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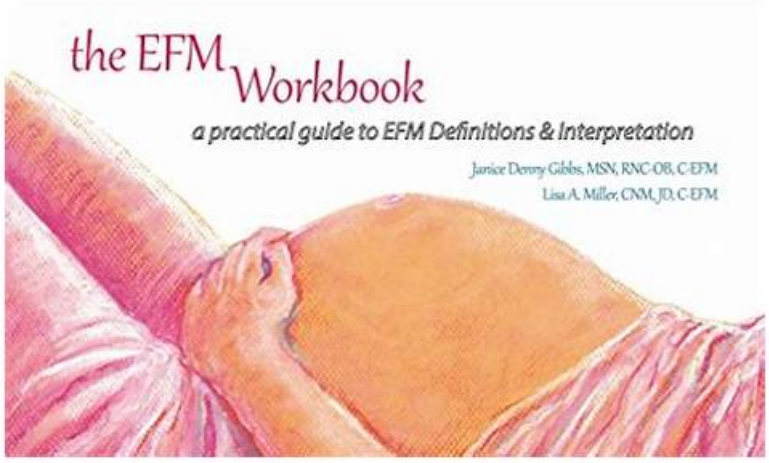

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NCC Certified - Electronic Fetal Monitoring Sample Questions (Q18-Q23):

NEW QUESTION # 18
A nonstress test is nonreactive in a 36-week gestational age fetus. Vibroacoustic stimulation (VAS) is applied with no fetal response. The next step is to proceed to:

- A. Biophysical profile
- B. Induction of labor
- C. Cesarean birth

Answer: A

Explanation:
Comprehensive and Detailed Explanation From NCC-Aligned Sources:
A nonreactive NST with no response to vibroacoustic stimulation indicates:
* Possible fetal sleep cycle
* Possible CNS depression
* Possible hypoxemia
NCC, AWHONN, and MFM guidelines state the next step is a biophysical profile because:
* It evaluates fetal tone, movement, breathing, amniotic fluid, and NST
* Provides a complete assessment of fetal well-being
* Is less invasive and more informative than immediate delivery decisions Why the wrong answers are incorrect:

* B. Cesarean birth - not indicated without confirming fetal compromise.
* C. Induction of labor - not indicated until BPP clarifies fetal status.
Correct answer: A. Biophysical profile.
References:NCC C-EFM Candidate Guide; AWHONN FHMPP; Creasy & Resnik; Simpson & Creehan.

NEW QUESTION # 19
Interventions undertaken to address fetal tachycardia are targeted at maximizing

- A. uteroplacental perfusion
- B. sympathetic autonomic tone
- C. maternal circulation

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract NCC-Recommended Sources Fetal tachycardia is typically caused by maternal fever, dehydration, hypoxia, medications, infection, or fetal stress. AWHONN and Simpson & Creehan emphasize that management focuses on improving oxygen delivery across the placenta, which is governed by uteroplacental perfusion.
Menihan's EFM text states that "interventions for fetal tachycardia must address oxygen transfer by optimizing uteroplacental blood flow," including hydration, reducing uterine activity, maternal repositioning, and treating maternal fever.
Increasing maternal circulation alone is insufficient unless it improves placental blood flow. Enhancing fetal sympathetic tone is not a clinical goal and would worsen tachycardia.
Creasy & Resnik highlight that fetal heart rate abnormalities resolve when uteroplacental perfusion is restored, confirming this as the primary target of intervention.
References:
AWHONN - Fetal Heart Monitoring Principles & PracticesSimpson & Creehan - Perinatal NursingMenihan - Electronic Fetal MonitoringCreasy & Resnik - Maternal-Fetal MedicineMiller's Pocket Guide

NEW QUESTION # 20
The decelerations seen in the fetal monitoring tracing shown are best described as:

- A. Late
- B. Variable
- C. Early

Answer: B

Explanation:
Comprehensive and Detailed Explanation From Exact Extract-Based NCC C-EFM References:
Accurate classification of decelerations requires evaluating their shape, onset, nadir, recovery, relationship to contractions, and variability characteristics. NCC uses the NICHD standardized definitions, reinforced across AWHONN, Miller's Pocket Guide, Menihan, Simpson, and Creasy & Resnik.
Key features in this tracing:
* Abrupt onsetThe FHR drops rapidly from baseline to nadir in less than 30 seconds-this is the defining hallmark of a variable deceleration per NICHD.
* Sharp V-shape and deep amplitudeThe tracing shows steep descents and ascents, characteristic of cord compression-type variable decelerations.
* Inconsistent timing with contractionsThe decelerations do not begin at the start of contractions (as early decelerations would) and do not consistently begin after the peak of contractions (as late decelerations would). Variable decelerations can occur before, during, or after a contraction-exactly what is demonstrated here.
* Rapid return to baselineAnother core feature of variable decelerations in NICHD/NCC definitions.
* No uniform contraction relationshipEarly decelerations are symmetrical and mirror contractions.
Late decelerations begin after the peak of the contraction. This strip does not match either pattern.
Differentiation per NCC-aligned definitions:
* Early Decelerations:Gradual onset (>30 sec), nadir mirrors contraction peak, shallow, uniform.Not present.
* Late Decelerations:Gradual descent, nadir after contraction peak, smooth shape.Not present.
* Variable Decelerations:Abrupt onset (<30 sec), variable timing, sharp V-shape, rapid recovery, often with shoulders.Exactly matches the tracing.
Therefore, according to NICHD/NCC criteria, the decelerations shown are variable decelerations.

References:NCC C-EFM Candidate Guide (2025); NCC Content Outline; NICHD Standardized Definitions; 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 # 21
(Full question statement)
Recurrent decelerations are defined as occurring with 50% or more of contractions in any window of how many minutes?

- A. 0
- B. 1
- C. 2

Answer: A

Explanation:
Comprehensive and Detailed Explanation From Exact Extract Without Links:
According to the NCC C-EFM Content Outline and AWHONN Fetal Heart Monitoring Principles, recurrent decelerations are specifically defined as decelerations that occur with #50% of uterine contractions in a
20-30-minute window, but standardized interpretation guidelines used by NCC and ACOG categorize recurrent patterns based on any 30-minute evaluation period.
AWHONN (FHM 6th Ed.) explains that fetal heart patterns must be evaluated over "a sufficiently long segment, typically 30 minutes, to determine whether the pattern is intermittent or recurrent." Menihan & Simpson further emphasize that recurrent decelerations imply a persistent physiologic stressor, requiring systematic evaluation and intrauterine resuscitation. NCC's Candidate Guide ties this rule directly into categorization within Category II and III tracings. Therefore, 30 minutes is the correct standard evaluation interval for determining recurrence.

NEW QUESTION # 22
A woman is admitted to labor and delivery with vaginal bleeding. This tracing is obtained. This is most consistent with:

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

Answer: B

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 # 23
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