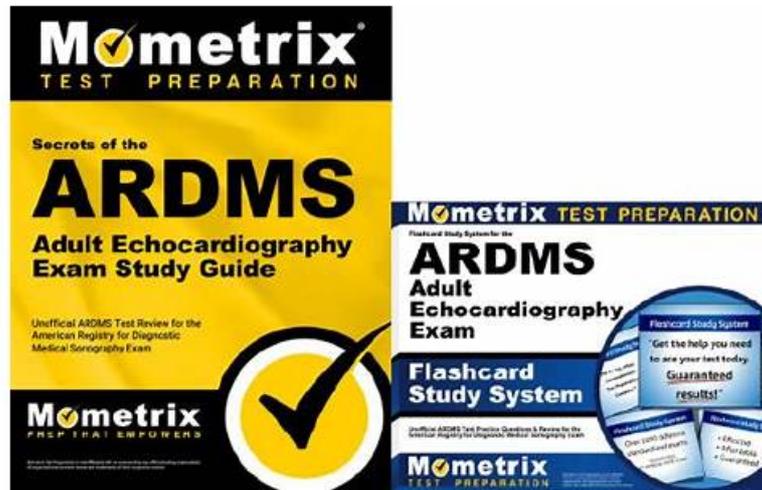


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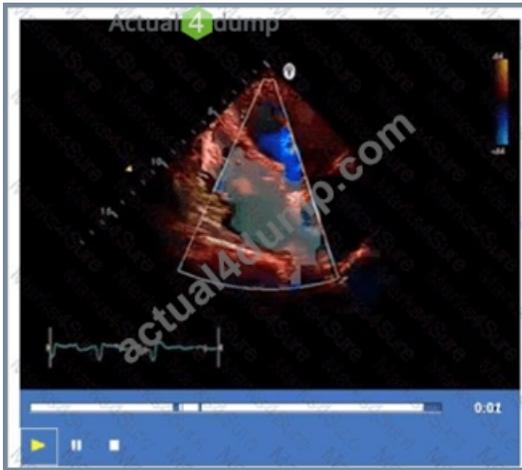
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## ARDMS AE Adult Echocardiography Examination Sample Questions (Q139-Q144):

### NEW QUESTION # 139

What is the incidental finding seen by color Doppler in this four-chamber view of a patient with left atrial enlargement?



- A. Coronary-cameral fistula
- B. Sinus venosus defect
- C. Patent foramen ovale
- D. Muscular ventricular septal defect

**Answer: C**

Explanation:

The color Doppler image in the four-chamber view shows a jet across the interatrial septum, indicating a shunt at the atrial level. In a patient with left atrial enlargement, the most common incidental finding causing such flow is a patent foramen ovale (PFO). A PFO is a small communication between the right and left atria that can open under certain pressure conditions, leading to shunting.

Muscular ventricular septal defect is a ventricular level defect and would be seen in different views. Coronary-cameral fistula is a rare anomaly involving abnormal connections between coronary arteries and cardiac chambers, not typical in this setting. Sinus venosus defect is an atypical atrial septal defect located near the superior vena cava and would require different imaging planes for detection.

This finding and its implications are discussed in the "Textbook of Clinical Echocardiography, 6e", Chapter on Atrial Septal Defects and Shunts#20:115-120Textbook of Clinical Echocardiography#.

#### **NEW QUESTION # 140**

Which finding is best demonstrated in this video?



- A. Left atrial elongation
- B. Mid-anteroseptal hypokinesia
- C. Aortic root dilatation
- **D. Systolic anterior motion of the mitral valve**

**Answer: D**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract:

The video shows a parasternal long-axis view of the left ventricle and mitral valve with the anterior leaflet of the mitral valve moving abnormally toward the interventricular septum during systole. This systolic anterior motion (SAM) of the mitral valve is characteristic of hypertrophic obstructive cardiomyopathy (HOCM) and contributes to left ventricular outflow tract obstruction.

Aortic root dilatation and left atrial elongation are structural findings seen in other views. Mid-anteroseptal hypokinesia is a regional wall motion abnormality not clearly visualized in this clip.

This echocardiographic sign is critical in diagnosing and managing HOCM and is discussed extensively in ASE guidelines and clinical echocardiography texts#16:Textbook of Clinical Echocardiography, 6p.350-355##12:ASE Cardiomyopathy Guidelinesp.120-130#.

#### NEW QUESTION # 141

During which phase of the cardiac cycle does mitral valve prolapse occur?

