LEARNING OBJECTIVES

Management of Maternal Collapse- ABCDE Approach
List differential diagnosis in obstetric patient
Be aware of acute management of AMI
Communication with SBAR

EQUIPMENT LIST

Noelle/ SimMom
Fluids / giving sets
Fake hand held notes
ODP grab bag
ECG/ downloaded image

Arrest trolley
GA drug box for T/F to theatre
IVC packs/Blood Bottles
Monitor for manikin

PERSONNEL

MINIMUM: 5
ROLES:
Obstetric Junior/Reg
Midwife
Anaesthetic Reg/Cons
Obstetric Consultant

FACULTY

MINIMUM: 3
Facilitator
Observer
Debrief Lead

TIME REQUIREMENTS
TOTAL 1.5hours

Set up: 30 mins
Pre Brief: 10 mins
Simulation: 15mins
Debrief: 30mins
INFORMATION TO CANDIDATE

PATIENT DETAILS

Name: Monika Lisowski  Phx: GORD
Age: 40  Allergies: Nil
Weight/BMI: 90kg/38  Smoker 30/day
  G5 P4  34 weeks / IUGR

SCENARIO BACKGROUND

Location: Triage
Situation: Monika has presented to triage with constant indigestion like chest pain for the past 2 hours but now feels unwell, dizzy and has vomited. She is found to be pale, hypotensive and tachycardic. The fetus has sustained a bradycardia of 90 that has not recovered yet.

Task: Attend the obstetric emergency call
Take hand over from the team
Manage the collapsed patient

RCOG CURRICULUM MAPPING

Module 10 Management of Labour:
  Manage Obstetric Collapse
  Liaise with other staff
Advanced Training Skills Module:
  Advanced Labour Ward Practice
INFORMATION FOR ROLEPLAYERS

BACKGROUND

Your name is Monika Lisowski. You are 40 years old. You are currently 34 weeks into your 5th pregnancy. You have previously had 4 normal deliveries, sadly your last child was delivered stillborn. This baby is being monitored with growth scans as it is small. You smoke over 30 cigarettes a day. You have known reflux disease and prior to this pregnancy you were taking lansoprazole. You have attended the hospital today as your usual indigestion is much worse. The pain has been constant for the past 2 hours. You feel it most in your central chest.

Whilst awaiting the doctor’s review you start to feel unwell, dizzy and you vomit. Eventually you collapse.

RESPONSES TO QUESTIONS

Initially can answer as above but then as you become more unwell you can only manage moaning noises until you become unresponsive.
INFORMATION TO FACILITATOR

SCENARIO DIRECTION

Assessment                                       STAGE 1
Cardiac arrest VF                                STAGE 2
Perimortem section                              STAGE 3

A:     Maintained
B:     AE equal fine bibasal inspiratory crepitations (See obs below)
C:     Pale
D:     Responds to voice pupils equal and reactive
E:     Mottled peripheries

Lying semi recumbent, fetal heart 70bpm
Wedge L lateral tilt
Establish ECG monitoring, BP, P, Sp02, RR
IV access and fluid bolus
Support BP (phenylepherine bolus)

Patient stops breathing and arrests

Interventions

VF
- Check patient confirm cardiac arrest start CPR 30:2
- Call for cardiac arrest team and consultants on call
- Confirm rhythm
- 2 minutes CPR (30:2) Airway maneuvers and Guedel,
- Connect defibrillation pads give 1st shock
- BVM assist respiration,
- Intubate, cricoid, ventilate (ETCO2)
- After 2 minutes reassess
- VF Give 2nd shock
- Continue CPR with uterine displacement
- Prepare for perimortem LSCS around 5 minutes
- Exclude likely reversible causes: 4Hs & 4 T’s
- After 2 minutes reassess
- VF give 3rd shock
- Perform Perimortem section
- Continue CPR 2 minutes
- Give adrenaline 1mg and amioderone 300mg
- After 2 minutes reassess
ROSC  Return of spontaneous circulation (RCOS) after perimortem section
STachy Check monitor and rhythm
Reassess ABCDE
Move to OT to complete section and stabilise

Stabilisation: Ventilation, inotropes, invasive monitoring
Post resuscitation investigations: =>
12 lead ECG shows anterior STEMI
bloods, bedside Echo
Urgent cardiology review? PCI/angiography

Critical care involvement: Obstetric / anaesthetic / critical care discussion of likely diagnosis

Transfer to ITU SBAR
End

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<th>SCENARIO OBSERVATIONS/ RESULTS</th>
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SCENARIO DEBRIEF

TOPICS TO DISCUSS

Management of cardiac arrest in an obstetric patient
Differences to non-obstetric adult
Uterine displacement

Review of ALS algorithm / RCOG version

Management of patient post arrest e.g. bloods, ECG, ITU, CTPA

Risk factors for ACS is pregnancy – same as non-pregnant

Management of ACS in pregnancy
atypical presentations,
Alternative pathology i.e. coronary artery dissection.

REFERENCES

Maternal Collapse in Pregnancy and the Puerperium, Green Top Guideline No.56 Jan 2011 RCOG Press