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ARDMS AB-Abdomen Exam Syllabus Topics:

Topic	Details
Topic 1	• Abdominal Physics: This section of the exam measures the knowledge of ultrasound technicians in applying imaging physics principles to abdominal sonography. It includes understanding how to optimize ultrasound equipment settings for the best image quality and how to identify and correct imaging artifacts that can distort interpretation. Candidates should demonstrate technical proficiency in handling transducers, adjusting frequency, and managing depth and gain to obtain clear, diagnostic-quality images while minimizing errors caused by acoustic artifacts.
Topic 2	• Pathology, Vascular Abnormalities, Trauma, and Postoperative Anatomy: This section of the exam evaluates the abilities of diagnostic medical sonographers and covers the detection and analysis of diseases, vascular issues, trauma-related damage, and surgical alterations in abdominal anatomy. Candidates are expected to identify abnormal growths, inflammations, obstructions, or vascular irregularities that may affect abdominal organs. They must also recognize post-surgical changes and assess healing or complications through imaging. The emphasis is on correlating pathological findings with clinical data to produce precise diagnostic reports that guide further medical management.

Topic 3	• Clinical Care, Practice, and Quality Assurance: This section of the exam tests the competencies of clinical ultrasound specialists and focuses on integrating patient care standards, clinical data, and procedural accuracy in abdominal imaging. It assesses the candidate ability to follow established medical guidelines, ensure correct measurements, and provide assistance during interventional or diagnostic procedures. Additionally, this domain emphasizes maintaining high-quality imaging practices and ensuring patient safety. Effective communication, adherence to protocols, and continuous quality improvement are key aspects of this section.
Topic 4	• Anatomy, Perfusion, and Function: This section of the exam measures the skills of abdominal sonographers and focuses on evaluating the physical characteristics, blood flow, and overall function of abdominal structures. Candidates must understand how to assess organs such as the liver, kidneys, pancreas, and spleen for size, shape, and movement. It also involves analyzing perfusion to determine how effectively blood circulates through these organs. The goal is to ensure accurate interpretation of both normal and abnormal functions within the abdominal cavity using sonographic imaging.

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ARDMS Abdomen Sonography Examination Sample Questions (Q144-Q149):

NEW QUESTION # 144
Which condition is most likely depicted in this image?

- A. Bowel obstruction
- B. Intussusception
- C. Appendicitis
- D. Diverticulitis

Answer: B

Explanation:
The ultrasound image shows a classic "target sign" or "donut sign," characterized by concentric rings of alternating echogenicity. This sonographic finding is pathognomonic for intussusception, particularly when seen in the transverse plane.
Intussusception occurs when a segment of bowel telescopes into an adjacent segment, typically in children aged 6 months to 3 years. It commonly presents with intermittent abdominal pain, vomiting, and sometimes
"red currant jelly" stools.
Key ultrasound features of intussusception:
* Target sign in transverse view (concentric rings of bowel layers)
* Pseudokidney or sandwich sign in longitudinal view
* May show intraluminal mesenteric fat or vessels dragged in with the intussusceptum Comparison of answer choices:
* A. Bowel obstruction may show dilated loops of bowel with air-fluid levels and to-and-fro peristalsis but lacks the concentric ring sign.
* B. Diverticulitis typically shows bowel wall thickening and pericolic fat stranding; not the concentric target appearance.
* C. Appendicitis may appear as a blind-ending tubular structure (>6 mm), not with concentric ring pattern.
* D. Intussusception - Correct. The image demonstrates the classic target sign seen with this condition.
References:
Coley BD. US of gastrointestinal tract abnormalities in infants and children. Radiographics. 2005;25(1):27-47.
Rumack CM, Wilson SR, Charboneau JW, Levine D. Diagnostic Ultrasound, 5th ed. Elsevier; 2017.
AIUM Practice Parameter for the Performance of Pediatric Ultrasound (2021).

NEW QUESTION # 145
Which hernia characteristic is demonstrated in these images?

