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## Is this a case of negligence?

Shoulder and abdominal dystocia during a vaginal delivery for fetal hydrops

### The case

A 26-year-old gravida 2 para 2 with a history of 2 elective abortions presented for prenatal care in the first trimester of pregnancy. She had a body mass index of 23, a prepregnancy weight of 135 lbs, and a height of 1.63 m. She had no chronic medical conditions and no prior surgeries. Her immunizations were up to date. An ultrasound at 7 weeks and 3 days confirmed an intrauterine pregnancy and dates by ultrasound were consistent with gestational age by known last menstrual period.

The patient declined prenatal genetic screening with both serum analytes and noninvasive prenatal testing. She accepted ultrasound assessments and had an anatomy scan at 18 weeks that demonstrated a normally grown fetus with normal fetal anatomy. An anterior, low-lying placenta was noted as well as a maternal heart-shaped uterus. A routine gestational diabetes

screening was normal at 25 weeks' gestation. Her hemoglobin (Hb) at 28 weeks was 9.4 with a mean corpuscular volume of 93.5 and she was Rh positive. An ultrasound at 29 weeks showed appropriate interval growth of the fetus and

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resolution of the low-lying placenta.

At 34 weeks' gestation, her fundal height was documented as 39 cm and an ultrasound was performed at 35 weeks. Placenta was anterior and normal appearing, and was over 2 cm from the internal cervical os. Polyhydramnios was diagnosed with an amniotic fluid index of 30. Fetus was cephalic with a normal heart

rate. Fetal hydrops was seen with fetal anasarca, ascites, and bilateral pleural effusions. No pericardial effusions were seen. Fetal abdominal wall measured 3 cm in thickness and the abdominal circumference was consistent with 41 weeks' gestation even though the pregnancy was at only 35 weeks' gestation. The estimated fetal weight (EFW) was greater than the 99th percentile and measured 5 weeks ahead of clinical dates. Also, middle cerebral artery Doppler interrogation was not performed.

A few days later, at 35 weeks and 5 days, the patient experienced a large gush of fluid and was admitted to a local hospital for preterm premature rupture of membranes. She was contracting every 5 minutes and found to be 1 cm dilated on 2 exams several hours apart. The fetal status was reassuring on electronic heart monitors. Magnesium sulfate for neuroprotection, latency antibiotics (ampicillin and azithromycin), and

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antenatal corticosteroids were initiated. Again, fetal ultrasound noted fetal hydrops; however, there was no maternal fetal medicine (MFM) specialist available for consultation or review of images. Furthermore, the hospital was not equipped to care for preterm deliveries; the patient was thus transferred to a tertiary facility for a higher level of care.

On arrival to the tertiary hospital, patient was again checked and found to be 1 cm dilated. Fetal status remained reassuring on electronic fetal monitoring. Patient continued to contract every 2 minutes. Maternal white blood cell count was elevated at 19 and Hb was stable at 10. A Kleihauer-Betke test was negative and TORCH serologies were normal for toxoplasmosis, cytomegalovirus, and herpes simplex virus. Parvovirus B19 immunoglobulin M was normal; however, immunoglobulin G was markedly elevated, consistent with recent parvovirus B19 infection. After further questioning, the patient endorsed a possible viral illness several months earlier that was associated with a rash on her chest and redness in her cheeks. Additionally, her thyroid-stimulating hormone levels were low but her free thyroxine was within normal limits. A repeat ultrasound was not performed.

The patient continued to contract and 12 hours after transfer, she

was found to be 6 cm dilated. A MFM consult was obtained and the consult note documented prior ultrasound findings, including the EFW from the prior hospital, but no new ultrasound was performed. Recommendation was to continue with expectant management given advanced cervical dilation, to continue with antenatal corticosteroids and latency antibiotics, and to have neonatologists present at delivery with plan for further neonatal workup after delivery. An epidural was placed per patient request.

She continued to contract spontaneously, and 6 hours later, the patient's cervical exam was anterior lip and +1 station. At that point, oxytocin augmentation was started given near-complete cervical dilation and rupture of membranes. Fetal heart tracing was within normal limits throughout. Forty-five minutes later, she was found to be 10 cm and began pushing. After 2.5 hours of pushing, the head delivered, followed by a 2-minute shoulder dystocia. McRoberts maneuver, suprapubic pressure, and attempt at delivery of posterior arm were performed without success. An episiotomy was cut, and the maneuvers were repeated, allowing delivery of the shoulders and arms; however, an abdominal dystocia was encountered. With traction on the fetal head and chest from below and fundal pressure from above, the baby was ultimately delivered

after an additional 1 min. Total time from delivery of fetal head until delivery of the full body was just over 3 minutes. Cord gases were not obtained and placenta delivered without difficulty.

