CLINICALJUDGE™ · MASTER STUDY GUIDE

OBSTETRIC EMERGENCIES

Every maternal & fetal emergency the 2026 NGN NCLEX-RN can test — across the antepartum, intrapartum, postpartum, and neonatal continuum — with pathophysiology, hallmark cues, the priority intervention and first action, the medications, and the must-know fact for each. Built to take you to 100%.

2026 NGN BLUEPRINT | ANTEPARTUM · INTRAPARTUM · POSTPARTUM | ~30 EMERGENCIES | PRIORITIES & FIRST ACTIONS | FETAL MONITORING · UTEROTONICS

RED CRITICAL CUES | BLUE PATHOPHYSIOLOGY | GREEN PRIORITY ACTIONS | ORANGE COMPLICATIONS | YELLOW MUST-KNOW FACT | PURPLE MEDICATIONS | TEAL TEACHING

⚠ THE TWO QUESTIONS EVERY OB EMERGENCY ANSWERS

For each: **what protects the mother's airway/circulation, and what protects fetal oxygenation?** When in doubt intrapartum, the rescue bundle is **reposition (left side) · stop oxytocin · O_2 8–10 L · IV fluid bolus · notify provider** — and relieve any cord pressure first.

01 ANTEPARTUM EMERGENCIES

PREGNANCY · BEFORE LABOR

ECTOPIC PREGNANCY

IMPLANTATION OUTSIDE UTERUS

PATHO

Embryo implants outside uterus (usually fallopian tube) → grows → tube ruptures → hemorrhage

CUES

Unilateral lower-abdominal/pelvic pain, scant dark bleeding, +hCG (lower than expected). **Rupture → sudden severe pain, hypotension/shock, referred shoulder pain.**

PRIORITY

1. Assess for shock; large-bore IV, fluids/blood
2. Unruptured/early → **methotrexate**; ruptured → emergency surgery (salpingectomy)
3. Monitor hCG, pain, bleeding; Rh-negative → RhoGAM

KEY

Shoulder pain + hypotension = rupture (intraperitoneal blood irritating diaphragm).

HYPEREMESIS GRAVIDARUM

SEVERE PERSISTENT VOMITING

CUES

Intractable N/V, >5% weight loss, dehydration, **ketonuria**, electrolyte imbalance (hypokalemia), metabolic alkalosis.

PRIORITY

1. IV fluids + electrolyte replacement (correct dehydration first)
2. Antiemetics; advance to small, bland, frequent meals
3. Monitor weight, I&O, labs, fetal well-being

MEDS Pyridoxine (B6) | Doxylamine | Ondansetron

PRETERM LABOR

CONTRACTIONS 20–37 WEEKS

CUES

Regular contractions, cervical change, low backache, pelvic pressure, >37 wks not yet; +fetal fibronectin / short cervix.

PRIORITY

1. Hydration, left lateral rest, continuous fetal monitoring
2. **Tocolytics** to delay (buy time for lung maturity)
3. **Betamethasone** for fetal lung maturity (<34 wks); magnesium for fetal neuroprotection
4. Identify/treat infection (common trigger)

MEDS Terbutaline | Nifedipine | Mag sulfate | Betamethasone

KEY

Betamethasone = fetal lung maturity (give <34 wks); takes ~24–48 h to work.

PROM / PPROM & CHORIOAMNIONITIS

PREMATURE RUPTURE OF MEMBRANES + INFECTION

CUES

Gush/leak of fluid; +nitrazine (blue)/ferning. **Infection (chorioamnionitis): maternal fever, fetal tachycardia, foul-smelling fluid, uterine tenderness, ↑WBC.**

PRIORITY

1. Assess for cord prolapse & infection; **limit vaginal exams**
2. Monitor temp, FHR, fluid color/odor
3. Antibiotics for infection; corticosteroids if preterm; plan delivery if infected

KEY

Once membranes rupture, **watch for cord prolapse** and rising infection risk over time.

HYDATIDIFORM MOLE (MOLAR PREGNANCY)
GESTATIONAL TROPHOBLASTIC DISEASE

CUES

Very high hCG, uterus larger than dates, "snowstorm"/grape-like vesicles on ultrasound, dark-brown bleeding, severe nausea, early preeclampsia signs; no fetal heart tones.