- A. Ventricular filling
- B. Diastasis
- **C. Ventricular contraction**
- D. Atrial systole

**Answer: C**

Explanation:

Mitral valve prolapse (MVP) occurs during ventricular contraction (systole). Specifically, during systole, the increased pressure in the left ventricle causes the mitral valve leaflets to billow or prolapse back into the left atrium. This abnormal systolic displacement of the mitral leaflets beyond the annular plane leads to mitral regurgitation in many cases.

The echocardiographic hallmark of MVP is systolic bowing or displacement of the mitral leaflets into the left atrium, best visualized in parasternal long-axis or apical views during ventricular contraction. MVP is not seen during ventricular filling phases such as early filling, atrial systole, or diastasis because the leaflets are normally open or positioned differently.

This is well-documented in the "Textbook of Clinical Echocardiography, 6e", Chapter on Mitral Valve Disease, explaining the pathophysiology of MVP and its timing during the cardiac cycle#20:390-395Textbook of Clinical Echocardiography#.

#### NEW QUESTION # 142

Which of the following is a feature of constrictive pericarditis?

- A. Dilated inferior vena cava with inspiratory collapse during sniff test
- **B. Interventricular septal bounce**
- C. Normal hepatic vein size
- D. Mitral inflow pattern has a large E-wave and a small A-wave without respiratory changes

**Answer: B**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract:

Constrictive pericarditis is characterized by thickening and fibrosis of the pericardium which restricts diastolic filling of the ventricles. Key echocardiographic features include a characteristic interventricular septal

"bounce" or shift during early diastole due to the abrupt cessation of ventricular filling imposed by the rigid pericardium. This septal bounce reflects rapid early diastolic filling followed by a sudden halt as filling pressures equalize, a hallmark of constriction physiology.

Additionally, Doppler studies show marked respiratory variation in mitral and tricuspid inflow velocities (>25%), with an inspiratory increase in tricuspid inflow and a decrease in mitral inflow velocity, reflecting ventricular interdependence caused by the noncompliant pericardium. The mitral inflow typically shows a large E-wave with a small or absent A-wave and a steep deceleration slope, but importantly these velocities vary significantly with respiration, which is not the case in restrictive cardiomyopathy. Hepatic vein Doppler often reveals a prominent a-wave and a deep y-descent with increased diastolic flow reversal during expiration, indicating elevated right atrial pressures and constrictive physiology.

The inferior vena cava (IVC) is usually dilated and shows no inspiratory collapse (i.e., no normal collapse with sniff test) because of elevated right atrial pressure and impaired venous return.

Therefore:

- \* Option A is incorrect because mitral inflow in constrictive pericarditis shows significant respiratory variation, not absence of it.
- \* Option B is incorrect because the hepatic vein is typically dilated with abnormal flow patterns, not normal size.
- \* Option C is incorrect because the IVC is dilated and does NOT collapse normally with inspiration/sniff in constrictive pericarditis.
- \* Option D is correct because the interventricular septal bounce is a classic feature reflecting ventricular interdependence and constrictive physiology.

These findings are summarized in the "Textbook of Clinical Echocardiography, 6e" (Catherine M. Otto, MD), Chapter 10 (Pericardial Disease), pages 280-285, with key illustrations showing septal bounce, Doppler inflow variations, hepatic vein flow patterns, and IVC findings in constrictive pericarditis. The "Mayo Clinic criteria" for echocardiographic diagnosis also emphasize ventricular septal shift as a critical feature, often combined with tissue Doppler annular velocity patterns and hepatic vein diastolic flow reversal for high diagnostic accuracy.

#### NEW QUESTION # 143

Which next step is appropriate after obtaining the Doppler signal in this image?



- A. Continuous wave through the left ventricle to localize intracavitary gradient
- B. Continuous wave through the mitral valve to assess for mitral stenosis
- C. Pulsed wave at the level of the mitral valve leaflet tips to assess for mitral stenosis
- D. Pulsed wave at various levels of the left ventricle to localize intracavitary gradient.

**Answer: A**

Explanation:

The Doppler signal shown is a continuous wave (CW) Doppler tracing typical of measuring high velocity flow, such as an intracavitary gradient in the left ventricle, often seen in hypertrophic obstructive cardiomyopathy (HOCM). CW Doppler is needed to capture the highest velocity flow across the entire ventricular cavity and outflow tract.

Pulsed wave Doppler has limited spatial resolution and cannot measure high velocities without aliasing; thus, it is less useful for localizing gradients in this context. Pulsed wave at mitral leaflet tips is used for mitral inflow assessment, not intracavitary gradients.

This approach is recommended in ASE guidelines for cardiomyopathy and valvular obstruction evaluation#12:

ASE Doppler Guidelinesp.120-125##16:Textbook of Clinical Echocardiography, 6ep.350-355#

## NEW QUESTION # 144

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