Nursing

NCC-RNC-MNN

NCC Maternal Newborn Nursing (NCC-RNC-MNN)

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Question: 1

Which of the following statements about descent of the fetus is least accurate?

A. A small reduction in fundal height is common following prelabor fetal descent.
B. Among many nulliparous women descent of the fetus may occur two or more weeks in advance of labor.
C. Lightening is synonymous with engagement.
D. Leopold's maneuvers will reveal that the presenting part is no longer ballottable above the symphysis pubis.

Answer: C

Explanation:
To answer the question on which statement about the descent of the fetus is least accurate, let's analyze each statement provided:
Statement 1: A small reduction in fundal height is common following prelabor fetal descent. This statement is accurate. Prelabor fetal descent, often referred to as "lightening" or "dropping," occurs when the fetus begins to descend into the pelvis in preparation for birth. This descent can lead to a decrease in the fundal height (the measurement from the pubic bone to the top of the uterus), which is why a small reduction in fundal height is commonly observed.
Statement 2: Lightening is synonymous with engagement. This statement is inaccurate. Lightening and engagement, although related, are not synonymous. Lightening refers to the fetus moving down into the pelvis, which can result in noticeable changes such as easier breathing and less heartburn for the pregnant individual because the uterus no longer presses as much on the stomach and diaphragm. However, lightening does not necessarily mean the baby's head (or presenting part) is engaged in the pelvis.
Statement 3: Lightening is not synonymous with engagement. However, engagement may be the end result of lightening. This statement is accurate and provides a clear distinction between the two terms. While lightening indicates the descent of the fetus into a lower position in the pelvis, engagement specifically refers to the settling of the fetal head (or presenting part) into the pelvis at the level of the ischial spines. Engagement is a more definitive position that often occurs closer to labor.
Statement 4: Among many nulliparous women, descent of the fetus may occur two or more weeks in advance of labor. This statement is accurate. In nulliparous women (those who have not given birth before), it is common for the fetus to descend into the pelvis several weeks before labor begins. This early descent helps prepare the birth canal for the upcoming labor process.
Statement 5: Leopold's maneuvers will reveal that the presenting part is no longer ballottable above the symphysis pubis. This statement is accurate. Leopold's maneuvers are a series of palpations that help assess the position and engagement of the fetus. If the fetus has descended and the presenting part (usually the head in cephalic presentations) is engaged, it will not be freely movable or "ballottable" above the pubis. This indicates that the fetus has descended sufficiently into the pelvis.
In summary, the statement "Lightening is synonymous with engagement" is the least accurate. Lightening involves the downward movement of the fetus into the pelvis but does not necessarily imply

that the fetal head has engaged, which is a specific obstetric condition indicating readiness for labor. Lightening can occur without engagement, and engagement can sometimes occur without prior noticeable lightening.

Question: 2

Which of the following hormones interacts with other mediators to inhibit uterine activity during pregnancy?

A. estrogen
B. relaxin
C. progesterone
D. prolactin

Answer: B

Explanation:
The correct answer to the question is "relaxin." Relaxin is a hormone primarily involved in the reproductive system, particularly in relation to pregnancy and childbirth.
Relaxin is produced by the corpus luteum in the ovaries, the placenta, the uterine lining, and also the myometrium (the middle layer of the uterine wall) during pregnancy. Its production is crucial for a successful pregnancy as it plays several key roles, one of which is to inhibit uterine activity.
The primary function of relaxin during pregnancy is to relax the ligaments in the pelvis and soften and widen the cervix to ease the birth process. However, another significant role of relaxin is its interaction with other mediators to suppress contractions in the uterus. This is crucial for maintaining the pregnancy, as premature contractions can lead to early labor.
Relaxin achieves this by reducing the expression of gap junctions and lowering the levels of prostaglandins, which are compounds that can induce labor by stimulating contractions. Relaxin also helps in the modulation of the immune response at the maternal-fetal interface, supporting pregnancy continuation.
In summary, relaxin not only prepares the body for childbirth but also ensures that the uterus remains relatively inactive and that the conditions are optimal for the fetus to grow and develop throughout the pregnancy period. This inhibition of uterine activity underscores the hormone's critical role in reproductive physiology.

