

Obs/Gynae Emergencies

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STI/PID

- ▶ PV discharge, offensive, LAP, menorrhagia
- ▶ Discharge details, Sexual history, cycle
- ▶ General exam and observations. If well-refer GUM clinic-no VE/treatment
- ▶ If fever, tachy, guarding=PID, refer gynae after IV, bloods, fluids, analgesia



Bleeding in early pregnancy

- ▶ Common-1 in 4 women will have had experienced a miscarriage, 15% of pregnancies result in miscarriage
- ▶ Remember it is emotionally damaging, be sympathetic
- ▶ Threatened/Inevitable/Incomplete/Complete +/-septic. Also missed



ПРЕГНАНСУ

Bleeding in early pregnancy

- ▶ ABCD and rapid IV fluids if heavy (++number of pads/clots/faints).
If shocked, speculum and product removal from os
- ▶ Check risk factors for ectopics (previous ectopic, PID, IUCD, infertility, infertility investigations, tubal surgery, IVF)
- ▶ Para, Gravida, Prev Hx, contraception, LMP, cycle, pain and bleeding amount, products?
- ▶ Examine abdomen for iliac fossa tenderness/guarding

Bleeding in early pregnancy

- ▶ GAU if little pain/bleeding + Bloods (only if time /space permits).
- ▶ Refer Gynae if risk factors, shocked, >moderate pain/ >moderate bleeding, specific iliac fossa tenderness, >14-16/40 refer to gynae
- ▶ >20/40 to delivery suite
- ▶ More pain, +/- less pv bleeding=?Ectopic



Antepartum haemorrhage

- ▶ Bleeding After 28/40
- ▶ Placenta previa (painless)
- ▶ placental abruption (pain++)
- ▶ Vasa praevia (painless)
- ▶ ABCD, IV fluids, refer obs/gynae, preferably in maternity if stable

Non-pregnancy Bleeding

see [NICE guidelines](#)

- ▶ Always check urine pregnancy test +/- ?Hb
- ▶ Rarely need admission (pouring with clots)
- ▶ Usually PID, or DUB, fibroids, trauma, bleeding problems, local causes (eg erosion)
- ▶ History/exam as for bleeding in pregnancy (clots, pain, previous, OCP, discharge, sexual history)
- ▶ Tranexamic acid/NSAIDs/Norethisterone
- ▶ GP f/u

Trauma in Pregnancy

- Early protection by pelvis, later uterus vulnerable to rupture. Pushes bowel up. Altered physiology. Placenta sensitive to catecholamines. Compression IVC.
- ALL pregnant patients (except trivial limb trauma) must be seen by O&G/midwives.



