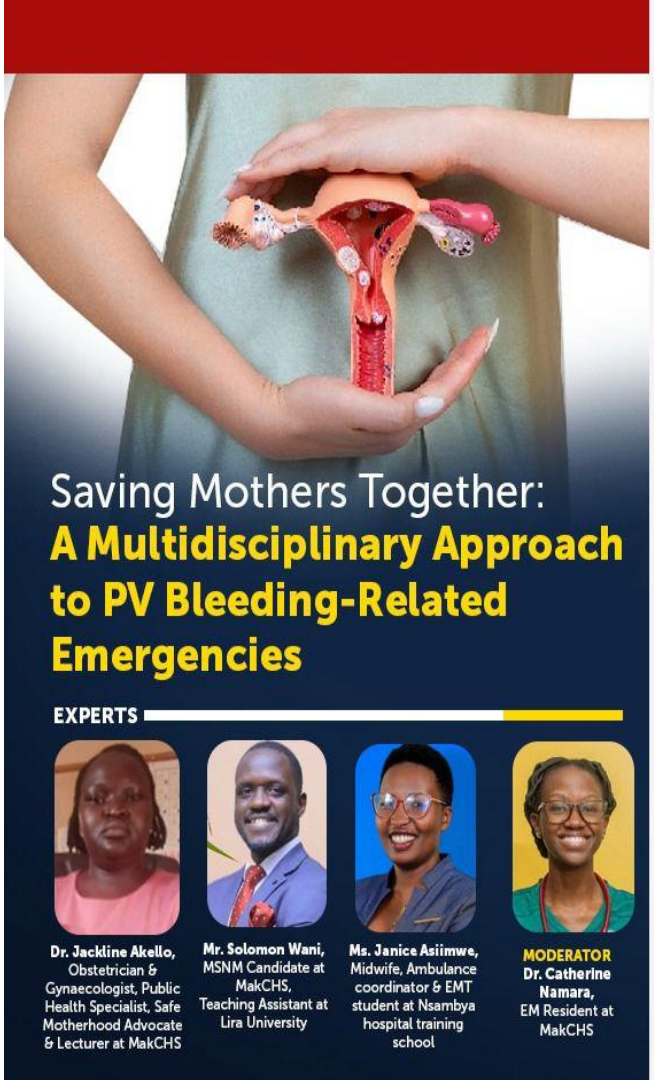
EMS ECHO 107



This session will delve into areas such as;

1. Key history in a mother with PV bleeding-related emergencies
2. Pre-hospital assessment, care and transportation of a mother with PV bleeding-related emergencies
3. ED assessment & investigations for a mother with PV bleeding-related emergencies
4. Emergency nursing care of a mother with PV bleeding-related emergencies
5. ED management & disposition plan for a mother with PV bleeding-related emergencies

scan to register

FRIDAY
19th December 2025
2-4pm EAT
Meeting ID: 942 1941 7289
use link:
https://shorturl.at/2cptF

CHAT & QUESTIONS
Dr. Sarah Oworinawe, EM Physician at Yumbe RRH

CASE PRESENTER
Dr. Kalute Lawrence, OBSGYN Resident MakCHS

ECAU EMERGENCY CARE ASSOCIATION OF UGANDA

Brief History

J.E, 41/F, nulliparous, presented with 9/7 hx of PV bleeding that started 2/52 after her normal periods, involving expulsion of clots and fresh blood associated with LAP, palpitations, dizziness, and easy fatigability; however, no headache, no DIB

Primary Survey (Emergency Assessment)

A	Patent air way
B	Not in obvious respiratory distress, RR=18 bpm, normal resonance on percussion, normal Equal air entry bilaterally SPO2=95% on RA

Primary Survey (Emergency Assessment)

C	cold extremities, CRT>2s, PR= 108 bpm, B.P=90/55 mmHg, active PV-bleeding
D	Alert with a GCS of 15/15, PEARL, No focal neurological deficit
E	Afebrile, severely pale, no visible skin rashes

POLL QUESTION 1

From the primary survey, what is the emergency condition in this patient?

What are the emergency Conditions?

