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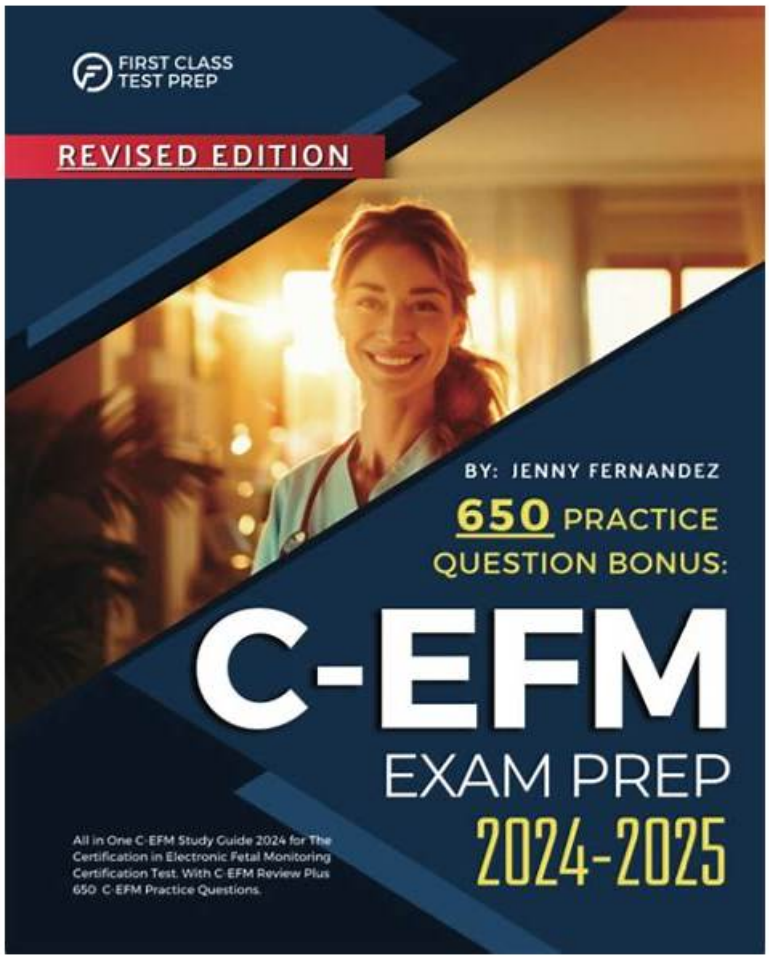

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q93-Q98):

NEW QUESTION # 93
When accelerations precede a variable deceleration pattern, this is caused by

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

Answer: A

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

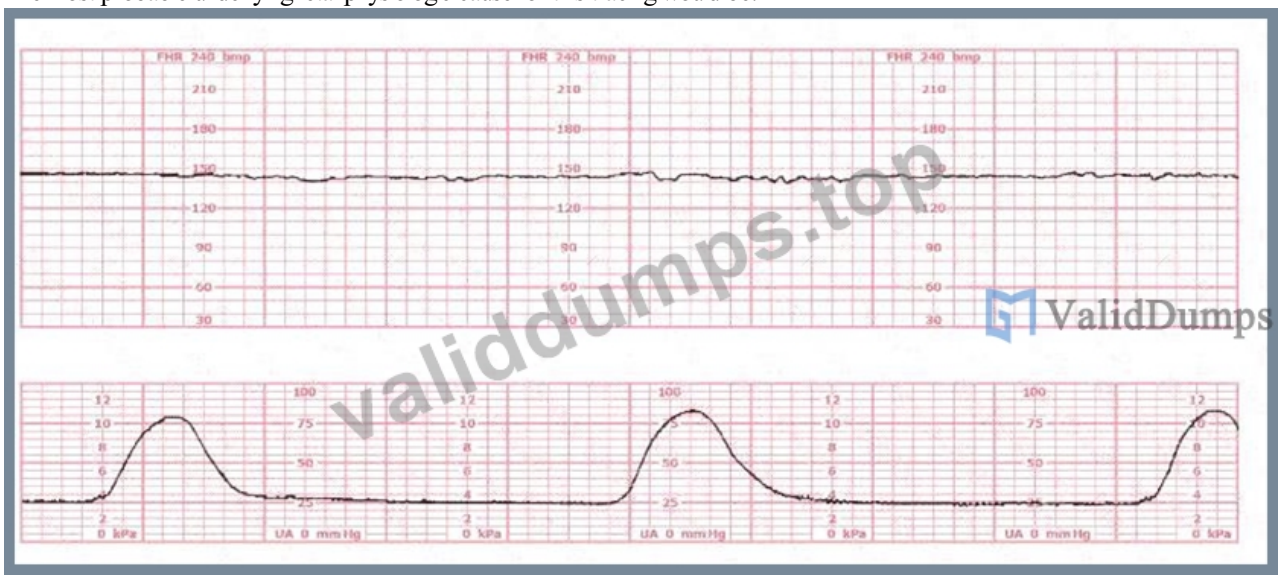
NEW QUESTION # 94
Nonstress testing is used more frequently for antepartum testing than contraction stress testing because contraction stress testing has a:

- A. Low predictability of fetal well-being within 7 days of a negative test
- B. Higher frequency of equivocal test results
- C. Limited reporting option for the compromised fetus

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
NCC and AWHONN explain that Contraction Stress Testing (CST):
* Has a higher rate of equivocal ("equivocal-suspicious" or "equivocal-hyperstimulation") results
* Frequently must be repeated or replaced with other tests
* Requires inducing contractions, which carries risk (hyperstimulation, preterm labor, uterine rupture in scarred uterus) NST is used more commonly because it is:
* Noninvasive
* Easier to perform
* Has fewer contraindications
* Has a lower rate of equivocal results
Why the others are incorrect:
* B - CST does detect fetal compromise reliably and is NOT limited in its reporting structure.
* C - A negative CST actually has very high negative predictive value for 7 days, making this answer incorrect.
Thus the correct choice is A. Higher frequency of equivocal results.
References:NCC C-EFM Candidate Guide; AWHONN; Menihan; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 95
The most probable underlying fetal physiologic cause for this tracing would be:



- A. Myocardial hypoxic depression
- B. Release of catecholamines
- C. Vagal nerve stimulation in response to hypoxemia

Answer: B

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Sources:
This tracing shows:
* Baseline ~145 bpm
* Minimal variability
* No accelerations or decelerations
* Very little fluctuation # resembles a flat/minimal variability Category II tracing The key physiologic mechanism behind minimal variability in the presence of a normal baseline and normal contraction pattern is most often:
Increased fetal sympathetic tone, driven by catecholamine release (epinephrine and norepinephrine).
NCC and AWHONN explain:
* Catecholamine release (due to fetal stress, early hypoxemia, or maternal stress) results in:
* Reduced beat-to-beat fluctuation
* Minimal baseline variability
* This is considered an early compensatory mechanism, not yet a decompensated hypoxic state.
Why the other answers are incorrect:
* A. Myocardial hypoxic depression
* Causes absent variability, NOT minimal variability.
* Represents advanced or severe hypoxia. The FHR here is not absent variability.
* C. Vagal stimulation in response to hypoxemia
* Produces decelerations, especially late or prolonged.
* This strip shows no decelerations, ruling this out.
Therefore the most accurate physiologic explanation is B. Release of catecholamines.
References:NCC C-EFM Candidate Guide; AWHONN FHMPP; NICHD Baseline Variability Definitions; Menihan EFM; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 96
An internal electronic fetal monitor tracing continues to record artifact despite equipment troubleshooting and replacement of the spiral electrode. The next action is to:

- A. Reposition the woman
- B. Auscultate the fetal heart rate
- C. Provide oxygen

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
When internal monitoring continues to record artifact despite:
* Changing the scalp electrode
* Ensuring correct attachment
* Checking cable connections
* Confirming maternal movement is not the cause
NCC requires confirmation of fetal well-being using another modality.
The correct next step is direct auscultation with Doppler or fetoscope.
Why other answers are incorrect:
* Oxygen is not indicated for equipment malfunction.
* Repositioning does not resolve internal FHR artifact.
Thus, Auscultate the fetal heart rate is the appropriate next step.
References:NCC C-EFM Candidate Guide; AWHONN; Miller's Pocket Guide; Menihan.

NEW QUESTION # 97
(Full question statement)
A woman at 39-weeks gestation is in labor, progressing normally. The baseline fetal heart rate has increased from 125 to 150 beats per minute over the last hour with moderate variability. What is the next step?

- A. Initiate antibiotic therapy
- B. Perform an ultrasound
- C. Continue to observe

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract Without Links:
NCC-recommended references (Simpson, AWHONN FHM, Creasy & Resnik) note that baseline increases within the normal range (110-160 bpm) accompanied by moderate variability are typically benign. Mild physiologic causes-maternal activity, fetal stimulation, or normal sympathetic activation-may transiently raise baseline FHR.
AWHONN stresses that intervention is required only when tachycardia exceeds 160 bpm or when variability is minimal/absent or accompanied by recurrent decelerations.
Here, the baseline increase to 150 bpm remains within normal limits and is paired with moderate variability, which the NCC recognizes as the strongest indicator of adequate fetal oxygenation.
Therefore, evaluation is complete, and continued observation is the appropriate course.

NEW QUESTION # 98
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