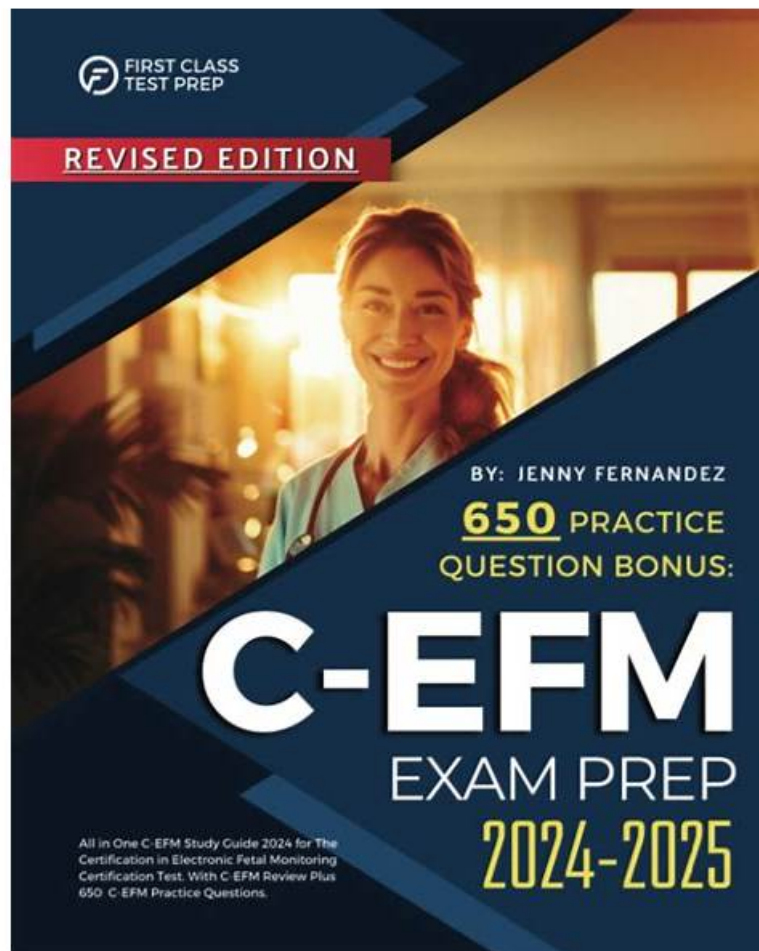


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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q62-Q67):

NEW QUESTION # 62

During the second stage of labor, a period of bradycardia develops. The fetal heart rate baseline variability is moderate. The most

likely cause of this bradycardia is:

- **A. Vagal stimulation**
- B. Vasospasm
- C. Cord compression

Answer: A

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

Second-stage bradycardia with moderate variability most commonly occurs from:

* Vagal stimulation caused by head compression, particularly during descent and pushing.

Moderate variability indicates:

- * Neurologically intact fetus
- * Sufficient oxygen reserve
- * Temporary nature of bradycardia

This aligns with physiologic vagal slowing rather than hypoxic mechanisms.

Why the incorrect answers are wrong:

- * A. Cord compression # typically produces variable decelerations, not sustained bradycardia with preserved variability.
- * C. Vasospasm # associated with late decelerations and decreased variability (uteroplacental insufficiency).

Correct answer: B. Vagal stimulation

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

NEW QUESTION # 63

A fetus displays a baseline heart rate of 125 beats per minute with moderate variability. During a contraction, the baseline rate drops abruptly to 80 beats per minute with gradual return to baseline over 90 seconds. This is classified as:

- **A. Variable deceleration**
- B. Prolonged deceleration
- C. Early deceleration

Answer: A

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

NICHD definitions:

A variable deceleration is identified by:

- * Abrupt onset (drop from baseline to nadir in <30 seconds)
- * Depth #15 bpm
- * Duration #15 seconds and <2 minutes
- * Variable timing relative to contractions
- * Variable shape (sharp drop, jagged descents, rapid recovery)

The scenario describes:

- * Abrupt drop from 125 # 80 bpm (rapid onset)
- * Lasting 90 seconds (still <2 minutes)
- * Gradual return but still within variable range
- * Occurring during a contraction
- * Depth >15 bpm

This meets ALL criteria for a variable deceleration.