PRIORITY

1. Evacuation (D&C); monitor bleeding
2. **Serial hCG monitoring** & avoid pregnancy ~1 year (choriocarcinoma risk)

KEY

Strict contraception & hCG follow-up — rising hCG signals malignancy.

VTE IN PREGNANCY (DVT / PE)
HYPERCOAGULABLE STATE

CUES

DVT: unilateral calf swelling/warmth/pain. **PE: sudden dyspnea, chest pain, tachycardia, hypoxia** (leading cause of maternal death).

PRIORITY

1. High-Fowler's, O_2, IV access, monitor
2. Anticoagulation with **heparin/LMWH** (warfarin is teratogenic)
3. Don't massage limb; VTE prophylaxis (ambulation, SCDs)

KEY

Heparin/LMWH in pregnancy — never warfarin (teratogenic).

02 HYPERTENSIVE DISORDERS
PREECLAMPSIA · ECLAMPSIA · HELLP

PREECLAMPSIA (WITH/WITHOUT SEVERE FEATURES)
NEW HTN + PROTEINURIA AFTER 20 WEEKS

PATHO

Abnormal placental perfusion → vasospasm + endothelial damage → HTN, proteinuria, multi-organ effects

CUES

MILD / BASELINE
BP ≥140/90, proteinuria, mild edema

SEVERE FEATURES
BP ≥160/110, severe headache, visual changes, RUQ/epigastric pain, hyperreflexia/clonus, ↓platelets, ↑LFTs, oliguria

PRIORITY

1. Monitor BP, DTRs, urine output, fetal status; quiet/low-stimulation
2. **Magnesium sulfate** for seizure prophylaxis (severe features)
3. Antihypertensives (labetalol, hydralazine, nifedipine) for severe BP
4. Definitive treatment = **delivery**

KEY

Headache + visual changes + epigastric pain = worsening → seizure may be imminent.

ECLAMPSIA (SEIZURE)
PREECLAMPSIA + TONIC-CLONIC SEIZURE

PRIORITY DURING SEIZURE

1. **Protect airway** — turn to side, suction, O_2; don't restrain or put anything in mouth
2. Ensure mag sulfate running; **after** seizure assess mother & fetus (FHR)
3. Prepare for delivery once mother is stabilized

MEDS: Magnesium sulfate · Antihypertensives

KEY

Airway/safety first during the seizure; **mag sulfate is for seizures, not for lowering BP** (use antihypertensives for BP). Can occur up to ~6 weeks postpartum.

HELLP SYNDROME
SEVERE PREECLAMPSIA VARIANT

CUES

Hemolysis · **EL**evated **L**iver enzymes · **L**ow **P**latelets. RUQ/epigastric pain, malaise, nausea; high risk of bleeding/DIC, liver rupture.

PRIORITY

1. Magnesium sulfate, antihypertensives, monitor labs (CBC, LFTs)
2. **Bleeding precautions** (low platelets); manage as severe preeclampsia
3. Stabilize & deliver

KEY

Low platelets → bleeding/DIC risk; RUQ pain may signal hepatic involvement.

MAGNESIUM SULFATE TOXICITY
COMPLICATION OF THERAPY

CUES

Earliest = **loss of deep tendon reflexes** → respiratory depression (RR <12) → ↓LOC → cardiac/respiratory arrest; flushing, ↓BP. Therapeutic 4–7 mEq/L.

PRIORITY

1. Monitor DTRs, RR (≥12), urine output (≥30 mL/h), LOC, mag level
2. Signs of toxicity → **stop the infusion**
3. Give the antidote & support ventilation

ANTIDOTE: Calcium gluconate

KEY

Absent DTRs / RR <12 / urine <30 mL/h = hold mag + give calcium gluconate.

03 BLEEDING EMERGENCIES
PLACENTAL · HEMORRHAGE · DIC

PLACENTA PREVIA
PLACENTA OVER/NEAR THE CERVICAL OS

CUES

Painless, bright-red vaginal bleeding in 2nd/3rd trimester; soft, non-tender uterus; normal tone.

