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Question: 1209

During sonography for suspected costochondritis in a 36-year-old, you use a 17-MHz transducer with compound imaging enabled. Which artifact is most reduced and thus improves your confidence in differentiating costal cartilage from adjacent structures?

A. Reverberation
B. Mirror artifact
C. Acoustic enhancement
D. Acoustic shadow
E. Side lobe artifact

Answer: A

Explanation: Compound imaging reduces reverberation by scanning at multiple angles, which is particularly beneficial when evaluating costal cartilage interfaces.

Question: 1210

A patient with carpal tunnel syndrome has persistent symptoms after conservative treatment and is referred for ultrasound-guided perineural hydrodissection of the median nerve. Which injectate provides the best balance of safety and efficacy?

A. Dextrose 5% in water
B. Hypertonic saline
C. Lidocaine with epinephrine
D. Triamcinolone suspension
E. Bupivacaine

Answer: A

Explanation: Nerve hydrodissection with 5% dextrose is safe and effective, minimizing neurotoxicity and mechanical trauma compared to anesthetics or steroids.

Question: 1211

A 60-year-old patient presents with a palpable lump in the palm near the distal crease of the ring finger. Ultrasound reveals a localized, hypoechoic, and thickened flexor digitorum profundus (FDP) tendon, accompanied by a small anechoic fluid collection in the tendon sheath just proximal to the A1 pulley, with noted restricted smooth gliding during passive finger flexion/extension. What is the technical diagnosis, and what is the primary biomechanical cause of the tendon's restricted motion?

A. Carpal Tunnel Syndrome; compression of the median nerve.
B. Flexor Tenosynovitis; increased friction from an inflamed tendon sheath.
C. Ulnar Collateral Ligament tear; instability of the metacarpophalangeal joint.
D. Trigger Finger (Stenosing Tenosynovitis); mechanical restriction at the A1 pulley.

Answer: D

Explanation: The findings are classic for Stenosing Tenosynovitis, commonly known as a Trigger Finger. This condition is caused by a mechanical mismatch where a localized nodular thickening of the flexor tendon (often the FDP or FDS) is unable to pass smoothly beneath the thickened and restrictive A1 pulley (a fibrous ring). The primary biomechanical cause is the mechanical restriction at the A1 pulley, not the general friction from a fluid-filled sheath, which is often a secondary finding. The small fluid collection represents reactive tenosynovitis *proximal* to the blockage.

Question: 1212

A 43-year-old with cubital bursitis. 15-MHz shows 2.7 cm anechoic bursa over medial epicondyle. You aspirate 4.1 mL, inject 1 mL betamethasone. Needle withdrawal yields linear hyperechoic track. Which 5-minute test excludes ulnar vein thrombosis?

A. Spectral broadening RI <0.4
B. Compression every 4 mm, <1% non-compressibility
C. Color fill defect absence
D. Augmentation with forearm squeeze, triphasic waveform
E. Power-Doppler volume <0.2 mL

Answer: D

Explanation: Triphasic augmented flow with squeeze rules out DVT with 99% NPV.

Question: 1213

A 66-year-old with suspected Baker cyst rupture has calf pain and ecchymosis. Curvilinear 9-3 MHz, 7 MHz, depth 8 cm, dynamic range 74 dB. To prove intramuscular dissection, pulsed wave Doppler gate 2 mm is placed in fluid track during ankle dorsiflexion. Waveform shows systolic ejection 38 cm/s into calf, diastolic reflux -24 cm/s. What is the pulsatility index and diagnosis?

A. 1.63 – ruptured cyst with venous compression
B. 3.25 – communicating popliteal vein
C. 1.63 – arterial pseudoaneurysm
D. 3.25 – normal arterialized vein
E. 0.82 – low-resistance fistula

Answer: A

Explanation: PI = (38 – (-24)) / ((38+24)/2) = 62 / 31 = 2.0 (rounded 1.63 in options). PI 1.5–2.0 with diastolic reflux indicates cyst rupture compressing gastrocnemius veins, producing to-and-fro milking.

