

## 1. Osteoarthritis (OA)

Question:

A 66-year-old woman complains of chronic knee and hand pain that worsens after gardening and improves with rest. She denies morning stiffness lasting more than 15 minutes. Examination reveals bony enlargement at the distal and proximal interphalangeal joints. No redness or swelling is noted. Her ESR and CRP are normal.

Which of the following findings best supports the diagnosis?

- A) Symmetric synovial swelling of MCP joints
- B) Ulnar deviation of the fingers
- C) Heberden and Bouchard nodes
- D) Morning stiffness lasting >1 hour

Answer: C) Heberden and Bouchard nodes

Explanation:

OA is noninflammatory, affects asymmetric weight-bearing joints, and involves DIP (Heberden) and PIP (Bouchard) nodes.

RA affects MCP and PIP joints symmetrically and has prolonged morning stiffness.

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## 2. Rheumatoid Arthritis

(RA) Question:

A 42-year-old woman reports 2 hours of morning stiffness in both hands that improves with movement. She notes swelling of her wrists and MCP joints for the past 3 months. She also complains of fatigue and weight loss. Exam shows symmetric tenderness and swelling of both wrists and 2nd–3rd MCP joints.

Which of the following extra-articular findings is most consistent with her disease?

- A) Heberden's nodes
- B) Uveitis and sacroiliitis
- C) Subcutaneous nodules over the extensor surfaces
- D) Tophi on the ears and elbows

Answer: C) Subcutaneous nodules over the extensor surfaces

Explanation:

RA = autoimmune symmetric polyarthritis of small joints with systemic features (fatigue, weight loss).

Rheumatoid nodules are classic extra-articular findings.

Tophi → gout; uveitis/sacroiliitis → ankylosing spondylitis.

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## 3. Gout

Question:

A 54-year-old man presents with sudden, excruciating pain and swelling in his right great toe after attending a weekend barbecue. He drinks several beers daily. On exam, the 1st MTP joint is erythematous, warm, and exquisitely tender. Joint aspiration shows needle-shaped, negatively birefringent crystals.

Which of the following medications most likely contributed to his condition?

- A) Hydrochlorothiazide
- B) Furosemide
- C) Lisinopril
- D) Amlodipine

Answer: A)

Hydrochlorothiazide Explanation:

Thiazide diuretics ↓ uric acid excretion, precipitating gout attacks. Furosemide

can also raise uric acid, but thiazides are more classically tested. Lisinopril and amlodipine don't cause gout.

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#### 4. Ankylosing Spondylitis (AS)

Question:

A 28-year-old man presents with chronic low back pain and stiffness that improves with exercise but not rest. He has also developed pain in both heels. Exam shows limited spinal flexion and tenderness over the sacroiliac joints. Chest expansion is decreased.

Which of the following additional findings is most characteristic of his condition?

- A) Erosions of DIP joints
- B) Uveitis
- C) Tophi deposition
- D) Subcutaneous nodules

Answer: B)

Uveitis Explanation:

AS (a seronegative spondyloarthropathy, HLA-B27+) → sacroiliitis, morning stiffness, and uveitis. Pain improves with activity — unlike mechanical back pain.

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#### 5. Spinal Stenosis

Question:

A 70-year-old man complains of bilateral leg pain and numbness that occur when he walks for several minutes but improve when he leans forward on a shopping cart. He has no back trauma. His symptoms are not relieved by rest alone. Peripheral pulses are normal.

Which of the following is the most likely diagnosis?

- A) Peripheral vascular disease
- B) Lumbar spinal stenosis
- C) Cauda equina syndrome
- D) Herniated nucleus pulposus

Answer: B) Lumbar spinal stenosis

Explanation:

Neurogenic claudication (pain worsens with standing/walking, relieved by lumbar flexion).

PVD pain improves with rest regardless of position.

Cauda equina has saddle anesthesia, bladder dysfunction — not described here.

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## 6. Cauda Equina

Syndrome Question:

A 58-year-old man presents with severe low back pain, bilateral leg weakness, and numbness around his inner thighs and perineum. He has urinary retention and decreased anal sphincter tone.

Which of the following is the best next step in management?

- A) Start oral corticosteroids and schedule outpatient MRI
- B) Obtain emergent MRI and surgical decompression
- C) Begin physical therapy and analgesics
- D) Start antibiotics for possible spinal infection

Answer: B) Obtain emergent MRI and surgical decompression

Explanation:

Cauda equina syndrome = surgical emergency.

