A uterine rupture case that led to the development of a culturally relevant patient handout for Aboriginal women considering VBAC

RANZCOG 2021 Virtual ASM

Background

25yo G2P1

Obstetric History

2011 Emergency LSCS for FTP at 4cm – 3.5kg baby

Past Medical History

T2DM – not medicated latest HbAlc 5.8%

Surgical History

LSCS

Medication

Nil
NKDA

Social History

Lives with husband and first child
From Central Australian community of Ampilatwatja
BMI 40
Non smoker

Antenatal care

Presented to ED due to leg pain - unknown pregnancy
Ultrasound performed - 29/40 gestational age, nil abnormalities detected, placenta right lateral and clear of os

Antenatal bloods

- O positive
- Antibodies: anti-P1
- Hb 122
- Rubella non-immune
- HepB/HIV/syphilis negative
- Vit D 26

Referred to Diabetes Antenatal Care clinic for review
- did not engage

Attended 2 antenatal clinics in community where she received treatment for scabies, flu vaccine and boostrix

Mode of delivery discussion not documented

38+4
- Growth USS - EFW 3708 normal AFI and dopplers

40+1
- Admitted with tightening 1:10 subsequently subsided
- Attempted discussion with patient re mode of delivery
- Aboriginal Liaison Officer also discussed options with patient
- Aboriginal Liaison Officer informed doctor that patient will have vaginal birth

40+2
- Discharged home

40+3
- Patient found to be extremely distressed as received news parter had committed suicide this evening
- Admitted to ward with moderate contraction 1:10

Labour

Initial
- SROM mec stained liquor, contracting 4:10
- VE 6cm, 75% effaced, -1

2 hours later
- Concerns with CTG not picking up
- On duty registrar contacted
- VE repeated 6cm, fully effaced, -1
- Blood clots noted
- FSE applied

2 hours 30mins
- Analgesia requested - sterile water injection attempted but declined after first 2 blebs

3 hours
- CTG concerns
- Fetal Scalp Lactate - 1.8
- VE 6cm, fully effaced, -1, not well applied
- Decision made to reassess progress in 2 hours

5 hours
- VE nil change
- Consultant advised for caesarean

6 hours
- Fetal Bradycardia 5 mins then recovered
- Small PV bleeding noted
- Decision made for caesarean

7 hours
- GA caesarean performed
- Uterine rupture noted
- Live male delivered, 3504g
- Babe born in poor condition
- Babe admitted to Special Care Nursery
- Haemostasis achieved - EBL 1700ml

Post-partum

Day 1
- Hb drop from 122 to 77 -- iron infusion given
- Babe discharged from Special Care Nursery

Day 2
- Depot provera given for contraception
- MMR given

Day 4
- Discharged back to community

Day 11
- Retrieved from community with wound dehiscence
- Readmitted to hospital
- Systemically well
- CRP 36, WCC 10.2
- IV antibiotics flucloxacillin commenced
- nmMRSA on swab sensitive to Bactrim

Day 15
- Discharged back to community on oral Bactrim

Northern Territory

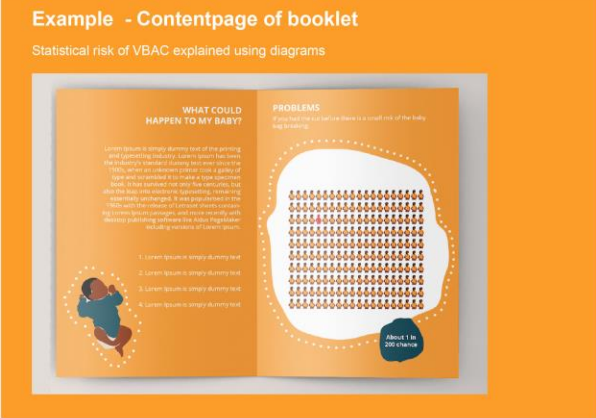
Ampilatwatja 300 km north-east of Alice Springs

Culturally relevant booklet (front and back cover)

Development with the assistance of the Aboriginal Liaison Officer

Example - Contentpage of booklet

Statistical risk of VBAC explained using diagrams



Discussion

This case presented many challenges. The patient was from a remote community 300km North east of Alice Springs Hospital. She presented late in her pregnancy and subsequently did not engage with medical services. Communication with her was difficult as her first language was Alyawarr and not English. The patient suffered significant psychological trauma with the sudden death of her partner, this meant that further counselling regarding her delivery was difficult due to her distress.

Although not ideal attempt was made by myself to council the patient regarding mode of delivery when she initially presented to Hospital in early labour. Using the RANZCOG patient information handout as a guideline i never felt convinced that I was able to properly council the women so that she could make an informed decision. I enlisted the help of an Aboriginal Liaison Officer however they visited the patient whilst i was not present, and when talking with them later it became apparent that they too had limited understanding of this subject matter other than giving the patient the choice of trial of labour vs repeat caesarean. Although I was not on duty during the patients labour and delivery, i spent time reflecting on the case.

The discussion of mode of delivery in a women who has previously had a caesarean section is common in the antenatal clinic. Cultural differences can make the transfer of information and understanding of VBAC challenging. The production of culturally relevant information is useful for both the patient and practitioner. RANZCOG has produced patient information for VBAC, however to my knowledge there is no available culturally relevant information for our Aboriginal consumers.

Following the above case I have created a culturally relevant educational booklet. The booklet has been developed in English with appropriate wording and diagrams made in consultation with the Alice Springs maternity Aboriginal Liaison Officers. If accepted for distribution within NT Health I hope the booklet will aid the practitioner to be able to better inform Aboriginal women, and her family about vaginal birth after caesarean section. With over 100 Aboriginal languages spoken in the Northern Territory, the next step would be to have the booklet translated in to local languages.

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