

ULTRASOUND REGISTRY REVIEW (URR) MV ABNORMALITIES AND DISEASE 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. Caseous Annular Calcification is best described as which of the following?**
 - A. Common variant of annular calcification
 - B. Rare variant of annular calcification
 - C. A calcification of the aortic annulus
 - D. A growth on the leaflets
- 2. Which finding is related to significant MR?**
 - A. Pulmonary Hypertension
 - B. Left Bundle Branch Block
 - C. Aortic Root Dilation
 - D. Pericardial Effusion
- 3. Which Carpentier type is associated with normal leaflet motion and MR caused by annular dilation or leaflet perforation?**
 - A. Type II
 - B. Type IIIa
 - C. Type IIIb
 - D. Type I
- 4. With MVP, leaflets are described as _____.**
 - A. Redundant
 - B. Stiff
 - C. Calcified
 - D. Normal
- 5. Where should the pulsed-wave Doppler sample volume be placed relative to the left atrial appendage entry into the left atrium?**
 - A. 1 cm distal
 - B. 3 cm proximal
 - C. 1 cm proximal
 - D. 5 mm proximal

- 6. Which of the following is a 2D finding associated with moderate to severe chronic mitral regurgitation?**
- A. Increased left atrial size
 - B. Left ventricular dilation
 - C. Volume overload
 - D. All of the above
- 7. Which statement best describes MAC?**
- A. MAC primarily involves the LV wall
 - B. MAC primarily involves the Mitral annulus with leaflets usually sparingly calcified unless severe
 - C. MAC affects the tricuspid valve
 - D. MAC is a disease of the aortic valve
- 8. Which auscultatory finding is characteristic of mitral stenosis?**
- A. Diastolic rumble with opening snap and loud S1
 - B. Systolic murmur with radiation to carotids
 - C. Continuous murmur
 - D. Ejection murmur
- 9. Which chamber's pressure buildup leads to pulmonary hypertension in MS?**
- A. Left Atrium
 - B. Right Atrium
 - C. Left Ventricle
 - D. Right Ventricle
- 10. Which view is commonly used to assess MVP?**
- A. PSAX
 - B. AP4-chamber
 - C. PLAX
 - D. Subcostal

Answers

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

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Explanations

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1. Caseous Annular Calcification is best described as which of the following?

- A. Common variant of annular calcification
- B. Rare variant of annular calcification**
- C. A calcification of the aortic annulus
- D. A growth on the leaflets

Caseous annular calcification is best understood as a rare variant of annular calcification, specifically involving the mitral annulus. The term "caseous" describes a central area of soft, cheese-like necrosis surrounded by a calcified shell. This sets it apart from the more common, solid annular calcification and explains why it can resemble a mass or vegetation on imaging. It is not a simple calcification of the aortic annulus, nor a growth on the valve leaflets, reinforcing why the correct description is that this is a rare form of annular calcification.

2. Which finding is related to significant MR?

- A. Pulmonary Hypertension**
- B. Left Bundle Branch Block
- C. Aortic Root Dilation
- D. Pericardial Effusion

Significant mitral regurgitation creates a systolic leak that sends blood from the left ventricle back into the left atrium, causing volume and pressure overload there. The elevated left atrial pressure is then transmitted back into the pulmonary veins and capillaries, raising pulmonary vascular pressures and leading to pulmonary hypertension. This downstream effect is why pulmonary hypertension is linked to significant MR. The other options aren't direct consequences of MR: left bundle branch block is a conduction issue, not a typical result of MR; aortic root dilation involves the aorta, not the mitral valve; and pericardial effusion is fluid around the heart, unrelated to MR's regurgitant mechanism.

3. Which Carpentier type is associated with normal leaflet motion and MR caused by annular dilation or leaflet perforation?

- A. Type II
- B. Type IIIa
- C. Type IIIb
- D. Type I**

Carpentier classification groups MR by how the valve leaflets move. In this scenario, the leaflets move normally, but regurgitation occurs because the annulus is dilated or there is a leaflet perforation. That combination—normal leaflet motion with MR due to extrinsic leaflet apparatus problems like annular dilation or perforation—fits Type I. By contrast, excess leaflet motion such as prolapse or flail points to Type II; restricted motion in multiple planes or during diastole suggests Type IIIa, and restricted motion mainly in systole from tethering or ischemic/dilated ventricle points to Type IIIb. So the described mechanism aligns with Type I.

4. With MVP, leaflets are described as _____.

A. Redundant

B. Stiff

C. Calcified

D. Normal

Mitral valve prolapse involves myxomatous degeneration that makes the leaflets floppy and excess in tissue. This results in the leaflets being described as redundant—there is more leaflet tissue than normal, allowing them to billow and prolapse into the left atrium during systole. Stiff or calcified leaflets point to different diseases, and normal would not describe an abnormal prolapse. So the best description for MVP leaflets is redundant.

5. Where should the pulsed-wave Doppler sample volume be placed relative to the left atrial appendage entry into the left atrium?

