

NCLEX-RN · LABOR & DELIVERY · 15-DAY NGN REVIEW

Day 08 · Hypertensive Disorders *in Labor*

Preeclampsia · Eclampsia · HELLP Syndrome · Magnesium Sulfate Safety — Mastering the highest-stakes maternal-fetal emergencies on the 2026 NGN exam.

FRAMEWORK: 2026 NCLEX-RN TEST PLAN MODEL: NGN CLINICAL JUDGMENT LEVEL: APPLICATION+

FOCUS: MATERNAL-FETAL SAFETY

TODAY'S 14 SECTIONS

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§ 01

High-Yield Overview / WHERE THE QUESTION WRITERS LIVE

Hypertensive disorders complicate roughly **10% of pregnancies** and remain a leading cause of maternal mortality worldwide. On the NCLEX, this topic is a goldmine for the test writers because it combines **medication safety, prioritization, fetal monitoring, complications, and emergency response** — exactly the higher-order thinking the NGN exam targets.

Think of hypertension in pregnancy as a **spectrum**, not a single diagnosis:

DIAGNOSIS	DEFINING CRITERIA	KEY NCLEX PEARL
Chronic HTN	HTN preexisting OR diagnosed before 20 wk gestation	Increased risk for superimposed preeclampsia

DIAGNOSIS	DEFINING CRITERIA	KEY NCLEX PEARL
Gestational HTN	New BP $\geq 140/90$ after 20 wk · NO proteinuria · NO end-organ damage	Up to 50% progress to preeclampsia — watch closely
Preeclampsia (without severe features)	BP $\geq 140/90$ after 20 wk + proteinuria <i>OR</i> end-organ involvement	Delivery generally at 37 wk; outpatient monitoring possible
Preeclampsia WITH severe features	BP $\geq 160/110$ · platelets $< 100,000$ · LFTs 2 $\times$ normal · creatinine > 1.1 · pulmonary edema · severe headache/visual changes · RUQ pain	Magnesium sulfate + delivery at 34 wk · Emergency
Eclampsia	Preeclampsia + new-onset seizure not attributable to other cause	Side-lying, airway, suction, O ₂ , mag — DO NOT restrain
HELLP Syndrome	Hemolysis · Elevated Liver enzymes · Low Platelets	RUQ pain + N/V often the first clue · delivery is treatment

THE ONE THING YOU MUST KNOW

The only definitive cure for preeclampsia/eclampsia/HELLP is delivery of the fetus and placenta. Every nursing action before and after that is a holding pattern: prevent seizures (magnesium), control severe BP (labetalol / hydralazine / nifedipine), and watch the fetus. The disease can develop *or worsen* up to **6 weeks postpartum** — never let your guard down after birth.

The pathophysiology in one sentence you should be able to recite: *abnormal placentation* → *systemic endothelial dysfunction* → *vasoconstriction, capillary leak, microthrombi* → *multi-organ ischemia (kidneys, liver, brain, placenta)* → *seizures, stroke, hepatic rupture, abruption, fetal compromise*.

§ 02

10 Must-Know Rules / NON-NEGOTIABLE NCLEX TRUTHS

01 Sustained BP $\geq 160/110$ for ≥ 15 minutes is a hypertensive emergency. Antihypertensive (labetalol, hydralazine, or nifedipine) within **30–60 minutes**.

02 Magnesium sulfate prevents seizures — it is NOT a BP medication. Don't expect BP to drop when you start mag.

03 Calcium gluconate is the antidote for magnesium toxicity. Keep it at the bedside whenever mag is infusing.

04 Therapeutic mag level for seizure prophylaxis is **4–7 mEq/L** (some sources 4–8). Above 7 → toxicity begins.

05 Loss of deep tendon reflexes is the **FIRST** sign of magnesium toxicity — assess DTRs and clonus q1–

06 Hold mag and notify provider if: RR < 12 , urine output < 30 mL/hr (or < 100 mL/4h), absent DTRs, or

2h.

decreased LOC.

07 Never give methylergonovine (Methergine) to a hypertensive client — it can cause severe HTN, stroke, MI. Use oxytocin or carboprost instead (but carboprost is contraindicated in asthma).

08 Preeclampsia/eclampsia can occur up to 6 weeks postpartum. Discharge teaching **MUST** include headache, visual changes, RUQ pain, swelling, and seizure precautions.

09 Seizure precautions: padded side rails, suction + O₂ ready, low bed, quiet room, lights dimmed, side-lying position during/after seizure. Do *not* restrain or put anything in the mouth.

10 HELLP is a true obstetric emergency. Platelets <100,000 may contraindicate epidural; platelets <50,000 contraindicate epidural and may require platelet transfusion before delivery.

§ 03

Maternal-Fetal Safety Table / FIND IT · EXPLAIN IT · ACT ON IT

FINDING	WHAT IT MEANS	MOTHER RISK	FETAL/NEWBORN RISK	PRIORITY NURSING ACTION	NOTIFY / ESCALATE WHEN...
BP 162/112 sustained	Severe-range HTN	Stroke, abruption, pulmonary edema	Hypoxia from ↓ uteroplacental perfusion	Repeat in 15 min; if still severe → IV labetalol/hydralazine per order; left lateral; continuous EFM	≥160/110 sustained 15 min → emergency antihypertensive within 30–60 min
Persistent severe HA unrelieved by Tylenol	Cerebral edema / vasospasm	Imminent seizure, stroke	Hypoxia if seizure occurs	Assess BP, neuro, reflexes; quiet room; verify mag infusing; notify provider	Always — sign of severe features
Visual changes (blurring, scotomata)	Retinal vasospasm / cerebral edema	Severe preeclampsia, eclampsia	Compromise if maternal seizure	Full neuro check, BP, reflexes, mag status; reduce stimuli	Always — severe feature
Epigastric / RUQ pain	Hepatic capsule stretch from edema/hemorrhage	HELLP, hepatic rupture	Compromise if maternal collapse	Draw CBC, LFTs, LDH, haptoglobin; notify provider STAT	Always — possible HELLP
Hyperreflexia + clonus	CNS irritability	Pre-seizure state	Risk if seizure occurs	Seizure precautions; verify mag rate; notify provider	Clonus >2 beats → notify
Absent DTRs	Magnesium toxicity	Resp depression, cardiac arrest	Hypoxia if maternal arrest	STOP mag , calcium gluconate at bedside,	Always — emergency

