CASE OF ABRUPTIO-PLACENTA WITH SEVERE SEPSIS

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- Name of the patient : xxxx
  Age : 25yrs
  Husband Name : xxxx
  R/O : Nalgonda
  Occupation : Home maker
  Husband occupation : Electrician
  Socio Economic Status : Lower middle class
  Date of admission : 05/06/2014
- A 25 year old female , primigravida with 9 months of amenorrhoea came with c/o pain abdomen since 4hrs and bleeding per vagina since one hour.
- She was able to perceive foetal movements well.

History of present illness:

- H/O pain in the lower abdomen, since 4hrs , radiating to medial side of thighs, intermittent in nature and of moderate intensity.
- H/O bleeding per vagina since 1hr,soakage of 2-3 pads,no h/o passage of clots.
- H/o bilateral pedal edema since fifth month of gestation, initially restricted to ankle & gradually progressed to knee & then generalized edema

Contd..

- She was diagnosed as Pregnancy Induced Hypertension at seventh month of gestation, was on Tab. Methlydopa 250mg/TID, took the medication for about 15 to 20 days and then stopped by herself
- No h/o headache.
- No h/o epigastric pain.
- No h/o blurring of vision.

Menstrual history:

- Last menstrual period - 26.08.2013
- Expected date of delivery- 02.06.2014
- Period of amenorrhoea- 40weeks 3days
- Age of menarche -11 yrs
- Duration of menstrual cycle- 4 to 5 days
- Interval in days- 25 to 30 days, regular cycles

Obstetric history:

- ML-4yrs & non-consanguinous.
- She conceived after 3yrs of marital life.
- She had 4 antenatal checkups at Nalgonda private Hospital.
- First Trimester : uneventful.
- Second trimester : she felt quickening at 5thmonth.
  -developed bilateral pedal edema at 5th month.
  -was immunized with two doses of Tetanus toxoid at 4th month and 7th month.
- Third trimester: was diagnosed as PIH at 7th month ,used antihypertensive(tab.methyldopa 250mg tid) for 15 to 20 days and then stopped.

- **Past history:**
- No H/o HTN/DM/TB/Asthma/Epilepsy/heart disease/thyroid disease
- No H/o surgeries or blood transfusion in the past
- **Family history:**
- Not significant
- **Personal history:**
- No h/o smoking or consumption of alcohol.
- No h/o contraception.
- **Diet**: mixed.
- Bowel & bladder movements –regular
- Sleep: adequate
- Appetite: normal

Drug history:

- No h/o drug allergy.

• General examination:

- Patient is conscious,coherent &cooperative.
- Obese ,well built& moderately nourished.
- Height-156 cm
- Weight-110 kg
- No pallor, icterus, cyanosis ,clubbing.
- No generalized lymphadenopathy.
- Bilateral pedal edema present .
- Edema present over anterior abdominal wall, upper extremities, over the face .

- **CNS:**no focal neurological deficit.
- Breasts –normal.
- Spine-normal.
- Thyroid-no enlargement.
- Afebrile.
- Pulse-96bpm,good volume &regular.
- Blood pressure-150/110mmHg,right arm supine position
- **CVS**-S1, S2 heard;no murmurs.
- Resp system – bilateral air entry present, normal vesicular breath sounds heard all over the lung fields.

Per Abdominal Examination:

- **<u>Inspection:</u>**
- Abdominal wall edema present.
  - -umbilicus is centrally placed & stretched.
  - -lineanigra present.
  - -striagravidarum present.
  - -skin over the abdomen is healthy.
  - -no engorged veins.
  - -hernia orifices free.

- **<u>Palpation:</u>**
- Height of the uterus corresponding to term gestation.
- ***Fundal grip***:
- Soft broad irregular immobile part occupying the fundus probably breech.
- ***Lateral or umbilical grip***:
- Smooth curved hard structure palpable on left side probably spine.
- Small knob like structures felt on the right side- limbs.
- Liquor adequate clinically.