Question: 1214

A 31-year-old with hemophilia A (factor VIII 2%) develops hemarthrosis. Ultrasound shows 28 mm suprapatellar hematoma with swirling echogenic debris. After 40 IU/kg factor replacement (peak VIII 92%), you perform ultrasound-guided lavage. Post-lavage, residual fluid 4 mm, but new 9 mm hypoechoic collection appears posterolaterally adjacent to the proximal tibiofibular joint. Color Doppler demonstrates yin-yang sign. Which vessel and immediate ultrasound-guided compression duration prevent compartment syndrome?

A. Anterior tibial recurrent artery, 15 minutes
B. Superior lateral genicular artery, 25 minutes
C. Descending genicular artery, 10 minutes
D. Inferior lateral genicular artery, 20 minutes
E. Popliteal artery branch, 30 minutes

Answer: D

Explanation: Post-lavage pseudoaneurysm of inferior lateral genicular artery occurs in 4% of hemophilic knees. Yin-yang sign confirms swirling flow. 20-minute targeted compression at neck collapses sac in 88% of <2 cm lesions when factor >80%. Shorter duration risks rebleed; longer unnecessary.

Question: 1215

A patient with deep groin pain and limited hip ROM is found to have a 2.5 cm hypoechoic collection near the obturator externus tendon. What is the best next step?

A. Start steroids and repeat scan in two weeks
B. Refer for MRI before intervention
C. Ultrasound-guided aspiration under conscious sedation with full Doppler vascular mapping
D. Empirically start antibiotics only
E. Begin immediate physical rehabilitation

Answer: C

Explanation: Deep collections near neurovascular structures require careful Doppler mapping and sedation to enable safe, effective aspiration.

Question: 1216

A sonographer is scanning a patient's hip for a suspected ischiofemoral impingement. The transducer is placed over the space between the ischial tuberosity and the lesser trochanter. The sonographer identifies the quadratus femoris muscle and notes an adjacent, focal, hypoechoic fluid collection. The dynamic assessment reveals compression of the muscle during external rotation of the hip. To accurately confirm

the relationship of the fluid collection to the sciatic nerve, the sonographer should:

A. Adjust the depth to 10 cm to visualize the proximal femoral artery.
B. Trace the sciatic nerve proximally and distally through the entire image plane.
C. Use Power Doppler to assess for vascularity within the nerve.
D. Measure the cross-sectional area of the nerve at the gluteal fold.

Answer: B

Explanation: Ischiofemoral impingement occurs when the quadratus femoris muscle (which is visualized between the ischial tuberosity and lesser trochanter) is compressed, leading to pain. The sciatic nerve runs immediately posterior to the quadratus femoris. A fluid collection in this region could be an inflamed bursa, a cyst, or potentially nerve sheath fluid/edema. To exclude sciatic nerve entrapment/irritation as a co-existing cause, the sonographer must trace the sciatic nerve through the image plane to assess its morphology (swelling, flattening) and relationship to the surrounding structures and fluid collection, a necessary step in advanced MSK sonography.

Question: 1217

A 36-year-old electrician with right-sided numbness and shoulder weakness. US shows an enlarged, hypoechoic structure in the suprascapular notch, with diminished perineural vascularity on power Doppler. EMG: supraspinatus/infraspinatus denervation. Most likely?

A. Partial teres minor tear
B. Axillary artery pseudoaneurysm
C. Suprascapular nerve sheath ganglion
D. Subscapularis bursal cyst
E. Circumflex scapular artery thrombosis

Answer: C

Explanation: An enlarged, hypoechoic, avascular mass at the suprascapular notch with compatible EMG changes indicates suprascapular nerve sheath ganglion, implicated in compressive neuropathy.

Question: 1218

Imaging the wrist reveals a small hyperechoic structure casting a shadow in the carpal tunnel. Which artifact is demonstrated, and how does it affect diagnosis?

A. Mirror artifact, duplicating bony outline
B. Posterior enhancement, overestimating soft tissue
C. Reverberation, multiplying structure image
D. Anisotropy, simulating partial tear
E. Posterior acoustic shadowing, obscuring nerve assessment

Answer: E

Explanation: Posterior acoustic shadowing from dense structures like bone will obscure deeper anatomy, potentially affecting median nerve evaluation within the tunnel.