Threats	*Emergencies*	*Findings*	*Associated Risks*
C	Hypovolemic shock 2° active vaginal bleeding	Cold peripheries, CRT>2s, PR= 108 bpm, B.P= 90/55mmHg, active fresh bleeding	- Multiple organ failure - Cardiac arrest

And always reassess to monitor response to treatments

POLL QUESTION 2

What is the emergency management priority for this patient?

What are the emergency Conditions?

Threats	*Emergencies*	*Findings*	*Associated Risk*	*Immediate Action Taken*
C	Hypotension, Active vaginal bleeding	Cold peripheries, CRT>2s, PR= 108 bpm, B.P= 90/55mmHg, active fresh bleeding	- Multiple organ failure - Cardiac arrest	I.V line, grouping and Xmatching, BT (3 units of fresh whole blood) Tranexamic acid 1g bolus

And always reassess to monitor response to treatments

Interventions to stabilize the patient

Great!

We have started to stabilize the patient
…let’s gather more details!

SAMPLE History

Signs & Symptoms	Vaginal bleeding associated with Abdominal pain, Palpitation, dizziness, easy fatigability, no oedema, no cough and no DIB, PR= 108 bpm, regular & strong, BP=90/55 mmHg,
Allergies	No known allergies
Medications	Lorsatan H 50mg/12.5mg, and Amlodipine 10mg No other medications

SAMPLE History

Past Medical History	Hypertensive for 5 years, controlling on medication
Last Oral Intake	About 4 hours prior to admission
Events Leading Up to Presentation	Patient was well before, with no history of travel, trauma and GBV

Secondary Survey (Head-to-toe examination)

RELEVANT POSITIVES	RELEVANT NEGATIVES
Head & Neck: Severe conjunctival & palmar pallor **Chest**: Symmetrical, SPO2=95% on RA, normal percussion, vesicular breath sounds **Abdomen:** Palpable mass, pelvic in origin **Pelvic Exam**: Blood clots and fresh blood	**MSSK**: Normal findings **Extremities**: cold extremities, no oedema **Skin**: No rushes, normal appearance

Diagnosis		For	Against
1	Severe anemia secondary to AUB	Cojuctiva pallor Pv bleeding	None
Differential diagnosis			
1	AUB due to uterine myoma	Pv bleeding Palpable pelvic mass	None
2	Abortion	Pv bleeding	Recent LNPM
3	Endometrial hyperplasia	40yr, with pv bleeding	Palpable pelvic mass

POLL QUESTION 3

What is the emergency bedside investigation for this patient?

Investigations

Investigation	Result
Urine HCG	Negative
CBC	**HGB- 3.8g/dl, HCT-12.8, PLT-173**
Blood group	AB Rh- positive
Abdominal USS	Multiple uterine myoma with largest measuring 7X6 cm

POLL QUESTION 4

What is the emergency-specific definitive care for this patient?

Supportive Management

- Blood transfusion 3units of whole blood, platalet 1 units
- Iv fluid (volume expanders)---not given in this case
- Tranexamic acid 1 gram start
- Oxygen 5l/min via nasal prongs
- Analgesia, iv pcm 1g 8hrly
- Ferrous sulphate
- Urinary catheter

Specific Management

Myomectomy	➢ Follow up on HGB level in Gyn clinic and book for myomectomy
TAH	➢ Possibility
Hormonal therapy	➢ Not likely in this case

Progression

The patient was in the emergency department for about 1 day, and then on the gyn ward for 2 days and allowed home when stable with post-transfusion HGB- 8.1g/dl

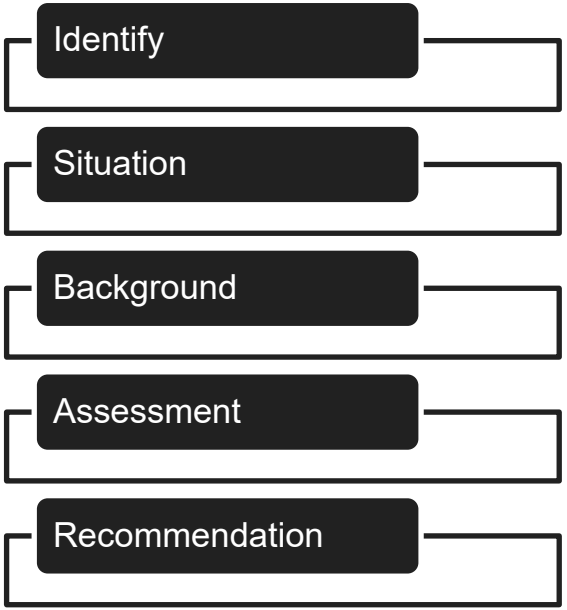
- Oral haematinics fefo 1 tab o.d
- Follow up in gyn clinic
- Booking for myomectomy/ TAH

