SIMulatED

Royal Darwin Hospital Emergency Department

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# Scenario Run Sheet: Postpartum syncope

## Scenario Overview

**Estimated Scenario Run Time:**  15-20 mins

**Estimated Guided Reflection Time:** 30-40 mins

**Target Group:** ED Registrars and Nurses

**Brief Summary:** 32yo G3P2 presents with brief unconscious collapse 10 days post routine SVD at term due to endometritis/RPOC and mild anemia.

## Learning Objectives

**General**

Broad approach to syncope in post-partum female, including non-obstetric causes

**Scenario Specific**

Focussed antenatal + birth history simultaneously with primary survey

Focussed maternal assessment including cardiovascular + neurological systems

Post-partum assessment of abdomen, pelvic and breasts +/- bedside pelvic USS

Consideration of infant wellbeing and breastfeeding status, rationalise maternal drug therapy in breastfed infant

Management of sepsis from endometritis

Informed consent and weighing pros/cons of TFN

## Equipment Checklist

**Equipment**

Vaginal examination pack,

**Medications and Fluids**

Giving set, 0.9% saline, antibiotics (metronidazole, ceftriaxone)

**Documents and Forms**

Antenatal chart, ED nursing chart, paediatric chart

**Diagnostics Available**

VBG, ECG, ultrasound, glucometer, UA (leuk, blood)

## Scenario Preparation/Later Parameters

**Initial Later**

GCS **14** RR 26 P 120 BP 90/50 GCS **15** RR 20 HR 90 BP 110/70

Sats 100% RA T 38.8 BSL gas SaO2 98% O2 T 37.9

**Mannequin Features**

Live simulated female patient plus SimMum for pelvic examination. ED Infant mannequin.

## Participants

**Staff Actors**

ED Registrars x3 Mother, partner (ED staff), J Bauert (tech)

Nurses x2ED, ED Consultant available by phone

 O+G registrar available by phone

**Instructor Roles**

- Provide the team with clinical signs

## Candidate Instructions/Triage Information

It is 0300h. “Cat 2 resus 1 now”. Triage sheet: 32yo woman 10 days post term delivery with dizziness, palpitations and syncope on standing up. Fell backwards and struck head with momentary LOC + occipital laceration. Driven in by husband. Babe in attendance – no issues.

## Patient Instructions

Initially slightly confused, improves during scenario. Discharged day 2 post SVD. Expects full disclosure of all information and questions MO/RN if not adequately informed. Concerned about effect of meds on baby.

**HPC** – increasing dizziness on standing past 2 days+ heart thudding, better if seated. Feeling chills, no temp recorded. No paracetamol or NSAID taken. No cough/SOB. Slight dysuria; bowels open. No calf pain or swelling, no chest pain. If specifically questioned: lochia: discharge initially pink, 1 pad change daily but now becoming heavier and darker with 3 pads changed yesterday, no pus or malodour noted. Mild suprpubic tenderness,no breast pain + breastfeeding well.

If asked about blood TFN – reluctant to have blood, but with adequate explanation will consent. Declines IDC, willing and able to sit on commode for UA.

**Medical History**: (AN record and partner): G0 P2, both SVD, uncomplicated. Chronic mild microcytic anemia – vegan. Discharge Hb 90g/L. GBS negative. Rh positive.

**Meds**: ferrogradumet 1 daily. Mild asthma – no attacks during pregnancy, NKDA.

**Social** Works as a lawyer at a local commercial firm, lives with husband and family in Malak

## Proposed Scenario Progression

* Patient lying in bed. Partner holding baby at bedside.
* Focussed maternal history and examination, noting fever and mild shock state; delivers IV fluid boluses against target MAP
* Tender suprapubic area, gallop rhythm noted, pale conjunctivae, normal chest/skin/calf exams, mild pedal oedema. No meningismus
* Recognises sinus tachycardia on ECG
* Performs VE with consent – dark bloody discharge per os, cervical excitation, uterus tender on bimanual exam, adnexae NAD; obtains endocx swab and HVS. No vault or labial trauma/infection.
* Baby well – no exam required – remains with father
* Recognises anemia Hb 75 on VBG and considers contribution to syncope
* Performs focussed blood tests and septic screen (BC, vaginal swabs, timely Urine MCS), gives appropriate first line antibiotics for presumed endometritis
* If bedside USS performed – shows wide endometrial stripe consistent with RPOC/endometritis (image), no free pelvic fluid.
* Early consultation with O+G re admission and D+C.
* Discusses pro’s cons of TFN with patient

## Debriefing/Guided Reflection Overview

**General Opening Questions**

* What happened in the scenario?

**Scenario Specific Questions**

* What were you looking for during your assessment to explain the syncope in this patient?
* What other differentials did you consider?
* What treatment did you give and why?
* If the patient hadn’t responded to Rx, what would you have done next?
* The patient had suffered a head strike and was septic and voiced multiple concerns regarding the details of her care. What approach did you take?
* The patient was also anemic and reluctant to be transfused. How important did you think blood transfusion was in this case and how did you address her concerns?

**General Wrap-Up Questions**

* What did you find most beneficial about this scenario?
* What was the most challenging point in this scenario?
* What would you do differently next time?

\*Midwifery CNE-led session (1 hr):

* Assessment of the woman with PPH