

Extreme obstetrics on a Pacific Island

Small Pacific Islands of Polynesia are well known for being pollution-free and stress-less – but being small emphasises the fears of being resourceless and isolated, especially when one is dealing with complicated cases. I had such a case in 1999.

A 22-year-old nulliparous woman had a caesarean section delivery for poor progress in labour. Four hours after she delivered, she started bleeding heavily and despite uterine fundal massage and fluid replacement, she continued to bleed until circulation collapse. A decision was made to take the patient back to the operating room for an examination under anaesthesia (EUA). The uterus was atonic and there were no lacerations found in the vagina or in the lower uterine segment. Several attempts were made to cause the uterus to contract. Uterine massage was continued as Oxytocin – intravenously and intramuscularly – was given, followed by two prostaglandin tablets that were inserted into the uterine cavity. Blood transfusion was commenced with packed red cells from the United States.

As I joined the team in the operating room, the patient was pulseless and resuscitation efforts were continuing, including external cardiac massage. These efforts were rewarded as the patient's pulse returned. I then took over the operating side of the table.

Two options were considered – a sub-total hysterectomy or a B-Lynch suture¹. I decided to try the B-Lynch suture considering the patient's young age and parity. Ligation of the uterine arteries was not one of my options because not only is it a more aggressive procedure than the B-Lynch suture, but it would probably not be helpful in maintaining the contraction and retraction actions of the uterus, which is what we wanted.

During the procedure, the patient developed disseminated intravascular coagulopathy (DIC). We were awaiting the availability of fresh blood drawn from family members, as we did not have fresh frozen plasma at the time. After applying the B-Lynch suture, the uterus remained relatively soft and its shape was like Mickey Mouse's head and ears. The bleeding from the uterus appeared to be subsiding at this stage but there was still general ooze of thin blood from the operation site. The first unit of fresh blood was completed at this stage.

A drain was placed in the lower abdomen and the abdominal wall was closed in layers. We continued to transfuse fresh blood to correct the DIC and observed patient in Intensive Care four hours. The plan was to perform a subtotal hysterectomy if she were to bleed again. Fortunately, with huge amounts of prayers, we did not need to take her back to theatre.

Her recovery in Intensive Care Unit (ICU) was gradual and complicated by paralytic ileus but there were no further life-threatening events. She was discharged 14 days later. The patient was advised that given the increased chance of PPH further pregnancies be managed in Hawaii where there would be better resources.

We have since been informed that she had a caesarean section delivery for the second baby in Hawaii in 2000, followed by PPH and was

Dr John Ah Ching

DSM DPH DIP.OBS
Lyndon Johnson Memorial Hospital
Pago Pago, American Samoa

Edited by **Alec Ekeroma**

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admitted to ICU and had a blood transfusion. She delivered the third baby by caesarean section again in Hawaii in 2004 and had a tubal ligation.

This mother is alive and well with three healthy children, but the outcome could have been disastrous. PPH is still a major cause of maternal mortality in the islands. Early intervention including surgery and blood transfusion saves lives.

Reference

1. B-Lynch C, Coker A, Lawal AH, Abu K, Cowen MJ. The B-Lynch surgical technique for the control of massive postpartum haemorrhage: an alternative to hysterectomy? Five cases reported. *BJOG*, 1997;104(3):275-7.

Senior Obstetrician/Gynaecologist required for LBJ Tropical Medical Center, Pago Pago, American Samoa

A senior obstetrician gynaecologist, preferably working in Australia or New Zealand at present, is required to work at the LBJ Tropical Medical Center on contract, negotiable for either one or two years.

Salary is over USD\$70,000 pa plus housing and transport from country of origin.

The successful applicant will work in a team of four O and G specialists and be required to undertake a comprehensive range of both obstetrical and gynaecological services.

This is the only hospital serving a population of about 69,000 people, with the number of deliveries at about 1,700 per year.

For further information, please contact:

Dr John Ah-Ching

Chief Obstetrician Gynaecologist
LBJ Tropical Medical Center

(e) ahchingjohn@yahoo.com or zelana2001@yahoo.com

(t) + 684 633 1222

(f) + 684 633 1794