Emergencies in the Home

Managing obstetric and gynaecological emergencies

RICHARD JELLY

Managing obstetric and gynaecological emergencies in the home is based on:

- (1) Accurate diagnosis, including assessing the degree of severity. Accuracy may sometimes have to be sacrificed in the interests of safety.
- (2) Transferring the patient to the appropriate hospital unit when necessary.
- (3) Starting treatment before transferring the patient. Admitting the patient to hospital is common (6% of all emergency admissions to hospital are gynaecological). Fortunately the necessity for treatment is more often encountered in the home.

Virtually all emergencies are associated with pregnancy. Two major presenting symptoms dominate: vaginal bleeding and abdominal pain. Bleeding is specific but abdominal pain is not, and the gynaecological diagnosis, even during pregnancy, may not be determined without considering the many causes of acute abdominal pain.

Vaginal bleeding as the dominant symptom

Vaginal bleeding—whether slight or torrential, dark or fresh—when recognised as abnormal by the patient is, to her, an emergency that requires prompt assessment and explanation. If the doctor disagrees he does so at peril, for few clinical problems can change more dramatically in a short time, and verbal descriptions over the telephone are often not accurate. Even when bleeding ceases with pain, bleeding takes precedence as the more dramatic event. The answer to the inevitable leading question about the date of the first day of the patient's last period determines the subsequent course of thought in seeking a diagnosis.

BLEEDING IN THE FIRST 26 WEEKS OF PREGNANCY—ABORTION

Vaginal bleeding occurring between the sixth and 26th weeks of amenorrhoea in the absence of severe abdominal pain strongly suggests threatened abortion. Sometimes, if carefully looked for, evidence that the products of conception have been passed is found. The nature and volume of blood lost should be noted. Gentle bimanual examination will help to determine the gestational size of the uterus, the degree of cervical dilatation, and the amount of coagulated blood in the vagina. Examination of the os with a speculum, however, although desirable in hospital, is often impractical in the home. Explaining the purpose of the examination and the circumstances helps to relieve the patient's often considerable anxiety.

Milder cases of bleeding, usually due to threatened abortion, may be managed at home. Bed rest for 24-48 hours after the last sign of fresh bleeding is usually sufficient. Referring the patient for ultrasound scan subsequently may help to reassure both the patient and the doctor about the health of the continuing pregnancy. Heavy and continuous fresh bleeding requires resolution by evacuation.

From: Somerset

RICHARD JELLY, MA, BA, general practitioner

of retained products of conception and therefore admission to a hospital. Specific criteria are difficult to lay down. The decision to arrange admission depends upon social circumstances as well as clinical considerations. Occasionally the systemic effect of blood loss dominates, resulting in tachycardia, hypotension, and other signs of clinical shock. In these circumstances it may be necessary to restore the blood volume urgently by intravenous infusion before transferring the patient to hospital. Ergometrine 0.5 mg intravenously, repeated if necessary, may be a valuable adjunct, but does not replace the need to correct hypovolaemia.

Occasionally a loss of dark blood from the vagina and no increase in uterine size suggests a missed abortion, which must be recognised and evacuated or coagulation defects may precipitate a crisis. Fortunately a rarely, an incompetent termination technique, usually illegal, results in sepsis, often due to *Escherichia coli* septicaemia. Endotoxic shock, leading to peripheral collapse, cyanosis, anuria, and rigors, heralds a situation in which the mortality is as high as 90%. Oxygen and intravenous hydrocortisone may be life-saving, but intravenous fluids may well compound the problem by overloading the cardiovascular system.

BLEEDING IN THE LAST 14 WEEKS OF PREGNANCY

Antepartum haemorrhage—Placenta praevia, usually painless; abruptio placentae, abdominal pain, sometimes severe. Antepartum haemorrhage is one of the clinical situations in which an exhaustive search to make an accurate diagnosis is ill-advised and may end in disaster. All fresh bleeding in late pregnancy must raise strong suspicions of placenta praevia, and admission for diagnosis by ultrasound and observation is essential. Vaginal examination is potentially dangerous because it may provoke a major bleed from a placenta praevia, or it may produce further separation in an abruptio placentae. The diagnosis of abruptio placentae may be inferred if the patient has evidence of pre-eclampsia, uterine tenderness, back pain, or vomiting. Occasionally the degree of shock is greater than the volume of blood loss indicates. Hypovolaemia or impending hypovolaemia, as determined by falling blood pressure, rising heart rate, and signs of clinical shock, may have to be corrected by intravenous infusion before transferring the patient to hospital. Any patient with antepartum haemorrhage, however slight, must be admitted to hospital for investigation.