PRIORITY

1. **NO vaginal/digital exam** (can trigger hemorrhage)
2. Monitor mother & fetus, IV access, type & crossmatch
3. Bed rest; **cesarean delivery** for complete previa

KEY

Painless bleeding = previa. Never perform a vaginal exam with suspected previa.

PLACENTAL ABRUPTION (ABRUPTIO PLACENTAE)
PREMATURE PLACENTAL SEPARATION

PATHO

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Placenta separates from uterine wall before birth → bleeding (may be concealed) → fetal hypoxia + maternal shock
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CUES

Painful dark-red bleeding (or concealed), **rigid/board-like tender uterus**, fetal distress, signs of shock, possible DIC.

PRIORITY

1. Continuous fetal + maternal monitoring; left lateral position
2. O_2, large-bore IV, fluids/blood; treat shock
3. Prepare for emergent delivery (often C-section); watch for DIC

KEY

Painful + rigid tender uterus = abruption (vs painless previa).

DISSEMINATED INTRAVASCULAR COAGULATION (DIC)
CLOTTING + BLEEDING CASCADE

PATHO

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OB trigger (abruption, AFE, retained fetus, sepsis) → widespread clotting → consumes platelets/factors → uncontrolled bleeding
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CUES

Oozing from IV sites/gums, petechiae, uncontrolled bleeding; **↑PT/PTT, ↑D-dimer, ↓platelets, ↓fibrinogen**.

PRIORITY

1. **Treat the underlying cause** (the real fix)
2. Replace components: platelets, FFP, cryoprecipitate, blood
3. Support oxygenation/perfusion; monitor coags

SPONTANEOUS ABORTION (HEMORRHAGIC)
PREGNANCY LOSS <20 WEEKS

CUES

Vaginal bleeding, cramping, possible tissue passage; heavy bleeding → hypovolemia.

PRIORITY

1. Assess bleeding/shock; IV fluids, monitor VS & hCG
2. Possible D&C for incomplete; emotional support
3. Rh-negative → **RhoGAM**

KEY

Save passed tissue for evaluation; provide nonjudgmental emotional support.

04 INTRAPARTUM EMERGENCIES
LABOR & DELIVERY

UMBILICAL CORD PROLAPSE
CORD SLIPS BELOW PRESENTING PART

CUES

Visible/palpable cord, **sudden variable or prolonged decelerations / fetal bradycardia**, often after rupture of membranes.

PRIORITY

1. **Relieve cord pressure** — gloved hand lifts presenting part off the cord (keep it there)
2. Reposition mother: **knee-chest or Trendelenburg**
3. O_2, call for help, prep for emergent C-section; keep cord moist, **don't push it back in**

KEY

Hand stays in to lift the presenting part until delivery — call for help simultaneously, don't leave.

UTERINE RUPTURE
TEARING OF THE UTERINE WALL

CUES

Sudden sharp "tearing" abdominal pain, loss of/abnormal contractions, fetal bradycardia, loss of fetal station, signs of hypovolemic shock. Risk = prior C-section/VBAC, oxytocin.

PRIORITY

1. **Stop oxytocin;** O_2, large-bore IV, fluids/blood
2. Notify provider STAT; prepare for emergency laparotomy/C-section
3. Treat for shock; possible hysterectomy

KEY

Sudden pain + abnormal/lost contractions + fetal bradycardia = rupture → immediate surgical delivery.

SHOULDER DYSTOCIA
FETAL SHOULDER LODGES BEHIND PUBIC BONE

CUES

Head delivers then retracts (**"turtle sign"**), no further descent; risk of brachial plexus injury & hypoxia.

PRIORITY

1. **McRoberts maneuver** — sharply flex maternal hips/thighs onto abdomen
2. **Suprapubic pressure** (NOT fundal pressure)
3. Call for help; assist with delivery maneuvers; assess newborn for injury

KEY

Suprapubic, never fundal pressure (fundal worsens impaction).

AMNIOTIC FLUID EMBOLISM
ANAPHYLACTOID SYNDROME OF PREGNANCY

PATHO

Amniotic fluid/debris enters maternal circulation → cardiopulmonary collapse + DIC

CUES

Sudden dyspnea, hypoxia, hypotension, cyanosis, cardiovascular collapse, then hemorrhage/DIC; abrupt onset during labor/delivery.

