

ECCO CARING FOR PATIENTS WITH CARDIOVASCULAR DISORDERS PART 1 PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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<https://eccocaringforcardiovasculardisorders1.examzify.com>



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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. A STEMI develops sudden difficulty in breathing, mental status change. The nurse should anticipate:**
 - A. Administer oxygen
 - B. Administer morphine
 - C. Administer diuretic
 - D. Prepare for endotracheal intubation and mechanical ventilation
- 2. What best describes the therapeutic effect of ACE inhibitors in heart failure?**
 - A. ACE inhibitors primarily improve preload
 - B. ACE inhibitors reduce afterload and mortality; monitor renal function and potassium
 - C. ACE inhibitors have no role in HF
 - D. ACE inhibitors worsen potassium levels
- 3. What is recommended exercise prescription for stable cardiovascular patients?**
 - A. Only light stretching once a week.
 - B. Moderate-intensity aerobic activity most days, 150 minutes per week, with resistance training; start gradually.
 - C. Vigorous daily exercise with no resistance training.
 - D. No exercise is recommended.
- 4. What is the clinical significance of D-dimer testing in suspected PE or DVT?**
 - A. It has high sensitivity but low specificity; a negative D-dimer can help rule out PE/DVT in low-risk patients.
 - B. It has high specificity but low sensitivity; a positive D-dimer confirms PE/DVT.
 - C. It directly visualizes clots in pulmonary arteries.
 - D. It is not useful in evaluating suspected thromboembolism.
- 5. What does a widened pulse pressure indicate in aortic regurgitation?**
 - A. Large difference between systolic and diastolic pressures due to regurgitant flow causing diastolic drop and systolic rise.
 - B. Narrowing of pulse pressure due to decreased stroke volume.
 - C. High diastolic pressure with low systolic.
 - D. No change in pulse pressure.

- 6. Which statement best describes the meaning of a high E/e' ratio on Doppler echocardiography?**
- A. It indicates lower LV filling pressures.
 - B. It indicates similar LV filling pressures as normal.
 - C. It indicates moderate LV filling pressures.
 - D. It indicates higher LV filling pressures.
- 7. What position is typically recommended to optimize ventilation in a patient with cardiogenic shock?**
- A. Trendelenburg
 - B. Semi-Fowler position
 - C. Prone
 - D. Supine flat
- 8. How would you recognize cardiogenic shock and what are the key initial management steps?**
- A. Hypotension with warm extremities; management includes IV fluids only.
 - B. Hypotension, cool clammy skin, reduced urine output, altered mental status; management includes vasopressors, inotropes, and reversing underlying cause.
 - C. Normal blood pressure with tachycardia; management includes beta-blockers.
 - D. Hypertension with warm skin; management includes diuretics only.
- 9. Which diagnostic test is primarily used to assess left ventricular ejection fraction in heart failure?**
- A. Echocardiography
 - B. Chest radiography
 - C. Electrocardiography
 - D. Cardiac MRI
- 10. To identify ACS, what information about chest discomfort should a nurse obtain?**
- A. Where is the discomfort and where does it radiate?
 - B. Did the discomfort start slowly or suddenly?
 - C. How long did it last?
 - D. All of the above

Answers

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

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Explanations

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1. A STEMI develops sudden difficulty in breathing, mental status change. The nurse should anticipate:

- A. Administer oxygen
- B. Administer morphine
- C. Administer diuretic

D. Prepare for endotracheal intubation and mechanical ventilation

When a STEMI patient suddenly develops difficulty breathing and a change in mental status, the immediate priority is securing the airway and ensuring adequate ventilation. These signs point to potential respiratory failure or impending airway compromise, and altered consciousness raises the risk of airway protection being lost. Endotracheal intubation with mechanical ventilation provides a controlled airway, improves oxygenation and CO₂ removal, and reduces the work of breathing, helping to stabilize both respiratory and hemodynamic status. Oxygen by itself may be necessary, but it doesn't protect the airway or rapidly correct severe respiratory failure. Morphine can depress respiration and lower blood pressure, which is undesirable in an acute MI with potential hemodynamic instability. A diuretic might help if there is fluid overload, but it does not address an acutely failing airway or respiratory drive. Therefore, preparing for airway protection and ventilation is the most appropriate action in this scenario.