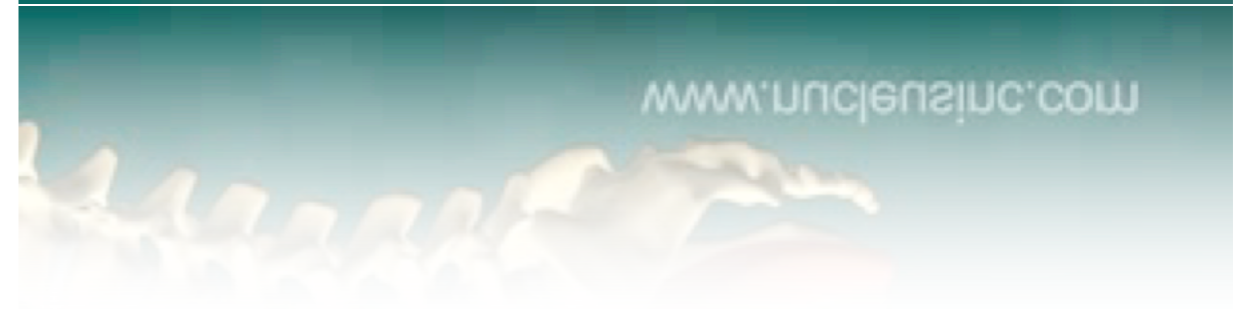
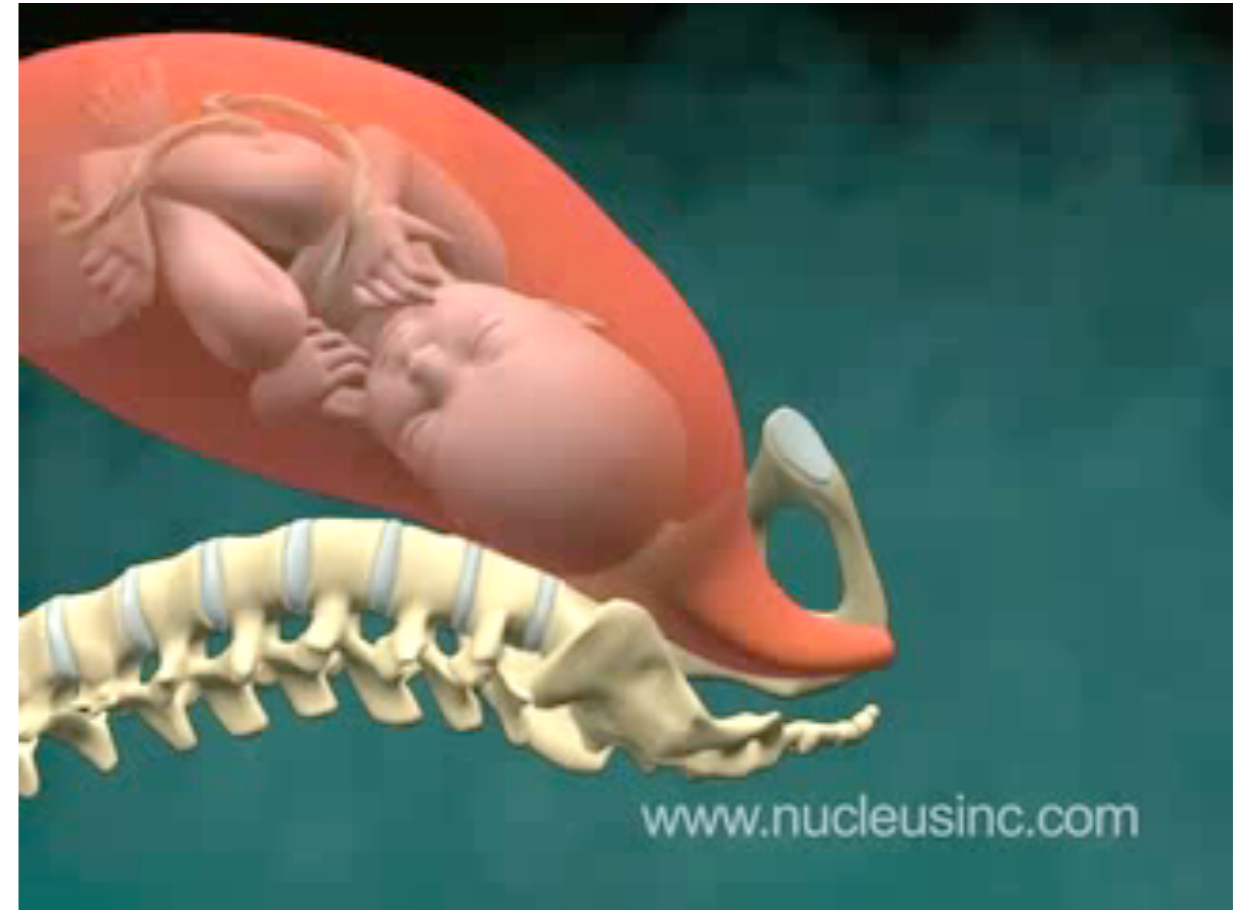
Eclampsia

- ▶ Extremes of age <20/>35
- ▶ Primups, multiple preg/molar, hydrops
- ▶ Consider in all fitting in women of child bearing age- always do pregnancy test
- ▶ After 20/40, headache, proteinuria, oedema. Pre-eclampsia, ↑tone & ↑reflexes, epigastric pain (HELLP Syndrome)

Eclampsia

- ▶ ABCD, O₂, left lateral decubitus position
- ▶ Magnesium (2-4g iv then 2g/hr),
- ▶ Urgent obs referral-delivery treatment of choice
- ▶ Bloods, coag (DIC) and urate levels
- ▶ May need phenytoin/diazepam/rapid BP control eg hydralazine/labetolol (specialist)

