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Question: 1684

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: 1685

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: 1686

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 mm^2. 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: 1687

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: 1688

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: 1689

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: 1690

A 70-year-old male with erectile dysfunction and bilateral buttock claudication undergoes CTA showing bilateral common iliac artery occlusions with reconstitution of external iliac arteries and infrarenal aortic stenosis of 70%. This lesion pattern is classified as TASC II.

A. Type B suitable for endovascular as preferred
B. Type C with endovascular feasible in experienced centers
C. Type A recommending endovascular therapy
D. Type D traditionally favoring open surgical reconstruction

Answer: D
Explanation: TASC II classification for aortoiliac lesions describes Type D as extensive disease including bilateral common iliac occlusions, diffuse aortic involvement, or complex bilateral iliac occlusions requiring reconstruction. These are traditionally recommended for open surgical repair (aortobifemoral bypass) due to superior long-term patency. However, advancements in endovascular techniques (covered stents, re-entry devices) have expanded feasibility for Type D in high-surgical-risk patients, though open surgery remains the durability standard in good-risk candidates. The described bilateral occlusions with aortic

involvement fits classic Type D morphology.

Question: 1691

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: 1692

Acute thromboembolism iliac stent thrombosis. Virchow?

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

Answer: D
Explanation: Triad.

Question: 1693

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: 1694

Thrombosis on DES: malapposition gap 0.3 mm. Cause?

A. Hypersensitivity polymer
B. Positive remodeling recoil
C. Stent underexpansion
D. Neoatherosclerosis lipid ingress

Answer: C
Explanation: Underexpansion <80% area creates flow disturbance.

Question: 1695

A 65-year-old male with PAD and recent endovascular iliac stenting is on aspirin. He develops atrial fibrillation requiring anticoagulation.

A. Switch to rivaroxaban 2.5 mg twice daily plus aspirin
B. Continue aspirin, add full-dose DOAC without overlap
C. Add warfarin, discontinue aspirin
D. Initiate apixaban full dose plus aspirin

Answer: D
Explanation: In PAD patients requiring anticoagulation for separate indications (e.g., atrial fibrillation), full-dose direct oral anticoagulant (preferably reduced-dose if eligible) combined with single antiplatelet therapy balances thromboembolic protection without excessive bleeding compared to triple therapy or vascular-dose regimens designed for atherothrombotic prevention alone.

Question: 1696

2026 WHO projections estimate LMIC PAD doubling by 2045 driven by smoking epidemic. A 51-year-old Chinese male 22 pack-year smoker, abdominal obesity, fasting glucose 118 mg/dL, ABI 0.93. What risk transition predominates emerging economies?

A. Diabetes predominance
B. Hypertension control improvement
C. Aging demographics
D. Smoking prevalence decline

Answer: A
Explanation: Westernization produces diabetes epidemic preceding obesity/smoking as dominant PAD driver in urbanizing LMICs. Insulin resistance accelerates atherogenesis 8-12 years premature versus Caucasians. Impaired fasting glucose 100-125 mg/dL triples risk with HbA1c >6.0% predicting conversion. Metformin initiation age <55 years reduces microvascular progression 37%.

Question: 1697

Aortic saccular coil jail cuff?

A. Rupt
B. Fail
C. Mig
D. Shrink no EL

Answer: D
Explanation: Unconventional success.

Question: 1698

A 65-year-old female presents with a 3 cm shallow ulcer over the medial malleolus, granulating base, surrounding stasis dermatitis, hyperpigmentation, and moderate edema worse with dependency. Pulses are palpable, no elevation pallor. Duplex shows great saphenous reflux >4 seconds standing. Per latest guidelines, which physical finding best differentiates pure venous from mixed arterial-venous ulcer?

