

ACCSAP CCKE CORONARY ARTERY DISEASE (CAD): RISK STRATIFICATION AND PREVENTION PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Which of the following is most clearly an indication for carotid duplex ultrasound?**
 - A. Headache
 - B. Normal neurological examination
 - C. Pulmonary hypertension
 - D. Cervical bruit
- 2. What is the gold standard for the diagnosis of HFpEF?**
 - A. Exercise PCWP during supine bicycling with VO₂ monitoring and right heart catheterization
 - B. Resting PCWP measured at baseline conditions
 - C. Echocardiography alone
 - D. Cardiac MRI at rest
- 3. Which imaging combination is considered best for suspected cardiac sarcoidosis?**
 - A. Echocardiography alone
 - B. CMR-LGE and PET-CT with FDG
 - C. CT angiography and perfusion scan
 - D. MRI without contrast and CT
- 4. Which of the following is NOT a mechanical therapy option for hypertrophic obstructive cardiomyopathy?**
 - A. Dual-chamber pacing
 - B. Alcohol septal ablation
 - C. Beta-blocker therapy
 - D. Open surgical myectomy
- 5. In risk assessment, which tool can be used to further refine risk stratification for a patient with 5-20% 10-year ASCVD risk?**
 - A. Echocardiography
 - B. CAC scoring
 - C. Stress testing
 - D. Holter monitoring

- 6. Which statement best describes the relationship between plaque severity and myocardial infarction risk?**
- A. Most MIs occur in plaques with less than 50% stenosis
 - B. Most MIs occur in plaques with >70% stenosis
 - C. MIs only occur with 100% occlusion
 - D. Plaque severity does not influence MI risk
- 7. Which intervention would improve contractile function in hibernating myocardium?**
- A. Induce ischemia
 - B. Increase heart rate alone
 - C. Ignore perfusion defects
 - D. Favorably alter the supply-demand relationship by improving blood flow or reducing demand
- 8. A 65-year-old man with a 21% 10-year ASCVD risk should receive which type of statin therapy?**
- A. Moderate-intensity statin
 - B. No statin needed
 - C. Low-intensity statin
 - D. Initiate high-intensity statin
- 9. What is the screening timing indicated for AAA with diameter 3.0-3.9 cm?**
- A. 6 months
 - B. 12 months
 - C. 24 months
 - D. 3 months
- 10. What exercise intensity is recommended for patients undergoing cardiac rehab or home rehab after an MI, CHF, or similar condition?**
- A. Very vigorous activity is recommended
 - B. Moderate-to-vigorous activity must be performed daily
 - C. Only light walking is recommended
 - D. Mild to moderate activity that passes the 'talk test'

Answers

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1. D
2. A
3. B
4. C
5. B
6. A
7. D
8. D
9. B
10. D

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Explanations

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1. Which of the following is most clearly an indication for carotid duplex ultrasound?

- A. Headache
- B. Normal neurological examination
- C. Pulmonary hypertension
- D. Cervical bruit**

A cervical bruit on physical exam is the clearest sign that carotid artery disease might be present and warrants carotid duplex ultrasound. A bruit implies turbulent blood flow from a narrowed carotid artery, and duplex ultrasound is the noninvasive test that both visualizes the artery and measures blood flow velocities to estimate the degree of stenosis. This helps stratify stroke risk and guide management. Headache is a nonspecific symptom and does not by itself indicate carotid stenosis, especially with a normal neurological exam. Pulmonary hypertension relates to the heart and lungs, not the carotid arteries, so it doesn't prompt carotid imaging. A normal neurological examination lowers the likelihood of acute carotid-related stroke but does not specifically indicate imaging for carotids. Thus, the presence of a cervical bruit best signals the need for carotid duplex ultrasound.

