Pre-eclampsia

Scenario

Miss Sarah Conor, a 28 year old woman who is 36+6 weeks comes into hospital after feeling developing a headache and nausea. You are the FY1 on Labour ward today. Take a Hx, examine (ask for examination findings), consider investigations you would do and come up with a management plan.

For actress

Background-Sarah is a single mum (not married)-test if student is tactful. She has been in a difficult relationship and has been abused in the past which ended the relationship (brownie points if student does ICE). She stopped smoking and drinking during her pregnancy and has not relapsed. She has as FHx of pre-eclampsia and one previous child. Normal delivery no assistance needed. Child is 2 currently doing well. No NKDA, takes contraceptive pill but stopped during pregnancy and occasionally paracetamol for her headaches. Unremarkable gynae Hx only had a cervical smear screening (25 onwards). Has got asthma as PMHx nothing else.

Sarah complains of very bad headache. She always gets migraines with aura even before pregnancy and thinks that is what she has although this time it feels different because it hurts all over and she could not tell it was coming on like she usually can. She always feels like vomiting especially when the headaches are really bad. (If prompted, mention noticed swelling on her face and her friend from dinner thought she looked a bit puffy. She assumed it is part of pregnancy as she has had one child previously. She also felt she could not see properly which is new. She thinks that must be due to her pregnancy and has had it the last 2 weeks). She has no other symptoms

For examiner to offer student if asked

O/E

Hyperreflexia/clonus on neurology examination

Swollen face and legs (oedema)

Ix

Urine dip (get student to perform)-identified proteinuria ++

Blood pressure-160/100 (normally 120/80-last check in pregnancy clinic)

Mark scheme

Symptoms (SOCRATES approach)- If asked RUQ pain, headache(severity how is it different to migraine or same?), visual disturbance, identifies swelling is not normal, seizures, SOB, systemic enquiry-fever, malaise **(5 marks)**

Discussed RF (PMHx, Gynae Hx, Obs Hx, Social Hx, DHx, FHx, SHx)**-(5marks)**

Offer to examine/Asks for examination findings and does urine dip appropriately (3 mark-consent, wash hands and wears gloves, compare dipstick to bottle and mention protein raised)

Offer management plan –Further investigations (Bloods- FBCs/U&Es/LFTs/coagulation screen, USS ultrasound and Doppler) and immediate management (Labetalol and Magnesium Sulphate). Explain to the patient that ultimately you will need to admit her and deliver the baby following discussion with consultants.Patient may require steroids if <34-36 weeks.-**5 marks**

Asks ICE- 1 marks bonus

General impression and actress rating of doctor-patient communication skills-1marks

Total 20 marks

Notes for students

1. *Introduction*
    a. Wash hands and introduce yourself
    b. Check the patient's name and DOB
    c. Establish the purpose of the patient's visit and build rapport
2. *History of current pregnancy*
    a. How has pregnancy been for you so far? Any recent illnesses?
    b. How many weeks are you into your pregnancy? Last menstrual period or dating by scan?
    c. What scans or tests so far? Ask about first trimester screening results - single or multiple?
    d. Current BMI/weight
    e. Smoking status
    f. How are fetal movements?
    g. Labour pains or unusual bleeding
    h. Planned method of delivery?
3. *Past obstetric history*
    a. Blood type
    b. Gravidity
    c. Parity
    d. For each previous pregnancy:
        i. Date of delivery
        ii. Length of pregnancy
        iii. Single/multiple pregnancy
        iv. Spontaneous or induced
        v. Mode of delivery
        vi. Birth weight
        vii. Current health of the child
        viii. Antenatal/intrapartum/postpartum complications
    e. Ask tactfully about any previous terminations and miscarriages
4. *Past gynaecological history*
    a. *Have you had any women-related health issues before?*
    b. Previous smears and latest results
    c. Previous STIs/PID
    d. Previous use of hormonal contraception
5. *Past medical history*
    a. VTE
    b. Diabetes
    c. Epilepsy

d. Hypothyroidism

6. *Drug history*
   a. Folic acid
   b. Anti-D immunoglobulin
   c. Aspirin
   d. Iron
   e. Antiemetics
   f. Antacids/PPIs
   g. Teratogenic drugs
   h. OTC drugs and herbal remedies
   i. Allergies
7. *Family history*
   a. Genetic conditions
   b. Pregnancy losses
   c. Pre-eclampsia
8. *Social history*
   a. Occupation
   b. Living situation and social support
   c. Smoking, alcohol, recreational drugs
9. *Investigation*
   a. Offer to measure BP and do a urine dipstick
10. *Management*
    a. Explain the differential diagnosis to the patient
    b. Consider further investigations
    c. Explain the need to stay in hospital
    d. Discuss birth plan and arrange counselling if appropriate
11. *Conclusion*
    a. Thank the patient
    b. Offer an information leaflet
    c. Safety net by telling the patient to stay in hospital
    d. ICE