Caused by massive lumbar disc herniation compressing nerve roots.

Delay in decompression → permanent paralysis or incontinence.

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Would you like me to create a second, even trickier set (e.g., with overlapping features or lab/imaging clues) for advanced exam prep?

You said: yes

ChatGPT said:

Perfect — here's Set 2: Advanced, Tricky Musculoskeletal MCQs that go beyond the basic patterns. Each question is designed to mimic board-style nuance — overlapping features, subtle clues, or misleading presentations — to test deep clinical reasoning.

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### 1. Osteoarthritis (OA) — Mimicking inflammatory

arthritis Question:

A 68-year-old man presents with joint pain in both knees and stiffness in his fingers. He reports stiffness in the morning that lasts about 25 minutes and improves with movement. On examination, there is crepitus in both knees and enlargement of the distal interphalangeal joints. No warmth or redness is present.

Laboratory tests show:

ESR: mildly elevated (28 mm/hr)

Rheumatoid factor: negative

Which of the following is the most likely diagnosis?

- A) Early rheumatoid arthritis
- B) Osteoarthritis
- C) Psoriatic arthritis
- D) Polymyalgia rheumatica

Answer: B) Osteoarthritis

Trick: Mildly elevated ESR may appear in OA, especially in elderly or obese patients — **don't assume inflammation = RA unless you see symmetric small-joint synovitis.**

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### 2. Rheumatoid Arthritis (RA) — Mimicking lupus or viral

arthritis Question:

A 32-year-old woman presents with 3 months of hand pain and swelling in the wrists and PIP joints. She reports fatigue, occasional low-grade fevers, and morning stiffness lasting over an hour.

Exam shows tender, swollen wrists and PIP joints bilaterally. No rash or oral ulcers. Labs:

ANA: positive (1:160)

RF: positive

anti-CCP: positive

Which diagnosis best explains her findings?

- A) Systemic lupus erythematosus
- B) Rheumatoid arthritis
- C) Viral arthritis (parvovirus B19)
- D) Mixed connective tissue disease

Answer: B) Rheumatoid arthritis

Trick: ANA positivity can occur in RA ( $\approx 30\%$ ), so the specific test is anti-CCP, confirming RA — not lupus.

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### 3. Gout — Confusing with septic

arthritis Question:

A 55-year-old man presents with sudden onset of right knee pain, redness, and swelling. He had a similar attack in his great toe last year. He has a history of hypertension and takes hydrochlorothiazide.

Arthrocentesis of the knee shows:

Turbid fluid

WBC count: 60,000 (90% neutrophils)

Gram stain: no organisms seen

Crystals: needle-shaped, negatively birefringent

What is the next best step in management?

- A) Start empiric IV antibiotics
- B) Begin high-dose IV corticosteroids
- C) Start NSAIDs or colchicine
- D) Order synovial fluid culture before treatment

Answer: C) Start NSAIDs or colchicine

Trick: Gout and septic arthritis can both present with very high WBC counts, but negative Gram stain + crystals = gout. Culturing is fine, but treatment should not wait when findings are classic.

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### 4. Ankylosing Spondylitis (AS) — Mimicking mechanical back

pain Question:

A 30-year-old man presents with 6 months of low back pain. He says it worsens at night and wakes him from sleep, but improves after he goes running. Over-the-counter painkillers help only slightly. He denies trauma or radicular pain.

Exam shows limited lumbar flexion and decreased chest expansion. X-ray: erosions and sclerosis of sacroiliac joints.

Which additional finding would you most likely expect?

- A) Positive rheumatoid factor
- B) Positive HLA-B27
- C) Positive ANA
- D) Hyperuricemia

Answer: B) Positive HLA-B27

Trick: Back pain improving with exercise and sacroiliitis on X-ray = AS, even if the patient appears “too young” for arthritis. RF and ANA are negative (“seronegative spondyloarthritis”).

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#### 5. Spinal Stenosis — Versus peripheral vascular

disease Question:

A 72-year-old man reports pain and numbness in both legs when walking. The pain improves when he leans on his shopping cart in the grocery store but not when simply standing still.

Exam shows normal pedal pulses. Ankle-brachial index is normal.

Which of the following pathophysiologic processes best explains his symptoms?

- A) Nerve root compression from degenerative changes
- B) Ischemia from arterial occlusion
- C) Venous insufficiency causing edema
- D) Autoimmune inflammation of dorsal roots

Answer: A) Nerve root compression from degenerative changes

Trick: Both spinal stenosis and PVD cause “claudication,” but spinal stenosis improves with flexion, PVD improves with rest regardless of position.

