Pregnant Trauma Patient

Initial Resuscitation & Maternal Assessment

- >18 weeks → manual displacement of uterus to left or tilt LBB >30°
- Mom is BEST life-support for fetus
- Supplemental oxygen to keep SPO_2 >95%
- Changes in maternal HR and BP may occur late and quickly, and reflect at least a loss of 10-15% of blood volume before becoming apparent
- DVE—hold until no placenta previa on U/S → Assess for bleeding/trauma to vagina & cervix, amniotic fluid, and thinning/lengthening of cervix
    - If evidence of labor < 20 weeks → inevitable abortion

Fetal Assessment

- Fetal heart rate (Doppler or Ultrasound)
- Fetal activity – Mother reported (≥ 18 weeks) and Ultrasound

Emergent C-Section

- Only if uterus is above umbilicus
- Fetal death in stable mother is NOT indication for ECSD
- Maternal cardiac arrest with no ROSC within 4 minutes → ECSD (1 minute)
    - Save fetus if imminent maternal death or fetal distress
    - Uterus/Placenta receives 15-20% of cardiac output at term

RhoGam

- Abdominal trauma or vaginal bleeding in Rh (-) mother
- Check K-B if administering – large volume maternal-fetal blood transfer may need additional RhoGam

Indication for admission/observation

- Admit to OB for fetal monitoring unless ICU level of care needed
- Abdominal brusing/pain, identified intra-abdominal injury, abnormal fetal HR, regular contractions (>q 10 min), vaginal bleeding or signs of labor, PLT < 150K, Fibrinogen < 200

Reviewed 9/27/23