Case No 1

PANEL DISCUSSION CASES

History

- Name : ABC
- 31yrs
- High risk referred case
- History of PPH – following LSCS

History

- Intra operative problems- adherent placenta previa
- Post operative – persistent bleeding PV with clots
- Managed conservatively- 4 units whole blood transfused
- Referred to BMJH for Tertiary care as bleeding not controlled and patient sinking.

OB History

- G2,P1,L1
- G1- FT LSCS (Ind : PIH)
- G2 – On Alpha Dopa since 13 weeks
- Antenatal USG – Central Placenta Previa
- Elective LSCS at 38 weeks

Menstrual History

- LMP – 16/04/08
- EDD – 23/01/09
- PMC – regular

Other significant History

- LMP – 16/04/08
- EDD – 23/01/09
- PMC – regular

Examination

- General Physical Examination – GC poor Drowsy, Disoriented, Pallor +++
- Peripheral pulses not felt
- HR-160/min
- BP-80/60
- RR-28
- SpO2-81%

Examination

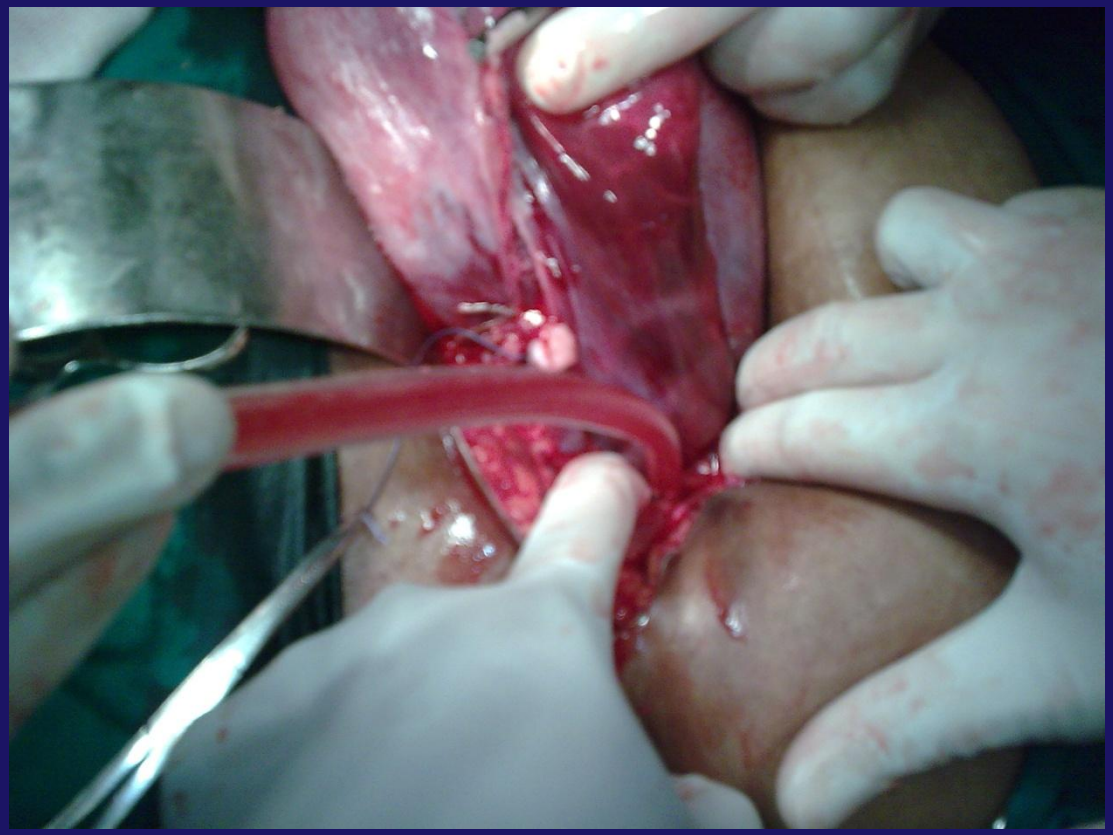
- CVS- Tachycardia
- RS- Clear
- PA- Uterus 24 weeks, contracted
- LE- Bleeding PV+++
- UOP- Minimal(15-20ml)
- HAEMATURIA++