- A. Reducible
- B. Strangulated
- C. Incarcerated
- D. Fat only

Answer: A

Explanation:
The ultrasound images show two views of the same groin region - one without compression (left image labeled "W/O COMPRESSION") and one with graded probe compression (right image labeled "W/ COMPRESSION").
In the non-compression image, a hypoechoic mass-like structure is visible protruding through the abdominal wall, consistent with a hernia sac. On the compression image, the herniated content is no longer visible, indicating that the contents have been pushed back into the abdominal cavity. This is the hallmark feature of a reducible hernia.
Key characteristics of a reducible hernia on ultrasound:
* Herniated contents are visible without pressure.
* Contents disappear or reduce back into the abdomen with graded probe compression or Valsalva release.
* Typically includes omental fat or bowel, but reduction confirms lack of incarceration or strangulation.

Comparison of answer choices:
* A. Fat only refers to the hernia content type, not the behavior or reducibility shown here.
* B. Reducible - Correct. The change in hernia appearance between images demonstrates successful reduction with compression.
* C. Incarcerated hernia would remain visible and not compressible or reducible.
* D. Strangulated hernia would show signs of ischemia (bowel wall thickening, absent perfusion, hyperechoic mesentery), and would also not reduce with compression.
References:
Radswiki. Ultrasound evaluation of hernia. Radiopaedia.org
Rumack CM, Wilson SR, Charboneau JW, Levine D. Diagnostic Ultrasound, 5th ed. Elsevier; 2017.
AIUM Practice Parameter for the Performance of a Focused Ultrasound Examination for Hernia (2021)

NEW QUESTION # 146
Which thyroid condition is most likely caused by a viral infection?

- A. De Quervain
- B. Hashimoto
- C. Abscess
- D. Graves

Answer: A

Explanation:
De Quervain thyroiditis (subacute granulomatous thyroiditis) is often triggered by a viral infection. Patients may present with painful thyroid enlargement, elevated inflammatory markers, and transient hyperthyroidism.
Hashimoto's and Graves' diseases are autoimmune in nature.
According to Braverman's The Thyroid:
"Subacute (De Quervain) thyroiditis typically follows a viral upper respiratory tract infection and is characterized by thyroid pain and transient thyrotoxicosis." Reference:
Braverman LE, Cooper DS. The Thyroid: A Fundamental and Clinical Text. 11th ed. Wolters Kluwer, 2021.
American Thyroid Association Guidelines, 2016.

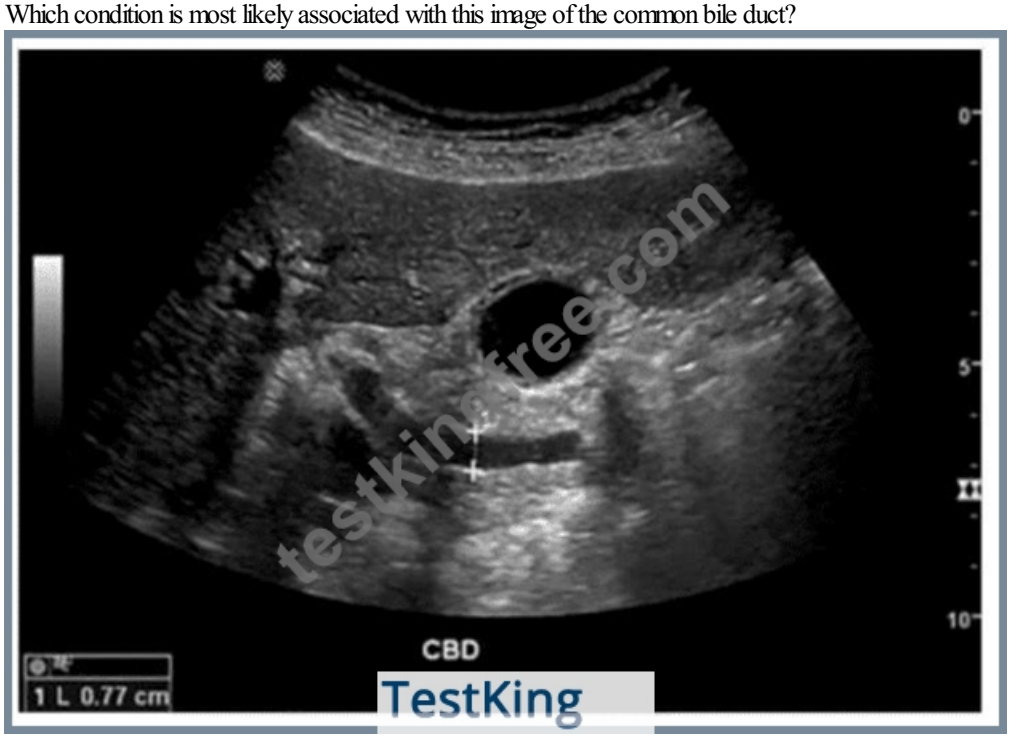
NEW QUESTION # 147
Which vascular condition is most likely associated with the sonographic findings demonstrated in this image?

