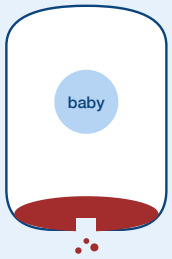
MATERNITY · NCLEX 2026 HIGH-YIELD

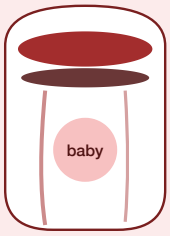
Third trimester bleeding

Placenta previa · abruptio placentae · placenta accreta



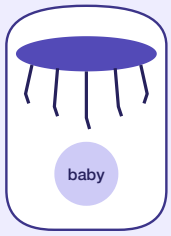
Previa

Low — covers cervix



Abruptio

Tears off wall



Accreta

Invades the wall

At-a-glance comparison

Feature	Previa	Abruptio	Accreta
Pain	Painless	Severe, sudden	None until delivery
Bleeding	Bright red	Dark red (may hide)	Massive postpartum
Uterus	Soft, non-tender	Rigid, board-like	Normal prenatally
FHR	Usually normal	Distress, late decels	Usually normal
Top risk	Prior C-section	Hypertension	Prior C-section + previa

Placenta previa

Painless bright red bleeding · 3rd trimester

1 · DEFINITION

Placenta implants in the lower uterine segment and partially or completely covers the internal cervical os. Classified as complete, partial, marginal, or low-lying.

2 · PATHOPHYSIOLOGY

Abnormal low implantation → cervix dilates/effaces in 3rd trimester → placental vessels tear → painless bleeding.

3 · SIGNS & SYMPTOMS

Classic

- Painless bright red bleeding
- Soft, non-tender uterus
- Normal fetal heart tones
- Often stops on its own (first bleed)

🚨 Red flags

- Heavy/recurrent hemorrhage
- Tachycardia, hypotension
- Pale, cool, clammy skin
- Fetal distress late in bleed

4 · PRIORITY NURSING INTERVENTIONS

- **NEVER perform vaginal or rectal exam** — can worsen hemorrhage
- Assess airway, breathing, circulation; place in left-lateral position
- Monitor VS q15min, continuous external FHR, fundal height, pad counts
- Insert two large-bore IVs; send type & crossmatch, CBC, coags
- Administer O_2 at 8–10 L non-rebreather if distress
- Strict bedrest; nothing per vagina (no intercourse, tampons, douches)
- Prepare for scheduled C-section (complete previa) at 36–37 weeks

5 · PHARMACOLOGY

Betamethasone
Accelerates fetal lung maturity. 12 mg IM × 2, 24 h apart, if <34 wk.

RhoGAM
Prevents isoimmunization if Rh-negative mother bleeds.

Tocolytics
Mag sulfate/terbutaline to suppress contractions if preterm and stable.

Magnesium sulfate
Fetal neuroprotection if delivery <32 wk anticipated.

6 · NCLEX TEST TRAPS ⚠️

- Vaginal exam is **wrong answer** until previa ruled out
- Painless = previa (not abruption)
- Bedrest before Trendelenburg
- Left lateral, not supine

7 · PATIENT EDUCATION

- Pelvic rest: no sex, tampons, douching
- Report any bleeding immediately
- Daily fetal kick counts
- Avoid heavy lifting and strain
- Plan for hospital birth by C-section

8 · MEMORY BOOSTERS

The 3 P's
Painless · **P**ink/bright red · **P**lacenta over os

Pattern recognition
If the question says "painless" + "bright red" + "3rd trimester" → pick previa + NO vag exam.

A Abruptio placentae

Painful dark red bleeding · rigid uterus · obstetric emergency

1 · DEFINITION

Premature separation of a normally implanted placenta from the uterine wall after 20 weeks. Bleeding may be revealed or concealed behind the placenta.

2 · PATHOPHYSIOLOGY

Vessel vasoconstriction or trauma → decidual artery ruptures → hematoma forms behind placenta → further separation → fetal hypoxia + maternal shock + DIC.

3 · SIGNS & SYMPTOMS

Classic

- Sudden, sharp abdominal pain
- Dark red vaginal bleeding (may be absent)
- Rigid, board-like, tender uterus
- Frequent, strong contractions

Red flags

- Concealed hemorrhage — no visible blood
- Late decels, bradycardia, loss of variability
- Shock out of proportion to bleeding
- DIC: oozing IV sites, low fibrinogen

4 · PRIORITY NURSING INTERVENTIONS

- **ABC first** — airway, O_2 8–10 L non-rebreather, left-lateral tilt
- Two large-bore IVs with lactated Ringer's or NS wide open
- Continuous FHR and tocodynamometer; prepare for emergency C-section
- Type & crossmatch for 2–4 units; blood products at bedside
- Draw CBC, PT/PTT, fibrinogen, D-dimer, platelets to trend for DIC
- Foley catheter; strict I&O; urine output ≥ 30 mL/hr
- Do **NOT** give tocolytics — delivery is the treatment

5 · PHARMACOLOGY

IV crystalloids
Lactated Ringer's or NS to restore volume and perfusion.

Blood products
PRBC, FFP, platelets, cryoprecipitate for hemorrhage and DIC.

