Ob/Gyn Sonography Review

1-2-3 Step Ultrasound Education & Test Preparation

Step 1 Review text

Step 2 Mock examination

Step 3 Q&A memory skills flashcard drill

Obstetrics & Gynecology A Q&A Review for the ARDMS Specialty Exam

Continuing Education Activity

Approved for 12 hours CME Credit

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Ob/Gyn Sonography Review

Test yourself before the ARDMS tests you! Ob/Gyn Sonography Review illuminates the facts and principles on which you will be tested, hones your test-taking skills, and reveals your strengths and weaknesses by exam topic. Based precisely on the ob/gyn specialty exam outline published by ARDMS, this review contains 520 registry-like questions together with answers, clear explanations, and quick references for further study. More than 100 image-based cases prepare you to tackle the images on the exam. Coverage includes obstetrics (first through third trimesters, placenta, assessment of gestational age, and complications), gynecology (normal pelvic anatomy, physiology, pediatric, infertility/endocrinology, postmenopausal, pelvic and extrapelvic pathology), patient care, patient preparation, and technique—all in the same proportion as the exam itself. Ob/Gyn Sonography Review is very effective in combination Ob/Gyn Sonography: An Illustrated Review and Ob/Gyn CD-ROM Mock Exam. Why are our mock exams so popular and effective? Because they contain the same kinds of thought-provoking questions you will find on the exam! 12 hours’ CME credit. Davies catalog #11032.

About the authors . . .

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THIS MOCK EXAM is a question/answer/reference review of ob/gyn sonography for those RDMS candidates who plan to take the ARDMS Obstetrics and Gynecology specialty examination. It is designed as an adjunct to your regular study and as a method to help you determine your strengths and weaknesses so that you can study more effectively. *Ob/Gyn Sonography Review* covers everything on the current ARDMS exam content outline and in fact follows that outline, which you will find in Part VI of this book.

Facts about *Ob/Gyn Sonography Review*:

- It precisely covers and follows the current ARDMS exam outline.
- It focuses exclusively on the Obstetrics and Gynecology specialty exam to ensure thorough coverage of even the smallest subtopic on the exam. (For the Ultrasound Physics and Instrumentation exam, see *Ultrasound Physics Review*.)
- Topics are covered to the same extent as on the exam itself. Subject headings include the approximate percentage of the exam that a particular topic represents so you know the relative importance of each topic and can study more effectively.
- *Ob/Gyn Sonography Review* contains more than 515 questions, many of which are image-based or otherwise illustrated.
- Explanations are clear and conveniently referenced for fact-checking or further study.
- Each section is keyed to the ARDMS exam outline so that you always know where you are, what you are studying, and how it applies to your preparation.
- A bibliography appears at the end of the book, as does the exam outline and contact information for the ARDMS.

*Ob/Gyn Sonography Review* effectively simulates content and experience of the exam. Current ARDMS standards call for approximately 170 multiple-choice questions to be answered during a three-hour period. That is, you will have an average time of 1 minute to answer each question. A passing score is between 65% and 75%, depending on the difficulty of the particular exam. Timing your practice sessions according to the number of questions you need to finish will help you prepare for the pressure experienced by RDMS candidates taking this exam. It also helps to ensure that your score accurately reflects your strengths and weaknesses so that you study more efficiently and with greater purpose in the limited time you can devote to preparation. Because the content of this
Q&A review is formatted and weighted according to the registry’s outline of topics and subtopics, you can readily identify those areas on which you should concentrate.

We include below and strongly recommend that you read *Taking and Passing Your Exam*, by Don Ridgway, RVT, who offers useful tips and practical strategies for taking and passing the ARDMS examinations.

Finally, you have not only our best wishes for success, but also our admiration for taking this big and important step in your career.

**Kathy Gill**

Kathryn A. Gill, MS, RT, RDMS
Daphne, Alabama
Taking and Passing Your Exam

by Don Ridgway, RVT

Preparing for your exam . . .