Thank you

Prehospital team:

What do you need to prepare for pre-hospital care for this patient?

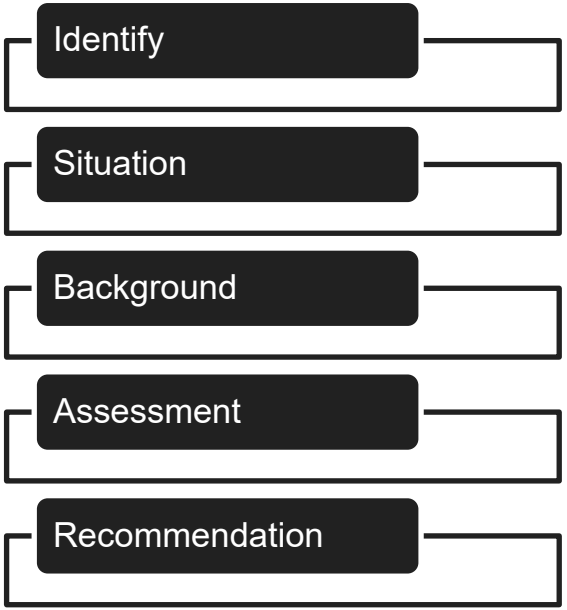
- Staff
- Patient
- Equipment / Medications
- Mode of transport
- Documentation/Handover



Ms Janice Asiimwe, Midwife, Ambulance coordinator & EMT student at Nsambya Hospital training

Prehospital team:
What do you need to prepare for pre-hospital care for this patient?

- Staff
- Patient
- Equipment / Medications
- Mode of transport
- Documentation/Handover



Ms Janice Asiimwe
Midwife/EMT_Ambulance coordinator St Francis Nsambya Hospital

Staff…

Staff
The team will require a composition of trained personnel ranging from a basic EMT to a critical/emergency care specialist

Note:
A basic provider can also work, but under MD from CAD or in contact with the receiving facility

Patient…

1. Stabilize-On scene care.

Manage Airway, Breathing, and Circulation; secure IV access etc To prevent clinical deterioration during transport.

2. Consider monitors.

Attach ECG, SpO2, and BP cuffs; record baseline vitals. To detect sudden changes in patient status in real-time.

3. Package.

Secure patient to stretcher; tie down all tubes and lines. To ensure safety and prevent injury or accidental extubating.

Patient Cont'd

4**. Document.**
Complete the PCF (Patient Care Form). To provide the receiving hospital with vital clinical history.

5. Notify
Give a "radio report" or to the receiving facility. To ensure the receiving team is ready upon arrival.

6. Consent
Patients should consent otherwise they have a right to reject the transportation

Equipment/Medication…..

HITMAN

The acronym serves as a "priorities of work" checklist to transition from immediate life-saving interventions for prolonged field care

H — Hydration, **Hygiene**, or **Heat** regulation

I — Infection: Follow aseptic techniques during care and use of appropriate PPE

T — Tubes & Tidy: Securing, labelling, and checking all intravenous lines, urinary catheters, and airway tubes

Equipment/Medication…..

M — Medications: Ensuring scheduled doses are given and reviewing the efficacy of current drug treatments.

A — Analgesia (or Administration): Managing pain relief over long periods or completing critical documentation and transfer paperwork.

N — Nursing /Nutrition: Implementing daily patient care tasks such as oral hygiene and pressure point relief. The patients also need nutrition care for long distance journey

Mode Of Transport…..

