

Postpartum Hemorrhage Hypothetical Case Studies

Wisconsin Association for Perinatal Care

Case 1: Identification and intervention

19-year-old G1 P0 female, admitted in active labor at 39 weeks with 3 cm dilatation after uncomplicated pregnancy. Patient has normal progress in cervical dilatation with a prolonged second stage requiring oxytocin augmentation and ultimately vacuum extraction (VE) delivery of a 4600-gram neonate. Placenta delivered within 5 minutes. Oxytocin was started by diluting 20 U in D₅RL and running at 125 cc/hr. Patient passed large clots 20 minutes after delivery. BP 120/80, pulse 90. Uterus soft and up to the umbilicus.

- Teaching points:
 - Atony vs. cervical/vaginal tear
 - Placenta inspected/complete?
 - Pelvic exam vs. uterine exploration vs. trial of carboprost (Hemabate®)?
 - When to type and screen

Patient received 1 ampoule of carboprost every 15 minutes IM. Patient was typed and crossed. Patient was not examined. Oxytocin infusion was opened wide. Bleeding does not stop. BP 90/60, pulse 130.

- Teaching points:
 - Dosing carboprost
 - Stepwise identification of bleeding source by OB exam
 - What blood products to order and in what amount
 - What other lab studies other than hematocrit
 - Response time:
 - Blood bank
 - Anesthesia
 - Surgeon

Pelvic exam reveals bleeding from cervical os with no tears in cervix or vagina and “boggy” uterus. Clots expressed, patient “shocky.” BP 70/40, pulse 158.

- Teaching points:
 - Treatment of shock
 - Oxytocic algorithm

In spite of 6 ampoules of carboprost and IM methylergonovine (Methergine®), bleeding continues and there is “oozing” from IV site.

- Teaching points:
 - Consumption coagulopathy and DIC
 - Rapid fluid and blood/blood component replacement
 - Surgical therapy
 - Timetable

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Table of Contents Postpartum Hemorrhage Hypothetical Case Studies Wisconsin

1. Understanding the eBook Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - The Rise of Digital Reading Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - Advantages of eBooks Over Traditional Books
2. Identifying Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - User-Friendly Interface
4. Exploring eBook Recommendations from Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - Personalized Recommendations
 - Postpartum Hemorrhage Hypothetical Case Studies Wisconsin User Reviews and Ratings
 - Postpartum Hemorrhage Hypothetical Case Studies Wisconsin and Bestseller Lists
5. Accessing Postpartum Hemorrhage Hypothetical Case Studies Wisconsin Free and Paid eBooks

- Postpartum Hemorrhage Hypothetical Case Studies Wisconsin Public Domain eBooks
- Postpartum Hemorrhage Hypothetical Case Studies Wisconsin eBook Subscription Services
- Postpartum Hemorrhage Hypothetical Case Studies Wisconsin Budget-Friendly Options
- 6. Navigating Postpartum Hemorrhage Hypothetical Case Studies Wisconsin eBook Formats
 - ePub, PDF, MOBI, and More
 - Postpartum Hemorrhage Hypothetical Case Studies Wisconsin Compatibility with Devices
 - Postpartum Hemorrhage Hypothetical Case Studies Wisconsin Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - Highlighting and Note-Taking Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - Interactive Elements Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
- 8. Staying Engaged with Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
- 9. Balancing eBooks and Physical Books Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - Setting Reading Goals Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - Fact-Checking eBook Content of Postpartum Hemorrhage Hypothetical Case Studies Wisconsin
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development

- Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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