Question: 3

A pregnant woman with a history of repetitive second trimester loss of fetus may be a candidate for a procedure to prevent a spontaneous abortion or premature birth. This procedure is a(n)

A. amniocentesis
B. a 3-day course of penicillin
C. Valsalva maneuver
D. cerclage

Answer: D

Explanation:
The correct procedure for a pregnant woman with a history of repetitive second trimester loss of the fetus, aiming to prevent spontaneous abortion or premature birth, is cerclage. Cerclage is a surgical intervention where a strong suture is placed around the cervix to physically reinforce it and keep it closed. This is particularly useful in cases of cervical insufficiency or incompetence, where the cervix is weak and dilates prematurely leading to pregnancy loss or preterm birth.
There are different types of cerclage, including McDonald, Shirodkar, and abdominal cerclage. The choice of method depends on the individual's medical history, the anatomy of the cervix, and previous obstetric outcomes. The McDonald cerclage, which is the most common type, involves placing a purse-string stitch around the cervix. The Shirodkar technique is similar but involves a deeper placement of the suture and may be chosen if the patient has had a previous cerclage or if the cervix is very short. Abdominal cerclage is less common and is usually reserved for women who cannot have a successful transvaginal cerclage due to anatomical reasons or multiple failed cerclages.
The timing for placing a cerclage is typically late in the first trimester or early in the second trimester, generally between 12 to 14 weeks of gestation, although it can be done later if necessary and is called a "rescue cerclage." The procedure is usually performed under regional anesthesia, and the patient may need to stay in the hospital briefly for monitoring.
Success rates for cervical cerclage are generally good, with studies showing an 80% to 90% effectiveness in preventing premature birth and improving pregnancy outcomes in women with a demonstrated cervical weakness. However, it's crucial for the procedure to be done by an experienced surgeon and for the patient to receive proper post-operative care, including possible activity restrictions and regular follow-up visits to monitor the cervix and pregnancy.
Importantly, cerclage is not suitable for everyone. It is contraindicated in cases where there are active vaginal or cervical infections, certain maternal medical conditions, or if preterm labor is already progressing. Therefore, a thorough evaluation including a detailed obstetric history, physical examination, and possibly an ultrasound assessment of the cervix, is essential before considering this procedure.

Question: 4

A pregnant patient has been diagnosed with placenta previa'. The plan for her would include all but which of the following?

A. normal sexual intercourse
B. abdominal ultrasound
C. bedrest
D. avoid placing any object in the vagina or rectum

Answer: A

Explanation:
Placenta previa is a condition in pregnancy where the placenta covers the cervix either partially or completely, posing risks during vaginal delivery. Managing this condition carefully is crucial to prevent complications such as severe bleeding. Here's a breakdown of the management options listed in the query, with explanations for why each is considered or excluded:

Normal Sexual Intercourse: In the case of placenta previa, normal sexual intercourse is generally advised against. This is because sexual activity can provoke bleeding by disturbing the cervix and the placenta. Therefore, engaging in sexual intercourse is not included in the management plan for a patient with placenta previa. Avoidance is crucial to minimize the risk of triggering bleeding, which can be life-threatening for both the mother and the fetus.
Abdominal Ultrasound: Regular monitoring of the placenta's position is essential in the management of placenta previa. An abdominal ultrasound is a non-invasive method that helps in assessing the location and movement of the placenta as the pregnancy progresses. This diagnostic tool is vital for planning the appropriate course of action, including the potential need for a cesarean section if the placenta remains over the cervix.
Bedrest: Although the evidence for strict bedrest is variable, it is often recommended in cases of moderate to severe placenta previa to reduce the risk of initiating bleeding. Bedrest minimizes physical activity and reduces pressure on the cervix, thereby decreasing the likelihood of bleeding. This precaution is particularly advised if the patient has had episodes of bleeding during the pregnancy.
Avoid Placing Any Object in the Vagina or Rectum: Similar to the recommendation against sexual intercourse, placing any objects in the vagina or rectum is strongly discouraged in cases of placenta previa. This includes tampons, douches, and rectal thermometers. The reason for this restriction is to avoid any disturbance to the cervix and lower uterine segment, which could provoke bleeding. This measure complements the general advice of minimizing any potential triggers for bleeding.
In summary, among the options listed, normal sexual intercourse is the one that should not be included in the management plan for a patient with placenta previa. This is because it poses a significant risk of provoking bleeding. The other listed interventions, including abdominal ultrasound, bedrest, and avoiding the insertion of any objects into the vagina or rectum, are all part of a conservative management strategy to ensure both maternal and fetal safety.

Question: 5

Which of the following would NOT be an indication for birth before term for a woman with diabetes?

A. vascular changes
B. worsening hypertension
C. a randomly higher than normal blood glucose level
D. evidence of IUGR

Answer: C

Explanation:
In pregnant women with diabetes, careful monitoring and management of their condition are critical for the health of both the mother and the baby. Certain complications associated with diabetes in pregnancy might necessitate delivery before term to ensure the safety and well-being of both parties. However, not all situations related to diabetes justify an early delivery.
One such condition that does not inherently require birth before term is a randomly higher than normal blood glucose level. While maintaining control of blood glucose levels is crucial in diabetes management during pregnancy, occasional spikes can occur. These sporadic high readings, while needing attention, can typically be managed by adjusting the diabetic treatment regimen, primarily through modifications in insulin dosage or dietary changes. The key here is that these are manageable fluctuations and do not immediately compromise the pregnancy to the extent that early delivery would be considered.

In contrast, other conditions related to diabetes in pregnancy might necessitate an earlier delivery. For instance, severe vascular changes due to prolonged high blood sugar levels can impair blood flow, affecting the placenta and thus the fetus, potentially leading to decisions favoring early birth. Similarly, worsening hypertension (high blood pressure) in a diabetic pregnant woman can increase the risk of preeclampsia, a serious condition that might require pre-term delivery to protect the health of the mother and baby. Another critical condition is the evidence of intrauterine growth restriction (IUGR), where the fetus is not growing at the expected rate inside the womb, often due to inadequate blood supply through the placenta, a situation that can be exacerbated by diabetes and might necessitate delivering the baby earlier than the expected due date for better neonatal care and outcomes.
Thus, while managing diabetes during pregnancy is complex and requires a proactive approach, a randomly higher than normal blood glucose level alone, without other complicating factors, is not typically an indication for birth before term. This is because it is usually possible to correct such fluctuations through medical interventions without resorting to early delivery, which carries its own risks and complications.

Question: 6

Folate deficiency is the most common cause of which of the following diseases?

A. megaloblastic anemia
B. anemia of prematurity
C. iron deficiency anemia
D. sickle cell anemia

Answer: A

Explanation:
Folate deficiency is the most commonly identified cause of megaloblastic anemia. Megaloblastic anemia is a type of anemia characterized by the presence of abnormally large and immature red blood cells called megaloblasts in the bone marrow. This occurs because of impaired DNA synthesis, which leads to ineffective erythropoiesis (production of red blood cells). Folate, or vitamin B9, is essential in the production and maintenance of new cells, including red blood cells. Its deficiency can disrupt cell division and lead to the characteristic large, immature red blood cells seen in megaloblastic anemia.
During pregnancy, the demand for folate significantly increases due to its role in the rapid cell division needed for fetal development. Folate deficiency during pregnancy not only leads to megaloblastic anemia but also increases the risk of neural tube defects in the fetus. The condition affects about 1% to 4% of pregnant women in the United States, with a higher prevalence in twin or multiple pregnancies due to an even greater demand for folate.
In contrast, other types of anemia like anemia of prematurity, iron deficiency anemia, and sickle cell anemia have different primary causes. Anemia of prematurity occurs in premature infants due to their underdeveloped body's inability to produce enough red blood cells. Iron deficiency anemia, the most common type of anemia globally, results from a shortage of iron, which is crucial for producing hemoglobin, the oxygen-carrying component of red blood cells. Sickle cell anemia is a genetic disorder that leads to the production of abnormal hemoglobin, resulting in distorted (sickle-shaped) red blood cells that can cause blockage and damage to parts of the blood circulation system.
Therefore, the direct link between folate deficiency and megaloblastic anemia, especially during pregnancy, highlights the importance of adequate folate intake through diet or supplements to prevent