2. What best describes the therapeutic effect of ACE inhibitors in heart failure?

A. ACE inhibitors primarily improve preload

B. ACE inhibitors reduce afterload and mortality; monitor renal function and potassium

C. ACE inhibitors have no role in HF

D. ACE inhibitors worsen potassium levels

ACE inhibitors in heart failure work by blocking the RAAS, which reduces angiotensin II-mediated vasoconstriction and aldosterone-driven sodium and water retention. This leads to vasodilation and a drop in afterload, making it easier for the heart to eject blood and improving forward flow. Over time, this neurohormonal modulation also slows adverse remodeling and lowers mortality in patients with reduced ejection fraction HF. The reason this option is the best is that it captures both the hemodynamic effect (reduced afterload) and the important clinical outcome (reduced mortality), along with a crucial safety consideration: renal function and potassium need to be monitored because ACE inhibitors can raise creatinine and potassium levels. This combination reflects both efficacy and real-world management. The other statements don't fit as well. ACE inhibitors do have a role in heart failure, not none. Their main action is afterload reduction rather than preload, though venodilation can modestly affect preload but is not the primary effect. While they can raise potassium, saying they always worsen potassium is an oversimplification; monitoring is essential to manage this risk, rather than assuming a universal worsening.

3. What is recommended exercise prescription for stable cardiovascular patients?

- A. Only light stretching once a week.
- B. Moderate-intensity aerobic activity most days, 150 minutes per week, with resistance training; start gradually.**
- C. Vigorous daily exercise with no resistance training.
- D. No exercise is recommended.

A safe, effective plan for stable cardiovascular patients combines aerobic activity with resistance training and progresses gradually. Aim for moderate-intensity aerobic exercise most days, totaling about 150 minutes per week (such as brisk walking, cycling, or swimming), distributed across several days. Add resistance training 2–3 days per week to improve muscular strength, starting with light weights and 1–2 sets of 8–12 repetitions, then gradually increasing as tolerated. Include a warm-up and cool-down, and monitor for warning signs like chest pain, undue shortness of breath, or dizziness, adjusting intensity or seeking medical clearance if needed. This balanced approach provides both cardiovascular and muscular benefits and is safer for most stable patients. Stretching alone doesn't improve aerobic fitness, and skipping resistance training misses important strength gains; exercising rigorously every day or not exercising at all are not recommended.

4. What is the clinical significance of D-dimer testing in suspected PE or DVT?

- A. It has high sensitivity but low specificity; a negative D-dimer can help rule out PE/DVT in low-risk patients.
- B. It has high specificity but low sensitivity; a positive D-dimer confirms PE/DVT.**
- C. It directly visualizes clots in pulmonary arteries.
- D. It is not useful in evaluating suspected thromboembolism.

D-dimer testing is most useful for ruling out thromboembolism rather than confirming it. The test is very sensitive for clot formation and breakdown, so a negative result strongly argues against a PE or DVT in patients who are low risk. This gives a high negative predictive value, meaning you can often avoid imaging in those low probability cases. However, D-dimer has low specificity. Many non-thrombotic factors—such as infection, inflammation, cancer, recent surgery, age, or pregnancy—can raise D-dimer levels. Because of that, a positive result does not confirm PE or DVT; it simply raises suspicion and usually leads to imaging to establish a diagnosis. In practice, you combine pretest probability with D-dimer results: if risk is low and the D-dimer is negative, you can rule out clot. If risk is intermediate or high, or if the D-dimer is positive, you proceed to definitive imaging (like CT pulmonary angiography for PE or compression ultrasound for DVT). Age-adjusted thresholds can help improve specificity in older patients.

5. What does a widened pulse pressure indicate in aortic regurgitation?

- A. Large difference between systolic and diastolic pressures due to regurgitant flow causing diastolic drop and systolic rise.
- B. Narrowing of pulse pressure due to decreased stroke volume.
- C. High diastolic pressure with low systolic.
- D. No change in pulse pressure.**

Widened pulse pressure in aortic regurgitation happens because the regurgitant flow causes a large gap between systolic and diastolic pressures. During diastole, blood leaks backward from the aorta into the left ventricle, pulling the aortic diastolic pressure down. At the same time, the ventricle responds by increasing stroke volume, which can raise the systolic pressure. The combination is a high systolic pressure paired with a low diastolic pressure, producing a noticeably widened pulse pressure. This pattern isn't seen with a narrowed pulse pressure, which occurs when stroke volume is reduced or systemic vascular resistance is high. It also doesn't fit a scenario where diastolic pressure remains high with low systolic, or where there's no change at all.

