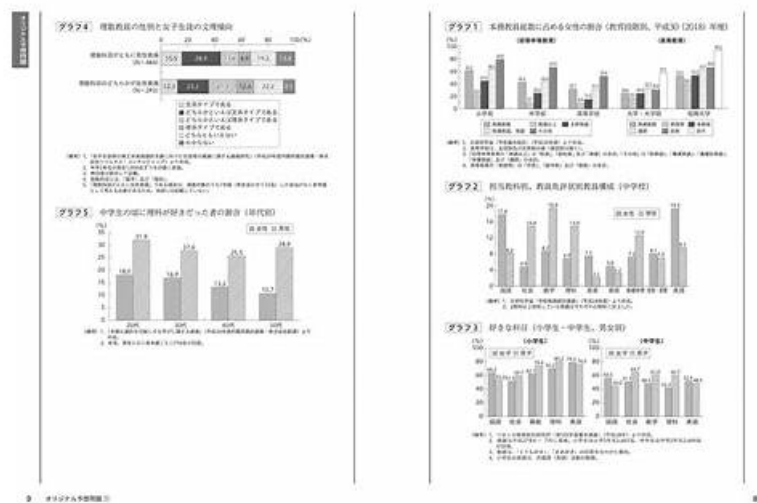


実用的EFM最新テスト & 資格試験のリーダー & 高パスレートEFM最新関連参考書



P.S. JPTestKingがGoogle Driveで共有している無料かつ新しいEFMダンプ：https://drive.google.com/open?id=1xAwVCOohCv_SJoEMqwCYZOb4vKEvnrWq

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合格できるNCC Certified - Electronic Fetal Monitoring試験はいくつありますか？ それらをすべて試してみてください！ JPTestKingは、Certified - Electronic Fetal Monitoring コーススペシャリストが開発した実際のNCC EFMの回答を含むCertified - Electronic Fetal Monitoring EFM試験問題への完全なアクセス権をUnlimited Access Planに提示します。NCC Certified - Electronic Fetal Monitoringテストに合格できるだけでなく、さらに良くなります！ また、すべての試験の質問と回答にアクセスして、合計1800以上の試験に合格することもできます。

>> EFM最新テスト <<

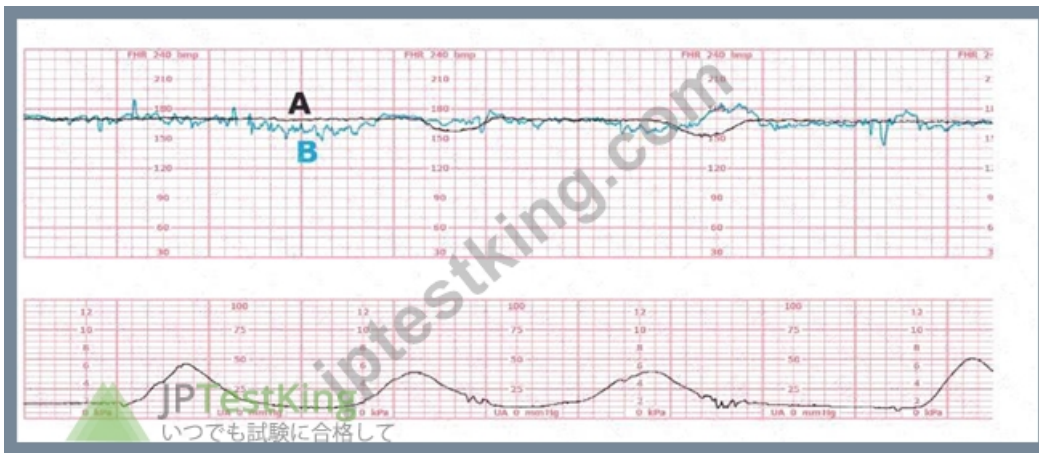
EFM試験の準備方法 | 素晴らしいEFM最新テスト試験 | 最高のCertified - Electronic Fetal Monitoring最新関連参考書

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NCC Certified - Electronic Fetal Monitoring 認定 EFM 試験問題 (Q38-Q43):

質問 # 38

This fetal heart rate tracing is of a woman in labor with dichorionic-diamniotic twins at 36-weeks gestation, 4 cm dilated. She is on oxygen via face mask. Based on the fetal heart rate tracing, what is the most appropriate action?



(Tracing A = black; Tracing B = blue)

- A. Continue to observe
- B. Cesarean birth
- C. Give terbutaline

正解: A

解説:

Comprehensive and Detailed Explanation From NCC-Aligned Sources:

Both fetal tracings (A and B) show:

- * Baselines around 140-150 bpm
- * Moderate variability
- * Intermittent accelerations
- * No recurrent decelerations
- * Normal contraction pattern
- * Overall Category I patterns for both twins

NCC, NICHD, and AWHONN emphasize that moderate variability with a normal baseline is the strongest reassurance of fetal well-being, even in multifetal gestations.

