MATERNITY · ANTEPARTUM COMPLICATIONS · NCLEX 2026

Oligohydramnios *vs.* Polyhydramnios

HIGH-YIELD REVIEW

Amniotic fluid volume is a window into fetal health. Too little or too much — both threaten mother and baby, but for very different reasons. This is the side-by-side you'll want in your brain on test day.

01 Definition & Overview

WHAT IT IS · WHY IT MATTERS

Oligohydramnios

low

"Oli-go = O-little"

Decreased amniotic fluid volume surrounding the fetus.

Fluid cushions the cord, supports lung development, and allows fetal movement — so a shortage causes **cord compression** and **lung/limb problems**.

AFI < 5 cm · Total fluid < 500 mL at term

Polyhydramnios

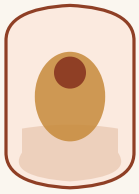
high

"Poly = Plenty"

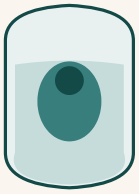
Excess amniotic fluid volume — the uterus is overstretched.

The big uterus causes **preterm labor**, **PROM**, **abruption**, **cord prolapse**, and **postpartum hemorrhage from atony**.

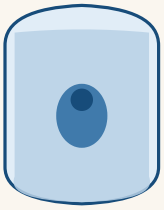
AFI > 24 cm · Total fluid > 2000 mL



Oligohydramnios
AFI < 5 CM



Normal
AFI 5–24 CM



Polyhydramnios
AFI > 24 CM

02 Pathophysiology — Simplified

CAUSE → MECHANISM → FETAL RISK

Oligohydramnios — fluid is LEAVING or not being MADE

Fetal kidney problem / PROM / placental insufficiency →

↓ Fetal urine or ↑ fluid leak → Low AFI →

Cord compression · Lung hypoplasia · Limb contractures

Polyhydramnios — fluid is BUILDING UP

Maternal DM · Fetal GI obstruction · Multiples →

Fetus can't swallow / makes extra urine → High AFI

→ Overdistended uterus · Preterm labor · PPH risk

03 Causes • Signs & Symptoms

= RED FLAG

Oligohydramnios

COMMON CAUSES

- **Fetal renal anomalies** (agenesis, dysplasia) — no urine made
- **PROM / ruptured membranes** — fluid leaks out
- **Post-term pregnancy** (>42 wks)
- **Placental insufficiency / IUGR**
- **Meds:** ACE inhibitors, ARBs, NSAIDs
- Maternal dehydration

MATERNAL / PHYSICAL FINDINGS

- Fundal height **smaller** than gestational age
- Fetal parts easily palpated (↓ cushion)
- Leaking fluid (if PROM)

FETAL FINDINGS

- Decreased fetal movement

Variable decelerations on FHR — cord compression

- IUGR on ultrasound

Potter sequence: pulmonary hypoplasia, flat facies, limb deformities

Polyhydramnios

COMMON CAUSES

- **Maternal diabetes** (GDM, Type 1/2) — #1 cause
- **Fetal GI obstruction** (esophageal atresia, TEF, duodenal atresia) — can't swallow
- **Neural tube defects** (anencephaly)
- **Multiple gestation** / TTTS
- Fetal hydrops · isoimmunization
- Idiopathic

MATERNAL / PHYSICAL FINDINGS

- Fundal height **larger** than gestational age
- **SOB / dyspnea** — diaphragm pressure
- Abdominal pain, taut/shiny skin, edema
- Difficulty palpating fetal parts / hearing FHR
- Maternal tachycardia

FETAL FINDINGS

- Malpresentation (baby floats — breech, transverse)

Cord prolapse when membranes rupture

Placental abruption with rapid decompression

Preterm labor / PROM

04 Priority Nursing Interventions

ABCS · SAFETY · PRIORITIZATION

ABC + SAFETY	**Airway (maternal SOB in poly) · Bleeding (abruption/PPH) · Cord (prolapse & compression) · Contractions**

Oligohydramnios

1. **Monitor FHR continuously** — watch for variable decelerations (cord compression = priority finding).
2. **Reposition — left lateral** to relieve cord compression & improve placental perfusion.
3. **Prepare for amnioinfusion** (warmed NS into uterus via IUPC) to cushion the cord.
4. **Encourage maternal hydration** — oral & IV fluids increase AFI.
5. **Teach kick counts** — report <10 movements in 2 hours.
6. **Assist with BPP & NST**; prepare for possible induction if term.
7. **At birth:** have NICU/resuscitation team ready — watch for respiratory distress (pulmonary hypoplasia).

Polyhydramnios

1. **Assess respiratory status** — semi-Fowler's for SOB; O_2 PRN.
2. **Monitor for preterm labor** — contractions, cervical changes; tocolytics as ordered.
3. **When membranes rupture — check FHR immediately** & do sterile vaginal exam to rule out **cord prolapse**.
4. **Assist with amnioreduction** (therapeutic amniocentesis) for symptom relief.
5. **Strict glucose control** if diabetic — the #1 modifiable cause.
6. **Watch for abruption** after ROM — sudden pain, bleeding, rigid uterus.
7. **Postpartum:** high risk for **uterine atony & hemorrhage** — fundal checks, oxytocin, quantify blood loss.

