Near Miss Cases in Women of Bangladesh

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Abstract

A Near Miss Case denotes a woman experiencing at least one near miss case event. The Near miss case events include hemorrhage, hypertensive disorder during pregnancy, dystocia, infection and anemia. The present study focuses about near miss case events in three women with different manifestations - 1st woman had hypertensive disorder in pregnancy, 2nd woman had dystocia, hemorrhage and infection disorder and 3rd woman had infection and hemorrhage.

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Introduction

Pregnancy is a very precious and happy event for women, but unfortunately in developing countries many pregnant women die due to pregnancy related complications and those who survive suffer from severe maternal morbidity. These surviving cases are known as ''Near Miss Case''. Near – miss events are defined as acute obstetric complications that immediately threaten a women's survival but do not result in her death either by chance or because of hospital care she receives during pregnancy, labor or within 6 weeks after termination of pregnancy or delivery[1]. For identifying near-miss events, there was a disease – specific criteria employed by Filippi et al based on five main diagnostic groups[2]. These are hemorrhage (Leading to shock, emergency hysterectomy, coagulation defects and/or blood transfusion of > - 2 liters), hypertensive disorders in pregnancy (eclampsia and severe pre-eclampsia with clinical/laboratory indications for termination of pregnancy to save the women's life), dystocia (leading to uterine rupture and impending rupture e.g. prolonged obstructed labor with a previous caesarean section), infection (hyperthermia or hypothermia or a clear source of infection and clinical sings of septic shock) and anemia (low hemoglobin level: hematocrit <6 g/dl) or clinical sings of severe anemia in women without severe haemorrhage[3].

Case report-1

Mrs. Ruma Akter, a young lady of 25 years belonging to below average socioeconomic status, Para 2+ 0, house wife, was admitted in Mymensigh Medical College Hospital with the history of delivery of severely asphyxiated female baby by caesarian section 1 day back. She had history of the convulsion for several times for the last 16 hours and respiratory distress for the last 10 hours. According to the statement of the patient's attendant she was pregnant for 34 weeks and had irregular antenatal check up but duly immunized against TT. At her 34 weeks of gestation, she underwent caesarian section due to severe pre-eclampsia at local Sadar hospital.

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The patient developed postpartum eclampsia after 12 hours of operation and respiratory distress after 3 hours of convulsion. Afterwards she was referred to MMCH for better management. At the time of admission she was found disoriented. General exam revealed severe anemia, marked edema, with pulse rate 90 beats/min, BP-170/130 mm of Hg and bilateral fine crepitations on both lungs. She was diagnosed as 3rd day of abnormal puerperium following caesarian section with postpartum eclampsia with acute left ventricular failure. After admission she was treated with oxygen inhalation by mask, propped up position, antibiotic, Inj. Frusemide and antihypertensive drug (Lebetalol). Due to severe respiratory distress she was then transferred to ICU and was on ventilatory support, antibiotic therapy, frusemide and nitro mint spray. Patient was later shifted from ICU to Gynae department at the 5th postoperative day with stable vital signs.

Case report 2

Mrs. Lovely 26 years old primi gravida coming from Netrokona was admitted in Mymensingh Medical College Hospital as a term pregnancy with obstructed labour with foetal distress. The patient had no antenatal checkup. During admission, the general examination revealed exhausted short stature woman, severe anemia, and temperature 101^0 F. Per abdominal examination revealed term pregnancy, vertex presentation, longitudinal lie and fetal heart sound– 160/minutes irregular. Per-vaginal examination revealed OS -8cm, Cervix -100% effaced, station-1, Rupture– Membrane and hot dry vagina. LUCS was done two hours after admission. Bleeding was average, a baby was delivered as severely asphyxiated and expired during resuscitation. After two hours of operation the patient developed primary PPH and went to shock. Medical management of PPH was given, but there was no improvement. Then Laparotomy was done. Uterus was found atonic. Be – Lynch suture was then given as uterine compression suture. After that the ligation of bilateral uterine artery was done. There was no PPH in first post operative day. On the second post operative day she had stable vital sign except rise of temperature. On the 8th post operative day the patient developed burst abdomen and it was repaired by tension suture. On the 13th post operative day, Mrs. Lovely had developed severe secondary PPH. Again she had undergone 3rd Laparotomy. Uterus was found to be gangrenous and emergency peripartum hysterectomy was done. On the 20th post operative day she developed dribbling of urine. There was wound infection and dressing was done.On the 45th day Mrs. Lovely was discharged without uterus, without living baby but with urinary fistula (VVF). During her treatment period she got 12 bottle of blood .She got several antibiotics, the cost of those antibiotics was near taka- 30,000or US dollar- 500.

