

PEBC CARDIOLOGY PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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THE FULL VERSION STUDY GUIDE**

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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 the normal QTc interval on an ECG?**
 - A. <400-440 ms
 - B. 400-480 ms
 - C. 440-480 ms
 - D. 300-350 ms

- 2. Which statement best describes HF-pEF in relation to ejection fraction?**
 - A. Decreased ejection fraction
 - B. Valve stenosis as sole cause
 - C. Obstructive hypertrophic cardiomyopathy
 - D. Decreased filling and relaxation

- 3. Which statement accurately describes CK and troponin elevations in myocardial infarction?**
 - A. CK elevations occur for 7-10 days; Troponin elevations may persist for 7-10 days
 - B. Troponin elevations may persist for 7-10 days; CK elevations occur for 48-72 hours
 - C. CK elevations for 48-72 hours; Troponin elevations for 7-10 days
 - D. CK elevations for 24-48 hours

- 4. Which statement best describes Virchow's triad components?**
 - A. Hypercoagulability
 - B. Venous stasis
 - C. Endothelial damage
 - D. All of the above

- 5. Immediate management for ventricular fibrillation should include?**
 - A. Defibrillation
 - B. Observation and monitoring
 - C. Rate control with a beta-blocker
 - D. Thrombolysis

- 6. When newly diagnosed with AF, what therapies should be assessed?**
- A. Rate control
 - B. Anticoagulation
 - C. Rhythm control
 - D. Rate and/or rhythm control and anticoagulation
- 7. What are the normal and reduced ejection fraction ranges?**
- A. Normal 60-70%; Reduced <40%
 - B. Normal 50-70%; Reduced <60%
 - C. Normal 60-80%; Reduced <50%
 - D. Normal 40-60%; Reduced <30%
- 8. Which of the following is NOT listed as a medication that can exacerbate hypertension?**
- A. ACE inhibitors
 - B. Amphetamines
 - C. NSAIDs
 - D. Oral Estrogen
- 9. Which of the following is NOT a component of the HAS-BLED bleeding risk score?**
- A. Bleeding history or predisposition
 - B. Hyperlipidemia
 - C. Drugs or Alcohol
 - D. Hypertension
- 10. In stable angina, which statement correctly describes the line of therapy?**
- A. Short-acting nitrates are ALWAYS used
 - B. First-line therapy is Beta blockers
 - C. Third-line therapy is Long-acting nitrates
 - D. Second-line therapy is Calcium Channel Blockers

Answers

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

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Explanations

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1. What is the normal QTc interval on an ECG?

- A. <400-440 ms**
- B. 400-480 ms
- C. 440-480 ms
- D. 300-350 ms

Normal QTc reflects the time of ventricular depolarization and repolarization corrected for heart rate. In adults, a QTc under about 440 ms is generally regarded as normal (with some guidelines allowing up to ~460 ms in women). Prolonged QTc, which increases risk of torsades de pointes, is usually above roughly 450–460 ms depending on sex. That makes the interval described as less than 440 ms the best fit for normal. Values around 400–480 ms can be borderline or prolonged, and 440–480 ms is not considered normal in most contexts, while 300–350 ms is abnormally short.

2. Which statement best describes HF-pEF in relation to ejection fraction?

- A. Decreased ejection fraction
- B. Valve stenosis as sole cause
- C. Obstructive hypertrophic cardiomyopathy
- D. Decreased filling and relaxation**

HFpEF means heart failure with a normal or near-normal ejection fraction. The key issue isn't the heart's ability to pump out blood (systolic function) but its ability to fill properly during diastole. The left ventricle is stiff or less compliant, so filling and relaxation are impaired, leading to higher filling pressures and heart failure symptoms despite a preserved ejection fraction. That's why the statement describing decreased filling and relaxation best matches HFpEF in relation to ejection fraction. By contrast, a decreased ejection fraction points to HF with reduced EF, and the other choices describe conditions or contributors that aren't the defining feature of HFpEF.

3. Which statement accurately describes CK and troponin elevations in myocardial infarction?

- A. CK elevations occur for 7-10 days; Troponin elevations may persist for 7-10 days
- B. Troponin elevations may persist for 7-10 days; CK elevations occur for 48-72 hours
- C. CK elevations for 48-72 hours; Troponin elevations for 7-10 days**
- D. CK elevations for 24-48 hours

After a myocardial infarction, the timing of marker elevation reflects the injury pattern. CK rises about 4–6 hours after onset, peaks around 24 hours, and returns to baseline within roughly 48–72 hours. Troponin I or T rises a bit later, within 3–6 hours, peaks at 12–24 hours, and remains elevated for about 7–10 days (sometimes longer in larger infarcts). This means the statement describing CK elevations lasting 48–72 hours and troponin elevations lasting 7–10 days fits the typical pattern. The other options mix shorter or longer windows than what is usually observed for these markers.

4. Which statement best describes Virchow's triad components?

- A. Hypercoagulability
- B. Venous stasis
- C. Endothelial damage
- D. All of the above**

The main idea tested is how thrombosis develops when three interrelated factors come together: a tendency of the blood to clot (hypercoagulability), slow or stagnant blood flow (venous stasis), and injury to the vessel lining (endothelial damage). Hypercoagulability means the blood is more prone to clot due to inherited factors like factor V Leiden or acquired states such as cancer or certain medications. Venous stasis reduces the washout of clotting factors and allows clot formation to proceed, as seen with prolonged immobilization, obesity, or heart failure. Endothelial damage exposes procoagulant surfaces and tissue factor, promoting platelet adhesion and activation of the coagulation cascade. In real life, thrombosis usually results from a combination of these factors rather than a single one. Therefore, the statement that includes all three components is the best description of Virchow's triad.

