# Clinical Pathological Case (CPC)

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CPC
CASE-BASED LEARNING SERIES
"Mastering Emergency Care"

## Disclaimer

**Clinical Pathological Case training videos are for educational purposes and should not be used as the sole source of reference during patient care. Always refer to official guidelines and consult qualified professionals before applying any practices**

# Case Based Learning Series

"Student Led Adult Learning"

CPC
CASE-BASED LEARNING SERIES
"Mastering clinical Reasoning in Emergency Medicine"

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GLOBAL HEALTH

## Clinical Pathologic Case (CPC)

Emergency Medicine Case Based Series



**THEME:**
**She came in Profusely Sweating**

**Date:** 25TH SEP 2026 | **Time:** 7:00 PM - 8:00 PM

| Expert | Case Presenter | Prehospital Presenter |
|---|---|---|
|  |  |  |
| **Dr. Sarah Oworinawe**<br>EM Physician at Yumbe RRH | **Aminye Alban**<br>Makerere University Emergency Medicine Interest Group. | **Nabwire Jane Mande**<br>Gulu College of Health Sciences |

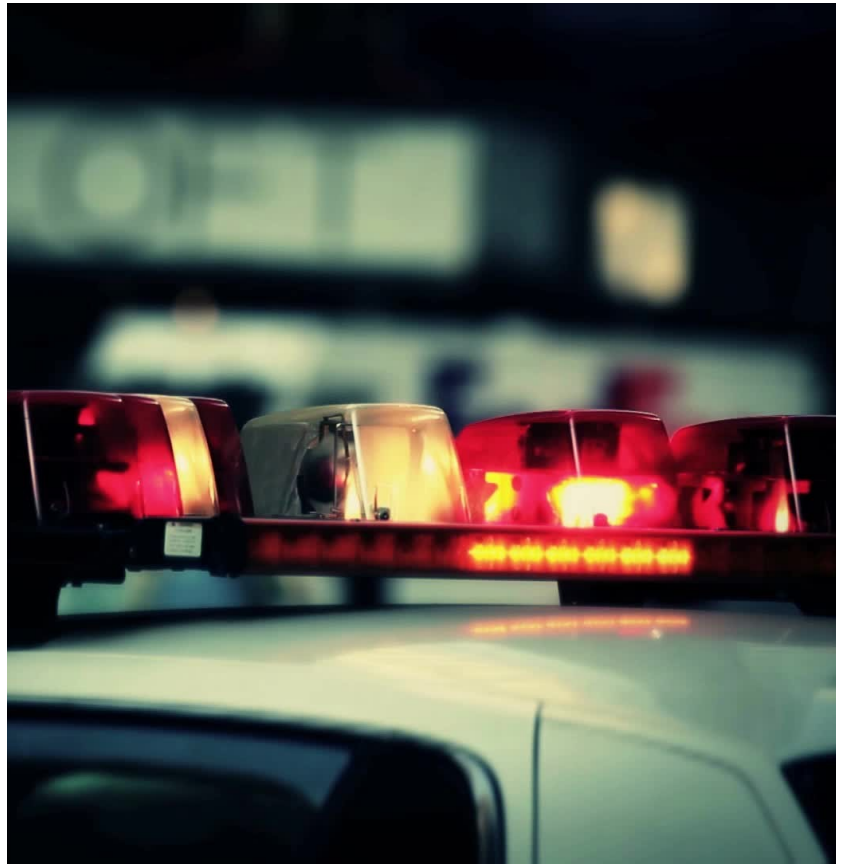
zoom SCAN QR CODE TO REGISTER
https://shorturl.at/kMzmn

FUMSA
DELTA EM
MAKERERE EMERGENCY MEDICINE INTEREST GROUP

# Presenting Complaint

25Y/F G2P1+0, 37 WOA who presented with

- profuse sweating
- lower abdominal pain for I hour



# Pre-hospital presentation and hand over



**Transfer Details:**



Community facility transfer.



Ambulance type C (ALS).



