

The “Can’t Miss” OB-GYN Emergencies

A Clinical Command Framework
for the Undifferentiated Patient

The ED Safety Net: Universal Non-Negotiable Rules



PREGNANCY TEST

Every female of childbearing age (10-60) with abdominal pain, amenorrhea, or bleeding gets a pregnancy test.
No exceptions.



ACCESS & FLUIDS

2 large-bore IVs for any unstable patient.
Resuscitate with crystalloids, then blood.



Rh STATUS

Every bleeding pregnant patient gets an Rh-status check.
Administer 300 μ g RhoGAM if Rh-negative to prevent alloimmunization.

The Chief Complaint Triage Board

Structuring the cognitive workflow by how patients present at the door

Monitor 01

The Acute Pelvic Pain Patient

Focus: Early/Non-Pregnant Emergencies

Monitor 02

The Third-Trimester Bleeding Patient

Focus: Placental Emergencies

Monitor 03

The Systemic Crisis Patient

Focus: Hypertensive Disorders

Monitor 04

The Post-Delivery & Trauma Patient

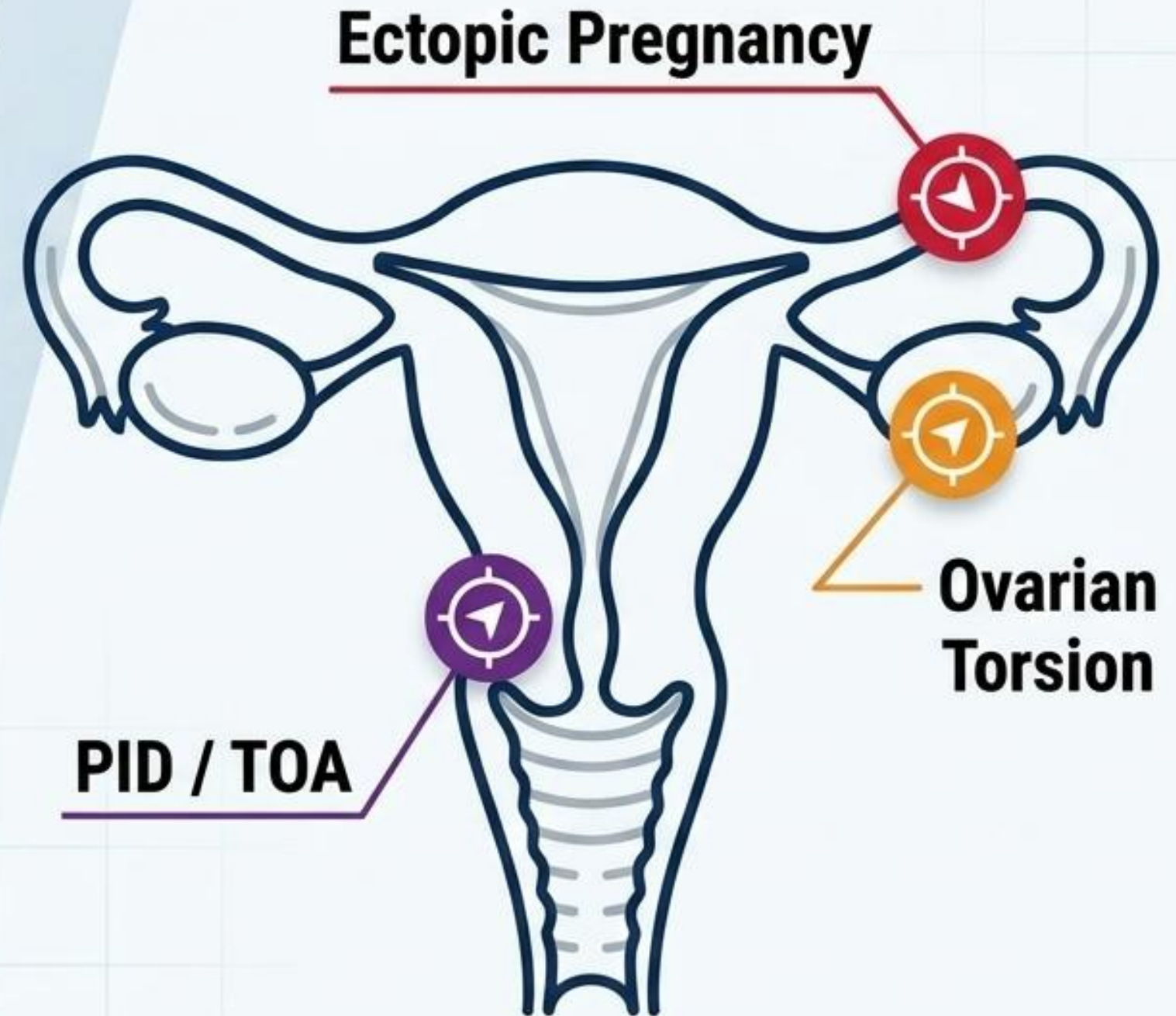
Focus: Hemorrhage and Resuscitation

Chief Complaint 01: Acute Pelvic Pain

The Clinical Reality:

The presentation is vague.
The pathologies are lethal.

