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ARDMS AE Adult Echocardiography Examination Sample Questions (Q127-Q132):

NEW QUESTION # 127

In patients with interrupted aortic arch, which structure allows blood to flow into the descending aorta?

- A. Persistent left superior vena cava
- B. Foramen ovale
- **C. Patent ductus arteriosus**
- D. Left carotid artery

Answer: C

Explanation:

In interrupted aortic arch, the normal continuity between the ascending and descending aorta is disrupted. The patent ductus arteriosus (PDA) provides a vital conduit for blood to flow from the pulmonary artery to the descending aorta, maintaining systemic circulation distal to the interruption.

Persistent left superior vena cava and left carotid artery do not provide this flow. The foramen ovale is an atrial-level shunt and does not compensate for interrupted aortic arch.

This clinical anatomy is described in the "Textbook of Clinical Echocardiography, 6e", Chapter on Congenital Aortic Arch Anomalies#20:135-140Textbook of Clinical Echocardiography#.

NEW QUESTION # 128

In cardiac tamponade, how do transvalvular pressure gradients change during expiration?

- A. Transmitral increases and transtricuspid increases
- **B. Transmitral decreases and transtricuspid increases**
- C. Transmitral decreases and transtricuspid decreases
- D. Transmitral increases and transtricuspid decreases

Answer: B

Explanation:

In cardiac tamponade, there is a characteristic reciprocal respiratory variation in transvalvular flow velocities due to ventricular interdependence and impaired cardiac filling. During expiration, the intrathoracic pressure increases, which leads to decreased right ventricular filling and thus decreased transtricuspid flow velocity.

Simultaneously, left ventricular filling increases, causing an increase in transmitral flow velocity.

Therefore, during expiration, the transmitral gradient increases while the transtricuspid gradient decreases.

This phenomenon reverses during inspiration, where transtricuspid flow increases and transmitral flow decreases. These respiratory variations are diagnostic hallmarks of tamponade physiology and help distinguish it from other conditions.

This principle is illustrated in Doppler echocardiographic studies of ventricular inflow and is described with diagrams in the "Textbook of Clinical Echocardiography, 6e" (Chapter 10: Pericardial Disease), highlighting the changes in transmitral and transtricuspid velocities during the respiratory cycle in tamponade .

NEW QUESTION # 129

What is the range of the aortic valve area in normal adults?

- A. 7- 8cm²
- B. 5 - 6cm²
- C. 1 - 2 cm²
- **D. 3 - 4cm²**

Answer: D

Explanation:

Comprehensive and Detailed Explanation From Exact Extract:

The normal aortic valve area (AVA) in adults typically ranges from 3 to 4 cm². This measurement is important for assessing aortic stenosis severity; values below this range suggest valve narrowing.

AVA values of 1-2 cm² indicate mild to moderate stenosis, while less than 1 cm² reflects severe stenosis.

Larger areas like 5-6 or 7-8 cm² are not physiologically typical.

This normal range is documented in the "Textbook of Clinical Echocardiography, 6e", Chapter on Aortic Valve Anatomy and Function#20:360-365Textbook of Clinical Echocardiography#.

NEW QUESTION # 130

Which is most likely the culprit coronary artery in a patient who presents with anteroseptal hypokinesis?

- **A. Left coronary artery**
- B. Posterior descending artery
- C. Circumflex artery

- D. Right coronary artery

Answer: A

Explanation:

Comprehensive and Detailed Explanation From Exact Extract:

Anteroseptal hypokinesis is most often due to ischemia or infarction in the left anterior descending (LAD) artery territory, a major branch of the left coronary artery. The LAD supplies the anterior wall and the interventricular septum.

The right coronary artery generally supplies the inferior wall and right ventricle. The circumflex artery supplies the lateral wall. The posterior descending artery supplies the inferior wall.

This coronary artery distribution and wall motion correlation is fundamental in stress echocardiography and ischemic heart disease assessment as detailed in ASE guidelines and clinical echocardiography references#12:

ASE Stress Echocardiography Guidelinesp.300-310##16:Textbook of Clinical Echocardiography, 6ep.380-385#.

NEW QUESTION # 131

How must the sonographer angle the transducer from the apical four-chamber view in order to visualize the aortic valve in the apical five-chamber view?

- A. Medially
- **B. Anteriorly**
- C. Laterally
- D. Posteriorly

Answer: B

Explanation:

To obtain the apical five-chamber view from the apical four-chamber, the transducer is angled anteriorly (towards the patient's chest). This brings the left ventricular outflow tract and aortic valve into the imaging plane anterior to the left ventricle and mitral valve seen in the four-chamber view.

Posterior, medial, or lateral angulations do not adequately visualize the aortic valve in this context.

This technique is described in adult echocardiography imaging protocols and ASE chamber quantification guidelines#12:ASE Imaging Protocolsp.30-35##16:Textbook of Clinical Echocardiography, 6ep.70-75#.

NEW QUESTION # 132

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