Investigations

- **Hb-2.6**
- PCV-7.9
- **Platelets-31000**
- **PT(INR)-2.33**
- PTT-65.0
- Urine-Alb-2+, RBC++
- GRBS-197

Management

- Resuscitation – A / B / C
- Massive blood transfusion
- Vaginal packing
- Surgical intervention – Obstetric hysterectomy



Post operative period

- Ventilatory support
- Blood & Blood products transfusion
- Persistence of bleeding PV
- Exploration per vagina
- Para cervical vessels and cx & vaginal tear sutured
- Antibiotics upgraded

Outcome

- Bleeding PV controlled
- Stable at discharge
- Per urethral catheter left *in situ*

Follow up

- Plan : suture removal after 3 days
  catheter removal after 3 weeks

Total transfusions

- 47 units
- 9 units of whole blood
- 9 units of packed cells
- 17 units of FFP + 12 Platelets


HAPPY MOTHER


SMILING PARENTS

Case No.2

- 30 years PGR at 36 weeks with antepartum hemorrhage

- BP 150/90 mm Hg
- Pulse rate 120/ minute
- Pallor +++
- P/A- uterine tone increased
    - FHS not localized

Catheterization- 30 ml urine

USG- Placenta fundal
RPC- 12X10 cm
Fetal cardiac activity absent

P/S- Fresh bleeding present

P/V- Cervix 2 cm, 30% effaced
Membranes intact

- Hb- 4 gm%
- Platelet count- 30,000/ mm3
- PTI- 52%
- Blood urea 50 mg/dl
- Serum creatinine- 1.2 mg/dl
- SGOT/ SGPT- 180/ 200 IU/L

- What will your initial management?
- What blood components do you suggest?
- Do you suggest that single donor plasma apharesis is required?
- What is the cost and storage life of SDAP?

- How will manage the setting of ARF in this patient?
- How will you plan the delivery of this patient?
- Where is the role of LSCS in women with abruptio?
- What should be the maximally allowed duration of labor

Case No. 3

26 year old G2P1001 at 34 weeks

Unsupervised pregnancy with breathlessness on minimal exertion for 1 week.

O/E- Pulse- 110/ minute,
Regular BP 100/70 mmHg ,
JVP raised,
No pallor
Chest bilateral
Basal crepts
Long MDM of MS
Echo- Mitral valve area 0.6 cm2,
No MR, Severe PAH.

What are the management options of MS in pregnancy ?

In case BMV cannot be performed then how will you manage the labor?

If patient is to be taken up for LSCS what will be your choice of anesthesia?

What are the peri-operative risks involved?

Case No. 4

PGR at 39 weeks,

Unsupervised pregnancy with Antepartum Eclampsia

P/V-2cms 30% effaced ,cephalic,

MSL+Hb-12gm/dl

Platelet count-2 lakhs

S. creatinine-1 mg/dl

PTI-91%

NST shows late decelerations upto 90 bpm

P/V-2cms 30% effaced ,cephalic, MSL+Hb-12gm/dl

Platelet count-2 lakhs

Liver enzymes- awaited

What would be your decision- LSCS/ Against LSCS?
MANAGEMENT of high blood pressure?

What are the risks involved in a cesarean and what informed consent would you suggest be taken?

What would be your choice of anaesthesia?

The baby born is IUGR with meconium, how would you resuscitate the neonate?

Case No. 5

A 26 yrsG2P001 with previous one

LSCS reffered from a pvt NH with placenta previa at 35 weeks in early labor.

On examination-PR-120/MIN

BP-120/70

PALLOR+

P/A-ut 36 weeks

Head free ,high up mild occasional contractions + FHS+

L/E -no active bleed

Would you do an USG yourself, and if yes what would you like to record?

Her Hb is 7 gm/dl

What are the initial preperations that should be done while taking her for LSCS?

What would be the anaesthesia of choice?

Baby is delivered as breech and appears pale and limp- How would you initially resuscitate the baby?

