Secondary assessment and management of pregnant trauma patient

Fetal assessment and secondary survey

As for non-pregnant patient AND
- Consult obstetric team
- Obtain obstetric history
  - Gestation
  - Pregnancy complications
- Assess and record FHR
- Maintain high index of suspicion for occult shock and abdominal injury
- Maintain position (tilt or wedge) left lateral 15-30° (right side up) or
  - Manual displacement of uterus
  - Wedge spinal board if required
- Physical examination
  - Assess uterus
    - Tone, rigidity, tenderness
    - Contractions
  - Estimate gestational age
    - Fundal height
    - USS
- If uncertain (i.e. severe trauma, no prior USS or lack of accurate records) presume viability

Consider - especially for major trauma
- Pelvic exam (obstetric team)
  - Sterile speculum
  - Assess for rupture of membranes, vaginal bleeding, cervical effacement and dilation, cord prolapse, fetal presentation
- Imaging
  - Formal obstetric USS
  - FAST if haemodynamically unstable
  - Other radiographs
- Blood tests
  - Standard trauma bloods
  - Group and Antibody screen
  - Coagulation Profile, ROTEM®/TEG® for major trauma
  - Kleihauer Test:
    - For all Rh D negative women ≥ 13+0 weeks gestation
    - Major trauma
  - If Rh D negative and ≥ 13+0 weeks gestation, administer Rh D immunoglobulin (but do not delay definitive care to do so)

Discharge criteria met?

Yes
- Obstetric team consulted/agree for discharge
- Reassuring maternal status
- No vaginal loss/bleeding
- Normal CTG/FHR (minimum 4 hours CTG)
  - Interpret CTG with caution at < 28 weeks
- No contractions
- Blood results reviewed
- Rh immunoglobulin given if required
- Social worker referral offered

No
- Maternal or fetal compromise?
  - Yes
    - CTG (minimum 4 hours)
      - Application and interpretation by experienced maternity team member
      - Interpret with caution at < 28 weeks
      - Monitor uterine activity
    - Admit
      - Assess for:
        - Placental abruption
        - FMH
        - Uterine rupture
        - Preterm labour
        - DIC
      - Continuous CTG if ≥ 23+0 weeks gestation
      - Intervene as appropriate
      - Consider emergency CS
  - No
    - Discharge criteria met?
      - Yes
        - Advise to seek medical advice if:
          - Signs of preterm labour
          - Abdominal pain
          - Vaginal bleeding or discharge
          - Change in fetal movements
        - Advise to inform usual maternity care provider and GP of trauma event
      - No
        - CTG (minimum 4 hours) Application and interpretation by experienced maternity team member
        - Interpret with caution at < 28 weeks
        - Monitor uterine activity
        - Consider discharge criteria
          - Obstetric team consulted/agree for discharge
          - Reassuring maternal status
          - No vaginal loss/bleeding
          - Normal CTG/FHR (minimum 4 hours CTG)
            - Interpret CTG with caution at < 28 weeks
          - No contractions
          - Blood results reviewed
          - Rh immunoglobulin given if required
          - Social worker referral offered

CS: Caesarean section, CTG: Cardiotocograph, DIC: Disseminated intravascular coagulation, FAST: Focused Abdominal Sonography for Trauma, FHR: Fetal heart rate, FMH: Feto-maternal haemorrhage, GP: General Practitioner, ROTEM®/TEG®: Point of care blood clotting analysers, USS: Ultrasound scan, <: less than, >: greater than, ≥: greater than or equal to