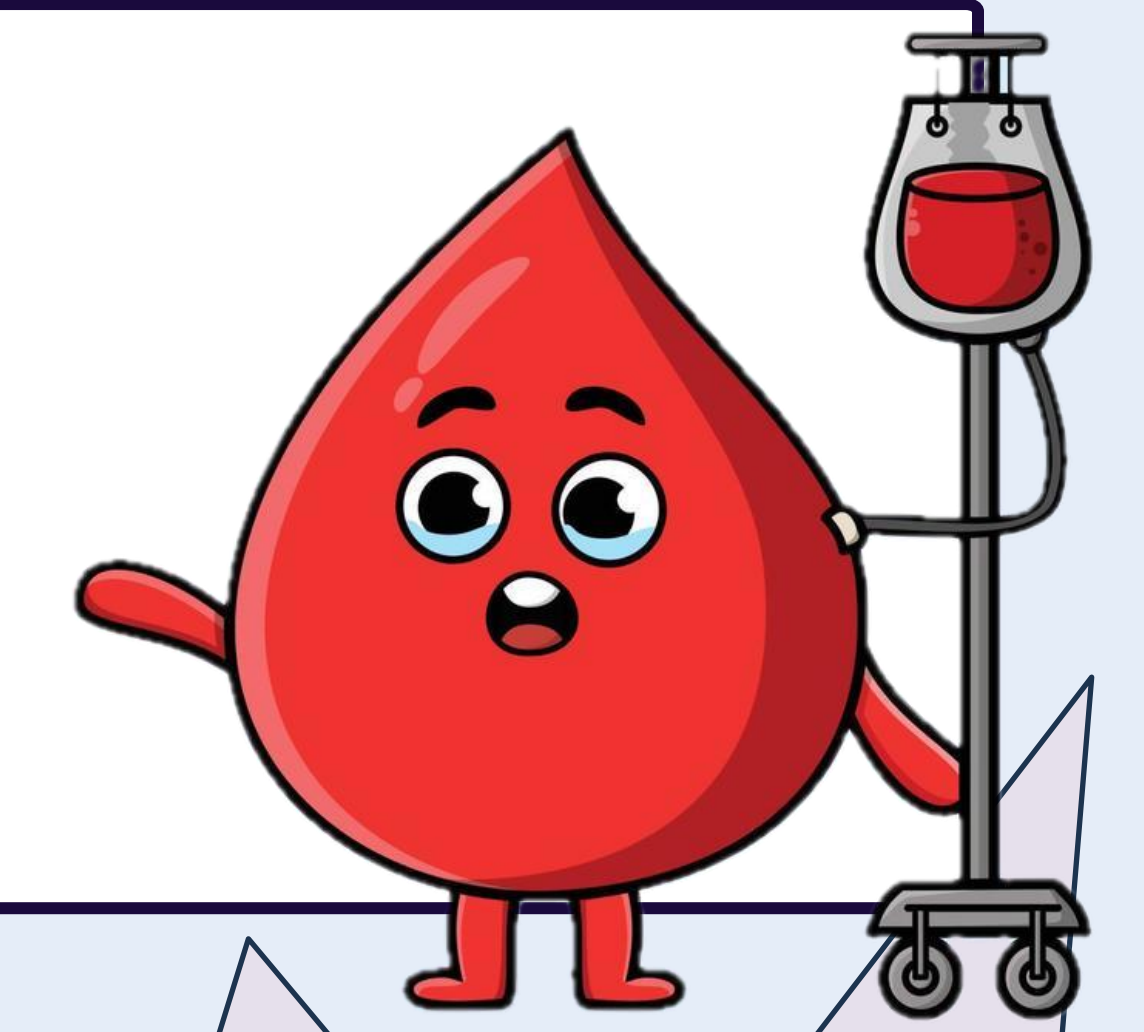


The Eventful Labour Of A Scientologist With Hyponatraemic Seizures And A Major Obstetric Haemorrhage

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1. Introduction

Severe hyponatraemia and postpartum haemorrhage are recognised risks in labour and are included in the Quick Reference Handbook for Obstetric Emergencies. [1]

Written patient consent has been given to share this case.

2. Setting The Scene

37F . 40+6 primip, low risk
PMH: Fit and well. Practicing scientologist.