Immediately following the delivery of the baby, there is excessive blood loss and accreta confirmed- What next?

Monitor shows BP -90/60 PR-150-160
How will you resuscitate?

Case 1

- Mrs. M aged 22 years **referred** with H/O convulsion two times at home, twice in the referring hospital at 7 ½ months amenorrhea.
- G3 P2 L0 ML 5 years, III degree consanguinity
-
- IHome delivery at Village. Post term. Male baby died after ½ hour ? Asphyxia

•II delivery in a private nursing home normal delivery Male baby ?

•IUGR No proper checkups hence details of hypertension or anomaly not available. Baby died after 3 months ? Failure to thrive

Present Pregnancy

- LMP : 2/2/09 EDD 9/11/09,Admitted at 31 wks
- PMC : Irregular once in 2-3 months flow for 5 days.
- Patient booked with regular ANC in a private clinic in Ulsoor, Bangalore, Pregnancy confirmed by UPT
- Blood group B +ve ,VDRL: NR TSH 0.01 miu/ml
- USG done on 23/5/09 said to be corresponding 15 @ 15
- No structural defects noted
- No significant past or family history

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P 2/2/09
9/11/09.

58 kgs

136/80 mm Hg

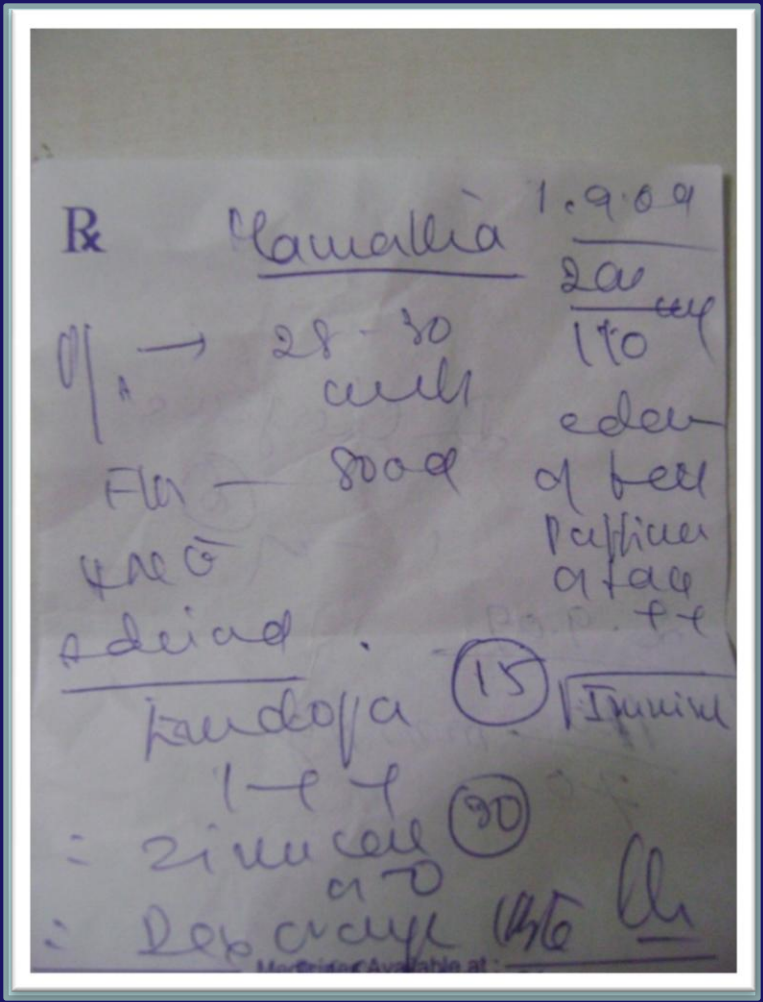
PA wt 24-26 wks

FHR +

(appreciable FM)

Adv FS (100)

Note: Wrong OB History/ IUGR noted
No action taken



Note :

Increased BP :200/110

Treated as Outpatient

No Investigations ordered

What should be the Minimum Investigations Ordered at this stage ??

Presence of IUGR noted previously – Of any clue ??

