OBSTETRIC EMERGENCIES

ERPM A MADE EASY

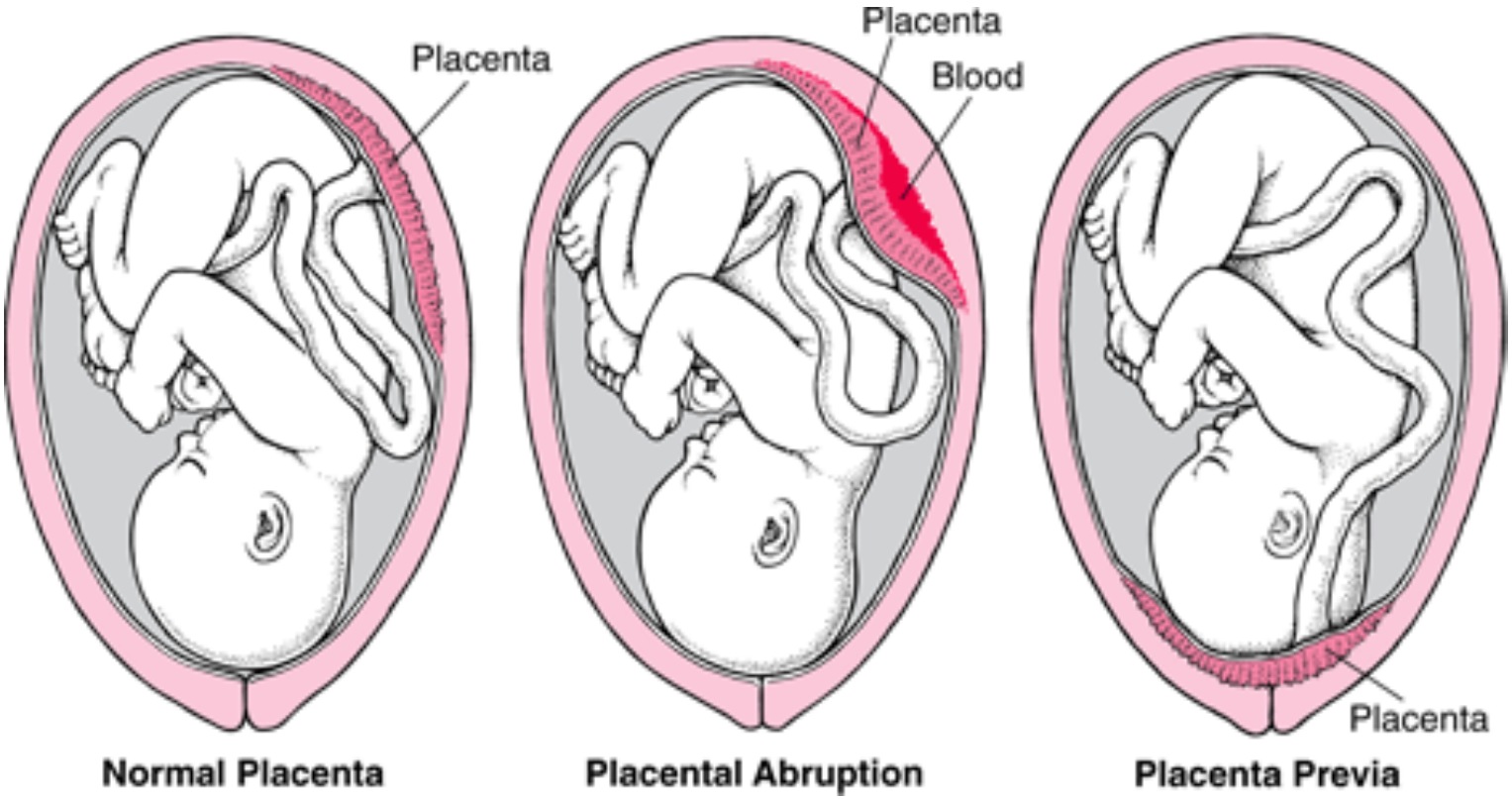
Ante partum Haemorrhage

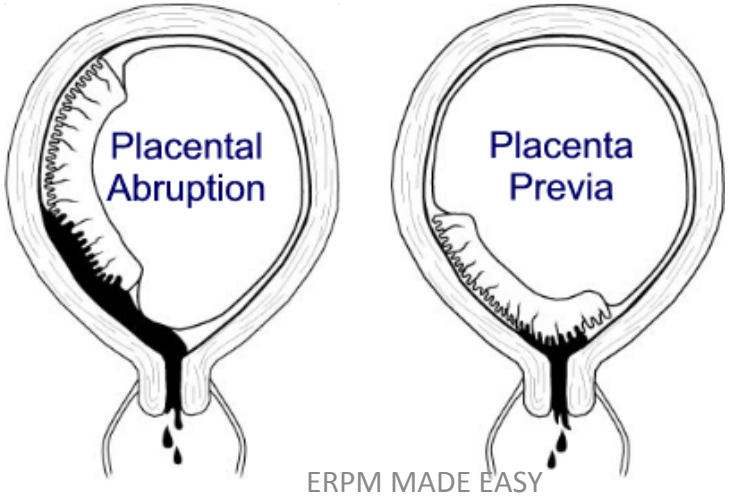
- Bleeding from the genital tract after 28 weeks of POA but before the birth of the baby

