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Original Research Paper

Gynaecology

STUDY OF REASONS OF REFERRAL OF EMERGENCY OBSTETRIC CASES AT SGH- A SYSTEMATIC REVIEW

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KEYWORDS :

Introduction

Maternal morbidity and mortality remains a major challenge to health systems worldwide. Referral services for identification and referral of high risk pregnancies are an integral part of maternal and child health services. Primary health care system have a linked referral system which have been strengthened under JSSK and NRHM by providing free referral services in government ambulance.

Identification and prompt referral of high risk pregnancies are an integral part of maternal and child health services.1 The 3-tier health care delivery system was conceived in such a manner that the patients in need of a higher level of expertise and care could be referred accordingly from primary to secondary or directly to tertiary level centre2 3,4. Although most obstetric complications (such as postpartum haemorrhage, sepsis, eclampsia, and obstructed labour that can cause maternal death cannot be predicted, the majority can be treated with timely provision of a package of evidence-based interventions known as emergency obstetric care (EmOC).5-7 The availability of EmOC is considered to be an indicator of how well a health system is prepared to manage conditions leading to acute maternal morbidity and mortality.8,9 Emergency obstetric care EmOC refers to elements of obstetric care needed for management of complications during pregnancy, delivery and postpartum period. EmOC services are of paramount importance in reducing maternal mortality and morbidity. It is still recommended to electively refer pregnant woman with previous caesarean section, breech presentation, transverse lie, multiple gestation, hypertension and severe anaemia for delivery before any complications arise to a health care centre where all the facilities to deal with the complications are available. With this background, present study was undertaken to evaluate the pattern of obstetric cases referred to tertiary teaching hospital and maternal outcomes amongst referred patients

METHODS

Study design: Prospective observational study.

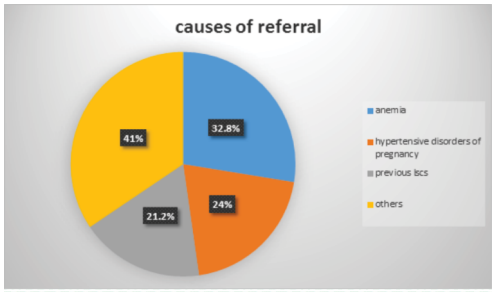
Study period: 1st October 2017 to 31st December 2017 .

Study population: All Obstetrics cases referred to the Department of Obstetrics and Gynecology of Sassoon General Hospital, B.J. Medical College, Pune, a tertiary care centre.

Data collection : The study data was collected from case sheets of the patients referred and managed at tertiary teaching hospital. Detailed clinical history, place of referral, type of transport used, causes of referral were studied. Complete physical and obstetric examination was done and relevant investigations were done. Management of the patient, clinical course, mode of delivery (i.e., whether vaginal or operative) and maternal outcome was documented. Descriptive statistics like percentages were used for analysis.

RESULTS

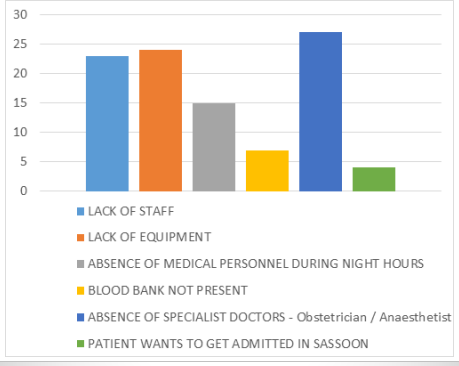
The total number of referred cases in above study period was 1684(54.86%) out of 3070 admissions. Most common cause of referral was Anaemia (32.8%) followed by hypertensive disorders of pregnancy (24%). Lack of staff, reluctance to induce labour, a tendency to by pass the middle level institution,non availaibility of blood bank and NICU facility, and during holidays and night hours especially from corporation run hospitals a higher inclination to get rid of responsibility and there by reffering patients for trivial reasons like NST machine not working ,lack of functional Operation Theatres, blood, and gynaecologists or anesthesists not available and so on, were other causes contributing to 41% of referrals.

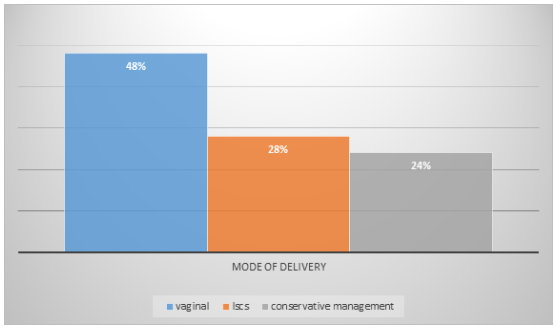


OTHER CAUSES OF REFERRAL (41%)

Distribution of cases according to mode of delivery. Out of the total referred cases, 48% had vaginal delivery (either spontaneous or induced), 28% had caesarean section and 24% were managed conservatively.

The commonest indication of caesarean section amongst referred patients in our study was fetal distress. Obstetric ICU admission was required in 22 out of 1684 referred cases i.e. in 1.34% of referred cases. Maximum number of cases in the present study were in the age group 20-30yrs, comprising 78% of total cases. Majority (47%) of cases in our study were primigravidae. . Mode of transport used by the referred patients were government ambulances under NHM(108) that is 98%.



