

Near-Miss Cases: Case Series of Intensive Obstetric Care

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ABSTRACT

A near miss case is defined as a woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy. Reviewing near miss cases provides us the significant information about the delay. Overcoming the challenge, identification and management of near miss cases is complement to maternal health. Case: 1: G3A2 at 14 weeks with missed abortion with phaeochromocytoma. 2: G4P3L3 at 40 weeks 3 days with ruptured uterus with haemorrhagic shock with severe anemia 3: G3P1L0A1 at 35 weeks with history of uterine rupture and perforation. 4: Elderly primi at 37 weeks with HELLP syndrome. In near miss cases, if proper diagnosis is made and with immediate intervention and ICU care is provided, patient can be saved.

KEY WORDS: anemia, obstetrics near miss cases, perinatal, phaeochromocytoma

INTRODUCTION:

A near miss case is defined as a woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy^[1]. Overcoming the challenge, identification and management of near miss cases is complement to maternal health^[2].

CASE PRESENTATION:

CASE 1:

A 26 yr old G4P3L3 with rupture uterus in hemorrhagic shock with severe anemia with IUFD was referred with history of 9 months amenorrhoea. The findings were as follows: pulse- 130/min, hypovolumic thread, BP- 70/40 mmhg, catheter in situ – 20 ml high coloured, POG- 40 weeks, history of: previous 3 FTND, on examination: semiconscious, oriented with cold clammy, skin, general condition- poor, severe pallor, per abdomen- ut~ 28 wks, flanks full, uterine margins cannot make out, FHR- absent, local examination- swelling over vulva and per vagina- hot and dry vagina, os fully dilated,

Presenting part- 0 station, caput present, membrane absent.

MANAGEMENT:

Emergency exploratory laprotomy was done. Per operative- Anterior wall uterine rupture with left lower segment extending upto left broad ligament; Hemoperitoneum~3 litres; Still born child 3 kg; Bladder integrity maintained. Subtotal caesarian hysterectomy was done. 4 units PRBC, 1 unit whole blood, 4 units FFP given. Post operative: Patient discharged after 21 days.

CASE 2:

A 28 yrs G3P1L0A1 at 35 weeks with history of uterine rupture and perforation was attended. Obstetric history -First FT LSCS for obstructed labour with rupture uterus 8yrs back(still birth). Post-op period was uneventful. Second second trimester MTP done at 16 weeks with history of some instrumentation leading to perforation 7yrs back, managed conservatively. Now Patient at 35 weeks unbooked in labor. The findings were as follows: General examination: GC fair, Pulse 100bpm, normovolumic, regular, BP 120/80 mm Hg, Pallor present. Per abdomen: Abdominal scar was transverse, healthy, no puckering, Ut 32wks, relaxed, reduced liquor, no scar tenderness, FHS140bpm. Per speculum: Os patulous, no bleeding, no leaking. Per vagina: Os patulous, cervix uneffaced, head high up, no leak, no show.

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Figure 1: Anterior wall uterine rupture.



Figure 2: Rent present on fundus which was involving whole myometrial thickness (old perforation).

MANAGEMENT:

Emergency caesarean section was taken. Per operative--flimsy peritoneal adhesions were present.-well formed lower uterine segment.-Previous scar thinned out-delivered female baby of 2kg with Apgar score of 7 and 8, alive and healthy with mother.-placenta was adherent (accreta).

Uterus was exteriorized and there was incidental finding of 2.5×2.5 cm circular rent present on fundus which was involving whole myometrial

thickness (old perforation). Rent was repaired, uterus closed and tubal ligation done.

CASE 3:

A 20 yrs primigravida at 29 weeks with severe anemia, hepatitis, severe sepsis, multiorgan dysfunction syndrome. She complained of breathlessness 8-10 days yellow discoloration of eyes 10-12 days. The findings were as follows: On examination: conscious , oriented severe pallor ,