- Bleeding during 1st stage & 2nd stage of labor

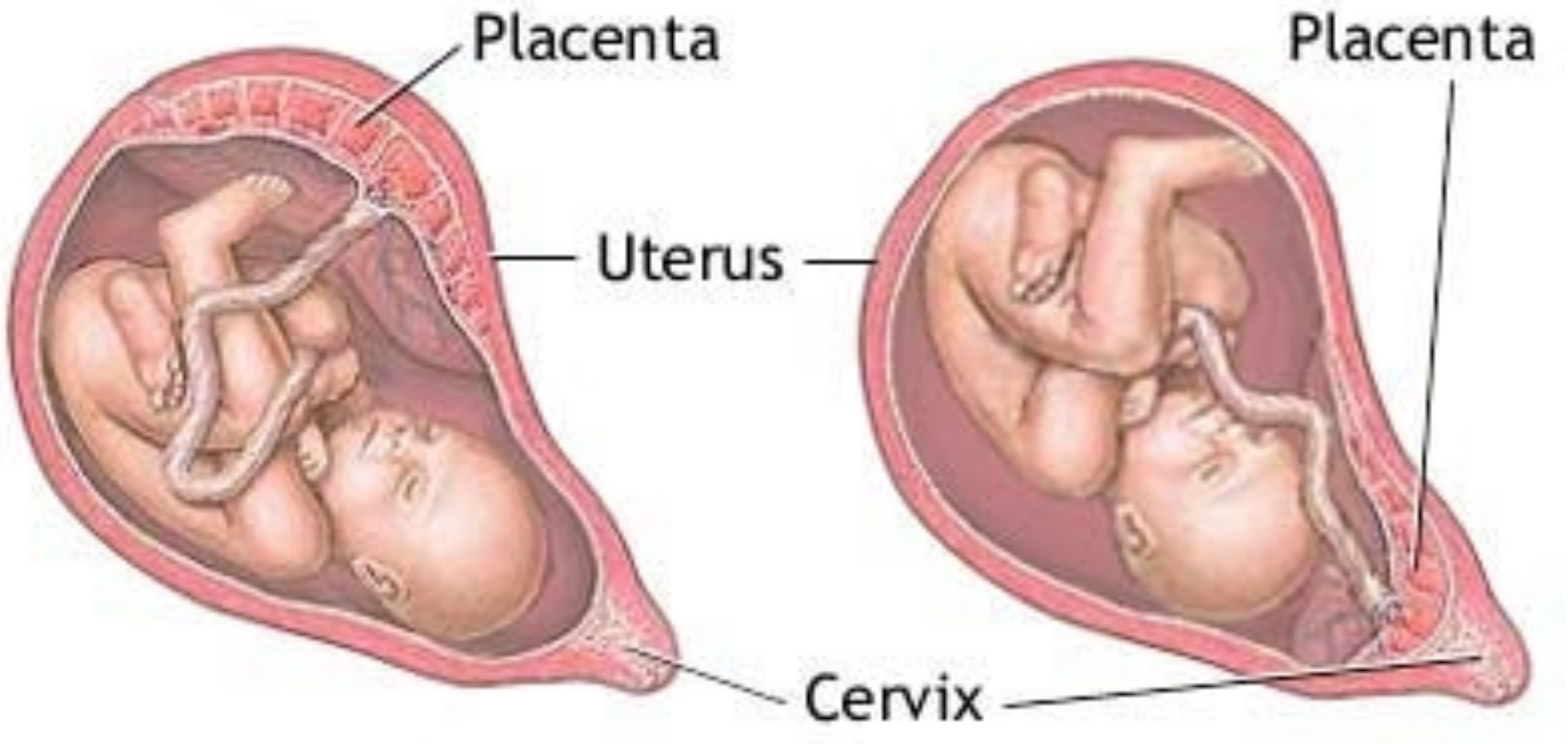
Causes

Placental Causes	Extra Placental Causes	Unexplained causes
1. Placental abruption	1. Cervicitis	1. Excluding placental and local causes
2. Placenta previa	2. Cervical ectropian	
3. Vasa previa	3. Cervical carcinoma	
	4. Local trauma	


Placenta
Placenta
Blood
Placenta
Normal Placenta
Placental Abruption
Placenta Previa