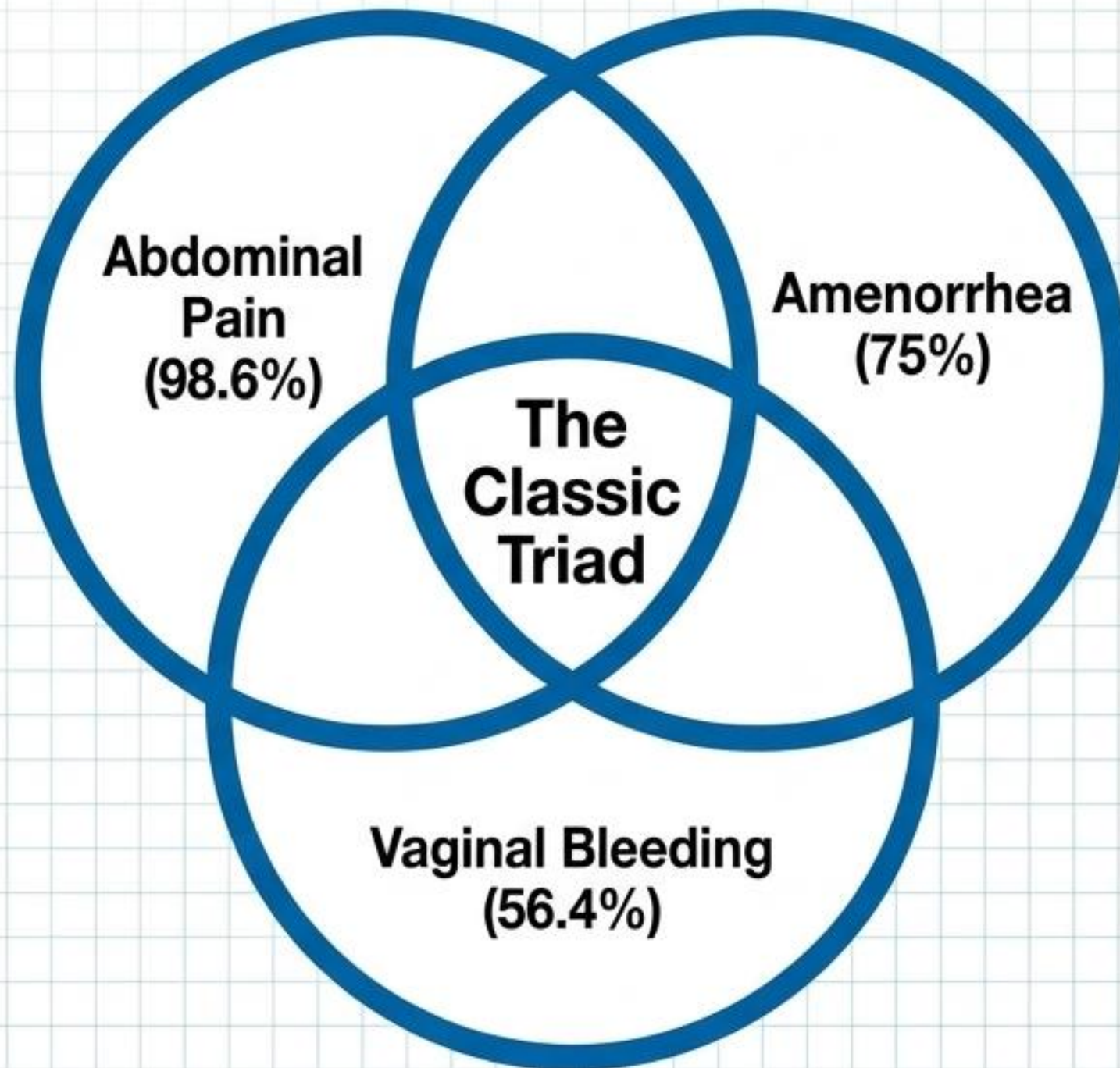
Your job is to rule out the
time-bombs before
diagnosing the benign.



The Acute Pelvic Pain Diagnostic Matrix

	Ectopic Pregnancy	Ovarian Torsion	PID / TOA
Onset & Quality	Sudden, severe, with syncope/dizziness.	Sudden, unilateral, colicky, with Nausea/Vomiting.	Gradual, bilateral, smoldering.
Ultrasound Findings	Empty uterus + free fluid / adnexal mass.	Enlarged/edematous ovary (>3cm), absent flow (or present!).	Tubal thickening, complex adnexal mass if TOA.
The Crimson Red Flag	Hemorrhagic shock.	Time is Ovary (Ischemia).	Sepsis / Fitz-Hugh-Curtis syndrome.

