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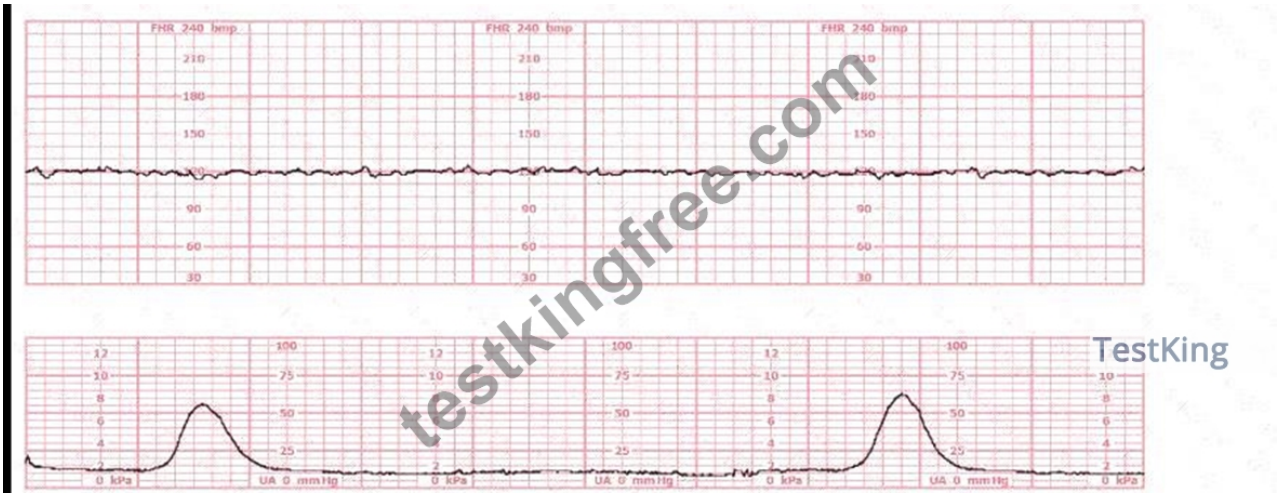
NCC Certified - Electronic Fetal Monitoring Sample Questions (Q45-Q50):

NEW QUESTION # 45
This tracing reflects:

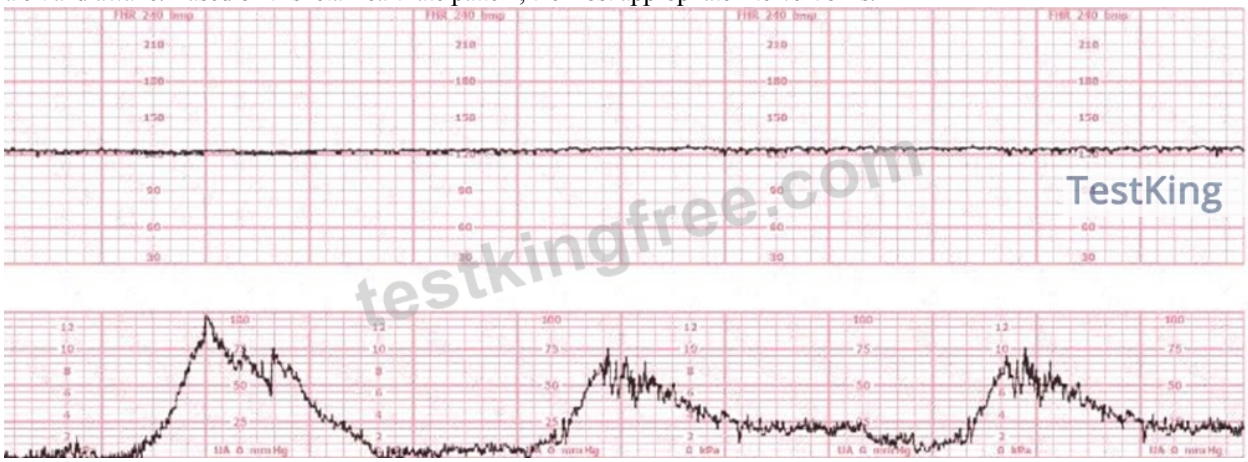


- A. Category II
- B. Category I
- C. Category III

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
In NCC C-EFM interpretation, classification of a fetal heart tracing is based on NICHD's three-tier system:
Category I, II, and III. Category III represents an abnormal tracing requiring immediate evaluation and prompt intervention.
Key findings in this tracing:
* Baseline:Baseline is approximately 140 bpm, within the normal range (110-160 bpm).Baseline alone does not determine category.
* Variability:The tracing shows absent variability:
* No beat-to-beat oscillations
* Flat, minimal fluctuationNICHD and NCC define absent variability as amplitude range undetectable.
* Accelerations:No accelerations are present.
* Decelerations:The strip does not show decelerations or bradycardia.However, absent variability alone with no accelerations for 20 minutes is highly concerning.
Category Classification per NICHD/NCC:
Category III criteria include ANY of the following:
* Absent variability with recurrent late decelerations
* Absent variability with recurrent variable decelerations
* Absent variability with bradycardia
* Sinusoidal pattern
Also recognized as Category III:
* Persistent absent variability lasting #20 minutes with no accelerations, which is strongly suggestive of fetal acidemia when sustained.
This tracing shows:
* Absent variability (flat line)
* No accelerations
* Persisting over an extended period
Under NCC and AWHONN guidance:
A persistently flat tracing must be classified as Category III unless proven otherwise (e.g., fetal sleep, maternal medications), and it requires immediate intrauterine resuscitation and evaluation for potential expedited delivery.
Why Category I is NOT correct:
Category I requires:
* Moderate variability
* No late or variable decelerationsThis tracing does not have moderate variability.
Why Category II is NOT correct:
Category II includes minimal variability, marked variability, intermittent variables/lates, absence of accelerations after stimulation.
This tracing is worse than Category II because variability is absent, not minimal.
Thus, the tracing fits Category III.
References:NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD Three-Tier FHR Interpretation System; 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 # 46
The tracing shown is from a woman at 28-weeks gestation in the post-anesthesia care unit (PACU) after an appendectomy. She is alert and awake. Based on this fetal heart rate pattern, the most appropriate intervention is:



- A. Continued monitoring
- B. Administer terbutaline
- C. Perform cesarean birth

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
The fetal heart rate tracing shows:
* Baseline around 140 bpm
* Minimal variability
* No accelerations
* No decelerations
* Regular uterine activity but not tachysystole
This pattern is Category II, but in the context of:
* 28-week gestation
* Immediate postoperative status after anesthesia
* Maternal alertness and stability
NCC and AWHONN emphasize that maternal sedation, post-anesthesia effects, medications, and physiologic stress commonly cause temporary minimal variability without acidemia, especially at preterm gestations where baseline variability is normally lower.
Key NCC principle:
Minimal variability in a stable mother without decelerations does NOT require emergent delivery.
Instead, the fetus should be observed as anesthesia effects wear off.
Why other answers are incorrect:
* A. Terbutaline - No tachysystole and no recurrent decels are present.
* C. Cesarean birth - No bradycardia, no late decels, no absent variability, and no Category III criteria.
Thus, appropriate management is B. Continued monitoring.
References:NCC C-EFM Candidate Guide; AWHONN FHMPP; Menihan EFM; Miller's Pocket Guide; NICHD Definitions; Creasy & Resnik.

NEW QUESTION # 47
A patient presents at 38-weeks gestation with complaints of decreased fetal movement and ruptured membranes. The fetal heart rate is not able to be determined with an external ultrasound monitor. A spiral electrode is placed, and the tracing shows a rate of 90 bpm. What is the next most appropriate action?

- A. Palpation of the maternal radial pulse
- B. Intrauterine resuscitation measures
- C. Request for an urgent bedside ultrasound

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
Whenever a fetal heart rate is unexpectedly low (such as 90 bpm), the FIRST step per NCC and AWHONN is to confirm that the signal is fetal, not maternal.
Even internal spiral electrodes can capture maternal heart rate, especially after:
* Rupture of membranes
* Maternal hypotension
* Maternal dehydration
* Maternal tachycardia or bradycardia
Thus, the first, most immediate action is:
Palpate the maternal radial pulse to determine whether the tracing is maternal or fetal.
If rates match # the monitor is falsely detecting the maternal pulse.
If rates differ # confirm true fetal bradycardia and begin intrauterine resuscitation.
Why the other options are incorrect:
* A. Intrauterine resuscitation - should NOT begin before confirming the tracing is fetal.
* C. Bedside ultrasound - appropriate after confirming that the tracing is not maternal, not before.
Correct answer: B. Palpation of the maternal radial pulse.
References:NCC C-EFM Candidate Guide; AWHONN FHMPP; Menihan; Miller's Pocket Guide; Simpson & Creehan.

NEW QUESTION # 48
Uterine contraction intensity is manually measured by degree of uterine:

- A. Pain
- B. Muscle strength
- C. Indentation

Answer: C

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Equipment Concepts:
When using external tocodynamometry, uterine contraction intensity cannot be measured in mmHg. It is assessed manually, using palpation. NCC and AWHONN teach:
* Contraction intensity is estimated by palpating the fundus during a contraction.
* The degree of firmness versus indentation determines intensity:
* Mild # uterus easily indented
* Moderate # firm, difficult to indent
* Strong # rigid, cannot be indented
Why the incorrect answers are wrong:
* B. Muscle strength - Not measurable by external or manual exam.
* C. Pain - Not a reliable indicator; pain perception varies widely and does not correlate with uterine intensity.
Thus, the correct manual measurement is done through uterine indentation, making A correct.
References:NCC C-EFM Candidate Guide; AWHONN Principles & Practices; Menihan EFM; Miller's Pocket Guide; Simpson & Creehan.

NEW QUESTION # 49
When monitoring monochorionic-monoamniotic twins, which of the following fetal heart rate patterns would be anticipated?

- A. Variable decelerations
- B. Minimal variability
- C. Baseline tachycardia

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract (NCC-Referenced Sources) Mono-mono twins share a single amniotic cavity, which significantly increases the risk of cord entanglement
, a concept highlighted in AWHONN FHM, Creasy & Resnik Maternal-Fetal Medicine, and Miller's EFM Pocket Guide.
These texts emphasize:

* "Cord entanglement is nearly universal in monoamniotic twins."
* "Variable decelerations are common due to recurrent cord compression." Baseline tachycardia or minimal variability are not expected baseline characteristics, but may appear only in pathologic circumstances.
Thus, variable decelerations are the expected and anticipated FHR pattern in mono-mono twins.

NEW QUESTION # 50
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