Placental Abruption
Placenta Previa

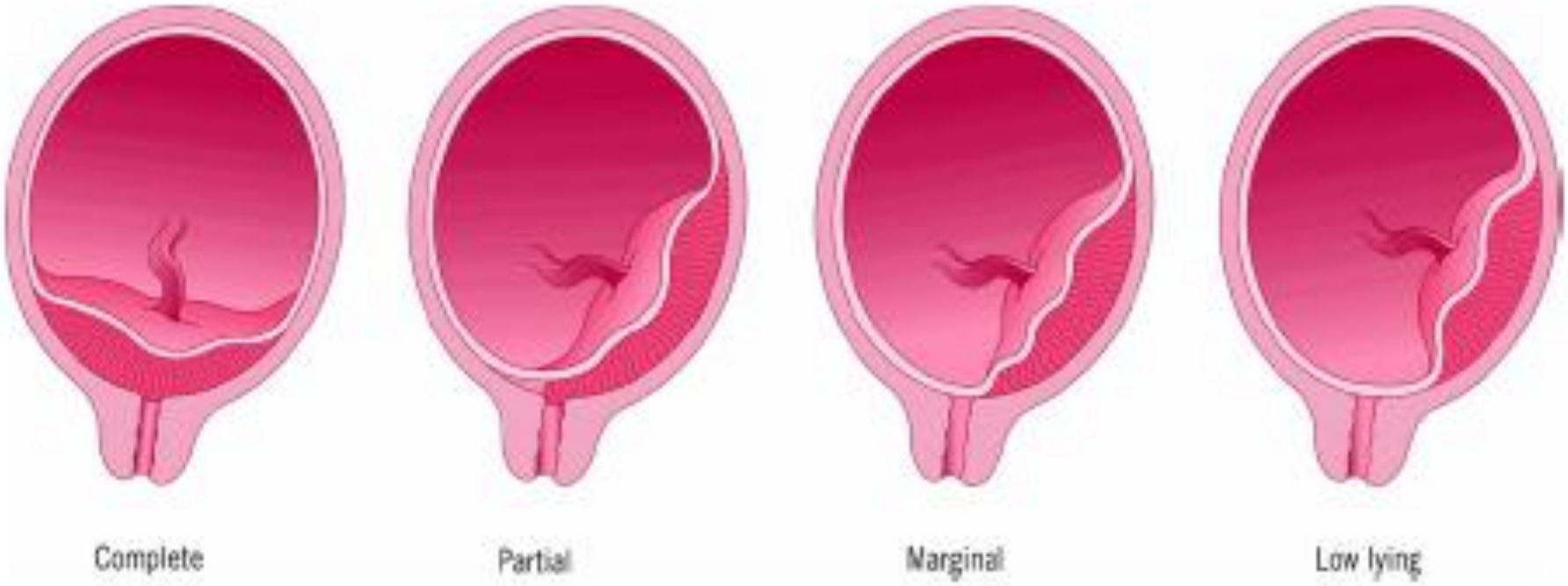
Placenta Previa

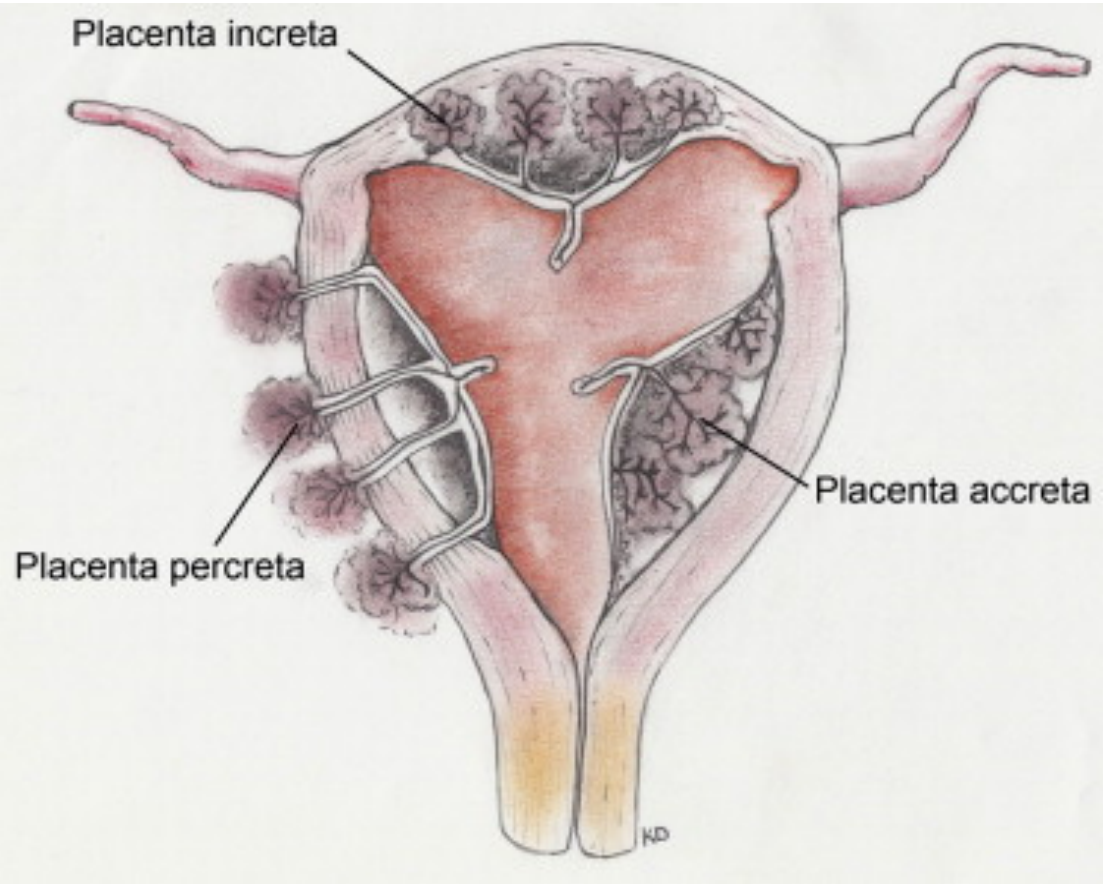


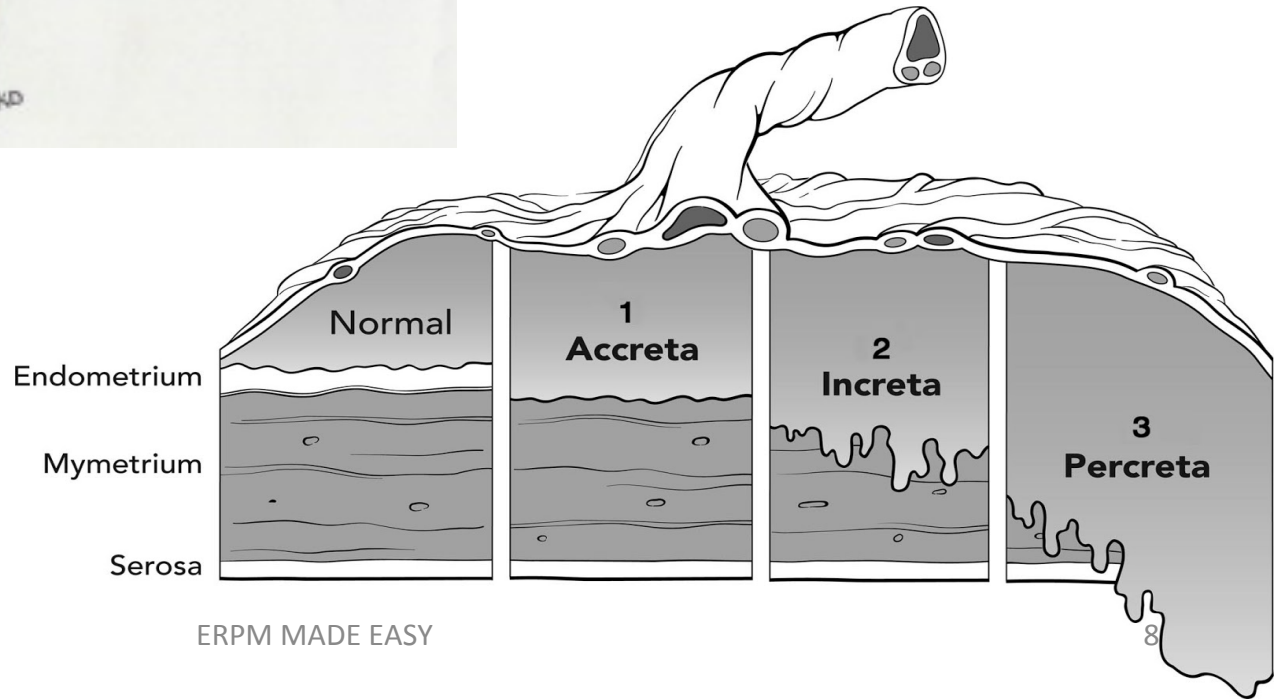
Grades of Placenta Praevia

Grade / Degree		Description	Mode of delivery
I		Low lying – placenta encroaching lower segment but not to os	NVD
II	A	Marginal – reaches margin of os – does not cover it - anteriorly	NVD
	B	Marginal – reaches margin of os – does not cover it - Posteriorly	EL - LSCS
III		Incomplete / partial central – covers internal os partially	EL - LSCS
IV		Central / total – completely covers internal os even fully dilated	EL - LSCS