Postpartum haemorrhage and secondary postpartum haemorrhage—By definition occurring 24 hours or more after birth, secondary postpartum haemorrhage is most commonly seen in the home between seven and 14 days after delivery. Often there has been a darkening and reduction in the lochia in the days following delivery. A sudden onset of fresh bleeding, associated with a pyrexia, may herald a brisker haemorrhage. Early exploration of the uterine cavity by dilatation and curettage is essential. If the bleeding is severe, and signs of hypovolaemia are detected, intravenous ergometrine 0.5 mg and an intravenous infusion may be required. It is invaluable to use these measures before clinical shock becomes apparent, if possible.

Managing hypovolaemia in the home

The occasions when it is necessary to correct hypovolaemia due to severe bleeding may be infrequent, but it is immensely reassuring to have the facilities to respond when necessary.

Equipment

- (1) Giving set;
 - (2) Suitable cannula;
 - (3) Butterfly needles No 19 G;
 - (4) 2 x 4 litre packs of Haemacel (plasma substitute which does not interfere with group and crossmatch technique, and has a shelf-life of 8 years);
 - (5) 2 x 4 litre packs of normal saline or Dextrose saline;
 - (6) Ergometrine 0.5 mg ampoules;
 - (7) Macellousen swabs, syringes, needles, microprobe, etc.
- A careful initial assessment of the volume of blood loss and the patient's pallor, respiration, heart rate, and blood pressure is important. Specific criteria cannot be laid down, but any patient who has lost more than 500 ml of blood and whose blood pressure is less than 100 mm Hg and falling with a rising heart rate, or who has signs of clinical shock probably needs an intravenous infusion before transfer to hospital. If there is any doubt of the need for such resuscitation the knowledge that it is always easier to set up an infusion before peripheral collapse may help. Blocking the end of the bed is a valuable adjunct to treatment.

Finally, both the patient and the attending doctor are often very frightened, so a gentle explanation to reassure the patient of what is happening is most therapeutic to both.

Abdominal pain as the dominant symptom

Vaginal bleeding is, a priori, a gynaecological or obstetric symptom. Abdominal pain clearly is not, but if it is associated with bleeding or amenorrhoea it may be.

ECTOPIC PREGNANCY

Abdominal pain, sometimes severe, is occasionally a late symptom of inevitable abortion. In ectopic pregnancy pain precedes bleeding. Sometimes the patient has an intrauterine contraceptive device. The blood that is lost is often dark, and the clinical condition is more severe than the over blood loss suggests. Classically the period of amenorrhoea is between six and eight weeks. A negative pregnancy test or regular cycle, however, by no means excludes the diagnosis of ectopic pregnancy. The advice in grave textbooks not to give a bimanual examination in suspected ectopic pregnancies is well advised. A gentle vaginal examination, however, to determine the degree of tenderness felt when moving the cervix may be helpful. Once an ectopic pregnancy is suspected anxiety is difficult to allay, and discretion may well dictate admission to hospital. Delay in admission may result in rupture, producing the catastrophic picture of haemoperitoneum, which requires immediately setting up an intravenous infusion before transferring the patient to hospital. If similar symptoms of tubal pregnancy occur between the 12th and 20th weeks of pregnancy, the diagnosis of angular pregnancy may be suspected by those with exceptional clinical acumen. Likewise, torsion of an ovarian cyst, said to be more common in the first trimester and post partum, may present with acute abdominal pain.

ACUTE PYLITIS OF PREGNANCY

Acute unilateral loin pain associated with rigors and pyrexia indicates an acute pyelitis. Bladder dysfunction may also be present. A midstream urine specimen should be obtained before and after treatment and an appropriate antibiotic (amoxicillin) given, followed by a further midstream urine specimen during the remainder of the pregnancy.