OBSTETRICS SONOLOGIC STUDY :
(L.M.P. - 02 / 02 / 2009, E.D.D. - 09 / 11 / 2009)
(GESTATIONAL AGE - 30 WEEKS 01 DAY)

Single live intrauterine fetus seen in cephalic presentation. Spine directed towards right side. Th following parameters noted.

Head circumferance	258 mm
Biparitial diameter	70.8 mm
Abdominal Circumference	236 mm
Femoral length	52.8 mm

The average gestational age corresponds to 28 weeks 01 day.
Expected date of delivery by USG - 23 / 11 / 2009
Fetal heart rate is 146 beats/min.
Approximate estimated fetal weight as on today 1165 grams.

* Fetal face and limbs to the extent seen are normal.
* Four chamber view of cardia and ventricular out flow tracts are normal.
* Kidneys and urinary bladder are normal.
* Three vesseled umbilical cord noted.

No fetal cranial , spinal or abdominal anomalies seen at present. Fetal cardiac activity and movem are normal.
Placenta is fundal anterior and has Grade " I " maturity. No previa noted. Internal Os of the cerv closed.

Amniotic fluid is adequate for the period of gestation.

IMPRESSION :
* SINGLE LIVE INTRA UTERINE FETUS SEEN IN CEPHALIC PRESENTATION WITH A GESTATIONAL MATURITY OF 30 WEEKS 01 DAY.

* THIS IS HER FIRST SCAN.

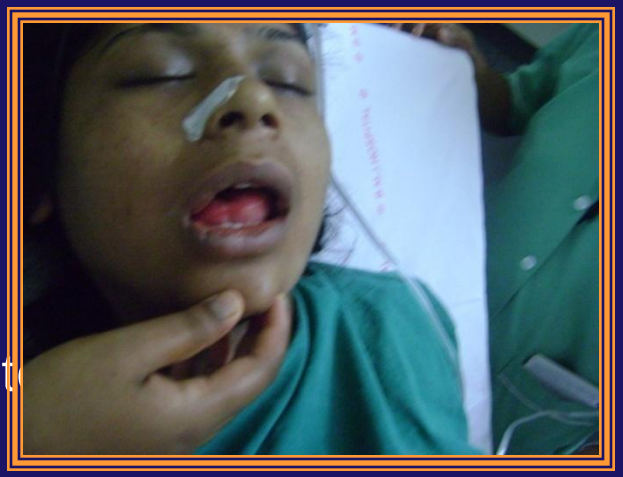
What has this scan reported ?

Any Errors?