Types

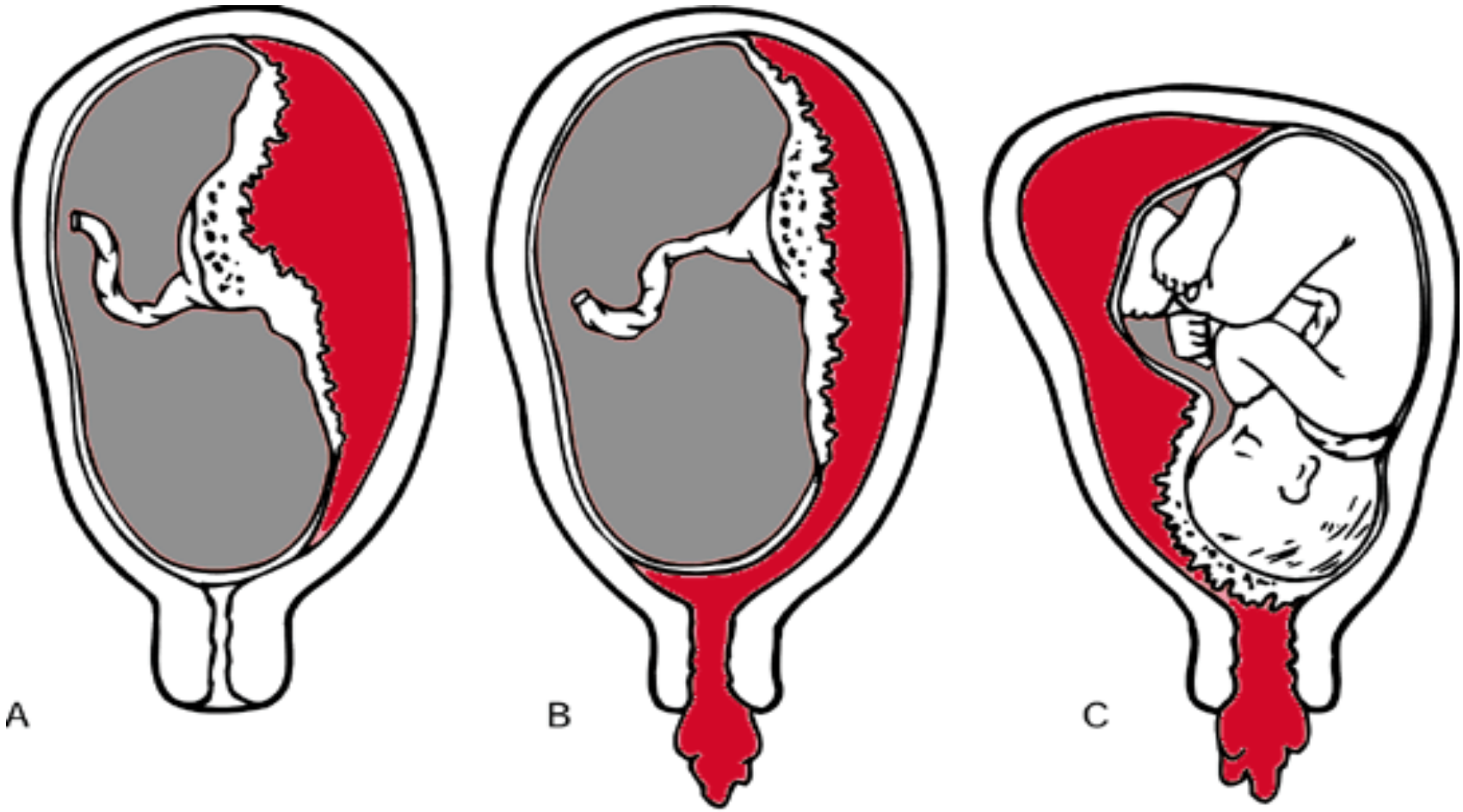



Placenta increta
Placenta accreta
Placenta percreta


Normal
1
Accreta
2
Increta
3
Percreta
Endometrium
Mymetrium
Serosa

	Placenta previa	Placental abruption
• **Bleeding-**	Painless, recurrent bleeding Always revealed	Painful, continuous bleeding Revealed / concealed
• **Uterus**	Soft & relaxed uterus	Tense, tender & rigid uterus Couvelaire uterus
• **Malpresentation**	Common	Uncommon
• **FHS**	Usually present	Absent Esp. in concealed type
• **Risk Factors**	1. Multiple pregnancy 2. Previous LSCS 3. Uterine structural anomaly 4. Assisted conception	1. Hypertension 2. Smoking 3. Trauma to abdomen 4. Poly hydramnios 5. IUGR
• **Harm**	More to mother	To both Fetal > mother

Placental Abruption



Management

- Resuscitation
- Confirm the diagnosis
- If placenta previa
  - Decide management depending on the grade
  - Bed rest, DVT prophylaxis, No vaginal examination
  - Grouping + DT – keep blood ready until delivery
  - Plan for timing of delivery depending on MOD
  - If EL LSCS – between 37 – 38 weeks
  - If Vaginal delivery – wait for SOL

- If placental abruption
  - Mother HD stable + fetus viable – EM LSCS
  - Mother HD unstable + fetus viable – Stabilize mother first – if fetus still viable – EM LSCS; if not allow for Vaginal Delivery
  - Mother HD stable + fetus non viable – vaginal delivery
  - Mother HD unstable + fetus non viable – Stabilize mother first – if hemostasis not achieved – EM LSCS

