What Can They Do in the ICU That We Can't Do in Labor and Delivery?

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Lisa M. Councilman, M.D.; James J. Konvicka, M.D.
Texas A&M HSC COM/Scott & White Hospital

Introduction: A 42-year-old multigravida at 34 weeks gestation with prolonged tachycardia develops acute cardiomyopathy leading to cardiogenic shock. This followed numerous attempts by the attending obstetric anesthesiologist to communicate the serious nature of the patient's condition to the attending obstetrician, who disregarded the warnings. We present this case of an acute cardiomyopathy rapidly leading to cardiogenic shock during the peripartum period which reminds us of the critical importance of open communication between the obstetricians and anesthesiologists and respect for each others' areas of expertise.

Case: A 42-year-old multiparous woman with chronic hypertension and untreated urinary tract infection presented to the emergency department (ED) at 36 weeks gestation complaining of palpitations and dizziness. Her heart rate (HR) was 170 bpm. Adenosine was administered twice without effect and patient was admitted to Labor and Delivery. The attending anesthesiologist advised the obstetrician that at minimal, a cardiac consult was warranted, and an ICU bed should be strongly considered. This advice was not heeded and the patient continued to remain profoundly tachycardic. Multiple attempts were made by the anesthesiologist to the obstetrician to reconsider their management strategy and the reply was, "What can they do in the ICU that we can't do in L&D?" Thirteen hours after arrival to the ED the patient developed a rapid decompensation in her cardiorespiratory status and required an emergent cesarean section for fetal bradycardia. An arterial line was placed simultaneously with the rapid sequence induction and the infant was delivered with a cord gas pH of 6.69. The patient was taken to the ICU postoperatively, started on epinephrine, norepinephrine, and dobutamine infusions, and a bedside echocardiogram was performed, revealing an ejection fraction of 10% with severe left ventricular hypokinesis. Serial troponins were 0.06, 1.11, 2.23, and 2.45 ng/mL, and BNP was 3010 pg/mL. At this time cardiology was consulted for cardiogenic shock. Aggressive diuresis was initiated with furosemide. Enalapril was initiated on ICU day 4. On hospital day 5 the patient was moved out of the ICU. The patient was discharged home on post-operative day #11.

Discussion: This case emphasizes the critical importance of interdisciplinary communication and respect for experts in other specialties when receiving clinical management advice for optimal patient outcome. The attending anesthesiologist, with training in critical care, was promptly disregarded when expressing concern for a patient who was showing signs of impending cardiovascular collapse. The obstetricians, with their lack of training in critical care, could not appreciate those signs and chose to ignore the pleas of the anesthesiologist, even to the point of making a condescending remark out of ignorance. Our hope is by highlighting this case, we will improve communication with our colleagues.