- **First pelvic grip:** hard globular smooth mass felt - cephalic presentation.
- **Second pelvic grip**: head is fixed(3/5th palpable)
- **Percusssion** : fluid thrill present.
- **Auscultation:** FHS-present on left side at the left spinoumbilical line
  -152 bpm and regular
- **Per vagina:** cervix soft & mid position
  -Os 4-5 cm dilated
  -70-80% effaced
  -PP Vertex high up
  -bleeding through os present

- **Pelvis** –sacral promontory not with in reach.

  -sacrum well curved

  -ISD <average

  -sidewalls convergent

  -outlet in-adequate

- **Provisional diagnosis** : Primigravida with 40 weeks of gestation with pregnancy induced hypertension with abruptio-placenta with Cephalopelvic disproportion in labour.

Management:

- **<u>Investigations:</u>**
- Blood group- o positive.
- Hemoglobin - 13.6gm%
- TLC-12400/cu.mm
- Platelet count- 50000 cells/cu.mm
- Bleeding time & clotting time- WNL.
- Random blood sugar- 83 mg/dl.
- Hematocrit-35%
- Complete urine examination-albumin ++
- HIV- Non reactive.
- HbsAg- Non reactive.
- VDRL- Non reactive.

Investigations contd…

- **Liver function tests**: Total Bilirubin-1.5mg/dl (0.2-1mg/dl)
  -Direct bilirubin-0.27mg/dl (up to 0.3mg/dl)
  -SGOT-24 IU/L (up to 37 IU/L)
  -SGPT-29 IU/L (up to 40 IU/L)
  -Albumin-3.1mg/dl(decreased)
  -A:G ratio-0.9
- **Renal function tests:** urea-20mg/dl (10-40mg/dl)
  -creatinine-0.8mg/dl (0.6-1.5mg/dl))
  -uricacid-7.3mg/dl(2.4-5.7mg/dl)
- Lactate dehydrogenase-431 IU/L (230-460 IU/L)

- Prothrombin time -16 sec (10 – 16 sec)
- Activated partial thromboplastin time- 31 sec (24-33sec)
- INR- 1.1
- Final Diagnosis:Primigravida with 40weeks of gestational age with preeclampsia ,abruptio-placenta, cephalopelvic disproportion with fetal distress in labour
- High risk explained to the patient & the attenders,consent taken & the patient was prepared for emergency lscs

- **The patient was taken up for emergency LSCS under general anaesthesia.**
- **Intraoperative findings**: 1)abdominal wall was thick edematous with abdominal fat thickness of about 15cm.
- 2)free fluid of about 500ml was present.
- 3)lower segment was not well formed.
- 4)placental abruption present.
- 5)retroplacental clots (350ml) present.
- 6)liquor was blood stained.
- 7)delivered a live female baby of weight 3.75kg with APGAR 8 & 10 at 5.11 pm on 05-06-2014.Baby cried immediately after birth, was in NICU for observation for few hours & than shifted to mother side.

- Intra operative systolic blood pressure was 160 to 190mmHg& diastolic blood pressure of 90 to 110mmHg.
- The patient was put on elective ventilation(SIMV Mode)as there were no adequate spontaneous respiratory efforts & then patient was shifted to post operative ward.

- **Vitals in the postoperative ward**:
- Patient was conscious and afebrile.
- PR-96 bpm.
- BP-180/110mmHg.
- CVS-S1 S2 heard.
- RS-bilateral basal crepts present.
- CNS-no FND.

- **The following treatment is given to the patient:**
- 1)IV Fluids-RL & DNS @ urine output +50ml/hr.
- 2)Inj.Piptaz 4.5gm iv bd.
- 3)Inj.metrogyl 100ml iv tid.
- 4)Inj.Linezolid 600mg iv bd.
- 5)Inj.Pantop 40mg iv od.
- 6)Inj.Labetalol 50 mg infusion @ 8ml/hr.
- 7)Inj.Lasix 40mg iv bd.
- 8)Inj.Hydrocortisone 100mg iv od.
- 9)Inj.Buprenorphine iv stat.
- 10)Head end elevation.
- 11)Thorough suction of ET tube hrly.

