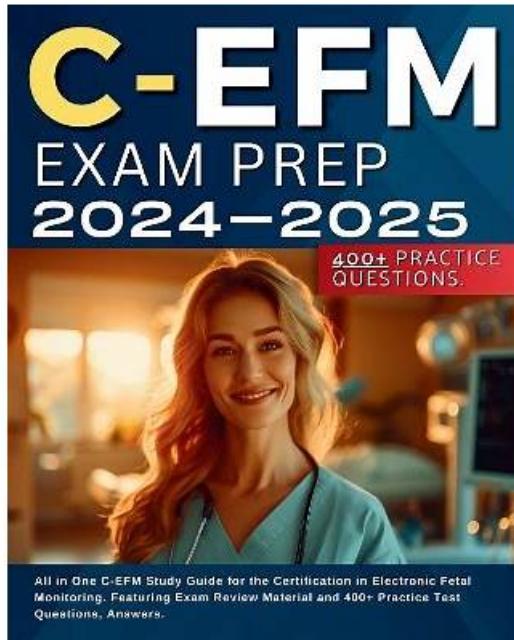


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## NCC Certified - Electronic Fetal Monitoring Sample Questions (Q14-Q19):

### NEW QUESTION # 14

Maternal conditions of autoimmunity can result in fetal heart block due to antibodies that target:

- A. The fetal atrioventricular node
- B. Fetal red blood cells
- C. Maternal white blood cells

**Answer: A**

Explanation:

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

NCC physiology content specifically includes maternal autoimmune influences on fetal cardiac conduction.

Conditions such as maternal lupus (SLE) or Sjogren's syndrome may produce anti-Ro/SSA and anti-La/SSB antibodies. These antibodies cross the placenta and damage fetal conduction tissue.

The primary site of injury is the fetal atrioventricular (AV) node, leading to:

- \* First-, second-, or complete third-degree heart block
- \* A slow, regular ventricular rate typically 50-70 bpm
- \* Loss of beat-to-beat variability because ventricular myocardium does not display normal autonomic modulation. This mechanism is extensively described in AWHONN, NCC physiology materials, and maternal-fetal physiology texts.

Option A: Antibodies do not target fetal RBCs; that describes hemolytic disease of the newborn.

Option B: Targeting maternal WBCs is not fetal-specific.

The correct affected structure is the fetal AV node.

Therefore, the correct answer is C. The fetal atrioventricular node.

References:NCC C-EFM Candidate Guide (2025); NCC Physiology Content Outline; AWHONN Fetal Heart Monitoring Principles & Practices; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing; Creasy & Resnik Maternal-Fetal Medicine.

### NEW QUESTION # 15

A woman (G1P0) arrives in triage with a pain score of 4/10 at 39-weeks gestation. The fetal heart rate tracing shown is obtained. The best intervention is to:

- A. Discharge to home
- B. **Adjust tocotransducer and continue to monitor**
- C. Admit for induction

**Answer: B**

Explanation:

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

This tracing demonstrates a normal, reassuring fetal heart pattern that is technically categorized as Category I, indicating normal fetal acid-base status. Before any decision regarding discharge or induction, NCC emphasizes correct assessment of the tracing quality, fetal status, and uterine activity.

Key Tracing Characteristics

\* Baseline:Approximately 135-145 bpm, well within the normal range of 110-160 bpm

\* Variability:The strip shows moderate variability (6-25 bpm), the strongest indicator of adequate fetal oxygenation per NCC, AWHONN, and NICHD.

\* Accelerations:Several accelerations are present-another reassuring feature of normal fetal well-being.

\* Decelerations:No variable, late, or prolonged decelerations are present.

\* Uterine Activity:The lower channel shows poor recording quality and inconsistent signal- suggesting the toco is not capturing contractions well, not that the patient is contracting excessively or not at all.

Correct interpretation per NCC:

NCC emphasizes distinguishing between physiologic assessment and technical artifact.

The fetal tracing is completely reassuring.

The only abnormality is the poor uterine activity signal, a common triage occurrence due to:

- \* Toco placement
- \* Maternal body habitus
- \* Positioning
- \* Low contraction intensity in early labor

Thus, the correct next step is to optimize equipment (reposition the toco, adjust belt, palpate contractions) and continue to monitor. Why the other options are incorrect:

B). Admit for induction - NOT indicated

\* There is no evidence of fetal compromise.

\* No indication for induction is present (pain score 4/10, reassuring FHR, term pregnancy).

\* NCC emphasizes avoiding unnecessary interventions.

C). Discharge to home - NOT yet appropriate

\* You cannot safely discharge a patient with a poorly monitored contraction pattern.

\* Adequate assessment requires confirming uterine activity-after fixing the toco.

Therefore, the appropriate action is:

A). Adjust tocotransducer and continue to monitor.