Vasa previa

- Fetal vessels traverse the fetal membranes over the internal cervical os
- Suspected when either spontaneous or artificial rupture of membranes is acompanied by painless fresh vaginal bleedingf from rupture of the fetal vessels
- Very high perinatal mortality
- If baby alive – EM- LSCS

Postpartum Haemorrhage

- **Primary PPH**:
  - Loss of >=500ml of blood following NVD or >= 100ml of blood following LSCS within first 24 hours

- **Secondary PPH**:
  - Loss of >= 500ml of blood following NVD or >= 100ml of blood following LSCS between 24 hours and 6 weeks post delivery

Risk Factors

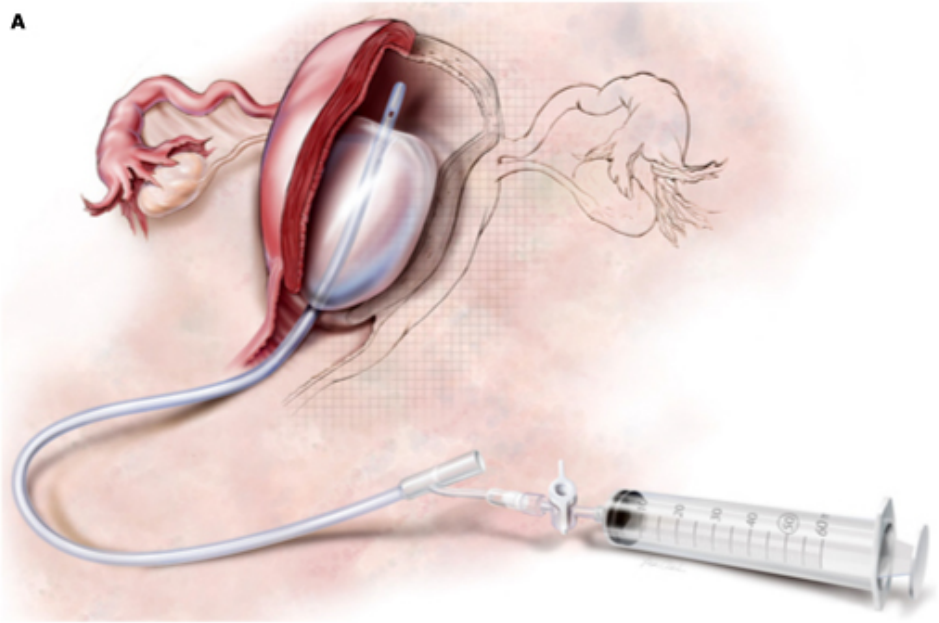
Maternal		Fetal
Pre existing	**Intra partum**	
• Raised maternal age	• Prolonged labor	• Large baby
• Primi	• Caesarean section	• Multiple pregnancy
• Grand multi	• Instrumental delivery	• Polyhydramnios
• Uterine fibroid	• Pyrexia in labor	• Shoulder dystocia
• Previous LSCS	• Episiotomy	
• Bleeding disorders		
• Obesity		
• APH		
• H/O PPH		

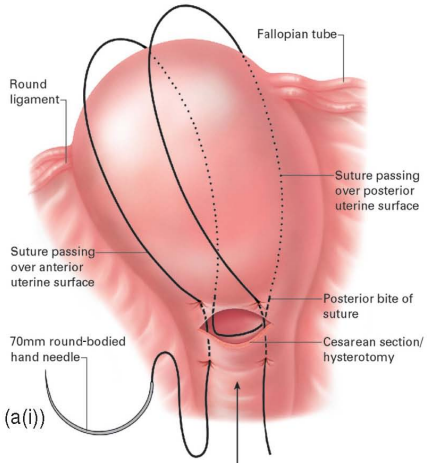
Causes

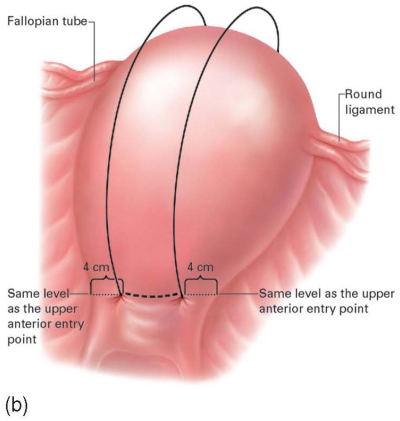
- **T – Tone**
- **T - Tissue**
- **T - Trauma**
- **T - Thrombin**

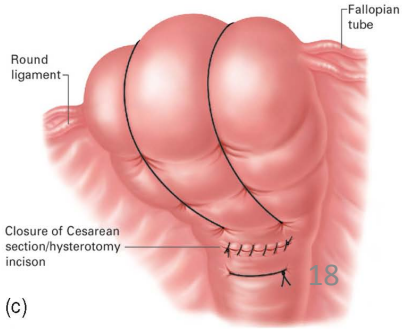
Management

Medical	Mechanical/Surgical
• Oxytocin	• Fundal massage
• Ergometrine	• Tamponade – External / Internal
• Syntometrine	• Systemic de-vascularisation
• Carboprost	• Arterial embolisation
• Misoprotol	• Hysterectomy

