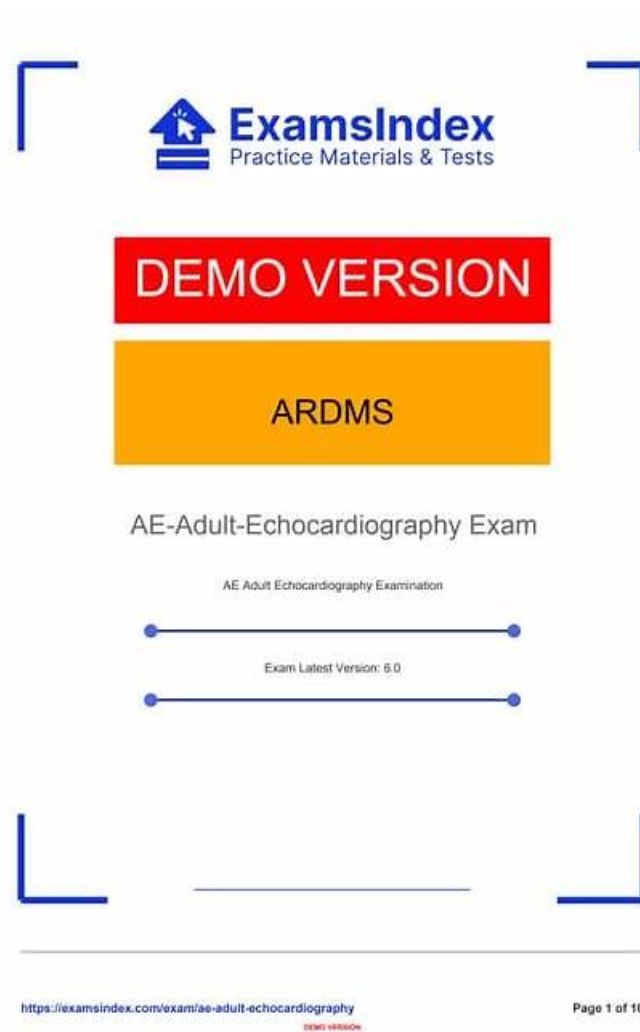


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ARDMS AE Adult Echocardiography Examination Sample Questions (Q42-Q47):

NEW QUESTION # 42

Which statement is most accurate regarding cardiac contusion?

- A. It can result from a myocardial infarction.
- **B. It affects the right ventricle more commonly than the left.**
- C. It leads to hypercontractility of the left ventricle
- D. It is focal ventricular hypertrophy.

Answer: B

Explanation:

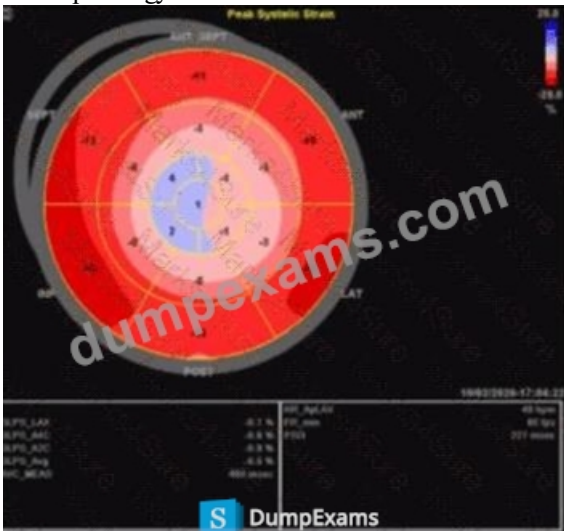
Cardiac contusion is a myocardial injury resulting from blunt chest trauma, typically affecting the right ventricle more commonly than the left ventricle because of its anterior location and proximity to the chest wall. The injury can range from mild bruising to severe myocardial damage and dysfunction.

It does not result from myocardial infarction (which is ischemic injury), nor does it cause hypertrophy or hypercontractility. Instead, it may cause wall motion abnormalities, arrhythmias, or even rupture.