6. Which statement best describes the meaning of a high E/e' ratio on Doppler echocardiography?

- A. It indicates lower LV filling pressures.
- B. It indicates similar LV filling pressures as normal.
- C. It indicates moderate LV filling pressures.
- D. It indicates higher LV filling pressures.**

A high E/e' ratio on Doppler echocardiography signals elevated left ventricular filling pressures. The E velocity reflects the pressure gradient driving early diastolic filling from the left atrium into the ventricle, while e' (tissue Doppler of the mitral annulus) reflects the ventricle's relaxation. When LV filling pressures are high, the gradient driving filling increases (E goes up) and myocardial relaxation is impaired (e' goes down). The combination raises the ratio, indicating higher LV filling pressures. In practice, an E/e' ratio above about 14 suggests elevated LV filling pressures, while a ratio below about 8 suggests normal pressures; values in between are less clear and should be interpreted with other findings.

7. What position is typically recommended to optimize ventilation in a patient with cardiogenic shock?

- A. Trendelenburg
- B. Semi-Fowler position**
- C. Prone
- D. Supine flat

Elevating the head of the bed to a semi-Fowler position (about 30–45 degrees) helps ventilation in cardiogenic shock by improving lung mechanics and reducing pulmonary congestion. This position decreases venous return just enough to lessen left sided filling pressures and edema around the lungs, making it easier for the lungs to expand and for oxygen to transfer into the blood. It also allows the diaphragm to descend more effectively, improving airflow. Lying flat increases preload and can worsen dyspnea in pulmonary edema, while Trendelenburg raises venous return further and can worsen edema. Prone positioning is not routinely used for typical cardiogenic shock. So, semi-Fowler is the most beneficial choice for optimizing ventilation in this scenario.

8. How would you recognize cardiogenic shock and what are the key initial management steps?

- A. Hypotension with warm extremities; management includes IV fluids only.
- B. Hypotension, cool clammy skin, reduced urine output, altered mental status; management includes vasopressors, inotropes, and reversing underlying cause.**
- C. Normal blood pressure with tachycardia; management includes beta-blockers.
- D. Hypertension with warm skin; management includes diuretics only.

Recognizing cardiogenic shock means identifying perfusion failure due to the heart's inability to pump effectively. The hallmark signs are low blood pressure with cool, clammy skin from generalized vasoconstriction, reduced urine output, and altered mental status from inadequate cerebral perfusion. This pattern points to a pump problem rather than simply a loss of volume or a distributive process, helping differentiate it from other shock states. Initial management focuses on supporting circulation while you address the cause. Use vasopressors to raise mean arterial pressure and inotropes to improve contractile function, so organs receive enough blood flow. At the same time, rapidly identify and treat the underlying cause (such as emergent revascularization for an acute myocardial infarction, correcting arrhythmias, or other reversible factors). Avoid relying on fluids alone, since the core issue is poor pump capacity. If the patient remains unstable, escalate to advanced circulatory support as needed and continue targeting the underlying cause.

9. Which diagnostic test is primarily used to assess left ventricular ejection fraction in heart failure?

- A. Echocardiography**
- B. Chest radiography
- C. Electrocardiography
- D. Cardiac MRI

Assessing left ventricular ejection fraction in heart failure is best done with echocardiography because ultrasound imaging provides real-time visualization of the heart's chambers and contraction, allowing calculation of LV volumes and the fraction of blood ejected with each beat. By using methods like the biplane Simpson's rule, echo yields a numerical LVEF, which directly reflects systolic function and helps classify heart failure, guide treatment, and track changes over time. In addition to LVEF, echocardiography offers information about chamber size, wall motion, and valve function, all without radiation and with wide availability, often at the bedside. Chest X-ray can hint at congestive changes but does not quantify LVEF. ECG shows rhythm and conduction or ischemia but not the amount of blood the ventricle pumps. Cardiac MRI can measure LVEF with high accuracy and may be used when precision is needed or echo windows are poor, but it is less accessible, more costly, and less practical in many clinical settings, making echocardiography the primary test for this purpose.

10. To identify ACS, what information about chest discomfort should a nurse obtain?

- A. Where is the discomfort and where does it radiate?
- B. Did the discomfort start slowly or suddenly?
- C. How long did it last?

D. All of the above

The main concept is that recognizing acute coronary syndrome relies on a thorough symptom history of chest discomfort, including where the pain is, whether it radiates, how it began, and how long it lasts. Each element adds important context: location and radiation help identify ischemic chest pain patterns, onset indicates whether the event started suddenly or gradually, and duration shows whether the pain is transient or ongoing—patterns typical of ACS. When you gather all three aspects together, you gain the clearest signal that the discomfort could be ACS, since relying on just one detail could miss other presentations. That's why all of the above is the best choice.

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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://eccocaringforcardiovasculardisorders1.examzify.com>

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

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