Case Report 3

Mrs. Nasreen 16 years young lady of average socio economic status, Para -1 hailing from URBAN AREA got herself admitted in Obs and Gynae unit of MMCH with the history of caesarean section 10 days back in a local clinic, bleeding from incision area and lower abdominal pain for 1 day. According to the patient's statement she was on antenatal checkup in Model clinic of MMCH and diagnosed as a case of pre-eclampsia at 30 weeks. At 34 weeks of pregnancy she got herself admitted to a local clinic with pre-eclampsia and premature rupture of membrane. Caesarean section was done. After her discharge on the same day she had developed bleeding from incision line and constant acute pain in lower abdomen. General examination revealed severe anemia, Pulse - 100 beats min, regular, BP-90/60 mm of Hg, Temp-100^0 F. Per abdominal examination revealed tense, tender abdomen and bluish color around the scar mark. There was bleeding coming through the incision area and sub involution of uterus. Per vaginal examination revealed Lochia rubra. She was diagnosed as 10th day of abnormal puerperium following caesarean section with rectus sheath haematoma, puerperal sepsis with severe anemia. Lab investigations revealed: Hb%- 6 gm /dl, Platelet Count- 2, 50,000/cu mm, post prandial blood sugar 6-9 m ml/L and C-reactive protein –18 mg/dl. Laparotomy was done to explore rectus sheath haematoma

under G/A. Huge amount of clotted blood was found under the rectus sheath. During procedure the peritoneal cavity opened up spontaneously. Uterine scar was found infected and was spontaneously disrupted. Frank pus came through the uterine scar. Exploration of rectus sheath hematoma, Toileting of peritoneal cavity and repair of uterus was done. One drain tube was kept in pouch of Douglas and another under rectus sheath. Proper hemostasis was ensured and abdomen was closed by tension suture. On 9th POD Abdominal wound was found healthy and patient was stable. She was then discharged. She got - 6 (six) bottle blood & antibiotic, inj -Imipenum. The cost of antibiotics was near taka 50,000 or US dollar-600.

Discussion

A pregnancy usually continues uncomplicated in most of the cases, but may have some complications. The study of cases of life threatening conditions (near miss cases) will give us a way of evaluating maternal health services and also this act as case control for maternal death cases. In one study WHO has developed a systematized approach to implement near miss criterion – based clinical audits to improve quality of care in the facilities. After getting the result health care facility have implemented a culture of early identification of complications and better preparedness for acute morbidities. There is a growing interest in the application of the maternal near – miss concept as an adjunct to maternal mortality [4]. A review of near miss maternal mortality may help delineate the continuing threats to maternal health and the types of support services most commonly required[5]. Tertiary care hospital in Nigeria has been found to obtain benefit from evaluation of their standard of obstetric care by including near miss investigations in their maternal death enquiries[6]. There is no denying the fact that 'Near miss appraisal' provides a large sample to assess the threat to maternal life. The overall maternal death to near miss ratio, however indicate that a significant proportion of critically ill women died, suggesting a suboptimal level of care for life threatening complications. Since there were little differences in the underlying disease processes causing near miss and maternal mortality, evaluation of the circumstances surrounding near miss cases could act as proxy for the maternal death in a centre.

Conclusion

We are to be serious in our effort to reduce maternal mortality and near miss case and for this we need to take action on some essential elements, such as (i) quality maternal case services to all (ii) access to resources, (iii) proper transport, (iv) all deliveries by a skilled birth attendant, (v) ANC to all, identifying risk factors, (vi) intrapartum risk approach and finally (vii) appropriate family planning method.

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