References:NCC C-EFM Candidate Guide (2025); NCC Content Outline; AWHONN Fetal Heart Monitoring Principles & Practices; NICHD Definitions; Miller's Fetal Monitoring Pocket Guide; Menihan Electronic Fetal Monitoring; Simpson & Creehan Perinatal Nursing; Creasy & Resnik Maternal-Fetal Medicine.

## NEW QUESTION # 16

(Full question statement)

Interobserver reliability in interpretation of fetal heart rate tracings is greatest when the tracing is:

- A. Indeterminate
- B. Abnormal
- C. Normal

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract Without Links:

NCC examination standards and AWHONN clearly state that normal Category I patterns have the highest interobserver agreement because they contain objective, easily identifiable components:

\* baseline 110-160 bpm

\* moderate variability

\* absence of late or variable decelerations

\* presence or absence of accelerations

Simpson highlights that Category II tracings have poor reliability due to multiple combinations of variability and decelerations, while Category III patterns have higher agreement but occur far less frequently, limiting reliability measures.

Research cited within NCC-endorsed materials confirms that clinicians demonstrate the greatest agreement in identifying normal Category I patterns, making normal the correct answer.

## NEW QUESTION # 17

(Full question statement)

The fetal heart rate tracing shown is obtained upon the woman's admission to labor and delivery. This tracing is most consistent with what maternal condition?

- A. Systemic lupus erythematosus
- B. Eisenmenger's syndrome
- C. Sickle cell anemia

**Answer: C**

Explanation:

Comprehensive and Detailed Explanation From Exact Extract (NCC C-EFM sources: AWHONN, Miller's Pocket Guide, Menihan, Simpson, Creasy & Resnik, 2025 Candidate Guide) The tracing displays baseline fetal bradycardia, with a rate near 100 bpm, minimal variability, and preserved periodic response. According to AWHONN's Fetal Heart Monitoring Principles & Practices and Menihan's Electronic Fetal Monitoring, maternal conditions that reduce oxygen-carrying capacity- including maternal anemia-can lead to lower fetal oxygen delivery, prompting a fetal compensatory bradycardic baseline.

Creasy & Resnik's Maternal-Fetal Medicine notes that sickle cell anemia decreases maternal hemoglobin function even when maternal vital signs appear stable, reducing uteroplacental oxygen transport. Fetuses of mothers with sickling disorders may demonstrate lower resting fetal heart rates due to chronic mild hypoxemia.

Conversely, Eisenmenger's syndrome is associated with severe maternal cyanosis and high fetal mortality, often producing late

decelerations and growth restriction rather than mild bradycardia. Systemic lupus erythematosus (SLE) is commonly associated with heart block (especially with anti-Ro/SSA antibodies), which is not displayed here, as true heart block presents with a fixed atrial-ventricular dissociation and FHR

< 60 bpm

Thus, based on fetal physiology and maternal disease correlations taught in NCC-recommended sources, the tracing is most consistent with maternal sickle cell anemia.

#### NEW QUESTION # 18

The main reason intrauterine pressure catheters are placed is to:

- A. Define the quality of the fetal baseline
- B. Rule out artifact
- C. Determine the contraction pattern

**Answer: C**

Explanation:

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

Intrauterine pressure catheters (IUPCs) are an internal uterine activity monitoring device used when external tocodynamometry does not provide adequate assessment of contraction strength or frequency.

According to NCC, AWHONN, Miller, and Menihan, the primary indication for placing an IUPC is to obtain accurate, quantitative measurement of uterine activity.

Purpose of IUPC (per NCC and AWHONN):

- \* Measures exact intrauterine pressure in mmHg
- \* Calculates Montevideo units (MVUs) to evaluate adequacy of labor
- \* Clearly differentiates:
  - \* Frequency
  - \* Duration
  - \* Strength (intensity)
  - \* Resting tone

NCC explicitly lists the primary purpose as:

"Accurate assessment of uterine contraction pattern and intensity."

Why the other options are incorrect:

A). Define the quality of the fetal baseline - Incorrect

\* Fetal heart rate (FHR) baseline quality is determined by fetal ECG or FSE, not IUPC.

\* IUPCs monitor the uterus, not the fetal cardiac signal.

C). Rule out artifact - Incorrect

\* While an IUPC can reduce artifact from the toco, this is not its primary purpose.

\* Artifact is more commonly an issue with external FHR monitoring, corrected by repositioning or placing a fetal scalp electrode-not by using an IUPC.

B). Determine the contraction pattern

This aligns directly with NCC's Electronic Monitoring Equipment domain: IUPCs provide the most accurate and reliable measurement of uterine activity when external monitoring is inadequate.

References:NCC C-EFM Candidate Guide (2025); NCC Content Outline; 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.

#### NEW QUESTION # 19

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