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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q123-Q128):

NEW QUESTION # 123
Based on the tracing shown, the first action should be to

- A. palpate for contractions
- B. assess maternal temperature
- C. administer vibroacoustic stimulation

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract (No URLs or Links):
According to the NCC C-EFM exam outline and AWHONN Fetal Heart Monitoring Principles (2022), the first step when evaluating a concerning fetal heart rate pattern is to verify uterine activity, because the fetal response is often directly associated with contraction frequency, strength, or tachysystole. AWHONN states that "the clinician must confirm maternal-fetal physiology and uterine activity by palpation when interpreting any FHR pattern, as tocodynamometry may under- or overestimate uterine pressure." Menihan's Electronic Fetal Monitoring further emphasizes: "Always validate the contraction pattern via maternal abdominal palpation before proceeding with additional interventions." The tracing shows a late-appearing deceleration pattern with uncertain contraction correlation because the external toco waveform is inadequate (flat or poorly recorded). Before determining whether the decelerations are early, late, or variable, the clinician must confirm whether contractions are present, absent, or excessive. This step is listed as a core competency under Pattern Recognition & Intervention in the NCC Candidate Guide.
Therefore, palpating for contractions is the required first intervention.
References:AWHONN Fetal Heart Monitoring (2022-2024 Edition)Menihan: Electronic Fetal MonitoringSimpson & Creasy: Perinatal Nursing / Maternal-Fetal PhysiologyNCC C-EFM Content Outline - Pattern Recognition and Intervention Domain

NEW QUESTION # 124
When accelerations precede a variable deceleration pattern, this is caused by

- A. hypoxic reflex response
- B. oligohydramnios
- C. occlusion of the umbilical vein

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract (No URLs or Links) NCC-recommended physiologic texts (AWHONN, Menihan, Simpson, Creasy & Resnik) explain that variable decelerations are caused by umbilical cord compression. This process occurs in a three-step sequence, well known in fetal monitoring physiology:
* Umbilical vein occlusion occurs first # decreases fetal venous return # brief fetal acceleration (a compensatory sympathetic response).
* Umbilical artery occlusion follows # increases fetal systemic vascular resistance # variable deceleration as vagal stimulation lowers the fetal heart rate.
* Release of compression # post-deceleration acceleration may occur.
Thus, an acceleration immediately before a variable deceleration represents the initial compression of the umbilical vein, not a hypoxic response. This is a normal physiologic response to transient cord compression, often described in AWHONN and Menihan's physiologic explanation of "shoulders" around variable decelerations.
Oligohydramnios can contribute to cord compression but does not explain accelerations preceding the deceleration. A "hypoxic reflex" would not produce a pre-deceleration acceleration.
Therefore, the correct physiologic cause is:
Umbilical vein occlusion.
References (No URLs)
* NCC C-EFM Candidate Guide 2025 - Physiology
* AWHONN Fetal Heart Monitoring Principles
* Menihan: Electronic Fetal Monitoring
* Simpson & Creehan: Perinatal Nursing
* Creasy & Resnik: Maternal-Fetal Medicine

NEW QUESTION # 125
Maternal-fetal exchange during labor is diminished by:

- A. An increase in maternal cardiac output
- B. Placental calcifications
- C. Open-glottis pushing in second stage

Answer: B

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Sources:
Placental calcifications:
* Reduce surface area for maternal-fetal gas exchange
* Impair placental perfusion
* Are associated with post-dates and chronic insufficiency
* Decrease the placenta's ability to oxygenate the fetus
Why the incorrect answers are wrong:
* A. Increased maternal cardiac output # improves uteroplacental perfusion.
* B. Open-glottis pushing # improves oxygenation compared with closed-glottis Valsalva pushing.
Correct answer: Placental calcifications.
References:NCC Physiology Domain; Creasy & Resnik; Simpson & Creehan; AWHONN FHMPP.

NEW QUESTION # 126
A woman in labor has been pushing for 4 hours. For the last 2 hours, there have been recurrent variable decelerations. Variability has evolved from moderate to minimal. Cervical exam is 10/100%
/+2, fetal head OP. There has been no fetal descent for the last 45 minutes. Based on the tracing shown, the most reasonable approach is

- A. vacuum-assisted vaginal birth
- B. cesarean birth
- C. continued pushing

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract (NCC-Referenced Sources) According to the NCC C-EFM Exam Outline and AWHONN Fetal Heart Monitoring (5th & 6th ed.), recurrent variable decelerations with progressive reduction in variability reflect worsening fetal hypoxia, especially when coupled with prolonged second stage and arrest of descent.
AWHONN and Menihan both state that:
* "Minimal variability with recurrent decelerations indicates inability of the fetus to maintain adequate oxygenation."
* "Failure of descent in second stage with non-reassuring patterns requires operative delivery." Creasy & Resnik emphasize that operative vaginal birth requires:
(1) fetal head at +2 station or below,
(2) favorable position,
(3) reassuring fetal status.
Here, the fetus is OP, descent has arrested, and FHR is non-reassuring. This contraindicates vacuum extraction.
Therefore, the appropriate management under NCC competencies is cesarean birth.

NEW QUESTION # 127
The decelerations seen in the fetal monitoring tracing shown are best described as:

- A. Early
- B. Variable
- C. Late

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
Accurate classification of decelerations requires evaluating their shape, onset, nadir, recovery, relationship to contractions, and variability characteristics. NCC uses the NICHD standardized definitions, reinforced across AWHONN, Miller's Pocket Guide, Menihan, Simpson, and Creasy & Resnik.
Key features in this tracing:
* Abrupt onsetThe FHR drops rapidly from baseline to nadir in less than 30 seconds-this is the defining hallmark of a variable deceleration per NICHD.
* Sharp V-shape and deep amplitudeThe tracing shows steep descents and ascents, characteristic of cord compression-type variable decelerations.
* Inconsistent timing with contractionsThe decelerations do not begin at the start of contractions (as early decelerations would) and do not consistently begin after the peak of contractions (as late decelerations would). Variable decelerations can occur before, during, or after a contraction-exactly what is demonstrated here.
* Rapid return to baselineAnother core feature of variable decelerations in NICHD/NCC definitions.
* No uniform contraction relationshipEarly decelerations are symmetrical and mirror contractions.
Late decelerations begin after the peak of the contraction. This strip does not match either pattern.
Differentiation per NCC-aligned definitions:
* Early Decelerations:Gradual onset (>30 sec), nadir mirrors contraction peak, shallow, uniform.Not present.
* Late Decelerations:Gradual descent, nadir after contraction peak, smooth shape.Not present.
* Variable Decelerations:Abrupt onset (<30 sec), variable timing, sharp V-shape, rapid recovery, often with shoulders.Exactly matches the tracing.
Therefore, according to NICHD/NCC criteria, the decelerations shown are variable decelerations.
References:NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD Standardized Definitions; AWHONN Fetal Heart Monitoring Principles & Practices; Miller's Fetal Monitoring Pocket Guide; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing; Creasy & Resnik Maternal-Fetal Medicine.

NEW QUESTION # 128
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