Differential Diagnosis

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The Mbrrace report

- Mbrrace reports have clearly stated women need clear assessment, communication between teams and plans of are regardless of place of admission
- Quite often pregnancy acts as a block for routine assessment- the risk of any investigation will always outweigh the risk of not doing it.
- Staff are often blind to other possibilities- thinking in terms of a single organ

Poor care of;

Airway

Breathing

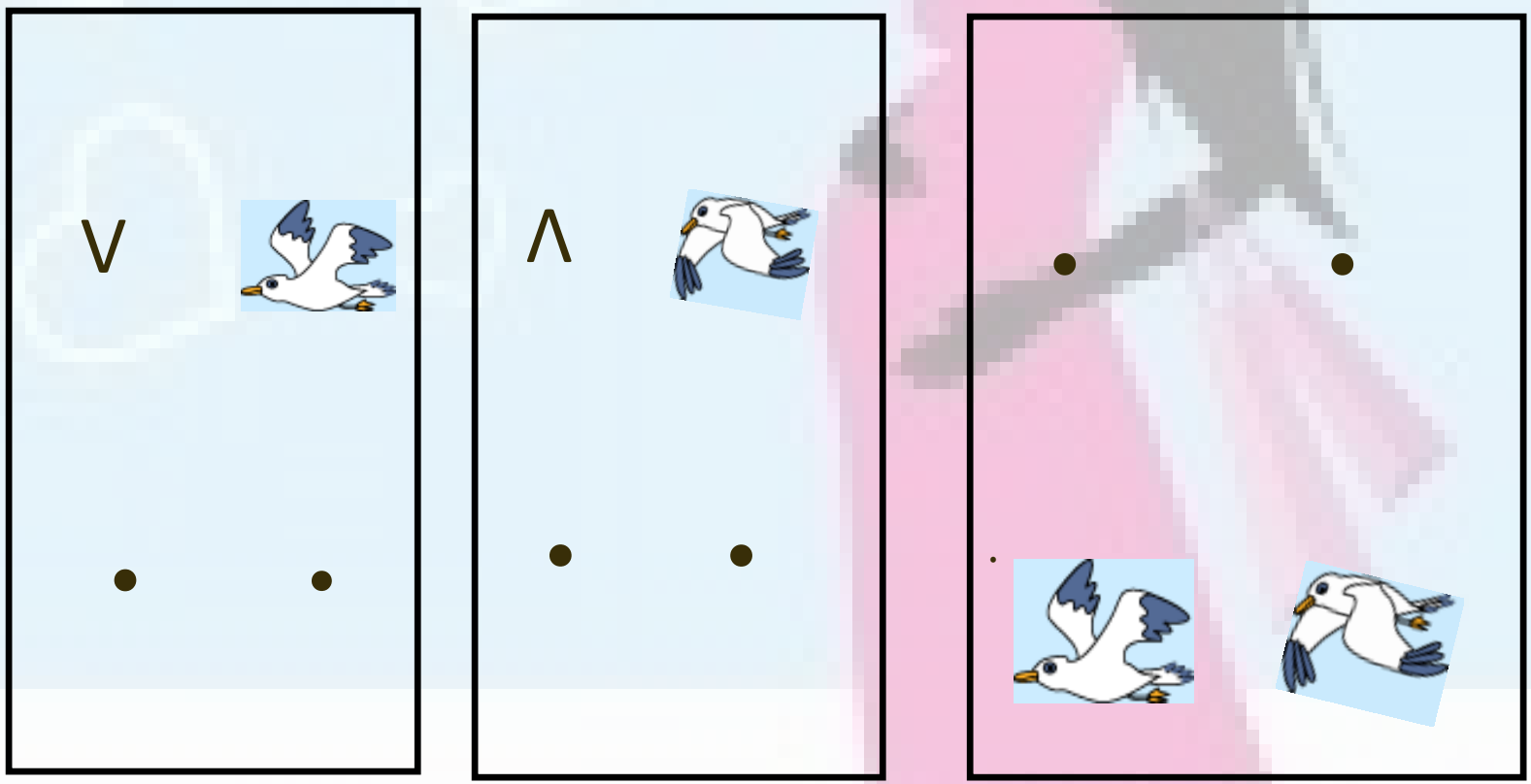
Circulation

Oxygen therapy

Monitoring

History

Portsmouth Sign



NORMAL PHYSIOLOGY

SICK

Use basic examination skills

1. Look

2. Listen

3. Feel

Assessing a Critically Ill Patient

Airway

Breathing

Circulation

Disability

Exposure

Assessing the Critically Ill Woman

Don’t progress from **A** to **E** until each stage is completed

Don’t forget your management plan!