FINDING	WHAT IT MEANS	MOTHER RISK	FETAL/NEWBORN RISK	PRIORITY NURSING ACTION	NOTIFY / ESCALATE WHEN...
				notify provider, draw mag level	
RR <12 on mag	Respiratory depression / toxicity	Respiratory arrest	Fetal hypoxia	STOP mag , give calcium gluconate 1 g IV slow, O ₂ , notify provider, prepare for intubation if needed	Always — STAT
Urine output <30 mL/hr	Renal hypoperfusion / mag accumulation	Mag toxicity, renal injury	Indirect (mom)	Notify provider; consider holding mag; strict I&O; check mag level	<30 mL/hr or <100 mL/4 h
Platelets <100,000	HELLP / consumption	Hemorrhage, no epidural	Risk if abruption	Type & crossmatch; cancel/hold epidural per anesthesia; monitor bleeding	<100k → notify; <50k → urgent
Seizure (eclampsia)	Cerebral ischemia / vasospasm	Aspiration, abruption, stroke, death	Hypoxia, bradycardia, abruption	Side-lying, airway, suction, O ₂ , call for help, mag bolus per order; AFTER seizure → assess FHR & for abruption	Always — code/rapid OB response
Late decels + minimal variability	Uteroplacental insufficiency	Indirect	Fetal hypoxia/acidosis	Reposition left lateral, IV bolus (if ordered), discontinue oxytocin, O ₂ 10 L NRB, notify provider	Category III → prepare for emergent C/S
Vaginal bleeding + rigid abdomen	Placental abruption	Hemorrhage, DIC, shock	Hypoxia, demise	Continuous EFM, IV access × 2, type & cross, prepare for emergent delivery, notify provider STAT	Always — OB emergency

§ 04

Red-Flag Cues / MATCH THE CUE TO THE ACTION

IMMEDIATE ASSESSMENT REQUIRED

- **New severe HA**, visual changes, RUQ/epigastric pain → full neuro, BP, reflexes, labs

- **BP rising** into severe range → repeat BP in 15 min, EFM, neuro check
- **Decreased fetal movement** reported by mother → EFM, NST, ultrasound as ordered
- **Sudden swelling** of face/hands → BP, weight, urine protein, reflexes

REPOSITION (LEFT LATERAL) WHEN YOU SEE...

- Late decelerations, prolonged decelerations, fetal bradycardia, recurrent variables
- Maternal hypotension (especially post-epidural)
- Any non-reassuring FHR pattern – repositioning is **step 1** of intrauterine resuscitation

IV FLUID BOLUS (WHEN ORDERED/APPROPRIATE)

- Maternal hypotension post-epidural (NOT for routine preeclampsia management – risk of pulmonary edema)
- Per intrauterine resuscitation protocol for Category II/III tracings
- **Caution:** Preeclamptic clients have capillary leak – fluids are usually *restricted* to ~80–125 mL/hr; do not aggressively bolus without an order

STOP OXYTOCIN IMMEDIATELY WHEN...

- Tachysystole (>5 contractions in 10 min averaged over 30 min)
- Category II tracing not responding to intrauterine resuscitation
- Category III tracing
- Suspected uterine rupture or abruption
- Maternal seizure (eclampsia) → stop oxytocin, manage seizure, then reassess

OXYGEN – ONLY WHEN CLINICALLY INDICATED

Current evidence and updated AWHONN guidance: **routine maternal O₂ for Category II tracings is no longer recommended.** Apply O₂ 10 L/min via non-rebreather *when* maternal hypoxemia is present (SpO₂ < 95%), during/after eclamptic seizure, during maternal resuscitation, or per institution policy for specific Category III patterns. Don't pick "apply O₂" as a reflex on NGN – pick the action that addresses the actual cause.

NOTIFY PROVIDER STAT FOR...

- Sustained BP ≥160/110 (×15 min)
- New severe HA, visual changes, RUQ pain, decreased LOC
- Any sign of mag toxicity (loss DTRs, RR < 12, UOP < 30, ↓LOC)
- Platelets < 100,000, rising LFTs, hemolysis labs

- Category III tracing, suspected abruption, vaginal bleeding

RAPID OB RESPONSE / EMERGENCY BIRTH

- Eclamptic seizure with non-reassuring FHR after seizure
- Suspected hepatic rupture (severe RUQ pain + hypotension + shock)
- Suspected abruption with maternal/fetal instability
- Category III tracing that does not resolve with intrauterine resuscitation
- Maternal stroke symptoms, respiratory arrest, or cardiovascular collapse

§ 05

Medication Safety Deep Dive / THE HIGH-YIELD 7

1. Magnesium Sulfate (MgSO₄) — The Most-Tested Drug on Today's Topic

Why given	Seizure prophylaxis in severe preeclampsia/eclampsia · Neuroprotection in preterm labor < 32 wk · NOT for BP control
Typical dose	Loading: 4–6 g IV over 15–20 min · Maintenance: 1–2 g/hr IV via infusion pump (high-alert med — independent double-check)
Assess BEFORE giving	BP, HR, RR, SpO ₂ , LOC, DTRs (patellar), clonus, urine output (Foley typically placed), baseline mag level if available, FHR
Most dangerous adverse effect	Respiratory depression / arrest → cardiac arrest
Toxicity progression	4–7 mEq/L: therapeutic · 7–10: ↓DTRs · 10–12: RR depression, somnolence · >12: respiratory paralysis · >15: cardiac arrest
HOLD & NOTIFY	RR < 12 · UOP < 30 mL/hr (or < 100 mL/4h) · absent DTRs · ↓LOC · mag level > 7 mEq/L
Antidote	Calcium gluconate 1 g IV over 3 min (keep at bedside)
Monitoring	VS & SpO ₂ q15–30 min initially, then q1h · DTRs q1–2h · strict I&O · continuous EFM · neuro checks · mag level per protocol
Client teaching	Expect feeling warm/flushed when loading dose given · drowsiness, blurred vision, slurred speech are common but report worsening · do not get up alone
Common NCLEX trap	Thinking mag treats HTN. It does NOT. BP requires a separate antihypertensive. Also: confusing therapeutic effects (warmth, mild drowsiness) with toxicity (RR↓, ↓LOC, absent

DTRs).

2. Calcium Gluconate — The Antidote

Why given	Reverses magnesium toxicity (and hyperkalemia, hypocalcemia)
Dose	1 g (10 mL of 10% solution) IV over 3 min
Most dangerous adverse effect	Tissue necrosis with extravasation · bradycardia/asystole if given too rapidly
Nursing pearl	Should always be available at the bedside of any client on mag infusion. Do NOT wait until toxicity occurs to find it.

3. Labetalol — First-Line for Severe HTN in Pregnancy

Why given	Acute treatment of severe-range BP ($\geq 160/110$) in pregnancy/postpartum
Class	Alpha- and beta-adrenergic blocker
Dose	IV: 20 mg → 40 mg → 80 mg → 80 mg q10 min, max 300 mg cumulative (per ACOG algorithm)
Assess before	BP, HR, asthma/COPD history (relative contraindication — beta-blocker can cause bronchospasm), bradycardia, heart block
Most dangerous adverse effect	Bradycardia · hypotension · bronchospasm · neonatal bradycardia/hypoglycemia after delivery
HOLD & NOTIFY	HR < 60 · BP < 100 systolic · history of severe asthma · 2nd/3rd degree heart block
Common NCLEX trap	Giving to a client with severe asthma. Choose hydralazine instead.

4. Hydralazine — Direct Vasodilator

Why given	Acute severe HTN in pregnancy (when labetalol contraindicated or not effective)
Dose	IV: 5–10 mg q20 min, max 30 mg cumulative
Most dangerous adverse effect	Reflex tachycardia · maternal hypotension → fetal bradycardia · HA, palpitations
Nursing pearl	Onset 10–20 min; watch for delayed BP drop. Continuous EFM during administration.

