

Initial assessment and management of the pregnant trauma patient

Principles of care for the pregnant trauma patient

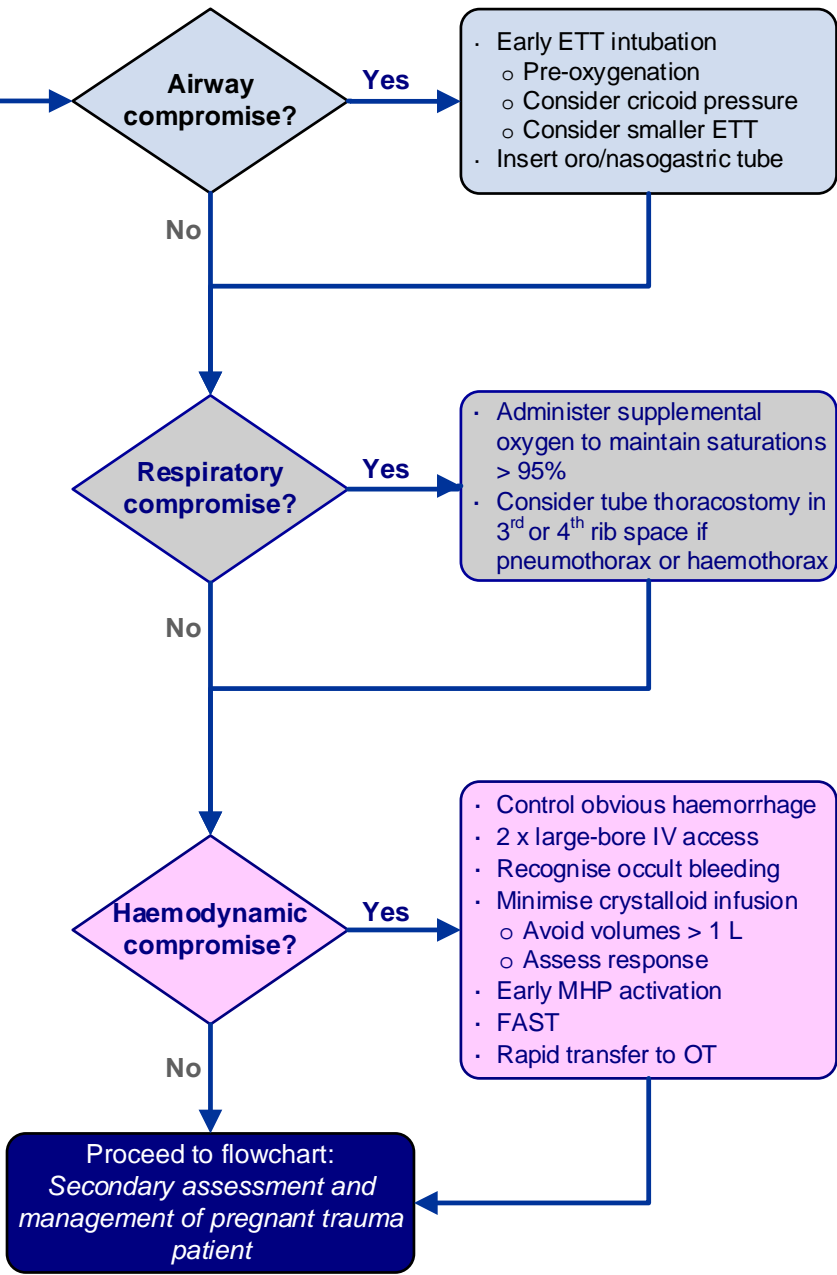
- Follow ATLS guidelines
- First priority is to treat the woman
- Multidisciplinary team that includes an obstetrician is essential
 - Contact neonatal team early if viable gestation and birth imminent/likely
- Recognise anatomical and physiological changes of pregnancy
- Clear, coordinated and frequent communication essential
- Generally, medications, treatment and procedures as for non-pregnant patient
- Refer pregnant women with major trauma to a trauma centre
 - < 23 weeks gestation: to the nearest trauma centre
 - ≥ 23 weeks gestation: to a trauma centre with obstetric services
- Thoroughly assess all pregnant women – even after minor trauma

Initial stabilisation

- As indicated for all trauma patients
 - Follow ATLS guidelines
 - Initiate early obstetric consultation
 - Contact RSQ (1300 799 127) to expedite transport & identify receiving facility as required
- Additionally for pregnancy**
- Position (tilt or wedge):
 - Left lateral 15–30° (right side up) or
 - Manual displacement of uterus
 - Place wedge under spinal board if necessary
 - Routinely administer oxygen therapy
 - Large-bore IV access

Cardiac arrest

- Manually displace uterus
- If ≥ 20 weeks gestation, commence Resuscitative Hysterotomy (Perimortem CS) as soon as possible
- Follow ATLS guidelines
- Defibrillate as for non-pregnant patient
- Advanced cardiac life support drugs as indicated for non-pregnant patients



ATLS: Advanced Trauma Life Support, CPR: Cardiopulmonary Resuscitation, CS: Caesarean section, ETT: Endotracheal tube, FAST: Focused Abdominal Sonography for Trauma, IV: Intravenous, MHP: Massive Haemorrhage Protocol, OT: Operating Theatre, RSQ: Retrieval Services Queensland, >: greater than, ≥: greater than or equal to

Queensland Clinical Guideline. *Trauma in pregnancy*. Flow chart: F19.31-1-V2-R24