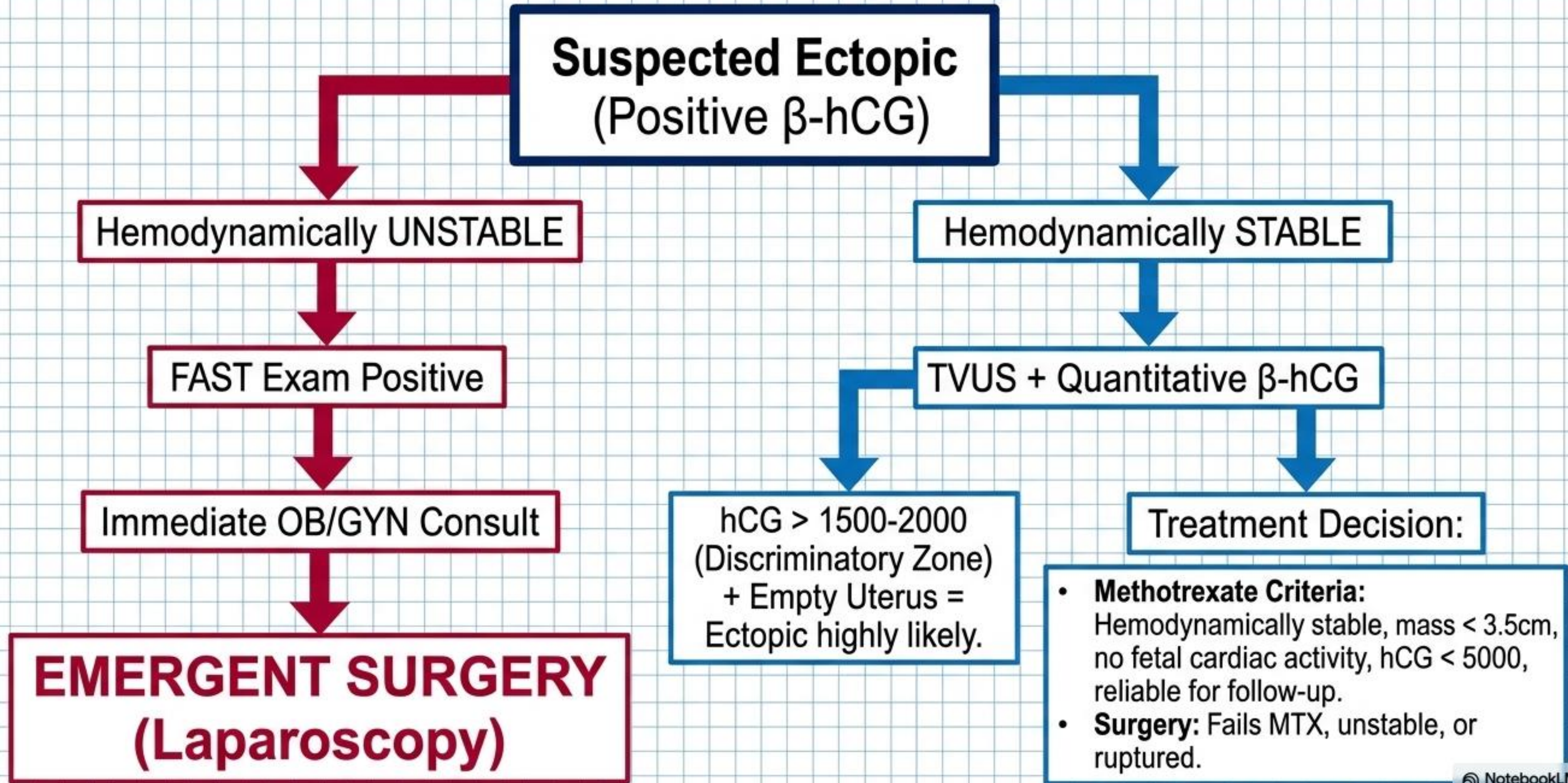
Ectopic Pregnancy: The Triad Trap



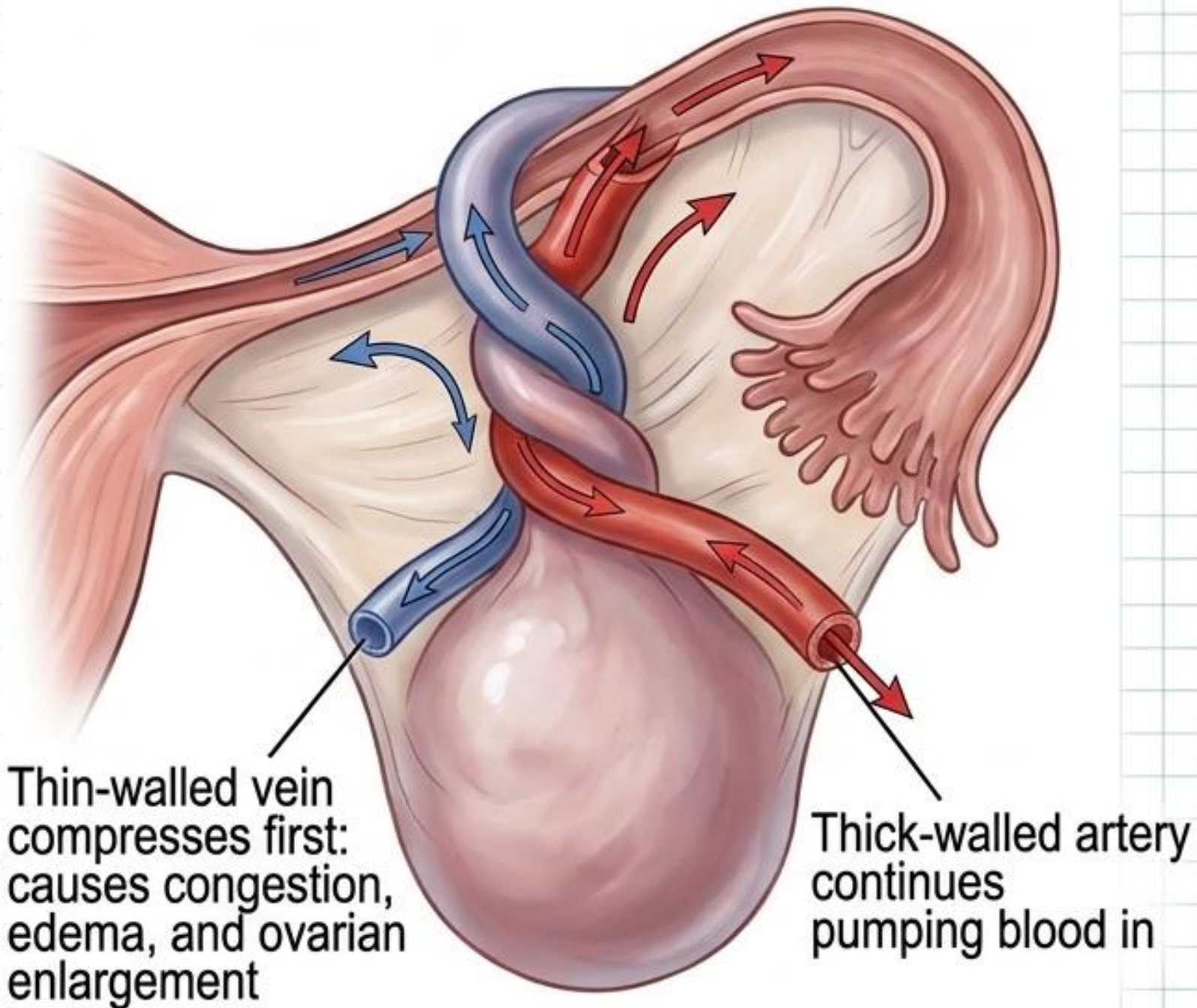
DANGER: The classic triad is neither sensitive nor specific.

A patient may present with isolated syncope, unexplained hypotension, or referred shoulder pain (phrenic nerve irritation from hemoperitoneum). Assume Ectopic until proven otherwise.

Ectopic Management Pathway



Ovarian Torsion: Trust the Patient, Not the Doppler



The Ultrasound Pitfall

Normal arterial Doppler flow does NOT rule out torsion. Over 50% of surgically proven torsions have intact arterial flow on ultrasound.

The Primary US Finding

Simple enlargement of the ovary (>3cm to <10cm).

Action Plan

“Time is Ovary.” Best outcomes if detorsed within 8 hours. Consult GYN early based on clinical suspicion, not just ultrasound.

The Pathogenesis of PID

Stage 1: The Cervical Infection

- **Organisms:** N. gonorrhea / C. trachomatis.
- **Presentation:** Purulent discharge, cervical motion tenderness (CMT).

Stage 2: The Ascending Infection (PID)

- **Organisms:** Polymicrobial.
- **Presentation:** Bilateral pelvic pain, fever, leukocytosis.
- **Treatment:** Ceftriaxone 250mg IM + Doxycycline x14 days.