Why the other options are wrong:

- * A. Early deceleration
- * Requires gradual onset (>30 seconds).
- * Mirrors contraction shape.
- * Caused by head compression.
- * This decel is abrupt, so NOT early.
- * B. Prolonged deceleration
- * Requires #2 minutes and <10 minutes.
- * This decel lasts 90 seconds, which is below the threshold.

Correct classification: Variable deceleration.

References: NICHD FHR Definitions; NCC Pattern Recognition Domain; AWHONN FHMPP; Menihan; Simpson & Creehan.

NEW QUESTION # 64

A woman (G1, P0) at 41-weeks gestation presents to OB triage to rule out labor. Her cervical exam is 1 cm/50%/-2. Membranes are intact. She would like to go home if not in labor. Based on this tracing, which represents the last two hours, the best approach is:

- A. discharge to home
- B. admission to hospital
- C. further observation

Answer: A

Explanation:

Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources The fetal heart rate tracing shows a normal baseline (120-150 bpm), moderate variability, and no decelerations, consistent with a Category I pattern. According to AWHONN's Fetal Heart Monitoring Principles & Practices and NCC Perinatal Safety recommendations, a Category I tracing reliably indicates normal fetal acid-base status at the time of assessment and is considered reassuring.

Simpson & Creehan emphasize that in triage, management decisions depend on cervical status, contraction pattern, membrane status, and fetal well-being. With a cervix at 1 cm/50%/-2, intact membranes, and no regular labor pattern, she is not in active or latent labor requiring admission, provided fetal status is reassuring.

Menihan states that a normal tracing lasting two hours with moderate variability supports safe discharge when maternal and fetal assessments are normal. Creasy & Resnik confirm that reassuring fetal testing plus absence of labor is appropriate for outpatient management.

References:

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

NEW QUESTION # 65

Tachysystole can have a negative effect on fetal oxygenation during labor by

- A. increasing maternal blood pressure
- B. blocking active transport of oxygen to the fetus
- C. interfering with reperfusion of the intervillous space

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources NCC-recommended physiology references (AWHONN, Simpson & Creehan, Menihan, Creasy & Resnik) consistently state that the primary mechanism by which tachysystole affects fetal oxygenation is reduced uteroplacental perfusion, specifically through impaired intervillous space reperfusion. During a normal contraction cycle, the fetus receives oxygen between contractions, when the uterus relaxes and maternal blood re-enters the intervillous space. AWHONN's Fetal Heart Monitoring Principles & Practices explains that tachysystole-defined as more than five contractions in 10 minutes averaged over 30 minutes-shortens or eliminates the relaxation phase, preventing adequate placental reoxygenation.

Simpson & Creehan highlight that "tachysystole decreases uteroplacental blood flow and interferes with replenishment of oxygenated maternal blood in the intervillous space." Menihan emphasizes that fetal hypoxemia in tachysystole results from interrupted perfusion, not from altered oxygen transport or maternal hemodynamic changes. Creasy & Resnik confirm that uterine overactivity reduces intervillous perfusion during contractions and impairs fetal oxygen exchange.

Thus, the physiologic problem is failure of the intervillous space to reperfuse, which compromises fetal oxygenation.

References:

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

NEW QUESTION # 66

The most highly oxygenated blood in the fetal circulation is found in the

- A. descending aorta
- B. pulmonary arteries
- C. ductus venosus

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract Sources:

In fetal physiology, the highest oxygen saturation exists in the umbilical vein, which then flows through the ductus venosus before entering the right atrium.

According to Creasy & Resnik Maternal-Fetal Medicine, and AWHONN physiologic foundations:

* The umbilical vein carries oxygen-rich blood from the placenta (approx. 80% saturation).

* Most of this blood bypasses the liver via the ductus venosus, which therefore contains the most highly oxygenated blood within the fetal circulatory system.

By contrast:

* The descending aorta contains mixed blood with significantly lower oxygen content due to mixing after passage through the ductus arteriosus.

* The pulmonary arteries in the fetus carry predominantly deoxygenated blood, since fetal lungs are fluid-filled and have high pulmonary vascular resistance.

Thus, the structure containing the highest fetal oxygen concentration is the ductus venosus.

References: Creasy & Resnik - Maternal Fetal Medicine; AWHONN Fetal Monitoring; Simpson & Miller - Fetal Monitoring Physiology; NCC C-EFM Content Outline - Physiology Domain.

NEW QUESTION # 67

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