2016

# Case No. 2 - Preventable Maternal Death Due to Hemorrhage

New York Law School

**Case No 2**

**PREVENTABLE MATERNAL DEATH DUE TO HEMORRHAGE**

**Ms Smith was a 30 G3 P1021 at 32 weeks gestation who presented with the sudden onset of contractions and vaginal bleeding significant for bright red blood soaking 4 pads in a hour which began while she was shopping approximately two hours prior to admission. She reported no abdominal trauma.**

**Her prenatal course had been otherwise unremarkable with normal blood pressures and fundal height recorded at the last prenatal visit two weeks previously and she had no other significant medical or surgical history. She had a 20 week anatomy ultrasound which revealed an anterior placenta without previa. Her obstetrical history was significant for one previous Cesarean documented a low transverse Cesarean section for breech two years previously and two first trimester spontaneous abortions followed by dilatation and curettage.**

**At the time of admission the patient's vital signs indicated a normal blood pressure and pulse of 88. The external fetal monitor indicated contractions every one minute with a normal fetal heart rate baseline, moderate variability with recurrent late decelerations. A placenta abruption was suspected and labs were drawn and sent for CBC, PT, PTT and a type and cross was ordered for two units of packed red cells. A stat Cesarean was performed under general anesthesia with delivery of a 2000 gram infant, Apgars 4 and 8, arterial cord gas of 7.2 with base excess of -4.5 A 25% placental abruption was noted however removal of the remainder of the placenta was difficult and a placenta accrete was diagnosed.**

**The senior surgeon back up was called, he arrived in ten minutes and a Cesarean hysterectomy was performed which included removal of the cervix. At some point during the procedure the anesthesiologist asked the surgical team if they felt the bleeding was controlled and the resident initially replied that she thought it was. Vital signs at that time were a blood pressure of 100/70 and a pulse of 110. The mother was noted to be shivering and since only one blood warmer could be found, several liters of Ringer's lactate were administered without it. The anesthesiologist then left the room as she was called to the emergency room for an incoming trauma. The obstetrical resident then indicated that the bleeding was not controlled however the**

**anesthesia resident, engaged in starting an arterial line, did not hear the request.**

**Approximately 20 minutes later the surgical team asked if the blood had been obtained and the anesthesia resident and circulating nurses denied hearing the request. The circulator stated she was unable to leave to get the blood and the resident un-scrubbed and went herself to the blood bank to obtain two units of blood. At this point the patient's vital signs began to deteriorate.**

**The hysterectomy had been difficult and an injury to the ureters had also been identified and was repaired following intraoperative consultation with urology. Toward the end of the procedure, approximately three and one half hours after the initial incision the surgeons noted that the blood was dark. Maternal pulse was now 140 and blood pressure was not able to be recorded. The resident attributed this to the maternal shivering and asked for a bear hugger. Stat CBC was reported by phone as Hct of 17. Stat arterial blood gas indicated the pH was 6.9 and the mother was very acidotic with a base excess of – 26. Shortly after closure of the abdomen the mother experienced a cardiac arrest. A code was called and the mothers was revived and transferred to the surgical intensive care unit.**

**The following day the mother was noted to be brain dead and life support was discontinued.**