

An examination of obstetric cases admitted to the intensive care unit

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Abstract

In an intensive care unit at Govt. Medical College Nagpur, Maharashtra, to determine the risk variables responsible for the complication leading to ICU admission and maternal outcome in terms of morbidity and mortality. We conducted a backward observational research. From 1 July 2012 to 30 June 2013, all patients admitted to the intensive care unit (ICU) during pregnancy and up to 42 days after delivery were examined. All of the events involving obstetric patients were documented, including demographic information and medical and surgical histories. Data was examined using the proper software.

1.5% of deliveries, or 170 obstetric patients, were admitted to the ICU. The average age was 24.65 $\pm$ 4.05. The average gravidity was 1.73 $\pm$ 0.95. Haemorrhage (n=52, 30.58%) and hypertensive condition of pregnancy (n=48, 28.23%) were the two most frequent obstetric reasons for admission. Tropical infectious cases were the most prevalent non-obstetric cause (n = 19, 11.17%). Mechanical breathing (n=114, 67%) and vasoactive infusion (n=55, 32.5%) were the most frequently used interventions. 52.9% of mothers died (n = 90). 93.33% (n=84) of them were referred cases to our tertiary care facility. Rural residents made up 63.52% (n=108). Only 16 (17.02%) of the 94 patients (n = 55.29%) who got prenatal care were scheduled at our facility. Obstetric bleeding, obstetric hypertension issues, and tropical infections such as swine flu, viral hepatitis, dengue fever, and viral encephalitis. 90 non-survivor cases were reported, of which 56 (62.22%) were obstetric cases and 32 (35.55%) were not. 57.7% (n=52) of non-survivors passed away within 48 hours of admission.

Keywords : Critical obstetric patients, maternal death, and intensive care unit (ICU).

Introduction

Most obstetric patients are young and in good health¹. However, despite recent therapeutic improvements, maternal mortality and morbidity still happen, and the possibility of fatal consequences exists. This might be brought on by the pregnancy itself, a deterioration of a current condition, or difficulties with an operation.

Obstetric patients who are critically unwell present a challenge to intensive care unit (ICU) doctors.

Obstetric patients make up only a small percentage (0.1–0.9%) (2,3) of ICU admissions in wealthy countries, whereas this number jumps to 8.5% in poor nations.

In most of these cases, the maternal mortality ratio is also greater. developing nations Morbidity rates in developed nations range from 0.05 to 1.7%. It ranges from 0.6 to 8.5% in nations with little resources. In the industrialised world, a number of scoring systems have been employed to predict the fate of obstetric patients, including the Glasgow Coma Scale (GCS), the Mortality Probability Model (MPM), and the Acute Physiology and Chronic Health Evaluation (APACHE).⁽⁴⁾ However, ICU patients from the Indian subcontinent hardly ever took part in these studies because dedicated ICUs are not available in developing nations^(5,6). As a result, the current study was carried out to assess obstetric ICU admissions in tertiary referral hospitals with certain resource restrictions, in an effort to identify the risk factors influencing these admissions.

Aim and Purpose

To determine the maternal outcome in terms of morbidity and death, as well as the risk factors responsible for complications that result in ICU hospitalisation.

MATERIAL AND TECHNIQUES

The current review was embraced in the division of Obstetrics and Gynecology Government Clinical School, Nagpur from first July 2012 to 30 June 2013. It was a review observational review. Consent from mmorals board had been taken. Concentrate on populace comprises of 170 obstetric cases conceded in ICU. The aggregate quantities of conveyances during this period were 10923. Test size was determined with reference by review BALOCH R et al.,⁽⁶⁾ study and with the understanding that extent of subjects having hypertensive turmoil of pregnancy are 36.2%. (Relative precision=20%, certainty level=95%). Consideration rules: All obstetric patients conceded in ICU

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The information recovered for investigation contained age, equality, gestational age, booking status, area of home, mode of conveyance, sign for ICU affirmation, mediation in ICU, length of ICU stay and result. The foundations for admission to ICU were named obstetric and NonObstetric. These patients were followed till released from emergency clinic or till death which at any point happen first.

Statistic review

Categorical data were given as percentages and continuous data as means and standard deviations. Software called Epi info 3.4.3 was used to examine the data. Using the chi square test, categorical variables were compared. P 0.05 was considered significant.

Conclusion

This study underlines the extraordinary attributes of basically sick obstetric patients. Obstetric drain, hypertensive issues of pregnancy and tropical illnesses like malarial fever, Dengue fever, pig influenza, viral hepatitis and so forth were most normal purposes behind ICU confirmations.

There is change in pattern in reason for maternal mortality as contrasted with different investigations as tropical illnesses arise as driving reason for mortality among Non-Obstetric bunch.

The affirmation rate to emergency unit issues looked by fundamentally sick parturient might be decreased by working on antenatal consideration through updating fringe wellbeing focuses, making them exceptional, furnishing them with prepared staff and refreshing their information by leading CMEs through telemedicine, so as to work with early recognizable proof of high gamble pregnancies also, their convenient reference to higher focuses. This will help in diminishing the dreariness and mortality related with hypertensive illnesses in pregnancy and obstetric drain.

It is of basic significance to make a connection between obstetric division and ICU focuses to early accomplish distinguishing proof of crediting factors prompting mortality in request to accomplish best forecast.

Doctor in the concentrated consideration ought to be know all about the inconveniences of pregnancy and ought to work intimately with obstetrician to work on maternal result in these patients. Early affirmation and the board of basically sick obstetric patients in ICU will diminish maternal distress and mortality.

At long last an exceptional obstetric ICU is expected to man-

age fundamentally sick obstetric patients as it were. We think this will further develop maternal medical services and this too related with legitimate and productive antenatal consideration, to forestall maternal grimness and mortality. In specific focuses worried about administration of obstetric patients.

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