

OET PRACTICE TESTS

READING 5



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Reading: Part A- Text booklet

Instructions

TIME LIMIT: 15 MINUTES

- Complete the summary on the next page of **Part A – answer booklet** using the information in the texts (A1-A3) below.
- You **do not** need to read each text from the beginning to end to complete the task. You should scan the text to find the information you need.
- Gaps may require **1, 2 or 3 words**. Answer **ALL** questions. Marks are **NOT** deducted for incorrect answers.
- You should write your answers next to the appropriate number in the **right-hand column**.
- Please use **correct spelling** in your responses. **Do not** use abbreviations unless they appear in the texts.
- Please write clearly.

Junior Sports Injuries: Texts

TEXT A1

Title: Patterns of injury in US high school sports: A review.

Authors: Field and O'Brien (2007)

OBJECTIVE: To characterize the risk of injury associated with 10 popular high school sports by comparing the relative frequency of injury and selected injury rates among sports, as well as the participation conditions of each sport. **DESIGN AND SETTING:** A cohort observational study of high school athletes using a surveillance protocol whereby certified athletic trainers recorded data during the 2005-2007 academic years. **SUBJECTS:** Players listed on the school's team rosters for football, wrestling, baseball, field hockey, softball, girls' volleyball, boys' or girls' basketball, and boys' or girls' soccer. **MEASUREMENTS:** Injuries and opportunities for injury (exposures) were recorded daily. The definition of reportable injury used in the study required that certified athletic trainers evaluate the injured players and subsequently restrict them from participation. **RESULTS:** Football had the highest injury rate per 1000 athlete-exposures at 8.1, and girls' volleyball had the lowest rate at 1.7. Only boys' (59.3%) and girls' (57.0%) soccer showed a larger proportion of reported injuries for games than practices, while volleyball was the only sport to demonstrate a higher injury rate per 1000 athlete-exposures for practices than for games. More than 73% of the injuries restricted players for fewer than 8 days. The proportion of knee injuries was highest for girls' soccer (19.4%) and lowest for baseball (10.5%). Among the studied sports, sprains and strains accounted for more than 50% of the injuries. Of the injuries requiring surgery, 60.3% were to the knee. **CONCLUSIONS:** An inherent risk of injury is associated with participation in high school sports based on the nature of the game and the activities of the players. Therefore, injury prevention programs should be in place for both practices and games. Preventing reinjury through daily injury management is a critical component of an injury prevention program. Although sports injuries cannot be entirely eliminated, consistent and professional evaluation of yearly injury patterns can provide focus for the development and evaluation of injury prevention strategies

TEXT A2

Literature review extract: Prevention of sports injuries. ...

Langran and Selvaraj conducted a study in Scotland to identify risk factors for snow sports injuries. They found that persons under 16 years of age most frequently sustained injury, which may be attributed to inexperience.

They conclude that protective wrist guards and safety release binding systems for skiboards help prevent injury to young or inexperienced skiers and snowboarders.

Ranalli and Rye provide an awareness of the oral health care needs of the female athlete. They report that a properly fitted, custom-fabricated or mouth-formed mouthguard is essential in preventing intraoral soft tissue lacerations, tooth and jaw fractures and dislocations, and indirect concussions in sports. Although custom-fabricated mouthguards are expensive, they have been shown to be the most effective and most comfortable for athletes to wear.

Pettersen conducted a study to determine the attitudes of Canadian rugby players and coaches regarding the use of protective headgear. Although he found that few actually wear headgear, the equipment is known

TEXT A3

Best practice guidelines for junior sports injury management and return to play

When coaches, officials, sports first aiders, other safety personnel, parents and participants follow the safety guidelines, the risk of serious injury is minimal.

If an injury does occur, the golden rule in managing it is “do no further damage”.

It is important that the injured participant is assessed and managed by an appropriately qualified person such as a sports first aider or sports trainer. Immediate management approaches include DRABCD (checking Danger, Response, Airway, Breathing, Compression and Defibrillation) and RICER NO HARM (when an injury is sustained apply Rest, Ice, Compression, Elevation, Referral and NO Heat, Alcohol, Running or Massage).

Young participants returning to activity too early after an injury are more susceptible to further injury. Before returning to participation the participant should be able to answer yes to the following questions:

- Is the injured area pain free?
- Can you move the injured part easily through a full range of movement?
- Has the injured area fully regained its strength?