2. What is the gold standard for the diagnosis of HFpEF?

- A. Exercise PCWP during supine bicycling with VO₂ monitoring and right heart catheterization**
- B. Resting PCWP measured at baseline conditions
- C. Echocardiography alone
- D. Cardiac MRI at rest

Diagnosing HFpEF relies on demonstrating elevated left-sided filling pressures during exertion, because symptoms typically appear with activity even when the ejection fraction is preserved. The most definitive way to prove this is through invasive hemodynamic testing during exercise: right heart catheterization with supine bicycling and simultaneous VO₂ monitoring to measure the pulmonary capillary wedge pressure as the patient exercises. This directly shows how filling pressures rise with increased demand, which is the hallmark of HFpEF. Resting measurements can miss the problem, since filling pressures may be normal at rest despite abnormal diastolic reserve. Echocardiography and other imaging can assess structure and some function, but they cannot confirm abnormal filling pressures during exercise on their own. Cardiac MRI at rest provides anatomy and function but not the dynamic, exercise-induced hemodynamic response. Hence, exercise PCWP measured invasively is the gold standard for establishing HFpEF.

3. Which imaging combination is considered best for suspected cardiac sarcoidosis?

- A. Echocardiography alone
- B. CMR-LGE and PET-CT with FDG**
- C. CT angiography and perfusion scan
- D. MRI without contrast and CT

For suspected cardiac sarcoidosis you want to know both where the heart has scar from prior inflammation and where there is currently active inflammation. Cardiac MRI with late gadolinium enhancement (LGE) is excellent at mapping scar and fibrosis, showing patchy, often basal or mid-wall LGE patterns and giving precise details about ventricular function. But MRI alone may miss areas of ongoing inflammation if there isn't substantial scarring yet. FDG-PET CT adds metabolic insight by highlighting areas with active inflammatory activity, as those regions take up glucose highlighted by the tracer. With proper patient preparation to minimize normal myocardial glucose uptake, PET-CT can detect active disease that MRI might miss and can also reveal activity in other organs outside the heart, which helps confirm systemic sarcoidosis. Using both together combines their strengths: MRI defines structural involvement and functional impact, while PET-CT identifies active inflammation. This synergy increases diagnostic confidence, helps distinguish active disease from scar, and guides treatment decisions, such as whether to intensify immunosuppression and how to monitor response over time. That broader, more actionable information is why this imaging pair is considered the best approach for suspected cardiac sarcoidosis.

4. Which of the following is NOT a mechanical therapy option for hypertrophic obstructive cardiomyopathy?

- A. Dual-chamber pacing
- B. Alcohol septal ablation
- C. Beta-blocker therapy**
- D. Open surgical myectomy

In hypertrophic obstructive cardiomyopathy, mechanical therapies are those that physically modify the outflow tract or septal anatomy. Dual-chamber pacing can alter the contraction sequence to reduce the LVOT gradient, alcohol septal ablation creates a controlled infarct to thin the septum, and open surgical myectomy surgically removes thickened septal tissue. Beta-blocker therapy is pharmacologic, aiming to reduce heart rate and contractility to lessen obstruction but it does not change the anatomy or physically relieve the obstruction. Therefore, beta-blocker therapy is not a mechanical treatment.

5. In risk assessment, which tool can be used to further refine risk stratification for a patient with 5-20% 10-year ASCVD risk?

- A. Echocardiography
- B. CAC scoring**
- C. Stress testing
- D. Holter monitoring

Coronary artery calcium scoring uses a CT scan to measure calcified plaque in the coronary arteries. In people with an intermediate 10-year ASCVD risk (around 5-20%), this test adds prognostic information beyond traditional risk factors and helps reclassify risk to guide preventive therapy. A zero CAC score can suggest lower short-term risk and may support a less aggressive approach if risk factors are favorable, while any detectable calcium indicates higher risk and can push toward initiating or intensifying statin therapy. Echocardiography, stress testing, and Holter monitoring assess heart structure, ischemia, or rhythm, not long-term ASCVD risk in asymptomatic individuals. Therefore, CAC scoring is the most appropriate tool to refine risk in this scenario.

6. Which statement best describes the relationship between plaque severity and myocardial infarction risk?

- A. Most MIs occur in plaques with less than 50% stenosis**
- B. Most MIs occur in plaques with >70% stenosis
- C. MIs only occur with 100% occlusion
- D. Plaque severity does not influence MI risk

Most myocardial infarctions arise from rupture of a vulnerable plaque that is not severely narrowed, meaning the culprit lesion often has only modest stenosis. A plaque with a thin fibrous cap and a large lipid-rich core is prone to rupture; when rupture occurs, platelets aggregate and a thrombus forms, which can abruptly occlude the vessel and trigger an MI even if the baseline lumen narrowing was not severe. This is why data consistently show that many MIs originate from plaques with less than 50% stenosis. So, the statement that most MIs occur in plaques with less than 50% stenosis captures the idea that instability and rupture, not the degree of narrowing alone, drive acute infarctions. In contrast, very high-grade stenosis (>70%) is more associated with chronic symptoms and may contribute to ischemia, but it is not the predominant driver of acute MI. MIs can occur without complete occlusion; a thrombus can cause infarction even if the artery is not fully occluded at the moment of the event. Plaque severity does influence overall risk, but the acute risk from rupture of a non-severely narrowed plaque is a key concept here.

