

ANTICOAGULATION AND ACS 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. What is CRUSADE used for in NSTEMI?**
 - A. To predict in-hospital major bleeding risk with antithrombotic therapy.
 - B. To predict risk of reinfarction.
 - C. To guide the choice of PCI device.
 - D. To determine time to discharge.
- 2. Which agent has a boxed warning for thrombotic events when used as prophylaxis in Hemophilia A?**
 - A. Desmopressin
 - B. Emicizumab
 - C. Factor VIII
 - D. Platelet transfusion
- 3. Before starting edoxaban after stopping warfarin, what INR threshold is required?**
 - A. $\text{INR} < 2.5$
 - B. $\text{INR} < 2$
 - C. $\text{INR} < 3$
 - D. $\text{INR} < 1.5$
- 4. Injectable anticoagulation indications include which scenario?**
 - A. Routine dental prophylaxis
 - B. Acute treatment of ACS
 - C. Long-term Afib prophylaxis
 - D. Chronic venous insufficiency management
- 5. What agent reverses unfractionated heparin?**
 - A. Vitamin K
 - B. Protamine sulfate
 - C. PCC
 - D. Idarucizumab

- 6. Which risk score is used to estimate mortality risk in ACS based on seven NSTEMI risk factors?**
- A. TIMI risk score for NSTEMI
 - B. GRACE score
 - C. CHA2DS2-VASc score
 - D. HEART score
- 7. Which drug has a loading dose of 60 mg in ACS?**
- A. Ticagrelor 60 mg
 - B. Prasugrel 60 mg
 - C. Clopidogrel 60 mg
 - D. Ticagrelor 180 mg
- 8. In atrial fibrillation stroke risk scoring, what is the threshold score for full anticoagulation?**
- A. 0
 - B. 1
 - C. 3 or more
 - D. 2 or more
- 9. What is the primary mechanism of GP IIb/IIIa inhibitors?**
- A. Prevent fibrinogen cross-linking
 - B. Inhibit ADP-induced platelet activation
 - C. Inhibit thrombin formation
 - D. Activate plasminogen
- 10. Which statement correctly differentiates unfractionated heparin from low molecular weight heparin regarding reversibility?**
- A. UFH is rapidly reversible with protamine; LMWH is only partially reversible with protamine
 - B. LMWH is rapidly reversible with protamine; UFH is not reversible
 - C. Both are fully reversible with protamine
 - D. Neither is reversible

Answers

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

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Explanations

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1. What is CRUSADE used for in NSTEMI?

- A. To predict in-hospital major bleeding risk with antithrombotic therapy.**
- B. To predict risk of reinfarction.
- C. To guide the choice of PCI device.
- D. To determine time to discharge.

CRUSADE is used to estimate the risk of major bleeding in NSTEMI patients who are treated with antithrombotic therapy during hospitalization. In NSTEMI, boosting antithrombotic therapy lowers ischemic risk but raises bleeding risk, so a validated bleeding risk score helps tailor treatment intensity and choices (anticoagulant strategy, antiplatelet regimen, vascular access decisions) to reduce bleeding while still protecting against ischemia. This score focuses on predicting bleeding, not reinfarction, device selection for PCI, or time to discharge.

