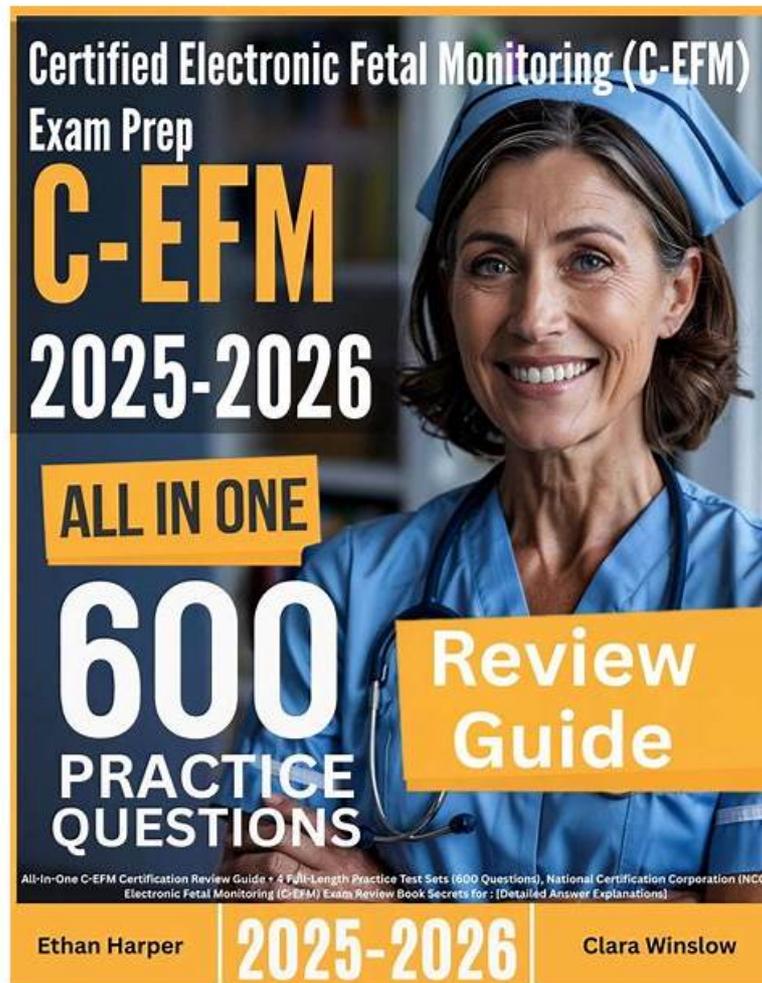


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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q11-Q16):

NEW QUESTION # 11

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 # 12

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 # 13

An electronic fetal monitoring factor that best correlates with fetal well-being is:

- A. Absence of decelerations
- B. Presence of variability
- C. Baseline heart rate 140-150 bpm

Answer: B

Explanation:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

The single best indicator of fetal oxygenation and neurologic integrity is:

* Moderate baseline variability

Variability reflects:

* Normal autonomic regulation

* Adequate fetal oxygenation

* Intact neurologic pathways

Absence of decelerations is helpful but not as predictive.

Baseline FHR (e.g., 140-150) is normal, but baseline alone does not confirm well-being.

Correct answer: C. Presence of variability

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

NEW QUESTION # 14

Fetal heart rate variability results from normal variance in fetal:

- A. Levels of carbon dioxide
- B. Cardiac responsiveness
- **C. R-R intervals**

Answer: C

Explanation:

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

Variability reflects the interplay of the autonomic nervous system-sympathetic and parasympathetic influences-on the fetal myocardium. NCC defines variability as variation in the R-R intervals on the fetal ECG.

Key points:

* Variability originates from beat-to-beat fluctuations in ventricular depolarization timing.

* These R-R interval changes result from baroreceptor and chemoreceptor responses, vagal modulation, and fetal behavioral states.

* Carbon dioxide levels affect chemoreceptors but do not directly define variability.

Thus, variability is best described as resulting from variance in R-R intervals.

References: NCC C-EFM Candidate Guide; NICHD Definitions; AWHONN Fetal Heart Monitoring Principles & Practices; Menihan Electronic Fetal Monitoring.

NEW QUESTION # 15

A woman at 38-weeks gestation is admitted to labor and delivery following a fall down the stairs three hours ago. She started feeling contractions in the ambulance. The fetal heart rate tracing shown is on initial evaluation and represents 25 minutes. This tracing is most consistent with a

□

- A. category III tracing
- B. category I tracing
- **C. category II tracing**

Answer: C

Explanation:

Comprehensive and Detailed Explanation From Exact Extract without any URL or Links According to the NCC C-EFM 2025 Candidate Guide, Pattern Recognition and Intervention requires the candidate to classify fetal heart rate (FHR) patterns using the NICHD 2008 three-tier system, which NCC endorses across all recommended resources (AWHONN Fetal Heart Monitoring Principles and Practices, Menihan Electronic Fetal Monitoring, Simpson & Creasy, Miller's Pocket Guide).

A Category II tracing is defined as "indeterminate" and includes any FHR pattern that is not Category I and not Category III. NCC references indicate that Category II may include:

* Minimal or marked variability

* Absence of accelerations after fetal stimulation

* Recurrent variable decelerations with moderate variability

* Prolonged decelerations lasting 2-10 minutes

* Baseline tachycardia or bradycardia without absent variability

In the tracing provided:

- * The baseline FHR is approximately 135-145 bpm, within normal limits.
- * Moderate variability is not consistently present; variability is borderline minimal-moderate at times.
- * No significant accelerations are seen over the 25-minute evaluation period.
- * No recurrent late or prolonged decelerations are present.
- * There are occasional subtle variable-type dips, but not enough to meet criteria for Category III.

NCC-endorsed texts (such as AWHONN and Menihan) state that a tracing with minimal variability for less than 40 minutes and without recurrent decelerations is Category II, as it fails to meet the requirements for Category I (must have moderate variability and accelerations absent decelerations) and lacks the criteria for Category III (must have absent variability with recurrent late decels, recurrent variable decels, bradycardia, or sinusoidal pattern).

Therefore, this pattern is indeterminate, consistent with Category II, and requires continued surveillance and evaluation, which aligns with NCC-recommended clinical decision-making competencies.

NEW QUESTION # 16

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