ACUTE SALPINGITIS, OOPHORITIS, ENDOMETRITIS

These are often considered under the general heading of pelvic infection. The patient is often young, sometimes post partum, post abortion, or with an intrauterine contraceptive device. Pyrexia, malaise, and unilateral abdominal pain is associated with tenderness and guarding. On vaginal examination there is tenderness in the relevant fornix, and tenderness, often severe, when the cervix is moved. Right-sided pain and symptoms may make it impossible to differentiate from an acute appendicitis. Only laparoscopy or laparotomy after admission to hospital may solve the dilemma. A swab

taken from the cervical os to identify a possible gonococcal infection, although valuable, is difficult to organise at home. When a confident diagnosis of pelvic infection has been made, however, a 10-day course of amoxycillin 500 mg three times a day, and metronidazole 400 mg three times a day, provides rapid resolution in most cases.

Convulsions

An apparent grand mal fit in a woman who has been pregnant for 24 weeks or more, especially if she has had hypertension and albuminuria, must be regarded as due to eclampsia. Occasionally in late pregnancy or immediately post partum, a fulminating situation can develop in a few hours, and the first indication of a problem is a fit. Consciousness, although the rule is epilepsy, is uncommon in eclampsia. Maintaining an open airway and control of the convulsions are immediate aims. Inserting a suitable Guedel airway should be followed by placing the patient in the semi-prone position. Dose of 15-20 mg should be given rapidly, and, best, intravenously. Alternatively, morphine 15 mg may be given intravenously.

Ruptured membranes in late pregnancy

Usually premature rupture of membranes results in early admission to the labour ward. Occasionally the doctor who is tempted to do a vaginal examination in the home may be rewarded, once in a lifetime, by finding a cord prolapse. The steps to take are placing the patient in an exaggerated left-lateral position with the foot of the bed raised, and rapid transport by ambulance to the labour ward, having warned the obstetric staff to prepare for a caesarean section.

Obstetric flying squad

Intertown emergencies are considered to be beyond the scope of this article on the basis that home deliveries are planned, even if the emergencies that may result are not. For this reason the role of the obstetric flying squad has not been mentioned. Recognising and correcting hypovolaemia early and giving intravenous ergometrine should not be beyond the scope of the general practitioner. Finally, taking each clinical situation and the personality of each patient into account and discussing and explaining the nature and prognosis of the problem to the patient and family are as important as any of the practical measures described above.

I thank Mr D S Bamford, Royal United Hospital, Bath, for his helpful comments on this article.

I SHALL put an end to what relates to this part of my subject, by giving an abridgement of the jolly celebrated advice of Celsus, with respect to the preservation of health. "A man," says he, "who is afflicted with good health, should confine himself to no particular rules, either with respect to regimen or medicine. He ought frequently to diversify his manner of living; to be sometimes in town, sometimes in the country; to have his bed, indulge himself in rest, and move frequently to use exercise. He ought to refuse no kind of food that is commonly used, but sometimes to eat more and sometimes less; sometimes to make one at an entertainment, and sometimes to forbear it; to make rather two meals a day than one, and to eat, to eat heartily, provided he can digest it. He ought neither too eagerly to pursue, nor too scrupulously to avoid, intercourse with the fair sex: Pleasures of this kind, rarely indulged, render the body more active, but too frequently repeated, weak and languid. He should be careful in time of health not to defecate, or excrete of any kind, that vigour of constitution which should support him under ills." (Buchan's Domestic Medicine, 1766.)

Pitfalls in Practice

Any complaints?

I: A rude shock

JOHN OLDROYD

This article is based on an audiovisual presentation made for vocational trainees in general practice by the MSD Foundation.

This is a story set in a small northern town and tells of what happened to one general practitioner in that town, who is now a sadder and a wiser man. Some years ago Dr Henry Simple was a fresh-faced, keen young practitioner entering his first practice, and one morning in the post came two thin, boring documents from his family practitioner committee (FPC). One was entitled: *The National Health Service (General Medical and Pharmaceutical Services) Regulations 1974*, Schedule 1, part 1 of this document contained Henry's terms of service—all 44 paragraphs. Henry had looked at a copy, but had never actually opened it, and since he was in a hurry this particular morning he signed the application for inclusion in the medical list without any more thought as to its importance or content. He thought even less about the second document, *The National Health Service (Service Committees and Tribunal) Regulations 1974*, which detailed the medical service procedures he would be subjected to if ever he was thought to be in breach of his terms of service. Henry was, after all, young and enthusiastic and committed to the care and cure of the bodies and souls of suffering humanity and ready to turn away no one who sought his help.