Study. And then study some more. Knowing your stuff is the most important factor in your success. Start early, set a regular study schedule, and stick to it. Make your schedule specific so you know exactly what to study on a particular day. Write it down. Establish realistic goals so that you don’t build a mountain you can’t climb.

As to what you study, don’t just read aimlessly. Focus your efforts on what you need to know. Rely on a core group of dependable references, referring to others as necessary to firm up your understanding of specific topics. Let the ARDMS exam outlines guide you. And use different but complementary study methods—texts, flashcards, and mock exams—to exercise those neural pathways.

Ease down on studying the week before. Wind down, reduce stress, build confidence, and rest up. Don’t cram! And no studying the night before. You had your chance. Watch a movie, relax, go to bed early, and sleep well.

Organize your things the night before. Lay out comfortable clothes (including a sweater or sweatshirt in case the testing center is cold), pencils, your ARDMS test-admission papers, car and house keys, glasses, prescriptions, directions to the test center, and any other personal items you might need. Be prepared!

The day of your exam . . .

Eat lightly. You do not want to fall asleep during the exam. Go easy on the coffee or tea so your bladder doesn’t distract you halfway through the exam.

Arrive early. Plan to arrive at the test center early, especially if you haven’t been there before. Take directions, including the telephone number of the testing center in case you have to make contact en route. You don’t need a wrong-offramp adventure.

Be confident. As you wait for the exam to begin, smile, lift both hands, wave them toward yourself, and say, “Bring it on.”

During the exam . . .

Read each question twice before answering. Guess how easy it is to get one word wrong and misunderstand the whole question.

Try to answer the question before looking at the choices. Formulating an answer before peeking at the possibilities minimizes the distractibility of the incorrect answer choices, which in the test-making business are called—guess what!—distractors.

Knock off the easy ones first. First answer the questions you feel good about. Then go back for the more difficult items. Next, attack the really tough ones. Taking notes on long or tricky questions often can jog your memory or put the question in new light. For questions you just cannot answer with certainty, eliminate the obviously wrong answer choices and then guess.

Guessing. Passing the exam depends on the number of correct answers you make. Because unanswered questions are counted as incorrect, it makes sense to guess when all else fails. The ARDMS itself advises that “it is to the candidate’s advantage to answer all possible questions.” Guessing alone improves your chances of scoring a point from 0 (for an unanswered question) to 20% (for randomly picking one of five possible answers). Eliminating answer choices you know or suspect are wrong further improves your odds of success. By using your knowledge and skill to eliminate three of the five answer choices before guessing, for example, you increase your odds of scoring a point to 50%.

Don’t second-guess. The common wisdom is that your first answer is more likely than revised answers to be correct. Actual studies indicate that when you return to a question and change the answer, you’ll probably be wrong. Change an answer only if you’re quite sure you should.

Pace yourself; watch the time. Work methodically and quickly to answer those you know, and make your best guesses at the gnarly ones. Leave no question unanswered.

Don’t despair 50 minutes into the exam. At some point you may feel that things just aren’t going well. Take 10 seconds to breathe deeply—in for a count of five, out for a count of five. Relax. Recall that you need only about three out of four correct answers to pass. If you’ve prepared reasonably well, a passing score is attainable even if you feel sweat running down your back.
Taking the exam on computer . . .

Some candidates express concern about taking the registry exam on computer. Most folks find this to be pretty easy; some find it off-putting, at least in prospect. But the computerized exams are quite convenient: You can take the exam at your convenience (a far cry from the days of one exam per year), you know whether or not you passed before you leave the testing center (compare that to waiting weeks and even months, as used to be the case), and you can reschedule the exam after 90 days if you happen not to pass the first time (rather than waiting another six months to a year). Another good point: The illustrations are said to be clearer on computer than in the booklets at a Scantron-type exam.

