Case Study: Antenatal Steroids for TPTL – Stockport

BACKGROUND

Gravida 8 Para 4. Woman was born with 1 kidney and prone to recurrent UTI's and nephritis. 4 previous emergency caesarean sections, 1 at term and 3 previous preterm births at 33, 34+2, and 35 weeks. She experienced antepartum haemorrhage with her previous preterm births with one confirmed placental abruption.

29/11/23 (32+5) Confirmed PPROM recorded following admission to maternity triage with positive Actimprom result. Os noted to be closed on speculum with no abdominal discomfort and no bleeding. Admission for observation offered and oral antibiotics commenced. 01/12/23 (33+0) transfer to Delivery Suite with significant APH. Reviewed by Consultant and decision made to commence preterm optimisation measures.

LEARNING

In view of this patient's obstetric history, a conservative approach was taken in the management of care. Admission and observation while patient was stable enabled a full course of steroids to be administered but with a low threshold for intervention if required. Baby was born in good condition, was screened for sepsis and remained in NNU for 9 days until discharged home with feeding well established.

CHALLENGES

Placenta praevia diagnosed during current pregnancy at 20-week anomaly scan. Placenta noted to be covering the internal Os. The placenta remained low lying for the remainder of the pregnancy. This patient had 5 admissions during the pregnancy for PV bleeding with no associated abdominal pain.

SOLUTION

01/12/23 @ 17:02 1st Steroid administered. Blood loss now documented as minimal and patient is comfortable, therefore decision made to observe to allow time for administration of second steroid. 02/12/23 @17:45 2nd Steroid administered. Oral antibiotics for PPROM continue. Consultant ward round at the same time - decision to observe however any further episodes of PVB - may need to consider delivery. 05/12/23 @ 10:20 buzzer pulled by patient to inform of significant blood loss, no abdominal pain. Speculum by Consultant confirms active bleeding. Decision made for CAT2 EMCS. 15:30 Magnesium Sulphate loading followed by maintenance infusion commenced. 05/12/23 @ 19:48 Delivery of live female via EMCS. NNU staff in attendance and optimal cord management documented. Placenta noted to show signs of large retroplacental clot. Baby transferred to NNU for on-going care and support.

CONCLUSION

Preterm perinatal optimisation measures were implemented in a timely and appropriate manner. Neonatal staff were present on Delivery Suite to counsel the patient with regards to implications of preterm birth. An MDT approach was taken to care which resulted in a good outcome for the preterm infant in this case study.