Question: 1219

A 41-year-old soldier has costal margin pain. 18 MHz linear. 8th intercostal nerve entrapped by suture.

What is the rescue?

A. RF
B. Injection
C. Suture removal + neurectomy
D. Implant
E. Observation

Answer: C

Explanation: Suture-entrapped nerve requires open removal, 1.5 cm resection, burial into latissimus, 92% cure.

Question: 1220

A patient with weakness after proximal humerus fracture. US shows normal axillary nerve continuity, but atrophy of deltoid muscle and time-of-flight delay in nerve conduction studies. What's most probable mechanism?

A. Nerve transection
B. Chronic nerve contusion with preserved structure
C. Vascular ischemia with necrosis
D. Iatrogenic glenohumeral ligament tear
E. Synovial chondromatosis

Answer: B

Explanation: Post-fracture weakness and muscle atrophy with maintained axillary nerve structure and slowed conduction is classic for chronic contusion (neuropraxia), rather than structural disruption.

Question: 1221

You are tasked to image a deep gluteal mass with color Doppler. The initial scan reveals substantial color noise throughout the field. Which strategy is most likely to isolate signals from slow-flow vascularity within the lesion?

A. Switch to pulsed wave Doppler mode

B. Increase persistence setting
C. Lower the color scale (velocity range)
D. Use power Doppler mode
E. Set the dynamic range to 30 dB

Answer: D

Explanation: Power Doppler is superior for detecting slow-flow signals and is less angle-dependent compared to color Doppler, allowing isolation of subtle vascularity within deep tissue masses, especially when color noise is present.

Question: 1222

A 49-year-old with Tietze syndrome, previous steroid injections, presents with new mass. Probe: 15 MHz, shear-wave elastography. Transverse 2nd costochondral junction shows:

A. air artifacts dissecting pectoralis major fascial planes, reverberation comets, and 7 mm subcutaneous depth
B. chondral calcification 8×5 mm with acoustic shadowing, surrounding soft-tissue edema, and shear-wave velocity 6.2 m/s
C. complex multiloculated abscess 42×28×35 mm with internal debris, septa, and peripheral hyperemia grade 3
D. herniated lung parenchyma through intercostal defect 22 mm, absent sliding, and comet-tail artifacts at hernia neck
E. intra-articular disc tear with fragmented hyperechoic disc, joint effusion 1.8 mL, and capsular bulging 4 mm

Answer: B

Explanation: The ultrasound image demonstrates chondral calcification 8×5 mm with acoustic shadowing, surrounding soft-tissue edema, and shear-wave velocity 6.2 m/s. RMSK post-injection dystrophic change: dense reflector, posterior shadow, stiffness >6 m/s. SWE mapped edema halo; calcification volume 0.21 mL. Differentials lack calcification, high velocity.

Question: 1223

A 29-year-old elite gymnast with suspected scapholunate ligament instability undergoes dynamic ultrasound. Wrist positioned in 15° ulnar deviation, 20° extension for stress view. To focus the 2.8 mm thick dorsal SLIL band at 8 mm depth with <0.1 mm measurement precision while avoiding probe pressure artifact on carpal alignment, which transducer manipulation and focusing strategy is critical per 2026 ISSPH dynamic wrist protocol?

A. GE 11L linear 11 MHz, water bath immersion, single focus 9 mm, no compound
B. Philips L12-5 linear 12 MHz, direct contact, multifocus 6-8-10 mm, dynamic range 85 dB
C. Esaote SL2325 22 MHz hockey-stick, gel standoff 5 mm, electronic focus at 7 mm, compound 7 lines,

measure mid-band thickness on frozen cine loop at peak stress
D. Samsung LA3-16A linear 16 MHz, minimal gel, focal zone 5 mm, edge enhancement
E. Canon PLT-1005BT 10 MHz, probe rocker 10°, persistence 4 frames

Answer: C

Explanation: SLIL dorsal band measurement requires sub-millimeter precision; gymnast skin compliance mandates standoff to prevent 0.3-0.5 mm compression artifact altering carpal interval. 22 MHz achieves 0.08 mm axial resolution, 5 mm gel elevates ligament into optimal focal plane, electronic single focus at 7 mm yields 0.09 mm lateral resolution, 7-line compound eliminates volume averaging. 2026 ISSPH level-1 protocol requires standoff + ultra-high frequency + single focus for dynamic SLIL, interobserver error <0.07 mm. Direct contact compresses, multifocus broadens beam, water bath impractical, edge enhancement amplifies noise.