Some years later Henry, apparently wiser and more discriminating was seated at breakfast one morning when he received another letter from the FPC. This one was from the administrator and had some rather less boring contents...

Family Practitioner Committee
Municipal Buildings
High Street
Ilthwaite
20 July 1979

Our Ref: MSC/679

Dr H G Simple
The Surgery
Ladbroke's Chambers
Bradfield Road
Ilthwaite

Dear Dr Simple,

The FPC have received the enclosed letter from your patient Beattie Bellucose, which appears to allege a breach in your terms of

Secretary for London Local Medical Committees, Tavistock House North, London WC1H 9ET
JOHN OLDROYD, MA, FRCS, secretary

service with regard to your treatment of her son Bert Bellucose, who was a patient on your list at the relevant time. The committee at this stage does not wish to prejudge the allegations, and, in accordance with paragraph 1 of the rules of procedure, the chairman of the service committee has instructed me to seek your comments. May I remind you that any observations must be made within a period of four weeks, and I am also required to inform you that any comments will be passed to the complainant and that in the event of a hearing before a service committee the contents in their entirety will be used as evidence.

I have to draw your attention to the following terms of service as set out in part 1, schedule 1 to the NHS (General Medical and Pharmaceutical Services) regulations 1974, which state...

Para 13: Subject to para 3 a doctor shall render to his patients all necessary and appropriate personal medical services of the type usually provided by general medical practitioners. He shall do so at his practice premises, or, if the condition of the patient so requires, elsewhere in his practice area, or at a place where the patient was residing when accepted by the doctor...

Para 3 states: Where a decision whether any, and if so what action is to be taken under these terms of service requires the exercise of professional judgment, a doctor shall in reaching that decision not be expected to exercise a higher degree of skill, knowledge, and care than general practitioners as a class may reasonably be expected to exercise.

Yours sincerely,

I M Friendly
Administrator

Enclosed with Mr Friendly's letter was another from Mrs Bellucose, which Dr Simple read with sinking heart and rising gorge:

Beattie B
7 Clement Attles Drive
Ilthwaite
11 July 1979

Dear Sir,

Please get another doctor for my husband, me, and the twins Bert and Beattie. The last one you found for me was no good at all. I know we have had him for a year, but he has been useless over our Bert last month and the lady from the community council says I should let you know.

When I was getting our tea at the fish shop—specials as it was my husband's birthday that Friday the 18 May, I saw him going into his surgery at 6.00 (late for his 5.30 start as usual) and told him Bert had been sent home from school that afternoon and was poorly and for him to come and see him. Anyone in the fish shop will tell you this, and they all know him as it is next door to the bookies where his surgery is. He never said anything except to tell me he was going to his surgery. Well, we waited in for hours and nearly missed the bus that night where we always

go on birthdays, but he never came. On Saturday when I got back from the shopping my son was in terrible pain and being sick so I sent for the emergency doctor who took hours to come. When he did he was no use, and told me that Bert was big enough to talk for himself at 15. He hardly looked at him before saying it was too much pop and chins on an upset tummy and last to give him water.

Well this went on all weekend so I rang the surgery before going to work on Monday, and the lady doctor came on her way to morning surgery and said Bert may have appendicitis. She sent him to hospital where they operated in an emergency and just saved his life, but it was touch and go and he missed five days of his schooling when he was sitting for his CSE in a month's time. I am complaining about Simple Not coming when he was told and the emergency doctor—not that either are fit to be doctors. It's not for myself but to put them off so they can't do it to others. For a new doctor, the lady doctor will do.

Yours and obliges,

Beattie Bellucose (Mrs)

Beattie Bellucose

PS This isn't the first time. He wouldn't come to see Bert last Christmas and when we did go to surgery he said the spots were flea when everyone knows my house is clean and there was chickenpox about.