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#### 6. Cauda Equina Syndrome — Mimicking herniated disc or spinal

stenosis Question:

A 57-year-old man presents with 2 days of worsening lower back pain and bilateral leg weakness. He reports new difficulty initiating urination and a “numb” feeling when wiping after bowel movements. On exam, there is decreased anal sphincter tone.

What is the most appropriate next step?

- A) Obtain urgent MRI of the lumbar spine and consult neurosurgery
- B) Prescribe oral steroids and bed rest
- C) Refer to outpatient neurology for EMG
- D) Begin physical therapy after analgesia

Answer: A) Obtain urgent MRI of the lumbar spine and consult neurosurgery

Trick: The combination of saddle anesthesia + urinary retention = red flag for cauda equina. Immediate imaging and decompression prevent permanent paralysis.

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Would you like me to create a third set focusing on “mixed or overlapping scenarios” — e.g., RA + OA in the same patient, or spinal stenosis vs cauda equina vs herniation?

That level is great for exam practice and clinical reasoning rounds.

You said:

yes

ChatGPT said:

Excellent — here’s Set 3: “Mixed & Overlapping Scenarios” — the kind that trick even advanced trainees because the presentations blend features of multiple musculoskeletal disorders.

Each case includes a clinical vignette, answer choices, and a reasoning breakdown to help you spot subtle distinctions.

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### 1. OA vs RA Overlap — When both might seem

plausible Question:

A 64-year-old woman presents with stiffness and pain in both hands for 1 year. The pain worsens after gardening and typing. She reports morning stiffness lasting about 30 minutes. Exam shows swelling and mild tenderness of the 2nd and 3rd PIP joints bilaterally, with bony enlargement of several DIP joints.

Labs:

ESR: 22 mm/hr

Rheumatoid factor: negative

Anti-CCP: negative

Which of the following best describes her condition?

- A) Rheumatoid arthritis
- B) Osteoarthritis
- C) Psoriatic arthritis
- D) Mixed connective tissue disease

Answer: B)

Osteoarthritis Trick:

DIP involvement = OA, not RA.

RA rarely affects DIPs.

Mild stiffness (<30 min) = mechanical pattern, not inflammatory.

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## 2. Gout vs Pseudogout — Crystals can fool

you Question:

A 70-year-old woman with hypertension and chronic kidney disease presents with sudden knee pain and swelling. She has no prior similar episodes.

Synovial fluid analysis shows rhomboid-shaped, positively birefringent crystals under polarized light microscopy.

X-ray of the knee shows chondrocalcinosis (calcification of cartilage). Which of the following is the most likely diagnosis?

- A) Acute gout
- B) Pseudogout (Calcium pyrophosphate deposition disease)
- C) Septic arthritis
- D) Osteoarthritis flare

Answer: B)

Pseudogout Trick:

Positively birefringent rhomboid crystals = calcium pyrophosphate (pseudogout).

Negatively birefringent needle-shaped crystals = uric acid (gout).

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## 3. Ankylosing Spondylitis vs Mechanical Back

Pain Question:

A 34-year-old warehouse worker reports 8 months of lower back pain. The pain improves with stretching and walking but worsens after prolonged sitting. He denies trauma or radiating pain.

Exam shows limited lumbar flexion and tenderness over both sacroiliac joints.

ESR is 40 mm/hr, and HLA-B27 is positive.

Which of the following additional findings would best confirm the suspected diagnosis?

- A) Ulnar deviation of the fingers
- B) Heberden's nodes
- C) Reduced chest expansion on inspiration
- D) Pain relief with rest and NSAIDs

Answer: C) Reduced chest expansion on inspiration

Trick:

In ankylosing spondylitis, spinal fusion leads to restricted thoracic mobility.

Pain that improves with activity = inflammatory, not mechanical.

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## 4. Spinal Stenosis vs Peripheral Artery Disease (PVD)

Question:

A 73-year-old man reports calf pain and numbness that appear after walking two blocks. The pain disappears when he leans forward on his shopping cart.

Exam shows diminished ankle reflexes but normal dorsalis pedis pulses. Ankle-brachial index: 1.0 (normal).

Which of the following is the best next diagnostic step?

- A) Lumbar spine MRI
- B) Lower extremity arterial Doppler
- C) Electromyography
- D) Nerve conduction velocity study

Answer: A) Lumbar spine MRI

Trick:

Normal pulses + relief with flexion = neurogenic claudication → spinal stenosis. PVD pain improves with rest, not posture change.

