NCLEX · 2026 TEST PLAN

Postpartum Complications

Endometritis · Mastitis · Thromboembolism

ENDOMETRITIS
Uterine lining infection

MASTITIS
Breast tissue infection

THROMBOEMBOLISM
DVT / Pulmonary Embolism

MATERNITY · POSTPARTUM CARE · CLINICAL JUDGMENT

⚡ Why These Matter

Leading causes of postpartum morbidity & mortality — prioritization & early recognition save lives.

🚨 THE 5 W's OF POSTPARTUM FEVER (Know These!)

W	W	W	W	W	W
WIND	**WATER**	**WOMB**	**WOUND**	**WALK**	**WEAN**
Pneumonia / atelectasis	UTI	Endometritis	Incision / episiotomy	DVT / thromboembolism	Mastitis / breast

📌 **NCLEX PRIORITY FRAMEWORK:** Apply **ABC** → **Safety** → **Acute over Chronic** → **Unstable over Stable**. A suspected **PE** always outranks a suspected **DVT** or infection.

REPRODUCTIVE · POSTPARTUM INFECTION

ENDOMETRITIS

1 DEFINITION / OVERVIEW

- **Infection of the endometrial lining** (inner uterine wall); can extend to myometrium & parametrium.
- **Most common postpartum infection** — typically develops **2–3 days postpartum** (range 24 hrs – 6 wks).
- **Why it matters:** can progress to peritonitis, pelvic abscess, sepsis → maternal death if untreated.

2 PATHOPHYSIOLOGY (SIMPLIFIED)

Break in tissue barrier (C/S, PROM, trauma) → **Vaginal flora ascends into uterus** → **Colonizes placental site / necrotic decidua** → **Local infection & inflammation** → **Systemic signs (fever, ↑ WBC) → sepsis if untreated**

Top risk factors: **C-section (10× risk)** · **PROM >18 hr** · **Prolonged labor** · **Multiple vaginal exams** · **Retained placenta** · **Chorioamnionitis** · **Internal fetal monitoring**

3 SIGNS & SYMPTOMS

EARLY / MILD

- Low-grade fever after first 24 hrs
- Mild uterine tenderness
- Malaise, chills, anorexia
- Tachycardia

LATE / SEVERE

- RED Fever **≥100.4°F (38°C)** on 2+ consecutive days after 24 hrs PP
- RED **Foul-smelling, purulent lochia**
- Subinvolution (boggy/enlarged uterus)
- Severe pelvic/abdominal pain
- ↑ WBC >15,000; signs of sepsis

HALLMARK TRIAD: Fever AFTER 24 hrs + Uterine tenderness + Foul lochia

4 PRIORITY NURSING INTERVENTIONS

- **ASSESS** vitals q4h, fundal firmness/location, lochia (amount, color, odor), pain.
- **OBTAIN cultures BEFORE antibiotics** (blood, endometrial, urine) — do not delay abx for cultures in septic patients.
- **ADMINISTER** IV broad-spectrum antibiotics — **Clindamycin + Gentamicin** = gold standard.
- **POSITION** in **Semi-Fowler's** to promote dependent drainage of lochia.
- **ENCOURAGE** fluids (3–4 L/day) & ambulation as tolerated.
- **MONITOR** I&O, temperature trend, WBC, and signs of sepsis (MEWS/qSOFA).
- **PAIN** management (acetaminophen / ordered analgesics).
- Maintain **standard precautions**; strict hand hygiene before/after perineal care.

5 PHARMACOLOGY

Drug / Class	Mechanism	Side Effects	Nursing Considerations
Clindamycin ***(lincosamide)***	Inhibits bacterial protein synthesis; covers anaerobes	C. difficile diarrhea, rash, ↑ LFTs	Monitor stools — **report diarrhea immediately**; infuse slowly
Gentamicin ***(aminoglycoside)***	Binds 30S ribosome; Gram (-) coverage	**Nephrotoxic, ototoxic**	Monitor **peak & trough**; BUN/Cr; hearing; dose by weight
Ampicillin ***(penicillin)***	Inhibits cell wall synthesis	Rash, anaphylaxis, GI upset	Screen PCN allergy; may be added for Gram (+) coverage

6 NCLEX TEST TRAPS ⚠

- **Fever in the first 24 hrs postpartum is usually NOT endometritis** — often dehydration. Look for fever *after* 24 hrs on 2 consecutive days.
- WBC is **normally elevated postpartum** (up to ~20,000) — trend matters more than a single value.
- Do **not** give antibiotics *before* drawing cultures unless patient is septic/unstable.
- Position = **Semi-Fowler's** (NOT supine) to promote lochia drainage.
- Endometritis ≠ endometriosis — NCLEX loves this lookalike.