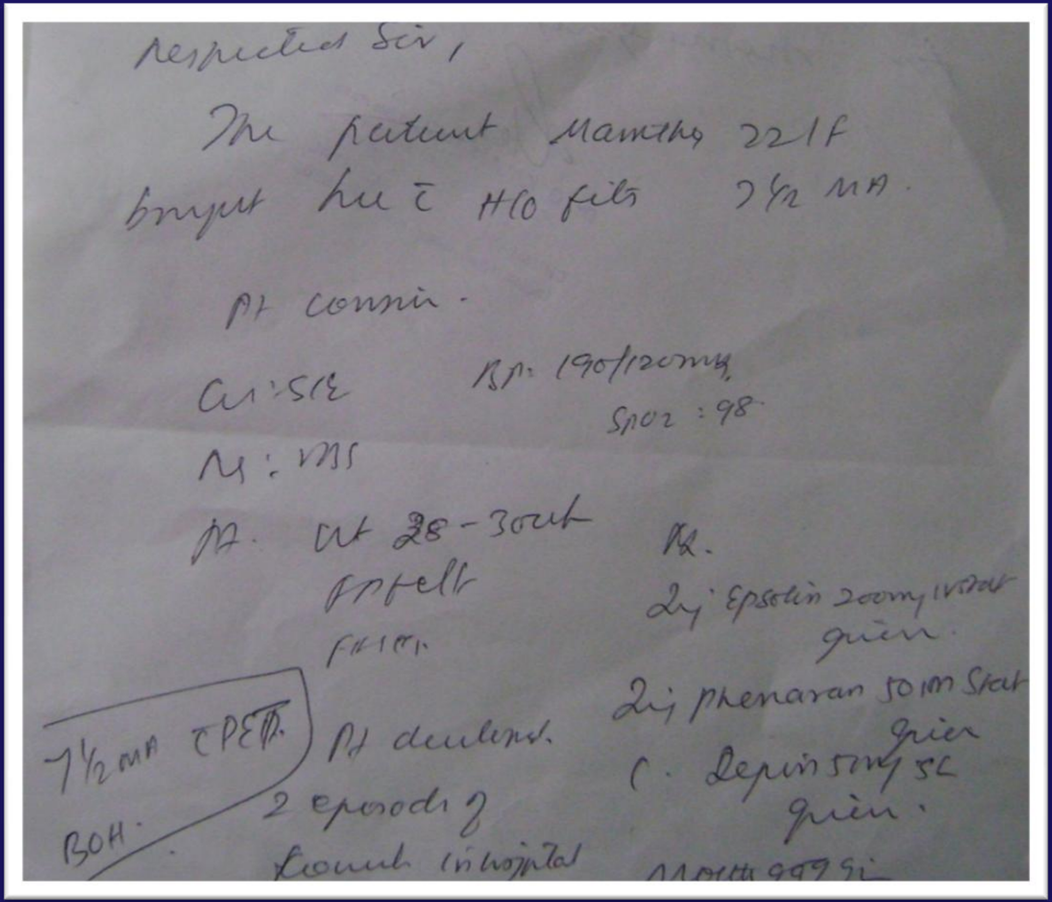
The Bolt

- Early morning of 3/9/09 at around 3.40 am patient had a convulsion. She had second attack of convulsion at home at 4 am.

Bit



Note the Tongue



Respected Sir,

The patient Mamatha 22/F brought here c H/O fits 7½ MA.

Pt conscious.

CVS: S1S2 BP: 190/120mmHg

RS: NVBS SpO2: 98

P/A. Ut 28-30wk

Fetal

FHS(+)

7½ MA c PET. BOH.

Pt delivered.

2 episodes of convulsions in hospital

Rx.

Inj Epsolin 200mg IV stat given.

Inj Phenargan 50mg stat given

C. Depin 5mg SL given.

Patient Shifted From Hospital To Hospital

Comments On Rx ??

Further course

Patient was shifted at 7.15 am on 3/9/09 from the Ambulance to HDU she threw one more convulsion which lasted for a minute.

Patient was highly irritable and needed restrain.

Examination

- Patient disoriented, irritable
- Moderately built and nourished. Pallor +
- Edema ++ Both facial and pedal
- BP 150/110 mm Hg Pulse 100/min
- CVS : NAD RS : Clear
- Reflexes exaggerated
- Plantars upgoing
- Pupils normally reacting
- Uterus 26-28 wks Not acting Not tender FHS +

Management

- IV access obtained. PET profile sent
- Blood arranged
- IV $MgSO_4$,4 gm stat + 1 gm /hour infusion
- Catheterized. Urine albumin 4 +
- PV : Cx uneffaced ,Os closed Presenting part high