PRIORITY

1. Call for help / rapid response; **CPR & full resuscitation** as needed
2. O_2/intubation, IV fluids, vasopressors, blood products
3. Emergent delivery; treat DIC

KEY

Sudden respiratory distress + collapse + DIC in labor = AFE — supportive resuscitation is all that can be done.

UTERINE TACHYSYSTOLE (OXYTOCIN)
HYPERSTIMULATION

CUES

>5 contractions in 10 min, contractions <60 s apart or lasting >90 s, ↑resting tone, often with late decels/fetal distress.

PRIORITY

1. **Stop the oxytocin infusion**
2. Reposition to left side, O_2 8–10 L, IV fluid bolus
3. Notify provider; consider terbutaline to relax uterus

KEY

First action = stop oxytocin, then the intrauterine rescue bundle.

PRECIPITOUS LABOR & UTERINE INVERSION
RAPID BIRTH · TURNED-INSIDE-OUT UTERUS

CUES

Precipitous: birth <3 h from onset (laceration/hemorrhage/fetal hypoxia risk). Inversion: uterus protrudes through cervix after delivery → **sudden hemorrhage + shock**.

PRIORITY

1. Inversion: **do NOT remove the placenta or massage**; large-bore IV/fluids, call provider for manual replacement
2. Stop uterotonics until replaced, then give to contract; treat shock

KEY

Uterine inversion is an emergency — replacement first, uterotonics after replacement.

05 FETAL MONITORING & INTRAUTERINE RESCUE
READING THE STRIP · ACTING ON IT

NONREASSURING FETAL HEART RATE
LATE DECELS / MINIMAL VARIABILITY / BRADYCARDIA

CUES

Late decelerations (uteroplacental insufficiency), **minimal/absent variability**, fetal bradycardia <110 or tachycardia >160, recurrent variables.

INTRAUTERINE RESUSCITATION

1. **Reposition** mother to left side (relieves vena cava compression)
2. **Stop oxytocin** if infusing
3. **O_2** 8–10 L via non-rebreather
4. **IV fluid bolus** (improves placental perfusion)
5. Notify provider; prepare for expedited delivery if no improvement

KEY

For variable decels (cord compression) → reposition first ± amnioinfusion. Late decels → the full rescue bundle.

VEAL CHOP MINE
DECODING THE DECELERATION PATTERNS

THE MNEMONIC

Match the cause (CHOP) and the action (MINE) to each pattern (VEAL).

PATTERNS

OK — NO ACTION
Early decel = Head compression · **Accelerations** = OK (reassuring)

ACT
Variable = Cord compression → reposition/Move · **Late** = Placental insufficiency → Execute rescue

KEY

Variable→Cord, Early→Head, Accel→OK, Late→Placenta. Lates are the most concerning.

06 POSTPARTUM EMERGENCIES
AFTER BIRTH

POSTPARTUM HEMORRHAGE (PPH)
>500 ML VAGINAL / >1000 ML C-SECTION

CUES

Boggy uterus (atony = #1 cause), saturating >1 pad/hour, bright-red bleeding, ↑HR, ↓BP, ↓LOC. Causes = **4 T's**: Tone, Trauma, Tissue, Thrombin.

PRIORITY

1. **Firm fundal massage first** (atony is most common)
2. Ensure bladder empty (distention displaces uterus); IV fluids, monitor blood loss
3. Uterotonics; blood products; surgical intervention if refractory

MEDS: Oxytocin | Methylergonovine | Carboprost | Misoprostol | TXA

KEY

Massage the boggy fundus first; a full bladder is a common, fixable cause.

RETAINED PLACENTA / HEMATOMA
CAUSES OF ONGOING BLEEDING

CUES

Retained tissue → **firm fundus but continued bleeding**. Hematoma → severe localized perineal/pelvic pain, swelling, ecchymosis, signs of hidden blood loss with a firm fundus.

PRIORITY

1. If fundus firm but still bleeding → suspect retained fragments or laceration/hematoma
2. Notify provider; prepare for evacuation/repair; monitor VS & blood loss

KEY

Firm fundus + ongoing bleeding points away from atony — think tissue/trauma/hematoma.

