CORONARY ARTERY BYPASS GRAFT (CABG) SURGERY 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.

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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!

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Questions

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1. Preoperative assessment for CABG includes evaluation of which of the following?

A. A full dental exam only

B. Assessment for S/S of angina or MI

C. Vision testing only

D. Preoperative anesthesia re-evaluation only

2. Which statement about MIDCAB is correct?

A. Performed with sternotomy and CPB

B. Small left chest incision w/ removal of 4th rib; No sternotomy, CPB, or cardioplegia

C. Robotic heart surgery uses large incisions

D. Requires CPB

3. How does diabetes mellitus influence CABG outcomes and graft patency?

A. Diabetes increases risk of graft occlusion, infection, wound healing problems, and mortality; arterial grafts and optimized metabolic control can improve outcomes.

B. Diabetes has no impact on CABG outcomes.

C. Diabetes reduces the need for arterial grafts.

D. Diabetes improves wound healing.

4. When should LDL optimization occur relative to CABG?

A. Lipids are not modifiable around surgery

B. Only postoperatively matters

C. Preoperative optimization of LDL is not important

D. LDL should be optimized pre- and postoperatively

5. Which strategy supports achieving the fasting blood sugar goal?

A. Reducing sugar & simple carb intake

B. Increasing refined carbohydrates

C. Delaying diabetes medications

D. Ignoring weight management

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6. Which finding should be reported immediately in suspected cardiac tamponade?

A. Sudden cessation of chest tube drainage

B. Increased midline chest incisional bleeding

C. Restlessness

D. Pulsus paradoxus

7. What is a common postoperative arrhythmia after CABG, and how is it typically managed?

A. Atrial fibrillation; managed with rate/rhythm control, beta-blockers, amiodarone, and other rhythm-control strategies as appropriate.

B. Ventricular fibrillation; managed with vasopressors only.

C. Sinus bradycardia; no treatment.

D. Third-degree AV block; immediately explanted.

8. What is commonly placed after grafting and before sternum closure in a traditional CABG?

A. Pacemaker wires & chest tubes

B. Only chest tubes

C. Only pacemaker wires

D. No tubes

9. What procedures are used to drain blood in tamponade?

A. Pericardiocentesis or emergency sternotomy

B. Paracentesis

C. Thoracentesis

D. Ventilation therapy

10. Which statement reflects a belief commonly affecting CABG care?

A. Jehovah's Witnesses do not believe in receiving blood products

B. Jehovah's Witnesses require aspirin for all surgeries

C. Jehovah's Witnesses can never consent to anesthesia

D. Jehovah's Witnesses demand immediate surgery without consent

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Answers

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

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Explanations

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1. Preoperative assessment for CABG includes evaluation of which of the following?

A. A full dental exam only

B. Assessment for S/S of angina or MI

C. Vision testing only

D. Preoperative anesthesia re-evaluation only

The main concept is that preoperative CABG planning centers on confirming cardiac stability by evaluating for signs and symptoms of angina or myocardial infarction. This matters because CABG carries a significant risk of perioperative myocardial ischemia, so identifying ongoing ischemia or a recent MI helps determine the timing of surgery and guides perioperative management. If a patient has active angina or recent MI, the team may optimize medical therapy, adjust the timing of the operation, or coordinate with cardiology for a revascularization plan, to reduce perioperative risk. Other options don't address the core risk the surgery aims to mitigate. A full dental exam, while potentially relevant for infection risk in some contexts, does not address the immediate cardiac stability required for CABG. Vision testing isn't related to perioperative cardiac risk. A preoperative anesthesia re-evaluation is important as part of overall care, but focusing only on that would miss the crucial assessment of current cardiac status and ischemia that guides timing and management.