Crew. 2 EMT and an emergency driver

***Type C ambulance because  patient may require ; Emergency resuscitation. Advanced monitoring. Management of complications during transport***

# Equipment and Requirements

***Airway:***
suction machine, OPA, NPA, O2 cylinder
***Breathing:***
pulse oximeter, stethoscope, timer, nasal prongs ,face mask, NRM, bag valve mask
***Circulation:***
Large bore cannula, giving set, fluids, analgesia, bp machine ,pulse oximeter, fetoscope, ECG , defibrillator monitor.
***Disability:***
*P*en torch, Glucometer And Strips
***Obstetric and delivery equipment***:
Fetoscope, Mama kit, new born Ambu Bag ,Penguin Sucker
***Drugs:***
Tranexamic acid, oxytocin, vitamin K,
Emergency Drugs Like Adrenaline

# ISBAR REPORT

**IDENTIFICATION**

I am Nabwire Jane Mande, an EMT student dispatched to the community to pick a 25y/F, G2P1+0 AT 37 weeks with profuse sweating and severe lower abdominal pain.

**SITUATION**

Was called by the patient's husband when she developed sudden lower abdominal pain, started sweating profusely and she was restless.

**BACKGROUND**

G2P1+0 at 37weeks, no known illness. Attended ANC only 5 times and were Uneventful. Last ANC visit was 2 months ago.

**ASSESSMENT**

Patent airway, tachypnic with **RR: 35** breaths/min,**SPO2:86%**R.A. **P.R 161b/m**, **BP 81/44** mmHg. **Shock index(161/88) 1.98**, patient alert

# ISBAR report

**Interventions**

- O2 given at 10L/min, via NRM. Secured IV access 2 large bore cannulas and administered 1L of RL, placed in lateral decubitus position
- IV PCM 1g to control the pain

**RECOMMENDATION**

- Urgent obstetric review.
- Further shock resuscitation and oxygenation
- Blood grouping and cross match and book blood, CBC, urinalysis
- Continuous Foetal heart monitoring

# Expert



What are your initial thoughts?



What is you preparation and approach to this patient?

# Primary Survey

- **Airway:** Patent, speaking in short broken phrases
- **Breathing:** Tachypnea ***RR =35breaths/min***, SpO2 86 on RA, chest was clear.
- **Circulation:** ***CRT>3***s, cold peripherals, regular, thready and fast pulse ***PR= 161 bpm***, Blood pressure ***81/44mmHg*** MAP(56) ***fetal heart -195***
- **Disability:** GCS=**14/15(E4V4M6**), pupils equal, round and reactive to light, RBS??
- **Exposure :** No bruises, Small PV clots at the vagina introitus but no active pv bleeding

# Audience

- Any additional information?



# POLL 1

What are the immediate life threatening conditions in this patient?

# ED Intervention

**AIRWAY:** patent, maintain open airway in lateral decubitus position

**BREATHING:**

administered oxygen via NRM at 15L/min; maintained SpO2at 97%

**CIRCULATION**:

- Gave IV RL 1L bolus via 2 large bore cannulas, Maternal BP improved to 98/52mmHg .
- Continued resuscitation with more 1.5L of RL, giving a total of 2.5L bolus
- *maternal BP improved to 123/84mmhg, PR-117. FHR improved slightly to -185BPM*
- Blood samples picked off for investigations

**OTHER INTERVENTIONS:**

Placed in lateral decubitus position

IM Diclofenac 75mg stat to manage pain

# SAMPLE History

**Signs & Symptoms:** DIB. associated with diaphoresis.

Severe lower abdominal pain.

she reports having seen a few PV spotting 1hour to arrival

**Allergies:** No known drug and enivornmental allergies

**Medications:** Routine ANC supplements

**Past Medical History and birth history:** G2P1+0, 37 WOA, attended ANC 2 times, no major challenges, no known chronic illness

**Last Meal:** 4hours prior to admission.

E**vents Leading to Presentation:** pain began suddenly at rest 1hour ago without history of direct abdominal trauma. Pain has been continuous and worsening.





