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Today's Health for the Empowered Woman

OBSTETRICAL EMERGENCIES PART TWO

Having written previously about gynecologic emergencies and first trimester obstetrical emergencies I felt it was time to provide some information about emergencies that might occur in the mid trimester of pregnancy; that is from 12-28 weeks. I will break this down into common medical and common surgical emergencies respectively understanding that the list is certainly not all encompassing. As in a previous article I stated that contagious diseases are always an obstetrical emergency because at this stage of pregnancy the unborn child might be at risk from getting the disease passed through the placenta or from the effects of a sick mother. Chicken pox is certainly not completely eradicated. A fever followed by a vesicular rash might be chicken pox. If the mother had chicken pox as a child she is immune to it and so will be her unborn child. If has not had vaccination as a child and is exposed to a person with chicken pox she can receive zoster immune globulin to prevent the fetus from getting the disease. Sexually transmitted diseases such as gonorrhea, Chlamydia and syphilis pose a huge threat to the fetus and can cause malformations, death, and blindness. Early recognition of symptoms and prompt treatment are mandatory and can usually be treated easily with antibiotics. The name of the partner must be submitted to the Health Department by law and treatment initiated. Both then need test of cure. Herpes can cause fetal malformations if the fetus is born through an infected birth canal within four weeks of active disease. There is no treatment for any viral disease so if there are active lesions in that time frame, c-section must be performed. Upper respiratory infections are more severe in pregnancy due to increased blood flow through the lungs and bacterial pneumonias can be treated with antibiotics but viral pneumonias are very dangerous and warrant hospitalization and ventilatory support. Kidney infections can cause early onset of labor secondary to fever and sepsis and are easy to diagnosis and treat. Severe dental infections must be treated as once again sepsis can cause labor. Minor dental procedures are best put off until the pregnancy is complete. A word here about trauma, that is accidents that require emergency room treatment. To fully evaluate the extent of an injury ct scans might be required. In the context of diagnosing a severe injury this is prudent even in the pregnant patient because the effect to the fetus of a late or missed diagnosis might be greater than the risk of radiation from the scan. Besides trauma the most common surgical emergencies are kidney stones, appendicitis, gall bladder disease and ovarian cysts. Kidney stones can be treated with intravenous fluids to try to move the stone out, otherwise a urologist can place a stent so that the kidney function is preserved. Appendicitis in pregnancy is a little more difficult to diagnosis as the appendix rises out of the pelvis as the uterus grows but failure to removed an infected and/or ruptured appendix is almost universally fatal and when done in the second trimester poses little risk to the fetus. Gall bladder disease is common in pregnancy but rarely needs surgical intervention. If ovarian cysts are large or suspicious of malignancy the patient must be treated as if she were not pregnant because failure to do so might endanger her life and therefore the life of her fetus as well.

Suspicious skin lesions can be biopsied during pregnancy and breast masses that are solid should be biopsied as well although breast cancer in pregnancy is rare. Lastly, there are emergencies that are unique to the pregnancy. Placental abruption (the placenta separating before the birth of the child) can cause life threatening bleeding and usually requires emergency c-section regardless of how early this occurs in pregnancy to save the mother's life. Toxemia generally occurs late in pregnancy but when it occurs early is usually more severe. The symptoms consist of headache, swollen extremities, protein in the urine, blurred vision, elevated blood pressure and sometimes liver and blood disorders. There can be expectant management with medications but might very well end in an early delivery as removal of the placenta usually ends the disease. Yes, a severely premature infant might result but neither the mom nor the fetus will survive severe toxemia. And, no minor emergency of pregnancy is premature rupture of the membranes and premature labor. We are not sure of all the reasons for premature rupture of the membranes but an infective process seems to be the reason. When this occurs, the patient must be seen for confirmatory tests and a sonogram and if the cervix is not open, antibiotic treatment and bed rest. If the cervix is open and the patient is in labor then delivery is inevitable. In the absence of premature rupture of the membranes, labor can sometimes be stopped with medications, at least long enough to give steroids that help to mature the lungs of the premature infant. As stated last month, ALL BLEEDING in pregnancy is abnormal and warrants immediate investigation. It must be remembered that pregnancy is a natural state and that most pregnancies do not have complications either medical or surgical and end in a happy event for all. Being aware of the above situations can result in early intervention should they occur and make for a better and safer outcome.