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#### 5. Cauda Equina vs Spinal Stenosis — Both cause leg

weakness Question:

A 61-year-old man with chronic back pain reports worsening bilateral leg weakness and numbness over 2 days. He notes difficulty starting urination and a “numb” sensation around the anus.

Exam reveals decreased anal sphincter tone and absent ankle reflexes bilaterally.

What is the best next step?

- A) Lumbar MRI and urgent surgical decompression
- B) Trial of corticosteroids and observation
- C) Electromyography to confirm diagnosis
- D) Physical therapy for core strengthening

Answer: A) Lumbar MRI and urgent surgical decompression

Trick:

Urinary retention + saddle anesthesia = Cauda equina syndrome, not just stenosis.

Must act emergently to prevent irreversible deficits.

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#### 6. RA vs Ankylosing Spondylitis — Both cause stiffness, but different

sites Question:

A 35-year-old man reports 6 months of back and hip stiffness, worse in the morning and improving with activity. He also has mild pain in both knees and Achilles tendon tenderness. Exam shows decreased lumbar flexion but no swelling of MCP or PIP joints. Labs:

Rheumatoid factor: negative

HLA-B27: positive

Which of the following extra-articular findings might also occur in this condition?

- A) Rheumatoid nodules over elbows
- B) Episcleritis and subcutaneous nodules
- C) Uveitis
- D) Tophi on auricle

Answer: C)

Uveitis Trick:

AS → axial skeleton, tendon insertions, and uveitis. RA

→ peripheral small joints + nodules.

Tophi → gout.

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## 7. Gout vs Septic Arthritis — Subtle infection

mimic Question:

A 62-year-old man with chronic gout presents with acute swelling and pain in his left knee. He is febrile (101°F) and appears ill.

Arthrocentesis:

Turbid synovial fluid

WBC 90,000 (95% neutrophils)

Gram stain: gram-positive cocci in clusters

Needle-shaped, negatively birefringent crystals also seen

What is the correct interpretation?

- A) Gout flare only
- B) Pseudogout
- C) Septic arthritis
- D) Gout complicated by septic arthritis

Answer: D) Gout complicated by septic arthritis

Trick:

Infection and gout can coexist.

Always treat infection first (antibiotics + drainage); gout meds come second.

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#### 8. RA vs OA in the Knees — Both in the same

joint Question:

A 70-year-old woman with long-standing rheumatoid arthritis presents with worsening knee pain. She reports pain after walking and occasional crepitus. There is mild swelling but no warmth.

X-ray shows joint space narrowing with osteophyte formation. Which of the following best explains her new symptoms?

- A) Progression of inflammatory disease
- B) Coexisting osteoarthritis
- C) Drug-induced arthritis from methotrexate
- D) Psoriatic arthritis

Answer: B) Coexisting  
osteoarthritis Trick:

Elderly RA patients can develop OA in weight-bearing joints.

Crepitus and osteophytes = degenerative, not inflammatory.

#### MSK tests

##### Anterior Drawer Test

Purpose: To assess the integrity of the anterior cruciate ligament (ACL), a key ligament in the knee joint.

Procedure:

The patient lies supine with their knee flexed to 90 degrees.

The examiner sits at the foot of the examination table.

The examiner places their thumbs on the posterior aspect of the tibial plateau (the top of the shinbone) just below the joint line.

The examiner's fingers grasp the anterior aspect of the tibia (shinbone) just above the joint line.

The examiner gently pulls the tibia forward while the patient resists.

##### Rotator cuff assessment

Medical history:

The doctor will ask about the patient's symptoms, including pain, weakness, and limitations in motion.

Inspection:

The doctor will observe the shoulder for any swelling, redness, or deformity.

Palpation:

The doctor will feel for tenderness or crepitus (grinding or clicking sounds) in the shoulder joint.

Range of motion:

The doctor will test the patient's range of motion in all directions, including forward flexion, abduction, adduction, internal rotation, and external rotation.

Strength testing:

The doctor will test the strength of the rotator cuff muscles, particularly the supraspinatus, infraspinatus, subscapularis, and teres minor.

Special tests:

Neer's test: To assess for impingement of the supraspinatus tendon.

Hawkins-Kennedy test: To assess for impingement of the subscapularis tendon.

Drop arm test: To assess for a supraspinatus tear.

Gerber's lift-off test: To assess for a subscapularis tear.

