NCLEX-RN 2026 · HIGH-YIELD STUDY CARD

Cervical Cerclage

Surgical reinforcement for cervical insufficiency

OB / MATERNITY | ANTEPARTUM | PRETERM BIRTH PREVENTION | SURGICAL

PLACED
12–14 wk
REMOVED
36–37 wk

<25	<24	3	85%
MM CERVIX = SHORT	WKS MAX FOR PLACEMENT	CERCLAGE TYPES	SUCCESS TO TERM

01 Definition & Overview

WHAT IT IS · WHY IT MATTERS

A purse-string suture placed around the cervix to mechanically reinforce it and keep it closed during pregnancy.

Indicated for **cervical insufficiency** — painless, premature cervical dilation in the 2nd trimester without contractions, which leads to membrane prolapse, PROM, and 2nd-trimester pregnancy loss or preterm birth.

Cerclage acts as a **structural barrier**, holding the cervix closed until late in pregnancy, then is removed prior to labor (or left in place for planned cesarean / abdominal cerclage).

AKA
Cervical Stitch · Cervical Suture · McDonald Procedure

GOAL
Prevent 2nd-trimester loss & preterm birth

ANESTHESIA
Spinal (preferred) · Epidural · General

02 Pathophysiology

MECHANISM · STEP-BY-STEP

Weak / Incompetent Cervix (congenital · trauma · LEEP · cone bx) → Painless Cervical Shortening & Dilation (2nd trimester) → Membranes Bulge into Cervix (hourglass membranes)

PROM / Chorioamnionitis ← 2nd-Trimester Loss or Preterm Birth ← CERCLAGE blocks this cascade

*Cervical insufficiency = a **mechanical** problem; cerclage provides a **mechanical** solution by physically holding the cervix closed.*

> *Cervical insufficiency is **painless** dilation — this is the key NCLEX distinction from preterm labor, which has contractions.*

2B Types of Cerclage

SURGICAL APPROACHES · KNOW MCDONALD

★ MOST COMMON

McDonald

Purse-string suture placed transvaginally at the cervicovaginal junction. Simpler, easier to remove. **Removed at 36–37 wk.**

TRANSVAGINAL

Shirodkar

Higher placement, suture is **buried submucosally**. Used when McDonald has failed or cervix is very short.

LAST RESORT

Transabdominal

Placed via abdomen (laparoscopy/laparotomy) when vaginal cerclage has failed or cervix is absent. **Always delivery via C-section**; cerclage left in place.

03 Signs & Symptoms

INSUFFICIENCY FINDINGS · RED FLAGS POST-CERCLAGE

• Cervical Insufficiency — Early / Subtle

- **Pelvic pressure** or "heaviness" in vagina
- Dull **low backache** (continuous, not contractile)
- Mild abdominal cramping
- Change in vaginal discharge — increase in volume, pink/brown tinge
- **Light spotting** or bleeding
- U/S finding: cervical length **< 25 mm** before 24 wk
- U/S finding: **funneling** of internal os

Post-Cerclage RED FLAGS — Call Provider

- **Regular contractions** or rhythmic cramping
- **Rupture of membranes** — gush or leak of fluid
- Vaginal **bleeding** (more than light spotting)
- **Fever ≥ 100.4°F (38°C)** → suspect chorioamnionitis
- Foul-smelling vaginal discharge
- Severe pelvic/perineal pain or pressure
- Suture displacement or visible at introitus
- Decreased fetal movement

NCLEX KEY: *If membranes have ruptured, infection is present, or labor is active* — **cerclage must be REMOVED.** *Do NOT attempt to maintain it.*

04 Priority Nursing Interventions

ABCS · SAFETY · PRIORITIZATION

Pre-Operative

1. **Confirm gestational age** (typically 12–14 wk) & viability via U/S
2. Verify **NO active labor**, ROM, infection, or bleeding (all contraindications)
3. **NPO** after midnight; obtain consent
4. Type & screen, CBC, baseline vitals & **FHR**
5. Pre-op antibiotics if ordered; void before procedure
6. Assess for **UTI/BV/STI** — must treat *before* cerclage

Post-Operative

1. **Monitor for contractions** via tocodynamometer × 1+ hr
2. **Auscultate FHR** before, during, & after procedure
3. Assess for **vaginal bleeding** & fluid leakage (ROM)
4. Monitor for signs of **infection** (fever, foul discharge)
5. Pain management — mild discharge of pink/brown spotting & cramps expected first 24–48 hr
6. Reinforce **pelvic rest** & activity restrictions
7. Schedule follow-up; **plan removal at 36–37 wk**

Priority Hierarchy: *Maternal stability → Fetal HR/well-being → Detect labor/PROM/infection → Comfort/education.* **ABCs first** *if anesthesia complication suspected.*

