PEBC CARDIOLOGY 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. Which of the following is NOT a compensatory mechanism activated in acute heart failure?

A. Parasympathetic nervous system

B. RAAS

C. Sympathetic nervous system

D. Ventricular remodeling

2. Which drug class is listed as required in HFrEF?

A. ARNI/ACEi/ARB

B. Calcium channel blockers

C. Nitrates

D. Digoxin

3. After an acute coronary syndrome, what is the general recommended duration for beta-blocker therapy?

A. Indefinitely

B. 6 months

C. 3 years

D. 1 year

4. Which statement about PAD symptoms is true?

A. PAD symptoms can be unilateral, so both legs should be tested.

B. PAD symptoms are always bilateral

C. Testing is not needed if symptoms are mild

D. PAD never presents unilaterally

5. Which therapy is unique to cardioembolic stroke prevention compared to atherosclerotic stroke prevention?

A. Anticoagulation

B. BP management

C. Lipid management

D. Antiplatelet therapy

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6. At what age should patients without underlying conditions be screened for dyslipidemia?

A. 20

B. 40

C. 50

D. 60

7. What is the normal PR interval on an ECG?

A. 60-100 ms

B. 120-200 ms

C. 200-260 ms

D. 80-140 ms

8. A large difference in systolic blood pressure between the legs on evaluation suggests PAD.

A. A large inter-limb SBP difference suggests PAD

B. Ankle-brachial index above 1.3 indicates PAD

C. Normal resting heart rate

D. High HDL cholesterol

9. For beta-blocker therapy after MI with a single affected artery, duration is generally:

A. Indefinitely

B. 3 years

C. 6 months

D. 1 year

10. Which statement best describes HF-pEF in relation to ejection fraction?

A. Decreased ejection fraction

B. Valve stenosis as sole cause

C. Obstructive hypertrophic cardiomyopathy

D. Decreased filling and relaxation

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Answers

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

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Explanations

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1. Which of the following is NOT a compensatory mechanism activated in acute heart failure?

A. Parasympathetic nervous system

B. RAAS

C. Sympathetic nervous system

D. Ventricular remodeling

In acute heart failure, the body mounts neurohormonal and structural responses to preserve perfusion. Activating the sympathetic nervous system increases heart rate and contractility and causes vasoconstriction to boost cardiac output. The kidneys sense reduced perfusion and launch the RAAS, leading to vasoconstriction and fluid retention to maintain blood pressure and preload. Over time, the heart undergoes ventricular remodeling in response to sustained stress, a process that aims to preserve function initially, though it can become maladaptive. Activating the parasympathetic nervous system would slow the heart and reduce contractility, which would worsen cardiac output when it's already compromised. Therefore, the parasympathetic system is not a compensatory mechanism in acute heart failure; it is typically downregulated to allow sympathetic drive to predominate.

2. Which drug class is listed as required in HFrEF?

A. ARNI/ACEi/ARB

B. Calcium channel blockers

C. Nitrates

D. Digoxin

Blocking the renin-angiotensin system is the foundation of therapy in reduced EF heart failure because it counteracts the maladaptive neurohormonal activation that drives remodeling, symptoms, and progression. The drugs that achieve this block—ACE inhibitors, ARBs, or the ARNI combination sacubitril/valsartan—are considered required components of guideline-directed medical therapy for most patients with HFrEF, started early and continued as tolerated. Among these, sacubitril/valsartan is often preferred after stabilization because trials have shown it reduces mortality and HF hospitalizations more than an ACE inhibitor. But any of these agents provide the core survival benefit. Calcium channel blockers, particularly non-dihydropyridines, do not confer mortality benefit in HFrEF and can worsen contractility, so they aren't part of the universal backbone. Nitrates with hydralazine help certain groups (for example, some patients who can't take ACE inhibitors or ARBs, or specific populations), but they aren't universally required. Digoxin may improve symptoms in some patients, especially with atrial fibrillation or persistent symptoms despite GDMT, but it does not reduce mortality and isn't a universal first-line therapy.

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3. After an acute coronary syndrome, what is the general recommended duration for beta-blocker therapy?

A. Indefinitely

B. 6 months

C. 3 years

D. 1 year

Beta-blockers after an acute coronary syndrome are used to lower heart rate and blood pressure, reduce myocardial oxygen demand, and prevent reinfarction and dangerous arrhythmias. The benefit is strongest in the early period after the event, when the risk of another event is highest. The general recommendation is to continue beta-blocker therapy for about three years. This timeframe captures the period of greatest risk reduction, after which the incremental mortality benefit becomes smaller and the decision to continue becomes more individualized based on tolerance, blood pressure, heart rate, and left ventricular function. If a patient has ongoing indications—such as persistent LV dysfunction or symptoms—the therapy may be continued longer, potentially indefinitely.

4. Which statement about PAD symptoms is true?

A. PAD symptoms can be unilateral, so both legs should be tested.

B. PAD symptoms are always bilateral

C. Testing is not needed if symptoms are mild

D. PAD never presents unilaterally

Peripheral arterial disease can affect one limb without the other, so symptoms may be unilateral. Because a patient might have claudication or other signs in just one leg, you should examine and test both legs to avoid missing disease and to accurately gauge its extent. In practice, this means measuring an ankle-brachial index for each leg and comparing it to the corresponding arm pressures; a normal result in one leg does not rule out disease in the other, and disease can be present with mild or even no symptoms. So the statement that PAD symptoms can be unilateral and that both legs should be tested captures the correct approach. The idea that symptoms are always bilateral, that testing isn't needed with mild symptoms, or that PAD never presents unilaterally are not accurate.

