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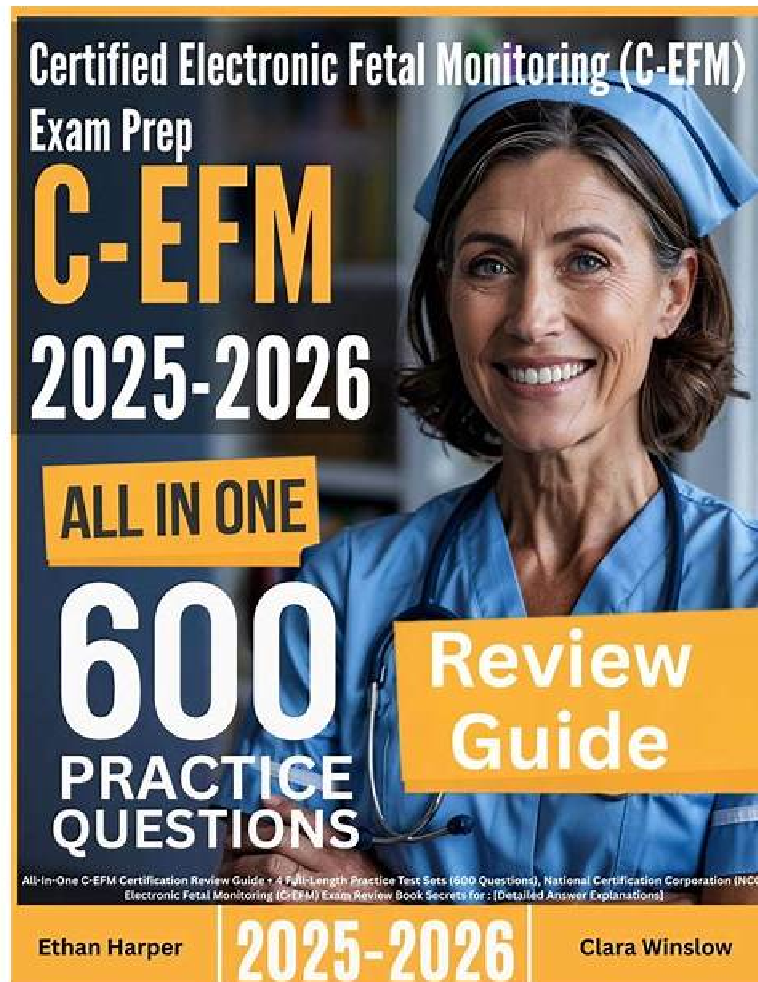

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q51-Q56):

NEW QUESTION # 51
A woman is admitted to labor and delivery with vaginal bleeding. This tracing is obtained. This is most consistent with:

- A. Dysrhythmia
- B. Normal baseline
- C. An indeterminate pattern

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
The tracing shows:
* Baseline approx. 120 bpm
* Minimal variability (amplitude <5 bpm) across the entire strip
* No accelerations
* No decelerations
* Contractions present but not excessive
NCC defines:
* Category I requires moderate variability # not present.
* Category III requires absent variability with recurrent decels, bradycardia, or sinusoidal pattern # not present.
* Thus this falls into Category II: "indeterminate."
Minimal variability for this length of time cannot be considered a normal baseline, especially in the setting of vaginal bleeding, which raises concern for:
* Abruption
* Maternal anemia
* Hypovolemia
* Decreased uteroplacental perfusion
There is no evidence of dysrhythmia (no irregular R-R intervals, no chaotic spikes, no sawtooth pattern).
Therefore, the correct interpretation is A. An indeterminate pattern (Category II).
References:NCC C-EFM Candidate Guide; NICHD Definitions; AWHONN Principles & Practices; Menihan; Simpson & Creehan; Creasy & Resnik.

