Case presentation ELBWT/PT

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- 27YR NB
- Obstetric Hx,
- Came as a referral from a peripheral clinic for further management
- Presented with a 2 days history of par vaginal bleeding.
- Had unremarkable ANC period – attended ANC 4 times from the referring center.
- Mother is blood group A+
- Dx – Antepartum hemorrhage secondary to placental abruption
- Decision for an EMC/S was made, mother informed about the decision by the obs team and prepared her for the admission to the Nicu and pediatrics team was informed.
- Preparations were made,

Prepared for the resuscitation, went through equipment checklist, and prepared the equipment required for the resuscitation.

(baby packs, switched on radiant warmer, suction and bulb syringes, ambubags tested functionality, masks appropriate size, oxygen and prepared warm transport with CPAP – boiled water for the insta- warmers, poly then bags and also informed NICU of a possible admission)

- B/O NB
- DOB 6/04/2025
- ELBW/PT delivered by EMC/S secondary to APH; abruption placentae
- BWT 860g, A/S 4-6-8
- GA 28w by Ballard
- At delivery baby was blue, floppy, and not breathing. Required resuscitation. (warmed, positioned, suctioned, dried and stimulated, initiated PPV via BMV foe about two minutes, gained spontaneous breathing and initiated on CPAP at a PEEP 7cm H_2O Baby wrapped in a polythene bag, placed in an exothermic mattress. (Warmilu)
- Nicu was called and informed to prepare for and extremely low birth weight preterm with RDS on BCPAP. Vitals –spo2 98% at PEEP 7cmH_2O, PR -167bpm, temp- 37.1, RR- 56bpm.
- and later transported to NICU for further management)

INITIAL ASSESMENT

Baby was pink, active, no jaundice, RBS low

R/S; RR 37 b/m, SAS 5/10, SPO2 98% ON CPAP at a PEEP of 7cm, equal air entry bilaterally, normal Broncho vesicular breath sounds

CVS; Warm peripheries, CRT<3s, HR 164b/m, HS1+HS2+0

P/A; normal fullness, soft, cord well ligated, no palpable organomegalies with normal female genetalia

CNS; HC 25.0cm, anterior and posterior fontanelle normotensives, sutures not apposed, partial Moro, other reflexes absent

Imp: ELBW/PT with RDS and hypoglycemia

Plan:

- Bubble CPAP PEEP 7
- TFI 90mls/kg/day; IV D5% 3.2mls/hour
- IV caffeine citrate; loading 26mg , maintain 17.2mg once daily
- IV X-pen 43000IU 12 hourly
- IV gentamicin 4.3mg once daily
- IV PCM 13mg 6 hourly
- Blood grouping
- APT, PT/INR
- CBC, CRP at 24hrs
- Counsel parents on need for surfactant if the SAS remains above 5/10 on BCPAP.

Summary

Baby spent 3days of life in the Nicu.

Was managed,

1. RDS on BCPAP – MV
2. Neonatal sepsis with septic shock on high dose x-pen, gentamycin, dopamine infusion.
3. Coagulopathy – transfused with FFPS*3 and vit k
4. Apnea of prematurity – Caffeine citrate
5. Pulmonary hemorrhage – transfused with blood and platelets
6. Possible PDA – iv paracetamol
7. Resolved hypoglycemia – bolus D10%

On the 3DOL,

Noted baby had profuse bleeding from the UVC site and through the ETT with desaturations on the MV spo2 54-64%, PR 178bpm suctioned via the ETT and applied pressure on the uvc, with stay suture placement, however there was no control on bleeding.

Initiated PPV via the ETT with no improvement in the saturations with PR reduced to 54 bpm, initiated chest compressions with PPV.

However there was no return of spontaneous breathing, and no improvement in HR

Baby pronounced dead. RIP.