- What would you recommend doing when you find a sick lady?

- Ensure

Appropriate staff

Appropriate monitoring

Appropriate equipment

Clinical assessment

- In ANDA, Lucy presenting with SOB.
- G1 26 years old
- No PV loss
- No abdo pain
- You are asked to see her- what do you want to know?

- A- SOB, cannot speak full sentences
- B- RR 26 but noted more shallow on one side- SpO2 on air 91% with 2lO2 via specs 94% equal air expansion
- C- has taken ventolin and HR 112bpm- not bounding, easy to palpate BP 112/76 CRT- 3 seconds
- D- Alert CBG- 4.6mmols
- E- CTG FH 150bpm (was 140bpm at reduced FM CTG) Calves non tender

- What are your thoughts? (think differential diagnosis)
- Have you got PMH?

- Impression:
- Exacerbation of asthma
- HR increased due to ventolin use
- Further questions- what do they normally take?
- Symptoms of chest infection
- Flu jab?
- Smoke?
- What is your plan?

- Vicky, G1 32 weeks 41 years old limited history available, seen in ANC and given whooping cough and flu jab.
- Left unit, felt unwell, dizzy, had vomited, coming to ANDA
- What would you prepare?

- Arrives:
- A- SV on air
- B- RR 14 SpO2 96% air
- C- HR 90bpm, BP 102/60 CRT below 2 seconds, clammy, cold
- D- Alert but anxious CBG- awaited
- E- no urticarial rash, clammy up arms, sweaty forehead, CTG normal
- Impression?

- About to do CBG and discusses has taken LA insulin, had waited in ANC for three hours, Insulin Dependant Gestational diabetic, went for lunch so took insulin and then vomited without eating
- CBG assessed and 1.6mml/l
- Have you changed impression?

Postnatal lady

- G2 P0+1, pre existing anxiety disorder
- Induced for PET at 39/40 (on labetolol qds)
- Quick first stage of labour
- Ventouse, PPH 1647mls
- On PN ward history of panic attacks- pre existing depression (medicated with sertraline 200mg and amitryptiline)
- Referred to Psychological medicine for review prior to weekend- reviewed- quetiapine added
- Worried re home situation- keen to go home adding to anxiety

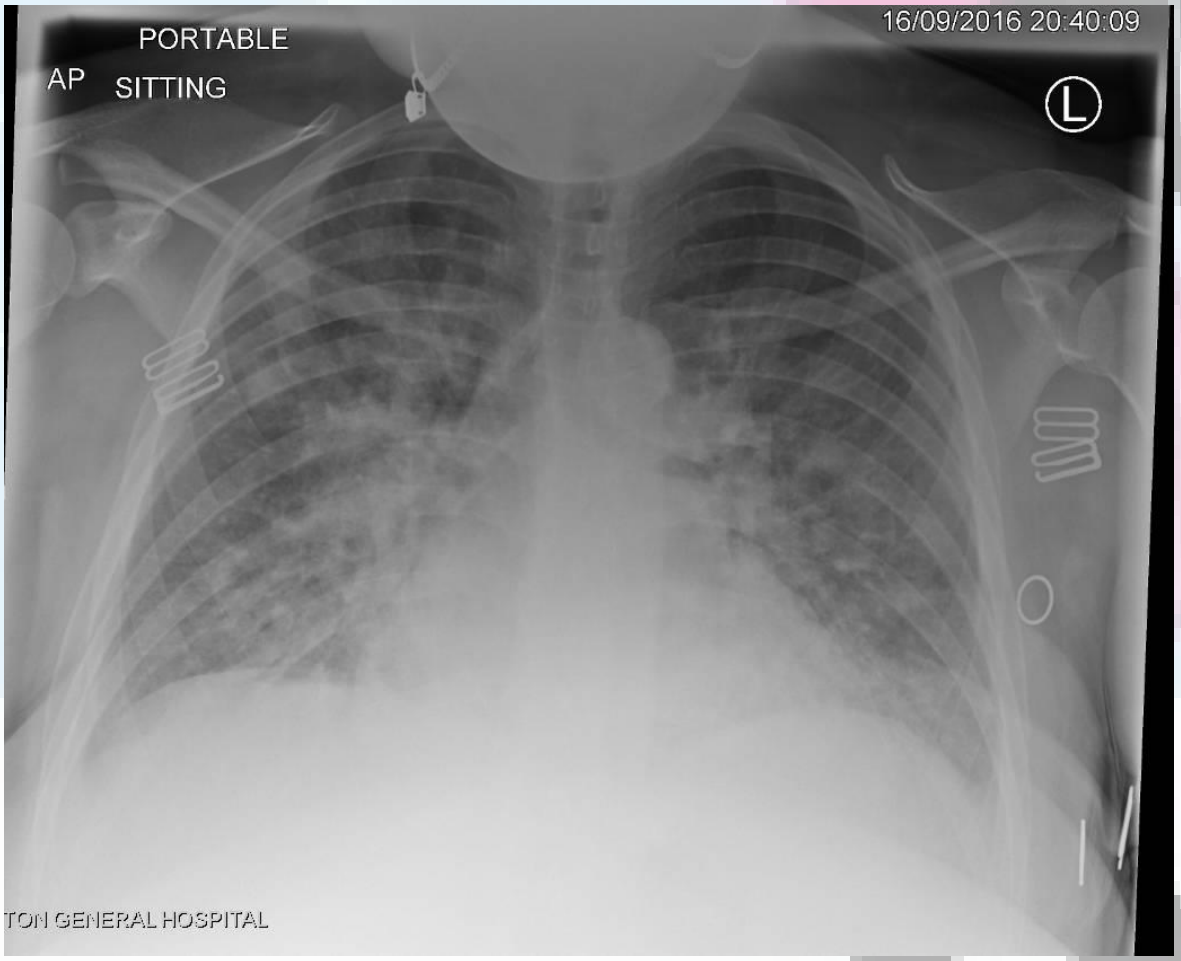
- While chatting noted to be SOB
- On questioning- felt pressure on chest when laying down, felt ‘rubbish’
- HQ 65g/l- no other observations done
- 15:50-SB SHO- based on HQ and SOB- chest auscultated clear
- For transfusion while await formal Hb (Hb 85g/l)- blood ordered
- 17:35- SB Reg as desaturating- chest clear and difficult to assess