5. Nifedipine (Immediate Release) — Oral Alternative

Why given	Acute severe HTN if IV access unavailable, or maintenance therapy
Class	Calcium channel blocker
Dose	10–20 mg PO q30 min, max 50 mg
Watch out for	Hypotension, tachycardia, HA, flushing · caution with concurrent magnesium — risk of profound hypotension and neuromuscular blockade (theoretical, but tested)

6. Methylergonovine (Methergine) — The Trap Drug

Why given	Postpartum hemorrhage from uterine atony (when oxytocin insufficient)
Dose	0.2 mg IM q2–4h
ABSOLUTE CONTRAINDICATION	Hypertension — and preeclampsia. Can cause severe HTN, seizure, stroke, MI.
Alternative in HTN	Oxytocin (first), carboprost (NOT in asthma), misoprostol
Common NCLEX trap	"Postpartum hemorrhage in preeclamptic client — administer methylergonovine." NO. This is a distractor that kills test-takers and patients.

7. Betamethasone — Fetal Lung Maturation

Why given	Accelerate fetal lung maturity when preterm delivery (24–34 wk, sometimes 34+0 to 36+6) is anticipated — including severe preeclampsia requiring early delivery
Dose	12 mg IM × 2 doses, 24 hr apart
Maternal effects	Hyperglycemia (especially gestational DM), transient leukocytosis, pulmonary edema risk if combined with tocolytics
Client teaching	Maximum benefit at 24 hr after first dose · benefit persists ~7 days · monitor blood glucose if diabetic

§ 06

Fetal Monitoring in Hypertensive Disease / WHAT THE STRIP IS TELLING YOU

Hypertensive disorders cause **uteroplacental insufficiency** — the placenta becomes a leaky, vasoconstricted, microthrombotic mess. Expect the strip to reflect that. Magnesium sulfate *itself* causes recognizable FHR changes that are NOT necessarily fetal compromise.

FEATURE	NORMAL/EXPECTED	HTN-RELATED CHANGE	ACTION
Baseline	110–160 bpm	May trend higher (early) or lower with chronic hypoxia · tachycardia with maternal fever/abruption	Compare to prior strip; reassess maternal VS
Variability	Moderate (6–25 bpm)	Minimal variability is common on magnesium sulfate (mag crosses placenta and depresses fetal CNS) — usually benign	Document mag effect; ensure no other concerning features (decels, ↓LOC mom)
Accelerations	≥15 × 15 sec (term)	May be diminished on mag · absence of accels + minimal variability raises concern for hypoxia	Consider scalp stim, NST evaluation
Early decels	Mirror contraction, head compression	Benign — same significance as in any labor	Continue routine monitoring
Late decels	Should not occur	Classic finding — uteroplacental insufficiency . Common in severe preeclampsia.	Reposition, stop oxytocin, IV bolus per order, notify provider, prepare for possible delivery
Variable decels	Cord compression	Can occur with oligohydramnios (chronic placental insufficiency)	Reposition, assess for cord prolapse, intrauterine resuscitation
Prolonged decel / bradycardia	<110 × >10 min OR decel ≥2 min	Can occur after hydralazine (maternal hypotension), eclamptic seizure, abruption	Reposition, IV fluids, stop oxytocin, O ₂ if hypoxemic, notify provider, prepare for emergent C/S

CATEGORY INTERPRETATION REFRESHER

Category I (normal): baseline 110–160, moderate variability, ± accelerations, ± early decels, NO late or variable decels. Continue routine care.

Category II (indeterminate): everything that isn't I or III. Most strips spend time here. Requires intrauterine resuscitation + ongoing assessment.

Category III (abnormal): absent variability + recurrent late decels OR recurrent variable decels OR bradycardia · OR sinusoidal pattern. Requires immediate intervention and likely emergent delivery.

INTRAUTERINE RESUSCITATION — MEMORIZE THE ORDER

1. **Reposition** mother (left lateral first, then right, then knee-chest)
2. **Stop oxytocin** if infusing
3. **IV fluid bolus** if hypovolemic/hypotensive (caution in preeclampsia)
4. **Vaginal exam** to rule out cord prolapse and assess progress

5. **Oxygen** 10 L NRB only if maternal hypoxemia or persistent Cat II/III per protocol

6. **Notify provider** · prepare for possible operative birth

Mnemonic: "LION" — Lateral position, IV fluids, **Oxygen** (if indicated), **Notify** provider/stop pitocin.

S 07

10 NGN Practice Questions / APPLICATION-LEVEL · MIXED ITEM TYPES

NGN

MULTIPLE CHOICE

TAKE ACTION

Q1. A nurse is caring for a client at 36 weeks gestation with severe preeclampsia who is receiving magnesium sulfate 2 g/hr IV. The nurse's most recent assessment reveals: BP 152/96, RR 10/min, patellar reflexes absent, urine output 20 mL in the past hour. Which action should the nurse take **FIRST**?

- A. Administer the next scheduled dose of labetalol
- B. Stop the magnesium sulfate infusion
- C. Increase IV fluids to 200 mL/hr
- D. Notify the obstetric provider

RATIONALE

Correct: B. Three signs of magnesium toxicity are present simultaneously: RR < 12, absent DTRs, and oliguria. The single **FIRST** action that protects this client from respiratory arrest is to **stop the infusion**. Calcium gluconate should be ready at the bedside. Then notify the provider and check a mag level.

A is wrong: BP is elevated but not severe-range ($\geq 160/110$); a routine antihypertensive is not the priority over impending respiratory arrest.

C is wrong: Increasing fluids worsens fluid overload risk and does not address the toxicity. Also, preeclamptic clients are at high risk for pulmonary edema.

D is wrong: Notification happens **AFTER** stopping the source of harm. ABCs/safety first.

NCLEX trap tested: "Notify the provider" looks correct because it always sounds safe — but on the NGN, if you can stop the harm yourself with an independent nursing action, do that **FIRST**, then notify. Step tested: **Take Action**.

NGN

SATA

RECOGNIZE CUES

Q2. A nurse is reviewing data on a client at 33 weeks gestation being evaluated for possible severe preeclampsia. Which findings would indicate **severe features**? *Select all that apply.*

- A. BP 158/108 on two readings 6 hours apart
- B. Platelets 78,000/mm³
- C. Serum creatinine 1.4 mg/dL
- D. AST 92 U/L (normal < 40)
- E. Trace protein on urine dipstick
- F. Persistent severe headache unresponsive to acetaminophen
- G. Reflexes 2+ bilaterally with no clonus

RATIONALE

Correct: B, C, D, F.

B – Platelets < 100,000: hematologic severe feature. **C – Creatinine > 1.1:** renal severe feature. **D – LFTs > 2× upper normal:** hepatic severe feature. **F – Severe persistent HA:** neurologic severe feature.

A: Severe-range BP requires $\geq 160/110$ — 158/108 is borderline but does not meet criteria.