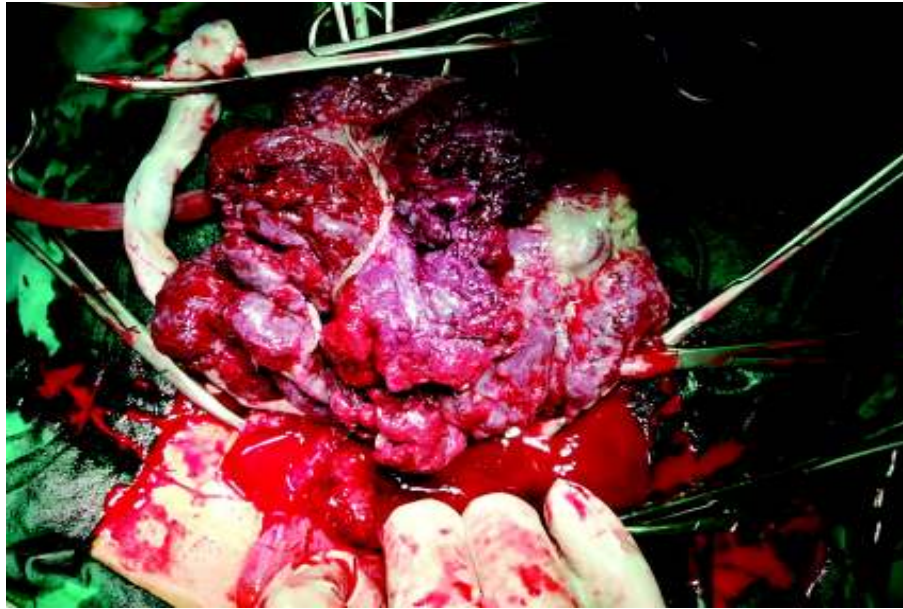


Figure 3: Adherent placenta (accreta).

INVESTIGATIONS:

Test	22-11-18	25-11-18	27-11-18
Hb	2.2	4.5	11.2
TLC, Platelet	87000, 2.9 lacs	35000, 180000	26000, 140000
APTT, PT, INR	37/35, 21/15, 1.4	36/35, 17/15, 1.1	
Serum protein/ Alb/Glob	7.55, 3.34, 4.21	6/3/3	
TB	5.02	3.3	
DB/IB	3.79/1.23	1.9/1.3	
SGOT/SGPT/ALP	106.5/48/292	26/39/166	
Sr Na+/Sr K+	141/5.63	145/2.76	134/3.83
BU/Creat	40.3/1.48	90/1.35	
HbsAg/ HCV/HbeAg	NR/NR/NR	NR/NR/NR	NR/NR/NR

icterus present, pedal oedema present, pulse- 104/ min and BP- 110/80 mm Hg, R/S chest clear. Per abdomen: ut~28 weeks, FHS present.

HOSPITAL COURSE:

Admitted in ICU in joint care with Medicine Department. Intubated and nor-adrenaline infusion was given. Extubated after 24 hrs, shifted on oxygen. After 24 hrs of admission, IUFD occurred. Induction and Preterm vaginal delivery interval was 7 hrs. Received 6 unit PRBCs. Got discharged after 7 days.

CASE 4:

G3A2 AT 14 weeks with missed abortion with phaeochromocytoma. She was admitted with 4 months amenorrhoea Palpitations, perspiration, epistaxis,

nausea and blood pressure of 200/110 mm Hg. Investigations: Her USG showed single intrauterine pregnancy of 14wks 3 days with absent fetal heart rate indicating missed abortion. The MRI scan of the abdomen showed a 5.1*4.8*6 cm³ T1Hyperintense T2 Hypointense enhancing mass arising from the right adrenal gland. 24-hour urinary Chromogranin A (203.3 ng/ml), Metanephrine (78.47 ug/g), Normetanephrine (10562.71ug/g) were elevated

MANAGEMENT:

She was started on prazosin (10 mg BD), Labetalol (100 mg TDS) and later propranolol (40mg BD). MTP was done by Prostaglandin (Dinoprostone gel and tab Misoprostol) administration. Induction abortion interval was 24 hours. Following adequate

control of her blood pressure, Right adrenalectomy was performed. Her BP normalized postoperatively and antihypertensive medications were continued. The 24-hour urinary catecholamines and metanephrines done three months later were normal.

DISCUSSION:

This study assessed the clinical spectrum of these patients in much depth. The term near-miss describes a serious adverse event whereby death did not occur either due to luck or prompt adequate management^[3]. Results of critically ill patients like with severe obstruction and its complications depends on various factors like prior health of patient, physiological stores, severity of disease and quality of care with adequacy^[4,5,8]. Severity affects risk of disease progression itself and quality of care like timely intervention, appropriateness and comprehensiveness. Since maternal deaths and near miss cases share similar features, they can be used to overcome obstacles and provide information regarding worsening of complications. Therefore, valuable information on obstetric care can be obtained through near miss cases. In present scenario with so much of antenatal supervision and modern facilities, still the labour in remote places are unattended and going into obstructed labour which leads to increasing operative intervention and increasing maternal and perinatal morbidity and mortality. Illegal abortions also lead to further obstetric complications in subsequent pregnancies^[6,7]. So, adequate screening, regular antenatal check-ups and timely management can reduce maternal and neonatal morbidity and mortality^[9].

CONCLUSION:

In near-miss cases, if proper diagnosis, immediate intervention and ICU care is provided, the patients can be saved.

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