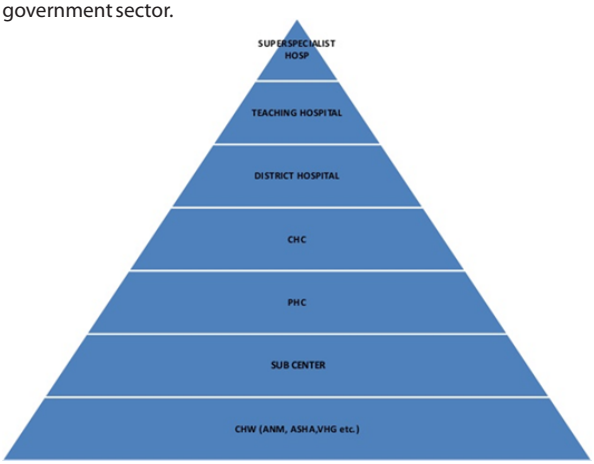


DISCUSSION

BJMC and Sassoon General Hospital, Pune is a tertiary care hospital , where complicated obstetrics and gynaecological cases are referred from various peripheral primary health centres, Civil Hospitals, Corporation run hospitals, Other Medical Colleges in the vicinity and private hospitals of surrounding districts. Worldwide it is estimated that 287,000 women die due to maternal causes every year [1]. The majority of maternal deaths are due to direct obstetric causes [2]. Most obstetric complications, except those abortion-related, occur during delivery or immediately after delivery, and they have the potential to rapidly become life threatening [3]. To prevent maternal deaths, the complications occurring at home or birthing centres require timely and appropriate referral to basic emergency obstetric care (BEmOC) or specialist comprehensive emergency obstetric care (CEmOC), and referral from BEmOC to CEmOC [4,5,6,7]. A systematic review on interventions for improving maternal health observed that most successful programs focused on training for CEmOC, the placement and motivation of care providers, refurbishment of existing health institutions and establishment of referral and transportation systems [8].

An efficient referral system provides access to treatment and skills by linking different levels of care through appropriate referrals [9]. To refer a patient is a medical decision and depends on many things including the skills of the referring staff, the tools for diagnosis, the availability of a health institution with specialist facilities, the quality of care at the referral institution, the cost of care, distance, transportation, communication, someone to travel with the patient, and feasibility of travel by the patient [7]. The type of obstetric complication determines the level of care needed and the place to be referred to, and this makes the referral pathways complex [7,10]. Compliance to referral may depend on the counselling skills of the referrer, the socio-cultural beliefs of the patient and her family, and perceptions of the quality of care

About one-third to one-half of pregnancies in rural populations are assessed as high risk and are referred from a Subcentre to a PHC or CHC for further antenatal check-up and delivery care. Almost half of these are anaemia or short stature cases which add large numbers to the high risk obstetric population in India. Simultaneously, low risk pregnant women delivering at Nurse run PHCs or Urban centres, which are capable of providing BEmOC care (except induction of labour), refer up to one-fifth to one-third of cases to a higher level institution. These findings suggest that about one-half to two-thirds of all pregnant women attending lower level health institutions are likely to be referred during pregnancy or delivery. ANMs, Nurses and even MOs were not confident and did not have skills to provide EmOC and referral care . The under-confident and unskilled health staff are likely to refer higher proportions of pregnant women on the slightest of indication of high risk or complication. The common causes for referral were prolonged labour and rupture of membranes which could have–in theory- been managed at the referring institutions .This suggests that there is tendency for over and unnecessary referral from peripheral institutions in the government sector.



Government should take measures to improve health infrastructure facilities, make provisions for developing new blood banks and appoint trained gynaecologists in the peripheries to reduce the burden on tertiary care centres. Previous caesarean section was the cause of reference in 23% of cases .The patients with previous caesarean section are referred to higher centres from PHC/CHC and even from corporate hospital due to unavailability of operation theatre, gynaecologists, anaesthetics, trained staff or basic infrastructure deficits.

CONCLUSION:

The high proportion of institution-referrals and pathways of referrals in India point towards a) the inability of primary health centres to provide basic delivery care and BEmOC services, b) inadequate pre-referral stabilizing care, c) a tendency for unjustified referrals to higher institutions, d) bypassing the CHCs as first referral choice, e) inadequate referral communication and record maintenance, and f) absence of standard guidelines for referral, facilities and monitoring of referrals for obstetric care.

Studies are required to assess the referral practices and problems faced by staff at lower level health institutions to decide when, where and how to refer the pregnant women. Strategies need to be developed a) to provide supervision and support to nurses for better BEmOC and referral, b) to standardize treatment and referral protocols and pathways, and c) monitor the quality of obstetric care and referrals from lower level health institutions and receiving these referrals at higher institution.

Peripheral health care system needs to be strengthened and in selected cases practice of early referral needs to be implemented for better maternal outcome. Health education to the community, better antenatal care up to grass root level, emergency intranatal care, availability of services of skilled birth attendants at the time of child birth, well organized first referral centre with better transportation facility, availability of blood round the clock, anaesthetic facilities and availability of specialist in the field of obstetrics at the referral unit will definitely reduce maternal morbidity and mortality

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