**Scenario Pulmonary oedema and eclampsia**

Kit and equipment required:

Pregnant mannequin

Oxygen + mask

CTG

MEOWs and I/O chart

Drugs: Frusemide, Magnesium sulphate bolus and infusion, labetalol, nifedipine

Fluids: 1 L Hartmann’s

**Handover takes place between Rothschild MW and EMC/Obs Bay MW at 4:00 am**

P0

Type II DM, Obstetric cholestasis

28 year old, BMI 16, 31 weeks gestation.

Well till 31 weeks gestation – admitted with high blood pressure – required labetalol 400mg qds and nifedipine 20mg bd on the ward but blood pressure still high so registrar asked to be transferred to observation bay at 4:00am

Nifedipine last given at 00:00

Steroids x 2 given (last one at 13:00)

USS growth Normal. USS abdo – Normal liver and pancreas

Last doctors review was at 20:00

Noted Reflexes brisk, Clonus 1 beat

Bloods: Hb 97, WCC 11, Plts 199, Na 136, K+ 5.6, Urea 11, Creatinine 88, (AKI stage2), AlT 65

Consultant review on the ward - Keep NBM in case needs delivery next day. Prescribed slow bag fluids running. (Normal saline via Baxter pump 166mls/hour)

CTGs not meeting criteria but STV normal

|  |  |
| --- | --- |
| **Initial settings** |  |
| BP 160/105 | Findings of clinical examination: |
| HR 72bpm  RR 22 | Oedema +++ lower limbs  Headache +++ |
| Temp 37 |  |
| SaO2 90% on air | Nifedipine last given 4 hours ago |

Action expected:

Insert cannula, take bloods and observations.

Escalate sats to medical team as well as blood pressure – should think of pulmonary oedema and refer to input output chart

Oxygen – remains at 92% at 2 Litres so increased to 4L

Stop fluids. Query whether needs catheter.

I/O chart shows + fluid balance 1.5 litres. Decreased urine output <10mls/hour in the last 4 hours.

Medical team will advise further nifedipine and ABG. Will request CXR. Chest examination audible crackles.

ABG results if needed:

On 4L oxygen: pH 7.36, pC02 4.6 , P02 15.9 (low as on oxygen), BE -4.9, HCO3 21.1, lactate 1.5

**Blood pressure reduces to 150/90 once nifedipine is given**

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Patient goes on to have Mobile CXR

After X-ray patient starts feeling very unwell, headache +++ and abdominal pain.

**Settings: BP 170/110, HR 72, RR 18**

Correct action – escalate to medical team, request outreach support

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**Eclamptic fit (lasts 30s) (**can choose to do before arrival of medical team or with them there after they arrive for review)

**Settings: HR 140, BP 200/110, CTG poor trace**

Expected actions:

Emergency bell

Oxygen and support airway, (postictal, loud snoring, unable to tolerate jaw thrust, needs NP airway)

Magnesium (loading dose 4g) followed by slow iv bolus over 5-15 mins

Maintenance infusion 1g/hr for 24 hours

Iv labetalol

CXR returns – shows evidence of pulmonary oedema. – frusemide may be discussed here.

Bloods return: Hb 96, WCC 10, Plts 110, Creat 95, ALT 70

Medical team will have MDT discussion about stabilising patient and transferring to theatre for delivery.