Delivery in ED

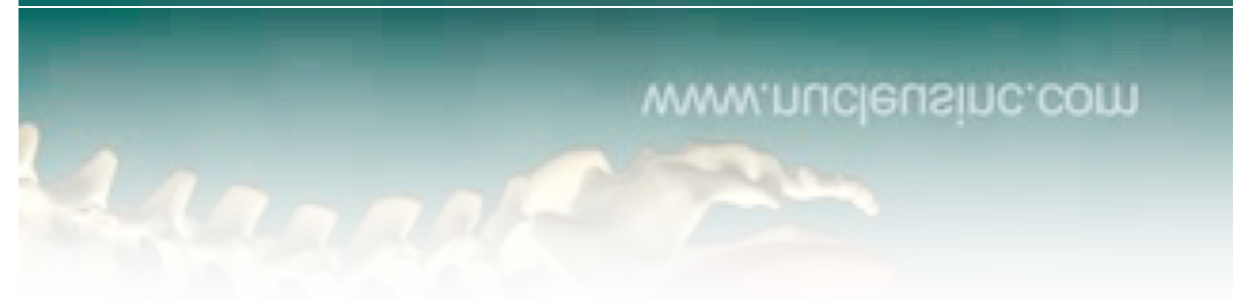
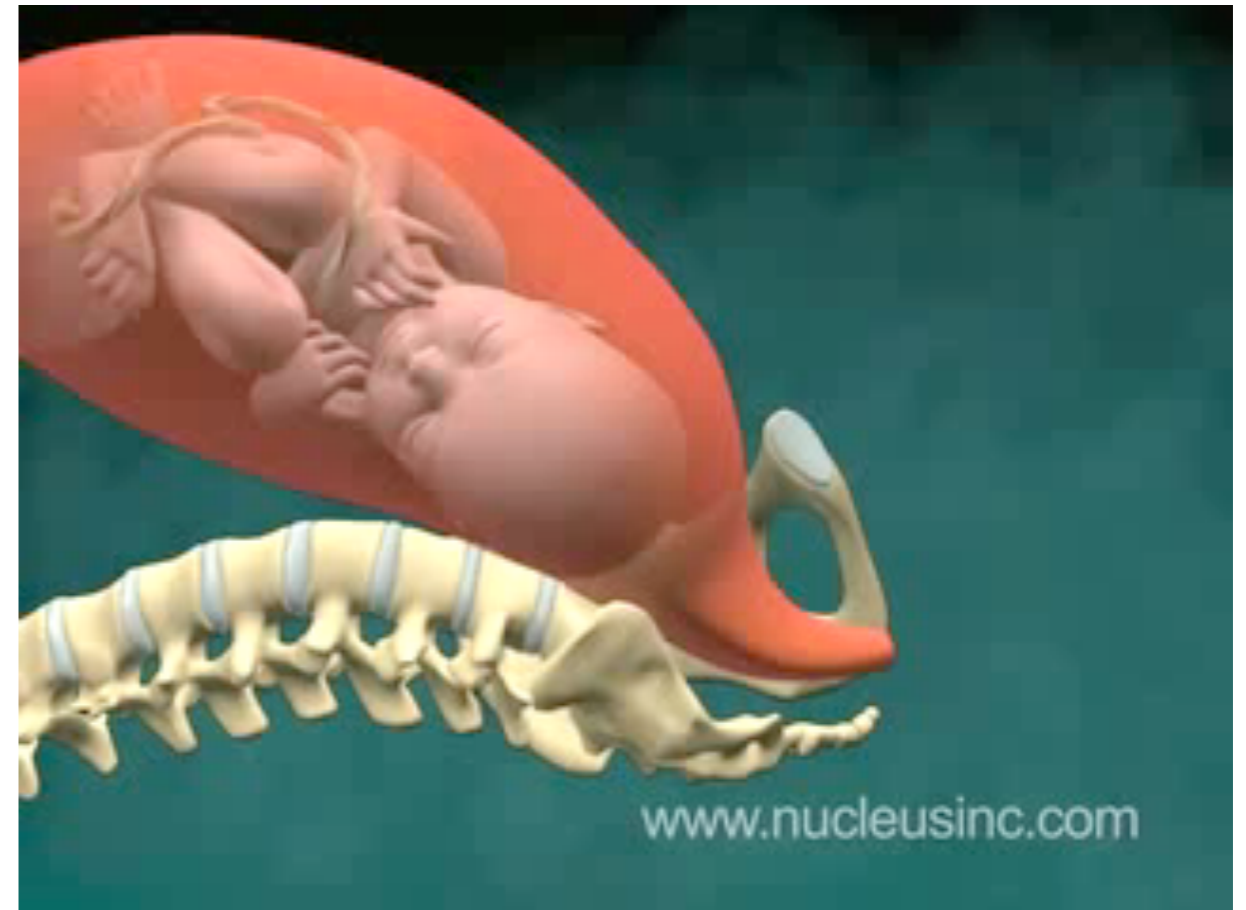


