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# Case No. 7 - Postpartum Maternal Death Associated with Pulmonary Edema and Severe Anemia in a Patient with Preeclampsia

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POSTPARTUM MATERNAL DEATH ASSOCIATED  
WITH PULMONARY EDEMA AND SEVERE ANEMIA IN A  
PATIENT WITH PREECLAMPSIA.

Lana, age 22, was a student at community college living with her mother, Stella, when she became pregnant and gave birth to her daughter Rachel on June 18, 2010. It was Lana's intent to raise Rachel as a single mother.

Lana had enrolled for pregnancy care with an obstetrical group that included Dr. Good and Dr. Heart who were each board certified obstetricians. Dr. Good and Dr. Heart were attending physicians at the hospital.

On June 11, 2010, Lana was admitted to the hospital under the care of her obstetricians, Dr. Good and Dr. Heart because preeclampsia had developed. Dr. Good and Dr. Heart alternated in overseeing the obstetrical care from June 11, 2010 through June 18, 2010. On June 18, 2010, the bag of waters broke and labor was induced. There was a normal spontaneous uncomplicated vaginal delivery of a healthy newborn named Rachel.

Post-delivery, both Lana and Rachel were each discharged from the hospital on June 20, 2010. Rachel had no complications, but was scheduled for a routine pediatric followup 2 days later on June 22, 2010.

Prior to Lana's discharge, a CBC obtained in the evening of June 19, 2010 at 10:00 p.m. revealed that Lana's white blood count was elevated at 25,400 and her hematocrit (HCT) was depressed at 21.9.

The next morning on June 20, 2010, Dr. Good authorized a discharge of Lana. Dr. Good documented in the record that Lana had a normal blood pressure but there is no documented awareness of the low hematocrit or high white blood count. Further, Dr. Good did not schedule Lana for a followup obstetrical visit until 2 weeks later.

Additionally, the hospital record reflects discharge instructions to Lana directing her to immediately call if she experienced swelling or shortness of breath. However, Lana was swollen at the time of her discharge and never received these instructions. The hospital document containing these discharge

instructions is dated June 23, 2010 which is 3 days after Lana was discharged from the hospital.

On June 22, 2010, Lana and her mother took Rachel to the pediatrician's office, where Rachel was seen and being evaluated by the pediatrician, Dr. Kind. At that time Lana began to experience shortness of breath and difficulty breathing.

Dr. Kind called the hospital emergency department asking them to expect Lana. The emergency department advised that the adult emergency room was crowded and requested that Dr. Kind send Lana to the pediatric emergency room. As such, Lana was sent by Dr. Kind to the pediatric emergency room.

Lana arrived at the pediatric emergency room at municipal hospital on June 22, 2010 at 11:00 a.m.

The pediatric emergency room physician Dr. Evans, spoke with Dr. Heart. Dr. Heart told the emergency physician that Lana had preeclampsia.

Lana was not admitted to the hospital until 5:00 p.m. The intention was to admit her to the intensive care unit (ICU), but unfortunately, the intensive care unit (ICU) was filled and there was not a bed available.

Dr. Evans, the emergency room attending physician assessed Lana as experiencing pulmonary edema due to preeclampsia.

The record reflects that on admission to the hospital at 5:00 p.m. that Lana had a low blood oxygen level and a very low hematocrit of 16 reflecting severe anemia. The plan was to support Lana's breathing and oxygenation with intubation and ventilation. The plan also was to monitor Lana's fluids and if necessary to give medication to support her blood pressure. The plan also was to transfuse packed red blood cells to increase the red blood cell volume and thereby improve the oxygen carrying capacity of the blood. A red blood cell transfusion was ordered at 5:00 p.m.

The record, however, does not contain any monitoring information between 5:00 p.m. and 1:06 a.m. (8+ hours). The record reflects that at 1:06 a.m. Lana was "suddenly" noticed to be experiencing a cardiac arrest prompting a resuscitation code.

The record reflects that a code team responded initiating CPR for the next 60 minutes during which time they were able to obtain only a feeble pulse rate of 2 to 5 beats-per-minute. At 2:06 a.m. Lana was pronounced dead.

The record reflects that the red blood cell transfusion ordered at 5:00 p.m. was not started until 1:42 a.m. which is 36 minutes after her cardiac arrest.

There is no documentation of what Lana's blood pressures were between 5:00 p.m. on 6/22/10 and 1:06 a.m. on 6/23/10. Though fluid management was ordered, there is no documentation what fluids or blood pressure supportive medication was given during this time frame.

The autopsy report listed the cause of death as a cardiac arrest due to anemia and pulmonary edema caused by preeclampsia.