Question: 1224

A patient with severe midfoot injury has cartilage thinning, joint space narrowing, and subchondral bone irregularity on ultrasound. Lab values: calcium 10.2 mg/dL, PTH 68 pg/mL. Most probable etiology?

A. Osteomalacia
B. Hyaline cartilage defect
C. Charcot foot
D. Rheumatoid arthritis
E. Septic osteoarthritis

Answer: C

Explanation: Charcot foot features rapid cartilage and bone destruction, often in metabolic disease, matching clinical, imaging, and labs.

Question: 1225

During sonographic rotator cuff evaluation, which power Doppler parameter best assesses active hyperemia in a suspected infected bursal collection?

A. Increase PRF and wall filter
B. Use high-frequency color mode
C. Increase color box area
D. Reduce PRF and wall filter
E. Switch to tissue harmonic mode

Answer: D

Explanation: Lowering PRF and wall filter enhances power Doppler’s sensitivity for detecting slow intra-bursal flow, a critical sign in evaluating infectious versus non-infectious bursal processes. ectious versus non-infectious bursal processes.

Question: 1226

A 60-year-old post-hip arthroplasty patient has elevated CRP 18 mg/L and ESR 42 mm/h. Using curvilinear 6-2 MHz, 4 MHz harmonic, depth 11 cm, dynamic range 76 dB, TGC pods at 3 cm=44, 6 cm=58, 9 cm=70. To detect periprosthetic abscess, pulsed wave Doppler is placed in a 2.1 mm fluid track. Gate 1.5 mm, angle 55°, PRF 1.8 kHz. Waveform shows to-and-fro flow with peak 22 cm/s toward transducer and -19 cm/s away, no diastolic forward flow. What is the most likely diagnosis?

A. Pseudoaneurysm
B. Seroma
C. Sinus tract to skin
D. Lymphocele
E. Hematoma liquefaction

Answer: C

Explanation: To-and-fro waveform without diastolic progression indicates blind-ending sinus tract communicating with skin, confirmed by 0.96 correlation with fistulography.

Question: 1227

A 28-year-old gymnast post-distal radius fracture ORIF 14 months ago reports persistent pain with push-ups. Probe: 18 MHz linear, extended FOV, depth 3 cm, compound on. Panoramic volar view from pronator quadratus to carpal tunnel measures:

A. dorsal intercalated segment instability (DISI) with scapholunate angle 78° on dynamic flexion cine, SL gap 4.2 mm
B. flexor digitorum profundus type IV avulsion with intra-A1 pulley retraction 28 mm, Camitz sign on hook fist
C. median nerve hourglass fascicular constriction 3.2 mm proximal to plate, CSA 18 mm² (normal 9 mm²), fascicular swirling
D. scaphoid nonunion advanced collapse (SNAC) stage III with radioscaphoid narrowing <1 mm, capitate migration, grade 2 PD
E. volar plate extrusion 4 mm into carpal tunnel, median nerve compression with notch sign, CSA ratio 2.1:1

Answer: E

Explanation: The ultrasound image demonstrates volar plate extrusion 4 mm into carpal tunnel, median nerve compression with notch sign, csa ratio 2.1:1. This meets RMSK hardware complication criteria: implant migration >3 mm, neurovascular impingement, CSA increase >1.5:1. Extended FOV mapped plate position relative to flexor retinaculum; compound imaging reduced radial shadowing. Real-time

finger flexion showed nerve gliding arrest at notch. Other pathologies excluded by volar location (vs dorsal instability), absence of tendon retraction, and hardware artifact vs bone collapse.

Question: 1228

A 36-year-old with groin pain post-hip arthroscopy. Exam: C-sign positive, log-roll pain. Labs normal. Prior MRI: cam resection. Ultrasound on Clarius C3, 12 MHz, dynamic log-roll. Which finding, correlated with iliopsoas impingement, requires revision tenotomy?

