Critical Obstetric and Gynecologic Procedures in the Emergency Department

Joanna Mercado, MD, MSc[a,*], Isabel Brea, MD[b],
Brian Mendez, MD[c], Hilsa Quinones, MD[c], David Rodriguez, MD[c]

KEYWORDS

• Labor • Delivery • Episiotomy • Breech presentation • Bartholin abscess

KEY POINTS

- The emergency medicine physician should be prepared to manage imminent delivery at any time in the emergency department.
- Malpresentation, shoulder dystocia, or multiple gestation could complicate any delivery in the emergency department. The emergency medicine physician should be familiarized with the different maneuvers, from alleviation of shoulder dystocia to breech delivery maneuvers.
- The emergency department is a dynamic and challenging setting in which time matters; knowledge of and proficiency in the obstetric and gynecology procedures enable physicians to develop strategies to treat patients and the complications.

OBSTETRICS PROCEDURES

Labor

Active labor is defined by consecutive, rhythmic, involuntary uterine contractions that result in dilation and effacement of the cervix.[1,2] Active labor is divided into 3 stages. The first stage begins when uterine contractions have sufficient frequency, intensity, and duration to result in effacement and progressive dilation of the cervix, and ends when the cervix is fully dilated (10 cm) to allow passage of the fetal head (**Fig. 1**).[3] The second stage begins when full cervix dilation is achieved, and ends when the fetus is delivered. The third stage begins when the fetus is separated from the mother, and ends with placenta delivery.

Evaluation

On arrival of the patient to emergency department, the evaluation begins with an adequate history and physical examination. Pertinent information to obtain includes

[a] Research Section, Department of Emergency Medicine, University of Puerto Rico, San Juan, PR, USA; [b] Department of Emergency Medicine, Life Lion & Critical Care Transport, Penn State Hershey Medical Center, College of Medicine, Hershey, PA, USA; [c] Department of Emergency Medicine, University of Puerto Rico, San Juan, PR, USA
* Corresponding author.
E-mail address: jmercadoa@gmail.com

Emerg Med Clin N Am 31 (2013) 207–236
http://dx.doi.org/10.1016/j.emc.2012.09.005 **emed.theclinics.com**
0733-8627/13/$ – see front matter © 2013 Elsevier Inc. All rights reserved.

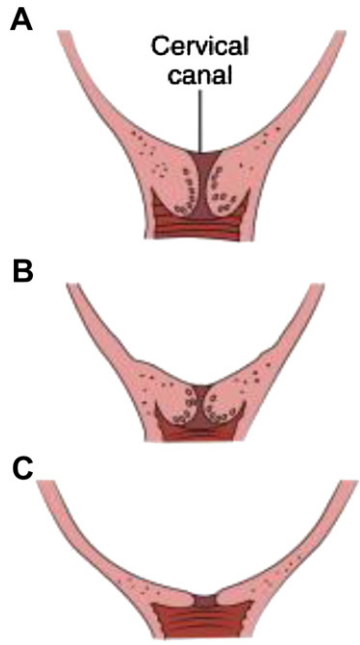

Fig. 1. Effacement of the cervix; (*A*) 0%, (*B*) 50%, and (*C*) 100%. (*From* Romney S, Gray MK, Little AB, et al [eds]: Gynecology and Obstetrics: The Health Care of Women. New York: McGraw-Hill, 1975; with permission.)

frequency of contractions, vaginal discharge or bleeding, and prenatal history. In addition, a focused physical examination is essential to determine the position and presentation of the fetus (**Fig. 2**).

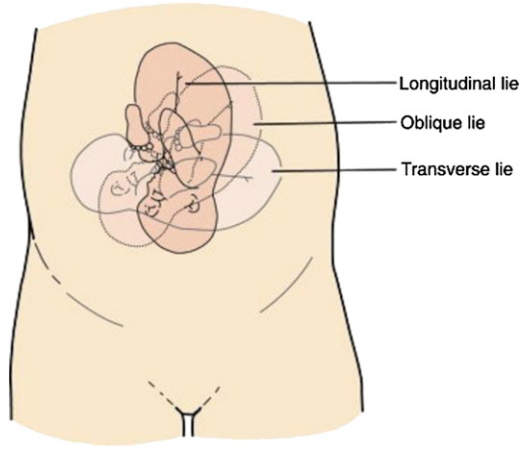

Fig. 2. Different presentations of the fetus. (*From* Lanni SM, Seeds JW. Malpresentations and shoulder dystocia. In: Gabbe SG, ed. Obstetrics: Normal and Problem Pregnancies. Philadelphia, Elsevier Churchill Livingstone, 2007; with permission.)

Download English Version:

https://daneshyari.com/en/article/3236788

Download Persian Version:

https://daneshyari.com/article/3236788

Daneshyari.com