such complications and promote overall health during pregnancy. Regular screening and supplementation during pregnancy are crucial steps in managing and preventing folate deficiency and its associated risks.

Question: 7

The most common method of determining the estimated date of birth is by using Nagele's rule. If the first day of the woman's last menstrual period is May 20, when is the estimated date of birth?

A. February 13 of the following year
B. March 13 of the following year
C. March 20 of the following year
D. February 27 of the following year

Answer: D

Explanation:
Nägele's rule is a standard way of estimating the due date for a pregnancy. The calculation is relatively simple and has been used widely in obstetrics. The rule involves taking the first day of the woman's last menstrual period, subtracting three months, and then adding seven days. This method assumes a regular menstrual cycle length of 28 days and ovulation occurring on the 14th day of the cycle.
To apply Nägele's rule to the provided scenario where the first day of the last menstrual period is May 20, we follow these steps: 1. **Subtract 3 months from May 20**: Subtracting three months from May brings us to February 20. 2. **Add 7 days to February 20**: Adding seven days to February 20 results in February 27.
Therefore, according to Nägele's rule, the estimated date of birth would be February 27 of the following year. This rule provides an easy method for calculating due dates and is often quite accurate, assuming regular menstrual cycles. However, it's important to note that actual delivery can typically occur anywhere between 37 and 42 weeks of pregnancy, and only about 5% of births occur on the exact estimated due date.

Question: 8

Which of the following would be an indication of false labor?

A. discomfort begins in back, radiating to the abdomen
B. progressive frequency and intensity of contractions
C. longer intervals between contractions
D. activity increases contractions

Answer: C

Explanation:
False labor, often referred to as Braxton Hicks contractions, can sometimes be mistaken for true labor due to the presence of contractions. However, there are distinguishing features that can help differentiate between true and false labor. One such feature is the pattern and spacing of contractions.

In true labor, contractions generally occur at regular intervals and the time between these contractions gradually decreases. Additionally, the intensity of contractions tends to increase over time. These contractions are usually felt starting at the back and radiating to the front of the abdomen. Furthermore, true labor contractions bring about progressive changes in the cervix, leading to dilation and effacement (thinning).
Conversely, an indication of false labor is characterized by longer intervals between contractions. In false labor, contractions do not follow a predictable pattern and do not consistently become closer together. The contractions may also vary in length and intensity, and they often do not increase in strength over time. Moreover, these contractions might stop when you change activity or position, which typically does not happen in true labor.
Other signs of false labor include contractions that are predominantly felt in the lower abdomen and groin, rather than starting in the back and moving to the front. Additionally, false labor does not cause significant changes to the cervix, such as dilation or effacement. Sometimes, applying measures such as hydration or rest can lead to a decrease or cessation of contractions in false labor.
Understanding these differences is crucial for expectant mothers to avoid unnecessary trips to the hospital and to better prepare for actual labor. If there is any uncertainty about whether labor is true or false, it is advisable to consult a healthcare provider who can assess the situation more accurately, often through monitoring contractions and examining cervical changes.