05 Pharmacology

ADJUNCT MEDS · HOLD PARAMETERS

DRUG / CLASS	MECHANISM · PURPOSE	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
Indomethacin NSAID TOCOLYTIC	Inhibits prostaglandin synthesis → suppresses uterine contractions. Given prophylactically peri-op.	GI upset, oligohydramnios with prolonged use, **premature closure of fetal ductus arteriosus**.	**AVOID after 32 wk** (ductal closure risk). Short courses only. Monitor amniotic fluid index.
Vaginal Progesterone HORMONAL ADJUNCT	Quiets myometrium; supports pregnancy maintenance. Often **continued with cerclage** in short-cervix patients.	Vaginal irritation, drowsiness, headache, breast tenderness.	Educate on **nightly insertion at bedtime**. Continue until ~36 wk. Do not abruptly stop.
Prophylactic Antibiotics VARIABLE	Reduce risk of infection peri-operatively, esp. with emergent/rescue cerclage.	GI upset, allergic reaction, candidiasis.	Verify **no allergies**. Assess for signs of yeast infection. Complete full course.
Betamethasone CORTICOSTEROID	Accelerates fetal lung maturation if delivery before 34 wk is anticipated.	Maternal hyperglycemia, transient leukocytosis, fluid retention.	**Two IM doses 24 hr apart.** Monitor glucose (esp. GDM). Peak benefit 24 hr after 2nd dose.
Nifedipine / Mag Sulfate TOCOLYTIC	Used if preterm contractions develop. Nifedipine = CCB; $MgSO_4$ = neuroprotection < 32 wk.	Hypotension (nifedipine); resp. depression, ↓ DTRs, ↓ urine output (Mg).	$MgSO_4$: hold for RR < 12, absent DTRs, UO < 30 mL/hr. **Antidote = calcium gluconate.**

06 NCLEX Test Traps

DISTRACTORS · PRIORITY PITFALLS

"Painless dilation" ≠ Preterm labor

Cervical insufficiency is **painless**. If the question says *painful contractions* → think preterm labor, not insufficiency. Different management entirely.

Cerclage placement timing

Placed in **early 2nd trimester (12–14 wk)**, NOT 1st trimester. Done after first-trimester loss risk passes. Emergent cerclage may go up to 24 wk.

When to REMOVE the cerclage

Routine removal at **36–37 weeks BEFORE labor begins**. Also remove emergently if: ROM, active labor, infection, or fetal demise — do **not** "wait and see."

Absolute contraindications

Do **NOT** place cerclage with: active labor, ROM, chorioamnionitis, active bleeding, fetal demise, lethal anomaly, or cervix > 4 cm dilated.

"Pelvic rest" — what it actually means

No intercourse · no tampons · no douching · nothing in the vagina. "Bed rest" is no longer routinely recommended — pelvic rest is the key term.

First action: ROM after cerclage

If ROM is suspected post-cerclage: **notify provider immediately** & prepare for cerclage removal. Continued cerclage with ROM → severe infection / sepsis.

Transabdominal = always C-section

Abdominal cerclage is **NOT removed** before delivery. The patient delivers via planned cesarean and the cerclage usually stays in place for future pregnancies.

Mild spotting & cramping ≠ emergency

Light pink/brown spotting and mild cramping in the **first 24–48 hr post-op are EXPECTED**. Heavy bleeding, fluid gush, or fever are the red flags.

07 Patient Education

SELF-CARE · WHEN TO CALL

✓ Do — Pelvic Rest & Self-Care

- ✓ **Pelvic rest:** no intercourse, no tampons, no douching
- ✓ Avoid **heavy lifting** (> 10 lb) & strenuous activity
- ✓ Limit prolonged standing; rest with feet elevated
- ✓ Continue **prenatal vitamins & folic acid**
- ✓ Maintain hydration & balanced nutrition
- ✓ Attend **all follow-up appointments** & cervical length scans
- ✓ Use **vaginal progesterone** as prescribed (bedtime)
- ✓ Plan for **cerclage removal at 36–37 wk**
- ✓ Use stool softeners to prevent straining
- ✓ Empty bladder regularly (full bladder can stress cervix)

! Report Immediately — Call Provider

- ! **Regular contractions** (> 4 in 1 hour)
- ! **Gush or steady leak of fluid** from vagina (ROM)
- ! **Heavy vaginal bleeding** (not light spotting)
- ! **Fever ≥ 100.4°F (38°C)** or chills
- ! **Foul-smelling vaginal discharge**
- ! Severe pelvic / abdominal / back pain
- ! **Feeling of pressure** as if something is "coming down"
- ! Decreased fetal movement (after viability)
- ! Suture coming loose or visible
- ! Dysuria or urinary symptoms (UTI risk → preterm labor)

08 Memory Boosters

MNEMONICS · PATTERN RECOGNITION

"CERCLAGE" — Master Mnemonic

C	E	R	C	L	A	G	E
CERVICAL INSUFFICIENCY	EARLY 2ND TRI (12–14 WK)	REMOVE AT 36–37 WK	CONTRAINDICATIONS: ROM, LABOR, INFECTION	LIMIT ACTIVITY / PELVIC REST	ANTIBIOTICS / PROGESTERONE	GESTATIONAL AGE CONFIRMED	EVALUATE FOR PRETERM LABOR

"STITCH" — When to Worry After Placement

S	T	I	T	C	H
SPOTTING (HEAVY)	TEMPERATURE ↑	INFECTION SIGNS	TIGHTENING (CONTRACTIONS)	CRAMPING (SEVERE)	H_2O LEAK (ROM)

QUICK ASSOCIATION

"Painless = Insufficient"

Painless cervical change = cervical **insufficiency**. **Painful** contractions = preterm **labor**. This is the #1 NCLEX differentiator.

PATTERN RECOGNITION

"12 — 24 — 36"

12 wk = earliest typical placement · **24** wk = upper limit for placement (viability) · **36** wk = remove before labor. Three numbers, whole pathway.

★ **Final NCLEX Pearl:** ***When in doubt — assess maternal stability first (ABCs), then fetal HR, then look for the four "no's":*** **no ROM, no labor, no infection, no bleeding.** ***If any are present, the cerclage comes out.***