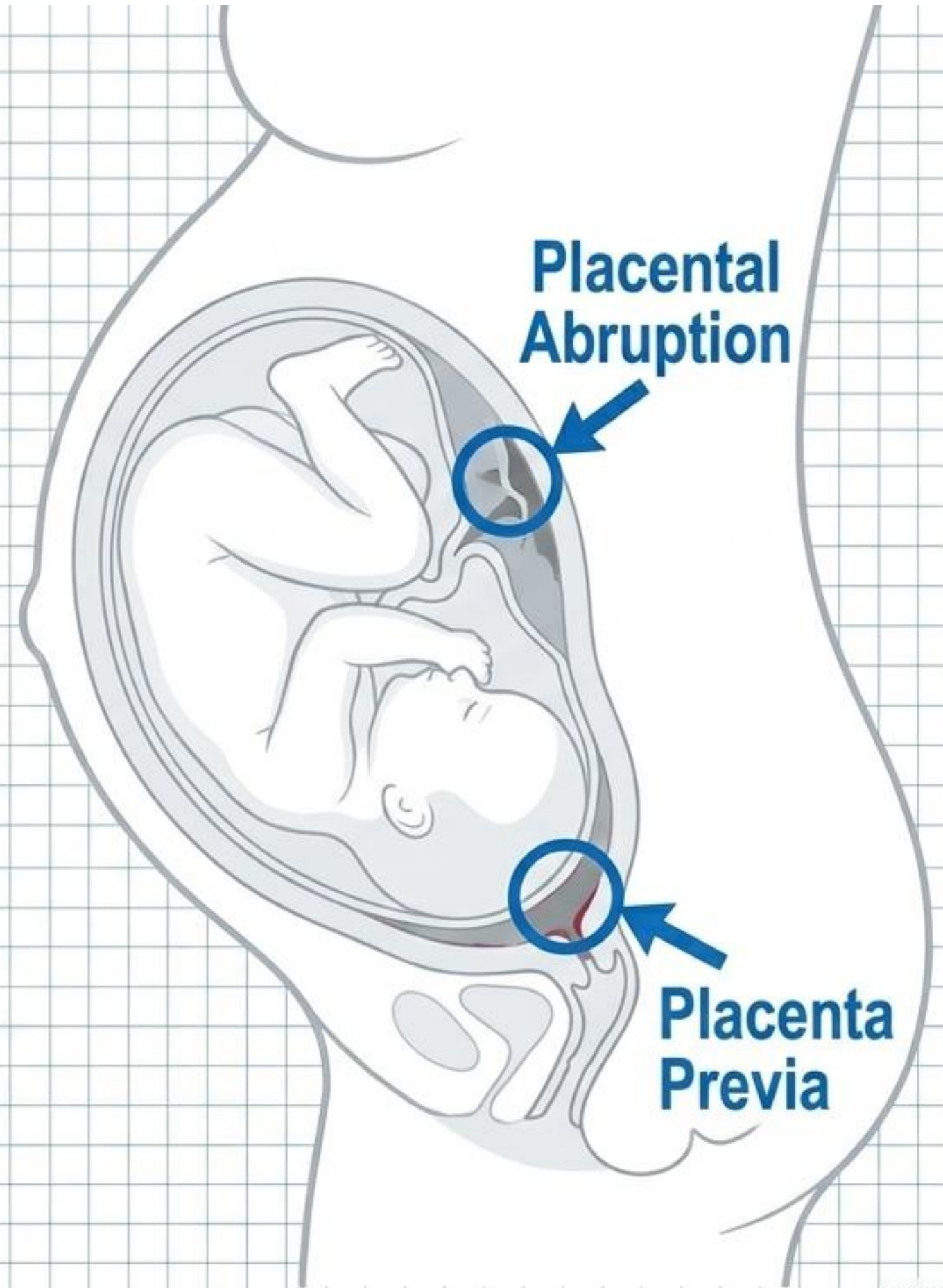
Stage 3: Critical Complications

- **Tubo-Ovarian Abscess (TOA):** Suspect if severe unilateral pain, fever, or failing antibiotics. Requires US/CT.
- **Fitz-Hugh-Curtis Syndrome:** Perihepatitis. RUQ pain + referred right shoulder pain.

Chief Complaint 02: Third-Trimester Bleeding

The Clinical Reality:

Two primary culprits. One causes fetal distress and maternal shock. The other creates a lethal trap for the unwary examiner.



Third-Trimester Bleeding: The Critical Distinction

Placental Abruption (Premature Separation)

- **Pain:** Highly Painful (Pain out of proportion).
- **Bleeding:** Dark red (may be concealed!).
- **Uterus:** Rigid, tender, hypertonic.
- **Risk Factors:** HTN, trauma, cocaine, preeclampsia.

Placenta Previa (Cervical Os Coverage)

- **Pain:** Painless.
- **Bleeding:** Bright red.
- **Uterus:** Soft, non-tender.
- **Risk Factors:** Prior C-section, multiple gestation.

THE AMBER WARNING: DO NOT PERFORM A DIGITAL PELVIC EXAM in third-trimester bleeding until Placenta Previa is ruled out via ultrasound. Risk of catastrophic hemorrhage.

Chief Complaint 03: The Systemic Crisis

The Clinical Reality:

Hypertension in pregnancy is not just a number; it is progressive endothelial failure leading to seizures and organ rupture.



The Hypertensive Spectrum in Pregnancy



- BP >140/90 after 20 weeks.
- No proteinuria.

- BP >140/90
- Proteinuria (>300mg/24hr).

- BP >160/110
- End-organ damage: Visual changes, Severe Headache, RUQ pain (Liver capsule stretching).
- HELLP: Hemolysis, Elevated Liver enzymes, Low Platelets.

