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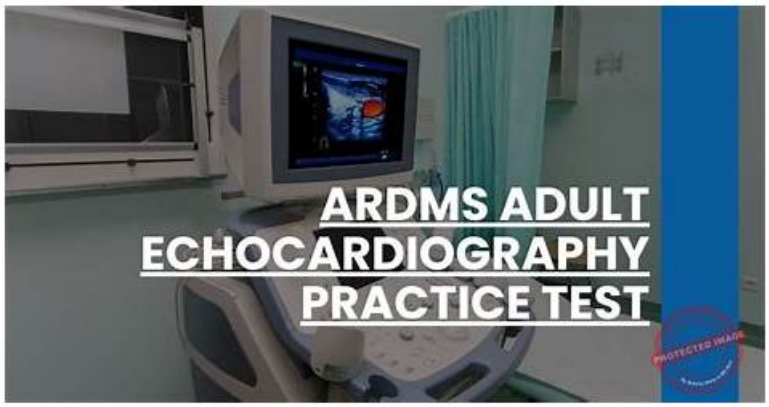

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ARDMS AE Adult Echocardiography Examination Sample Questions (Q73-Q78):

NEW QUESTION # 73
Which of the following is a feature of constrictive pericarditis?

- A. Normal hepatic vein size
- B. Interventricular septal bounce
- C. Dilated inferior vena cava with inspiratory collapse during sniff test
- 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 # 74
In which view is the superior vena cava visualized in its long axis?

- A. Subcostal four-chamber
- B. Suprasternal notch
- C. Parasternal long axis
- D. Apical five-chamber

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract:
The superior vena cava (SVC) is best visualized in its long axis from the suprasternal notch window. This approach provides a longitudinal view of the great vessels including the aortic arch and the SVC entering the right atrium. Other standard transthoracic echocardiographic views such as the parasternal long axis or apical views do not provide clear visualization of the SVC in its long axis. The subcostal four-chamber view typically shows the inferior vena cava but not the superior vena cava.
The suprasternal notch window is particularly useful for evaluating flow and anatomy in the SVC and the ascending aorta. This view allows clear identification of the vessel course as it enters the right atrium, making it valuable in assessment of venous return and possible pathologies involving the SVC.
This is supported in the echocardiography text under the description of transthoracic views for major venous structures and great vessels, which identifies the suprasternal notch as the best window for the long-axis visualization of the superior vena cava.

NEW QUESTION # 75
Which flow component is indicated by the arrows on this image?

- A. Atrial reversal
- B. Diastolic flow reversal
- C. Ventricular reversal
- D. Systolic forward flow

Answer: A

Explanation:
The Doppler waveform shows pulmonary vein flow with several components. The arrows point to small reversed flow spikes just

after the atrial contraction wave, which corresponds to the atrial reversal (AR) flow component. Atrial reversal occurs as blood briefly flows backward into the pulmonary veins during atrial contraction.
Ventricular reversal is not typically seen in pulmonary veins. Diastolic flow reversal is abnormal and usually not part of normal pulmonary vein flow. Systolic forward flow is the major forward component during ventricular systole.
This interpretation is standard in ASE guidelines on diastolic function assessment and pulmonary vein Doppler evaluation#12:ASE Diastolic Function Guidelinesp.85-90##16:Textbook of Clinical Echocardiography, 6ep.130-135#.

NEW QUESTION # 76
Which congenital abnormality is most consistent with the findings in this video?

- A. Ventricular septal defect
- B. Ebstein anomaly
- C. Patent foramen ovale
- D. Eisenmenger syndrome

Answer: B

Explanation:
The video shows an apical four-chamber or subcostal echocardiographic view demonstrating a markedly enlarged right atrium with atrialization of part of the right ventricle, displacement of the tricuspid valve septal leaflet downward into the RV cavity, and severe tricuspid regurgitation. These findings are hallmark features of Ebstein anomaly, a congenital malformation of the tricuspid valve causing apical displacement of the septal and posterior leaflets.
Patent foramen ovale and ventricular septal defects have different echocardiographic features without tricuspid leaflet displacement. Eisenmenger syndrome refers to advanced pulmonary hypertension due to shunts but is not a specific congenital structural abnormality.
These diagnostic criteria and echocardiographic hallmarks are described in adult congenital heart disease literature and echocardiography textbooks#16:Textbook of Clinical Echocardiography, 6ep.570-575##12:
ASE Adult Congenital Guidelinesp.400-405#.

NEW QUESTION # 77
During which phase of the cardiac cycle does mitral valve prolapse occur?

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

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 # 78
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