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The most attractive thing about a learning platform is not the size of his question bank, nor the amount of learning resources, but more importantly, it is necessary to have a good control over the annual propositional trend. The AE-Adult-Echocardiography quiz guide through research and analysis of the annual questions, found that there are a lot of hidden rules are worth exploring, plus we have a powerful team of experts, so the rule can be summed up and use. The AE Adult Echocardiography Examination prepare torrent can be based on the analysis of the annual questions, it is concluded that a series of important conclusions related to the qualification examination, combining with the relevant knowledge of recent years, then predict the direction which can determine this year's exam. AE-Adult-Echocardiography test material will improve the ability to accurately forecast the topic and proposition trend this year.

ARDMS AE-Adult-Echocardiography Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> Instrumentation, Optimization, and Contrast: This section of the exam measures skills of adult echocardiography technicians related to use and optimization of ultrasound instrumentation and the application of contrast agents. Candidates should recognize imaging artifacts, utilize non-imaging transducers, and adjust ultrasound console settings for optimal imaging and Doppler recordings. Knowledge of harmonic imaging, principles of contrast agents, and the safe and effective use of saline and echo-enhancing contrast agents is essential. Candidates must also be able to optimize images when using contrast agents to ensure diagnostic quality.
Topic 2	<ul style="list-style-type: none"> Pathology: This section of the exam measures skills of adult echocardiography technicians and focuses on identifying and evaluating abnormal physiology and perfusion and postoperative conditions. It includes assessment of ventricular aneurysms, aortic and valve abnormalities, arrhythmias, cardiac masses, diastolic dysfunction, endocarditis, ischemic diseases, cardiomyopathies, congenital anomalies, and postoperative valve repair or replacement and intracardiac devices. Candidates must demonstrate ability to recognize abnormal Doppler signals, EKG changes, wall motion abnormalities, and a wide range of cardiac pathologies including pulmonary hypertension and septal defects.
Topic 3	<ul style="list-style-type: none"> Clinical Care and Safety: This section of the exam measures skills of adult echocardiography technicians in applying clinical care principles and safety protocols. It includes evaluating patient history and external data, preparing patients including fasting state and intravenous line management, proper patient positioning, EKG lead placement, blood pressure measurement, and ergonomic techniques. Candidates are expected to identify critical echocardiographic findings, know contraindications for procedures, and be able to respond and manage medical emergencies that may arise during echocardiographic exams.
Topic 4	<ul style="list-style-type: none"> Measurement Techniques, Maneuvers, and Sonographic Views: This section of the exam measures skills of adult echocardiography technicians in performing accurate cardiac measurements, conducting provocative maneuvers, and obtaining optimized sonographic imaging views. It involves applying 2D, 3D, M-mode, and Doppler techniques to measure heart valves, chambers, and vessels, including the aortic valve, mitral valve, left and right ventricles, atria, pulmonary artery, and shunt ratios. Candidates must instruct patients in maneuvers such as Valsalva, cough, sniff, and squat. They should also be proficient in acquiring standard echocardiographic views including apical, parasternal, subcostal, and suprasternal notch views.
Topic 5	<ul style="list-style-type: none"> Anatomy and Physiology: This section of the exam measures skills of adult echocardiography technicians and covers knowledge and abilities related to normal cardiac anatomy and physiology. It includes assessing great vessels like the aorta and pulmonary arteries, recognizing anatomic variants of the heart, and evaluating cardiac chambers, pericardium, valve structures, and vessels of arterial and venous return. Candidates must document normal systolic and diastolic function, normal valve function and measurements, the phases of the cardiac cycle, normal Doppler changes with respiration, and appearance of arterial and venous waveforms. This also involves assessing the normal hemodynamic response to stress testing and maneuvers such as Valsalva, respiratory, handgrip, and postural changes.

ARDMS AE Adult Echocardiography Examination Sample Questions (Q82-Q87):

NEW QUESTION # 82

Which of the following is a feature of constrictive pericarditis?

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

Answer: A

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 constrictive 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 # 83

What does the Qp represent in an atrial septal defect shunt ratio measurement (Qp/Qs)?

