Uterine Rupture: How Can We Improve Maternal Safety?

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CLINICAL CASE

- 21yo G4P1111 F, 31w6d
- **PMHx:** BMI 40, HTN
- **OB Hx:** full-term VD, prior classical CD for preterm labor
- Transferred from OSH in preterm labor with UTI
- **Dx with IUFD on admission**
  - OB providers deliberate whether to proceed with CD or attempt VBAC
  - Risk of uterine rupture with VBAC 2-9% after classical CD
- **Physical Exam:** diaphoretic, obtunded, hypothermic (94.8° F)

Vitals	BP (mmHg)	HR (bpm)
2326*	166/96	113
2342	96/51	155
0041**	78/48	165

*On Admission, **Anesthesia Called

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HYPOTENSION HYPERVIGILANCE

- Anesthesia Team → 16g PIV, Art Line, 3L Crystalloid, 1,000 Mcg Phenyl
- OB Team → exam, bedside US repeated - showing no signs of bleeding

- Transfer to ICU
  - **DDX: Hemorrhage vs. Sepsis** vs. MI, Arrhythmia, HF, PE, AFE, Anaphylaxis, Medical Error
- Labs: Hgb 11.5, Lactate 6.6 → sepsis treatment initiated
  - Receives infusion of Norepi, but MAP < 55 mmHg

- Transfer to OR for emergent Ex Lap
  - EBL 2.5 L → 5u pRBC

- Dx of anterior uterine rupture is made

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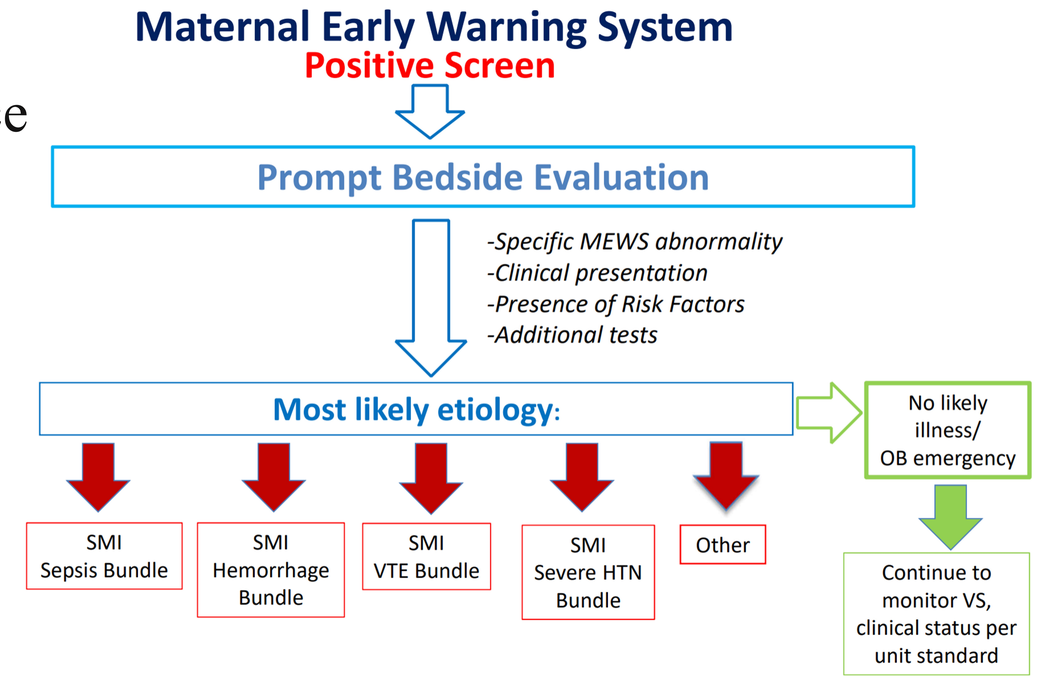
QI INITIATIVES

- Maternal Early Obstetric Warning System (MEOWS) task force
  - ➢ Per ACOG recommendation
- ↑ frequency of huddles &/or safety rounds
  - ➢ OB, anesthesia, nursing
- Point of Care US (POCUS) certification for physicians
- Availability of 2 Hemorrhage Kits
  - ➢ Contains: IV supplies, vials (CBC, Coagulation Panel), TXA
- Thromboelastography (TEG)
- Bedside H&H analyzers



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ACOG
The American College of Obstetricians and Gynecologists

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