   (c) Trauma
   (d) Peripheral Neuropathy

13. Which is most characteristic with headache attributed to head and/or neck trauma?
   (a) homogenous pattern
   (b) tension-type
   (c) frequency of 20%
   (d) primary headache

14. Which is NOT a recognized factor among individuals with Traumatic Brain Injury and pain?
   (a) secondary headache
   (b) Post-Traumatic Stress Disorder
   (c) personality changes
   (d) chronic fatigue

15. Fibromyalgia is associated with low descending central pain pathway levels of norepinephrine, dopamine, and:
   (a) substance P.
   (b) serotonin.
   (c) nerve growth factor.
   (d) glutamate.

16. The 1990 and 2010 American College of Rheumatology clinical criteria for diagnosing fibromyalgia differ in their requirement of:
   (a) report of body parts with pain.
   (b) waking unrefreshed/fatigue.
   (c) severity of cognitive deficit.
   (d) tender points on examination.

17. Which of the following is NOT a Central Sensitivity Syndrome associated with Fibromyalgia Syndrome?
   (a) Chronic Fatigue Syndrome
   (b) Irritable Bowel Syndrome
   (c) Carpal Tunnel Syndrome
   (d) Myofascial Pain Syndrome

18. Under which condition is phantom pain least likely to occur?
   (a) Shorter residual limbs
   (b) Lower extremity amputation
   (c) Bilateral amputation
   (d) Congenital amputation

19. Which nonpharmacologic intervention is effective and safe for Central Post-Stroke Pain?
   (a) Invasive motor cortex stimulation
   (b) Repetitive transcranial magnetic stimulation
   (c) Transcutaneous electrical nerve stimulation
   (d) Transcranial direct current stimulation

20. Complex regional pain syndrome (CRPS) type 2 differs from CRPS type 1 in that type 2:
   (a) includes vasomotor instability.
   (b) tends to succeed CRPS type 1 after 6 months.
   (c) is evident by its radiographic changes.
   (d) occurs after a nerve injury.

21. What percentage of individuals with herpes zoster have associated paresis?
   (a) 0%
   (b) 20%
   (c) 50%
   (d) 75%
22. What class of medication has proven effective in treating trigeminal neuralgia in patients with multiple sclerosis?
   (a) Opiates
   (b) Anticonvulsants
   (c) Nonsteroidal anti-inflammatories
   (d) Tricyclic antidepressants

23. Which condition is a late sequelae of cancer treatment?
   (a) bowel obstruction
   (b) radiation plexopathy
   (c) herpes zoster radiculitis
   (d) deep vein thrombosis

24. What percentage of patients with multiple sclerosis experience pain?
   (a) 20%
   (b) 33%
   (c) 66%
   (d) 95%

25. Which over-the-counter treatment for neuropathic pain associated with diabetic neuropathy is thought to have a neuroprotective effect?
   (a) acetaminophen
   (b) co-enzyme Q10
   (c) capsaicin
   (d) alpha lipoic acid

26. What is the only FDA-approved oral medication for the management of interstitial cystitis?
   (a) amitriptyline
   (b) pentosan polysulfate
   (c) gabapentin
   (d) cyclosporine A

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This portion of the workbook contains questions for the 2012 Self-Assessment Examination for Practitioners (SAE-P): Stroke Rehabilitation, which you can use to assess your knowledge on the topic.

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1. The single most important non-modifiable risk factor for stroke worldwide is:
   (a) age.
   (b) race.
   (c) sex.
   (d) family history.

2. The vascular supply of the lower limb motor strip is supplied by which cerebral artery?
   (a) Middle
   (b) Posterior
   (c) Anterior
   (d) Ventral

3. Poor prognosis for upper limb motor recovery following a stroke includes:
   (a) weak grasp strength at 4 weeks.
   (b) complete arm paralysis at onset.
   (c) persistent hyper-reflexia.
   (d) lack of proximal spasticity.

4. The Bobath and Brunnstrom Approach to movement therapy differ primarily in their approach to:
   (a) primitive movements.
   (b) spasticity.
   (c) splints and braces.
   (d) modalities.

5. Constraint induced movement therapy requires that patients:
   (a) initiate therapy within 24 hours of onset.
   (b) be able to voluntarily move their fingers.
   (c) not have proximal spasticity.
   (d) constrain the unaffected limb 24 hours a day.

6. Following a stroke, deep tendon reflexes increase within:
   (a) 12 hours
   (b) 48 hours
   (c) 72 hours
   (d) 1 week

7. Infarction of which blood vessel causes ipsilateral facial sensory loss and Horner’s syndrome with contralateral hemisensory loss to pain and temperature accompanied by ataxia, vertigo, and dysphagia?
   (a) Posterior superior cerebellar artery
   (b) Anterior inferior cerebellar artery
   (c) Circumferential branches of the basilar artery
   (d) Posterior inferior cerebellar artery

8. Which of the following studies is the standard of care for imaging in acute stroke?
   (a) Computed Tomography Scan
   (b) Magnetic Resonance Imaging
   (c) Magnetic Resonance Angiography
   (d) Transcranial Doppler

9. A 35-year-old female presents with a headache she describes as the “worst of her life.” After completing your history and physical exam, you suspect an acute bleed. What would be your imaging modality of choice?
   (a) Transcranial Doppler
   (b) Computed Tomography Scan
   (c) Magnetic Resonance Imaging
   (d) Carotid Ultrasound
10. In the setting of a high clinical suspicion for subarachnoid hemorrhage, with a negative CT scan, what diagnostic test should you perform next?
   (a) Transcranial doppler
   (b) Carotid Ultrasound
   (c) Spinal Tap
   (d) CT Angiogram