E: Proteinuria itself is not a severe feature; massive proteinuria is no longer in the diagnostic criteria.

G: 2+ reflexes without clonus is normal.

NCLEX trap: Test-takers often pick “trace protein” because they associate preeclampsia with protein. But severity is defined by end-organ damage, not protein amount. Step tested: **Recognize Cues / Analyze Cues.**

NGN

DRAW-AND-DROP / ORDERED RESPONSE

TAKE ACTION

PRIORITY

Q3. A laboring client with severe preeclampsia suddenly experiences a generalized tonic-clonic seizure. Place the nurse's actions in the order they should be performed.

1. Notify the provider and call for help
2. Turn the client to her side and ensure a patent airway
3. Administer a magnesium sulfate bolus per protocol
4. Suction the airway and apply oxygen 10 L via non-rebreather
5. Assess fetal heart rate and uterine activity for abruption
6. Document the seizure event and post-ictal assessment

RATIONALE · CORRECT ORDER: 2 → 4 → 1 → 3 → 5 → 6

2 (Turn & airway): Airway is always first. Side-lying prevents aspiration and improves uteroplacental perfusion. Do NOT restrain or place objects in the mouth.

4 (Suction & O₂): Once safe positioning is achieved, clear the airway and oxygenate. This is one of the exceptions where maternal O₂ is clearly indicated.

1 (Call for help): Activate the OB rapid response. Stabilization comes first, but help should be summoned as soon as possible — in real practice this happens almost simultaneously with positioning.

3 (Mag bolus): Per protocol, an additional 2 g IV bolus is typically given to control eclamptic seizures. Provider order required.

5 (FHR + abruption): After the mother is stable, assess the fetus. Eclamptic seizures cause hypoxia and dramatically increase abruption risk.

6 (Document): Last — but never skipped.

NCLEX trap: Students often pick "notify provider" first or "give mag bolus" first. Wrong — airway/safety always precedes pharmacology and notification. Step tested: **Take Action / Generate Solutions.**

NGN

CLOZE / DROP-DOWN

ANALYZE CUES

Q4. Complete each blank using the appropriate option.

The most concerning finding in a client receiving magnesium sulfate for severe preeclampsia is [absent DTRs], because it indicates a serum magnesium level of approximately [7–10 mEq/L]. The nurse should immediately [stop the infusion] and prepare to administer [calcium gluconate 1 g IV].

Option pool: warm flushing · absent DTRs · BP 140/90 · 2–4 mEq/L · 7–10 mEq/L · 15–20 mEq/L · stop the infusion · increase the infusion · diphenhydramine · calcium gluconate 1 g IV · naloxone 0.4 mg IV

RATIONALE

Absent DTRs is the **first reliable clinical sign** of magnesium toxicity and correlates with a level around 7–10 mEq/L (loss of reflexes typically appears just above the therapeutic ceiling of 7). At this level, the next stage – respiratory depression – is imminent if action is not taken.

The antidote is calcium gluconate, given 1 g IV slowly over 3 minutes. Naloxone reverses opioids, not mag. Diphenhydramine treats allergic reactions, not toxicity.

Trap: Warm flushing is an expected effect during the loading dose – not toxicity. Step tested: **Analyze Cues**.

NGN

MATRIX / GRID

EVALUATE OUTCOMES

Q5. Two hours after initiating magnesium sulfate for severe preeclampsia, the nurse reassesses the client. Indicate whether each finding is **Improving**, **Worsening**, or an **Expected Effect of Therapy**.

FINDING	IMPROVING	WORSENING	EXPECTED EFFECT
BP decreased from 168/110 → 145/92 after labetalol	✓		
Reports feeling warm and slightly drowsy			✓
Urine output: 45 mL over the past hour	✓		
Reports new-onset epigastric pain rated 7/10		✓	
DTRs now 1+ bilaterally (were 3+ at baseline)	✓ <i>but watch</i>		✓
RR 10/min, SpO ₂ 94%		✓	
Platelets dropped from 142,000 → 88,000		✓	
FHR baseline 140 with minimal variability			✓ (<i>mag effect</i>)

RATIONALE

Improving: BP decrease post-labetalol (target reached without overshoot); UOP >30 mL/hr (renal perfusion adequate, mag not accumulating).

Worsening: New epigastric pain (HELLP / hepatic capsule stretch); RR 10 (mag toxicity onset); platelets dropping into HELLP range.

Expected: Warmth/drowsiness (loading dose effect); diminished but present DTRs (therapeutic range edge); minimal FHR variability is a known mag effect when other findings are reassuring.

Trap: A drop in DTRs from 3+ to 1+ can indicate therapeutic effect (decreased CNS hyperexcitability) — but watch closely; the next drop to 0 is toxicity. Documenting "improving" is acceptable here, but re-checking q1h is required.

Step tested: *Evaluate Outcomes.*

NGN

MULTIPLE CHOICE · MEDICATION SAFETY

GENERATE SOLUTIONS

Q6. A client with severe preeclampsia is experiencing postpartum hemorrhage from uterine atony 30 minutes after vaginal birth. Oxytocin 40 units in 1 L LR is infusing. Bleeding continues. The provider asks the nurse to anticipate the next medication. Which medication should the nurse **question** if ordered?

- A. Carboprost (Hemabate) 250 mcg IM
- B. Methylergonovine (Methergine) 0.2 mg IM
- C. Misoprostol 800 mcg rectally
- D. Tranexamic acid 1 g IV

RATIONALE

Correct: B. Methylergonovine is **contraindicated in hypertension/preeclampsia**. It causes vasoconstriction, which is exactly what a preeclamptic vascular system does not need — risk of severe HTN crisis, stroke, MI, seizure.

A: Carboprost is appropriate IF no asthma history. The client's preeclampsia does not contraindicate it.

C: Misoprostol is safe in HTN.

D: Tranexamic acid is increasingly used for PPH and is not contraindicated in HTN.

Classic NCLEX trap: *Methylergonovine appears in PPH algorithms, so students reflexively choose it. Always cross-check the client's BP/HTN history first. Step tested: **Generate Solutions / Take Action**.*

NGN

BOW-TIE

MULTI-STEP

Q7. A client at 38 weeks gestation presents with BP 172/114, severe headache, RUQ pain, AST 110, ALT 98, platelets 82,000, LDH elevated, and hematocrit dropping. Complete the bow-tie diagram by selecting the most likely **condition**, two priority **actions**, and two key **parameters to monitor**.

PRIORITY ACTIONS

1. Initiate magnesium sulfate IV per protocol
2. Prepare for emergent delivery

MOST LIKELY CONDITION

HELLP Syndrome

PARAMETERS TO MONITOR

1. Platelet count and LFTs (serial)
2. BP, neuro status, FHR, signs of abruption

RATIONALE

The combination of **hemolysis** ($\downarrow$ Hct, $\uparrow$ LDH), **elevated liver enzymes**, and **low platelets** defines HELLP. Severe BP, severe HA, and RUQ pain confirm a hypertensive emergency overlay. The treatment is **delivery**. Magnesium prevents seizure during stabilization.

