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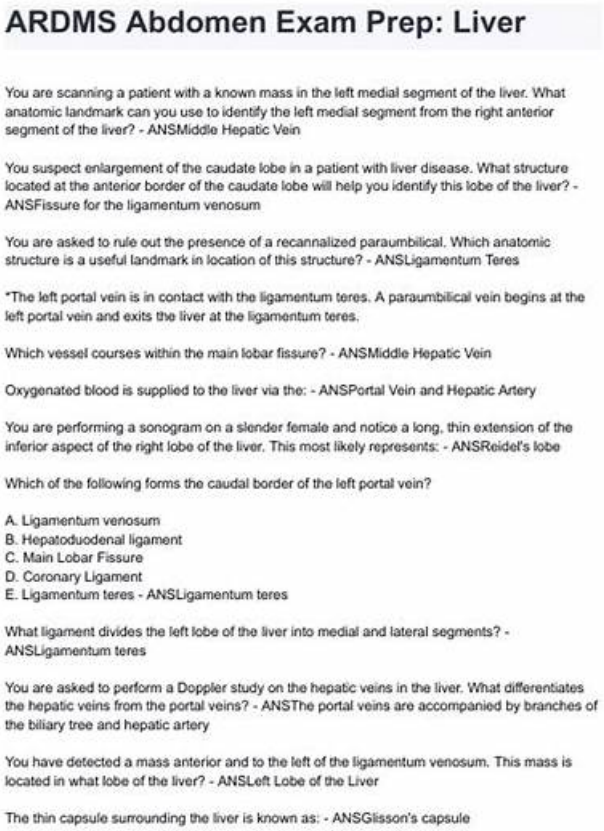

ARDMS Abdomen Exam Prep: Liver

You are scanning a patient with a known mass in the left medial segment of the liver. What anatomic landmark can you use to identify the left medial segment from the right anterior segment of the liver? - ANSMiddle Hepatic Vein

You suspect enlargement of the caudate lobe in a patient with liver disease. What structure located at the anterior border of the caudate lobe will help you identify this lobe of the liver? - ANSFissure for the ligamentum venosum

You are asked to rule out the presence of a recannalized paraumbilical. Which anatomic structure is a useful landmark in location of this structure? - ANSLigamentum Teres

*The left portal vein is in contact with the ligamentum teres. A paraumbilical vein begins at the left portal vein and exits the liver at the ligamentum teres.

Which vessel courses within the main lobar fissure? - ANSMiddle Hepatic Vein

Oxygenated blood is supplied to the liver via the: - ANSPortal Vein and Hepatic Artery

You are performing a sonogram on a slender female and notice a long, thin extension of the inferior aspect of the right lobe of the liver. This most likely represents: - ANSReidel's lobe

Which of the following forms the caudal border of the left portal vein?

A. Ligamentum venosum
B. Hepatoduodenal ligament
C. Main Lobar Fissure
D. Coronary Ligament
E. Ligamentum teres - ANSLigamentum teres

What ligament divides the left lobe of the liver into medial and lateral segments? - ANSLigamentum teres

You are asked to perform a Doppler study on the hepatic veins in the liver. What differentiates the hepatic veins from the portal veins? - ANSThe portal veins are accompanied by branches of the biliary tree and hepatic artery

You have detected a mass anterior and to the left of the ligamentum venosum. This mass is located in what lobe of the liver? - ANSLeft Lobe of the Liver

The thin capsule surrounding the liver is known as: - ANSGlisson's capsule

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ARDMS Abdomen Sonography Examination Sample Questions (Q147-Q152):

NEW QUESTION # 147
A lactating female presents with a tender, swollen breast, erythema, and fever. Which condition is most likely present in this image?

- A. Mastitis
- B. Galactocele
- C. Abscess
- D. Ductal carcinoma

Answer: A

Explanation:
The clinical presentation-tender, swollen breast with erythema and fever-in a lactating female strongly suggests acute mastitis. The sonographic findings support this diagnosis. In the image, the breast parenchyma shows diffuse, hypoechoic, and heterogeneous echotexture with increased vascularity, which is consistent with inflammatory changes typical of mastitis.
Mastitis is a common complication during lactation, particularly in the first few weeks postpartum. It results from milk stasis and subsequent bacterial infection, commonly due to Staphylococcus aureus. Ultrasound features of mastitis include:
* Ill-defined, hypoechoic, edematous areas in the breast parenchyma
* Increased Doppler flow due to hyperemia
* Skin thickening
* Ductal dilatation may also be present
If left untreated, mastitis may progress to abscess formation, which would appear as a localized, complex fluid collection with peripheral hyperemia and internal debris. However, the image does not show a well- formed fluid collection consistent with abscess.
Option B (Ductal carcinoma): Inappropriate here due to the acute clinical scenario and patient age. Ductal carcinoma typically presents as a hypoechoic mass with irregular margins and posterior shadowing, not diffuse edema or inflammatory changes.
Option D (Galactocele): This benign milk-filled retention cyst typically appears anechoic or with fluid-fluid levels but lacks signs of inflammation and systemic symptoms such as fever.
Option A (Abscess): This could be a differential, but abscesses usually present with a well-defined anechoic or complex mass. The absence of a discrete collection and the diffuse appearance makes mastitis more likely.
References:
Mendelson EB. Practical Ultrasound: An Illustrated Guide. Springer, 2004. Chapter: Breast Ultrasound.

American College of Radiology (ACR). ACR Practice Parameter for the Performance of a Breast Ultrasound Examination, 2022.
Rumack CM, Wilson SR, Charboneau JW, Levine D. Diagnostic Ultrasound. 5th Edition. Elsevier, 2018.
Chapter: Breast, pp. 1169-1175.