- A. Splenic artery aneurysm
- B. Budd-Chiari syndrome
- C. Median arcuate ligament syndrome
- D. Recanalized umbilical vein

Answer: D

Explanation:
The ultrasound image demonstrates a tubular, anechoic structure coursing anterior to the left portal vein and heading toward the anterior abdominal wall. This is consistent with a recanalized umbilical vein, which is an important collateral pathway that reopens in cases of portal hypertension.
Normally, the umbilical vein becomes obliterated after birth and forms the ligamentum teres. However, in the setting of significant portal hypertension, the umbilical vein may recanalize and serve as a collateral route to decompress the portal system.
Sonographic features of a recanalized umbilical vein:
* Anechoic, tubular structure in the ligamentum teres fissure
* Seen anterior to the left portal vein
* Color Doppler confirms hepatofugal venous flow
* Associated with signs of portal hypertension (e.g., splenomegaly, varices) Differentiation from other options:
* A. Budd-Chiari syndrome: Involves hepatic vein outflow obstruction; ultrasound shows absent or narrowed hepatic veins and may have caudate lobe hypertrophy.
* B. Splenic artery aneurysm: Typically visualized near the splenic hilum as a pulsatile cystic mass; Doppler shows arterial flow.
* D. Median arcuate ligament syndrome: Involves compression of the celiac axis; best assessed with Doppler showing elevated velocities on expiration.
References:
Rumack CM, Wilson SR, Charboneau JW, Levine D. Diagnostic Ultrasound. 5th Edition. Elsevier, 2018.
Chapter: Portal Hypertension and Collaterals, pp. 101-104.
American Institute of Ultrasound in Medicine (AIUM). Practice Parameter for the Performance of a Vascular Ultrasound Examination, 2020.
Radiopaedia.org. Recanalized umbilical vein: https://radiopaedia.org/articles/recanalised-umbilical-vein

NEW QUESTION # 148
Which condition is most likely associated with this image of the common bile duct?



- A. Cystic duct stone
- B. Pancreatic head mass
- C. Gallbladder stones
- D. Liver mass

Answer: B

Explanation:
The ultrasound image demonstrates a dilated common bile duct (CBD), measuring approximately 7.7 mm in diameter. A normal CBD should generally measure less than 6 mm in a patient under 60 years old and may increase approximately 1 mm per decade thereafter or after cholecystectomy.
In the absence of gallstones within the CBD, one of the most concerning causes of CBD dilation is distal obstruction due to an

extrinsic compressive lesion. The most common and clinically significant cause of distal CBD obstruction is a mass at the head of the pancreas.
A pancreatic head mass (e.g., adenocarcinoma) may compress the distal CBD and pancreatic duct simultaneously, resulting in the "double duct sign" - dilation of both the CBD and pancreatic duct. This is a classic finding in pancreatic cancer.
Comparison of answer choices:
* A. Liver mass - unlikely to cause isolated CBD dilation unless invading the porta hepatis.
* B. Cystic duct stone - may cause gallbladder hydrops but typically not CBD dilation unless Mirizzi syndrome is present.
* C. Pancreatic head mass - Correct. This is the most likely cause of painless progressive CBD dilation without visible intraductal stones.
* D. Gallbladder stones - These may be associated with biliary colic or cholecystitis but typically do not cause CBD dilation unless the stone has migrated and obstructed the distal duct.
References:
Rumack CM, Wilson SR, Charboneau JW, Levine D. Diagnostic Ultrasound, 5th ed. Elsevier; 2017.
Lee JK, Sagel SS, Stanley RJ.Computed Body Tomography with MRI Correlation, 4th ed. Lippincott Williams & Wilkins; 2006.
ACR Appropriateness Criteria Right Upper Quadrant Pain (2021).

NEW QUESTION # 149
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