7 PATIENT EDUCATION

- **Complete the full antibiotic course** even when feeling better.
- Perform **perineal care front-to-back**; change peri-pad every 2–4 hrs.
- Strict **hand hygiene** before/after pad changes and toileting.
- **Return precautions:** fever ≥100.4°F, worsening pain, foul lochia, heavy bleeding, fainting.
- Rest, hydrate (>8 glasses/day), nutrient-dense diet, and increase activity gradually.

8 MEMORY BOOSTERS

🧠 **"FOUL 24" → Think Endometritis**
F oul-smelling lochia · **O** ver 100.4°F · **U** terine tenderness · **L** eukocytosis · after **24** hrs postpartum

🧠 **REEDA** (wound/perineum check — same tool helps assess infection signs):
R edness · **E** dema · **E** cchymosis · **D** ischarge · **A** pproximation

REPRODUCTIVE · LACTATION / BREAST

MASTITIS

1 DEFINITION / OVERVIEW

- **Infection of breast tissue** — almost always **unilateral** in a lactating person.
- Peak onset: **2–4 weeks postpartum**; most commonly caused by **Staphylococcus aureus**.
- **Why it matters:** untreated → breast abscess → surgical drainage & possible cessation of breastfeeding.

2 PATHOPHYSIOLOGY (SIMPLIFIED)

Cracked / fissured nipple + milk stasis → Bacteria (S. aureus) enter via skin break → Multiply in stagnant milk → Localized inflammation of breast tissue → If untreated → abscess formation

Top risk factors: Cracked nipples | Milk stasis / skipped feeds | Poor latch | Tight bra | Abrupt weaning | Fatigue / stress

3 SIGNS & SYMPTOMS

EARLY (ENGORGEMENT-LIKE)

- Localized breast tenderness
- Mild warmth / firmness
- Minor fatigue
- Typically still bilateral discomfort

FULL MASTITIS

- RED **UNILATERAL** hard, red, **wedge-shaped** area
- RED **Fever >101°F (38.3°C)** + chills
- Flu-like symptoms: body aches, malaise
- Axillary lymph node tenderness
- ↓ milk supply on affected side
- Fluctuant mass → **abscess** ⚠️

ENGORGEMENT vs. MASTITIS: Engorgement = *bilateral*, no fever, resolves with feeding. Mastitis = *unilateral*, fever >101°F, flu-like symptoms.

4 PRIORITY NURSING INTERVENTIONS

- **CONTINUE BREASTFEEDING** — this is the #1 NCLEX answer. Milk is safe for baby & drainage is therapeutic.
- **FEED from affected side FIRST** (stronger suckle = better emptying).
- **ADMINISTER** antibiotics (dicloxacillin or cephalexin) — safe in lactation; 10–14 day course.
- **APPLY** warm moist compresses BEFORE feeding → promotes letdown.
- **APPLY** cold compresses AFTER feeding → reduces inflammation.
- **ASSESS** latch; teach alternating feeding positions to empty all quadrants.
- **ENCOURAGE** rest, hydration, adequate calories.
- Pain relief: **acetaminophen or ibuprofen** (both compatible with breastfeeding).

5 PHARMACOLOGY

Drug / Class	Mechanism	Side Effects	Nursing Considerations
Dicloxacillin ***(anti-staph PCN)***	Inhibits cell wall; covers S. aureus	GI upset, rash, anaphylaxis	Take on **empty stomach**; screen PCN allergy; safe in lactation
Cephalexin ***(1st-gen cephalosporin)***	Inhibits cell wall synthesis	GI upset, rash; 1% PCN cross-reactivity	Take with food; safe in lactation; full 10–14 day course
Acetaminophen / Ibuprofen	Antipyretic / anti-inflammatory	Liver (APAP), GI/renal (NSAID)	Both compatible with breastfeeding; max APAP 3g/day

6 NCLEX TEST TRAPS ⚠

- ⚠ **NEVER tell patient to stop breastfeeding** — biggest mastitis trap answer. Continue nursing!
- Mastitis is almost always **unilateral** — if bilateral think engorgement.
- Warm compresses **BEFORE**, cold **AFTER** — do not mix these up.
- If fluctuant mass or no improvement in 48–72 hrs → think **abscess** (needs I&D).
- Engorgement answer ≠ mastitis answer — no fever/flu symptoms with engorgement.

7 PATIENT EDUCATION

- **Continue breastfeeding or pumping** every 2–3 hours to prevent stasis.
- Ensure **proper latch**; alternate positions (cradle, football, side-lying).
- **Air-dry nipples** after feeds; apply lanolin for cracks.
- Wash hands before feeds; wear a supportive (not tight) bra; avoid underwire.
- **Complete antibiotics** even when symptoms resolve.
- Call provider if: no improvement in 48 hrs, fluctuant mass, red streaks, fever persists.

