Pregnancy Case for Medicine Consult Rotation

Patient 1

A 30 year old G1PO at EGA of ~32 weeks by LMP (confirmed by a 1st trimester USG) presents with acute onset of right lower quadrant abdominal pain. She has associated nausea and anorexia with subjective fever. Abdominal pain started about 4 hours prior to presentation. Pain is constant and worsening. She denies any vaginal bleeding or discharge. She continues to feel regular fetal movement. She has no chronic medical problems and only takes prenatal vitamins. Patient has a prior surgical history of a T&A at 4 years old with no reported complications. No history of drug allergies. She has been routinely following up with her Obstetrician and no complications of pregnancy have previously been identified. General Surgery and OB/GYN have been consulted; however, the general surgery resident is in the OR performing an emergency splenectomy and the Ob/Gyn resident is delivering a baby at another hospital. The ER physician calls you, the internal medicine resident on call, to come and assess the patient until the surgical or Ob/Gyn resident arrives.

What are your differential diagnoses for this patient's abdominal pain?

You go to evaluate the patient. She is afebrile with HR 114, BP 121/74, and RR 20. She appears uncomfortable and has pain in the RLQ extending to the RUQ on examination with no rebound tenderness or guarding. She has a gravid uterus with fundal height of ~32cm. You perform a bedside Doppler which confirms the presence of fetal heart tones with FHR of ~130 bpm. What are the next appropriate steps in the work-up of this patient's acute abdominal pain?

You have an excellent ultrasonography technologist at your hospital who comes urgently to the ER to perform an ultrasound. He confirms that the fetus appears well with a normal appearing placenta with no evidence of abruption and there are strong, regular fetal heart tones. The gallbladder, liver, and kidneys are visualized and appear normal. Unfortunately, the appendix cannot be visualized. Your lab results reveal a normal-appearing urinalysis with no pyuria. CBC shows a WBC count of 12.5 with a normal differential and an H&H of 10/30. Electrolytes, Creatinine, and LFTs appears normal.

How do you interpret these lab results? What are some expected abnormalities that you expect to find on lab work that can be attributed to the physiological changes of pregnancy? What is your next step in determining the cause of your patient's abdominal pain?

The imaging you chose confirms your suspected diagnosis of appendicitis. Luckily, there is no evidence of a perforated appendix on imaging. The surgery and Ob/Gyn resident arrive and are impressed with your diagnostic work-up. The surgery resident states that her attending is available to take the patient to the operating room in a few hours and notifies the on call anesthesiologist. The Ob/Gyn resident examines the patient and confirms that she has no signs of preterm labor. He also has notified the on call neonatologist that the patient will need to undergo surgery in her 3rd trimester and ensures that the NICU is ready if an emergency delivery is needed. You, the surgery resident, the Ob/Gyn resident, the anesthesiologist, and the Neonatologist discuss the best way to manage this patient is the perioperative period.

What recommendations will you make to the team in regards to the pre-operative and post-operative management of this patient? Specifically, make recommendations in regards to VTE prophylaxis, pain control, and antibiotic choices. What questions do you have for the other members of the team in regards to management of this patient and their fields of expertise?

that the safest and most efficient treatment plan is developed for the patient and fetus.

Pregnancy Case References:

1. Stewart MK, Terhune KP. Management of pregnant patients undergoing general surgical procedures. SCNA 2015; 95:429-442.
2. Rebarber A, Jacob BP. Acute appendicitis in pregnancy. In: UpToDate, Lockwood CJ, Levine D, Weiser M (Eds), UpToDate, Waltham, MA, 2016