CAD should dispatch a minimum of type B ambulance, the level of equipment and types of ambulances described in the NNSAV, 2021

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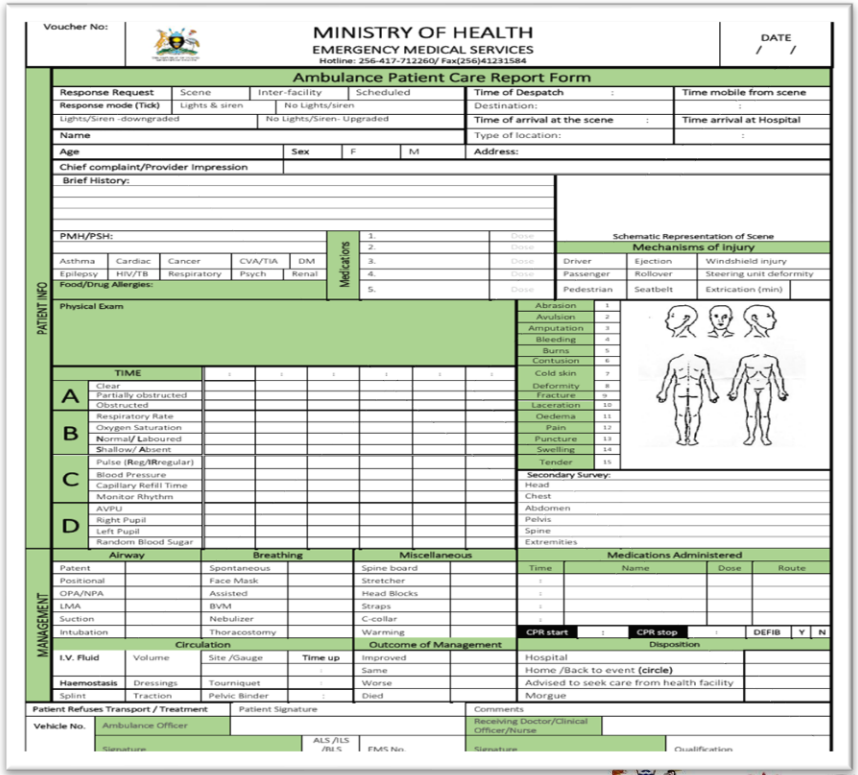
NATIONAL NORMS AND STANDARDS
FOR
AMBULANCE VEHICLES IN UGANDA

March 2021

Type C would be ideal; however, Type C ambulances are very few. after on-scene stabilization, a type B can be dispatched

The ambulance **MUST** also have the EMTs/healthcare professional aboard

Documentation And Handover…



MINISTRY OF HEALTH
EMERGENCY MEDICAL SERVICES
Hotline: 256-417-712260/ Fax(256)41231584

Voucher No:

DATE / /

Ambulance Patient Care Report Form

PATIENT INFO

Response Request | Scene | Inter-facility | Scheduled
Response mode (Tick) | Lights & siren | No Lights/siren
Lights/Siren -downgraded | No Lights/Siren- Upgraded
Name
Age | Sex | F | M
Chief complaint/Provider Impression
Brief History:
PMH/PSH:
Asthma | Cardiac | Cancer | CVA/TIA | DM
Epilepsy | HIV/TB | Respiratory | Psych | Renal
Food/Drug Allergies:
Medications: 1. 2. 3. 4. 5. (Dose)
Physical Exam

Time of Despatch :
Destination:
Time of arrival at the scene :
Type of location:
Time mobile from scene :
Time arrival at Hospital :
Address:

Schematic Representation of Scene

Mechanisms of injury
Driver | Ejection | Windshield injury
Passenger | Rollover | Steering unit deformity
Pedestrian | Seatbelt | Extrication (min)

Abrasion 1, Avulsion 2, Amputation 3, Bleeding 4, Burns 5, Contusion 6, Cold skin 7, Deformity 8, Fracture 9, Laceration 10, Oedema 11, Pain 12, Puncture 13, Swelling 14, Tender 15

TIME
A: Clear / Partially obstructed / Obstructed
B: Respiratory Rate / Oxygen Saturation / Normal/ Laboured / Shallow/ Absent
C: Pulse (Reg/Irregular) / Blood Pressure / Capillary Refil Time / Monitor Rhythm
D: AVPU / Right Pupil / Left Pupil / Random Blood Sugar