Question: 9

Chorionic villus sampling (CVS) is ideally performed at

A. 15.0 to 18.0 weeks gestation
B. 12.5 to 16 weeks gestation
C. 10.0 to 13 weeks gestation
D. 7.5 to 9.0 weeks gestation

Answer: C

Explanation:
Chorionic villus sampling (CVS) is a prenatal test that involves collecting a small sample of cells from the placenta, the organ that nourishes the fetus during pregnancy. The procedure is typically recommended for detecting genetic abnormalities in the fetus and can provide information about the baby's health much earlier in pregnancy compared to other tests like amniocentesis.
The ideal timeframe for conducting CVS is between 10.0 to 13 weeks of gestation. Performing the test during this period is crucial for several reasons. Firstly, at 10 weeks, the placenta is sufficiently developed to allow for an adequate sample to be collected, which is essential for reliable results. Secondly, conducting the test within this window minimizes the risk of complications associated with the procedure such as miscarriage, which though rare, tend to be slightly higher if CVS is performed too early.
During the procedure, the doctor may choose one of two methods to collect the sample from the chorionic villi, which are tiny finger-like projections on the placenta. The first method is transabdominal, where a needle is inserted through the abdomen and uterus to reach the placenta. The second is transcervical, where a thin tube or forceps are inserted through the cervix to sample the villi. The choice between these methods depends on the position of the placenta and the medical history of the patient.

It's important to note that while CVS can provide early detection of chromosomal conditions like Down syndrome and genetic disorders such as cystic fibrosis, it cannot detect neural tube defects. For this reason, women undergoing CVS are also advised to have a blood test at around 16 weeks of pregnancy to screen for these types of anomalies.
In summary, chorionic villus sampling is ideally performed at 10.0 to 13 weeks gestation. This timing ensures the placenta is adequately developed for sampling while also minimizing the risk of procedure-related complications. CVS provides crucial early insights into the genetic health of the fetus, aiding expectant parents and healthcare providers in making informed decisions about pregnancy management.

Question: 10

All of the following are indications of severe preeclampsia EXCEPT:

A. oliguria
B. blood pressure of 145/95 mm Hg
C. thrombocytopenia
D. pulmonary edema

Answer: B

Explanation:
*Preeclampsia is a condition that occurs during pregnancy, characterized primarily by high blood pressure and often a significant amount of protein in the urine. The severity of preeclampsia can vary, and it is classified into mild and severe forms based on specific clinical criteria. Understanding these criteria is crucial for managing the condition effectively and reducing risks for both the mother and the baby. *One of the options listed, "blood pressure of 145/95 mm Hg," is indicative of mild preeclampsia rather than severe. Mild preeclampsia is generally defined by blood pressures that are elevated above normal but do not exceed severe thresholds. Specifically, a blood pressure reading of 140/90 mm Hg or higher is needed to diagnose preeclampsia, but severe preeclampsia typically involves blood pressure that reaches or exceeds 160/110 mm Hg. Therefore, a blood pressure of 145/95 mm Hg, while concerning and requiring management, does not meet the criteria for severe preeclampsia. *In contrast, the other symptoms listed – oliguria (low urine output), thrombocytopenia (low platelet count), and pulmonary edema (fluid accumulation in the lungs) – are indicators of severe preeclampsia. Oliguria in preeclampsia reflects renal impairment, a serious complication. Thrombocytopenia in this context indicates a disruption in blood clotting factors, which can lead to further complications such as the development of HELLP syndrome (Hemolysis, Elevated Liver enzymes, and Low Platelet count). Pulmonary edema is another severe and potentially life-threatening complication, indicating that the body is struggling to manage the fluid shifts and blood pressure changes caused by severe preeclampsia. *Therefore, among the options provided, a blood pressure of 145/95 mm Hg is the only one that does not indicate severe preeclampsia. This distinction is critical for appropriate monitoring and treatment planning to ensure the safety and health of both the mother and the developing fetus. Handling preeclampsia with precision and care can help prevent the progression to more severe forms and associated complications.

Question: 11

The cheesy white substance found on the entire body of the newborn is which of the following?

