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Product Version

1. **Up to Date products, reliable and verified.**
2. **Questions and Answers in PDF Format.**

Latest Version: 6.0

Question: 1

Rivaroxaban 2.5 + ASA vs DAPT PAD?

A. Inferior
B. Superior MALE
C. Equal bleed
D. MACE worse

Answer: B

Explanation:
Better limb outcomes COMPASS/VOYAGER.

Question: 2

Post-thrombolysis for Rutherford IIb ALI (motor deficit onset 6 hours), tPA at 0.75 mg/hr x 18 hours lyses 80% SFA thrombus. Labs: D-dimer 4500 ng/mL, platelets 95k/µL, no bleeding. Angiogram shows residual thrombus with poor runoff. Optimal adjunct?

A. Extend tPA to 36 hours
B. Percutaneous mechanical thrombectomy (PMT)
C. Balloon maceration alone
D. Systemic heparin 18 units/kg/hr

Answer: B

Explanation:
For Rutherford IIb (irreversible risk if delayed), hybrid CDT+PMT (e.g., AngioJet) clears residual thrombus in 95% cases, shortening lysis time/reducing tPA dose (bleeding OR 0.4 vs CDT alone). High D-dimer/platelets signal ongoing thrombosis; balloon risks distal embolization without extraction. 2024 guidelines Class I for hybrid in <14-day onset.

Question: 3

A 50-year-old with leg ulcers painful punched stellate atrophie blanche white ivory plaques medial ankles surrounded telangiectasia livedo reticularis broken net irregular persistent cold-aggravated, non-pitting edema mild Stemmer negative arms normal, pulses normal no bruits abdominal silent. Skin finding vasculitis subtype?

A. Lymphedema Stemmer positive

B. Livedoid vasculopathy livedo racemosa
C. Physiologic cutis marmorata
D. FMD string beads palpable

Answer: B

Explanation:
Livedoid vasculopathy (livedo racemosa irregular + painful ulcers atrophie blanche) thrombophilic arteritis microvessels fibrin thrombi, antiphospholipid common; vs physiologic regular transient.

Question: 4

Elderly man with polymyalgia rheumatica develops vision loss. ESR 105. TA biopsy: giant cells, elastic disruption. MRA: vertebral stenosis causing vertebrobasilar ischemia.
What MMP-driven process affects intracranial vessels?

A. Distal corkscrew recanalization
B. Lymphocyst compression
C. Giant cell elastolysis and intimal hyperplasia extending intracranially
D. Popliteal myofibroblast entrapment

Answer: C

Explanation:
Giant cell arteritis intracranial extension (5-10%) involves granulomatous inflammation with MMP-9/granzyme from CD68+ macrophages destroying internal elastic lamina, leading to stenosis/thrombosis; endovascular balloon angioplasty/stenting for refractory vertebrobasilar. Temporal artery classic; PET differentiates mimics. High-dose steroids urgent.

Question: 5

Acute thromboembolism iliac stent thrombosis. Virchow?

A. Injury metal
B. Hypercoag clopi resist
C. Stasis stent
D. All

Answer: D

Question: 6

A 48-year-old female post-iliac vein stenting for chronic occlusion develops acute calf pain 6 hours later, anterior compartment pressure 42 mmHg (diastolic BP 85 mmHg), CK 8,500 U/L rising, no arterial injury on angiogram. Scenario confirms reperfusion after 14-day occlusion. Intervention?

A. Leg elevation and mannitol
B. Hyperbaric oxygen therapy
C. Four-compartment fasciotomy
D. CDT of venous thrombus

Answer: C

Explanation:
Atypical compartment syndrome from reperfusion injury post-venous recanalization occurs via edema from oxygen free radicals and neutrophil activation in ischemic tissue, indicated by delta pressure <20 mmHg; emergent fasciotomy decompresses all four compartments to halt myonecrosis progression, with 80% limb salvage if <12 hours delay. Supportive alkalinization prevents AKI from myoglobin.

Question: 7

A 38-year-old female with May-Thurner anatomy (left CIV stenosis 65%) develops acute DVT post-partum (day
5). After catheter-directed thrombolysis (CDT) with tPA 0.5 mg/hr x 24 hrs reducing clot burden >90%, venogram shows residual 50% recoil stenosis. IVUS confirms post-balloon area 55 mm².
What is the primary risk if stenting is deferred, and the most evidence-based anticoagulation duration post-stenting?

A. Pulmonary embolism (25% risk); indefinite LMWH
B. Chronic PTS (50% risk); 6-12 months anticoagulation
C. Recurrent ipsilateral DVT (40% risk); 3 months DOAC
D. Stent fracture (15% risk); 1 month warfarin

Answer: B

Explanation:
Untreated residual iliofemoral stenosis >50% post-DVT predicts chronic PTS in 50% at 2 years due to ambulatory venous hypertension; stenting reduces this to <20%. Guidelines recommend 6-12 months therapeutic anticoagulation post-venous stenting in provoked DVT with thrombophilia, transitioning to DOAC; indefinite only if unprovoked/recurrent. PE risk is mitigated by filter if needed, but not primary here; fracture rare with proper sizing.

Question: 8

Rutherford 6 CLI diabetic, AT/PTA CTOs diffuse, angiosome direct revascularization anterior wound. 2026 BTK strategy maximizes wound healing?

A. Loop technique AT-PTA

B. Single runoff vessel
C. Angiosome indirect
D. Above-ankle only

Answer: A

Explanation:
Infrapopliteal CLI, loop revascularization AT/PTA restores foot arch, healing >80% vs single vessel; angiosome adjunct.

Question: 9

Complex polyvascular atherosclerosis patient with borderline ABI, elevated ABI in one leg from calcification, low TBI. Illustrates need for?

A. Multimodal assessment (ABI + TBI + duplex) in high-risk
B. Invasive angiography first
C. Single-test reliance
D. No testing

Answer: A

Explanation:
Guidelines advocate complementary tests in diabetes/CKD where ABI limited by calcification.

Question: 10

A 71-year-old male with calcified iliac lesion undergoes balloon-expandable stenting. Post-dilation required due to:

A. Incomplete expansion
B. Elastic recoil
C. Fracture concern
D. Migration risk

Answer: A

Explanation:
Calcified lesions resist full balloon-expandable stent expansion. High-pressure post-dilation ensures optimal apposition and radial strength in rigid plaques.

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