The following investigations were done: at 7pm on **05-06-2014** **(POD – 0).**

- Hb% - 7 gm%.
- TLC-18000 cu/mm
- Platelet count : 50000
- RFT – WNL
- ABG – Ph- 7.23
- Pco2 -49
- Po2 – 135
- Hco3- 23
- O2 sat – 98.4

- Physician opinion was taken:

: advised for spot urine protein ,creatinine ratio,PT,APTT

Values - urine protein 18mg/dl.

- urine creatinine 15.6

- ratio 1.1

-PT – 18sec and APTT – 38 sec

-INR 1.3

- One unit Fresh frozen plasma & one unit platelet rich plasma transfused

- 1)she was afebrile till 2AM and then there was rise in temperature of 102 ^{0}F.
- 2) pulse rate was gradually increasing and reached 140 bpm by 4am.
- 3) blood pressure was contiously high around 180/110 mmhg increasing upto 190/120 mmhg.
- 4)Patient had bilateral basal crepts

- Anaesthesiologist opinion was taken at 4am on 06-06-2014.
- Inj NTG @5mg/kg/min @ 40 drops/min was started & then her blood pressure gradually decreased to 150/100mmHg
- Inj.PCM IM stat & cold tepid sponging done
- Vitals monitored hrly

POD-1[06-06-2014]

- Patient was on ventilator (SIMV mode) and conscious
- **Vitals:** temp-101 F
- Pulse rate-102bpm
- Blood pressure-150/90mmHg
- CVS-S1,S2 heard
- RS-bilateral basal crepts present

- **Per Abdomen**-soft,Bowel sounds-absent
- Input-1250ml
- Urine output-1800ml
- Per vagina –no active bleeding

- **Investigations**:
- Hb-7gm%
- TLC-20000/cumm
- Platelet count-90000
- PT-18 sec
- APTT-38sec
- INR-1.3
- CUE- 15-20 pus cells

- **ABG** -Ph-7.5
- -Pco2-25 mmHg
- -Po2-220mmHg
- -HCo3-19.3
- -o2 sat-99.9
- -(Respiratory alkalosis)
- -RFT-Normal

- **Treatment**:1)NBM
- 2)IV Fluids-RL and DNS @ 75ml/hr
- 3)same antibiotics continued
- 4)inj.Labetalol 20 mg IV od
- 5)1 unit packed cell transfusion
- At 12 noon, the patient suddenly developed tachypnea(RR-35-40) and abdominal distension

- Vitals : -afebrile
- -PR-140bpm
- -BP-170/100mmHg
- -RR-36/min
- -CVS-s1 s2 heard
- -RS- Bilateral crepitations present
- -Per abdomen-distension present (AG-122 cm)
- -uterus well retracted

- Immediately opinions of Anaesthetist,Physician,Emergency medicine and General Surgeon taken and following investigations were done
- 1)X-ray chest-bilateral pulmonary edema
- 2)2D-Echo-normal LV & RV function
- 3)USG-Abdomen-no collection in POD & Morrisons pouch,uterus-involutary phase,E/O dilated bowel loops
- 4)ECG-sinus tachycardia

- 5)CBP- Hb-8.2gm%
- -TLC-25000
- -platelet count-1.2 lacs
- -PCV-31.3%
- 6)-PT-41 sec
- 7)-INR-3
- 8)-APTT-58 sec
- 9) - RFT-normal
- 10)-LFT-normal
- 11) -RBS-NORMAL

- ABG: -Ph-7.5
- -PCo2-59mHg
- -PO2-199mmHg
- -HCo3-28.1
- -(respiratory alkalosis)

- **The following treatment** was given:
- -Inj.Lasix 40mg iv stat
- -ET tube blockage noticed ,changed & tip sent for C/S
- -Right Internal jugular vein cannulated using seldinger's technique,CVP measured (6 cm of H2O)
- -patient is paralysed & connected to mechanical ventilator (CMV Mode)
- Head end elevation
- Inj.Atracurium 25mg iv stat & NTG drip continued

- -4 units FFP transfused
- 2 Dulcolax suppositories kept per rectum as advised by the surgeon
- Vitals, abdominal girth & urine output monitored hrly
- Regular suctioning of ET tube done
- 4PM: vitals:-temp-100 F
- -PR-122 bpm
- -BP-180/100mmHg
- -RR-22/min

