SNIPPETS OF CRMD MEETING ON 17/12/2023 AT IMCH, KOZHIKODE

A total of 23 cases of 2023-2024 were discussed in a confidential manner. The causes were as follows:

Traumatic PPH	2
Cardiac causes	1
AFLP	1
Intracranial haemorrhage Hypertension	2
Sepsis	3
Septic abortion	1
Amniotic fluid embolism	1
Meckel's diverticulitis	1
Rupture of aneurysm	1
Covid Pneumonia	1
Rupture uterus	1
Suicide	2
Anaesthesia related	1
Dengue haemorrhagic fever	1
SLE flare	1
Renal	1
Cerebral venous thrombosis	1
Placenta accreta	1

We analysed each of these deaths and subcategorised into the following :

TYPE OF DELAY	NUMBER
1.Delay from the part of patient and family	3
2.Delay after reaching the institution	Nil
3.No delay identified	20

AVOIDABLE OR NOT	NUMBER
1.Unavoidable	11
3.Avoidable	9
4.Cannot comment	3

There were 2 cases of traumatic PPH

Observations

1. 32 year old gravida4 para 3 living 2 LCB 6 years, was induced with PgE1 25 ugm orally at 11 pm. ARM at 11 30 am the next day.Delivered at 1pm. Baby 3.6 kg. After removal of placenta developed PPH. Cervical tear 5 to 6 cm long seen on the left lateral side. Same sutured. Uterus relaxing. Medical management tried. Haemacoel given. Pulse and BP not recordable. Blood transfusion started referred to MCH on Dopamine. On the way adrenaline given. On reaching MCH rushed to the theatre. At laparotomy rupture posterolateral wall in lower segment with broad ligament haematoma. Proceeded with hysterectomy. She was in DIC.

Internal iliac artery ligation done. Drain inserted. Post operatively patient on ventilator, developed multiorgan failure and expired the next day 32 hours after delivery.

Recommendations

If traumatic PPH is suspected, meticulous inspection with adequate light and good instruments in the theatre is recommended. If apex is not seen suspect extension of tear upwards. Then an immediate laparotomy should be done along with volume replacement.

As very often DIC is imminent, a vertical incision is ideal. An Aorta clamp can be used to arrest the bleeding while proceeding with hysterectomy. Internal iliac artery ligation in the presence of DIC is best avoided.

Cryoprecipitate is the one which replaces fibrinogen and should be the first choice rather than FFP along with PRBC and platelets.

Haemacoel is not recommended for volume replacement due to adverse reactions. A traumatic PPH may later lead to an atonic uterus if bleeding is not arrested.

Observations

2. 27 year old 2nd gravida 1st abortion with a BMI of 30, GDM and hypertension, underwent elective CS on demand in a local hospital at 9 30 am. 22 hours post operative, patient had cardiac arrest at 7 20 am. Resuscitated and referred to MCH. Reached there in shock. Immediate laparotomy done 1.5 L of blood and 850 gm clots in the peritoneal cavity. No active bleeding points seen. Suspicious bleeding at the apex of peritoneum beneath the rectus sheath sutured. Uterus flabby. Heyman's sutures applied. Extubated after 6 hours. On 3rd day condition worsened, reintubated. Developed ischaemic hepatitis and thrombocytopenia. She was on Teicoplanin and Meropenam. Expired 7th day after delivery.

Recommendations

Intensive post operative monitoring should have picked up the problem before the patient developed cardiac arrest. Valuable time is lost on referral. Meticulous inspection for haemostasis at the angles, uterine wound, bladder base and beneath the rectus sheath can avoid such a situation. Stretching the

incision with fingers under the peritoneum may prevent bleeding from inferior epigastric vessels. Also care should be taken not to injure the vessels when an abdominal drain is inserted.

Observations

3. 34 yearold gravida 3 para2 both LSCS, LCB 7 years. Antenatal USG placenta low lying anterior. Elective CS done . Lower part of placenta adherent. Developed PPH and hypovolaemic shock, Blood transfusion started and obstetric hysterectomy done. Referred to MCH. Death 20 minutes after reaching there.

Recommendations

Placenta acreta was not suspected in spite of an anterior low lying placenta. In every case of previous Caesarean, this should be looked for. A TVS in first trimester can identify if the sac is located at the scar site.