Betamethasone
Only if mother and fetus are stable and <34 weeks.

RhoGAM
Prevents isoimmunization in Rh-negative patients.

6 · NCLEX TEST TRAPS ⚠

- Concealed bleed = shock without visible blood
- Board-like uterus = abruption, not previa
- HTN is top risk factor, not previa history
- Delivery is priority — do not delay with tocolytics

7 · PATIENT EDUCATION

- Avoid cocaine, smoking, and alcohol
- Tight BP control with preeclampsia/chronic HTN
- Seatbelt low across hips; seek care after trauma/MVA
- Report sudden severe pain or decreased kicks

8 · MEMORY BOOSTERS

DETACHED

Dark red bleeding · **E**xtreme pain · **T**ender rigid uterus · **A**bnormal FHR · **C**ontractions · **H**TN/trauma · **E**mergency delivery · **D**IC risk

Pattern recognition

"Sudden severe pain" + "board-like uterus" + hypertensive mom → abruption → deliver now.

Ac

Placenta accreta spectrum

Abnormally deep placental attachment · massive postpartum hemorrhage risk

THE THREE DEPTHS

Accreta (80%)
Attaches to myometrium surface

Increta (15%)
Invades into the myometrium

Percreta (5%)
Perforates through to other organs

1 · DEFINITION

Abnormally deep placental attachment that fails to separate from the uterus after delivery, causing life-threatening postpartum hemorrhage.

2 · PATHOPHYSIOLOGY

Damaged decidua from prior C-section or uterine surgery → placenta invades myometrium → cannot detach → severe hemorrhage at delivery.

3 · SIGNS & SYMPTOMS

Prenatal

- Usually asymptomatic
- Diagnosed by ultrasound or MRI
- Suspicion if prior C-section + previa
- Possible painless bleeding late in pregnancy

Red flags at delivery

- Placenta fails to deliver in 30 min
- Postpartum hemorrhage > 1000 mL
- Hypovolemic shock
- DIC, bladder/bowel injury (percreta)

4 · PRIORITY NURSING INTERVENTIONS

- Coordinate planned C-section at a tertiary center, typically 34–36 weeks
- Prepare for cesarean hysterectomy; consent for possible hysterectomy preop
- Activate massive transfusion protocol; crossmatch 4+ units PRBC, FFP, platelets
- Place two large-bore IVs or central line; consider arterial line
- Coordinate with anesthesia, interventional radiology, urology, NICU
- **NEVER** attempt manual placental removal — triggers massive hemorrhage
- Postop: ICU monitoring, trend H&H, coags, urine output, fundal checks

5 · PHARMACOLOGY

Oxytocin (Pitocin)
First-line uterotonic to promote uterine contraction.

Methylergonovine
IM uterotonic. Avoid with hypertension or preeclampsia.

Carboprost (Hemabate)
IM prostaglandin. Avoid with asthma — can cause bronchospasm.

Tranexamic acid (TXA)
Antifibrinolytic given within 3 hours of hemorrhage onset.

Blood products
PRBC, FFP, platelets, cryoprecipitate in 1:1:1 ratio.

Betamethasone
For fetal lung maturity before planned preterm delivery.

6 · NCLEX TEST TRAPS

- Prior C-section + previa = huge accreta red flag
- Do not attempt manual removal — hemorrhage
- Plan delivery; do not wait for labor
- Hysterectomy often needed — not a failure

7 · PATIENT EDUCATION

- Deliver at hospital with ICU and blood bank
- Prepare emotionally for possible hysterectomy and fertility loss
- Grief and mental health support resources
- Future pregnancies carry high recurrence risk
- Report bleeding or contractions before planned date

8 · MEMORY BOOSTERS

AIP — going deeper

Accreta = **A**ttaches (surface)

Increta = **I**nvades (into muscle)

Percreta = **P**erforates (through muscle)

Pattern recognition

Prior C-section + previa on ultrasound + planned delivery → think accreta → prep for hysterectomy.

RAPID DECISION HOOK

Which one is the question describing?

If you see…

- Painless bleeding
- Bright red blood
- Soft uterus
- Stable vitals at first

→ Previa · no vag exam

If you see…

- Sudden severe pain
- Dark blood or none
- Rigid, board-like uterus
- Fetal distress + HTN

→ Abruption · deliver now

If you see…

- Prior C-section history
- Previa on ultrasound
- Placenta won't deliver
- Massive PPH

→ Accreta · prep hysterectomy

UNIVERSAL RED FLAGS — all three conditions

Hypotension · tachycardia · cool clammy skin · urine output < 30 mL/hr · late decels · loss of variability · oozing IV sites (DIC) · board-like or persistently contracted uterus · sudden change in maternal mental status.

NCLEX PRIORITIZATION REMINDERS

Order of operations

1. ABCs — airway, breathing, circulation
2. Left-lateral position + O_2
3. Two large-bore IVs + fluids
4. Continuous FHR + maternal VS
5. Type & crossmatch, labs, prep OR

Never-do answers

- Never vaginal exam in suspected previa
- Never tocolytics in abruption
- Never manual placenta removal in accreta
- Never supine position — always left lateral
- Never delay delivery when fetus is in distress