2. Which agent has a boxed warning for thrombotic events when used as prophylaxis in Hemophilia A?

- A. Desmopressin
- B. Emicizumab**
- C. Factor VIII
- D. Platelet transfusion

The question tests safety labeling for prophylactic therapies in Hemophilia A, specifically a serious boxed warning for thrombotic events. Emicizumab is a bispecific antibody that substitutes the function of missing factor VIII to prevent bleeds in Hemophilia A, including in patients with inhibitors. A boxed warning exists for emicizumab when it is used concomitantly with activated prothrombin complex concentrates (aPCC) to treat bleeds or during breakthrough bleeding. In that combination, there can be excessive thrombin generation, leading to thrombotic microangiopathy and thrombotic events. This safety signal makes emicizumab the agent with a boxed warning for thrombotic events in this prophylaxis context. Desmopressin, factor VIII replacement, and platelet transfusion do not carry this specific boxed warning regarding thrombotic events with concurrent bypassing agents. Desmopressin raises endogenous factor VIII and von Willebrand factor and is generally not associated with that boxed risk profile; factor VIII concentrates can cause thrombosis in inappropriate high-dose or underlying conditions but do not have this particular boxed warning tied to prophylaxis with emicizumab; platelet transfusion is not a standard prophylactic approach for this issue and lacks this boxed warning context.

3. Before starting edoxaban after stopping warfarin, what INR threshold is required?

- A. INR < 2.5**
- B. INR < 2
- C. INR < 3
- D. INR < 1.5

When switching from warfarin to edoxaban, you want to avoid overlapping anticoagulant effects. Warfarin's effect is tracked by the INR, and starting a DOAC like edoxaban while the INR is still high risks excessive bleeding. The safe, recommended moment to begin edoxaban is once the INR has fallen to less than 2.5. At that point the residual warfarin effect is sufficiently reduced, allowing edoxaban to provide anticoagulation without excessive bleeding risk. If you wait longer, you still have protection from the DOAC, but you risk a longer gap; starting before the INR drops below 2.5 would increase bleeding risk due to overlapping effects.

4. Injectable anticoagulation indications include which scenario?

- A. Routine dental prophylaxis
- B. Acute treatment of ACS**
- C. Long-term Afib prophylaxis
- D. Chronic venous insufficiency management

Injectable anticoagulants are used when rapid, short-term anticoagulation is needed in acute, high-thrombotic-risk situations. In acute coronary syndrome, parenteral anticoagulation helps prevent further thrombus formation and works alongside antiplatelet therapy and reperfusion strategies. That makes it the appropriate indication among the options. Routine dental prophylaxis isn't an indication for starting injectable anticoagulation; dental care focuses on local hemostasis and may require adjusting existing anticoagulation, but it doesn't require initiating injectable anticoagulation. Long-term atrial fibrillation prevention is typically managed with oral anticoagulants (warfarin or DOACs) rather than injectable agents. Chronic venous insufficiency is managed with compression and other non-anticoagulation approaches.

5. What agent reverses unfractionated heparin?

- A. Vitamin K
- B. Protamine sulfate**
- C. PCC
- D. Idarucizumab

Reversing unfractionated heparin works by directly neutralizing the drug's effect. Heparin works by boosting antithrombin, which blocks thrombin and factor Xa. Protamine sulfate is a positively charged protein that binds to the negatively charged heparin, forming a stable complex and stopping heparin's anticoagulant action. Because of this direct neutralization, protamine sulfate is the standard reversal for unfractionated heparin. Vitamin K reverses warfarin by restoring production of vitamin K-dependent clotting factors, so it doesn't affect heparin. Prothrombin complex concentrate is used mainly to reverse warfarin, not to neutralize heparin. Idarucizumab specifically reverses the direct thrombin inhibitor dabigatran, not heparin.

6. Which risk score is used to estimate mortality risk in ACS based on seven NSTEMI risk factors?

- A. TIMI risk score for NSTEMI**
- B. GRACE score
- C. CHA2DS2-VASc score
- D. HEART score

In ACS risk stratification, the TIMI risk score for NSTEMI is the tool designed to estimate mortality risk using seven NSTEMI-specific factors. These seven are: age 65 or older, three or more cardiovascular risk factors, known coronary artery disease, aspirin use within the past 7 days, severe angina (three or more episodes in 24 hours), ST-segment deviation on the ECG, and positive cardiac biomarkers. Each factor adds points, and a higher total score corresponds to higher mortality risk and greater likelihood of adverse events, guiding decisions about aggressive therapy or invasive evaluation. The other scores serve different purposes or populations. GRACE provides broader in-hospital and post-discharge mortality risk and uses a mix of clinical and laboratory data, not framed specifically around seven NSTEMI factors. The HEART score uses four domains (History, ECG, Age, Risk factors) and is simpler, not seven-factor NSTEMI-specific. CHA2DS2-VASc is for estimating stroke risk in atrial fibrillation, not ACS mortality risk.

