Care of the pregnant or recently pregnant patient in the non-obstetric setting

NHS SCOTLAND

! Obstetric specific early warning scores (MEWS) must be used to document observations in all pregnant women or those within 6 weeks post delivery

Normal pregnancy physiology

Cardiovascular
- HR ↑ 10–20 bpm
- BP ↓ 10–15 mmHg by ~20 weeks → returns to baseline at term
- Cardiac output ↑ 30–50%
- Soft systolic murmur may be normal

Respiratory
- RR unchanged → RR >20 = abnormal
- SpO_2 unchanged
- ↑ O_2 consumption + ↓ FRC → rapid desaturation
- ABG: compensated respiratory alkalosis (PCO_2 3.7–4.2 kPa)

Haematology
- Hypercoagulable → ↑ VTE risk
- Dilutional anaemia

Other
- Aortocaval compression from ~20 weeks → avoid supine (use left tilt)
- ↑ Airway oedema → difficult intubation risk
- ↑ Aspiration risk (↓ LOS tone)

Red flags require early escalation to consultant clinicians Recurrent presentations or readmission during pregnancy is a red flag

Palpitation
! Palpitations in a woman with a family history of sudden cardiac death
! Palpitations in a woman who has structural heart disease or previous cardiac surgery
! Palpitations with syncope
! Palpitations with chest pain
! Persistent, severe tachycardia

Chest pain
! Pain requiring opioids
! Pain radiating to arm, shoulder, back or jaw
! Sudden-onset, tearing or exertional chest pain
! Associated with haemoptysis, breathlessness, syncope or abnormal neurology
! Abnormal observations

Breathlessness
! Sudden-onset breathlessness
! Orthopnoea
! Breathlessness with chest pain or syncope
! Respiratory rate >20 breaths per minute
! Oxygen saturation <94% or falls to <94% on exertion
! Breathlessness with associated tachycardia

Headache
! Sudden onset, thunderclap or worst headache ever
! Taking longer than usual to resolve or persisting >48 hours
! Associated with fever, focal neurology, photophobia, diplopia, excessive use of opioids

Key principles for all patients

☐ Presence and involvement of a senior clinician in the area the patient is being assessed to liase with senior obstetric clinician
☐ Key information: History of presenting complaint, co-morbidities, any red flags listed above, gestation, presence of vaginal bleeding, abdominal pain, fetal movements (>24 weeks), history of previous c-section, headache, visual disturbance, severe epigastric or right upper quadrant pain
☐ Make positive diagnosis, don't simply exclude a diagnosis
☐ Document in patient records e.g. handheld notes, digital obstetric records
☐ Patients should only be transferred to non-obstetric wards, critical care or transferred to another hospital after discussion with the obstetric team
☐ Depending on presentation & gestation, formulate a plan for obstetric & midwifery review & any fetal monitoring required
☐ Discuss indications for escalation of care & key contacts
☐ All diabetic patients should have BM check: if <4 treat as hypoglycaemia; if >10 check serum ketones

Stable patient

☐ Inform senior obstetric registrar of patients admission to your location & labour ward coordinator
☐ Record MEOWS
☐ Use 'care of the pregnant patient in non-obstetric setting' check-list (see www.socn.scot.nhs.uk)

Unstable patient?

! Airway compromise
! Respiratory distress
! Altered conscious level
! Major trauma/haemorrhage
! Severe chest pain
! Ongoing seizure
! Shock/collapse
! Suspected ectopic pregnancy & unstable
! Prolapsed umbilical cord
! Any other presentation causing haemodynamic compromise or clinical concern

☐ Ensure a registered healthcare professional remains with the patient
☐ Perform manual uterine displacement or left lateral tilt

☐ Assign another registered healthcare professional to:
- ▹ Phone 2222 & state "obstetric emergency in *state your location*"
- ▹ Contact labour ward:
- ▹ Contact obstetric and anaesthetic consultants

☐ Patient may require early transfer to labour ward/theatre/critical care or transfer to a tertiary centre if clinically appropriate & recommended by the senior multi-disciplinary team relevant to the patients condition
☐ If delivery required/imminent contact 2222 for "neonatal emergency"

Cardiac Arrest - See algorithm for maternal collapse

SOCN SCOTTISH OBSTETRIC CARDIOLOGY NETWORK

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