5. Immediate management for ventricular fibrillation should include?

- A. Defibrillation**
- B. Observation and monitoring
- C. Rate control with a beta-blocker
- D. Thrombolysis

Ventricular fibrillation is a chaotic, nonpumping rhythm where the heart cannot deliver blood. The immediate management is to deliver a defibrillation shock. This unsynchronized high-energy impulse aims to depolarize the entire myocardium at once, momentarily resetting electrical activity so the heart's natural pacemaker can regain control and a pulse may return. Time matters—the sooner defibrillation is delivered, the better the chance of return of spontaneous circulation. Other options don't address the acute electrical chaos: observation won't restore rhythm, rate control with a beta-blocker is irrelevant during a pulseless arrest, and thrombolysis isn't an immediate solution for VF and won't promptly restore circulation in the moment. After the shock, CPR continues and additional ACLS steps are taken as needed.

6. When newly diagnosed with AF, what therapies should be assessed?

- A. Rate control
- B. Anticoagulation
- C. Rhythm control
- D. Rate and/or rhythm control and anticoagulation**

When AF is diagnosed, management must address three aspects: controlling the heart rate, deciding whether to pursue rhythm control to restore or maintain normal rhythm, and reducing stroke risk with anticoagulation. Controlling the rate helps prevent a very rapid ventricular response that can worsen symptoms and heart failure; this is typically achieved with medications like beta-blockers or certain calcium channel blockers, chosen based on the patient's blood pressure, heart function, and other conditions. Rhythm control is considered when symptoms persist despite good rate control, or when restoring sinus rhythm may improve quality of life or cardiac function. Options include antiarrhythmic drugs, electrical cardioversion, or catheter ablation, each with its own risks and benefits. Anticoagulation is guided by stroke risk, often assessed with a scoring system that weighs factors such as age, heart failure, hypertension, diabetes, prior stroke, vascular disease, and sex. The goal is to reduce embolic risk, using a direct oral anticoagulant or warfarin, unless there are contraindications, with special considerations around cardioversion timing to minimize thromboembolism. Because AF affects symptoms, rhythm, and stroke risk, the most appropriate approach is to evaluate and address rate control, rhythm control, and anticoagulation together rather than focusing on a single strategy.

7. What are the normal and reduced ejection fraction ranges?

- A. Normal 60-70%; Reduced <40%**
- B. Normal 50-70%; Reduced <60%
- C. Normal 60-80%; Reduced <50%
- D. Normal 40-60%; Reduced <30%

Ejection fraction is the proportion of blood the left ventricle pumps out with each beat. Normal EF is typically around the mid-50s to low 70s, with many teaching resources using about 60-70% as the normal range. An EF below about 40% indicates reduced systolic function, i.e., reduced ejection fraction. Values in the 40s may be described as mildly reduced or mid-range, but exam conventions often set the cutoff at <40% for reduced EF. Therefore, the pairing of normal 60-70% with reduced <40% aligns with standard definitions, making it the best choice.

8. Which of the following is NOT listed as a medication that can exacerbate hypertension?

- A. ACE inhibitors**
- B. Amphetamines
- C. NSAIDs
- D. Oral Estrogen

The main idea here is which medications are known to raise blood pressure versus those that do not. ACE inhibitors actually lower blood pressure by blocking the conversion of angiotensin I to angiotensin II, leading to vasodilation and reduced aldosterone. So they are not medications that exacerbate hypertension. In contrast, amphetamines boost sympathetic activity and can raise blood pressure and heart rate; NSAIDs can cause sodium and water retention and may blunt the effects of antihypertensive drugs, potentially raising BP; and oral estrogen can increase fluid retention and blood pressure in some individuals. Therefore, ACE inhibitors are the one that does not exacerbate hypertension.

9. Which of the following is NOT a component of the HAS-BLED bleeding risk score?

- A. Bleeding history or predisposition
- B. Hyperlipidemia**
- C. Drugs or Alcohol
- D. Hypertension

HAS-BLED is a tool used to estimate bleeding risk in patients on anticoagulation by counting several specific risk factors. Each factor contributes one point: Hypertension, Abnormal liver or renal function, History of stroke, Bleeding history or predisposition, Labile INRs, Elderly (age >65), and Drugs or alcohol. Hyperlipidemia is not among these factors, so it does not add to the HAS-BLED score. That's why the option describing hyperlipidemia is the correct choice for "not a component."

10. In stable angina, which statement correctly describes the line of therapy?

- A. Short-acting nitrates are ALWAYS used
- B. First-line therapy is Beta blockers**
- C. Third-line therapy is Long-acting nitrates
- D. Second-line therapy is Calcium Channel Blockers

The main idea is how stable angina is managed in a stepwise way to lower heart work and oxygen demand. Beta blockers are preferred as the initial treatment because they blunt the heart's response to exercise and stress. By slowing the heart rate and reducing contractility and blood pressure, they lower myocardial oxygen consumption, which directly helps prevent angina during activity and improves exercise tolerance. They also offer prognostic benefits in coronary disease, especially after a heart attack or with reduced ventricular function, making them a solid first choice. Short-acting nitrates do provide quick relief from current chest pain, but they don't change the underlying oxygen balance over time, so they're used for immediate symptoms rather than as a first-line disease-modifying therapy. Long-acting nitrates are useful for prevention, but typically as add-on therapy if symptoms persist despite beta-blockade or if beta-blockers aren't tolerated; they're not the primary line of therapy. Calcium channel blockers are a good alternative or add-on when beta-blockers aren't suitable, but they're usually considered second-line options or used in combination to control symptoms. So, starting with beta blockers as the initial therapy aligns with the goal of reducing myocardial oxygen demand and improving anginal control, which is why that statement is the best answer.

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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