NEW QUESTION # 52
When auscultating the fetal heart rate, the Doppler should be placed over the fetal:

- A. Back
- B. Abdomen
- C. Chest

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
NCC and AWHONN standards state that the fetal heart tones are most clearly heard when the Doppler probe is placed over the fetal back, because:
* The fetal heart transmits sound most directly through the fetal spine.
* Amniotic fluid and fetal position allow the strongest conduction at the back.
* During Leopold maneuvers, identification of the back guides optimal placement.
Placing the Doppler over the abdomen or chest does not provide the strongest or most reliable fetal signal.
Therefore, the correct placement is over the fetal back.
References:NCC C-EFM Candidate Guide; AWHONN Fetal Heart Monitoring Principles & Practices; Simpson & Creehan Perinatal Nursing.

NEW QUESTION # 53

A woman is admitted at 41-weeks gestation for fetal evaluation following a motor vehicle accident. She reports that she hit her abdomen on the steering wheel. The underlying physiology of the tracing is most likely:

- A. Placental abruption
- B. Fetal trauma
- C. Cord accident

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
This tracing shows recurrent late decelerations, decreased variability, and subtle baseline shifts-findings that strongly correspond to uteroplacental insufficiency. In trauma cases, NCC emphasizes that placental abruption is the most common fetal complication, caused by shearing forces separating the placenta from the uterine wall.
Key physiologic points per NCC/AWHONN/Menihan:
* Maternal blunt abdominal trauma frequently leads to partial or concealed abruption.
* Abruption produces decreased uteroplacental blood flow, resulting in:
* Late decelerations
* Minimal/absent variability
* Baseline shifts or instability
Cord accident (option A) typically produces variable decelerations, not late-pattern decelerations.
Fetal trauma (option B) is extremely rare and does not produce a consistent deceleration pattern.
Thus, the physiology most consistent with this tracing and mechanism of injury is placental abruption.
References:NCC C-EFM Candidate Guide (2025); NCC Physiology Domain; AWHONN Fetal Heart Monitoring Principles & Practices; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing; Creasy & Resnik Maternal-Fetal Medicine.

NEW QUESTION # 54
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 # 55
The tracing shown is a:

- A. Category III
- B. Category I
- C. Category II

Answer: C

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References (No URLs):
Interpretation of fetal heart rate (FHR) tracings in the NCC C-EFM exam follows the standardized NICHD three-tier classification, which is fully adopted in NCC's content outline and recommended references such as AWHONN Fetal Heart Monitoring Principles & Practices, Miller's EFM Pocket Guide, Menihan, Simpson' s Perinatal Nursing, and Creasy & Resnik.
Baseline:
The tracing demonstrates an FHR baseline around 145-150 bpm, which falls within the normal range of 110-160 bpm. NCC references define baseline as the mean FHR rounded to increments of 5 bpm over a 10-minute window.
Variability:
The strip shows minimal variability, with amplitude fluctuations approximately 0-2 bpm.
According to NCC-aligned definitions:
* Moderate variability: 6-25 bpm
* Minimal variability: 1-5 bpm
* Absent variability: undetectable amplitude
This tracing shows minimal variability, not moderate, so it cannot be Category I.
Accelerations:
No accelerations are present. Lack of accelerations alone does not classify the tracing as Category III.
Decelerations:
There are no recurrent late decelerations, no recurrent variable decelerations, and no prolonged decelerations. Without these, and with minimal variability, the tracing does not meet Category III criteria.
Category III criteria (per NICHD/NCC):
Must include at least one of the following:
* Absent variability with recurrent late decelerations
* Absent variability with recurrent variable decelerations
* Absent variability with bradycardia
* Sinusoidal pattern
None of these are present.
Category II criteria (per NICHD/NCC):
Category II includes tracings that are not Category I or III.
Examples specifically listed include:
* Minimal variability
* Absent accelerations after fetal stimulation
* Tachycardia
* Bradycardia without absent variability
* Variable or late decelerations occurring intermittently
Because this tracing shows minimal variability, a normal baseline, no accelerations, and no recurrent decelerations, it fits squarely into Category II.
Therefore, the correct classification is Category II.
References:NCC C-EFM Candidate Guide and Content Outline (2025); 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; NICHD Three-Tier FHR Interpretation System.

NEW QUESTION # 56
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