- The onset of grand mal seizures or coma.

Action Protocol: Severe Preeclampsia & Eclampsia

Stop the Seizures (Neuroprotection)

Drug: Magnesium Sulfate (4-6g IV load over 15-20 mins).

- **Monitor for Mag Toxicity:** Loss of DTRs, respiratory failure.
- **Antidote:** Calcium Gluconate.

Control the Pressure

Drugs: IV Labetalol or Hydralazine.

- **Goal:** Prevent stroke/intracranial hemorrhage.
- **Warning:** Do NOT use ACE Inhibitors.

The Definitive Cure

Action: Delivery of the fetus and placenta.

- **Rule:** If severe/eclamptic, proceed to immediate delivery regardless of gestational age.

Chief Complaint 04: Postpartum Hemorrhage (PPH)

The Clinical Reality:

- The leading cause of maternal mortality worldwide.
- Primary PPH occurs within the first 24 hours.

Clinical Definition:

- >500mL blood loss (Vaginal Delivery)
- >1000mL blood loss (C-Section)

The 4 Ts of Postpartum Hemorrhage

1. TONE (70% of cases)

- **Sign:** Soft, “boggy” uterus.
- **Action:** Bimanual massage, IV Oxytocin, Misoprostol.

2. TISSUE

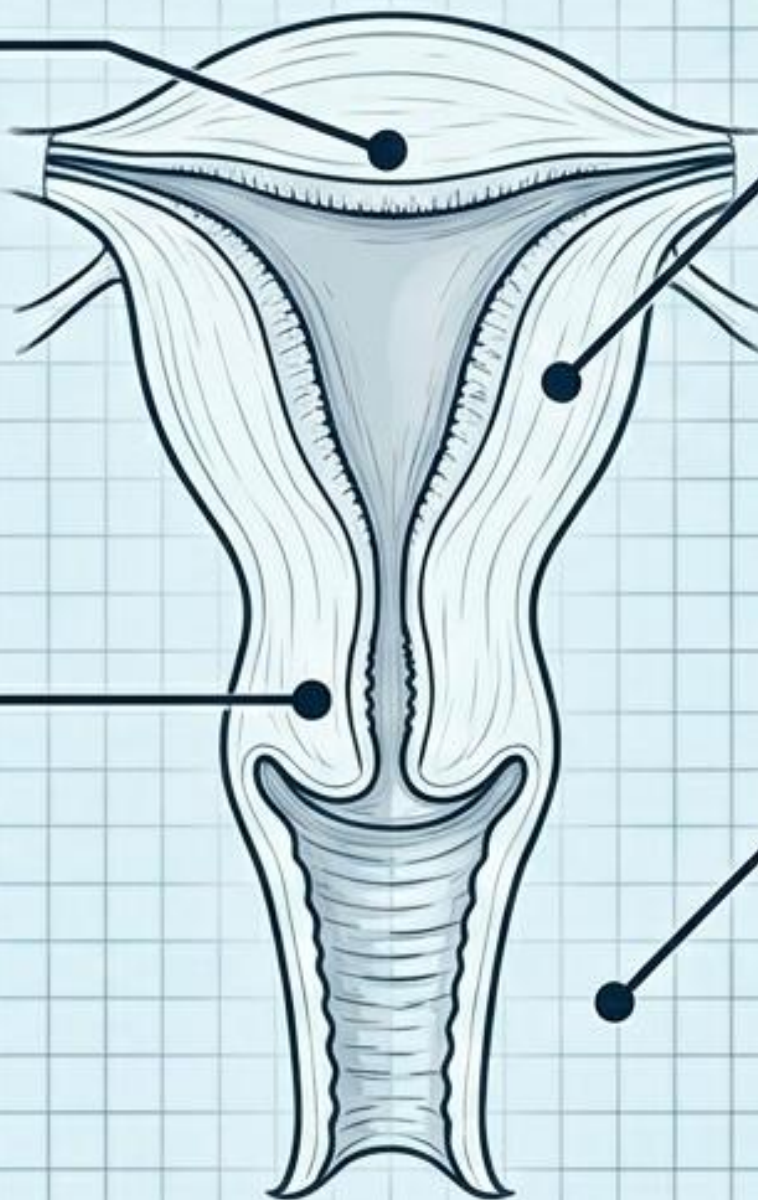
- **Sign:** Retained placenta / incomplete expulsion.
- **Action:** Manual extraction or D&C.

3. TRAUMA

- **Sign:** Firm uterus, but persistent bright red bleeding.
- **Action:** Surgical repair of lacerations.