Distractor conditions to rule out: pure severe preeclampsia (doesn't have hemolysis); acute fatty liver of pregnancy (similar but with hypoglycemia and coagulopathy without same hemolysis pattern); ITP (isolated platelet drop, no liver/hemolysis).

Distractor actions: terbutaline (relax uterus – wrong direction), methylergonovine (contraindicated), large fluid bolus (risk pulmonary edema in preeclampsia).

Trap: Treating HELLP as "regular" severe preeclampsia and missing the platelets/LFTs/hemolysis triad. Step tested: Recognize Cues → Analyze → Prioritize Hypotheses → Generate Solutions → Take Action.

NGN

FETAL MONITORING STRIP

ANALYZE + ACTION

Q8. A nurse reviews the EFM tracing of a client with severe preeclampsia receiving oxytocin and magnesium sulfate: baseline 165 bpm, minimal variability, recurrent late decelerations with each contraction, contractions every 2 minutes lasting 80 seconds. What is the nurse's **FIRST** action?

- A. Apply oxygen via non-rebreather at 10 L/min
- B. Discontinue the oxytocin infusion
- C. Reposition the client to her left side
- D. Notify the obstetric provider

RATIONALE

Correct: C. The strip shows a **Category II tracing trending toward III** (tachycardia, minimal variability, recurrent late decels, tachysystole). The first step of intrauterine resuscitation is **repositioning** — it is the fastest, simplest, no-order-required intervention that improves uteroplacental perfusion.

A: Oxygen is no longer the routine first step per updated AWHONN guidance; it is reserved for maternal hypoxemia or persistent abnormal patterns. Reposition first.

B: Stopping oxytocin is critical and happens immediately after (or simultaneously with) repositioning — but if forced to pick ONE first, repositioning addresses the cause (perfusion) and requires no order.

D: Notification happens after independent nursing interventions have been started.

***Trap:** Many test-takers still pick "apply O₂" reflexively. The 2026 NCLEX reflects current AWHONN guidance — reposition first, oxygen only when clinically indicated. Also realize: NCLEX accepts repositioning OR stopping oxytocin as defensible "firsts" — read carefully whether oxytocin is mentioned, and prioritize stopping a harmful intervention if it's clearly the cause. In this question, both apply; reposition is the most universally first because it requires no order. Step tested: **Take Action**.*

NGN

SATA · DISCHARGE TEACHING

GENERATE SOLUTIONS

Q9. A client who delivered 24 hours ago with a history of severe preeclampsia is preparing for discharge. Which statements indicate the client understands her discharge instructions? *Select all that apply.*

- A. "If I get a really bad headache that doesn't go away with Tylenol, I should call my provider."
- B. "My risk of high blood pressure is over now that I delivered."
- C. "I need to take my blood pressure at home and report readings above 150/100."
- D. "Pain in my upper right belly area means I just need to rest."
- E. "I should report swelling of my face or hands, vision changes, or feeling really short of breath."
- F. "I'll keep my follow-up appointment in 7 days for a BP check."
- G. "I have a higher risk of preeclampsia in future pregnancies."

RATIONALE

Correct: A, C, E, F, G.

A: Severe HA = warning sign of postpartum preeclampsia/eclampsia. **C:** Home BP monitoring is standard discharge instruction; cutoff varies but $\geq 150/100$ is a reasonable reporting threshold. **E:** Classic preeclampsia warning signs. **F:** Postpartum BP follow-up at 3–10 days is standard ACOG recommendation. **G:** True — preeclampsia in one pregnancy raises future risk and long-term cardiovascular risk.

B: WRONG — preeclampsia/eclampsia can occur up to 6 weeks postpartum. Many maternal deaths happen *after* discharge.

D: WRONG — RUQ/epigastric pain may indicate HELLP and requires immediate evaluation, not rest.

Trap: "Discharge teaching" questions often hide the wrong answers in seemingly reasonable phrases ("just rest"). Always identify any normalizing of a danger sign as incorrect. Step tested: **Generate Solutions / Evaluate Outcomes.**

NGN

MULTIPLE CHOICE · PRIORITIZATION

PRIORITIZE HYPOTHESES

PRIORITY

Q10. A nurse on a labor and delivery unit is managing four clients. Which client should the nurse assess **FIRST**?

- A. A client at 39 weeks in active labor, dilated 6 cm, BP 128/82, FHR baseline 138 with moderate variability
- B. A client at 34 weeks with severe preeclampsia on magnesium sulfate who reports a new headache rated 9/10 and "spots" in her vision
- C. A postpartum client 4 hours after vaginal birth with fundus firm, lochia rubra moderate, BP 130/78
- D. A client at 37 weeks with gestational diabetes whose 0700 fasting glucose was 102 mg/dL

RATIONALE

Correct: B. A client with severe preeclampsia reporting severe HA + visual changes is on the verge of an **eclamptic seizure or stroke**. Both are imminent life threats to mother and fetus. This client needs immediate neuro, BP, reflex check, and confirmation mag is infusing at the correct rate.

A: Normal active labor — important but not unstable.

C: Normal postpartum findings.

D: Glucose slightly elevated for fasting GDM target (typically <95) — addressable but not emergent.

Trap: Test-takers may pick A or D because labor and diabetes "sound important." On NCLEX prioritization, the **unstable/deteriorating client wins every time**. Step tested: **Prioritize Hypotheses**.

§ 08

Detailed Rationales Snapshot / HOW TO "THINK" EACH QUESTION

Each rationale in Section 7 is tied to a specific CJMM step. Here's the master pattern so you can apply it to *any* NGN question on this topic:

CJMM STEP	WHAT YOU'RE DOING	TODAY'S APPLICATION
Recognize Cues	Spot abnormal/relevant data	BP ≥160/110, RR ↓, absent DTRs, RUQ pain, severe HA, low platelets
Analyze Cues	Connect findings to pathophysiology	Headache + visual changes + BP 170/110 → severe preeclampsia → imminent eclampsia
Prioritize Hypotheses	Which is most life-threatening?	Eclampsia > hypertensive emergency > mild preeclampsia · Mag toxicity (resp arrest) > BP control
Generate Solutions	List safe options	Stop mag · administer calcium gluconate · IV antihypertensive · reposition · prepare for delivery

CJMM STEP	WHAT YOU'RE DOING	TODAY'S APPLICATION
Take Action	Do the right thing first	Stop the harm (mag) → call for help → give antidote → notify provider
Evaluate Outcomes	Did it work? What's next?	RR back to 16, DTRs return, BP <160/110, no seizure, FHR Category I

THE "FIRST ACTION" TEST

On NGN priority/action questions, ask yourself in order:

1. Is there an **airway, breathing, or circulation** threat right now? → Address that.
2. Is there an **ongoing harm** I can stop with a nursing-independent action? → Stop it.
3. Is there a **position change or simple maneuver** that improves perfusion? → Do it.
4. Is the cause **medication-related**? → Stop or antidote.
5. THEN notify the provider.