These features are detailed in echocardiography and trauma cardiology literature, including the "Textbook of Clinical Echocardiography" and clinical guidelines on blunt cardiac injury#16:Textbook of Clinical Echocardiography, 6ep.600-605##12:ASE Trauma Cardiology Guidelinesp.500-505#.

NEW QUESTION # 43

Which pathology is consistent with the left ventricular strain pattern shown in this image?



- A. Apical hypertrophy
- B. Right coronary artery infarct
- C. Non-ischemic cardiomyopathy
- **D. Amyloidosis**

Answer: D

Explanation:

The strain imaging shown is a classic example of the "apical sparing" pattern, highly characteristic of cardiac amyloidosis. In cardiac amyloidosis, the basal and mid segments of the left ventricle show markedly reduced longitudinal strain (represented here by more positive or less negative strain values), while the apical segments retain relatively preserved strain (more negative strain values). This "cherry on top" or "bull's eye" pattern with apical strain preserved distinguishes amyloidosis from other causes of LV dysfunction. This pattern is not typical of apical hypertrophy, which would show focal thickening and abnormal strain limited to the apex. Non-ischemic cardiomyopathy generally has a more diffuse and uniform reduction in strain without the apical sparing. Right coronary artery infarcts affect the inferior and posterior walls and would have segmental strain abnormalities corresponding to the infarct distribution, not the typical apical sparing.

The left ventricular global longitudinal strain (GLS) in amyloidosis is typically severely reduced, but the relative preservation of apical strain is a hallmark useful for diagnosis, as described in the "Textbook of Clinical Echocardiography, 6e" (Chapter on strain imaging and infiltrative cardiomyopathies).

NEW QUESTION # 44

Which wall is indicated by the arrow on this video?



- A. Inferoseptum
- B. Anteroseptum
- C. Inferolateral
- D. Anterolateral

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract:

The apical two-chamber echocardiographic view displays the inferolateral wall (also called posterior lateral).

The arrow points to this inferolateral segment, which is located inferiorly and laterally in the left ventricle.

Anteroseptum and inferoseptum relate to the interventricular septum, while anterolateral is the anterior lateral wall, opposite the inferolateral wall. Correct regional wall motion assessment is essential for ischemic disease evaluation.

This identification and terminology are described in ASE stress echocardiography and chamber quantification guidelines#12:ASE Stress Echocardiography Guidelinesp.310-315##16:Textbook of Clinical Echocardiography, 6ep.380-385#.

NEW QUESTION # 45

Which parameter is expected to increase in the presence of cardiac tamponade?

- A. Oxygen saturation
- B. Heart rate
- C. Systolic blood pressure
- D. Diastolic blood pressure

Answer: B

Explanation:

In cardiac tamponade, pericardial fluid accumulation restricts cardiac filling leading to decreased stroke volume and cardiac output.

As a compensatory mechanism, the heart rate increases (tachycardia) to maintain cardiac output.

Oxygen saturation typically does not increase; it may be normal or decreased if tamponade leads to hypoperfusion. Systolic and diastolic blood pressures often decrease due to reduced cardiac output.

This physiological response is well described in clinical cardiology texts and ASE pericardial disease guidelines#12:ASE Pericardial Disease Guidelinesp.300-305##16:Textbook of Clinical Echocardiography, 6ep.280-285#

NEW QUESTION # 46

How is the aorta in a structurally normal heart oriented?

- A. Anterior to both the pulmonary artery and the coronary sinus
- B. Parallel to the pulmonary artery
- C. Posterior and to the right of the pulmonary artery
- D. Anterior and to the left of the pulmonary artery

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract:

In a normal heart, the ascending aorta arises from the left ventricle and courses superiorly and posteriorly to the right of the pulmonary artery, which arises anteriorly from the right ventricle. The aorta is positioned posterior and to the right of the main pulmonary artery, reflecting the normal spatial relationship.

The pulmonary artery is anterior and to the left of the aorta, and the coronary sinus lies posteriorly in the atrioventricular groove.

This anatomical relationship is detailed in the "Textbook of Clinical Echocardiography, 6e", Chapter on Cardiac Anatomy and Echocardiographic Landmarks#20:50-55Textbook of Clinical Echocardiography#.

NEW QUESTION # 47

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