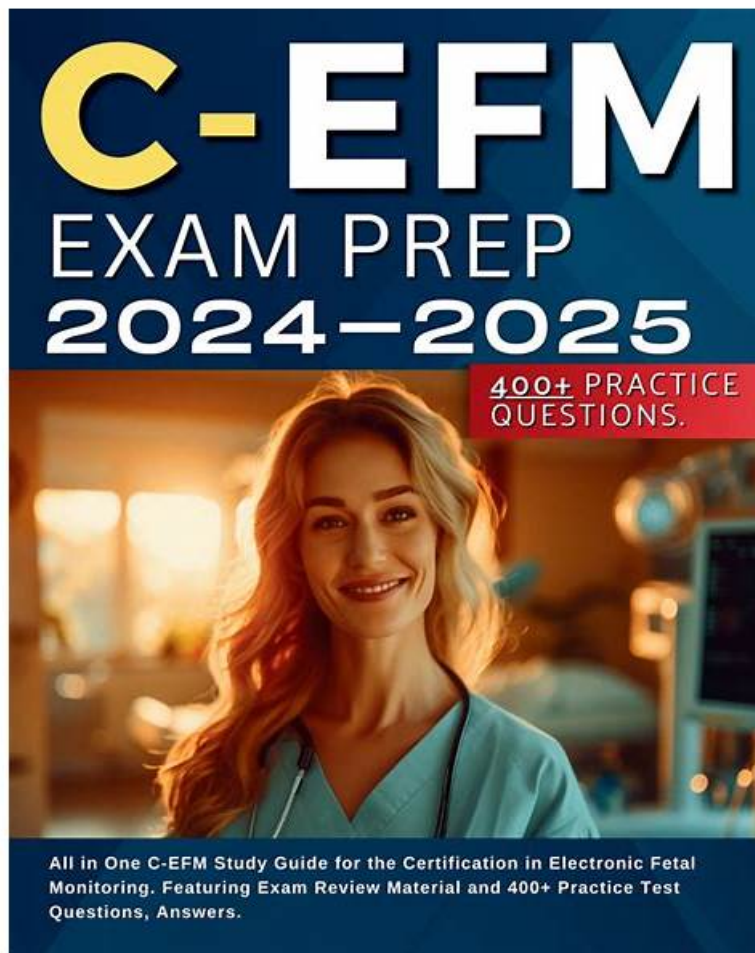


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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q37-Q42):

NEW QUESTION # 37

A woman is being induced with oxytocin. The tracing shown is representative of 20 minutes. Based on this tracing, the next step would be to:

- **A. Discontinue oxytocin**
- B. Proceed to operative birth
- C. Place a spiral electrode

Answer: A

Explanation:

Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:

Evaluation of a tracing during oxytocin induction requires analysis of fetal status (baseline, variability, accelerations, decelerations) and uterine activity, with attention to tachysystole and fetal intolerance. NCC, AWHONN, Miller, Menihan, Simpson, and the NICHD guidelines all emphasize that oxytocin must be adjusted based on fetal response and contraction frequency.

Baseline:

The fetal heart rate baseline is approximately 150 bpm, which is within the normal range of 110-160 bpm.

Variability:

The tracing shows minimal variability (approximately 1-4 bpm amplitude). Minimal variability for a sustained period is categorized as a Category II pattern under NCC/NICHD classification.

Accelerations:

No accelerations are present during the 20-minute representative segment.

Decelerations:

There are no recurrent variable, no recurrent late, and no prolonged decelerations.

Uterine Activity:

The tracing shows very frequent contractions—approximately every 1½ to 2 minutes, which meets the NCC definition of tachysystole when averaged over 10 minutes (more than 5 contractions in 10 minutes).

According to NCC and AWHONN standards, when tachysystole is present with minimal variability, oxytocin must be reduced or discontinued even in the absence of late decelerations.

Clinical decision-making (per NCC principles):

NCC emphasizes that management of Category II patterns during induction starts with intrauterine resuscitative measures, including decreasing or stopping oxytocin when uterine activity is excessive or fetal response is suboptimal. Minimal variability with tachysystole requires correction of uterine stimulation before escalating to invasive monitoring or considering operative birth.

Option B (place a spiral electrode) is not indicated because the pattern is clearly visible and the priority is correcting uterine overstimulation, not refining the tracing.

Option C (operative birth) is not indicated; there is no Category III pattern or recurrent decelerations.

Option A (discontinue oxytocin) is the correct first-line action according to NCC-aligned guidelines when tachysystole and minimal variability occur.

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 # 38

Fetal cardiac output is essentially dependent on the fetal:

- **A. Heart rate**
- B. Activity
- C. Baroreceptors

Answer: A

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

Because the fetal myocardium is immature, it has:

* Limited ability to increase stroke volume

* Limited ability to increase contractility

Therefore, fetal cardiac output (CO) is almost entirely dependent on heart rate.

NCC and AWHONN physiology describe:

* $CO = \text{stroke volume} \times \text{heart rate}$

* In the fetus, stroke volume is relatively fixed

- * Therefore, changes in HR directly affect cardiac output
- * Tachycardia # increases CO
- * Bradycardia # decreases CO # decreased perfusion and oxygen delivery

Why the other options are incorrect:

- * A. Activity does not fundamentally determine CO.
- * B. Baroreceptors regulate HR reflexively but are not the primary determinant of cardiac output.

Correct answer: C. Heart rate

References: NCC Physiology Domain; AWHONN FHMPP; Menihan; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 39

Amnioinfusion can cause what changes in the fetal heart rate tracing?

- A. Increase in fetal heart rate baseline
- B. Improvement in fetal heart rate variability
- C. Resolution of variable decelerations

Answer: C

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

NCC defines amnioinfusion as indicated for:

- * Recurrent variable decelerations caused by cord compression
- * Oligohydramnios reducing buffer around the cord

Expected effect:

- * Reduction or elimination of variable decelerations

Why the other answers are incorrect:

- * A. Variability does not improve with amnioinfusion.
- * B. Baseline FHR does not increase as a result of amnioinfusion.

Correct answer: C. Resolution of variable decelerations.

References: NCC C-EFM Candidate Guide; AWHONN FHMPP; Menihan; Simpson & Creehan.

NEW QUESTION # 40

When accelerations precede a variable deceleration pattern, this is caused by

- A. oligohydramnios
- B. hypoxic reflex response
- 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 # 41

When the fetal heart rate is measured by a Doppler transducer and the intervals between heart beats are persistently identical, this shows as

- A. bradycardia
- B. normal baseline
- C. absent variability

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources Variability is created by beat-to-beat differences in fetal cardiac intervals due to autonomic nervous system modulation. AWHONN specifies that absent variability appears as "a near-straight line with minimal or no discernible oscillations," which occurs when all beat intervals are identical. Menihan notes that Doppler displays variability based on mechanical motion and will show flat, unchanging intervals when fetal autonomic modulation is suppressed, reflecting absent variability.

Bradycardia refers to a baseline <110 bpm and does not describe the uniformity of intervals. A normal baseline may still show variability; it cannot have identical beat-to-beat intervals, as this violates the definition of variability in NICHD terminology.

Simpson & Creehan state that absent variability is a significant marker of impaired fetal oxygenation or CNS depression.

References:

AWHONN - Fetal Heart Monitoring Principles & Practices
Menihan - Electronic Fetal Monitoring
Simpson & Creehan - Perinatal Nursing
Creasy & Resnik - Maternal-Fetal Medicine
Miller's Pocket Guide

NEW QUESTION # 42

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
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