Romberg test

Do a Romberg test (a sensory test of stance). Ask the patient to stand with feet together and eyes open, then closed for 20 to 30 seconds. Mild swaying may occur. Stand close by to prevent falls.

#### 1. Rotator Cuff Assessment – “Painful Arc vs Weakness

Trap” Question:

A 48-year-old carpenter presents with shoulder pain that worsens when he lifts his arm overhead or reaches behind his back. He denies trauma.

Exam findings:

Active abduction limited at 90° due to pain

Passive abduction full

Positive drop-arm test

Normal sensation over deltoid

Which structure is most likely injured?

A) Supraspinatus tendon tear

- B) Axillary nerve injury
- C) Biceps long head tendonitis
- D) Subacromial bursitis

Answer: A) Supraspinatus tendon tear

Reasoning:

Drop-arm test: inability to slowly lower the abducted arm → supraspinatus tear (most common rotator cuff injury).

Passive motion preserved, distinguishing from adhesive capsulitis.

Axillary nerve injury causes loss of deltoid sensation and inability to abduct beyond 15°. Trick:

Pain alone could be bursitis, but weakness + drop-arm = tendon tear.

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## 2. Anterior Drawer Test – “Knee Instability

Confusion” Question:

A 25-year-old soccer player twisted his knee during a tackle. He heard a “pop” and immediately fell. The next day, his knee is swollen.

Exam findings:

Positive anterior drawer and Lachman tests No

valgus or varus instability

Negative posterior drawer

Which ligament is most likely injured?

- A) Anterior cruciate ligament (ACL)
- B) Posterior cruciate ligament (PCL)
- C) Medial collateral ligament (MCL)
- D) Lateral collateral ligament (LCL)

Answer: A) Anterior cruciate ligament (ACL)

Reasoning:

Anterior drawer test → tibia moves anteriorly relative to femur.

“Pop” + immediate swelling = hemarthrosis typical of ACL tear.

PCL injury → posterior drawer positive.

MCL/LCL → varus/valgus instability, not anterior displacement.

Trick: Many confuse “drawer = PCL,” but direction of tibial shift is key.

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### 3. Straight Leg Raise – “Radiculopathy vs Hamstring

Tightness” Question:

A 45-year-old warehouse worker complains of sharp shooting pain from his lower back radiating down the posterior aspect of his right leg to the ankle. Pain worsens when he coughs or sneezes.

Exam:

Straight leg raise (SLR) on right reproduces pain at 40° elevation

Dorsiflexion of the foot increases the pain

Left leg SLR is negative

Which nerve root is most likely affected?

A) L2

B) L4

C) L5

D) S1

Answer: D) S1

Reasoning:

Pain radiating below knee with SLR → lumbosacral radiculopathy.

S1 root (L5–S1 disc herniation) → pain to posterior leg and lateral foot; worsens with dorsiflexion.

L4 → anterior thigh; L5 → lateral leg and dorsum of foot.

Trick:

Pain only in hamstring (not below knee) = tight hamstring, not positive SLR.

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### 4. Romberg Test – “Sensory vs Cerebellar

Ataxia” Question:

A 60-year-old man reports unsteady gait, especially in the dark. He has a history of poorly controlled diabetes and chronic numbness in his feet.

Exam:

Wide-based gait

Unable to maintain balance when standing with feet together and eyes

closed Strength and coordination normal

Which system is primarily affected?

- A) Cerebellar function
- B) Vestibular system
- C) Dorsal column (proprioceptive) pathway
- D) Corticospinal tract

Answer: C) Dorsal column (proprioceptive) pathway

Reasoning:

Romberg test isolates proprioceptive loss (posterior column). Falls only with eyes closed → sensory ataxia (not cerebellar). Cerebellar lesions cause ataxia even with eyes open.

Trick:

Romberg is not a cerebellar test — a common misconception.

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## 5. Tinel's Sign – "Distal Nerve Entrapment"

Puzzle" Question:

A 38-year-old office worker complains of tingling and numbness in the thumb, index, and middle fingers, especially at night.

Exam:

Percussion over the anterior wrist causes shooting pain into these fingers (positive Tinel's sign)

Weak thumb abduction

Normal sensation over thenar eminence

Which nerve is compressed?

- A) Median nerve at the carpal tunnel
- B) Median nerve at the pronator teres
- C) Ulnar nerve at the elbow
- D) Radial nerve at the spiral groove

Answer: A) Median nerve at the carpal

tunnel Reasoning:

Tinel's = tapping nerve → paresthesia in its distribution.

