Amniotic Fluid Embolism: The Unpredictable Catastrophe

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Rare (≈1 in 20,000–50,000 deliveries) but often catastrophic

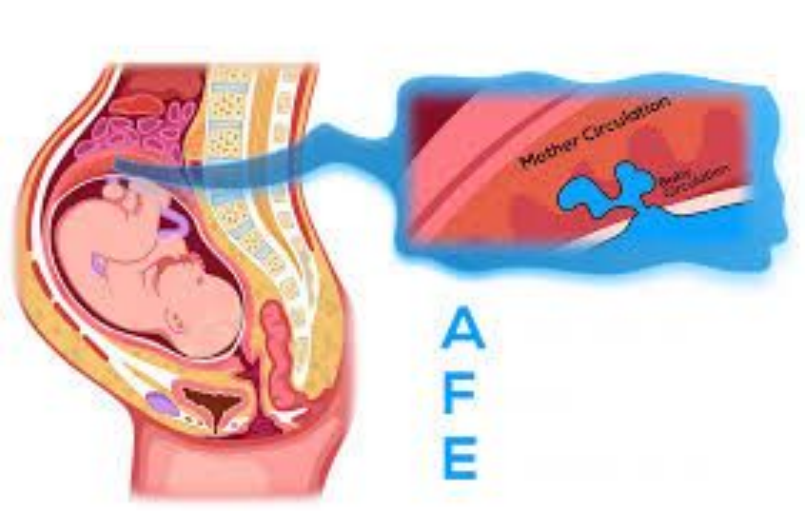
Classically presents during labor or postpartum with:

- Sudden hypotension, hypoxia, altered mental status
- Possible coagulopathy / DIC

Pathophysiology: Maternal immune response to amniotic components → inflammatory and vasospastic cascade

**Mortality remains high without rapid recognition and resuscitation

Case: Twin Delivery Complicated by Suspected AFE



- 30-year-old G-DiDi pregnancy under epidural, in OR for twin delivery
- After delivery of twin A → internal version for breech twin B
- Abrupt bradycardia, hypotension, altered mental status → suspected AFE
- Excluded anesthetic toxicity, PE, hemorrhage
- A-OK protocol initiated:
  - Atropine, Ondansetron, Ketorolac
    - Epinephrine, intubation, supportive care
- Rapid emergency C-section for twin B → both neonates and mother recovered
- Extubated after 24 h in ICU, no neurologic sequelae

Teaching Points & Takeaways

- Always suspect AFE with sudden hemodynamic or respiratory collapse during labor or delivery
- Diagnosis of exclusion: no definitive test
- Immediate supportive resuscitation = survival:
  - Airway control, oxygenation, vasoactive support
  - Consider A-OK protocol to modulate cardiovascular reflexes
- Multidisciplinary readiness—OB, anesthesia, ICU, neonatology—is essential
- Successful outcomes hinge on team communication and rapid decision-making

Recognize fast, act faster — that’s the difference in AFE.