7. Which drug has a loading dose of 60 mg in ACS?

- A. Ticagrelor 60 mg
- B. Prasugrel 60 mg**
- C. Clopidogrel 60 mg
- D. Ticagrelor 180 mg

In acute coronary syndrome, choosing a P2Y₁₂ inhibitor involves understanding how quickly and strongly the drug blocks platelets. Prasugrel is given as a 60 mg loading dose to produce rapid and potent platelet inhibition, which is then followed by a 10 mg daily maintenance dose. This 60 mg loading dose is unique to prasugrel among the common options listed here. By contrast, ticagrelor uses a 180 mg loading dose to achieve fast onset, and clopidogrel typically uses a 300–600 mg loading dose with more variable activation. Therefore, prasugrel's 60 mg loading dose makes it the correct choice. (Note: prasugrel has safety considerations, such as avoidance in patients with prior stroke/TIA and caution in older age or low body weight.)

8. In atrial fibrillation stroke risk scoring, what is the threshold score for full anticoagulation?

- A. 0
- B. 1
- C. 3 or more
- D. 2 or more**

Strokes risk scoring in atrial fibrillation is used to decide who should receive anticoagulation. Each risk factor adds a point, so the total score reflects how high a patient's annual stroke risk is. When the total reaches two or more, anticoagulation is recommended because the benefit of preventing stroke generally outweighs the bleeding risk of therapy. This threshold integrates major factors like prior stroke/TIA (which adds substantial risk) and age, while other factors add smaller increments. In practice, a zero score typically means no anticoagulation, a single risk factor (score of one) is a case-by-case decision, and a score of two or more strongly supports full anticoagulation. Note that some guidelines adjust for female sex within the score, but the typical takeaway for a straightforward threshold is two or more.

9. What is the primary mechanism of GP IIb/IIIa inhibitors?

- A. Prevent fibrinogen cross-linking**
- B. Inhibit ADP-induced platelet activation
- C. Inhibit thrombin formation
- D. Activate plasminogen

GP IIb/IIIa inhibitors block the platelet receptor GP IIb/IIIa, preventing fibrinogen from binding and cross-linking activated platelets. This stops platelet aggregation at its final common pathway, regardless of how the platelets were activated (ADP, thrombin, collagen, etc.). Because of this central action, these drugs blunt aggregation rather than specifically inhibiting ADP signaling, thrombin formation, or plasminogen activation. The effect is most relevant during high-risk ACS and during PCI, where limiting platelet aggregation reduces thrombus formation.

10. Which statement correctly differentiates unfractionated heparin from low molecular weight heparin regarding reversibility?

- A. UFH is rapidly reversible with protamine; LMWH is only partially reversible with protamine
- B. LMWH is rapidly reversible with protamine; UFH is not reversible
- C. Both are fully reversible with protamine
- D. Neither is reversible

Reversal with protamine hinges on how strongly protamine can neutralize the anticoagulant. Unfractionated heparin has long, variable-length chains, so protamine binds it tightly and forms a stable complex that rapidly abolishes both anti-Xa and anti-IIa activities. That makes UFH effectively and quickly reversible with protamine. Low molecular weight heparin consists of shorter chains and mainly exerts its effect through anti-Xa activity with less impact on anti-IIa. Protamine can neutralize only part of its activity, and it's less effective at reversing the anti-Xa effect. As a result, reversal with protamine is incomplete and slower for LMWH. Clinically, this means UFH can be reversed quickly and nearly completely with protamine, whereas LMWH reversal is partial and not as rapid.

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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:

<https://anticoagulationacs.examzify.com>

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

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