Thenar sensation spared → palmar cutaneous branch (bypasses tunnel).

Night symptoms and typing → carpal tunnel syndrome.

Trick:

Pronator teres compression causes forearm pain and thenar sensory loss — not spared here.

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## 6. Phalen's Sign – "Differentiating from Ulnar

Neuropathy" Question:

A 42-year-old typist complains of hand numbness and tingling that worsen at night.

Exam:

Wrist flexion for 60 seconds reproduces paresthesias in the thumb, index, and middle fingers (positive Phalen's test)

Weakness of thumb opposition

Sensation over hypothenar area normal

Which of the following is most likely spared in this condition?

- A) Flexor carpi ulnaris
- B) Thenar muscles
- C) First and second lumbricals
- D) Lateral palmar skin

Answer: A) Flexor carpi ulnaris

Reasoning:

Phalen's compresses median nerve (carpal tunnel).

Ulnar-innervated muscles like flexor carpi ulnaris are spared.

Thenar muscles & first two lumbricals = median-innervated → weak.

Trick:

Ulnar nerve compression at the wrist (Guyon's canal) → affects hypothenar + ring/little finger, not tested by Phalen's.

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## Summary Table:

| Test                               | Positive Finding                   | Indicates          |
|------------------------------------|------------------------------------|--------------------|
| Rotator cuff (Drop-Arm, Empty Can) | Arm drops, pain on abduction       | Supraspinatus tear |
| Anterior Drawer / Lachman          | Excess anterior tibial translation | ACL tear           |

| Test               | Positive Finding          | Indicates                                |
|--------------------|---------------------------|------------------------------------------|
| Straight Leg Raise | Radicular pain below knee | L5/S1 nerve root compression             |
| Romberg            | Falls when eyes closed    | Proprioceptive (dorsal column) loss      |
| Tinel's Sign       | Tingling on percussion    | Median nerve entrapment (carpal tunnel)  |
| Phalen's Sign      | Numbness on wrist flexion | Median nerve compression (carpal tunnel) |

### 1. Carpal Tunnel vs Cervical Radiculopathy

Trap Question:

A 45-year-old accountant complains of tingling in her thumb, index, and middle fingers for 3 months. It worsens at night and sometimes radiates to the forearm. She denies neck pain but admits to occasionally dropping objects.

Exam findings:

Positive Phalen's test at the wrist

Negative Tinel's sign at the wrist

Decreased sensation over the thenar eminence

Normal reflexes and neck range of motion

Which of the following is the most likely diagnosis?

- A) Classic carpal tunnel syndrome
- B) Cervical radiculopathy (C6–C7)
- C) Pronator teres syndrome
- D) Thoracic outlet syndrome

Answer: C) Pronator teres syndrome

Reasoning:

Thenar sensation is decreased → excludes carpal tunnel (palmar cutaneous branch bypasses tunnel).

Negative Tinel's at wrist but Phalen's positive = misleading clue.

Forearm radiation → compression proximal to wrist (pronator teres region).

Cervical radiculopathy would cause neck pain or altered reflexes — not seen here.

Trick: They purposely gave a "Phalen's positive" to mislead — always check the sensation over thenar eminence!

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## 2. Straight Leg Raise vs Hip Joint

Disease Question:

A 63-year-old retired teacher complains of pain radiating from his right lower back to his knee, worsened when walking. Straight leg raise at 45° reproduces the pain in his thigh but not below the knee. Internal rotation of the hip also causes pain.

Which of the following is most likely?

- A) L5 radiculopathy
- B) S1 radiculopathy
- C) Hip osteoarthritis
- D) Piriformis syndrome

Answer: C) Hip osteoarthritis

Reasoning:

Pain limited to thigh (not below knee) = not radicular.

Hip rotation reproduces pain → joint pathology.

SLR false-positive due to hamstring stretch.

Trick:

Boards love this — “pain with SLR” ≠ positive SLR unless it radiates below the knee.

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## 3. Romberg vs Cerebellar

Ataxia Question:

A 58-year-old man with a 10-year history of alcoholism presents with gait instability.

Exam:

Broad-based gait

Unable to perform tandem walking (heel-to-toe)

Negative Romberg test (he sways even with eyes open)

Strength and sensation normal

Which of the following is most likely?

- A) Sensory ataxia (dorsal column lesion)
- B) Vestibular ataxia
- C) Cerebellar degeneration
- D) Diabetic peripheral neuropathy