A. lanugo
B. vernix caseosa
C. acrocyanosis
D. erythema toxicum

Answer: B

Explanation:
The correct answer to the question regarding the cheesy white substance found on the entire body of a newborn is "vernix caseosa." Vernix caseosa is a naturally occurring biofilm covering the skin of the fetus during the last trimester of pregnancy and is still present on the skin of newborns. This whitish, cheese-like coating primarily serves as a protective barrier in the womb, where it helps to shield the baby's delicate skin from the amniotic fluid. As well as providing a layer of insulation, it assists in maintaining the body temperature of the newborn.
Vernix caseosa is composed mainly of water, lipids (fats), and proteins, including antimicrobial proteins that help in protecting the newborn against infections. Its thick, creamy nature is what makes it particularly effective as a waterproof barrier, ensuring that the skin underneath remains moist and supple. Typically, the vernix is thicker in the folds of the newborn's skin and may vary in amount from baby to baby.
On the other hand, "lanugo" is another term often associated with newborns but refers to something quite different. Lanugo is a fine, soft hair that covers the body of some fetuses as a layer of insulation. It is most predominantly found on the back and shoulders and usually sheds before or shortly after birth.
The other options listed, such as "acrocyanosis" and "erythema toxicum," refer to different conditions found in newborns. Acrocyanosis is a temporary condition where the hands and feet appear blue due to poor blood circulation in the skin's small vessels upon exposure to cold. Erythema toxicum is a common, benign, self-limiting rash that appears in some newborns after birth, characterized by red spots with a small white or yellow pustule at the center.
Thus, for the query about the cheesy white substance on a newborn's body, "vernix caseosa" is the accurate answer. Understanding these various terms is important for recognizing the normal physiological processes in newborns and distinguishing them from possible pathological conditions.

Question: 12

Causes of hemorrhaging in the postpartum patient would include all but which of the following?

A. Retained placenta
B. Pneumonia
C. Uterine atony
D. Greater than 500 mL blood loss/24 hours that is caused by a boggy uterus

Answer: B

Explanation:

The question presented is regarding the causes of hemorrhaging in a postpartum patient. It specifically asks for a cause which does not contribute to postpartum hemorrhaging. The options given are: retained placenta, pneumonia, uterine atony, and greater than 500 mL blood loss/24 hours due to a boggy uterus. To answer this question, it is crucial to understand each term and its relevance to postpartum hemorrhaging.

Retained placenta is a condition where all or part of the placenta or membranes remain in the uterus after childbirth. This can lead to significant postpartum bleeding because the uterus cannot contract effectively until the placenta is expelled. The retained tissue prevents the uterine muscles from contracting fully, which is necessary to compress the blood vessels and stop the bleeding.

Uterine atony refers to a lack of tone in the uterine muscles. Normally after childbirth, the uterus contracts to help push out the placenta and to compress the blood vessels in the uterine wall to minimize bleeding. If the uterus does not contract strongly enough, known as uterine atony, significant bleeding can occur because the blood vessels are not sufficiently compressed.

Greater than 500 mL blood loss/24 hours caused by a boggy uterus directly describes a scenario where the uterus remains unusually soft and uncontracted (boggy), which can lead to excessive bleeding. This condition is closely related to uterine atony as both involve the inability of the uterus to contract effectively to control bleeding after delivery.

Pneumonia, however, is an infection of the lungs and is not directly related to postpartum hemorrhaging. While severe illnesses like pneumonia can indirectly affect overall health and may complicate recovery from childbirth, they do not directly cause the uterus to bleed. Thus, among the options provided, pneumonia is the correct answer as it does not include a direct cause of postpartum hemorrhaging.

In conclusion, while conditions like retained placenta, uterine atony, and a boggy uterus are direct causes of excessive bleeding following childbirth, pneumonia does not have a direct mechanistic link to causing postpartum hemorrhaging. Hence, it is the correct answer to the question about what does not cause postpartum hemorrhaging.

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