# Secondary survey

- **Head and Neck:** No head or cervical spine injury
- **Chest:** chest was clear , normoactive pericordium. heart sounds S1 and S2 present, no added sounds.
- **Abdomen:** fundal height 38/40; **Uterus hard woody and tender; FHR 185(fetal tachycardia**); presentation & lie longitudinal cephalic
- **Speculum examination:** dark red blood clots in the posterior fornix, open **cervical os ~2-3cm**, no cervical or vaginal lacerations, no lying placental tissue visible or covering the os
- **Extremities:** cold extremities, no bruises
- **Neurological:** Alert though **restless,confused and anxious**, but well oriented in  place and person, PEARL

# Expert opinion?



Any additional thoughts at this point?



Any additional info you would want to get?

# PROBLEM LIST.

**Clinical problems**

1. DIB
2. Hemorrhagic shock, class III
3. Severe abdominal pain
4. Severe fetal distress

**Immediate ED Non-gyn priorities**

1. Hemodynamic stabilization: maintain the MAP >65mmHg with fluid/blood
2. Fetal oxygenation: oxygen therapy and left lateral tilt
3. Activate blood bank: booked blood
4. Transfer to OR: prepare for emergency c-section

# INVESTIGATIONS

| Test | Parameter | Value | Reference |
|---|---|---|---|
| **Complete blood count.** | Hb | 12.4 | 11.5-15.5g/dL |
| | HCT | 33.7(L) | 34.0-45.0% |
| | PLT | 267 | 150-450×$10^3$/uL |
| | WBC | 7.79 | 2.80 – 8.20×$10^3$/uL |
| | ANC | 8.3(H) | 1.70 – 7.70×$10^3$/uL |
| **RFTs** | Creatinine | 64 | 44-80umol/L |
| | urea | 3.8 | 2.5-6.5umol/L |
| LFTs | ALT | 18 | 7-35u/L |
| | AST | 22 | 10-40u/L |
| | Total bilirubin | 10 | 3-20umol/L |
| | Serum albumin | 36 | 35-50g/L |
| **Coagulation profile** | PT | 11.8 | 11.0-13.5 sec |
| | INR | 1.0 | 0.8-1.2 |
| | aPTT | 28.5 | 25.0-35.0 sec |
| **Urinalysis**: no proteins, glucose or leukocyctes | | | |

# POLL 2

What are the most likely differential diagnoses for this patient?

# Expert opinion



What are your differentials at this point



What is your management plan?

# DIFFERENTIAL DIAGNOSIS

| DIFFERENTIAL | IN VIEW OF |
| --- | --- |
| 1. **Abruptio Placentae** | • *Sudden PV bleeding, hard woody tender uterus, lower abdominal pain, maternal hypotension.* |
| 2. Placenta Previa | • PV bleeding, lower abdominal pain, maternal hypotension. |
| 3. Vasa previa | • Antepartum PV bleeding, fetal distress |
| 4. Hypovolemic/Hemorrhagic Shock | • Cold extremities, weak pulse, hypotension. |

# Working diagnosis

25/F G2P1+0 at 37WOA with

- ***hemorrhagic shock secondary to obstetric Hemorrhage***
- ***PLACENTA ABRUPTIO with fetal distress***

# POLL 3

What is your definitive management Plan for this patient?

# Definitive Management Plan

- Delivered by EMC/S  due to persistent fetal distress
- **Outcome**: live male baby, weight 2.8kg APGAR score ***4 at 1min***, ***7 at 5min.***Transferred to NICU for observation
- **IntraOperatively**-A large Retroplacental hematoma(clot) dark clotted blood covering more than half about of placental bed, with a ¾ way detached placenta was discovered after delivery of the baby