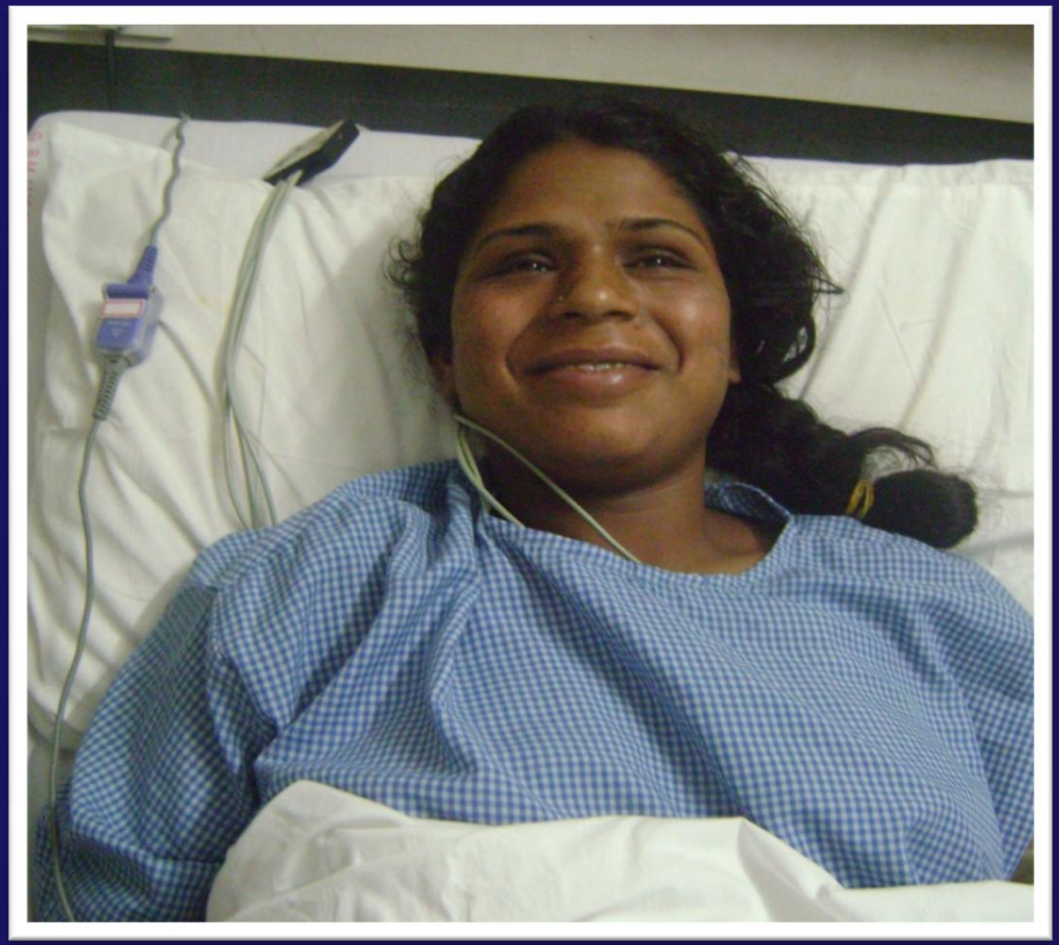
  No discharge PV
- Rpt BP 160/90 mm NTG drip standby
- NST- NR
- Rescue dose of steroid given
- Inj Pan 40 Inj. Augmentin IV given

Investigations

- Hb 11.7 gm% PCV : 36.7%
- TC : 17210 P 82 L 17 M1 E0
- Platelet count : 1,15,000
- Uric acid : 8.3 mg %
- S. Creatinine & Blood Urea : WNL
- LFT : Total Bilirubin : 0.4 mg %
- SGOT : 70 u/L (N=0-40) SGPT : 84 u/L (N=0-41)
- LDH : 545u/L (N=200-415)
- INR : 0.8 PTT : 33.7 S (control 32)
- Serum Albumin 2.4 g/dl (3.2-5.5)
- GRBS : 123 mg%
- Urine Albumin ++++

LSCS

- Ascites +
- Lower segment not formed, vascular
- 1.05 Kg Male baby extracted by breech at 8.34 am on 3/9/09 5 min apgar good
- Liquor grossly decreased ,clear
- Placental wt 150gm, calcified
- Accidental hemorrhage +
- Baby shifted to NICU. Stabilized and discharged on Day 21



