



Real emergencies through gynaeco-obstetric emergency consultations

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INTRODUCTION/BACKGROUND

Gynaecological emergencies are generally different from medical-surgical emergencies. Because of their specialised nature, patients cannot be treated by an emergency doctor and are immediately referred to gynaecological and obstetric emergencies. Most of the time, emergency rooms are overcrowded with patients who do not fall within the definition of a true emergency as defined in medical circles, which adds to the workload of medical and paramedical staff who have to manage the delivery room and obstetric emergencies simultaneously, beside ; this saturation of emergency rooms can lead to the risk of delayed treatment and often long waits.

OBJECTIVES

to stratify emergencies according to their truth and to study the diagnoses used in the gynaecological emergency room.

METHODS

We conducted a longitudinal, prospective, single-centre study over 3 weeks from 9 October 2023 to 28 October 2023. We included all women who consulted the emergency department, with the exception of full-term parturients admitted for labour and patients under 14 years of age. The evaluation criteria were the the nature of the emergency in terms of the need for urgent treatment, surgery or hospitalisation.

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RESULTS

Patients who came to our department on their own represented 60% of all patients, 32.9% were referred by an emergency doctor and 7.1% were referred by an independent gynecologist or midwife. No gynecological pathology was observed in 37.5% of patients, 64.5% of whom were initially referred from general emergency. An obstetric pathology was identified in 28.9% of cases. Threatened abortion was the most common diagnosis in 23.1% of cases, followed by preterm labor in 17.7%, aborted pregnancy (15.4%) and vomiting in pregnancy (14.6%). Hypertensive emergencies accounted for 4.6% of cases, serious hemorrhagic emergencies 0.8%, such as bleeding placenta previa, and infectious emergencies in 3.1%. Retained gynecological diagnoses accounted for 16.4% of cases, the most frequently retained being: pregnancy with unknown location (9 cases), lower genital infection (9 cases) and infectious mastitis (7 cases). Gynecological emergencies were hemorrhagic in 3.1% of cases and infectious in 6%. Among patients referred by a gynecologist or midwife, 37.5% were admitted to hospital. Among patients who consulted on their own initiative, 23% were admitted to hospital. Of those referred by the general emergency department, only one patient was hospitalized in 0.7% cases. No gynecological pathology was identified in 42.2%. Gynecological pathologies were diagnosed in 57.8%. These pathologies constituted: an extreme emergency in 2% of cases, a delayed emergency in 13.6% of cases, a legitimate emergency with outpatient treatment in 21.8% of cases, no emergency in 20.4% of cases. In total, the patients were divided into three groups: True emergencies in 15.6% of cases; Legitimate emergencies in 21.8% of cases; and false emergencies in 62.6% of cases.

DISCUSSION

Serious obstetric pathologies occur in 3 to 9% of pregnant women who have to give birth in referral maternity units (1). ‘Pre-eclampsia’ was the third pathology encountered in our study (1.3%), and is a dreaded dysgravida which complicates 2 to 8% of pregnancies (1).

The circuit between general or surgical emergencies and gynecological emergencies is often poorly organized, while in fact they can sometimes overlap. To avoid wasting time and energy, establishing a clearly defined circuit between the two emergencies could be a solution, and it is the role of general emergencies to triage patients before referring them to specialist emergencies (2). Several studies have shown the advantages of such ‘general or central’ emergencies, not only in terms of saving time and money, but also in terms of quality of care (2).

Also, Several studies have shown that emergency rooms are overcrowded, which affects the performance and concentration of nursing staff (3). For example, Darai E et al (4) found that emergency room activity affects the availability of healthcare staff for the delivery room. In fact, more than third to half of the patients who present to emergency departments are not medical emergencies. Legru et al (5) showed that a sense of urgency motivated patients to consult a doctor in 38% of cases, whereas 46% of patients left the emergency department without a prescription, which underlines an anxiety often wrongly felt by patients. Breen M et al (6) showed that nurses, doctors, emergency physicians and ambulance staff felt that 98% of consultations were not urgent.

CONCLUSIONS

The majority of emergency room patients are false emergencies, which underlines the importance of triage and training for front-line doctors.