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Case No. 21 - Trauma in Pregnancy

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CASE NO. 21

TRAUMA IN PREGNANCY

NARRATIVE

Cora, a 30 year old G_3 P_2 at 39 weeks gestation was brought to the emergency room via ambulance following a head on collision with deployment of front airbags. She was semi-conscious and confused. She was immediately brought for CT of the head - preliminarily read as negative. Initial VSs 120/70, P 82 within normal limit. The Emergency Department attending noted some facial lacerations and bruising and some mild abdominal and back pain. There was no apparent leakage of fluid or vaginal bleeding. IV D_5 RL was started at 3:00 p.m. and labs drawn at that time were reported at 3:45 p.m. as H/H 12/36, platelets 204k. There was an order to crossmatch two units of blood.

At 3:30 p.m. attending on call obstetrician, Dr. Jones saw the patient. Portable U.S. was done, revealing a single vertex, anterior placenta, adequate fluid, and positive fetal movement. At 3:35 p.m. a fetal heart monitor was placed and Cora remained in emergency room #201. At 3:40 p.m. the fetal tracing was reassuring with a baseline of 140 bpm and moderate variability with accelerations and rare contractions.

Dr. Jones, the obstetrical attending, then left the hospital without discussing with the emergency department attending, any management plan. No management plan is documented in the record.

Thereafter, starting at 4:30 p.m. the fetal monitoring tracing that had previously been "normal" and reassuring began to reveal uterine activity consistent with a developing placental abruption along with decreased fetal heart variability and shallow late decelerations. A nursing note at 6:30 p.m. documented normal maternal VSs, B.P. 125/75, P 80. There was no documentation with regard to the aforesaid non-reassuring fetal heart tracing as E.R. nurses were not qualified to interpret the tracing and the nurse did not ask for help. At 7:00 p.m. the E.R. nurse documented a P of 90. At 7:30 p.m. a P of 100 with a B.P. of 100/60 is documented. The fetal heart tracing by 7:30 p.m. revealed even more uterine activity consistent with abruption progression and revealed even more obvious late FHR decelerations with minimal variability.

It is at 7:30 p.m. that the E.R. nurse first notified the

emergency department attending of what was to the nurse alarming maternal VSs. (Elevated heart rate and low B.P.). The E.R. attending immediately transferred Cora to the operating room. No obstetrician was available. A neurosurgeon at 7:45 p.m. agreed to perform a cesarean delivery. At 7:45 p.m. the maternal VSs were then B.P. 90/50, P 115 and there was active vaginal bleeding. Cora was non-responsive since 7:30 p.m. Blood previously typed and crossmatched was ordered and administered starting at 8:00 p.m.

The STAT emergency cesarean was under a general anesthesia. The newborn, Mary, was delivered at 8:05 p.m. She had APGARs of 1-2-5-8. A newborn resuscitation team responded to the O.R. At birth they intubated and then oxygenated and ventilated Mary. The U-A cord blood gas had a PH of 6.9 and a base deficit of -18. Mary was transferred to a NICU. Mary was stabilized in the NICU. Mary's neonatal course which included seizures was diagnosed as neonatal encephalopathy. Neonatal head U-S and then MRI confirmed a pattern of hypoxic-ischemic encephalopathy (HIE).

Cora was stabilized and recovered. Mary is disabled from HIE.

These details bring to mind questions that responsible providers and risk managers can ask with regard to their institution.