PRACTICE GUIDLINE: Management of Injury in Pregnancy

OBJECTIVES:

1. To establish guidelines for rapid assessment and treatment of critically injured pregnant patients.

2. To effectively manage trauma patients that are pregnant, the Trauma Team must mobilize the resources essential to diagnosis and treat both mother and fetus.

3. Injury Prevention

DEFINITIONS:

For purposes of this policy, a potentially viable fetus is one at 24 weeks gestation, although some exceptions may exist.

I. Mechanisms of Injury

1. Motor Vehicle Accident
2. Assault
3. Domestic Violence
4. Other trauma, such as gunshot wound

GUIDLINE:

II. Initial Evaluation and Management

1. If > 23 weeks gestation and/or fundus above umbilicus; sustaining a traumatic injury, activate Trauma Alert
2. Page: MFM (315) 464-4458, OB Resident (315)441-0612, Crouse L+D (315) 470-7753, Crouse NICU (315) 470-7577
3. Place roll under the torso to give a gentle right-side-up position (10-15 degrees)
4. Early intubation when indicated
5. Chest x-ray and FAST completed during the primary survey as indicated in non-pregnant patients
6. Consider avoiding the plain pelvic radiograph if:
    - Hemodynamically normal patient
    - No gross instability or tenderness on physical exam
    - Planned CT scanning would cover imaging of the pelvis
7. Simultaneous fetal assessment should be completed by the OB team from Crouse; including monitoring. EM nursing will be responsible for FHT only.
8. In the case of maternal shock with a positive FAST, where emergent laparotomy is indicated, the fetal assessment can be completed in the OR
9. If distress is identified in a potentially viable fetus, every effort should be made to expedite transfer to the Crouse OR for emergent cesarean section via a midline incision

10. When significant mechanism or concern for associated intra-abdominal injury are present, exploratory celiotomy at the time of C-section is indicated in Upstate OR.

III. Diagnostic Studies

1. Lab studies:

- Urine pregnancy or serum beta-HCG, especially with a questionable history
- Clotting factors and plasma fibrinogen
- Kleihauer-Betke test, especially when blunt uterine trauma is suspected >12 weeks gestation

2. Imaging

- Avoid duplicating films
- Shield the fetus whenever possible

SUMMARY

Focus all initial evaluation and resuscitation efforts on the mother. Do not deviate from standard practice. **TREAT THE MOTHER FIRST**, as what is good for the mother is good for the fetus.

- Complete a primary survey before moving the mother from the trauma bay for any reason.
- Secondary survey should include simultaneous fetal evaluation.
- Plan radiographic studies and avoid duplication. Shield the fetus whenever possible.
- Emergent cesarean sections should be performed through a midline incision.

REFRENCES

1. Refer to attached presentation *Management of the Pregnant Trauma Patient*

2. SOGC Clinical Practice Guideline: Guideline for the Management of a Pregnant Trauma Patient

- http://sogc.org/wp-content/uploads/2015/06/gui325CPG1505E.pdf