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Today's Health for the Empowered Woman

OBSTETRICAL EMERGENCIES PART ONE

Having written last month of gynecologic emergencies I thought it would be educational as well as imperative to discuss those emergencies concerning the pregnant female. The list is quite comprehensive so I thought I would break it down into three parts coincident to the three trimesters of pregnancy. In the human female pregnancy last forty weeks from the date of the last menstrual period. It is then divided into trimesters: the first from conception to 12 weeks; the second from twelve weeks to 28 weeks and the third from 28 to 40 weeks. This article will concern those emergencies encountered in the first trimester. First of all a situation is an emergency when the patient perceives it as such. It does not mean an immediate visit to the emergency room or urgent care. It would be prudent to call the obstetrician's office first for a phone evaluation. Additionally this is where the medical record is kept which is most important for the person fielding the phone. This enables a review of past medical history and any current problems that may be important to this emergency. The next line of call would be to the labor and delivery unit of the hospital where the birth is planned to occur. They also have the medical record and can directly communicate to the obstetrical provider but cannot make recommendations about care. Last would be a visit to the emergency room if the problem is perceived to be so severe that immediate action in a hospital setting is necessary. We are seeing an increased trend to not keep scheduled office visits. This results in patients unnecessarily presenting to emergency rooms and labor and delivery units "just to be checked out" and "reassured". This is an abuse of the system that makes it difficult for true emergencies to be seen in a timely manner.

That being said, the most common first trimester emergency is bleeding. **THERE IS NO BLEEDING IN PREGNANCY THAT CAN BE CONSIDERED NORMAL.** All bleeding however slight must be evaluated. Early first trimester bleeding can be due to implantation bleeding when the fertilized egg burrows into the uterus to find a blood supply for the newly developing placenta. No treatment is necessary and a sonogram should rule out other more serious reasons for bleeding—primarily miscarriage. Miscarriage most often occurs in the first trimester, involves the loss of a fertilized egg with placenta and rarely an embryo as no development beyond placenta has occurred. If bleeding with no cramps occurs this is a threatened miscarriage but if the bleeding is accompanied by cramping then miscarriage is a certainty. No medication or treatment can prevent this from happening. The care must be to control the bleeding, treat the emotional component of the grieving mother and, if the contents are not expelled, to perform a dilation and curettage under anesthesia to remove the contents and stop the bleeding. Another source of first trimester bleeding might be an ectopic pregnancy that involves the embryo growing in the fallopian tube instead of the uterus. This can cause severe pain and bleeding and almost always results in surgery to empty the tube.

The next most frequent emergency is severe nausea and vomiting (hyperemesis gravidarum) that can lead to dehydration and severe illness. The cause is unclear and is treated with intravenous fluids, medications, antacids and rest. It might very well recur but usually ends after the first trimester and has no effect on the developing fetus. Vaginal discharge is more profuse during pregnancy secondary to the hormones being produced by the placenta and is not emergent. If, however, there is itching or a foul smell it warrants evaluation in an office setting and is easily treatable after a microscopic analysis. The symptoms of upper respiratory infection and flu are more pronounced in pregnancy and harder to treat so if symptoms seem to be more than just a common cold a visit would be wise. Parenthetically flu shots are recommended for ALL pregnant women as the virus in the vaccine is not a live one. Constipation is common in all stages of pregnancy and is made worse by the iron in prenatal vitamins. While not an emergency it can be quite discomforting and stool softeners, fiber and increased fluid intake can ameliorate the symptoms. Urinary tract infections can be perceived as emergency when urination is difficult or painful or blood is found in the urine. These symptoms can easily be evaluated in an office setting and treated with antibiotics that are safe to use in pregnancy. Obstetrical providers are well trained to deal with all these emergencies and others that might not be listed here. The mother should also use some common sense and review the materials that were given at the first obstetrical visit. However, it is understood that many times these issues arise even before that first visit was made. In our country all patients can be seen at any time even though the setting may vary according to the problem. Once again, it is an emergency when the patient herself perceives it to be so.