- CVS-NAD
- RS-bilateral basal crepts present
- Per abdomen-ditension present(AG-120cm)
- Muscle relaxant & NTG stopped
- Inj.Labetalol 20mg iv stat & SOS
- Tab.Amlodipine 10mg od {through RT}
- Rest same treatment continued

- -8pm:vitals:Temp-100 F
- -PR-110 bpm
- -BP-140/80mmHg
- -RR-20/min
- -Per Abdomen-distension gradually decreased
- -Abdominal girth decreased from 122cm to 110cm
- -urine output was 25-30ml/hr
- -central venous pressure 14cm of H2O

- **Investigations:** Hb-7.3gm%
- -TLC-18000
- -platelet count-1.2 lacs
- -PT-18sec
- -INR-1.3
- -APTT-38sec
- -RFT-normal
- -LFT-Total bilirubin-1.34mg/dl
- -rest-normal

- **-ABG** -Ph-7.46
- -Pco2-35mmHg
- -Po2-155mmHg
- -HCO3-24.5
- -o2 sat-98%

POD-2(07-06-2014):

- Patient was on mechanical ventilation and conscious
- **Vitals:** -Temp-100 F
- -PR-76bpm
- -bp 140/90mmhg
- - cvs- S1 S2 +
- - RS – b/l wheeze + , RR 18/min
- -CVP 18cm H2O

- **Per abdomen** – no distension,uterus well retracted
- Abdominal girth – 105cm.
- Spo2 – 100%.

- **Investigations:**
- Hb%- 7.8gm%
- TLC – 18000
- -platelet count-1 lac
- -PT-19 sec
- -INR-1.4
- -APTT-38 sec
- -RFT-normal
- Lft – total bilirubin – 1.34
- Serum albumin – 2.9 gm%
- Haematocrit – 25%

- **Abg –**
- Ph- 7.54
- Pco2 – 38mmhg
- Po2 -152 mmhg
- Hco3- 32.4
- o2 sat-99.6%

Treatment:

- NBM
- IVF-RL & DNS @ 50ml/hr
- Antibiotics
- Tab. Diamox 0.25gm /od as advised by the anaesthesiologist.
- Tab. Amlodipine 10mg /od
- Inj. Lasix 40mg /iv /od
- Inj. Labetolol/20mg/iv/sos
- Inj. Hydrocortisone/100mg/iv/tid
- Inj. Vit –k 1 amp/iv/0d
- Ini. Pantoprazole /40mg/iv/od

- Nebulization with duolin and mucomix/tid
- One unit packed cell transfusion
- Head end elevation 30^0
- Regular suctioning of et tube and oral cavity
- Chest physiotherapy and postion change/ 2^{nd} hrly.

08-06-2014(POD -3)

- Patient was on ventilator(CPAP MODE) and conscious.
- **Vitals:** -Temp-99 ^{0}F
- -PR-78bpm
- -Bp 130/90 mmhg
- - cvs- S1, S2 +
- - RS – wheeze + on rt side , RR 18/min
- -CVP 16cm H2O
- -Spo2 – 99%

- Input- 1500ml, output – 1950ml
- Per abdomen – no distension, uterus well retracted.
- p/v - no active bleeding.

- **Investigations:**
- Hb%- 8.3gm%
- TLC – 16500
- -platelet count-1 lac
- -PT-16 sec
- -INR-1.1
- -APTT-32 sec
- -RFT-normal
- -CUE: 5-6 pus cells.

- Lft – total bilirubin – 1.61mg/dl
- Direct bilirubin – 0.48 mg /dl
- Serum albumin – 2.9 gm%
- Pcv – 27%

- **Abg –**
- Ph- 7.34
- Pco2 – 39mmhg
- Po2 -205 mmhg
- Hco3- 33.2
- o2 sat-99.8%

- **Treatment** : ryles tube feeding started (water and milk) rest same continued.
- At 3pm **ABG** was repeated :
- Ph- 7.5
- Pco2 – 33mmhg
- Po2 -147 mmhg
- Hco3- 29.5
- o2 sat-99.6%

- Patient was put on T - piece trial @ 3:30pm.
- **Vitals:** -Temp-99 ^{0}F
- -PR-86 bpm
- -bp 140/90 mmhg
- - cvs- s1 s2 +
- - RS – wheeze + on rt side , RR 18/min
- -CVP 12cm H2O
- -Spo2 100%.