Whilst serious head injuries are uncommon in children and young peoples' sport, participants who have lost consciousness or who are suspected of being concussed must be removed from the activity.

Prior to returning to sport or physical activity, any child who has sustained an injury should have medical clearance

TEXT A4

Research briefs on sports injuries in Canada

- Approximately 3 million children and adolescents aged 14 and under get hurt annually playing sports or participating in recreational activities.
- Although death from a sports injury is rare, the leading cause of death from a sports-related injury is a brain injury.
- Sports and recreational activities contribute to approximately 18 percent of all traumatic brain injuries among Canadian children and adolescents.
- The majority of head injuries sustained in sports or recreational activities occur during cycling, skateboarding, or skating incidents.

Summary

Junior Sports Injuries

Guidelines for junior sports injury management suggest that there is only a small risk of being(1).... . However statistics show that injury of some kind is reasonably common. In Canada, for example, around(2).... children under 15 are injured every(3).... . While it is very unusual for these injuries to(4).... they do make up just under one fifth of(5).... among children and adolescents in Canada.

A US study which investigated the(6).... of injuries across a range of sports found that the safest sport was(7).... , whereas(8).... was the most likely to cause injury. Of the injuries observed, more than half were(9).... , and knee injuries accounted for 60.3% of those that(10).... . The scope of the US study was limited, however, with(11).... being the only non-ball game studied. Canadian data, on the other hand, revealed that cycling, skateboarding and(12).... were the cause of most(13).... associated with sporting activities.

For those adults and children involved in junior sports, it is best practice to ensure that(14).... is done if an injury does occur. In the first instance, the injury should be evaluated by a(15).... . Two management plans which should be followed are RICER NO HARM and(16).... ; a key feature of the former is that the child should be prevented from doing any further(17).... . It is advised that any child who has been injured should have(18).... before returning to play.

Head injuries are considered very serious, and children who have lost consciousness should be(19).... . Ideally, children involved in sports such as rugby should wear(20).... , because according to recent research such preventative measures can(21).... of concussion and also stop(22).... . Other preemptive measures that might be considered are(23).... to prevent intraoral(24).... and fractures of the(25).... , as well as(26).... and(27).... systems to help prevent snow sports injuries.

END OF PART A.

Reading: Part B- Text booklet

Instructions

TIME LIMIT: 45 MINUTES

There are **TWO** reading texts in Part B. After each of the texts you will find several questions or unfinished statements about the text, each with four suggested answers or ways of finishing.

You must choose the **ONE** which you think fits best. Answer **ALL** questions. Marks are **NOT** deducted for incorrect answers.

NOTE: You must complete your answer sheet for Part B within 45 minutes allowed for this part of the sub-test.

TEXT B1

Going blind in Australia

Paragraph 1

Australians are living longer and so face increasing levels of visual impairment. When we look at the problem of visual impairment and the elderly, there are three main issues. First, most impaired people retire with relatively “normal” eyesight, with no more than presbyopia, which is common in most people over 45 years of age. Second, those with visual impairment do have eye disease and are not merely suffering from “old age”. Third, almost all the major ocular disorders affecting the older population, such as cataract, glaucoma and age-related macular degeneration (AMD), are progressive and if untreated will cause visual impairment and eventual blindness.

Paragraph 2

Cataract accounts for nearly half of all blindness and remains the most prevalent cause of blindness worldwide. In Australia, we do not know how prevalent cataract is, but it was estimated in 1979 to affect the vision of 43 persons per thousand over the age of 64 years. Although some risk factors for cataract have been identified, such as ultraviolet radiation, cigarette smoking and alcohol consumption, there is no proven means of preventing the development of most age-related or senile cataract. However cataract blindness can be delayed or cured if diagnosis is early and therapy, including surgery, is accessible.

Paragraph 3

AMD is the leading cause of new cases of blindness in those over 65. In the United States, it affects 8–11% of those aged 65–74, and 20% of those over 75 years. In Australia, the prevalence of AMD is presently unknown but could be similar to that in the USA. Unlike cataract, the treatment possibilities for AMD are limited. Glaucoma is the third major cause of vision loss in the elderly. This insidious disease is often undetected until optic nerve damage is far advanced. While risk factors for glaucoma, such as ethnicity and family history, are known, these associations are poorly understood. With early detection, glaucoma can be controlled medically or surgically.