NEW QUESTION # 148
Which vascular condition is most commonly associated with a wandering spleen?

- A. Torsion
- B. Portal hypertension
- C. Infarction
- D. Rupture

Answer: A

Explanation:
A wandering spleen occurs when the spleen is not adequately anchored by its supporting ligaments, allowing it to move freely within the abdomen. This increases the risk of splenic torsion, which compromises vascular supply and may result in infarction if not corrected.
According to Rumack's Diagnostic Ultrasound:
"The most serious complication of a wandering spleen is torsion, which may result in splenic infarction." Reference:
Rumack CM, Wilson SR, Charboneau JW, Levine D. Diagnostic Ultrasound. 5th ed. Elsevier, 2017.
Moore KL, Clinically Oriented Anatomy. 8th ed. Wolters Kluwer, 2018.
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NEW QUESTION # 149
Which cause of transudative pleural effusion is most common?

- A. Lymphoma
- B. Empyema
- C. Pulmonary emboli
- D. Congestive heart failure

Answer: D

Explanation:
Transudative pleural effusions result from imbalances in hydrostatic and oncotic pressures, most commonly caused by congestive heart failure (CHF). In CHF, elevated hydrostatic pressure in the pulmonary capillaries leads to fluid leakage into the pleural space without significant protein or cellular content (hence, transudate).
Exudative effusions (associated with infections, malignancy, and inflammation) are more often seen with pulmonary emboli, lymphoma, or empyema.
According to Light's criteria (which differentiates transudates from exudates):
"Congestive heart failure remains the leading cause of transudative pleural effusions." (Light RW. Pleural Diseases, 6th ed.).
Reference:
Light RW. Pleural Diseases. 6th ed. Lippincott Williams & Wilkins, 2013.
American Thoracic Society Guidelines for Diagnosis and Management of Pleural Effusion, 2019.
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NEW QUESTION # 150
Which structure is most likely shown in this image of the right lower quadrant?

- A. Jejunum
- B. Fallopian tube
- C. Ureter
- D. Appendix

Answer: D

Explanation:
The ultrasound image shows a blind-ending, non-compressible, tubular structure in the right lower quadrant with a target or bullseye appearance in transverse section - highly suggestive of the appendix.
Sonographic features of the appendix (especially in suspected appendicitis):
* Blind-ending tubular structure arising from the cecum
* Non-compressible on graded compression
* Diameter >6 mm is suggestive of appendicitis
* May demonstrate a "target sign" in transverse view (concentric ring-like appearance)
* Increased echogenicity of surrounding fat in cases of inflammation
* May contain an appendicolith or show hyperemia on color Doppler if inflamed The location (right lower quadrant) and appearance in this case are classic for the normal or potentially inflamed appendix.
Differentiation from other options:
* A. Fallopian tube: Located more in the adnexal regions and usually not visible unless distended (e.g., hydrosalpinx).
* B. Ureter: Usually not visualized on ultrasound unless dilated due to obstruction.
* D. Jejunum: Has valvulae conniventes ("keyboard sign") and peristalsis; does not present with a blind- ending tubular appearance from the cecum.
References:
Rumack CM, Wilson SR, Charboneau JW, Levine D. Diagnostic Ultrasound. 5th Edition. Elsevier, 2018.
Chapter: Gastrointestinal Tract, pp. 460-468.
American College of Radiology (ACR). ACR Appropriateness Criteria - Right Lower Quadrant Pain - Suspected Appendicitis.
AIUM Practice Parameter for the Performance of a Pediatric Abdominal and/or Retroperitoneal Ultrasound Examination, 2020.

NEW QUESTION # 151
Which condition results in the vascular abnormality shown in this image of a renal transplant?

- A. Renal vein thrombosis
- B. Iliac arteritis
- C. Renal artery stenosis
- D. Arteriovenous malformation

Answer: C

Explanation:
The Doppler ultrasound image shows an elevated peak systolic velocity (PSV) of 637 cm/s, an elevated end- diastolic velocity (EDV) of 312 cm/s, and a low resistive index (RI) of 0.51 at the arterial anastomosis of a renal transplant. These findings are characteristic of significant renal artery stenosis (RAS) at the transplant vascular anastomosis.
Key sonographic features of renal artery stenosis:
* Peak systolic velocity (PSV) > 250-300 cm/s at the stenotic segment (this case: 637 cm/s)
* Post-stenotic turbulence with spectral broadening
* Low resistive index (RI < 0.56 suggests downstream vasodilation)
* Elevated acceleration time (AT > 0.07 sec), and reduced acceleration slope
* Aliasing on color Doppler due to high velocity
In this image, the marked increase in velocity with spectral aliasing and low RI is diagnostic of transplant renal artery stenosis - the most common vascular complication post-transplant, typically occurring at the site of surgical anastomosis.
Differentiation from other options:
* A. Iliac arteritis: A rare condition, not typically presenting with these Doppler changes.
* C. Renal vein thrombosis: Would show reversed or absent diastolic flow, not elevated systolic velocities.
* D. Arteriovenous malformation (AVM): Produces a high-velocity, low-resistance waveform but is associated with color bruit, aliasing, and pulsatile venous waveforms - not evident here.
References:
Rumack CM, Wilson SR, Charboneau JW, Levine D. Diagnostic Ultrasound. 5th Edition. Elsevier, 2018.
Chapter: Transplant Imaging, pp. 1035-1045.
American Institute of Ultrasound in Medicine (AIUM). Practice Parameter for the Performance of a Renal Artery Duplex Sonographic Examination, 2020.
Radiopaedia.org. Renal artery stenosis (transplant): https://radiopaedia.org/articles/renal-artery-stenosis- transplant

NEW QUESTION # 152
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