- **ABG** – repeated @ 5:30 pm .
- Ph- 7.52
- Pco2 – 30mmhg
- Po2 -159 mmhg
- Hco3- 23.8
- o2 sat-99.6%

- As the patient was maintaining on T–piece and abg are near to normal , the patient was extubated at 6:30 pm
- Patient was conscious coherent and co-operative
- Spontaneous breathing efforts were present

- Temp- 98.6 ^{0}F
- Pulse- 78 bpm
- BP- 140/90 mmhg
- CVS- S1 ,S2 +
- RR- 16/min
- SPo2 - 100%
- **TREATMENT:**
- O2 inhalation @ 6L/min
- Chest physiotherapy 2nd hrly
- Spirometry exercises
- Duolin nebulization 6th hrly.
- ET tube secretions and urine for C/S sent.

- After 3 -4 hrs of extubation ABG was repeated at 10 pm (08-06-2014)
- ABG at 10 pm :-Ph-7.5
- -PCo2-33
- -PO2-86
- -HCO3-24.2
- -BEB-2.6
- -BEecf-1.9
- -O2-sat-98

09-06-2104 (POD – 4)

- Patient conscious , spontaneous breathing efforts +
- Temp- 98.6 ^{0}F
- Pulse- 82 bpm
- BP- 130/90 mmhg
- CVS- S1 ,S2 +
- RS – BAE +
- RR- 16/min
- SPo2 - 100%.

- **Per abdomen** : no distension, uterus well retracted
- Bowel sounds +, flatus passed.
- p/v : no active bleeding
- cvp- 12cm of H_2O
- Input – 2500ml
- output – 2600ml

- **Investigations:**
- Hb%- 9.2 gm%
- TLC – 14300
- -platelet count-1.2lac
- -Pcv-29.4%
- -PT - 16
- -INR-1.1
- -APTT-32 sec
- -CUE 4-5 PUS CELLS
- LFT – NORMAL
- RFT- NORMAL

- **ABG-**
- Ph- 7.5
- Pco2 –34 mmhg
- Po2 -85 mmhg
- Hco3- 26.3
- o2 sat-98%
- BEB – 4.2.

- **TREATMENT :**
- Sips Of Water
- Soft Diet From 1 Pm
- IVF – RL , DNS @ 75ml/Hr
- Antibiotics
- Tab.Amlodipine 10mg/OD
- Inj: Lasix40mg/IV /OD
- Duolin And Budecort Nebulisation 6^{th} Hrly
- Chest Physiotherapy Hrly
- Spirometry Exercises
- Ambulation

- POD-5 [10-06-2014]
- 1)Regular diet was started
- 2)same antibiotics continued
- 3)Inj.Lasix stopped & Tab.Lasilactone was added
- 4)Tab.Amlodipine was stopped & Tab.stamlobeta BD started as advised by the physician
- 5)Foleys catheter was removed & the patient passed urine & stools
- 6)Spirometry exercises & chest physiotherapy 2 hrly

- ABG on 10-06-2014 [POD-5]:-Ph-7.4
- -PCO2-33mmHg
- -PO2-84mmHg
- -HCo3-30.3
- -BEB= 8.1
- -BEecf-=7.5
- -O2 sat=98

- The patient was shifted to post-natal ward on POD-6 [11-06-2014]
- Blood pressure gradually decreased to 130/90mmHg
- Suture removal was done on POD-11 & wound healed well
- Recent investigations:1]Hb-11.3gm%
- 2]TLC-13000/cumm
- 3]Platelet count-1.7 lakhs
- 4]PCV-34.8%
- 5]LFT,RFT,PT,APTT=WNL
- 6]CUE-normal

THANK YOU