Night shift

Intended scientology practices for this patient's labour:

- Minimise medical monitoring and interventions
- no-one to speak directly to the labouring woman (speak via her advocates) – all medical team to leave room during these discussions
- no analgesia
- the woman must remain silent throughout birth
- silence in the room during delivery of child.

Long latent phase at home. Declining most obs, VEs & obstetric input.

Declining any labour augmentation until **22:00** when it was agreed to start syntocinon infusion and have an epidural sited beforehand.

3. First Anaesthetic Involvement

23:00 L3/4 Epidural → 10ml LDM at siting, PCEA thereafter.

Within 1 hour: patient calmer, comfortable, eating. Syntocinon started.

Drinking water from large 'stanley' cup, refilled by friend during epidural insertion.

02:17 alarm pulled in the patient's room



4. First Seizure

Tonic clonic seizure, 60 secs, self-terminating.

Patient had been on hands and knees pushing just before seizure, behaving 'normally'.

- A. Snoring on back, unobstructed in left lateral
- B. saO2 85% on RA, RR 30
- C. BP cycling repeatedly, one reading 180/110, HR 120
- D. GCS 3, seizure just terminated

Rapid run to theatre, emergency calls

5. Differentials

BP
180/110

VBG:
Na 117

- Eclamptic fit
- LA toxicity
- **Electrolyte disturbances**
- Intracranial event (e.g. CVST, aneurysm)
 - Other drug toxicity
 - Hypoglycaemia
 - First epileptic seizure
 - Other intracranial pathology

Epidural
running,
conservative
use



6. Management In Theatre

- Fully dilated, CTG reassuring
- **4g Mg, 20mg labetalol**
- **Bolus hypertonic saline**
 - Over following 5-10 mins patient calmed
- Repeat Na 117, **further hypertonic saline**
 - Note: patient noted altered sensation in lower lip (clearly bitten in seizure, quite swollen and bruised)
- Concerns re: baby's Na and cerebral state, delivery ASAP.
- **Delivery – forceps and episiotomy** calm and quick.
 - Baby APGARs good at delivery.
 - Baby Na 120, taken to SCBU for observation.
 - Later needed small amount of NIV but generally good condition.

Scientology silence during final pushes for baby
Husband was present
Delayed cord clamping with skin to skin

7. Second Seizure

At placental delivery, gush of PV blood loss.
2 x Haemobate 250mcg, misoprostol 1g and TXA 1g

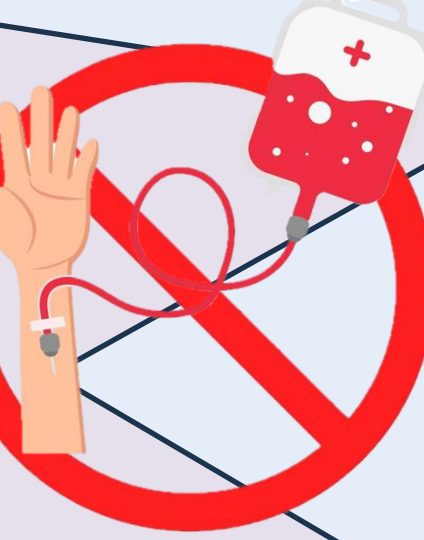
Within seconds patient reported feeling unwell
2nd seizure tonic clonic, 60 secs, self terminated.

8. Treatment Dilemmas!

Further hypertonic saline, repeat Na 121, HB 137→105

- Symptomatic dips in SBP to 70mmHg
- bed ramping, legs up, vasopressor
 - cautious with IV crystalloid volumes!!
 - Requested O- emergency blood but refused issue as patient had **G&S antibodies** therefore risk of transfusion reaction.....

Final EBL 1.5L



9. Outcome

Mother and baby recovered well, home 2 days later
1) 12 hours in ICU via CT head (NAD)
2) Transfused 2x RBC crossmatched blood
3) Fluid restricted as per trust protocol 30ml/hr

10. Reflection

It is tricky to balance hyponatraemia and MOH management!

Patient education is key – safe hydration advice

Things are always clearer in retrospect!

Hyponatraemia section added to emergency trolley



Reference: 1. Obstetric Anaesthetists' Association. The Quick Reference Handbook for Obstetric Emergencies. Accessed 22 January 2025. <https://www.oaa-anaes.ac.uk/downloads/oaa-qrh/june-2024-v1.2/final-obs-qrh-v.1.2.pdf>; 2024.