Secondary Survey:
Head
Chest
Abdomen
Pelvis
Spine
Extremities

MANAGEMENT

Airway: Patent, Positional, OPA/NPA, LMA, Suction, Intubation
Breathing: Spontaneous, Face Mask, Assisted, BVM, Nebulizer, Thoracostomy
Miscellaneous: Spine board, Stretcher, Head Blocks, Straps, C-collar, Warming

Medications Administered
Time | Name | Dose | Route

CPR start : CPR stop : DEFIB Y N

Circulation
I.V. Fluid | Volume | Site /Gauge | Time up
Haemostasis | Dressings | Tourniquet
Splint | Traction | Pelvic Binder

Outcome of Management: Improved, Same, Worse, Died

Disposition: Hospital; Home /Back to event (circle); Advised to seek care from health facility; Morgue

Patient Refuses Transport / Treatment | Patient Signature | Comments
Vehicle No. | Ambulance Officer | Receiving Doctor/Clinical Officer/Nurse
Signature | ALS /ILS /BLS | EMS No. | Signature | Qualification

Documentation Is Key.

- ✓ Handover of care
- ✓ Record purpose
- ✓ Data for Monitoring & Evaluation
- ✓ Research and development
- ✓ etc.

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…..And Handover

This has to be brief and relevant focusing on life threatening issues

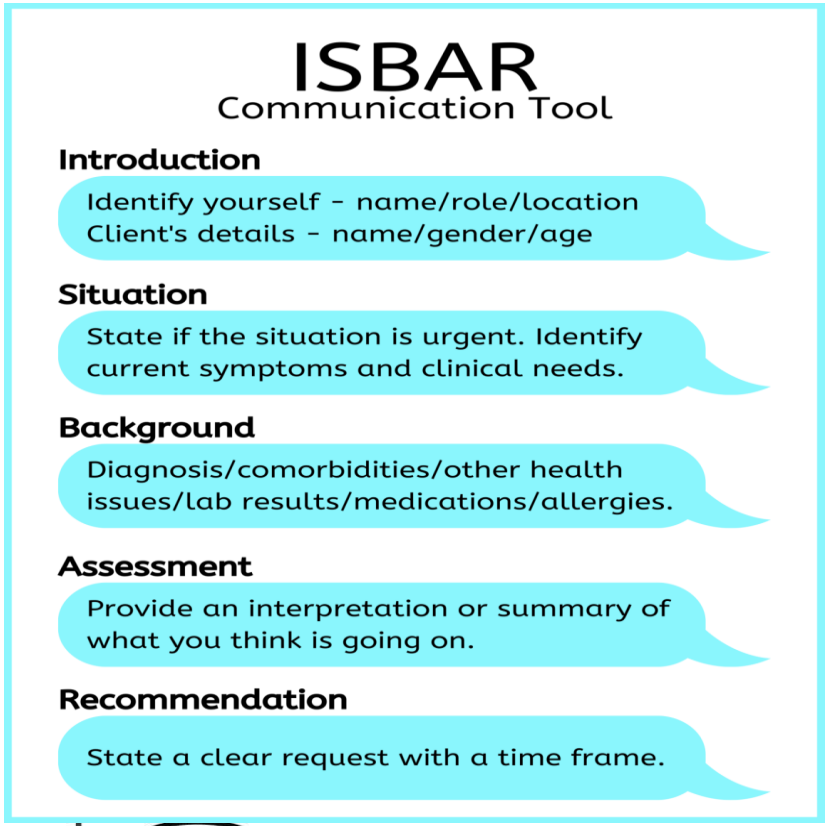
Example

Good afternoon…..

*My name is Janice from EMS, I'm handing over J.E, 41/F, **n**ulliparous, presented with 9/7 hx of PV bleeding that started 2/52 after her normal periods, involving expulsion of clots and fresh blood with associated with LAP, palpitations, dizziness, and easy fatigability, J.E is known HTN on Lorsatan H, and Amlodipine*

His blood pressure was 90/55mmHg,PR=108bpm. She has padded, given TXA, analgesia and oxygen

I recommend OBSGYN and urgent blood transfusion review her



References

- *The national norms and standards for ambulance vehicles in Uganda, March 2021.*
- *MOH-EMS HMIS 002*
- *WHO/IRC BEC*

THANK YOU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MINISTRY OF HEALTH


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Project
ECHO

Nursing team:

Is there anything else you would like to know now?