8 MEMORY BOOSTERS

🧠 **"MILK" — Mastitis Management**
M ore feeding (don't stop!) · **I** ce after feeds · **L** atch & Lanolin · **K** eep going with antibiotics

🧠 **"Warm IN, Cold OUT"**
War BEFORE feeding (milk flows IN/out) · **Cold** AFTER feeding (inflammation OUT)

HEMATOLOGIC / CARDIOVASCULAR · POSTPARTUM

THROMBOEMBOLISM (DVT & PE)

1 DEFINITION / OVERVIEW

- **DVT** = blood clot in deep veins (usually calf/thigh). **PE** = clot dislodges → travels to pulmonary artery.
- Pregnancy & postpartum = **hypercoagulable state** (up to 5× higher risk).
- **Why it matters:** PE is a **leading cause of maternal death** — recognize early!

2 PATHOPHYSIOLOGY — VIRCHOW'S TRIAD

① STASIS (↓ movement, uterus compresses IVC) + **② HYPERCOAGULABILITY** (↑ clotting factors in pregnancy) + **③ ENDOTHELIAL INJURY** (trauma from birth / C-section) →

CLOT forms in deep vein (DVT) → **Clot dislodges → lungs = PE**

Top risk factors: C-section · Obesity (BMI >30) · Smoking · Age >35 · Prolonged bed rest · Multiparity · Hx of clots / thrombophilia · Varicose veins

3 SIGNS & SYMPTOMS

DVT (LEG)

- **UNILATERAL** leg swelling
- Warmth, redness, tenderness
- Calf pain — may feel cord-like
- ↑ calf circumference (measure both!)
- Pain with ambulation
- Homan's sign — *unreliable, do NOT rely on it*

PE (LIFE-THREATENING)

- RED **SUDDEN dyspnea / SOB**
- RED Pleuritic chest pain
- RED Tachycardia & tachypnea
- Hypoxia / cyanosis / ↓ SpO_2
- Hemoptysis, anxiety, "sense of doom"
- Low-grade fever, diaphoresis

PE = EMERGENCY: Sudden SOB + chest pain + tachycardia in postpartum pt → **RAPID RESPONSE**.

4 PRIORITY NURSING INTERVENTIONS

FOR SUSPECTED DVT

- **BED REST** with leg elevated
- **DO NOT MASSAGE the leg** (can dislodge clot → PE!)
- Warm, moist compresses to affected leg
- Measure calf circumference daily (same spot, both legs)
- Administer **anticoagulants** (heparin IV, then LMWH/warfarin)
- Pain management; assess neurovascular status

FOR SUSPECTED PE (EMERGENCY)

- **HIGH-FOWLER'S position** (improves lung expansion)
- **Administer O_2** (high-flow, non-rebreather)
- **CALL rapid response / provider**
- Establish IV access; draw labs (ABG, D-dimer)
- Continuous cardiac monitor + SpO_2
- Prepare for **heparin / thrombolytics**

PREVENTION (Priority on ALL postpartum pts): Early ambulation · SCDs / TED hose · Hydration · Avoid prolonged sitting · Smoking cessation · Leg exercises in bed.

5 PHARMACOLOGY — ANTICOAGULANTS

Drug	Mechanism / Route	Monitoring	Antidote / Key Points
HEPARIN ***(unfractionated)***	Enhances antithrombin III → inhibits thrombin & factor Xa · **IV / SQ**	**aPTT** (goal 1.5–2.5× control / ~60–80 sec) · Platelets (HIT!)	**Antidote: Protamine sulfate** · Safe in pregnancy/lactation
WARFARIN ***(Coumadin)***	Blocks Vit K → ↓ clotting factors II, VII, IX, X · **PO**	**INR** (goal 2–3) · takes 3–5 days to work	**Antidote: Vitamin K** · **CONTRAINDICATED in pregnancy** · OK in lactation · Limit green leafy veg
ENOXAPARIN ***(Lovenox / LMWH)***	Inhibits factor Xa · **SQ only**	No routine labs (anti-Xa if needed) · Platelets	Partial reversal: protamine · Inject in abdomen "love handles" · Do not expel air bubble · Do not rub site

6 NCLEX TEST TRAPS ⚠

- ❌ **NEVER MASSAGE a suspected DVT** — can release clot → fatal PE.
- PE position = **HIGH FOWLER'S** (not Trendelenburg, not left lateral).
- **Heparin → aPTT** · **Warfarin → INR** (don't mix up monitoring).
- **Warfarin is teratogenic** — never in pregnancy. Heparin & LMWH are safe.
- Homan's sign is **unreliable** — do not use it to rule in/out DVT.
- **Amniotic fluid embolism vs. PE:** AFE happens during/immediately after delivery with sudden respiratory collapse + DIC; PE can occur anytime postpartum.
- Early ambulation ≠ vigorous exercise — NCLEX prefers "ambulate as tolerated."