Paragraph 4

While older people use a large percentage of eye services, many more may not have access to, or may underutilise, these services. In the United States, 33% of the elderly in Baltimore had ocular pathology requiring further investigation or intervention. In the UK, only half the visually impaired in London were known by their doctors to have visual problems, and 40% of those visually impaired in the city of Canterbury had never visited an ophthalmologist. The reasons for people underutilising eye care services are, first, that many elderly people believe that poor vision is inevitable or untreatable. Second, many of the visually impaired have other chronic disease and may neglect their eyesight. Third, hospital resources and rehabilitation centres in the community are limited and, finally, social factors play a role.

Paragraph 5

People in lower socioeconomic groups are more likely to delay seeking treatment; they also use fewer preventive, early intervention and screening services, and fewer rehabilitation and after-care services. The poor use more health services, but their use is episodic, and often involves hospital casualty departments or general medical services, where eyes are not routinely examined. In addition, the costs of services are a great deterrent for those with lower incomes, who are less likely to have private health insurance. For example, surgery is the most effective means of treatment for cataract, and timely medical care is required for glaucoma and AMD. However, in December 1991, the proportion of the Australian population covered by private health insurance was 42%. Less than 38% had supplementary insurance cover. With 46% of category 1 (urgent) patients waiting for more than 30 days for elective eye surgery in the public system, and 54% of category 2 (semi-urgent) patients waiting for more than three months, cost appears to be a barrier to appropriate and adequate care.

Paragraph 6

With the proportion of Australians aged 65 years and older expected to double from the present 11% to 21% by 2031, the cost to individuals and to society of poor sight will increase significantly if people do not have access to, or do not use, eye services. To help contain these costs, general practitioners can actively investigate the vision of all their older patients, refer them earlier, and teach them self-care practices. In addition, the government, which is responsible to the taxpayer, must provide everyone with equal access to eye health care services. This may not be achieved merely by increasing expenditure – funds need to be directed towards prevention and health promotion, as well as treatment. Such strategies will make good economic sense if they stop older people going blind.

1. In paragraph 1, the author suggests that

- A many people have poor eyesight at retirement age.
- B sight problems of the aged are often treatable.
- C cataract and glaucoma are the inevitable results of growing older.
- D few sight problems of the elderly are potentially damaging.

2. According to paragraph 2, cataracts

- A may affect about half the population of Australians aged over 64.
- B may occur in about 4–5% of Australians aged over 64.
- C are directly related to smoking and alcohol consumption in old age.
- D are the cause of more than 50% of visual impairments

3. According to paragraph 3, age-related macular degeneration (AMD)

- A responds well to early treatment.
- B affects 1 in 5 of people aged 65–74.
- C is a new disease which originated in the USA.
- D causes a significant amount of sight loss in the elderly.

4. According to paragraph 3, the detection of glaucoma

- A generally occurs too late for treatment to be effective.
- B is strongly associated with ethnic and genetic factors.
- C must occur early to enable effective treatment.
- D generally occurs before optic nerve damage is very advanced.

5. Statistics in paragraph 4 indicate that

- A existing eye care services are not fully utilised by the elderly.
- B GPs are generally aware of their patients' sight difficulties.
- C most of the elderly in the USA receive adequate eye treatment.
- D only 40% of the visually impaired visit an ophthalmologist.

6. According to paragraph 4, which one of the following statements is NOT true?

- A Many elderly people believe that eyesight problems cannot be treated effectively.
- B Elderly people with chronic diseases are more likely to have poor eyesight.
- C The facilities for eye treatments are not always readily available.
- D Many elderly people think that deterioration of eyesight is a product of ageing.

7. In discussing social factors affecting the use of health services in paragraph 5, the author points out that

- A wealthier people use health services more often than poorer people.
- B poorer people use health services more regularly than wealthier people.
- C poorer people deliberately avoid having their eye sight examined.
- D poorer people have less access to the range of available eye care services.

8. According to paragraph 6, in Australia in the year 2031

- A about one tenth of the country's population will be elderly.
- B about one third of the country's population will be elderly.
- C the proportion of people over 65 will be twice the present proportion.
- D the number of visually impaired will be twice the present number.

9. According to paragraph 6, the author believes that general practitioners

- A should be more active in investigating patients' possible sight difficulties.
- B should not be required to deal with sight deterioration.
- C should not refer patients to specialists until the problems are advanced.
- D should seek assistance from eye specialists in detection of problems.

10. In paragraph 6, the author suggests that

- A increased government funding will solve the country's eye care problems.
- B government services should include prevention and health promotion.
- C general practitioners should reduce the cost of treating sight problems in the elderly.
- D general practitioners should take full responsibility for treating sight problems.

