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Antepartum Pulmonary Embolism

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ABSTRACT *Pulmonary embolism is a relatively rare complication of pregnancy. Maternal mortality is increased as pulmonary embolism is one of the leading causes of maternal deaths.Mrs. Sudha , 21/F , Primi, GA - 38W1D, referred from Poonamallee PHC as Primi/Mobile head in labour and PIH(BP 140/90mm Hg came for further management.*

KEYWORDS :

Introduction:
Pulmonary embolism is hyper coagulation state,combined with other pregnancy associated physiologic changes, may lead to the development of pulmonary embolism, especially in the presence of additional risk factors. It has higher rate of mortality in pregnancy, a timely and accurate diagnosis of pulmonary embolism along with early institution of appropriate therapy is crucial in the management.

CASE REPORT:
Mrs. Sudha , 21/F , Primi, GA - 38W1D, referred from Poonamallee PHC as Primi in labour and PIH ,BP 140/90mm Hg , Tablet Labetalol 50mg stat.came with

c/o pains since 3 a.m,Perceiving Fetal movements well.No other positive history.

On examination Patient conscious, oriented , afebrile , mild pallor +,PR :86/min,regular,BP : 130/80 mm hg.

P/A : Uterus Term,acting,Head engaged,FH □ 140/min.

P/V : Cervix 50 % Effaced,

Os 2cm dilated ,Bag of membranes + ,Head at □-3 station,Pelvis adequate.

At around 12:30 p.m patient 1st episode of hypoxia,complained of sudden onset chest discomfort and difficulty in breathing.Her SPO2 suddenly fell 60%,pR: 140 bpm,No Lung signs,vitals normal.

Patient was given back rest, nasal O2.Injection hydrocortisone and inj 25% dextrose given.

ECG normal,saturation 90% with nasal oxygen.

Emergency LSCS done in view of fetal distress and maternal hypoxia. At around 2:00 p.m ,Patient again became Dyspnoeic, Tachypnoeic ,saturation was 80%,CVS : Tachycardia ,RS : Harsh breath sounds +, Bilateral crepitations +

She was treated with lasix.

Immediately after the skin incision was made , patient went in for cardio respiratory arrest.CPR initiated, ventilated.Patient was revived , LSCS done and delivered an alive term boy baby.

Patient threw one episode of GTCS immediate post operatively.

Injection phenytoin given,echo was normal,CVP 5 cm H2O , Urine output 200ml/hr.Patient started on Injection Meropenam 500mg iv bd and continued for 11 days.

One packed cell and 2 FFP were given immediate post op.
CBC TC 38900 cells, DC 92/4 , platelets 2.54 lakhs, ESR 28/52. Hb 16 gm.RFT Urea 39mg, creatinine 1.7 mg.LFT SB 0.64 mg, OT 359 IU/L, PT 225 IU/L, SAP 148 IU/L, GGT 28,PT_13 sec,aPTT 40.2 sec.D_dimer 4.53mcg (>0.5 mcg positive),crp 150.1 mg% (< 5mg normal)

patient started on Inj.LMWH on pod1, weaned off from Inotropic support.
PT 1.12 sec. APTT 28.8 sec,echo was taken on 9th POD -LV Systolic dysfunction, mildly dilated MPA/RPA, Trivial TR , No PHT,doppler of both lower limbs normal . No evidence of DVT. CT - Pulmonary angiogram - few filling defects were present in distal peripheral branches of the left and right pulmonary arteries. There were no signs of pleural effusion and pulmonary infarction, discharged on 18th POD.

Discussion:
This case was a similar condition of one of the rare forms of antepartum pulmonary embolism which was diagnosed and managed early and the lives of both the mother and the baby were saved.