2. Which statement about MIDCAB is correct?

A. Performed with sternotomy and CPB

B. Small left chest incision w/ removal of 4th rib; No sternotomy, CPB, or cardioplegia

C. Robotic heart surgery uses large incisions

D. Requires CPB

MIDCAB stands for Minimally Invasive Direct Coronary Artery Bypass. It is performed through a small left chest incision, often via the 4th intercostal space and sometimes with removal of part of the left 4th rib to access the target artery, most commonly the LAD. Crucially, it avoids a full sternotomy and does not use cardiopulmonary bypass; the graft is placed on a beating heart with stabilization, so there is no cardioplegia. This explains why the statement describing a small left chest incision with removal of the 4th rib and no sternotomy, no CPB, and no cardioplegia is the correct characterization of MIDCAB. The other options describe approaches that do not match MIDCAB: sternotomy with CPB corresponds to conventional CABG, robotic procedures use different port configurations and are not defined by a large incision, and requiring CPB would not be MIDCAB.

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3. How does diabetes mellitus influence CABG outcomes and graft patency?

A. Diabetes increases risk of graft occlusion, infection, wound healing problems, and mortality; arterial grafts and optimized metabolic control can improve outcomes.

B. Diabetes has no impact on CABG outcomes.

C. Diabetes reduces the need for arterial grafts.

D. Diabetes improves wound healing.

Diabetes mellitus raises risk in CABG by promoting higher rates of graft occlusion, infection, wound-healing problems, and death. This happens because hyperglycemia and its metabolic consequences drive immune dysfunction, increased inflammation, endothelial damage, and diffuse vascular disease, all of which blunt healing and favor clotting and graft failure. When arterial conduits are used—such as internal mammary arteries—they tend to stay open longer than vein grafts, and this advantage is especially important in diabetics who have accelerated atherosclerosis and graft occlusion risk. Pairing this with optimized metabolic control around the time of surgery further reduces infection, improves wound healing, and supports better graft patency and overall outcomes. So the statement that diabetes adds risk and that arterial grafting with good metabolic control can improve results best describes the impact on CABG outcomes and graft patency. The other ideas—no impact, reduced need for arterial grafts, or improved wound healing in diabetes—don't fit the evidence.

4. When should LDL optimization occur relative to CABG?

A. Lipids are not modifiable around surgery

B. Only postoperatively matters

C. Preoperative optimization of LDL is not important

D. LDL should be optimized pre- and postoperatively

LDL management around CABG should occur both before and after the operation. Optimizing LDL preoperatively helps stabilize plaques and reduce perioperative risk, including myocardial injury and inflammatory responses. Continuing lipid lowering after the surgery is essential to protect grafts and native vessels from progressive atherosclerosis and to reduce future cardiac events. The beneficial effects of statins and other lipid-lowering therapies extend across the perioperative period, improving short-term safety and long-term graft patency. So, LDL should be optimized pre- and postoperatively.

5. Which strategy supports achieving the fasting blood sugar goal?

A. Reducing sugar & simple carb intake

B. Increasing refined carbohydrates

C. Delaying diabetes medications

D. Ignoring weight management

Managing fasting blood sugar hinges on controlling the source of glucose entering the bloodstream during meals. Reducing sugar and simple carbohydrate intake lowers the rapid glucose load and the overnight hepatic glucose production that can push fasting levels higher, making it the most effective way to reach fasting goals. This approach also supports better weight management and improves insulin sensitivity, both of which help keep fasting glucose in the target range. Increasing refined carbohydrates would raise glucose input and worsen fasting levels, while delaying diabetes medications or ignoring weight management misses important steps that help sustain control of fasting glucose.

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6. Which finding should be reported immediately in suspected cardiac tamponade?

A. Sudden cessation of chest tube drainage

B. Increased midline chest incisional bleeding

C. Restlessness

D. Pulsus paradoxus

Pulsus paradoxus signals that the heart's filling is being severely limited by pressure in the pericardial sac, which is exactly what happens in tamponade. In tamponade, the increased intrapericardial pressure prevents the ventricles from filling properly, so during inspiration venous return rises but stroke volume falls, producing a marked drop in systolic blood pressure with inspiration—this is pulsus paradoxus. It is a direct, clinically urgent sign that hemodynamics are collapsing, so it should be reported immediately to initiate rapid intervention (such as re-exploration or pericardiocentesis) to relieve the tamponade. While other findings like sudden cessation of chest tube drainage, increased chest incisional bleeding, or restlessness may accompany postoperative issues, they do not specifically indicate evolving tamponade. Sudden chest tube drain cessation could be tube obstruction or other issues; increased bleeding reflects hemorrhage rather than tamponade physiology; restlessness is nonspecific and not diagnostic of tamponade.