Delivery in ED

First Stage; onset of labour to full cervical dilation (10cm)

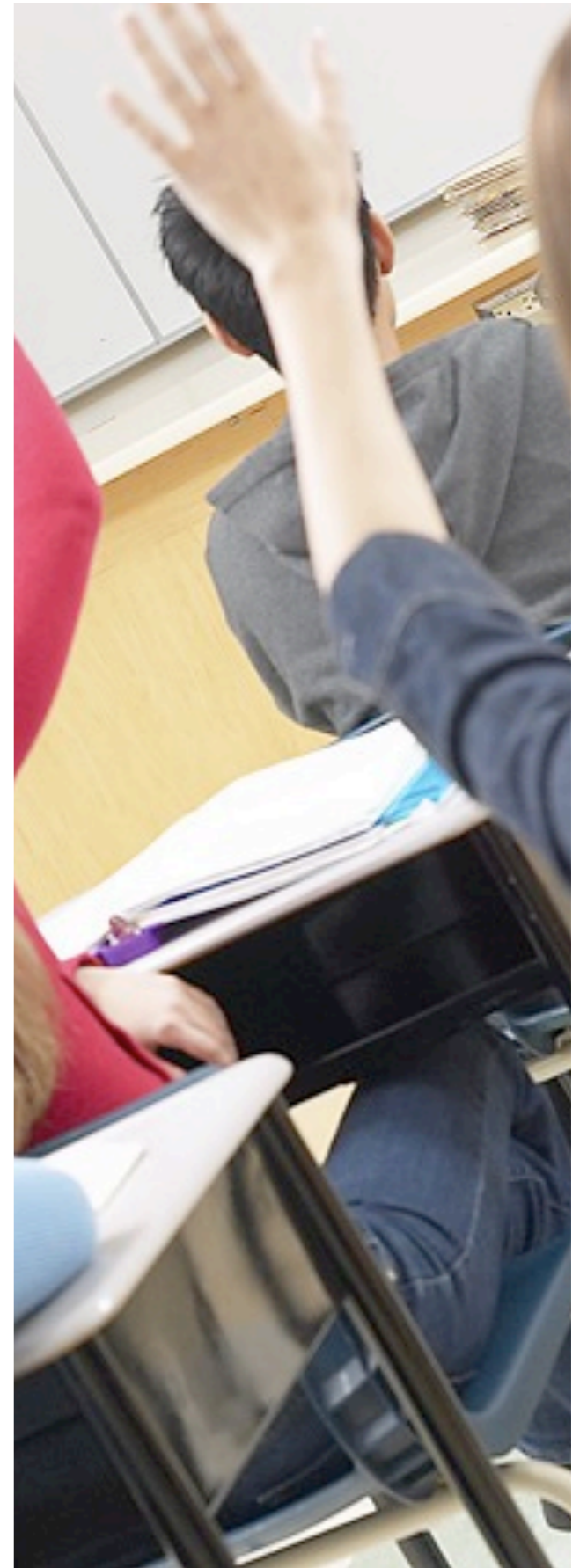
Second stage; full cervical dilation to delivery of baby, <1hr

Third Stage; delivery of baby to placental delivery, <20mins



Delivery in ED

- ▶ Call midwife/obstetrician. Don't transfer if delivery imminent.
- ▶ Get overhead heater on and pack ready.
- ▶ Don gloves/piney/gown.
- ▶ Get Syntometrine drawn up ready to give. Have someone ready to take baby
- ▶ Support perineum with large pad. As head crowns, tell Mum to pant and not to push
- ▶ Encourage head to turn & slightly down
- ▶ On delivery, give Syntometrine IM and clamp cord at 10cm. Dry baby.





Questions?

