AN OBSTETRIC EMERGENCY—MENDELSON'S SYNDROME

(A Case Report)

by

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Introduction

In 1946 Mendelson described it as a syndrome most commonly occuring in obstetrics, but it seems that obstetricians are not fully aware of it, looking to the literature in textbooks and Journals. It has been taken for granted that immediate postoperative pulmonary oedema should be taken care of by anesthesiologist, but sometimes when this emergency occurs, anaesthetist is not available and obstetrician has to deal with it. It is nearly a always fatal emergency and every obstetrician should be aware of its occurance and its treatment. As there is only one case report in last 5 years in journal of obstetrics and gynaecology of India, and its severity and fatality has prompted me to report this case.

CASE REPORT

A young primigravida, admitted with labour pains in emergency on 9-11-82 at 2-35 AM.

She had no antenatal care. Her general examination revealed nothing abnormal.

During labour her progress was good till 8 Cms of cervical dilatation. Despite good contractions there was no further progress for 1 hour. Membranes were intact and presenting part was at—1 station. ARM was done and thick meconium expelled. After 1 hour she was taken for LSCS at 5-0 AM for foetal distress. Against medical advise she had taken tea and water several times during the whole night.

Induction was by thiopentone sodium followed by scoline. Intubation was done by plain tube 8 mm in size. Pharyangeal packing was not done. She was maintained on nitrous oxide and oxygen. Till skin closure procedure was uneventful. After extubation she vomited large quantity of gastric contents. Suction was done by laryngoscope only. Reintubation was not done. She was transferred to the ward at 6-30 A.M.

The patient had mild PPH. After one and one half hour patient was in shock and serious. The nursing staff attributed this to the PPH. When the call was attended by the author, the patient was gasping for oxygen. She had severe air hunger with indrawing of intercostal and subclavicular spaces and prominence of accessory muscles of respiration. The patient was deeply cyanosed. Pulse was imperceptible and BP not recordable. Pupils were moderately dilated and only sluggishly reacting to light, but patient was not in coma, rather she was irritable, roudy and hyperactive. There were profuse secretions in the throat.

Immediately suction was done and oxygen was given by nasal catheter (2L/min.). Boyle's apperatus was brought to the ward and anaesthetist was called for. Meanwhile patient was given 200 mg hydrocortisone, 40 mg lasix, 2 amp Derriphylline, 8.4% NaHCO3 2 amp I/V stat was given. Venesection done on both the legs and slow drip started.

Anaesthetist intubated the patient and IPPV (Inermittent Positive Pressure Ventilation) started with 100% oxygen. Patient responded to the treatment and pulse became palpable with BP still 50 mm of Hg.

Urgent X-Ray chest with portable machine showed massive bilateral pulmonary congestion with patchy areas of consolidation. ECG showed only sinus tachycardia (Figure 1).

Patient was restless with airhunger and semi-dilated pupils till 12.15 PM. BP fluctuating between 70 to 80 mm of Hg. One unit of blood was given slowly.

Patient settled on 2nd day. Afer that postoperative course was smooth and uneventful.

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See Fig. on Art Paper III