The following abstract will be presented at the Southern Medical Association Annual Scientific Assembly, October 30-November 1, 2014 in Destin, Florida.

Author and Co-Authors

Robert Dachs, MD, Vice Chair, Dept. of Emergency Medicine, Clinical Associate Professor and Director of Research; Alvin Varghese, DO, PGY-2, Family Medicine Resident; Ellis Family Medicine, Schenectady, NY.

Objectives

Upon completion of the lecture, attendees should be better prepared to:

1) Identify risk factors for perimortem cesarean delivery.
2) Realize the impact of aortocaval compression during resuscitation.
3) Reflect medical decision making dilemmas.

Introduction: Cardiopulmonary arrest occurs in approximately 1 in 30,000 pregnancies. Pulmonary embolism, hemorrhage, sepsis, peripartum cardiomyopathy, stroke and pre-eclampsia/eclampsia are the most common causes. Recommendations for performing a cesarean delivery in attempt to save the lives of the mother and fetus vary. We present a case of an emergency department perimortem cesarean delivery, followed by immediate hysterectomy due to placental abruption and uterine atony.

Case Presentation: A 41 year old gravid female, G6P3, 35 weeks pregnant and currently being treated for gestational hypertension, was found unresponsive at home. She was brought to the ED by EMS in PEA. Bedside ultrasound revealed no cardiac activity for either mother or infant. While CPR continued, a decision was made to perform a perimortem cesarean delivery in the ED in hopes of saving the mother’s life. Upon entering the uterus, the uterus was noted to be filled with blood. Maternal pulses and breathing were re-established during resuscitation once the non-viable fetus was removed and epinephrine and saline were given. However, extensive uterine bleeding persisted despite packing the uterus. With obstetrical coverage present, a hysterectomy was performed. Massive transfusion was initiated along with pressor support and the patient was admitted to the ICU in critical condition.

Final Diagnosis: Placental Abruption

Outcome/Discussion: Unfortunately, the patient remained comatose with multiple organ failure. EEG showed electrocerebral silence and she was declared brain dead from anoxic brain injury. Support was withdrawn on the 3rd hospital day and the patient quickly died. While the AHA recommends that perimortem C-section be performed within 4 minutes of arrest, others have suggested a 5 minute rule. Other reports suggest that successful resuscitation can occur beyond these time frames. A review of the published literature will be presented.

Disclosure

Robert Dachs, MD – No Relevant Financial Relationships to Disclose
Alvin Varghese, DO – No Relevant Financial Relationships to Disclose