Clinical Practice Review

THE ROYAL WOMEN'S HOSPITAL QUALITY AND SAFETY UNIT NEWSLETTER

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A Kimberley experience

Derrick Thompson

Over the past six years I have been spending my mid year holiday at Broome and became aware that there was no regional Obstetrician/ Gynaecologist for the last three years. Through the Specialist Obstetric Locum Service introduced by RANZCOG, I spent the 18th – 29th of Feb 2008 as Locum Obstetrician/ Gynaecologist Kimberley region Western Australia. This arrangement with Kimberley Health started in January 2007 providing a locum service on a three monthly rotation for a two week duration.

The Kimberley region includes Broome, Derby, Fitzroy Crossing, Halls Creek, Kununurra and several remote indigenous communities.

The locum service provides for consulting clinics especially including colposcopy in the above regions together with operating sessions at Broome, Derby and Kununurra. You have the option of being flown or driving between these centres. You may also be asked to provide emergency obstetric cover for the region if someone is on leave.

"..someone had crashed into the rear of my car. The driver must have thought it a little strange, as I kept on talking on the phone"

In October 2007, Dr Pallavi Desai, an Obstetrician/Gynaecologist from India was appointed by Kimberley Health to service the region. Her full time employment has been of immense benefit in relieving the waiting list of patients awaiting consultation and/or surgery. There is room for another Obstetrician/Gynaecologist to be appointed to the area, but in the meantime a locum facility provides assistance with Commonwealth funding and this service is now known as the Medical Specialists Outreach Assistance Project.

Dr. Clare Myers, our Senior Registrar accompanied me during my first week working in Broome. She was involved with consulting, colposcopy and I assisted her with an all-day operating session which included hysteroscopy, LEEPs operative laparoscopy and abdominal hysterectomy.

Over the middle weekend I was on call for emergency caesareans based at Broome and then had to drive 220kms to Derby late Sunday afternoon ready for an all day operating session with Dr. Desai on Monday. At the end of our day's operating, Dr. Desai invited me for an Indian meal. I had just driven into the local Woolworth's car park at about 6.30pm to purchase some wine for the evening when my mobile phone rang. The phone call was from a GP in Broome requesting Dr. Desai and myself fly down to Broome immediately to treat a primigravid lady having severe primary post-partum haemorrhage of uncertain aetiology and which they were having difficulty arresting the bleeding. In the middle of this conversation there was an almighty crashing sound and I turned around to find someone had crashed into

...continued page 2

EDITORIAL

Clinical Life Goes On

I could start this editorial with 'this is the last newsletter from Carlton…' which it is but looking at the bigger picture there will be an editorial next month just like there will be operating lists, antenatal clinics and other clinical activities. Although our history in Carlton has been duly acknowledged and celebrated over the last few weeks and administrative activity has been at fever pitch, disruption to patient care has been imperceptible. This has been to everybody's credit. We are about to go into reduced elective activity as I write this and there is an air of anticipation, excitement and a little nervousness in the clinical air around the hospital.

Next month we will cover some of the clinical transition issues so can I ask you to consider telling us the stories you would like to share with your reader colleagues. Until then, I wish you a safe move low on stress, high on quality…

Leslie Reti, Editor
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the rear of my car. The driver must have thought it a little strange, as I kept on talking on the phone, ignoring the accident! I finally told the driver involved that I was discussing a medical emergency, so we exchanged telephone numbers and I hastily left.

Dr Desai and I drove straight to the Derby airport with three units of blood to find the Royal Flying Doctor aircraft waiting on the tarmac. We took off immediately for the 35 minute flight to Broome. I couldn't really enjoy the scenery as I was going through in my mind what steps might be required on arrival to control the bleeding eg? an atonic uterus with some retained products,? placenta accreta,? a lacerated cervix/uterus, and associated procedures eg B-Lynch suture, internal iliac artery ligation, hysterectomy.

On arrival in theatre, the bleeding had been controlled somewhat with three vaginal packs, eight units of blood and two units of fresh frozen plasma. Blood stained footprints throughout theatre were an indication of the severity of the blood loss. On examination, I removed the vaginal packs, checked for unrecognized vaginal lacerations and performed a vaginal examination where it became evident that the lady was suffering from acute uterine inversion. There was a persistent moderate blood loss from the fundus of the inverted uterus and a barely palpable rim of the cervix in the vaginal fornices.

I have never experienced an acute uterine inversion at vaginal delivery during my 35 years practising obstetrics, but I was aware of O'Sullivan's hydrostatic technique for treatment of this condition.

I used a large bore infusion pump set, inserting the tube into the vagina and manually blocking the introitus with a pack and digital pressure. Under ultrasound control, three litres of Compound Sodium Lactate(CSL) was required to completely evert the uterus. It was amazing to observe the slow eversion over 5-10 minutes as the fluid was infused. Unfortunately the photographic equipment on the ultrasound machine was not working, therefore the potentially great images during reduction of the inverted uterus were not taken.

Following complete eversion, 0.25mg of Ergometrine was given intravenously and after a few minutes, the fluid was slowly drained from the vagina. 400mcg of Misoprostol was inserted vaginally to help maintain a contracted uterus. The blood loss resolved and the lady was transferred to the ward for continued observation.

Kimberley Health chartered a private twin-engine plane which flew me back to Derby later the same evening – 10.30pm, as I had to leave Derby early next morning to drive another 258km to Fitzroy Crossing for a full day of consulting.

6B Eagle Drive, Jandakot WA 6164 'Road landing'
Courtesy of Fiona Davey Public Relations Office, Royal Flying Doctor Service of Australia (Western Operations)

In all, the round trip Derby–Broome–Derby took about four hours. The only other interesting facet of this emergency experience was that Derby airport and surrounding security fencing and gates had been locked for the night, so on my return and with help from the pilot, I managed to climb over the 10ft barbed wire fence to get to my car to drive the 10kms back to my hotel in Derby!

On reflection, I must admit I did not consider acute uterine inversion until I examined the patient and I feel I should have. The hydrostatic technique is very simple, incredibly effective especially under ultrasound control as this allows you to know more precisely when the uterus has been completely everted.

The aetiology was uncertain, but I can only assume excess traction on the cord was applied before separation of the placenta with a contracted uterus. Syntocinon had been given for the third stage. No further complications were encountered. The patient, with healthy baby, was discharged home on Day four.

Broome Hospital is a 50-55 bed hospital with an Accident and Emergency Department, two labour ward beds from which 270 deliveries per year are carried out and one operating theatre. A new theatre is currently being built and a 14 bed Mental Health Unit is being established. The Obstetric Unit is staffed by GPs – two of whom perform caesarean sections. The resident general surgeon also goes on call for emergency caesarean sections. GPs also perform the anaesthetics including epidurals. I was very impressed by the quality and dedication of the GPs and the nursing staff.

I have discussed acute uterine inversion following vaginal delivery with a number of colleagues. About half have not encountered it and half have experienced this situation but only once, apart from Dr. Peter Heath, who claims to have been exposed to six! Few have used the hydrostatic method of reduction although all were aware of this treatment.

The remainder of my locum requiring consulting at Fitzroy Crossing and Halls Creek was uneventful, although I did drive over 700kms in one day to return to Broome to catch my flight back to Melbourne!

Derrick Thompson
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