2 COMPLICATIONS OF PREGNANCY

2.17 MANAGEMENT FOLLOWING ABDOMINAL TRAUMA

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2.17.1 Quick Reference Guide Management following Abdominal Trauma
Section B
Clinical Guidelines
King Edward Memorial Hospital
Perth Western Australia

2.17.1 QUICK REFERENCE GUIDE FOR MANAGEMENT FOLLOWING ABDOMINAL TRAUMA

This Quick Reference Guide must be used in conjunction with its respective Clinical Guidelines, Section B 2.17 Management following suspected abdominal trauma.

CRITERIA FOR REFERRAL

Women with suspected/confirmed abdominal trauma from 20 weeks gestation.

ASSESSMENT

1. The Triage midwife will make an immediate assessment when the woman is admitted. A **CODE BLUE MEDICAL EMERGENCY** should be called if the woman is physiologically unstable, which may include:
    - Symptoms of haemodynamic compromise
    - Significant vaginal blood loss
    - Severe pain
    - Altered state of consciousness

    Commence resuscitation of the woman as required.

    The triage midwife and the medical staff will decide if the woman is to be transferred to theatre, the labour and birth suite, Adult Special Care, the ward, or another hospital.

2. Auscultate the fetal heart. Note any fetal movements. Commence a cardiotocograph (CTG) if the woman is 24 weeks or more gestation. Continuous FHR monitoring should be continued until medical review by a level 3 Obstetric Registrar or above.

3. Perform maternal assessment of:
    - temperature, pulse, respirations and blood pressure
    - urinalysis
    - vaginal loss – assess type of loss, and amount
    - additional observations as maternal conditions requires e.g. neurological

4. Perform a gentle abdominal palpation. This should be done by a medical officer or senior midwife. Note:
    - Uterine tenderness
    - Uterine activity
    - Uterine tone e.g. rigidity, “spongy” feeling
    - Lie and presentation
    - Fundal height

- Evidence of bruising or haematoma or wounds

5. Arrange an urgent Ultrasound to establish fetal well-being, identify the placental location and signs of placental abruption or injury. Confirm placental location prior to attending speculum examination.
6. Perform a sterile speculum to observe for blood loss or rupture of membranes.
7. Insert an intravenous cannula and collect:
   - Full blood picture
   - Kleihauer – mark on pathology form ‘urgent’, and notify laboratory by phone that it is being sent down
   - Blood group and antibody screen
   - Consider coagulation screen if blood loss is estimated over 200mls, or symptoms suggestive of concealed abruption
8. Administration of Anti-D when required. See Clinical Guideline, Section A 1.9.3 Rh D Immunoglobulin
9. Transfer the woman to the ward after review by Obstetric Registrar. All women who have experienced trauma to the abdomen should be observed and monitored for 24 hours in hospital.

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FLOW CHART FOR MANAGEMENT OF A WOMAN FOLLOWING SUSPECTED ABDOMINAL TRAUMA