Taking the test by computer is not complicated. The center even gives you a tutorial to be sure you know what you need to do. You sit in a carrel with a computer and answer the multiple-choice questions by pointing and clicking with a mouse. There is a clock on the display letting you know how much time is left. Use it to pace yourself. Scratch paper is available; make liberal use of it.

You can mark questions to return for answering later. A display shows which questions have not been answered so you can return to them. When you have finished, you click on “DONE,” and you find out immediately whether you passed.

It’s nothing to be afraid of. The principles are the same as those for any exam. Be methodical and keep breathing.

Summary . . .

Preparing for the exam:
- Study
- Use flashcards
- Join a study group
- Wind down a week before
- Don’t cram
- Relax!

The day of your exam:
- Eat lightly, arrive early, avoid coffee
- Arrive early
- Take a sweater
- Be confident!
During the exam:

- Read each question twice
- Answer the question before looking at the answer choices
- Answer the easy ones first
- Guess when necessary
- Don’t second-guess your first answers
- Pace yourself
- Don’t despair

Taking the exam on computer:

- Just point and click
- Take notes
- Mark and return to the hard questions
- Use the on-screen clock to pace yourself
- Be methodical
- Breathe!
Preface
Taking and Passing Your Exam

PART I Obstetrics 1

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Yolk sac
Embryo
Ovaries
Cul-de-sac
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Ectopic pregnancy

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PART I

Obstetrics

First Trimester
Second/Third Trimester (Normal Anatomy)
Placenta
Assessment of Gestational Age
Complications
Amniotic Fluid
Genetic Studies
Fetal Demise
Fetal Abnormalities
Coexisting Disorders

FIRST TRIMESTER [6–8%]

Gestational sac
Yolk sac
Embryo (normal physiologic development/sonographic appearance)
Ovaries (corpus luteum)
Cul-de-sac
Pregnancy failure
Ectopic pregnancy

1. The pelvic mass most commonly seen during a normal first trimester pregnancy is:
   A. Leiomyoma
   B. Cystic teratoma
   C. Corpus luteal cyst
   D. Theca lutein cysts
   E. Cystadenoma

2. The primitive hindbrain can be seen as a cystic structure within the embryonic head. It is called the:
   A. Diencephalons
   B. Rhombencephalon
   C. Prosencephalon
D. Mesencephalon
E. Encephalocele

3. The maternal side of the developing placenta is referred to as the:
   A. Decidua basalis
   B. Decidua capsularis
   C. Decidua vera
   D. Decidua parietalis
   E. Decidua chorion

4. Up to 10 weeks gestational age, the mean diameter of the normal gestational sac should grow:
   A. 0.5 mm/day
   B. 1 mm/day
   C. 2 mm/day
   D. 3 mm/day
   E. 4 mm/day

5. Physiologic herniation of fetal intestine outside the fetal abdomen should not be seen after gestational age:
   A. 6 weeks
   B. 8 weeks
   C. 10 weeks
   D. 12 weeks
   E. 14 weeks

6. One should be able to image a normal intrauterine gestational sac transabdominally when the International Reference Preparation (IRP) level for hCG is equal to or greater than:
   A. 1000 units/liter
   B. 1200 units/liter
   C. 1800 units/liter
   D. 2400 units/liter
   E. 3600 units/liter

7. Which of the following is NOT an indication of ectopic pregnancy?
   A. Fluid in the cul-de-sac
   B. Fluid within the endometrial cavity
   C. Double decidual ring
   D. Adnexal mass
   E. Fluid in the right upper quadrant

8. A missed abortion is defined as:
   A. Retention of a dead conceptus for a prolonged period (e.g., 2 months)
   B. Retention of products of conception with bleeding
C. Blighted ovum without bleeding  
D. Blighted ovum with bleeding  
E. Ectopic pregnancy without bleeding  

