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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q36-Q41):

NEW QUESTION # 36

To differentiate a fetal dysrhythmia from artifact, it is important to recognize that artifact appears as deflections that are:

- A. Uniform but occur irregularly
- B. Similar in pattern
- C. Varied and disorganized

Answer: C

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

Artifact on fetal monitoring:

- * Appears erratic, disorganized, and without physiologic pattern
- * Shows random amplitude changes
- * Often correlates with maternal movement, monitor displacement, or poor signal
- * Lacks cyclical, repetitive characteristics seen in true dysrhythmias

Fetal dysrhythmias, by contrast:

- * Have repetitive, patterned, predictable rhythm disturbances
 - * May show uniform premature beats, bigeminy, or sudden rate shifts
- Therefore, varied and disorganized = artifact.

References: NCC Candidate Guide; AWHONN FHMPP; Menihan; Miller's Pocket Guide.

NEW QUESTION # 37

A woman experiences an eclamptic seizure during the second stage of labor. An anticipated fetal heart rate abnormality post-seizure would be:

- **A. Bradycardia**
- B. Variable decelerations
- C. Sinusoidal pattern

Answer: A

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Emergency Fetal Response Principles:

Following an eclamptic seizure:

- * Maternal hypoxia, apnea, and intense sympathetic discharge occur
- * Uteroplacental perfusion drops
- * Fetus experiences acute hypoxemia
- * The expected fetal heart rate response is a prolonged bradycardia

This is well-described in NCC and AWHONN emergency physiology:

- * "Post-seizure fetal bradycardia is common and often resolves within 5-10 minutes as maternal oxygenation stabilizes." Why other answers are incorrect:
- * B. Sinusoidal pattern - Rare and usually indicates fetal anemia, not post-seizure status.
- * C. Variable decelerations - Associated with cord compression, not seizures.

Correct answer: A. Bradycardia

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

NEW QUESTION # 38

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 # 39

A fetal heart rate tracing is abnormal. A change in maternal position and oxygen administration do not correct the pattern. Following birth, a fetal cord blood sample is taken:

pH = 7.25

PaCO# = 46 mm Hg

PaO# = 20 mm Hg

HCO# = 22 mEq/L

Base deficit = -4 mEq/L

These results are best interpreted as:

- **A. Normal**
- B. Acidosis
- C. Hypoxia

Answer: A

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

Normal umbilical arterial values per NCC/AWHONN/Menihan:

* pH: 7.20-7.30

* PaCO#: 45-55 mmHg

* HCO#: 20-24 mEq/L

* Base deficit: 0 to -5 (normal to mild respiratory changes)

This sample shows:

* pH 7.25 # normal

* Base deficit -4 # no metabolic acidosis

* HCO# normal

* Slightly elevated PaCO#, consistent with mild respiratory influence but still normal

* PaO# 20 mmHg is normal for cord arterial blood

This profile is not acidotic (acidosis requires pH <7.10 and base deficit #12).

It also does not indicate hypoxia, which would present with metabolic acidosis.

Therefore: Normal.

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

NEW QUESTION # 40

Intrapartum asphyxia can be determined by:

- A. One-minute Apgar score
- **B. Cord blood gas analysis**
- C. Fetal heart rate interpretation

Answer: B

Explanation:

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

NCC emphasizes that only objective acid-base assessment can diagnose intrapartum asphyxia. This is accomplished with cord arterial blood gas analysis showing:

* pH < 7.0-7.1

* Base deficit # 12 mmol/L

* Elevated PCO#

FHR patterns suggest risk, but do not diagnose asphyxia.

Apgar scores, especially at 1 minute, do not correlate reliably with acidemia.

Thus, cord gas analysis is the correct determinant.

References: NCC C-EFM Candidate Guide; AWHONN; NICHD; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 41

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