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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/ μ L, 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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