4. THROMBIN

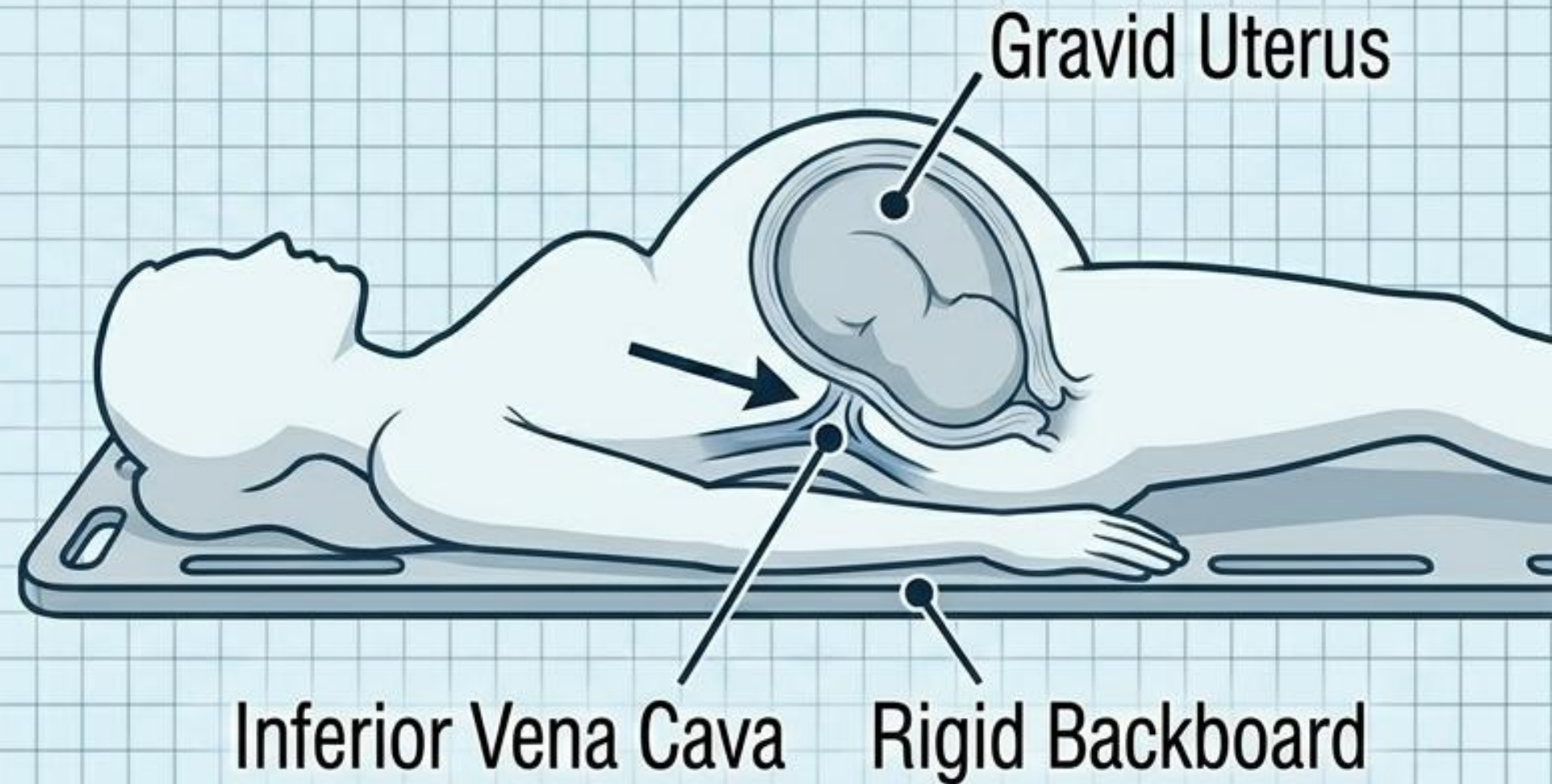
- **Sign:** Oozing from IV sites, coagulopathy (DIC).
- **Action:** FFP, Cryoprecipitate, Platelets, TXA.



Chief Complaint 05: The Pregnant Trauma Patient

The Clinical Reality:

You are treating two patients, but the mother's survival is the absolute prerequisite for the fetus's survival.



Resuscitation Priorities in Pregnancy

1. Relieve IVC Compression

Displace the uterus to the left (Left lateral decubitus or elevate the right side of the backboard). Supine hypotension syndrome can mask shock.