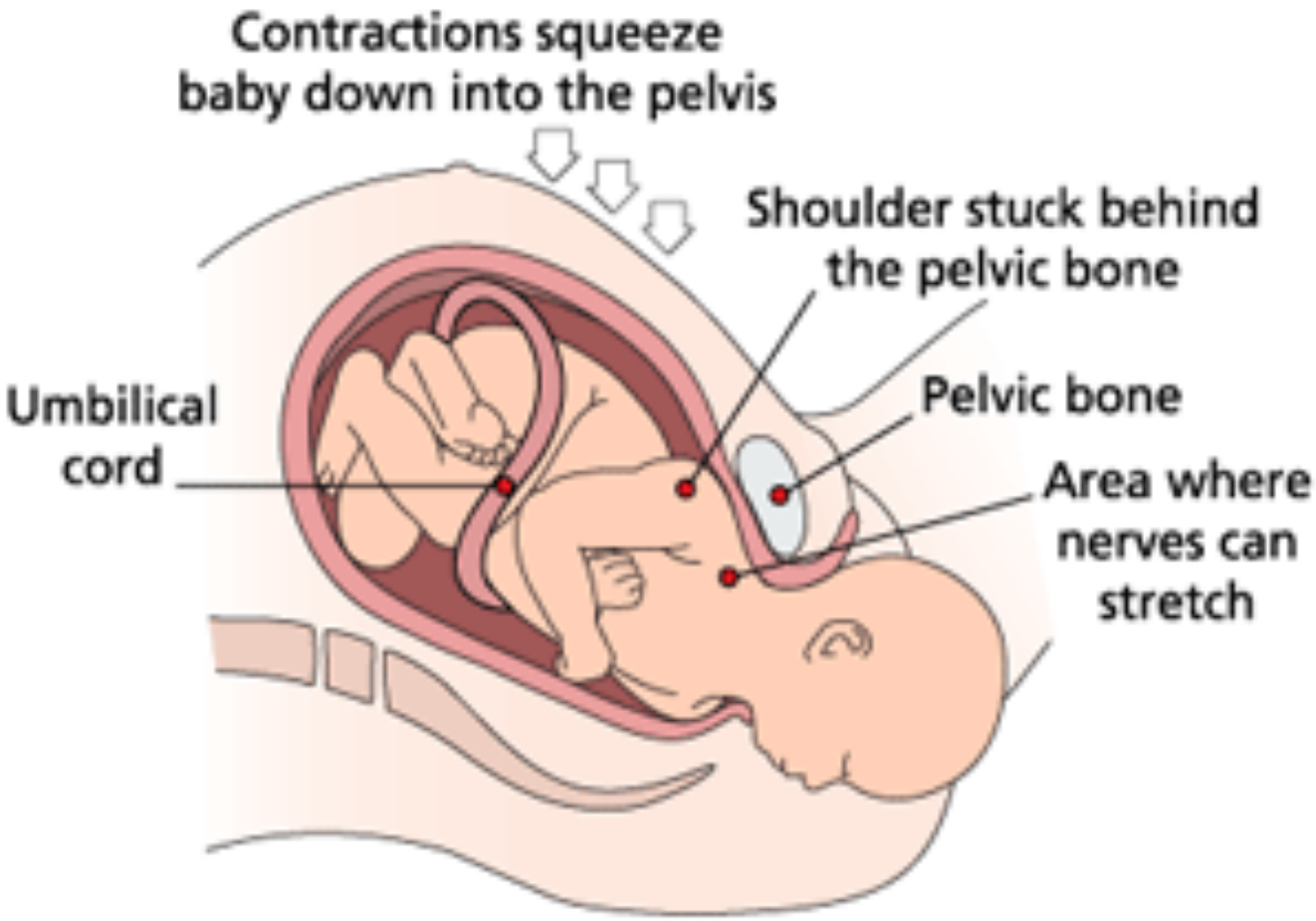








Shoulder Dystocia



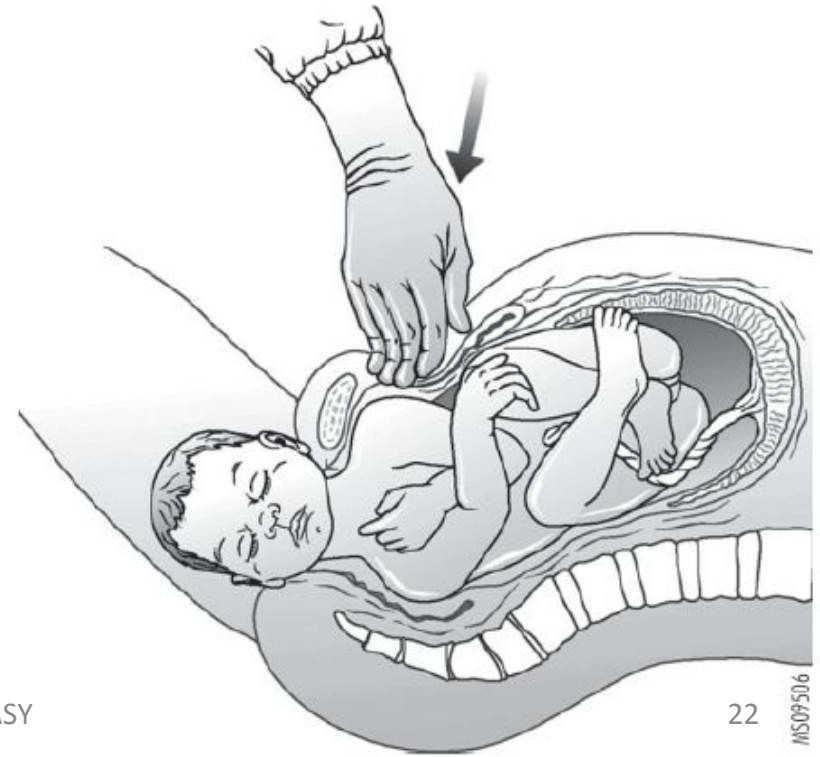
Risk factors

Maternal	Fetal	Intra partum
• DM	• Macrosomia	• Long 1st stage
• Short stature	• Post maturity	• Long 2nd stage
• H/O Shoulder dystocia		• Instrumental delivery
• Obesity		• IOL
		• Use of oxytocin

Management

- **H** : Help – call for help – you can't handle alone
- **E** : Episiotomy - !
- **L** : Legs
- **P** : Pressure
- **E** : Enter – to perform manouvers
- **R** : Remove posterior arm
- **R** : Roll (Gaskin manouver)

Figure. 2 Shoulder Dystocia and the Application of Suprapubic Pressure