7. What is a common postoperative arrhythmia after CABG, and how is it typically managed?

A. Atrial fibrillation; managed with rate/rhythm control, beta-blockers, amiodarone, and other rhythm-control strategies as appropriate.

B. Ventricular fibrillation; managed with vasopressors only.

C. Sinus bradycardia; no treatment.

D. Third-degree AV block; immediately explanted.

The main concept here is recognizing the most common rhythm problem after CABG and how it's typically handled. Atrial fibrillation is the usual culprit, arising in the immediate postoperative period—often within the first 24 to 48 hours—likely from atrial irritation from surgery, inflammation, and shifts in autonomic tone and electrolytes. Management focuses on controlling the heart rate and, if needed, restoring or maintaining a normal rhythm. Rate control is commonly started with beta-blockers to slow the ventricular response and lessen myocardial demand. If rhythm control is pursued, amiodarone is a favored option after CABG because it is effective at converting or maintaining sinus rhythm with a favorable safety profile in the postoperative setting. Other rhythm-control strategies can be used as appropriate, including electrical or chemical cardioversion if the arrhythmia persists or causes symptoms. In addition, decisions about anticoagulation are guided by how long AF lasts and the patient's stroke risk once the patient is stabilized. Why the other scenarios aren't the typical post-CABG pattern: ventricular fibrillation is a life-threatening event that triggers immediate resuscitation rather than a routine postoperative management plan. Sinus bradycardia can occur but is not treated with a blanket "no treatment" approach; it may require observation, atropine, or pacing if symptomatic. A third-degree AV block is a pacing indication, not an "immediate explant" situation, and requires pacing support.

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8. What is commonly placed after grafting and before sternum closure in a traditional CABG?

A. Pacemaker wires & chest tubes

B. Only chest tubes

C. Only pacemaker wires

D. No tubes

After completing the grafts in a traditional CABG, surgeons place temporary epicardial pacing wires on the heart and mediastinal chest drainage tubes before closing the sternum. The pacing wires provide immediate external pacing support if the heart's rhythm is slow to recover or there are conduction issues, while the chest tubes drain blood and air from the mediastinal space to prevent tamponade and other complications as healing begins. This combination is standard because it covers both critical postoperative needs: pacing if needed and reliable drainage. Opting for only one or no tubes would leave either pacing capability or drainage absent, which is not typical practice.

9. What procedures are used to drain blood in tamponade?

A. Pericardiocentesis or emergency sternotomy

B. Paracentesis

C. Thoracentesis

D. Ventilation therapy

Relieving tamponade requires immediate decompression of the pericardial space to restore the heart's ability to fill properly. The best approach is to drain the blood from the pericardial sac. This is done with pericardiocentesis, a percutaneous needle or catheter drainage procedure, often guided by ultrasound, to quickly remove the blood. If the bleeding is ongoing or in a trauma or post-surgical setting, emergency sternotomy may be performed to open the chest, evacuate the blood, and control the source of bleeding directly. Paracentesis drains fluid from the abdominal cavity, thoracentesis drains pleural fluid in the chest, and ventilation therapy supports breathing but does not remove blood from the pericardial space, so they don't treat tamponade.

10. Which statement reflects a belief commonly affecting CABG care?

A. Jehovah's Witnesses do not believe in receiving blood products

B. Jehovah's Witnesses require aspirin for all surgeries

C. Jehovah's Witnesses can never consent to anesthesia

D. Jehovah's Witnesses demand immediate surgery without consent

Beliefs about blood transfusion commonly affect CABG care. Jehovah's Witnesses often refuse blood products for religious reasons, so the care team plans around potential blood loss and uses strategies to preserve the patient's blood, such as blood-conservation techniques and exploring acceptable alternatives before surgery. This is why the statement about refusal of blood transfusions best captures a belief that can shape perioperative management. The other ideas don't fit common patient beliefs in this context: aspirin use is not universally required for all surgeries, consent to anesthesia is not categorically denied, and there is no general demand for immediate surgery without consent.

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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:

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

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