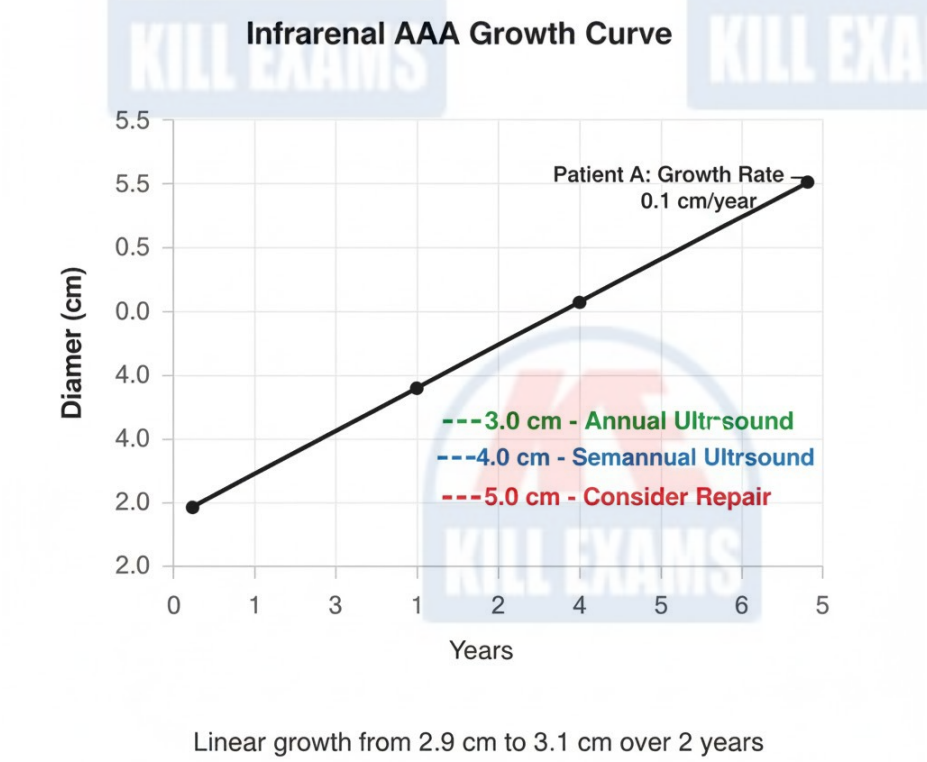
A. Pain worsening with leg dependency
B. Granulating base with moderate exudate

C. Palpable pedal pulses without ischemic signs
D. Shallow irregular shape with sloping edges

Answer: C
Explanation: Palpable pedal pulses without ischemic signs (prolonged elevation pallor, rubor delay) strongly favor pure venous etiology, as arterial/mixed ulcers often have diminished pulses or ABI <0.9. Shallow irregular ulcers with granulation are classic venous; dependency worsening relates to venous hypertension; sloping edges typical venous vs punched-out arterial.

Question: 1699

A 70-year-old male with 35 pack-year history has AAA ultrasound showing 3.1 cm diameter. His calculated AAA growth rate from prior study (2 years ago) was 0.2 cm/year.



Linear growth from 2.9 cm to 3.1 cm over 2 years

According to 2026 SVS surveillance guidelines, what is the appropriate follow-up interval?

A. No further imaging needed
B. Every 3 years
C. Every 6 months
D. Annually

Answer: B
Explanation: The 2026 SVS guidelines recommend ultrasound surveillance every 3 years for AAA 3.0-3.9 cm, every 12 months for 4.0-4.9 cm, and every 6 months for 5.0-5.4 cm. Growth rate <0.5 cm/year does not alter these intervals unless size thresholds are met.

Question: 1700

In MESA study 2025 update, asymptomatic 60-year-olds screened ABI<0.9. Multivariate model: diabetes OR 2.8, CKD eGFR<60 OR 3.2. Calculate combined relative risk (assume independence) for PAD if both present vs neither.

A. 8.96-fold
B. No multiplicative
C. 2.8-fold
D. 5.9-fold

Answer: A
Explanation: Multiplicative risk: diabetes OR 2.8 × CKD OR 3.2 = 8.96; CKD+PAD doubles amputation/mortality vs single. eGFR<45 OR>5; diabetes duration >15 years triples. Intensive glycemic/BP control slows progression 25%.

Question: 1701

GCA temporal biopsy + PET aorta SUV 6.2 active vision loss ESR 95.

A. Entrapment
B. Venography
C. Duplex carotid
D. PET systemic

Answer: D
Explanation: PET GCA.

Question: 1702

A 65-year-old male with cancer-associated PE and thrombocytopenia (platelets 60 x10^9/L).

A. Transfuse platelets then anticoagulate
B. Full-dose DOAC
C. Hold anticoagulation
D. Reduced-dose LMWH with monitoring

Answer: D
Explanation: Mild-moderate thrombocytopenia allows cautious reduced-dose LMWH.

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