Day 3

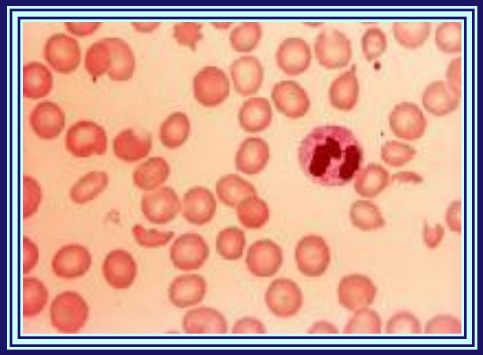
Happy Mother

Stable Baby

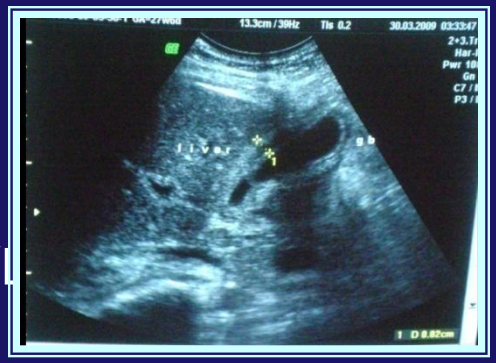
Case 2

- 25 year old primi gravida with 28 wks GA
- Well booked outside, edema for last few days
- Epigastric pain for 2 days treated with antacids.
- Did not improve admitted in afternoon.
- BP 140/90 Inj Pan repeated.
- 11pm: Episode of Convulsion.
- Catheterized – hematuria , Platelet count sent = 46,000
- Inj $MgSo_4$ 4 gm IV + 10 gm IM given and **transferred at 1 am.**
- O/E:GC- unsatisfactory, confused, not pale
- Edema ++ Pulse 118 bpm, BP 150/110 mm Hg
- Uterus 26 @ 28 wks , relaxed, FHS : 158 bpm
- Catheter– Tube empty, 20 ml of frank blood in bag

Case 2



Investigations



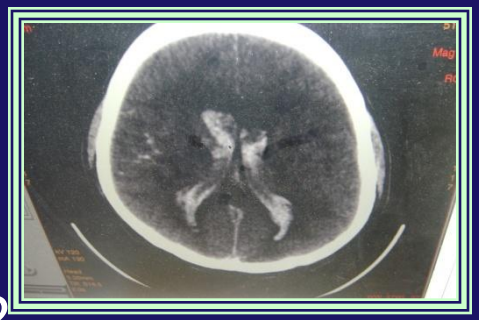
- Hb : 15.3 gm% PCV : 43.7
- Platelets : 51,000 INR : 1.49
- S. Bilirubin : 11.3 mg
- SGPT: 144 u/L SGOT : 429 u/L
- S. Albumin : 3.5 Uric acid : 5
- Creatinine : 1.1 Urine albumin : ++++
- NST : Reactive
- U/S scan : 27 @ 28 wks, AFI :9, Umb Doppler : N
- MCA:N, Ut.Artery:No notch
- Maternal kidneys : Gr II nephropathy
- GB wall thick, ascites ++ Minimal Pleural & Pericardial effusion

Course

- Pt started on IV MgSo4 1gm/hr & Platelets infusion
- Pt had convulsions on $MgSo_4$ – rescue dose of $MgSO_4$ given
- Platelet & FFP`s transfusion contd
- Emergency LSCS done – live baby of 900 gms – shifted to NICU on ventilator
- Post Sx pt ventilated – on Fentanyl, NTG & blood products
- Pt had hypotension 6 hrs post Sx, pupils dilated, uterus well contracted, bleeding WNL, urine clearing up in tube

Course

- Pt gradually lapsed in coma – Neuro opinion – possibility of intra cranial bleed – CT brain : Sub arachnoid hemorrhage with inter ventricular extension.



- Total transfusions – 22
- Pt`s condition deteriorated .CPR & ACLS protocol followed – declared dead with in 24 hours of referral.
- Relatives took the baby away.

Lessons Learnt

- HELLP/Eclampsia need not be accompanied by severe hypertension. A history of mild PIH can trigger events leading to HELLP.
- HELLP can present for the first time after delivery.
- Accidental Hemorrhage is a frightening complication in HELLP especially with DIC.
- In spite of delivery, the pathological process may continue and hence there should be no let up in the monitoring of the patient.

Lessons Learnt

- Wrong diagnosis is a possibility in HELLP syndrome because of non specific symptoms.
- Large amount of blood for transfusion must be available
- Renal failure needs to be managed actively and the return of normal renal function is possible in spite of apparently hopeless situation.

Lessons Learnt

Any pregnant woman who presents with malaise or a viral-type illness in the third trimester should be evaluated with a complete blood cell count and liver function tests.