What are the **nursing priorities** for this patient in the ED?

Mr Solomon Wani, MSNM Candidate at MakCHS,
Teaching Assistant at Lira University

Introduction

Nursing Management of PV Bleeding in the ED focuses on:

- ✓ Rapid assessment using the ABCDE approach
- ✓ Prompt interventions to stabilize the patient
- ✓ Continuous monitoring and reassessment
- ✓ Early detection of complications and timely escalation of carerise.
- ✓ Interdisciplinary collaboration

Assessment	Nursing Diagnosis	Goal/Desired Outcome	Intervention	Rationale	Evaluation
Subjective data. ▪ Patient reported PV bleeding for 9 days. ▪ Expulsion of clots and fresh blood ▪ Palpitations. **Objective data.** • Hypotension of 90/55 mmHg. • Tachycardia of 108bpm, strong & regular. • SPO2: 99% on RA • Severely pale	Inadequate fluid volume related to excessive blood loss due to abnormal uterine bleeding as evidenced by prolonged PV bleeding, hypotension (90/55), tachycardia (108 bpm),	Restore adequate fluid volume within 2 hrs (BP≥100/60 mmHg, PR Heart rate <100 bpm)	Establish two large-bore Intravenous line	To obtain blood sample for CBC, grouping & crossmatching. For IV fluid administration and blood transfusion.	After 2 hours the patient regained her adequate fluid volume evidenced by blood pressure of 100/60 mmHg, PR 90bpm to 100 bpm, PV bleeding reduced with very few clots seen.
			Prepare patient for blood transfusion and transfuse with compartible blood group.	To restore intravascular volume and also improve on the cardiac output.	
			Position patient supine with legs elevated	To Improves venous return.	
			Administer IV tranexamic acid 1G	To reduce active bleeding by stabilizing blood clots	
			Monitor vital signs (BP, PR, RR, SPO2) every 15 to 30 minutes. Assess amount, color, and presence of clots in PV bleeding	To detect early shock or worsening hypovolemia & evaluate response to treatment.	

Assessment	Nursing Diagnosis	Goal/Desired Outcome	Intervention	Rationale	Evaluation
Subjective data. Dizznss, easy fatigability, Palpitations **Objective data.** PR 108bpm Hb 3.8g/dl RR 18bpm SPO2 99% RA Severe palor, Slow capillary refill >2 secs and cold extremities	Impaired tissue perfussion related to reduced blood volume evidenced by severe palor, slow capillary refill >2 secs, cold extremities and Low Hb	Restore adequate tissue perfussion withion 3 days Improve Hemoglobin levels within 3 days Rreduce symptoms of dizziness, fatigue and palpitations Stable Vital signs (PR, RR, SPO2, LOC)	Encourage bed rest	To minimize cardiac workload, conserve and reduce oxygen demand.	After 7 hrs, patient reported reduced dizzness, and palpitations. After 3 days, the Hb improved to 8.1g/dl Vitals became Stable within 7 hrs
			Administer oxygen ttherapy 5L/min via nasal prongs	Oxygen improves tissue oxygen delivery.	
			Administer prescribed ferrous sulphate whole blood and platelet	Iron promotes erythropoiesis. To correct anemia and reduce symptoms of dizzness, fatigue, and palpitations	
			Monitor Hb and hematocrit levels	To evaluate treatment effectiveness	
			Monitor vital signs such PR, RR, SP02 and level of consciiousness	Are indicators of perfusion indicator e.g to the Brain. Early detection prevents complications	

Assessment	Nursing Diagnosis	Goal/Desired Outcome	Intervention	Rationale	Evaluation
Subjective data. Lower abdominal pain Passage of clots **Objective:** Multiple uterine myoma	Acute Pain related to uterine contractions as evidenced by patient verbalizing "I feel pain in my lower abdomen"	To reduce pain levels within 1 hr	Administer prescribed analgesics (IV Paracetamol 1G 8hrly)	Analgesics relieve uterine and pelvic pain.	With 1 hr, patient reported reduced pain Patient also reported improved comfort
			Provide reassurance and calm environment.	Reassurance reduces anxiety-related pain perception	
			Position patient in bed comfortably	Comfort positioning reduces abdominal strain	

References

- Herdman, T. H., Kamitsuru, S., & Takáo Lopes, C. (Eds.).(2024). NANDA International nursing diagnoses: Definitions and classification, 2024–2026. Thieme.