S 09

Unfolding NGN Case Study / MAYA THOMPSON · G2 P1001 · 34+2 WEEKS

Maya Thompson, age 29 · G2 P1001 · 34 weeks 2 days

TRIAGE → L&D → POSTPARTUM · UNFOLDING OVER 6 HOURS

INITIAL PRESENTATION – TRIAGE 0830

NURSE'S NOTES · 0830

Client arrives ambulatory with husband. States, "I've had this terrible headache since last night, and my vision keeps getting blurry. My face feels really puffy." Reports decreased fetal movement since this morning. No vaginal bleeding, no leaking fluid, no contractions she can identify. Last prenatal visit 1 week ago: BP 138/88, trace protein, no symptoms reported.

VITAL SIGNS · 0830

BP **168/112** HR 96 RR 18 Temp 98.4°F
SpO₂ 97% Pain HA **8/10**

ASSESSMENT · 0840

3+ pitting edema bilateral lower extremities, periorbital edema noted. DTRs 4+ with 3-beat clonus. Patient reports "spots" in vision and intermittent flashing lights. No epigastric pain noted on

direct questioning. Cervix: 1 cm / 50% / -2 station. Membranes intact. EFM applied.

EFM • 0845

FHR baseline 155 bpm, minimal variability, no accelerations observed in 20 min, occasional early decelerations. Contractions: irregular, every 7-10 min, mild.

ITEM 1 • CJMM: RECOGNIZE CUES

Which findings require immediate follow-up? *Select all that apply.*

- A. BP 168/112
- B. 3+ pitting lower extremity edema
- C. 4+ DTRs with 3-beat clonus
- D. Cervix 1 cm / 50% / -2
- E. Headache 8/10 with visual changes
- F. FHR minimal variability with no accelerations
- G. Maternal HR 96

ANSWER: A, C, E, F

A: Severe-range BP — hypertensive emergency. **C:** Hyperreflexia + clonus = CNS irritability, pre-seizure state.

E: Severe HA + visual changes = severe features of preeclampsia, imminent eclampsia risk. **F:** Minimal variability + absent accelerations is non-reassuring at 34 weeks.

B (edema) is common in pregnancy and not by itself diagnostic. D is normal early labor exam. G (HR 96) is mildly elevated but explained by pain/anxiety.

ITEM 2 • CJMM: ANALYZE CUES

The nurse synthesizes the findings. The client most likely has:

- A. Chronic hypertension
- B. Gestational hypertension
- C. Preeclampsia **with severe features**
- D. HELLP syndrome

ANSWER: C

BP $\geq 160/110$ + severe headache + visual changes = preeclampsia with severe features. HELLP would require evidence of hemolysis, elevated LFTs, and low platelets — labs pending. Gestational HTN excludes severe BP and end-organ symptoms.

LAB RESULTS — 0915

STAT LABS · 0915

Hgb 11.2 · Hct 32.4 · Platelets 88,000 ↓
 AST 96 ↑ · ALT 84 ↑ · LDH 612 ↑
 Cr 1.3 ↑ · BUN 22
 Urine dipstick: 3+ protein
 Type 0+, antibody screen negative

ITEM 3 · CJMM: PRIORITIZE HYPOTHESES

Given the new lab data, what is now the most likely diagnosis?

- A. Preeclampsia without severe features
- B. Preeclampsia with severe features only
- C. HELLP syndrome
- D. Acute fatty liver of pregnancy

ANSWER: C

The platelets <100,000 + elevated AST/ALT + elevated LDH (suggests hemolysis) = the HELLP triad. This is HELLP *superimposed* on severe preeclampsia, which is the most dangerous presentation. Acute fatty liver typically shows hypoglycemia, severe coagulopathy, and is rarer.

PROVIDER ORDERS — 0925

ORDERS

1. Admit to L&D · NPO
2. Continuous EFM
3. IV access × 2 (18g) · LR at 80 mL/hr
4. Magnesium sulfate: 4 g IV loading dose over 20 min, then 2 g/hr maintenance
5. Labetalol 20 mg IV push now; repeat BP in 10 min
6. Betamethasone 12 mg IM × 1 now, repeat in 24 hr
7. Foley catheter to gravity drainage · strict I&O
8. Type and crossmatch 2 units PRBCs
9. Anesthesia consult for delivery planning
10. Notify OB attending of any BP ≥160/110, RR <12, UOP <30 mL/hr, absent DTRs, or seizure

ITEM 4 · CJMM: GENERATE SOLUTIONS

Which interventions should the nurse implement BEFORE starting the magnesium infusion? *Select all that apply.*

- A. Place calcium gluconate at the bedside
- B. Establish baseline DTRs, RR, BP, LOC, and FHR
- C. Apply pneumatic compression devices
- D. Confirm independent double-check of mag pump settings

- E. Insert a Foley catheter for strict urine output measurement
- F. Administer betamethasone after mag is at maintenance rate
- G. Place suction and oxygen equipment at bedside

ANSWER: A, B, D, E, G

All are standard "magnesium safety bundle" components. C (SCDs) is reasonable for VTE prophylaxis but is not specifically pre-mag. F is wrong because betamethasone does not need to wait — it can be given concurrently and the sooner the better for lung maturity given the 24-hour onset.

UPDATE — 1330 (4 HOURS INTO THERAPY)

REASSESSMENT · 1330

Mag infusing at 2 g/hr × 4 hr. Client drowsy but rousable, "feels heavy." HA reduced to 4/10. No further vision changes. BP 148/92. RR 10/min. SpO₂ 95%. DTRs 1+ patellar, no clonus. Foley output last hour: 22 mL. EFM: baseline 145, minimal variability, no decels, no contractions of note.

ITEM 5 · CJMM: TAKE ACTION

Which action should the nurse take FIRST?

- A. Notify the provider of the change in client condition
- B. Stop the magnesium sulfate infusion
- C. Prepare to administer calcium gluconate 1 g IV
- D. Increase IV fluid rate to improve urine output

ANSWER: B

Three findings indicate magnesium toxicity: RR 10, DTRs 1+ (dropping), UOP < 30 mL/hr. The first independent nursing action is to **stop the source of the toxicity**. Calcium gluconate is the antidote and is administered next, per protocol. THEN notify the provider. Increasing fluids would not address the toxicity and risks pulmonary edema in this preeclamptic client.

Bonus reasoning: The minimal FHR variability is concerning by itself but is also explained by maternal mag — once you stabilize the mother, the FHR pattern often improves.

UPDATE · 1415

Mag infusion was held at 1335. Calcium gluconate 1 g IV given over 3 min at 1340. By 1400: RR 16, DTRs 2+, SpO₂ 97%, BP 142/88, UOP 45 mL last hour. Mag level draw at 1345 returned at 9.2 mEq/L. Provider notified, plans induction tonight after second dose of betamethasone. FHR baseline 140, moderate variability returns, no decels.

