

1. Lead examiner

Candidate Number:

2. Co-examiner

Final Mark:

SCENARIO

A 28 yo female is brought by ambulance to your tertiary ED. She was the front seat passenger involved in a medium speed motor vehicle accident less than one hour ago. She is 32 weeks pregnant. The patient is in your resuscitation room, with full cardio-respiratory monitoring and spinal immobilization. The trauma team is assembled.

On examination: GCS 15/15; HR 128/min; BP 92/48 mmHg; RR 22/min; O₂ sats 99% on 6 L/min O₂.

Question 1: What are the key features of your initial examination? (included in stem)**3.5 min**

Expected Response	Details	
	Worrying vital signs, indicating potential abdo injury and shock. This is a surgical / obstetric emergency. Examination concurrent with early Rx as required.	
Aims	Confirm pregnancy and gestational age Assess maternal and foetal wellbeing Risks of injuries, and indications for specific Ix and/or Rx Complications, such as placental abruption, early labour	
Mother	A and B: compromised by gravid state Cervical spine Circulation: wedge under hip , other signs of shock; potential sites of blood loss Caveats: Lower BP may be normal at 32/40; high circulating blood volume, so potential 30-40% blood loss before signs.	
	Primary and secondary survey Abdomen: difficulties in assessing for intra-abdominal injury, given advanced pregnancy. Bruising (eg seatbelt) Signs of abruption or uterine rupture; contractions evidence of vaginal bleed, ROM	
Foetus PROMT what obstetric issues do you need to assess	Consistent with dates, Heart rate (needs urgent CTG) Movements , liquor volume.	

Question 2: The patient has abdominal tenderness. DISCUSS the options for pelvic / abdominal imaging for this patient.

1.5 min

Expected Response	Details	
	Radiation exposure of negligible concern in this case, given 3rd trimester plus risk:benefit ratio. Mother assumes priority over foetus. Key factors: stability of mother, foetal state, diagnostic yield (esp skill of operator in ultrasound, skill of person reading scans), availability of tests.	
Plain XR	Only pelvic XRs taken. Aim to identify pelvic #s. Pros: Accessible, rapid and non-invasive. Cons: Radiation dose, difficult to interpret, with foetus superimposed.	
FAST/abdo u/s	Pros: rapid, bedside, non-invasive, immediate results. Aim to indentify intra-peritoneal fluid, suggesting bleed or visceral rupture. May assess foetal features concurrently: HR, lie, position, movements. Cons: technically difficult, for anatomical reasons. Insensitive for retroperitoneal pathology and specific organ injury. Of value when patient unstable: assists decision re laparotomy vs pelvic angiography. Operator dependent.	
CT Abdo and Pelvis	Pros: high definition scans with radio-contrast have high sensitivity and NPV. Detects visceral injuries, views retroperitoneal space. Reconstructions allow anatomical detail: spine, pelvis, foetus! Cons: limited access to patient, high radiation dose. Potential radio contrast allergy or nephropathy. Limited availability (of scan or radiologist), although should be high in tertiary centre. Expertise limited: even trauma centres do NOT read many 3 rd trimester trauma scans!	

Question 3 There is persistent foetal bradycardia. Describe your management.

2 min

Expected Response	Details	
<i>Possible placental abruption, or early labour. If possible, needs urgent Caesarean, but mother assumes priority. Recruit best available expertise, esp Anaesthetics for airway.</i>		
oxygenation	adequate	
breathing	Maintain BP and uterine circulation. Additional risks in this patient: gastric stasis / GOS incompetence, low FRC (resp reserve), increased O ₂ consumption and demand, large breasts, pharyngeal soft tissue swelling. In-line C spine immobilisation. Ventilation: high F _I O ₂ , settings to optimise pO ₂ and pCO ₂ .	
Circulation		
Positioning	Left lateral - prevent aortocaval compression & uterine hypoT. For spinal precautions, use spinal board with tilt to left.	
Resuscitate	Volume,	
Delivery	Urgent obstetric consultation. Consider stability for Caesarean, given unlikely need for neurosurgical intervention in OT. Disposition to OT (or ICU)	
Other	Urgent blood group. Consider need for prophylaxis against rhesus iso-immunisation. IDC, oro-gastric tube and stomach decompression. Liaise with NOK	

Comments: (if you fail the candidate, please state why)

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If the candidate fails the exam overall, what feedback would you suggest CIC provide for this SCE?

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On examination:

GCS	15 / 15	
HR	128	bpm
BP	92 / 48	mmHg
RR	22	bpm
O ₂ Saturation	99%	On 6 L / min O ₂

Question 1: What are the key features of your initial examination?

Se:5
Im:16

[AH]

B.BARRY, WALTER
Study Date:30/03/2003
Study Time:13:42:57
MRN:

[R]



50
mm

[L]

[PF]

C35
W80