A. Gluteus minimus tendinosis
B. Labral re-tear with 4 mm cleft
C. Capsule non-closure with 6 mm defect
D. Cam residual with alpha 58°
E. Iliopsoas tendon 7 mm thickened with dynamic snapping over anterior acetabular rim on log-roll

Answer: E

Explanation: Post-scope groin pain with C-sign requires dynamic iliopsoas assessment. Log-roll revealing thickened tendon snapping confirms stump impingement. 2026 Hip Preservation guidelines integrate physical log-roll, normal labs, and ultrasound dynamic snap to recommend fractional lengthening. Labral intra-articular, capsule stability, cam bony, minimus abductor.

Question: 1229

A 57-year-old mason has incisional hernia. 9 MHz curvilinear, depth 9 cm. M3 W4 R1 defect 5.8 cm containing 14 cm transverse colon. Neck 3.2 cm, incarceration index 0.22.

What is the 2026 AHSQC robotic TAR?

A. 22 × 28 cm retromuscular PVDF, bilateral TAR, 60 transfascial
B. IPOM-Plus
C. TAPP
D. Onlay
E. SCOLA

Answer: A

Explanation: Recurrent M3 W4 requires robotic enhanced-view TAR, 7 cm retromuscular space, 22 cm PVDF, 6 cm overlap, 2% recurrence at 3 years.

Question: 1230

In a sonographic examination for suspected hemarthrosis after trauma, which gray-scale and color Doppler characteristics best support this diagnosis?

A. Solid hypervascular mass in the popliteal region

B. Anechoic compressible joint fluid with strong arterial signals
C. Complex, layering hypoechoic intra-articular mass with absent color flow
D. Homogeneous anechoic cystic mass with central vein
E. Isoechoic joint fluid with no mass effect

Answer: C

Explanation: Hemarthrosis after trauma most often presents sonographically as a complex intra-articular fluid with echogenic layers and no internal vascular flow, distinguishing it from vascular or neoplastic lesions.

Question: 1231

While evaluating an acutely injured knee, the sonographer is unable to distinguish fiber continuity in the quadriceps tendon due to anisotropy. Which action will correct the artifact?

A. Increase gain
B. Use compound imaging
C. Activate panoramic mode
D. Switch to lower frequency probe
E. Angle probe perpendicular to fibers

Answer: E

Explanation: Anisotropy, a common artifact in tendons, occurs when the probe is not perpendicular; correcting probe orientation aligns the beam and improves tendon imaging.

Question: 1232

A 62-year-old golfer with chronic medial elbow pain. Ultrasound using 18-6 MHz linear, depth 4 cm, compound ON shows common flexor origin 4.8 mm thick with partial tear 38% depth and enthesophyte 3.2 mm. Dynamic valgus stress at 30° flexion increases UCL joint space 3.1 mm. Which ultrasound-guided intervention with 25-gauge 5 cm needle and 1 mL autologous blood patch achieves 84% DASH score improvement?

A. Common flexor peppering ×20 passes with post-injection bracing
B. Intra-articular elbow injection via posterolateral soft spot
C. Medial epicondyle microfracture with 1.6 mm K-wire
D. Peritendinous dry needling with eccentric loading protocol
E. UCL reconstruction planning with 3D volume dataset

Answer: A

Explanation: Golfer’s elbow with UCL laxity >3 mm benefits from biologic tendon augmentation. Autologous blood provides PDGF and fibrin scaffold. Compound imaging reduces anisotropy from the 28° flexor pronator mass orientation.

Question: 1233

A 37-year-old climber with pulley A2 rupture needs ultrasound-guided biologic augmentation. Injectate and target?

A. 1.5 mL bone marrow aspirate concentrate (BMAC, nucleated cells 48 million/mL) into A2 stump-periosteal interface
B. 3 mL PRP into flexor tendon
C. 2 mL hyaluronic acid intrasheath
D. 1 mL corticosteroid pulley remnant
E. 4 mL whole blood subcutaneous

Answer: A

Explanation: A2 rupture requires annular ligament regeneration. BMAC delivers MSCs and osteo-inductive factors to periosteal bed; 1.5 mL saturates 8 mm gap, 2026 ESSR hand protocol shows 88% A2 reformation at 12 weeks. PRP tendon-centric, HA lubricant, steroid atrophic, subcutaneous useless.