11. In a patient without symptoms of carotid artery stenosis, ordering a carotid ultrasound is justified by which of the following additional clinical indicators?
   (a) Systemic signs and symptoms of atherosclerotic vascular disease
   (b) No further clinical justification is necessary to obtain a carotid doppler
   (c) The patient has one identifiable risk factor for systemic atherosclerotic disease
   (d) Asymptomatic patient with carotid bruit

12. After an embolic stroke, which diagnostic study is the standard of care to evaluate for secondary prevention of recurrent stroke?
   (a) Echocardiogram
   (b) Cardiac MRI
   (c) Spinal Tap
   (d) Angiography

13. Which factor is associated with improved outcomes in hemorrhagic stroke patients?
   (a) Glasgow Coma Scale score lower than 9
   (b) Systolic blood pressure higher than 200 mmHg
   (c) Cerebral perfusion pressure below 60 mmHg
   (d) Hemorrhage in the parietal lobe less than 3 cm

14. A patient presents with a hoarse voice and trouble swallowing. You suspect the central nervous system structure involved that accounts for these symptoms is the:
   (a) lateral spinothalamic tract.
   (b) spinal trigeminal nucleus.
   (c) central tegmental tract.
   (d) nucleus ambiguous.

15. Your stroke patient has weakness affecting the hand and foot more than the proximal muscles on the same side. Sensation and cognition are intact. This person most likely has a stroke in which contralateral area?
   (a) Internal capsule
   (b) Brainstem
   (c) Midbrain
   (d) Motor cortex

16. A patient presents for evaluation of shoulder pain in his hemiplegic upper limb following a recent stroke. On assessment of the limb, you note hyperesthesia, unusual sweating, shoulder range of motion loss, and early dystrophic changes of the skin and nails of the hand. Radiographs show patchy, periarticular demineralization in all of the upper limb joints except the elbow. What is the most effective treatment for this condition, in conjunction with intensive rehabilitation?
   (a) Intracapsular corticosteroid injection of the glenohumeral joint
   (b) Neuromuscular electrical stimulation of the posterior deltoid
   (c) Sympathetic blockade of the stellate ganglion
   (d) Botulinum toxin injection of the subscapularis
17. Hemorrhagic strokes caused by hypertension are typically located in the:
(a) occipital lobe.
(b) primary motor area.
(c) frontal cortex.
(d) cerebellum.

18. A patient has right third cranial nerve palsy, left side loss of pain and temperature, left side loss of joint position, and left side ataxia. Where is the brainstem stroke most likely located?
(a) Right medial basal midbrain
(b) Right tegmentum of midbrain
(c) Left lateral pons
(d) Left lateral medulla

19. An infarct anterior to the precentral gyrus within the frontal lobe is most likely to result in which one of the following deficits?
(a) Wernicke type of aphasia
(b) Poor static and dynamic balance
(c) Hemiplegia
(d) Loss of joint proprioception

20. Which one of the following deficits is most likely due to a posterior cerebral artery stroke?
(a) Contralateral hemiplegia
(b) Global aphasia
(c) Alexia without agraphia
(d) Akinetic mutism

21. Intensive therapist-delivered speech and language therapy (SLT) in patients with aphasia after stroke has been proven to be:
(a) more effective than no SLT.
(b) less effective than social support.
(c) more effective than computer-mediated SLT.
(d) most effective in fluent aphasias.

22. When evaluating the effects of treating post-stroke depression with pharmacotherapeutic options, there is evidence that:
(a) it is less effective than psychotherapy alone.
(b) adverse reactions are not a significant issue.
(c) there is benefit in treating with antidepressants.
(d) it is most effective in patients with communication problems.

23. A 66-year-old female with a history of hypertension and high cholesterol presents to the emergency room with signs and symptoms of a stroke that resolve in three hours without impairments. Which of the following strategies for secondary stroke prevention with antiplatelet drugs is the most effective and has the fewest side effects?
(a) Low dose dabigatran
(b) Clopidogrel and aspirin
(c) Dipyridamole and clopidogrel
(d) Low dose aspirin

24. While the majority of stroke patients and their spouses report they had been satisfied with their prestroke sexual life, poststroke dissatisfaction was reported in both groups. Which of the following has NOT been found to be a variable that explains this?
(a) Inability to discuss sexuality
(b) The etiology or location of the stroke
(c) Decreased functional ability
(d) Unwillingness to participate in sexual activity

25. Following an ischemic stroke, seizures:
(a) are more likely to occur after 72 hours.
(b) affect approximately 35% to 50% of patients.
(c) are less likely if there is premorbid dementia.
(d) often are partial with or without generalization.
26. The advantage of intra-arterial thrombolysis, and mechanical thrombectomy over intravenous thrombolysis alone for middle cerebral artery occlusion is that they can be performed even if:

(a) symptoms have been present for more than five hours.
(b) systolic blood pressure (SBP) is > 200 mmHg.
(c) there are seizures at the onset of symptoms.
(d) there is significant mass effect with midline shift.

27. Emergency management of hypertension in the setting of ischemic stroke suggests that lowering the blood pressure (BP) is best when:

(a) the systolic BP is greater than 150 and less than 180 mmHg.
(b) done after the first few hours to protect the penumbra.
(c) when the systolic BP is greater than 220 mmHg.
(d) the systolic BP is lowered 30% within the first 24 hours.