ITEM 6 · CJMM: EVALUATE OUTCOMES

Which findings indicate that the interventions were effective? *Select all that apply.*

- A. RR increased from 10 to 16
- B. DTRs improved from 1+ to 2+
- C. Urine output improved from 22 mL to 45 mL
- D. Mag level 9.2 mEq/L
- E. FHR variability returned to moderate
- F. BP decreased from 148/92 to 142/88

ANSWER: A, B, C, E, F

All show measurable improvement after stopping mag and administering calcium gluconate. **D is not "effective"** — a mag level of 9.2 confirms the toxicity that occurred; it is the explanation, not the outcome.

Note that variability returning is partially explained by reversing the mag effect on fetal CNS — beautiful illustration that maternal stability drives fetal stability.

§ 10

"What Should the Nurse Do First?" / 5 MINI-SCENARIOS

SCENARIO 01

A client with severe preeclampsia receiving magnesium sulfate suddenly stops responding to verbal stimuli; RR drops to 8. **What is the FIRST action?**

FIRST ACTION

Stop the magnesium sulfate infusion immediately. The client has crossed into significant respiratory depression. Next: call for help, prepare to give calcium gluconate 1 g IV slow, apply oxygen, position to support airway, and notify provider. Anticipate need for intubation if RR continues to fall.

SCENARIO 02

A laboring client with severe preeclampsia begins a generalized tonic-clonic seizure. **What is the FIRST action?**

FIRST ACTION

Turn the client to her side and protect her airway. Side-lying decreases aspiration risk and improves uteroplacental perfusion. Do not restrain. Do not put anything in the mouth. Call for help; expect mag bolus per protocol; assess FHR and for abruption AFTER the seizure ends.

SCENARIO 03

A client with chronic HTN at 32 weeks reports severe RUQ pain (8/10) and one episode of vomiting. BP 142/94. **What is the FIRST action?**

FIRST ACTION

Notify the provider and prepare for STAT labs (CBC with platelets, AST/ALT, LDH, haptoglobin) and continuous EFM. RUQ pain in late pregnancy with HTN is HELLP until proven otherwise. Do not dismiss as "indigestion." Anticipate magnesium and possible expedited delivery.

SCENARIO 04

A postpartum client at 6 hours post-vaginal delivery for severe preeclampsia is bleeding heavily with a boggy uterus. Oxytocin is running. BP 158/100. **What is the FIRST action?**

FIRST ACTION

Perform vigorous fundal massage. Mechanical stimulation is the immediate intervention for atony. Next: assess bladder (have client void or cath), confirm oxytocin infusing at correct rate, call for help, anticipate *carboprost* or *misoprostol* – **NOT methylergonovine** because of HTN. Recheck BP and FHR (if undelivered fetus) frequently; monitor for ongoing HELLP/eclampsia risk.

SCENARIO 05

A client at 38 weeks with severe preeclampsia has BP 178/118 on two readings 15 minutes apart. Labetalol IV is ordered. **What is the FIRST action?**

FIRST ACTION

Verify the order, assess for contraindications (severe asthma, bradycardia, heart block), confirm IV access, and administer the labetalol within the 30–60 minute window for severe-range BP. Continuous EFM, frequent BP monitoring (q5–10 min initially), and prepare to escalate to hydralazine or nifedipine if labetalol contraindicated or insufficient.

§ 11

Stop, Hold, or Escalate / 5 DECISION-POINT SCENARIOS

DECISION 01 · STOP

Client on oxytocin augmentation with severe preeclampsia. EFM shows recurrent late decelerations, baseline 155, minimal variability, contractions every 90 seconds lasting 90 seconds.

STOP

Discontinue oxytocin immediately. This is tachysystole + Category II tracing trending toward III. Reposition left lateral, IV bolus per protocol, oxygen if hypoxemic, notify provider, prepare for possible operative delivery.

DECISION 02 · HOLD

Mag sulfate has been infusing at 2 g/hr × 6 hr. Routine assessment: RR 11, DTRs 1+, UOP 90 mL over 4 hours. Client awake and alert.

HOLD

Stop the infusion, notify the provider, draw a mag level. Urine output is borderline (<100 mL/4 hr) and combined with RR < 12 and diminishing DTRs, this is early toxicity. Keep calcium gluconate at bedside. Resumption depends on level and clinical reassessment.

DECISION 03 · ESCALATE

Postpartum client (24 hr after C/S for severe preeclampsia) suddenly reports severe HA, photophobia, and right-arm numbness. BP 192/118.

ESCALATE IMMEDIATELY

Call a rapid response or stroke alert. Postpartum eclampsia/stroke is a major cause of maternal mortality. Immediate IV antihypertensive (labetalol), restart mag if not already infusing, CT head urgent, neurology consult. Do not assume "just a headache."

DECISION 04 · STOP & ESCALATE

A nurse is preparing to administer methylergonovine 0.2 mg IM for postpartum hemorrhage to a client with a history of severe preeclampsia and current BP 156/98.

STOP & ESCALATE

Do NOT administer. Methylergonovine is contraindicated in HTN. Call the provider, recommend an alternative uterotonic (carboprost if no asthma, misoprostol, or tranexamic acid). Document the contraindication discussion. This is patient safety AND a tested competency.

DECISION 05 · PREPARE FOR EMERGENT BIRTH

A 36-week client with HELLP syndrome on mag develops sudden severe RUQ pain (10/10), HR 128, BP 88/52, and pallor.

EMERGENCY BIRTH

Suspect hepatic capsule hematoma rupture. Activate massive transfusion protocol, second large-bore IV, type and cross 4 units PRBCs, surgical OB and general surgery consults, prepare for emergent C/S. This is a life-threatening complication of HELLP.

TRAP 01

Mistaking Magnesium for a BP Medication

Mag sulfate prevents seizures. It does NOT treat HTN. Both interventions are typically needed simultaneously – mag + an antihypertensive (labetalol/hydralazine/nifedipine).

WRONG THINKING

"BP is 178/112, so I'll start the mag and the BP should come down."

RIGHT THINKING

"BP severe → need labetalol or hydralazine within 30–60 min. Also need mag for seizure prevention. These are separate problems with separate drugs."

TRAP 02

Giving Methylergonovine to a Hypertensive Client

The classic PPH cascade is oxytocin → methylergonovine → carboprost → misoprostol. **Skip methylergonovine** in any client with HTN, preeclampsia, recent eclampsia, migraine with vascular history, or CAD.

WRONG THINKING

"PPH with atony – pull out the Methergine."

RIGHT THINKING

"Always check BP/HTN history before any uterotonic. In HTN: oxytocin → carboprost (if no asthma) or misoprostol or TXA."

TRAP 03

Missing Magnesium Toxicity

Toxicity progresses in a predictable order: diminished DTRs → absent DTRs → RR < 12 → ↓ LOC → respiratory arrest → cardiac arrest. Catching it at the DTR stage saves lives.

WRONG THINKING

"DTRs are 1+ now but she was 3+ at baseline – that's just the mag working, no need to do anything."

RIGHT THINKING

"Trending toward absent DTRs. Reassess in 30 min; recheck RR, UOP. Anticipate possible hold of mag if RR drops or UOP falls."

TRAP 04

Treating "Postpartum" as "Out of the Woods"

Up to ~40% of eclamptic seizures and a substantial fraction of preeclampsia-related maternal deaths occur AFTER delivery, often days to weeks later.