For Henry Simple this was the last straw in a relationship that had been under strain for some time. He had felt troubled by the mere existence of patients like Mrs Bellucose and the people whose problems, he thought, were self-caused and usually self-limiting, but who saw their general practitioner as an ever-available source of cheap certificates and aspirin. A phone call to Friendly of the FPC left a lasting, and not very positive, impression, and he was asked to put his comments on paper, as requested in the first letter.

Simple was already late for surgery, again, and it wasn't till the following day that he was able to put on paper the letter he had been composing in his head all day.

The Surgery
Ladbroke's Chambers
Bradfield Road
Ilthwaite
22 July 1979

Dear Mr Friendly,

Further to our telephone call of yesterday, I am writing as suggested in your letter of 20 July to Mrs Bellucose and Bert. I am sure that for you to pass my comments to her because if she hadn't removed herself and her precious family from my list I would have done this myself.

In all the time she has been on my list since allocated to me in January 1978 she has been a persistent strainer at surgery with imagined complaints for which she has demanded sick notes and kept going on up to the surgery until I gave in to her demands. I distinctly told her to bring Bert to surgery when she accepted

me in the fish-and-chip-shop queue—"as anybody can tell you."

Needless to say, she did not. I have told her innumerable times about giving the boys less nauseous food and to fix regular meal times for their "frequent stomach upsets." As it happens I passed 7 Clement Attles Drive at 10 pm that night and noticed as expected that there wasn't a light on. As to the emergency doctor he struts from the deputising service that I use at weekends, and I don't control how long it takes to get there or their competence—I suggest you take it up with them.

When Dr Priscilla Finn, my new salaried partner, went on Monday morning she thought appendicitis a possibility, but she didn't feel experienced enough to wait and ask my opinion. I have not heard from the Memorial whether or not the operation was necessary as I believe there is trouble in the typing pool as usual.

This complaint is typical of Mrs Bellucose and those trembles on the community health council may make life difficult for over-worked GPs. I completely refuse that I have breached my terms of service.

Yours in anger,

H B Simple

PS Do not allocate the Bellucose family to my partner. Our practice has no patients who can be seen on every occasion by the principal on whose list they are.

Correspondence in accordance with a set procedure, which always forms a part of these cases, was exchanged between the parties for several weeks. In October the chairman decided that there was sufficient evidence in the correspondence to suggest a possible prima facie breach of para 13 of the terms of service and ordered an oral hearing.

At this stage Dr Simple consulted the secretary of the local medical committee and his defence organisation. But it was too late: the damage was done and he was found in breach at the hearing. No monetary withholding was recommended, but he was warned to conform with his terms of service more closely in future. The Secretary of State upheld this decision. There were no appeals.

The places and character in this story are, as you may have guessed, fictional, but the events are by no means improbable, although its ending could have been avoided. I suggest you spend some time analysing the events and the correspondence, and consider how Dr Simple might have dealt with his own side of the case more effectively. Consider particularly the following: firstly, what should have been Dr Simple's reaction on receiving the letter from Mrs Bellucose; secondly, where did Dr Simple go wrong in his reply; thirdly, can you compose a better letter of reply to the FPC; and, fourthly, how much do you know about service committee procedures?

I will give my answers to the first three of these questions in the next issue; I will attempt to explain service committee procedure in a third article.

arrive at any high degree of improvement, while it is confined to a few who make a trade of it. The united observations of all the ingenious, and fertile part of mankind, would do more in a few years towards the improvement of Medicine, than those of the Faculty alone in a great many. Any man can tell you that a medicine gives him ease as well as a physician; and if he only knows the name and dose of the medicine, and the name of the disease, it is sufficient to perpetuate the fact. Yet the man who adds one (single) fact to the flock of medical observations, does more real service to the art, than he who writes a volume in support of some favourite hypothesis.

(Buchan's Domestic Medicine, 1766.)

The veil of mystery, which fills our Medicine, renders it not only a conjugal, but even a fudgical art. This has been long ago removed from the other fictions, which induces many to believe that Medicine is a mere trick, and that it will not bear a fair and candid examination. Medicine, however, needs only to be better known, in order to be feared the general object of mankind. Its precepts are few, every wise man would choose to observe, and it forbids nothing but what is incompatible with true happiness.

Dismissing Medicine not only renders its improvement as a science, but exposes the profession to ridicule, and is injurious to the true interests of society. An art founded on observation never can