References

- Herdman, T. H., Kamitsuru, S., & Takáo Lopes, C. (Eds.).(2024). NANDA International nursing diagnoses: Definitions and classification, 2024–2026. Thieme.


Thank
You

Now, let's dive into the Acute Care Management of this Patient's condition

Dr Jackline Akello, Obstetrician &Gynaecologist, Public Health Specialist, Safe Motherhood Advocate & Lecturer at MakCHS

How should you approach this patient as ED doctor?

Approach To Acute PV Bleeding

This section focuses ONLY on emergency decision-making.

- ED assessment
- Investigations
- Emergency management
- Disposition & follow-up

Goal: What saves lives in the first 30–60 minutes

Primary ED Assessment: ABCDE ALGORITHM

A – Airway: Ensure patency
B – Breathing: RR, SpO_2, Oxygen
C – Circulation: IV access, shock control
D – Disability: GCS, perfusion
E – Exposure: Abdomen & PV assessment

ED Primary Survey (ABCDE)

PV bleeding is a cause of hemorrhagic shock until proven otherwise

Key Red Flags in ED

- Ongoing heavy bleeding with clots
- Hypovolemic shock
- Severe anemia symptoms
- Suspected structural pathology

which red flag worries you most in your setting?

Recognising Hemorrhagic Shock

Heavy PV bleeding

Tachycardia
Hypotension

Dizziness
Syncope

→ Treat as SHOCK until proven otherwise

Brief Focused ED History

Symptoms, Allergies, Medications
Past gynecologic history
Last menstrual period
Events leading to illness

(SAMPLE)

Priority Bedside Investigations

-Pregnancy test in all reproductive-age women.
-Point-of-care tests recommended
- Continuous vital monitoring

Bedside FIRST

Hb / FBC
Pregnancy test
Vitals

Parallel
(not sequential)

Blood group & cross-match

Ultrasound AFTER stabilization

Emergency Management Priorities

- Control bleeding
- Restore circulation
- Correct anemia
- Prevent complications

Parallel processing: resuscitate while investigating. Early TXA saves lives.

Two wide-bore IV lines

Crystalloids

Tranexamic Acid 1g IV

Blood transfusion
if unstable / symptomatic

Early senior & GYN
involvement

Blood Transfusion Decision-making

Clinical status matters more than Hb alone.

Treat the patient, not the number

Clinical status
> Hb value

Indications:
- Shock
- Ongoing bleeding
- Severe symptoms

Monitor reactions
& response

Disposition & Definitive Care

Nurses as the backbone of emergency hemorrhage care

Admit if:
- Unstable
- Ongoing bleeding
- Transfusion needed

Plan definitive treatment (myomectomy / TAH)

Clear handover & follow-up

Specific Gynecologic Management

- Medical therapy
- Mechanical measures
- Surgical planning

Key Take-Home Messages

- ABCDE first
- Early TXA & blood save lives
- Team-based care

ED Checklist: First 30 Minutes Of Acute Pv Bleeding

- ✓ ABCDE completed
- ✓ Two large-bore IV lines
- ✓ Oxygen if unstable
- ✓ Blood drawn (Hb, group & cross-match)
- ✓ Pregnancy test sent
- ✓ Tranexamic acid 1 g IV
- ✓ IV fluids started
- ✓ Blood requested if unstable/symptomatic
- ✓ Senior clinician + GYN informed
- ✓ Continuous monitoring instituted

GUIDELINE ANCHORS (GLOBAL)

- WHO: Management of obstetric & gynecologic hemorrhage
- RCOG: Acute Heavy Menstrual Bleeding
- ACOG: Abnormal Uterine Bleeding – Acute Management

All emphasize: ABCDE, early TXA, blood first, surgery later.

Thank You For Listening


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