WRONG THINKING

"She delivered already, so the preeclampsia is resolved. Discharge planning."

RIGHT THINKING

"Postpartum BP monitoring × 6 weeks. Discharge teaching: report HA, visual changes, RUQ pain, severe swelling, SOB. Follow-up at 3–10 days."

TRAP 05

Reflexively Picking "Apply Oxygen" or "Notify Provider"

On modern NGN questions, "apply O₂" is no longer the automatic first answer (updated AWHONN guidance), and "notify provider" is rarely first when an independent nursing action can stop the harm.

WRONG THINKING

"FHR has late decels → apply oxygen." Or "Mag toxicity → call the doctor first."

RIGHT THINKING

"Reposition first, stop oxytocin if running, oxygen only if hypoxemic. Mag toxicity → STOP the mag (independent action), THEN notify."

BONUS TRAP 06

Confusing HELLP with Cholecystitis or Gastroenteritis

A pregnant or recently postpartum client with RUQ pain, nausea, and malaise gets a HELLP workup — not just antiemetics. The trap is to "treat the symptoms" without thinking pathophysiology.

WRONG THINKING

"Nausea, RUQ pain — must be a stomach bug or gallbladder."

RIGHT THINKING

"Pregnant + RUQ + nausea → rule out HELLP first. Draw CBC + LFTs + LDH + haptoglobin. Check BP and reflexes."

S 13

End-of-Day Quick Review / SCREENSHOT THIS

10 MUST-REMEMBER ONE-LINERS

1. Severe BP = $\geq 160/110$
2. Mag prevents seizures, not HTN
3. Calcium gluconate = mag antidote
4. Therapeutic mag = 4–7 mEq/L
5. Loss of DTRs = first toxicity sign
6. RR < 12 → STOP mag
7. UOP < 30 mL/hr → notify
8. No Methergine if HTN
9. HELLP = delivery
10. Preeclampsia can occur 6 wk postpartum

5 RED-FLAG FINDINGS

- Severe HA unrelieved by Tylenol
- Visual changes (scotomata, blurring)
- RUQ / epigastric pain
- BP $\geq 160/110$
- Platelets < 100,000

5 "NEVER DO THIS" RULES

- NEVER give Methergine in HTN
- NEVER ignore decreased DTRs on mag
- NEVER restrain a seizing client
- NEVER bolus fluids aggressively in preeclampsia
- NEVER assume postpartum = safe from PEC

5 FETAL MONITORING CLUES

- Late decels → uteroplacental insufficiency
- Minimal variability + no accels = concerning
- Mag can cause minimal variability (often benign)
- Sinusoidal pattern = Category III
- Bradycardia after hydralazine = maternal hypotension → reposition + fluids

5 MEDICATION SAFETY CLUES

- Mag pump = high alert · independent double-check
- Calcium gluconate at bedside whenever mag runs
- Labetalol → check HR + asthma history
- Hydralazine → watch for maternal hypotension + fetal brady
- Betamethasone → ↑ glucose in GDM clients

THE BIG 4 SEVERE FEATURES

- **BP** ≥160/110 sustained
- **Neuro:** HA, visual changes, ↓LOC
- **Hepatic:** AST/ALT 2× normal, RUQ pain
- **Hematologic/Renal:** Platelets <100k, Cr >1.1, pulmonary edema

§ 14

Standalone Infographic Summary / DAY 8 AT A GLANCE

Hypertensive Disorders in Labor

Preeclampsia · Eclampsia · HELLP · Magnesium Sulfate · NCLEX-RN 2026

THE SPECTRUM

- **Chronic HTN** · before 20 wk
- **Gestational HTN** · after 20 wk, no proteinuria
- **Preeclampsia** · BP ≥140/90 + proteinuria or end-organ
- **Severe features** · BP ≥160/110, ↓plt, ↑LFT, ↑Cr, neuro, RUQ
- **Eclampsia** · seizure
- **HELLP** · hemolysis + ↑LFT + ↓plt

THE BIG 4 SEVERE FEATURES

- **BP** ≥160/110 sustained
- **Neuro** severe HA · visual changes · ↓LOC
- **Hepatic** AST/ALT 2× · RUQ pain · HELLP
- **Heme/Renal** Plt <100k · Cr >1.1 · pulm edema

MAGNESIUM SULFATE

- Purpose: **seizure prevention**
- Therapeutic: **4–7 mEq/L**
- Hold: RR <12 · UOP <30 · absent DTRs · ↓LOC
- Antidote: **calcium gluconate 1 g IV**
- Expected: warmth, drowsiness, ↓ variability

BP CONTROL

- **Labetalol** IV (avoid in asthma, bradycardia)
- **Hydralazine** IV (watch maternal hypotension)
- **Nifedipine** PO (caution with mag)
- Target: <160/<110 within 30–60 min
- Goal: avoid stroke, abruption, pulm edema

SEIZURE MANAGEMENT (ECLAMPSIA)

- Side-lying · airway · suction · O₂
- Call for help → mag bolus
- NO restraints · NO mouth objects
- After: assess FHR + abruption
- Anticipate delivery

HELLP RED FLAGS

- RUQ/epigastric pain
- Nausea, vomiting, malaise
- Plt <100k · AST/ALT ↑ · LDH ↑ · Hct ↓
- Hepatic rupture = shock + severe RUQ
- Treatment = **delivery**

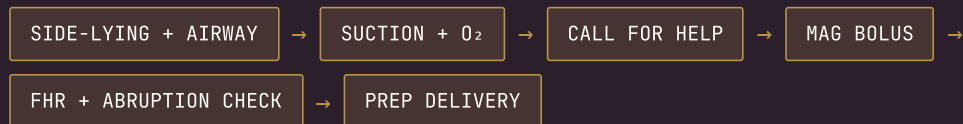
PPH IN HTN CLIENTS

- 1st: **oxytocin** + fundal massage
- 2nd: **carboprost** (NO asthma) or **misoprostol**
- **AVOID methylergonovine** ☹
- Consider **tranexamic acid**
- Watch for rebound HTN + late seizure

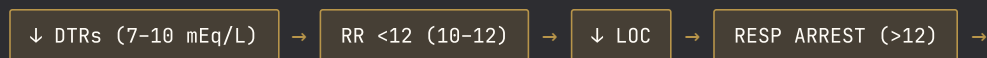
POSTPARTUM TEACHING

- Report: HA, visual changes, RUQ pain
- Home BP monitoring
- F/U BP check at 3–10 days
- Risk persists ×6 weeks
- Long-term CV risk ↑ — encourage health screening

EMERGENCY PATHWAY · ECLAMPTIC SEIZURE



MAGNESIUM TOXICITY LADDER



CARDIAC ARREST (>15)

Intervention at every step: STOP MAG → CALCIUM GLUCONATE 1 g IV → SUPPORT ABCs → NOTIFY

DAY 08 · NCLEX-RN LABOR & DELIVERY · TOMORROW: DAY 9 – GESTATIONAL DIABETES & NEWBORN HYPOGLYCEMIA