7 PATIENT EDUCATION

- **Ambulate early** & often after delivery; avoid prolonged sitting/crossing legs.
- Wear **compression stockings / SCDs** as ordered; stay hydrated.
- **Anticoagulant teaching:** soft toothbrush, electric razor, no contact sports, report bleeding (gums, urine, stool, bruising).
- For warfarin: keep **Vit K intake consistent** (don't avoid greens, just stay consistent).
- Avoid aspirin/NSAIDs unless prescribed; disclose anticoagulant use before any procedure.
- **Call 911** for: sudden SOB, chest pain, coughing blood, one-sided leg swelling.

8 MEMORY BOOSTERS

🧠 **Virchow's Triad — "3 S's"**
Stasis · **S**ticky blood (hypercoagulable) · **S**cratched vessel (endothelial injury)

🧠 **Anticoagulant monitoring**
P TT → He**P**arin · **I** NR → War**IN**

🧠 **PE Recognition — "SUDDEN"**
SOB · **U**nilateral chest pain · **D**yspnea · **D**oom feeling · **E**levated HR · **N**eeds O_2 NOW

🎯 QUICK COMPARE & FINAL REVIEW

Side-by-side distinctions · Top traps · Ready-to-go priority actions

⚖️ SIDE-BY-SIDE COMPARISON

Feature	ENDOMETRITIS	MASTITIS	THROMBOEMBOLISM (DVT/PE)
Site	Endometrial lining (uterus)	Breast tissue (usually unilateral)	Deep leg veins → may travel to lungs
Onset	2–3 days PP (after 24 hrs)	2–4 weeks PP	Any time PP (peak first 6 wks)
Key Sign	Foul lochia + uterine tenderness + fever	Unilateral red, wedge-shaped, painful breast + fever >101°F	DVT: unilateral leg swelling · PE: sudden SOB, chest pain
Top Risk	C-section, PROM, prolonged labor	Cracked nipples, milk stasis	C-section, obesity, immobility, smoking
First-line Tx	Clindamycin + Gentamicin IV	Dicloxacillin / Cephalexin PO	Heparin IV → LMWH/warfarin
Position	Semi-Fowler's (drain lochia)	Any comfortable; support breast	DVT: elevate leg · PE: **HIGH FOWLER'S**
#1 NCLEX Trap	Fever in first 24 hrs = usually NOT endometritis	NEVER stop breastfeeding!	NEVER massage a suspected DVT
Emergency?	Can progress to sepsis	Can progress to abscess	**PE = life-threatening** ⚠️

🧭 NCLEX PRIORITY CHEAT SHEET (CJ MODEL)

- **Recognize cues:** Postpartum fever + unilateral leg swelling? → Think DVT *AND* infection simultaneously.
- **Analyze cues:** Sudden SOB + chest pain ALWAYS outranks local infection → PE first.
- **Prioritize hypotheses:** ABC → Safety → Acute over chronic. PE > sepsis > localized infection.
- **Generate solutions:** Always include O_2, IV access, positioning, rapid response for unstable patients.
- **Take action:** Culture BEFORE antibiotics (if stable) · Anticoagulate BEFORE confirmed DVT imaging if high suspicion · Position FIRST in respiratory distress.
- **Evaluate outcomes:** Trend vitals, WBC, SpO_2, calf circumference, lochia, breast exam.

⚠️ TOP 10 NCLEX TRAPS (MEMORIZE THESE)

- **1.** Fever in first 24 hrs PP = usually dehydration, not endometritis.
- **2.** Mastitis → **continue breastfeeding**, don't stop.
- **3. Never massage** a suspected DVT.
- **4.** PE = **High-Fowler's** + O_2 (NOT Trendelenburg).
- **5.** Heparin → aPTT · Warfarin → INR.
- **6.** Warfarin is **teratogenic** — never in pregnancy (OK postpartum/lactation).
- **7.** Draw cultures **before** antibiotics when patient is stable.
- **8.** Engorgement is *bilateral & fever-free*; mastitis is *unilateral with fever*.
- **9.** Postpartum WBC is normally elevated — trend & clinical picture matter.
- **10.** Protamine = heparin antidote · Vitamin K = warfarin antidote.

🧠 ONE-LINE MEMORY HOOKS

Endometritis: "FOUL + FEVER after 24 hrs = uterus FOE" 🤰

Mastitis: "Keep the MILK moving — More feed, Ice, Latch, Keep going" 🤱

DVT/PE: "Virchow's 3 S's → Clot → SUDDEN SOB = HIGH FOWLER'S + O_2" 🦵🫁