A. 1 cm distal

B. 3 cm proximal

C. 1 cm proximal

D. 5 mm proximal

When using pulsed-wave Doppler to assess flow into the left atrial appendage (LAA), you want to capture the velocity as blood moves from the main left atrium into the LAA. Placing the sample volume about 1 cm proximal to the LAA ostium means you're sampling from the left atrial side, just before the entry into the LAA. This location gives a clean, representative measurement of the LAA's inflow (the emptying of the LAA toward the atrium is reflected at this boundary) and helps keep the Doppler beam aligned with the jet for accurate velocity. If you place the sample inside the LAA (distal to the ostium) or too far back into the LA, flow becomes more complex and the measured velocity may be less reliable or not reflect the true LAA emptying velocity. The 1 cm proximal position is a practical, reproducible spot that yields meaningful velocity values for assessing LAA function and thromboembolism risk.

6. Which of the following is a 2D finding associated with moderate to severe chronic mitral regurgitation?

A. Increased left atrial size

B. Left ventricular dilation

C. Volume overload

D. All of the above

Chronic moderate-to-severe mitral regurgitation creates a volume overload of the left heart. The regurgitant blood that escapes into the left atrium increases the preload of both the atrium and the ventricle because some of that volume returns to the ventricle during diastole. In response, the left atrium enlarges to accommodate the extra volume, and the left ventricle dilates due to the increased preload and the heart's remodeling to handle the higher volume (eccentric hypertrophy). On 2D imaging you typically see an enlarged left atrium and an enlarged left ventricle, reflecting this volume-overload state. Since the volume overload drives these structural changes, all of these findings are associated with moderate-to-severe chronic MR.

7. Which statement best describes MAC?

- A. MAC primarily involves the LV wall
- B. MAC primarily involves the Mitral annulus with leaflets usually sparingly calcified unless severe**
- C. MAC affects the tricuspid valve
- D. MAC is a disease of the aortic valve

Mitral annular calcification is calcification of the fibrous ring around the mitral valve, not the LV wall. It tends to cluster along the mitral annulus, often the posterior portion, and the leaflets themselves are usually not heavily calcified unless the disease is severe. On ultrasound, you'd see a bright, dense rim at the annulus with possible shadowing; only in advanced cases does the calcification extend toward the leaflets and can contribute to mitral stenosis or regurgitation. The statement that best describes MAC is the one that highlights the annular location and notes that leaflets are sparingly calcified unless the disease is severe. Other choices would imply involvement of the LV wall, the tricuspid valve, or the aortic valve, which is not characteristic of MAC.

8. Which auscultatory finding is characteristic of mitral stenosis?

- A. Diastolic rumble with opening snap and loud S1**
- B. Systolic murmur with radiation to carotids
- C. Continuous murmur
- D. Ejection murmur

Mitral stenosis is characterized by a diastolic murmur produced by turbulent flow across a narrowed mitral valve. The hallmark auditory finding is a low-pitched diastolic rumble heard best at the apex with the patient in the left lateral decubitus position. This rumble typically begins after an opening snap, which follows S2 and results from the sudden tensing of the stenotic mitral leaflets as they finally open in early diastole. The first heart sound is often loud because the thickened valve leaflets snap shut against a high left atrial pressure. The murmur can become louder with expiration and may show presystolic accentuation just before S1 of the next beat due to atrial contraction filling a stiff ventricle. These features together are distinctive for mitral stenosis, whereas a systolic murmur radiating to the carotids suggests aortic stenosis, a continuous murmur points to a PDA, and an ejection-type murmur is not typical of MS.

9. Which chamber's pressure buildup leads to pulmonary hypertension in MS?

- A. Left Atrium**
- B. Right Atrium
- C. Left Ventricle
- D. Right Ventricle

Mitral stenosis creates an obstacle to flow from the left atrium to the left ventricle, so pressure builds up in the left atrium. That elevated left atrial pressure is transmitted backward into the pulmonary veins and capillaries, raising pulmonary venous and eventually pulmonary arterial pressures. Over time this backward transmission leads to pulmonary hypertension. The right heart may later struggle against this increased afterload, but the initiating pressure rise comes from the left atrium.

10. Which view is commonly used to assess MVP?

- A. PSAX
- B. AP4-chamber
- C. PLAX**
- D. Subcostal

The main idea is that MVP is best assessed in a view that shows the mitral leaflets in their long-axis relationship to the left atrium, so prolapse can be seen as the leaflets billowing or moving into the LA during systole. The parasternal long-axis view does this clearly: it displays both leaflets and their motion through the annulus toward the left atrium, allowing you to recognize prolapse and gauge its extent, along with associated regurgitation using color Doppler. Other views can provide useful information about overall valve function, but they're not as reliable for visualizing the prolapsing leaflet motion. Subcostal windows are more limited for detailed leaflet visualization, and the apical four-chamber view can show MR and chamber size but may not depict the prolapse as clearly. Parasternal short-axis can show the mitral apparatus in cross-section but is more susceptible to foreshortening and isn't the standard view for identifying MVP.

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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://urrmvabnormalitiesdisease.examzify.com>

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

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