05 Pharmacology

HIGH-YIELD DRUGS TIED TO AFI

FOR POLYHYDRAMNIOS

Indomethacin

NSAID · prostaglandin synthesis inhibitor

MECHANISM

Decreases fetal urine output → reduces amniotic fluid volume.

KEY SIDE EFFECTS

Premature closure of fetal ductus arteriosus; oligohydramnios if overused; fetal renal impairment.

NURSING CONSIDERATIONS

Do **NOT use after 32 weeks gestation**. Serial ultrasound to monitor ductus & AFI. Stop if signs of fetal distress.

⚠ AVOID IN PREGNANCY

ACE Inhibitors · ARBs · NSAIDs

Cause or worsen oligohydramnios

MECHANISM OF HARM

Reduce fetal renal perfusion → ↓ fetal urine → ↓ amniotic fluid + fetal renal failure.

CLASSIC NCLEX CUE

Pregnant patient on *lisinopril, enalapril, losartan,* or chronic *ibuprofen* → expect teaching to **stop medication and call provider**.

NURSING CONSIDERATIONS

Hold drug, notify HCP, expect switch to pregnancy-safe antihypertensive (e.g., methyldopa, labetalol, nifedipine).

SUPPORTIVE / RELATED

Tocolytics, Corticosteroids & Oxytocin

When preterm labor or delivery is imminent

TOCOLYTICS (NIFEDIPINE, TERBUTALINE, MAG SULFATE)

Delay preterm labor triggered by overdistended uterus in polyhydramnios.

BETAMETHASONE / DEXAMETHASONE

Accelerate **fetal lung maturity** — 24–34 wks; critical given lung risk in both conditions.

OXYTOCIN (POSTPARTUM)

Prevents / treats **uterine atony & PPH** — especially after polyhydramnios delivery.

06 NCLEX Test Traps

WHAT STUDENTS MISS

01 **Confusing the FHR patterns.** ~~Late decels = cord compression~~ → **VARIABLE decels = cord compression → think OLIGO.** Late decels = uteroplacental insufficiency.

02 **Wrong priority after ROM in polyhydramnios.** ~~Document fluid color~~ first? No — **check FHR immediately to rule out CORD PROLAPSE.** Sudden decompression + floating fetus = prolapse risk.

03 **Missing the maternal diabetes link.** Large fundal height + SOB + known GDM → think **polyhydramnios**. Tight glucose control is the #1 preventive measure.

04 **Fundal height direction.** Small fundus = oligo. Large fundus = poly. Don't reverse them under test pressure.

05 **NSAIDs & ACE inhibitors.** These **CAUSE** oligohydramnios — never the treatment for it. Indomethacin only *treats* polyhydramnios, and only before 32 weeks.

06 **Postpartum risk in poly.** Overstretched uterus can't clamp down → **uterine atony + hemorrhage** is the #1 postpartum priority. Assess fundus q15 min.

07 **Amnioinfusion vs. amnioreduction.** **Amnio*in*fusion = ADD fluid = OLIGO. Amnio*reduction* = REMOVE fluid = POLY.** The prefix tells you the direction.

07 Patient Education

WHAT MOM NEEDS TO HEAR

Oligohydramnios

- ✓ **Hydrate:** 8–12 glasses of water daily — increases AFI.
- ✓ **Kick counts daily:** call provider if <10 movements in 2 hrs.
- ✓ Report any **gush or trickle of fluid** immediately.
- ✓ Keep all prenatal appointments — serial BPP/NST.
- ✓ Avoid NSAIDs, ACE inhibitors, ARBs — use Tylenol for aches.
- ✓ Rest on **left side** to optimize blood flow to baby.
- ✓ Understand induction may be needed if term + low AFI.

Polyhydramnios

- ✓ **Strict blood sugar control** if diabetic — #1 modifiable factor.
- ✓ Small, frequent meals — reduce reflux & SOB.
- ✓ Sleep with head of bed elevated; side-lying for comfort.
- ✓ Report **contractions, leaking fluid, sudden abd pain, or bleeding**.
- ✓ Go to hospital **immediately** if water breaks — cord prolapse risk.
- ✓ Avoid heavy lifting / long standing — eases pressure.
- ✓ Know the plan for postpartum bleeding monitoring.

08 Memory Boosters

MAKE IT STICK

Mnemonics & pattern recognition

OLI-go = O-LITTLE

Small word, small fluid. AFI < 5 cm. Small fundus, small cushion, big cord-compression problem.

POLY = PLENTY

Plenty of fluid, plenty of problems: Preterm labor, PROM, Placental abruption, Prolapsed cord, PPH.

Potter's sequence — "POTTER"

P ulmonary hypoplasia **O** ligohydramnios **T** wisted face **T** wisted skin **E** xtremity contractures **R** enal agenesis

Causes of POLY — "DIME"

D iabetes (maternal) · **I** diopathic · **M** ultiples / anomalies (GI, NTD) · **E** rythroblastosis / hydrops

FHR clue: VARIABLE = V for "Very squished cord"

Variable decels → cord compression → think oligohydramnios first.

Fundal height rule

Small fundus = Scarce fluid (Oligo). Big fundus = Bountiful fluid (Poly). Alliteration saves lives on test day.

Study smart. Pass once.

NCLEX-RN · MATERNAL/NEWBORN · 2026