Blood results

	Hb (g/l)	WBC	Platelets	Urea	Creatinine	ALT	Alk Phos	Urate
12/9/16 (IOL)	110	11.6	398	2.8	44	5	199	328
13/9/16 (Labour)	93	21.5	336	3.0	50	8	163	385
13/9/16 (PPH)	87	18.8	343	-	-	-	-	-
14/9/16 (day 1)	79	15.8	346	3.8	49	16	132	-
16/9/16 (day 3)	85	16.0	483	-	-	-	-	-

- T/F to labour ward as desaturating on air to 90%
- Anxious- did not want to go back into a labour ward
- Declined to be examined, requesting to go home
- S/B consultant/ reg and anaesthetics difficult consultation, refused all care, taking O2 off saying felt fine and needed to go home. Declined all observations, auscultation of chest eventually done and creps auscultated
- CXR ordered as desaturating

Chest XRay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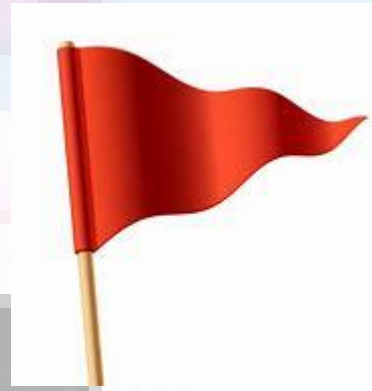
TON GENERAL HOSPITAL

- Blood transfusion- 1 unit already given, 2nd unit stopped
- Referred to cardiology as pulmonary oedema/ dropping SpO2 and unable to tolerate lying down and furosemide IV given.
- Reg did not think needed urgent review so obstetrician said if too busy she would contact their consultant as warrants escalation and review for postpartum cardiomyopathy



- Bedside echo showed severe LV dysfunction
- Admitted to cardiac unit-
- Overloaded (Furosemide given IV then orally- 40mgs)
- TTE 19/09/2016
- Dilated LV cavity with <20% function, normal RV size, Mild to moderate functional MR
- Aortic, tricuspid, pulmonary valve normal function
- AKI noted
- Transferred to cardiology ward, stayed for 1 week then discharged, took 8 months to return to normal.
- Still on yearly reviews.

- Questions?

Summary

- Use structured approach to assessment meaning cannot miss vital clues
- Preconceived ideas not always the correct
- Think outside single organ
- Do you need more information on diseases- NELH medical problems in pregnancy e learning module