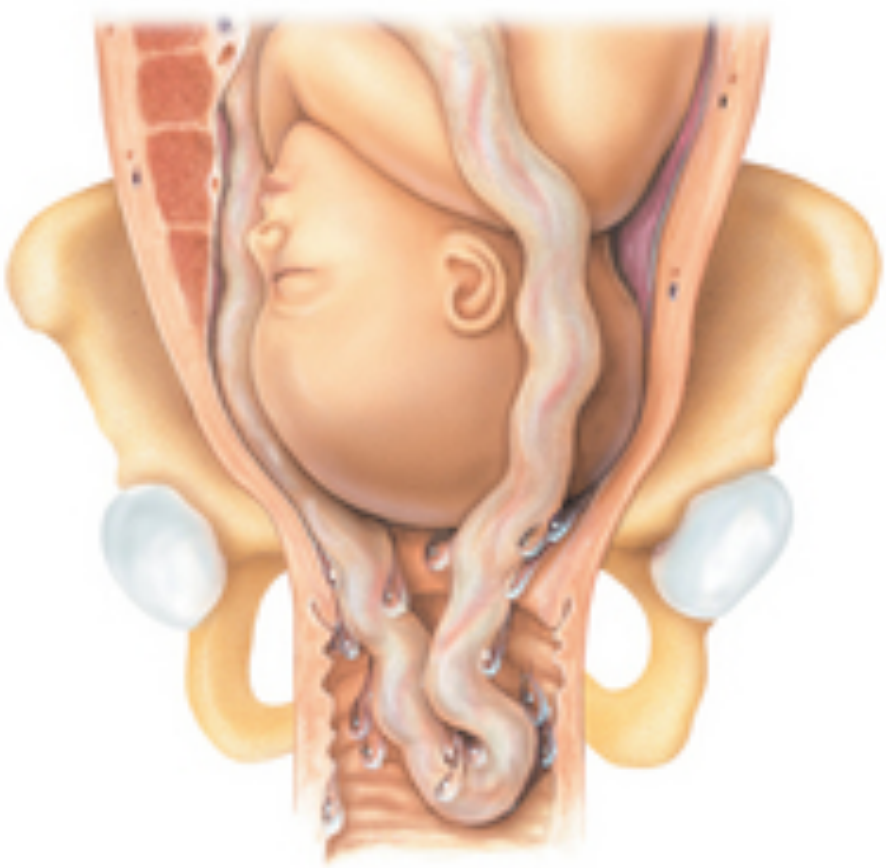


- Destructive procedures –

- Zavenelli procedure –

- Complications
  - Maternal genital tract trauma
  - Birth asphyxia
  - Trauma to the baby

CORD PROLAPSE



Causes		Management
Maternal	fetal	
1. Pelvic tumours	• Prematurity	Do not handle the cord too much
	• Malpresentation • Eg: Breech, Transverse	Cord outside – Wrap with swabs soaked in warm N/S
2. Narrow pelvis	• Multiple pregnancy	Oxygen via FM
	• Poly HA	ExaggaratedSim's / Knee chest position
	• P/Praevia	If VD possible – DO IT
	• Large baby	If not EM – LSCS