END OF PART B – TEXT 1.

TURN OVER FOR PART B- TEXT 2.

TEXT B2

Exercise, fitness and health

Paragraph 1

Physical inactivity is a substantial risk factor for cardiovascular disease. Exercise probably works by increasing physical fitness and by modifying other risk factors. Among other benefits, it lessens the risk of stroke and osteoporosis and is associated with a lower all-cause mortality. Moreover, it has psychological effects that are surely underexploited. A pervasive benefit is the gain in everyday reserve capacity – that is, the ability to do more without fatigue. Nevertheless, there is much debate about how intense the exercise should be. Some studies show a dose-response relation between activity and reduction of risk, with a threshold of effect; some suggest that vigorous aerobic activity is needed and others that frequent moderate exercise is adequate – and indeed safer if ischaemic heart disease might be present. A few surveys have found a slightly increased risk of heart attack with extreme activity, though further analysis in one study suggested this applied only to men with hypertension.

Paragraph 2

A commonly recommended minimum regimen for cardiovascular benefit is thrice weekly exercise for 20 minutes, brisk enough to produce sweating or hard breathing (or a heart rate 60–80% of maximum). Indeed, this is what the Allied Dunbar national survey of fitness among adults in the UK recommends. It conveys a simple popular message of broad minimum targets for different age groups expressed in terms of activities of different intensity. The aim is to produce a training effect through exercise beyond what is customary for an individual.

Paragraph 3

The main reason why people fail to take exercise is lack of time. Thus an important message is that exercise can be part of the daily routine – walking or cycling to work or the shops, for instance. Relatively few people in the national fitness survey had walked continuously for even 1–25 km in the previous month (11–30% depending on age and sex), and other surveys have also found little walking. Cycling is also beneficial, however many are put off cycling to work by the danger. Certainly more cycle routes are needed, but even now life years lost through accidents are outweighed by the estimated life years gained through better health. Employers could encourage people to make exercise part of the working day by providing showers and changing rooms, flexible working hours, individual counselling by occupational health or personnel staff, and sometimes exercise facilities – or at least encouragement for exercise groups.

Paragraph 4

In the promotion of exercise, children, women, middle aged men, and older people need special thought. Lifelong exercise is most likely to be started in childhood, but children may have little vigorous exercise. Women tend to be much less active than men and are less fit at all ages. The proportion judged on a treadmill test to be unable to keep walking at 5km/h up a slight slope rose with age from 34% to 92% – and over half of those aged over 54 would not be able to do so even on the level. Women have particular constraints: young children may prevent even brisk walking. Thus they need sensitive help from health professionals and women's and children's groups as well as the media.

Paragraph 5

A high proportion of men aged 45–54, who have a high risk of coronary heart disease, were not considered active enough for their health. Promotion of exercise and individual counselling at work could help. Forty percent of 65–74 year olds had done no “moderate” activity for even 20 minutes in a month. Yet older people especially need exercise to help them make the most of their reduced physical capacity and counteract the natural deterioration of age. They respond to endurance training much the same as do younger people. Doctors particularly should take this challenge more seriously.

Paragraph 6

People need to be better informed, and much can be done through the media. For instance, many in the survey were mistaken in thinking that they were active and fit. Moreover, many gave “not enough energy” and “too old” as reasons for not exercising. Precautions also need publicity – for example, warming up and cooling down gradually, avoiding vigorous exercise during infections, and (for older people) having a medical check before starting vigorous activity. Doctors are in a key position. Some general practitioners have diplomas in sports medicine, and a few are setting up exercise programmes. As the Royal College of Physicians says, however, all doctors should ask about exercise when they see patients, especially during routine health checks, and advise on suitable exercise and local facilities. Their frequent contact with women and children provides a valuable opportunity. Excluding ischaemic heart disease and also checking blood pressure before vigorous activity is started are important precautions. But above all doctors could help to create a cultural change whereby the habit of exercise becomes integral to daily life.

11. All of the following are mentioned in paragraph 1 as benefits of exercise EXCEPT...

- A increase in the capacity to withstand strenuous activity.
- B significant decrease in the risk of osteoporosis.
- C reduction of the risk of heart disease.
- D weight control and decrease in levels of body fat.

12. According to paragraph 2, the recommendations of the report on the national fitness survey included

- A long, vigorous aerobic sessions for all men, women and children.
- B no more than three, 20 minute exercise sessions per week.
- C avoiding any exercise that brought on hard breathing.
- D different levels of exercise intensity for different age groups.