# HOSPITAL COURSE

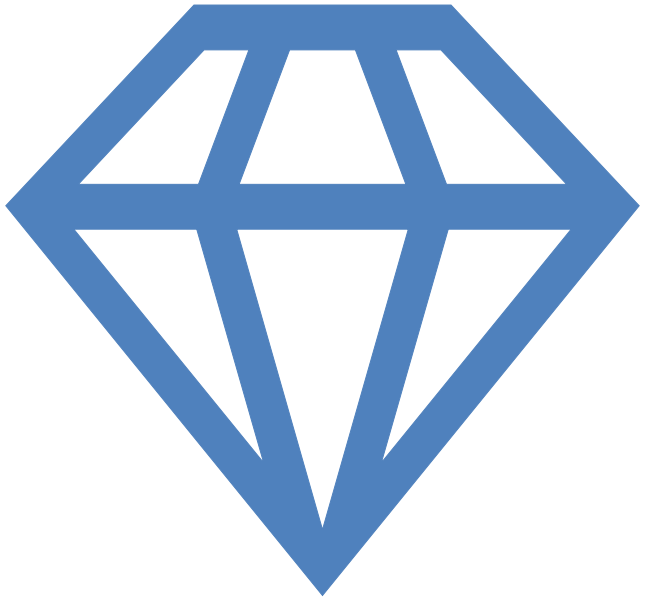
- 20 minutes  post delivery, she developed severe PV bleeding, filling 3 pad sin 5 minutes. Uterus was boggy and soft

**Dx- PPH secondary to uterine atony**

**ACTION COURSE TAKEN**

- Uterine massage every 15 minutes for 2hours and manual  evacuation of  clots
- Oxytocin 10IU iv bolus + 40IU infusion in 500mL NS
- IV TXA 1g over 10mins
- Blood transfusion 2units packed Red Cells

# Expert



Pearls and pitfalls ?

# ABRUPTIO PLACENTA

**Definition:**

bleeding into the genital tract after ***at*** or ***after 26 weeks*** of gestation and before delivery in a normally situated placenta.

**Predisposing factors**.

- previous hx of abruptio,
- hypertensive disorders of pregnancy,
- polyhydramnios,
- chorioamnionitis,
- folate deficiency, smoking….

**Investigations**

- Blood grouping and cross matching
- Blood for CBC/Hb, platelet count
- Ultrasound scan
- Clotting time, Prothrombin time, activated partial thromboplastin time
- Urinalysis
- Mobile Obstetric USS

# HEMORRHAGIC SHOCK IN ABRUPTIO

**Defn;** A form of hypovolemic shock caused by rapid, significant intravascular blood loss leading to tissue hypoperfusion and cellular hypoxia.

**Hallmark Clinical Indicators Of Shock.**

- Hypotension(BP<90/60mm Hg. MAP<65)
- Tachycardia. Weak thready pulse
- Cold clammy, pale mottled skin, cap refil>3s
- decreased urine output<0.5ml/kg/hr
- altered mental status, confusion, restlessness,

**Special Considerations**

- Laboratory values are not helpful in acute hemorrhage.
- Hemoglobin and hematocrit values remain unchanged immediately after acute blood loss.
- Maternal vitals remain normal until >30% blood loss occurs
- Pregnancy hypervolemia(40-50% blood volume expansion) masks shock.
- **The lethal triad**; hypothermia, acidosis and coagulopathy.

# SHOCK MANAGEMENT

- Primary treatment is to *control the source of bleeding as soon as possible* and to replace fluid.
- Crystalloids vs colloids? Crystalloids are always the first choice.(RL.NS)
- Massive transfusion protocol is also instituted in severe cases

**Controlled hemorrhagic shock( CHS):**

fluid replacement is aimed toward normalization of hemodynamic parameters.

