3rd Prize

Patient who was expected to live but Die
16.11.07
By AKS Sr.

Patient age 22 was admitted on OB ward with the history of two home delivery with both fetus born dead in February and September 2002. The last delivery which ended with VVF, was repaired in March 2003.. It was after her VVF was repaired that she was advised never to have a home delivery, but a C-section.

By August 1, 2004 when she was at term she left her village and moved to a nearby village , so that when she was in labour she could go to the Hospital for the C-section.

On August 2, 2004 she visited the prenatal clinic, where she was then advised by the midwife to be admitted so that an elective C-section could be done by her doctor. This Mary agreed and was admitted on OB ward on August 3, 2004 a day after prenatal clinic.

The surgeon visited her at 2.30pm and informed her that her surgery was to be done on August 4, at 10.00am. She and her husband signed the consent form and she was informed that she was going to be on NPO as of 1200MN.

The anaethetist was informed and pre-anesthesia assessment shows – General condition was stable, well nourished. Wt 112 lbs, height 4'8". Skin afebrile to touch, conj pink, sclera white, oral cavity – mouth opening > 3 finger, teeth intact, and no over bite. Tongue normal, Uvula clearly seen, neck short and chest symmetrical. CVS – normal and Resp. system – normal. Abd-pregnant uterus 36cm. F36.4C, P 82, R-18c/m and B/P 100mg/70mg/Hg. Anaesthesia plan spinal anaesthesia.

On August 4, 2004, pre-anesthesia reassessment – N/S . T36C, P88b/m, R22c/m and B/P 120/75 mmHg. And pt appears stable not in stress because of pt education. The anaesthetist got RL3 Litre, which was made in the hospital and set up OR2 for surgery (Labs msu-neg, Hb 10g/d and WBC5,000)

Mary was then taken to OR2, spinal given in sitting position, She then lay flat on the OR table and tilted to the left. When the neonate was out with Apga score of 9/10 and placenta removed, oxytocin 10 IU given IV slowly. Dr Bah then discovered that a vessel was cut and bleeding which took about five minutes to be stopped.

Pt B/P decreased to 80/60, and pulse increased to 132 @ 10.08 am, bed head lower and Ringer Lactate (RL) increased at open rate.
After the first liter, B/P was 70/40, and pulse 132 B/M. Another litre of RL put up at open rate after 3 minutes pt started having tetany and in < 30 seconds heart sounds ceased.

CPR was started, and after about five minutes, pupil checked it was dilated, CPR discontinued and body prepared and taken to the morgue.

Investigation after her death shows that, the Ringer Lactate made in the hospital had increased K+ in it. They were taken off the shelf and out of service to avoid such from reoccurring.

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