POSTPARTUM INFECTION (ENDOMETRITIS)
UTERINE/GENITAL TRACT INFECTION

CUES

Fever >38°C after 24 h, **uterine tenderness, foul-smelling/profuse lochia**, tachycardia, ↑WBC, chills.

PRIORITY

1. Cultures, IV antibiotics, fluids, antipyretics
2. Fowler's/upright to promote lochia drainage; monitor for sepsis

POSTPARTUM VTE & POSTPARTUM PREECLAMPSIA
CLOTS & LATE-ONSET HYPERTENSION

CUES

VTE: calf pain/swelling (DVT), sudden dyspnea/chest pain (PE). **Postpartum preeclampsia/eclampsia can occur up to ~6 weeks after birth** — severe headache, visual changes, high BP, seizures.

PRIORITY

1. VTE: O_2, anticoagulation, don't massage, ambulation/SCD prophylaxis
2. Postpartum preeclampsia: BP control, magnesium, seizure precautions

KEY

Teach discharged mothers warning signs of clots **and** preeclampsia — both can appear after going home.

POSTPARTUM DEPRESSION & PSYCHOSIS
MENTAL-HEALTH EMERGENCY

CUES

"BABY BLUES" (TRANSIENT)	DEPRESSION / PSYCHOSIS
Mild mood swings, tearfulness, resolves within ~2 weeks	Depression: persistent >2 wks, hopelessness. Psychosis: hallucinations, delusions, thoughts of harming self/baby — EMERGENCY

PRIORITY

1. Assess for thoughts of harm to self or infant — **ensure safety first**
2. Never leave mother alone with baby if psychosis; psychiatric referral/treatment

KEY

Postpartum psychosis = emergency (risk to mother & infant); requires immediate intervention.

07 NEONATAL EMERGENCIES
IMMEDIATE NEWBORN PERIOD

NEONATAL RESPIRATORY DISTRESS / RESUSCITATION
FAILURE TO TRANSITION

CUES

Apnea/gasping, grunting, nasal flaring, retractions, cyanosis, HR <100; low Apgar.

PRIORITY (NRP)

1. **Warm, dry, stimulate, position & clear airway**
2. Apnea/HR <100 → positive-pressure ventilation
3. HR <60 despite PPV → chest compressions; consider epinephrine

KEY

The newborn's first need is establishing respirations — warmth & ventilation are the priorities.

MECONIUM ASPIRATION
MECONIUM-STAINED FLUID INHALED

CUES

Meconium-stained fluid, respiratory distress, cyanosis, low Apgar.

PRIORITY

1. If non-vigorous → support airway/ventilation per NRP (suction as indicated)
2. O_2/ventilation support, monitor for pneumonia/pneumothorax

NEONATAL HYPOGLYCEMIA

GLUCOSE TYPICALLY <40–45 MG/DL

CUES

Jitteriness, lethargy, poor feeding, hypothermia, high-pitched cry; risk in IDM, LGA/SGA, preterm.

PRIORITY

1. Check glucose; **feed** (breast/formula) for mild low
2. IV dextrose if severe/symptomatic; recheck glucose

COLD STRESS & PATHOLOGIC JAUNDICE

THERMOREGULATION · HYPERBILIRUBINEMIA

CUES

Cold stress → hypothermia → hypoglycemia/acidosis/respiratory distress. **Pathologic jaundice = appears <24 h**, rapidly rising bilirubin → kernicterus risk.

PRIORITY

1. Cold stress → warm (radiant warmer/skin-to-skin), dry, hat; minimize heat loss
2. Jaundice → phototherapy (eye protection, hydration), monitor bilirubin

KEY

Jaundice in the **first 24 hours is pathologic** (not physiologic) and must be evaluated.