5. Which therapy is unique to cardioembolic stroke prevention compared to atherosclerotic stroke prevention?

A. Anticoagulation

B. BP management

C. Lipid management

D. Antiplatelet therapy

Cardioembolic strokes come from clots formed in the heart, such as with atrial fibrillation or certain valve problems. The way to most effectively prevent these heart-origin clots is anticoagulation, which directly reduces clot formation in the heart and lowers the risk of clots traveling to the brain. That targeted effect on the cardiac clot source is why anticoagulation is the therapy uniquely associated with preventing cardioembolic events. Other measures like blood pressure control, lipid management, and antiplatelet therapy are important for stroke prevention in general and are especially relevant for atherosclerotic (plaque-related) stroke. They reduce vascular risk from arteries outside the heart and from platelet-driven events, but they don't specifically address the heart-origin clot mechanism as anticoagulation does.

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6. At what age should patients without underlying conditions be screened for dyslipidemia?

A. 20

B. 40

C. 50

D. 60

The main idea is to establish a baseline lipid status to assess future cardiovascular risk and guide prevention. For people with no underlying conditions, starting lipid screening around age 40 provides a practical point in time when lipid abnormalities become more common and the risk of ASCVD begins to rise with age. A baseline lipid panel at this age lets you categorize overall risk, plan lifestyle interventions, and decide if further monitoring or treatment is needed. If no risk factors are present, you typically repeat the test every few years (often every 4–6 years) to catch any changes early. Screening earlier is reserved for those with risk factors such as diabetes, hypertension, smoking, a family history of premature ASCVD, or obesity, where measuring lipids sooner can meaningfully influence management.

7. What is the normal PR interval on an ECG?

A. 60-100 ms

B. 120-200 ms

C. 200-260 ms

D. 80-140 ms

The PR interval reflects the time it takes for the electrical impulse to travel from the atria through the AV node to the ventricles. In a healthy adult, this conduction time is normally 120 to 200 milliseconds (0.12–0.20 seconds). Measuring from the start of the P wave to the start of the QRS complex captures this AV nodal conduction window, which is just long enough for the atria to contract and contribute to ventricular filling before the ventricles beat. If the interval is longer than 200 ms, that suggests some delay in AV conduction (first-degree AV block). If it's shorter than about 120 ms, that's not typical for a normal AV nodal pathway and can be seen with other conduction anomalies or measurement nuances. Among the options, 120–200 ms is the standard normal range, making it the best answer.

8. A large difference in systolic blood pressure between the legs on evaluation suggests PAD.

A. A large inter-limb SBP difference suggests PAD

B. Ankle-brachial index above 1.3 indicates PAD

C. Normal resting heart rate

D. High HDL cholesterol

A large difference in systolic blood pressure between the legs points to peripheral artery disease because it reflects asymmetric blood flow due to narrowed or blocked arteries in one leg. When an artery such as an iliac or femoral vessel is stenosed, the downstream pressure in that leg drops compared with the other leg, creating a noticeable inter-limb SBP gap. This noninvasive clue often leads to confirmation with an ankle-brachial index test and follow-up imaging to assess the extent of arterial obstruction. An ABI above 1.3 suggests calcified, noncompressible arteries rather than PAD, which can give falsely high readings, so it does not indicate PAD. A normal resting heart rate or high HDL cholesterol doesn't specifically diagnose PAD in this context.

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9. For beta-blocker therapy after MI with a single affected artery, duration is generally:

A. Indefinitely

B. 3 years

C. 6 months

D. 1 year

The main idea is that beta-blocker protection after a heart attack is strongest early on, and the duration of therapy is often finite in uncomplicated cases to allow reassessment later. For a patient who has had an MI from a single affected artery and who is clinically stable with preserved heart function, the usual approach is to continue beta-blockade for about 6 months. This window captures the period of highest risk for recurrent events while giving time to evaluate recovery of function and tolerability. If the patient remains stable and LV function is good, clinicians can re-evaluate at that point; in patients with LV dysfunction, heart failure, or ongoing symptoms, therapy is often continued longer.

10. Which statement best describes HF-pEF in relation to ejection fraction?

A. Decreased ejection fraction

B. Valve stenosis as sole cause

C. Obstructive hypertrophic cardiomyopathy

D. Decreased filling and relaxation

HFpEF means heart failure with a normal or near-normal ejection fraction. The key issue isn't the heart's ability to pump out blood (systolic function) but its ability to fill properly during diastole. The left ventricle is stiff or less compliant, so filling and relaxation are impaired, leading to higher filling pressures and heart failure symptoms despite a preserved ejection fraction. That's why the statement describing decreased filling and relaxation best matches HFpEF in relation to ejection fraction. By contrast, a decreased ejection fraction points to HF with reduced EF, and the other choices describe conditions or contributors that aren't the defining feature of HFpEF.

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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:

https://pebccardiology.examzify.com

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

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