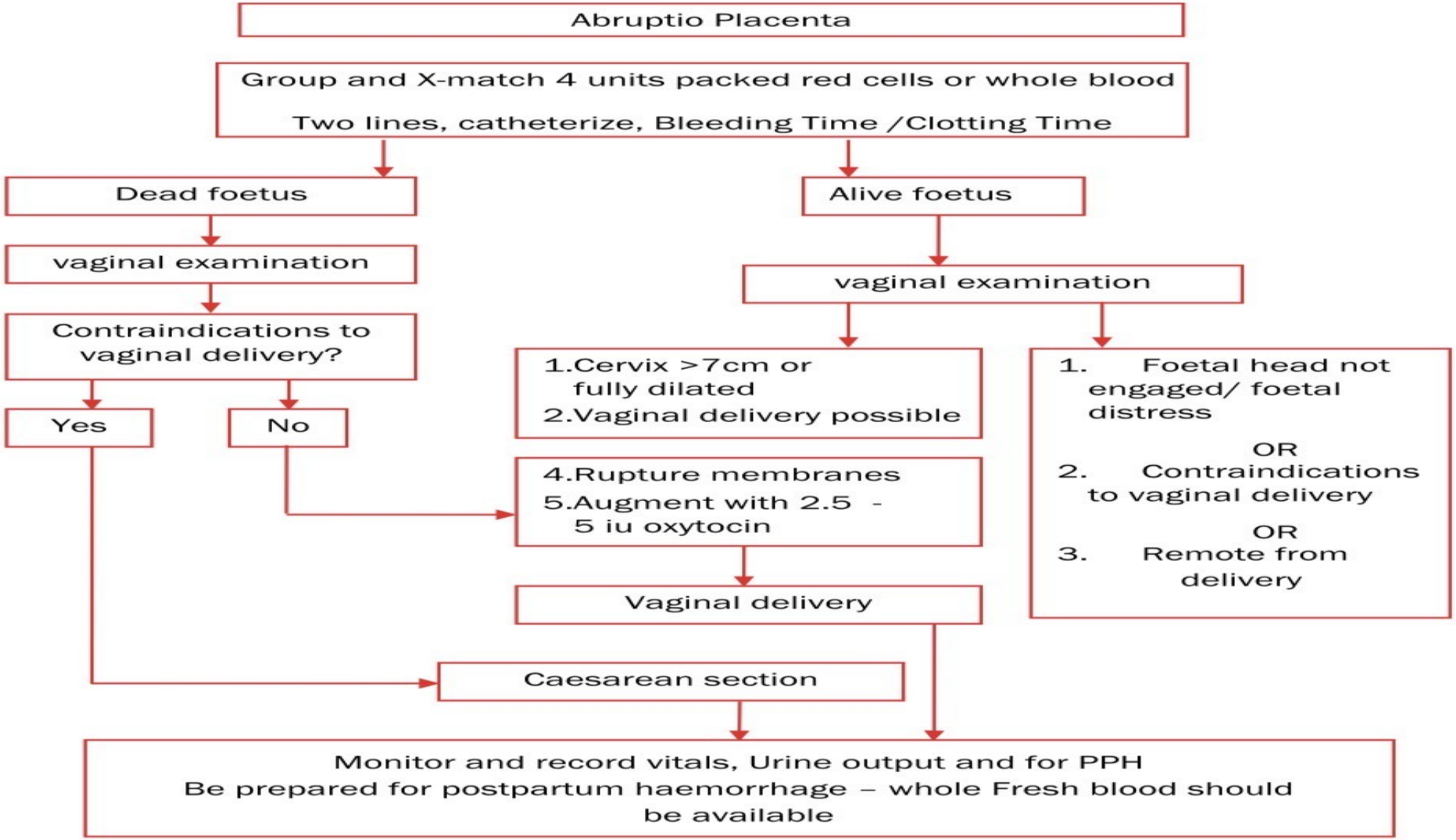
**Uncontrolled hemorrhagic shock** :

When bleeding has temporarily stopped because of hypotension, vasoconstriction, and clot formation, fluid treatment is aimed at hypotensive resuscitation.

- Abruptio qualifies under uncontrolled hemorrhagic shock. Shock resuscitation is always 1$^{st}$ priority before delivery of the baby

**Adjunctive therapies:** Tranexamic acid, temperature control

# ABRUPTIO MANAGEMENT ALGORITHM.



# References.


- UpToDate
- Medscape
- Essential Maternal and Newborn Clinical Guidrlines for Uganda 2022

# Acknowledgements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