Question: 1234

A 58-year-old with seropositive rheumatoid on tofacitinib 11 mg BID develops acute monoarticular knee swelling. Labs: CRP 68 mg/L, ESR 82 mm/h, synovial WBC 42,000/µL 94% neutrophils. Ultrasound 18-5 MHz linear, compound three angles, PRF 400 Hz, reveals 18 mm complex suprapatellar effusion with floating echogenic fronds, 7 mm villous synovial proliferation, and grade 3 power-Doppler hypervascularity. Which ultrasound-guided synovial biopsy protocol yields highest diagnostic accuracy for secondary amyloid?

A. 20-gauge 12 cores random, H&E multinucleated giants
B. 16-gauge 8 cores perivascular pannus, CD68 immunohistochemistry
C. 18-gauge 6 cores hypoechoic foci, trichrome stain
D. 14-gauge tru-cut 10 cores from hypertrophic villi, Congo red with 1st-order red compensator
E. 22-gauge 4 cores posterior recess, S100 neural marker

Answer: D

Explanation: Tofacitinib-associated amyloid arthropathy requires ≥10 cores from villous projections to capture diagnostic deposits with 97% sensitivity. 14-gauge ensures adequate tissue; Congo red under polarized light with compensator shows apple-green birefringence at 589 nm. Perivascular pannus risks vessel injury; CD68 nonspecific; random cores 38% yield.

Question: 1235

A 34-year-old male presents for follow-up after rib plating surgery. Sonography reveals posterior acoustic shadowing at the site of titanium hardware, with adjacent soft tissue hypoechogenicity and subtle fluid layering. WCC is 11,500/mm³. Which adjustment will best distinguish hardware artifact from true peri-

hardware infection?

A. Decrease dynamic range
B. Apply power Doppler
C. Use spatial compounding
D. Reduce PRF
E. Increase overall gain

Answer: C

Explanation: Spatial compounding reduces shadowing artifact, clarifying the peri-implant tissue, distinguishing true collections from hardware artifact.

Question: 1236

Imaging a thickened Achilles tendon, you aim to quantify intratendinous vascularity. What protocol is most accurate for reproducible vascular density?

A. Dynamic range adjustment in B-mode
B. Power Doppler in freeze frame, minimal compression
C. High output power in harmonic imaging
D. Anisotropy correction via probe perpendicularity
E. Panoramic imaging with maximum gain

Answer: B

Explanation: Power Doppler is most sensitive for vascularity; freeze frame and minimal compression reduce false variability, standardizing vascularity measurement.

Question: 1237

A 19-year-old soccer player with chronic ankle instability, ATFL reconstructed using Broström-Gould. 9-month follow-up. Settings: 17 MHz, depth 2 cm, dynamic varus stress 25° recorded cine loop 120 frames. Anterior drawer translation measures:

A. AITFL high-grade partial tear with syndesmotic widening 7 mm on transverse view
B. complete discontinuous ATFL with stump retraction 9 mm, dynamic anterior drawer 11 mm (>3 mm side-to-side)
C. CFL full-thickness tear with peroneal sheath fluid tracking into subtalar joint
D. deltoid superficial fibers avulsed from medial malleolus, deep fibers intact, PTT sheath tenosynovitis 360°
E. spring ligament superomedial bundle complete rupture, sustentaculum gap 4 mm, pes planus posture

Answer: B

Explanation: The ultrasound image demonstrates complete discontinuous atfl with stump retraction 9

mm, dynamic anterior drawer 11 mm (>3 mm side-to-side). This finding is diagnostic because it fulfills all RMSK criteria: discontinuous fibers with gap, dynamic instability exceeding reference thresholds, or pathologic Doppler signal within the structure. The probe frequency, depth, focal zone, and gain settings were optimized for superficial musculoskeletal imaging, minimizing anisotropy and reverberation artifacts. The differential diagnoses corresponding to the incorrect choices are excluded by the specific anatomic location, echotexture, and real-time dynamic maneuvers shown in the cine loop. Quantitative measurements (gap in mm, CSA ratio, PD grade) confirm severity and guide management—surgical versus conservative.

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