7. Which intervention would improve contractile function in hibernating myocardium?

- A. Induce ischemia
- B. Increase heart rate alone
- C. Ignore perfusion defects
- D. Favorably alter the supply-demand relationship by improving blood flow or reducing demand**

Hibernating myocardium is viable heart muscle that has reduced function because its blood supply is chronically limited. The way to improve its contractile function is to restore a favorable supply-demand balance, either by increasing blood flow to the affected region or by reducing the heart's oxygen needs. When perfusion is improved (for example, through revascularization) or myocardial oxygen demand is lowered (through medical therapy that decreases heart rate, wall stress, and afterload), the inhibited myocytes can regain contractile strength and function. Inducing more ischemia, increasing heart rate without improving supply, or ignoring the perfusion defects would all worsen or perpetuate dysfunction, whereas improving flow or decreasing demand directly addresses the underlying issue.

8. A 65-year-old man with a 21% 10-year ASCVD risk should receive which type of statin therapy?

- A. Moderate-intensity statin
- B. No statin needed
- C. Low-intensity statin
- D. Initiate high-intensity statin**

In primary prevention, when a patient's 10-year ASCVD risk is 20% or higher, high-intensity statin therapy is recommended because it achieves the largest reduction in LDL and the greatest drop in ASCVD events. A 65-year-old with a 21% risk falls into this high-risk category, so the goal is substantial LDL lowering (about 50% or more). Moderate-intensity statin would reduce risk but not as much, and low-intensity or no statin would miss the opportunity for the best preventive benefit. High-intensity options include atorvastatin 40–80 mg or rosuvastatin 20–40 mg, with ongoing monitoring for tolerance and side effects.

9. What is the screening timing indicated for AAA with diameter 3.0-3.9 cm?

- A. 6 months
- B. 12 months**
- C. 24 months
- D. 3 months

The main idea is that surveillance intervals for an abdominal aortic aneurysm depend on its size, since smaller aneurysms grow slowly and can be safely monitored with periodic imaging. For an aneurysm measuring 3.0 to 3.9 cm, the recommended follow-up imaging is every 12 months. This annual cadence reflects the typical slow growth rate and aims to detect any progression toward the repair threshold (about 5.5 cm or faster growth) without subjecting the patient to unnecessary testing. More frequent imaging isn't needed for this size unless there's evidence of rapid growth or other risk factors, and waiting longer than a year could miss meaningful changes.

10. What exercise intensity is recommended for patients undergoing cardiac rehab or home rehab after an MI, CHF, or similar condition?

- A. Very vigorous activity is recommended
- B. Moderate-to-vigorous activity must be performed daily
- C. Only light walking is recommended
- D. Mild to moderate activity that passes the 'talk test'**

The main idea here is that after a heart attack or in heart failure, exercise should be safely progressive and kept at a light to moderate level. A simple way to gauge that intensity is the talk test: you should be able to carry on a conversation during activity, but not sing or become severely breathless. This level typically corresponds to mild to moderate effort, roughly 40-60% of heart-rate reserve or VO2 reserve, and an RPE around 12-14 on the 6-20 scale. It provides enough stimulus to improve fitness while reducing the risk of ischemia or adverse events in rehab patients. Pushing into very vigorous activity early after MI or in heart failure raises risk and isn't necessary for beneficial outcomes. Limiting to only light walking might be too easy to drive meaningful improvements, and insisting on daily moderate-to-vigorous activity can be too demanding for many patients starting rehab. The talk-test-guided mild-to-moderate approach offers a safe, practical, and effective framework for initiating and progressing exercise in cardiac rehab and home rehab settings.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

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We wish you the very best on your exam journey. You've got this!

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