9. All of the following characteristics suggest an abnormal early pregnancy EXCEPT:
   A. Irregular sac shape  
   B. Poor decidual ring  
   C. Dilated cervix  
   D. Fundal implantation  
   E. Fluid around the sac  

10. Your patient is 10 weeks by good menstrual dates but presents with pregnancy-induced hypertension. You suspect:
    A. Threatened abortion  
    B. Hydatidiform mole  
    C. Normal pregnancy  
    D. Ectopic pregnancy  
    E. Blighted ovum  

11. Your patient has a positive pregnancy test and presents with bleeding and cramping. Of the following sonographic findings, which one would make you suspect an inevitable abortion?
    A. Low implantation  
    B. Irregular sac shape  
    C. Poor decidual reaction  
    D. Double yolk sac  
    E. Dilated cervix  

12. A heterotopic pregnancy is:
    A. An abdominal ectopic pregnancy  
    B. An ectopic pregnancy with a normal intrauterine pregnancy  
    C. A twin ectopic pregnancy  
    D. A cervical ectopic pregnancy  
    E. A fertility-assisted pregnancy  

13. To differentiate an early intrauterine pregnancy from a pseudogestational sac, it helps to visualize the:
    A. Decidualized endometrium  
    B. Chorionic villi  
    C. Yolk sac  
    D. Vitelline duct  
    E. Corpus luteal cyst  

14. A yolk sac is considered abnormal when its diameter exceeds:
    A. 2 mm  
    B. 3 mm
C. 4 mm
D. 5 mm
E. 6 mm

15. Which of these drugs may be used to treat an early unruptured ectopic pregnancy in order to preserve fertility?
   A. Thalidomide
   B. Methotrexate
   C. Diethylstilbestrol (DES)
   D. Pergonal
   E. Danazol

This transvaginal image applies to questions 16 and 17.

16. This sagittal transvaginal image demonstrates a normal appearing intrauterine gestational sac. The hypoechoic structure indicated by the calipers most likely represents a(n):
   A. Leiomyoma
   B. Engorged vessel
   C. Cyst
   D. Artifact
   E. Ovary

17. The previous image shows the uterine position to be:
   A. Levoposed
   B. Dextroposed
C. Anteflexed
D. Retroflexed
E. Unidentifiable

This transverse image applies to questions 18–21.

18. A patient presents with a positive pregnancy test and bright red spotting. By dates she is 8–9 weeks. What does this transverse image demonstrate?
   A. An anembryonic pregnancy
   B. Subchorionic hemorrhage
   C. Placental abruption
   D. Normal amnion
   E. Second gestational sac

19. What is being measured in this image?
   A. Gestational sac
   B. Embryonic disc
   C. Crown-rump length
   D. Biparietal diameter
   E. Abdominal circumference

20. To what is the arrow pointing?
   A. Gestational sac
   B. Fetal head
   C. Amniotic cyst
D. Yolk sac
E. Umbilical cord

21. Your patient relates a history of amenorrhea for 7 weeks. Her home pregnancy test was negative, but her serum beta-hCG exceeds 4000. What does this image demonstrate?

A. Normal empty uterus with periovulatory endometrium
B. Normal early intrauterine pregnancy
C. Fluid contained within the endometrial cavity
D. Pseudocyesis with an endometrial cyst
E. Degenerating submucosal fibroid

22. In a ruptured ectopic pregnancy, which section of the fallopian tube is potentially the most life-threatening?

A. Interstitial
B. Ampulla
C. Isthmus
D. Fimbria
E. Ligamentous

23. The double bleb sign refers to the sonographic presentation of:

A. The amnion and chorion
B. Two intrauterine gestational sacs
C. The amnion and yolk sac
D. A heterotopic pregnancy
E. A bicornuate uterus

24. This patient is 10 weeks by good menstrual dates, but her doctor feels that she is small for gestational age and he cannot hear any fetal heart tones. He orders a sonogram to confirm viability. An M-mode was not included. Referring to the image on the following page, what do you suspect?