Neonatologists were present at delivery and performed immediate resuscitation. A fractured humerus was noted as well as a pneumothorax, intracranial hemorrhage, and profound neonatal anemia. The neonate was ultimately found to have a severe hypoxic ischemic encephalopathy with postnatal and childhood complications.

#### Filing

The parents filed a lawsuit claiming negligence on behalf of the accepting hospital for negligent management of labor and on behalf of the physicians for substandard intrapartum care. Specifically noted were negligence in failing to perform a repeat ultrasound to determine an accurate estimated fetal weight, failing to recommend a cesarean delivery, and negligent management of a shoulder dystocia.

#### Deposition

At deposition, the patient stated that she was never offered the option of a cesarean delivery. While she had expressed interest in a vaginal birth, she stated that no one discussed with her other alternatives and that she would have openly accepted a cesarean delivery had that been

communicated as the safer delivery route. She further stated that the delivering obstetrician was very curt in her communications and was often on the phone when entering her room. Finally, she noted that the physician was shouting at the nurses during the delivery and that the team did not appear coordinated; she believes that despite the complications, delivery could have been expedited had the team been working together.

The plaintiffs were seeking a multimillion-dollar settlement because of the damages. The initial 2 settlement offers by the defense were rejected, but the plaintiffs accepted the third offer, and the case settled for an undisclosed sum.

### Learning points

Transfer of care to a higher level of care is warranted for the safety of the patient. When transferring care—within a facility or between 2 facilities—measures should be taken to ensure proper handoffs, including the transfer of pertinent medical records. Electronic records can often be shared by hospitals within the same medical network; however, when electronic systems are not compatible, paper records should be sent along with CDs as needed for necessary images. In this case, the transferring hospital did not send the ultrasound images of the original ultrasound nor did the accepting maternal fetal medicine physician perform a repeat ultrasound. Had the images been reviewed or a new ultrasound performed, the estimated fetal weight as well as the discrepancy between the fetal head circumfer-

ence and fetal abdominal circumference would have been known intrapartum and might have altered management.

Although the patient desired a vaginal delivery, there is no indication in the medical record that a cesarean delivery was ever discussed with her. She further supported this finding in her deposition testimony. Plaintiffs argued that cephalopelvic disproportion should have been anticipated and a cesarean delivery should have been recommended

The plaintiff believes that despite complications, delivery could have been expedited had the team been working together.

outright. They further argued that the fetus was known to have hydrops, which reduces the compressibility of the abdomen and thus further precluded an attempt at a vaginal birth. While the recommended mode of delivery is a matter of clinical judgment, this case highlights the importance of counseling and shared decision-making. The patient should be informed of clinical factors that weigh into recommended decisions, and those decisions and their alternatives should be documented in the medical record. Lack of documentation of *any* consideration for a cesarean delivery became an important point in the plaintiff's case.

Obtaining cord gases at delivery can often be helpful when a delivery

is complicated. Both arterial and venous cord gases should be obtained and carefully labeled. These blood gases can reveal the oxygen status of a fetus just prior to delivery and thus may be helpful in causation-related claims associated with hypoxemic injury. In this case, the neonate had multiple comorbidities that could have contributed to encephalopathy, and the fetal heart tracing had been normal up to the point of delivery. Cord gases might have helped by demonstrating the acid-base status of the fetus at that time. Placental pathological evaluation is also often important and can further assist with establishing causation.

The patient experience is an important element of intrapartum care. Careful communication with a patient about her labor progress, the medical options available to her, and the plan of care can strengthen the doctor-patient relationship, especially in labor and delivery units that rely on shift-work providers who may not have an antecedent relationship with a laboring woman. In this case, the patient felt dismissed on several occasions by her care team and did not feel as if she had the opportunity to ask questions or have her concerns addressed. Additionally, the perceived curtness of the obstetric provider and the lack of communication among the delivering team was a crucial element of the plaintiff's case. ■