MASTER REFERENCE TABLES

THE CONSOLIDATED HIGH-YIELD DATA

08 · VEAL CHOP & DECELERATION RESCUE

PATTERN (VEAL)	CAUSE (CHOP)	ACTION (MINE)
Variable decel	Cord compression	Move/reposition mother (± amnioinfusion)
Early decel	Head compression	Identify — no action needed (benign)
Acceleration	OK / well-oxygenated	No action — reassuring
Late decel	Placental insufficiency	Execute rescue: reposition, stop oxytocin, O_2, IV bolus, notify

09 · UTEROTONICS FOR PPH

DRUG	USE	KEY CAUTION
Oxytocin (Pitocin)	First-line uterine contraction	Hypotension; water intoxication with prolonged use
Methylergonovine (Methergine)	Sustained contraction	Hold if hypertensive (raises BP)
Carboprost (Hemabate)	Refractory atony	Avoid in asthma (bronchospasm); causes diarrhea/fever
Misoprostol (Cytotec)	Atony; can be given rectally	Fever, shivering, diarrhea
Tranexamic acid (TXA)	Antifibrinolytic adjunct	Caution with thromboembolism history

10 · MAGNESIUM SULFATE MONITORING

PARAMETER	SAFE / TARGET	SIGN OF TOXICITY (HOLD & TREAT)
Deep tendon reflexes	Present (1–2+)	Absent reflexes (earliest sign)
Respiratory rate	≥12/min	<12/min (respiratory depression)
Urine output	≥30 mL/hr	<30 mL/hr (accumulation risk)
Serum level	4–7 mEq/L (therapeutic)	>7 → toxicity; arrest at high levels
Antidote	—	Calcium gluconate

11 · PLACENTA PREVIA VS ABRUPTION

FEATURE	PLACENTA PREVIA	PLACENTAL ABRUPTION
Bleeding	Painless, bright red	Painful, dark red (may be concealed)
Uterus	Soft, non-tender, normal tone	Rigid, board-like, tender
Vaginal exam	Contraindicated	Avoid; monitor
Key complication	Hemorrhage with exam/labor	DIC, fetal hypoxia, shock

12 · OB MEDICATIONS QUICK REFERENCE

MEDICATION	PURPOSE	KEY POINT
Magnesium sulfate	Seizure prophylaxis (preeclampsia); tocolysis; fetal neuroprotection	Monitor DTRs/RR/UOP; antidote calcium gluconate
Betamethasone	Fetal lung maturity (<34 wks)	Takes ~24–48 h; transient maternal hyperglycemia
Terbutaline	Tocolytic; uterine relaxation	Maternal tachycardia; short-term use

MEDICATION	PURPOSE	KEY POINT
Oxytocin	Induction/augmentation; postpartum contraction	**Stop for tachysystole/late decels**
RhoGAM (Rho(D) Ig)	Prevent Rh isoimmunization	**28 wks & within 72 h postpartum if baby Rh+; also after bleeding/loss**
Methotrexate	Unruptured ectopic pregnancy	**Avoid folic acid; monitor hCG**
Labetalol / hydralazine / nifedipine	Severe-range BP in pregnancy	**For BP — not the same as seizure prophylaxis**

OB EMERGENCY MASTERY CHECKLIST

SELF-CHECK BEFORE TEST DAY

I CAN CONFIDENTLY... ✓

- ☑ Distinguish placenta previa (painless) from abruption (painful, rigid uterus)
- ☑ Recognize uterine rupture: sudden pain, lost contractions, fetal bradycardia
- ☑ Identify amniotic fluid embolism and respond with full resuscitation
- ☑ Decode VEAL CHOP and which patterns require action
- ☑ Monitor magnesium toxicity (DTRs, RR, UOP) and give calcium gluconate
- ☑ Manage PPH: fundal massage first, empty bladder, uterotonics, the 4 T's
- ☑ Recognize ectopic rupture (shoulder pain + shock) and its treatment
- ☑ Treat postpartum psychosis as an emergency (safety of mother & infant)
- ☑ State the first action in cord prolapse: lift the presenting part off the cord
- ☑ Apply McRoberts + suprapubic (never fundal) pressure for shoulder dystocia
- ☑ Run the intrauterine rescue bundle for late decels
- ☑ Manage preeclampsia/eclampsia: magnesium, antihypertensives, seizure precautions, delivery
- ☑ Recognize HELLP and its bleeding/DIC risk
- ☑ Match each uterotonic to its caution (Methergine→HTN, carboprost→asthma)
- ☑ Identify postpartum infection, VTE, and late-onset preeclampsia
- ☑ Prioritize newborn warmth & ventilation; flag jaundice <24 h as pathologic

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