2. Anticipate Hidden Shock

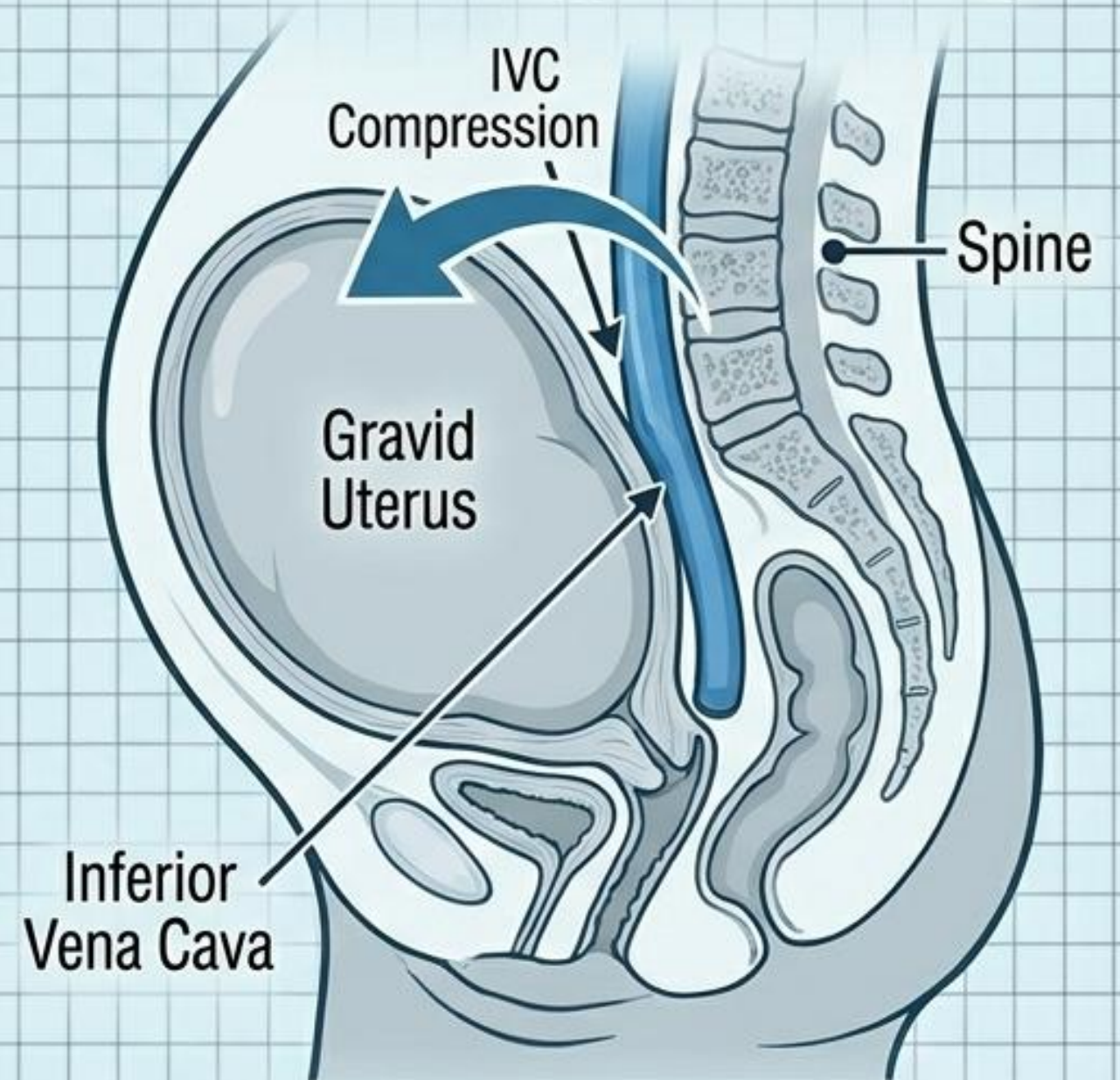
A pregnant patient can lose up to 35% of blood volume before showing signs of hypotension due to increased baseline plasma volume. Resuscitate early.

3. Fetal Monitoring

Monitor all viable fetuses (>20 weeks) for at least 4-6 hours. Look for loss of variability or late decelerations indicating placental abruption.

4. Rh Status

Perform Kleihauer-Betke test to quantify fetal blood. Give RhoGAM within 72 hours for Rh-negative mothers.



Manual Uterine Displacement

The Perimortem C-Section Window

Condition: Maternal cardiac arrest,
Gestation >24 weeks (uterus
above umbilicus).

Minute 5

Delivery of the fetus.

Minute 0

Maternal Arrest.
Initiate ACLS.

Minute 4

Make the decision. If no return of
spontaneous circulation (ROSC),
prep for surgery.



The Core Insight:

This is a maternal resuscitation procedure. Emptying the uterus relieves aortocaval compression, increasing venous return and cardiac output by up to 30%, giving the mother the best chance of ROSC.

The OB-GYN Emergency Lifelines

The Universal Rule-Out

Every female of childbearing age gets a pregnancy test. Assume ectopic until an IUP is confirmed.

Trust the Physiology, Not the Tech

Doppler ultrasound does not perfectly rule out torsion. The "Classic Triad" of ectopic is rare. Treat the patient's symptoms.

THE UNIVERSAL RULES

The Rh Imperative

Any bleeding in pregnancy mandates an Rh-status check. RhoGAM saves future pregnancies.

Mom Comes First

Whether in trauma, eclampsia, or hemorrhage, aggressive maternal resuscitation is the only way to save the fetus. Fix the mother's tank and pressure.