- A. Left ventricular outflow tract (LVOT) time velocity integral
- B. Stroke volume of the LVOT
- C. Right ventricular outflow tract (RVOT) time velocity integral
- **D. Stroke volume of the RVOT**

Answer: D

Explanation:

In the calculation of the shunt ratio Qp/Qs, Qp represents pulmonary blood flow, which is calculated as the stroke volume of the right ventricular outflow tract (RVOT). Stroke volume is obtained by measuring the RVOT cross-sectional area and the RVOT time velocity integral (VTI).

Qp (pulmonary flow) divided by Qs (systemic flow) quantifies the magnitude of left-to-right shunting in atrial septal defects and other congenital heart diseases.

This method is described in the "Textbook of Clinical Echocardiography, 6e", Chapter on Shunt Quantification and Flow Calculations#20:360-365Textbook of Clinical Echocardiography#.

NEW QUESTION # 84

Which finding is indicated by the arrow on this image?



- A. Left pleural effusion
- B. Ascites
- C. Pericardial effusion
- **D. Hiatal hernia**

Answer: D

Explanation:

Comprehensive and Detailed Explanation From Exact Extract:

The echocardiographic image shows a structure posterior to the left atrium, pointed to by the arrow. This is consistent with a hiatal hernia, which often appears as an echolucent or mixed echogenicity structure behind the left atrium in the parasternal or apical views. Hiatal hernias occur when part of the stomach herniates through the esophageal hiatus of the diaphragm into the thoracic cavity and may mimic pericardial or pleural effusions on echocardiography.

Pericardial effusions appear as an anechoic (dark) space surrounding the heart but usually anterior or around the entire heart rather than posterior localized structure. Left pleural effusions also appear posteriorly but typically have different echogenicity and anatomical location. Ascites refers to free fluid in the abdomen and would not appear in this thoracic echocardiographic window.

Recognition of hiatal hernia on echocardiography is important to avoid misdiagnosis, as it may cause artifacts or false-positive effusions. The presence of swirling or movement of echogenic material with respiration and positional changes helps in diagnosis. This finding is described in the "Textbook of Clinical Echocardiography, 6e" (Catherine M. Otto), Chapter on Pericardial Disease and Miscellaneous Echocardiographic Findings, including differential diagnosis of echolucent areas around the heart#20:280-285Textbook of Clinical Echocardiography#.

NEW QUESTION # 85

Mid to distal septal akinesis in post-stress imaging of the apical four-chamber view is suggestive of disease in which coronary artery?

- **A. Left anterior descending**
- B. Left circumflex
- C. Obtuse marginal
- D. Posterior descending

Answer: A

Explanation:

The mid to distal interventricular septum is supplied predominantly by the left anterior descending (LAD) coronary artery. Post-stress echocardiography showing akinesis or hypokinesis of these segments is highly suggestive of ischemia or infarction in the LAD territory.

The posterior descending artery supplies the inferior wall, the obtuse marginal supplies lateral walls, and the left circumflex supplies lateral and posterior walls.

This coronary artery segmental relationship is a cornerstone of ischemic heart disease evaluation by stress echocardiography and is well documented in ASE guidelines and clinical echocardiography literature#16:

Textbook of Clinical Echocardiography, 6ep.380-385##12:ASE Stress Echocardiography Guidelinesp.300-310#.

NEW QUESTION # 86

Which color Doppler adjustment would optimize visualization of flow across the interatrial septum?

- A. Increased wall filter
- B. Increased color sector size
- **C. Decreased color scale**
- D. Decreased color gain

Answer: C

Explanation:

Decreasing the color scale (velocity range) improves the sensitivity of color Doppler for detecting low- velocity flow, such as shunting across the interatrial septum (e.g., patent foramen ovale). A lower scale allows subtle flow jets to be visualized.

Decreasing color gain would reduce sensitivity, increasing color sector size can degrade frame rate and resolution, and increasing the wall filter may remove low-velocity signals.

This optimization is discussed in the "Textbook of Clinical Echocardiography, 6e", Chapter on Color Doppler Imaging

NEW QUESTION # 87

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