- 13. According to paragraph 3, one reason many people do not exercise is**
- A they are unaware of its importance.
 - B difficulty in fitting it into their daily routine.
 - C they are unaware of its long-term health benefits.
 - D they live too far from work to walk or cycle.
- 14. Which one of the following is mentioned in paragraph 3 as a way in which employers can help improve the physical fitness and health of their staff?**
- A Making it mandatory for employees to exercise during lunch breaks.
 - B Providing encouragement and advice from staff within the organisation.
 - C Hiring trained sports educators to counsel members of staff about exercise.
 - D Setting an example, as individuals, by regularly exercising themselves.
- 15. According to paragraphs 4 and 5, older men and women need to remain physically active and fit because**
- A they need to counteract the risk of coronary disease.
 - B fitness levels decrease rapidly over the age of 54.
 - C they need to guard against poor health and inactivity.
 - D exercise works against the physical effects of ageing.
- 16. Which one of the following is NOT mentioned in paragraph 6 as a precaution to be taken when considering exercise?**
- A The need to balance aerobic activity with stretching.
 - B The need to warm up before and cool down after exercise.
 - C The need to eliminate the risk of ischaemic heart disease before starting.
 - D The need to exclude strenuous exercise from the routine during infection.
- 17. Which one of the following needs in relation to the improvement of national fitness is NOT mentioned in the article?**
- A The need for people to make exercise a regular daily habit.
 - B The need to provide information on health and fitness to the community.
 - C The need for doctors themselves to improve their own fitness levels.
 - D The need to consult a doctor before starting an exercise program

18. According to the article, which one of the following is FALSE?

- A** It is unsafe for people with high blood pressure to do regular moderate exercise.
- B** Experts agree on the importance of both type and intensity of exercise.
- C** Men are generally fitter and more active than women.
- D** Cycling, though unsafe, is a beneficial form of exercise.

END OF PART B – TEXT 2

END OF READING TEST

Reading sub-test

Part A: Junior Sport Injuries

Answer key

Total of 29 questions

- 1 seriously/badly injured
- 2 three/3 million OR 3,000,000
- 3 year
- 4 result in/cause death/fatality OR kill OR be fatal/deadly/lethal OR lead to death
- 5 traumatic brain injuries
- 6 relative frequency OR pattern(s) OR risk(s) OR rate(s)
- 7 girls' volleyball
- 8 football
- 9 sprains and strains
- 10 required/needed surgery/needed an operation
- 11 wrestling
- 12 skating accidents/incidents
- 13 head injuries
- 14 no further damage
- 15 sports first aider OR sports trainer OR (suitably) qualified person
- 16 DRABCD
- 17 running
- 18 (a) medical clearance
- 19 removed/withdrawn (from play/activity)
- 20 (protective) headgear
- 21 minimise/reduce the risk OR reduce rates
- 22 lacerations and abrasions
- 23 custom-fabricated mouthguard OR mouth-formed mouthguard
- 24 soft tissue laceration(s)
- 25 tooth and jaw OR teeth OR jaw
- 26 (protective) wrist guards
- 27 safety release binding

END OF KEY

Reading Sub-test

Text B1

Answer Key

Total of 10 questions

- 1 B sight problems of the aged are often treatable.
- 2 B may occur in about 4–5% of Australians aged over 64.
- 3 D causes a significant amount of sight loss in the elderly.
- 4 C must occur early to enable effective treatment.
- 5 A existing eye care services are not fully utilised by the elderly.
- 6 B Elderly people with chronic diseases are more likely to have poor eyesight.
- 7 D poorer people have less access to the range of available eye care services.
- 8 C the proportion of people over 65 will be twice the present proportion.
- 9 A should be more active in investigating patients' possible sight difficulties.
- 10 B government services should include prevention and health promotion.

END OF KEY

Text B2

Answer Key

Total of 8 questions

- 11 D weight control and decrease in levels of body fat.
- 12 D different levels of exercise intensity for different age groups.
- 13 B difficulty in fitting it into their daily routine.
- 14 B Providing encouragement and advice from staff within the organisation.
- 15 D exercise works against the physical effects of ageing.
- 16 A The need to balance aerobic activity with stretching.
- 17 C The need for doctors themselves to improve their own fitness levels.
- 18 B Experts agree on the importance of both type and intensity of exercise.

END OF KEY