There is no evidence of:

- * Tachysystole
- * Recurrent variables
- * Recurrent lates
- * Prolonged decelerations
- * Category III patterns

Therefore, the appropriate action is ongoing observation.

Why the incorrect answers are wrong:

- * A. Cesarean birth - Not indicated with Category I FHR patterns.
- * C. Terbutaline - Reserved for tachysystole or prolonged deceleration patterns, not present here.

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

質問 # 39

This is a fetal heart rate tracing of a multiparous woman whose cervix is 7 cm dilated on admission. The most likely cause for this pattern is:



- A. Tachysystole
- B. Rapid fetal descent
- C. Placental abruption

正解: A

解説:

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

The tracing shows a clear relationship between uterine activity and fetal heart rate changes:

- * The uterine activity strip demonstrates very frequent contractions with little resting time between them, exceeding five contractions in 10 minutes, averaged over a 30-minute window.
- * NCC and NICHD define tachysystole as "more than 5 contractions in 10 minutes, averaged over 30 minutes, regardless of whether the labor is spontaneous or stimulated." As uterine activity intensifies and becomes excessively frequent, the fetal heart rate strip begins to show:
 - * Progressive decrease in baseline
 - * Recurrent decelerations with gradual onset and recovery
 - * Reduced variability in the latter portion of the strip

This pattern is consistent with uteroplacental insufficiency caused by excessive uterine activity (tachysystole). NCC and AWHONN emphasize that tachysystole can result in decreased uterine blood flow and fetal oxygenation, leading to late or prolonged decelerations and eventual bradycardia if not corrected.

Why the other options are less likely:

- * A. Placental abruption Typically associated with maternal symptoms (pain, vaginal bleeding, firm /boardlike uterus) and often a sustained increase in resting tone or a hypertonic contraction, not simply very frequent contractions. These maternal findings are not described in the vignette.
- * B. Rapid fetal descent Usually causes variable or early decelerations related to head compression, but the tocodynamometer would not necessarily show this degree of contraction frequency. The lower strip here clearly highlights excessive contractions as the primary problem.

Thus, the tracing's FHR abnormalities are best explained by tachysystole, making C. Tachysystole the most appropriate answer.

References: NCC C-EFM Candidate Guide (2025); NCC Content Outline - Pattern Recognition and Intervention; NICHD Three-Tier FHR Interpretation System; 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.

質問 # 40

The decelerations seen in the fetal monitoring tracing shown are best described as:

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

正解: C

解説:

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 onset The 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 amplitude The tracing shows steep descents and ascents, characteristic of cord compression-type variable decelerations.

* Inconsistent timing with contractions The 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 baseline Another core feature of variable decelerations in NICHD/NCC definitions.

* No uniform contraction relationship Early 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.

質問 # 41

(Full question statement)

The American College of Obstetricians and Gynecologists (ACOG) recommends continuous electronic fetal monitoring in pregnancies when there is:

- A. A history of preterm birth
- B. Maternal diabetes
- C. Macrosomia

正解: B

解説:

Comprehensive and Detailed Explanation From Exact Extract Without Links:

NCC relies heavily on ACOG Practice Bulletins for risk-based monitoring decisions. ACOG identifies maternal diabetes (pregestational or poorly controlled gestational diabetes) as a key high-risk obstetric condition warranting continuous electronic fetal monitoring due to risks such as fetal hypoxia, macrosomia, and metabolic complications.

In contrast, a history of preterm birth does not necessarily require continuous monitoring unless current pregnancy complications are present.

Macrosomia alone does not automatically justify continuous EFM unless accompanied by other risk factors.

Therefore, according to NCC-aligned ACOG clinical criteria, maternal diabetes is the correct indication.

質問 # 42

When accelerations precede a variable deceleration pattern, this is caused by

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

正解: B

解説:

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

質問 # 43

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EFM最新関連参考書: <https://www.jpctestking.com/EFM-exam.html>

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有難いEFM | 完璧なEFM最新テスト試験 | 試験の準備方法Certified - Electronic Fetal Monitoring最新関連参考書

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- よくできたEFM最新テスト - 認定試験のリーダー - 検証するEFM最新関連参考書 □ サイト ➡ www.passtest.jp □ で (EFM) 問題集をダウンロードEFM日本語版サンプル
- EFM日本語版サンプル □ EFMファンデーション □ EFM日本語版サンプル □ ウェブサイト ➡ www.goshiken.com □ □ □ を開き、【 EFM 】を検索して無料でダウンロードしてくださいEFM復習解答例
- EFM復習時間 □ EFM資格取得講座 □ EFM日本語版試験解答 □ 時間限定無料で使える ☀ EFM □ ☀ □ の試験問題は □ www.jpexam.com □ サイトで検索EFM資料的中率
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