Placenta acreta should be looked for and managed by 36 weeks or earlier in a systematic manner planning the abdominal and uterine incision, not disturbing the placenta and using the aorta clamp.

Observations

4.At Caesarean section for FGR at 9.15 am, on opening the abdomen, a small bowel loop found adherent to anterior abdominal wall. As it was away from the operating field, proceeded with CS. At 11.30 pm patient developed fever and tachycardia. By next day abdomen distended, progressed to septic shock. USG showed free fluid. Relaparotomy done on the same day. The adherent loop was diagnosed as Meckel,s diverticulum with inflammation. Ileal resection and end to end anastomosis done. But her condition worsened and expired on 4th day of CS.

Recommendations

It was reasonable to proceed with the CS thinking that the bowel loop may not be interfering at the operating area. And anyone would do the same.

On retrospective analysis, the help of a surgeon on the table could have detected the problem and possibly prevented the tragedy. Involving the surgeon at CS for any such problem is of medico legal importance.

Observations

5.26 year old primi Hypothyroid, GDm on MNT, admitted at MCH leaking at 38 weeks. History of fever and tiredness prior to admission. Emergency CS done for fetal distress, grade 3 meconium. Post operatively LFT, RFT deranged. Platelets 86000. Consulted gastroenterologist and nephrologist. Suspected, AFLP, HELLP syndrome, Acute kidny injury. Viral markers negative. Started on Piptaz, Azithromycin, Tamiflu and supportive measures. On day 2 developed abdominal distension and saturation fall. Hb 3.5. Relaparotomy done1.5-2 L of haemoperitoneum and 500 gm clots in the peritoneal cavity. MTP activated. CS wound site reinforced. Uterine artery ligation done. Post operatively Meropenam started. Patient showed initial improvement but sudden onset of dyspnea and tachycardia on 10 th day after relaparotomy. Expired the next day.

Recommendations

There is a suspicion of preexisting liver disease. An LFT should be done in any unexplained tiredness or fever in pregnancy. Here, we can go only by the post operative values. In case of liver dysfunction, DIC should be anticipated and a vertical incision for CS would then be better. This could also be a case of sepsis with multiorgan dysfunction.

Observations

6.A 40 year old gravida 2, previous caesarean, obese, referred to a tertiary care centre with seizures at 28 weeks. Loading dose of Magsulph given and referred to MCH. On the way had seizures and vomiting. On arriving at MCH, patient unresponsive, developed cardiac arrest 5 minutes after admission. Resuscitated and perimortem CS done and live baby delivered. . But the patient expired the next day.

Recommendations

This is a case of early onset preeclampsia which could be predicted. BP monitoring in an obese patient should be using a larger cuff. Age itself is a risk factor. Screening for preeclampsia has not been considered in this case. The loading dose of magsulf should be 4gm IV and 4gm IM along wth IV Labetalol to bring down the BP. Patient might have developed an intracerebral bleed . She is also at risk for aspiration. A perimortem CS was the right thing to do as the baby could be saved.

Observations

7. 28 year old gravida2, abortion1a case of hypertension with FGR induced at 39 weeks due to abnormal LFT and underwent CS for failed induction. On day 2, urine output decreased and noticed abdominal distensionand breathing difficulty. RFT deranged. Referred to MCH . Started on higher antibiotics. With CRRT, renal function improved. ARDS resolved. However hypotension and hypokalaemia persisted inspite of being managed by a multidisciplinary team. Death on 14th day after CS.

Recommendations

Preeclampsia once diagnosed should be terminated by 37 to 38 weeks depending on the severity. If severe, pregnancy may be terminated even by 34 weeks. Thre was a delay in induction. Final contributing cause leading to death was sepsis.

Other Observations

There was a case of IUD related sepsis where blood sugars were very high at 21 weeks. Screening for diabetes should be done in the first trimester itself and if detected should be managed appropriately. Control of diabetes can go hand in hand with measures to deliver the dead fetus.

There was a case of stage 4 metastatic carcinoma (borderline serous cystadenoma operated in 2019) at 35 weeks presenting with lung and liver metastasis diagnosed only when patient presented with breathing difficulty.

There was 1 case each of SLE flare, Cortical vein, thrombosis, Dengue haemorrhagic fever, Category C Covid pneumonia and rupture of posterior inferior cerebellar artery aneurysm (PICA) and anaesthesia related cause.

2 cases in this series were suicides.