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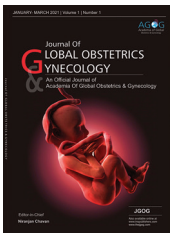

A Day in Ward 12 at Lokmanya Tilak Municipal Medical College and General Hospital

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"Sion Hospital" refers to Lokmanya Tilak Municipal General Hospital (GH), located in Mumbai, India. It is a prominent public hospital affiliated with Lokmanya Tilak Municipal Medical College (LTMMC). Sion Hospital is a major healthcare institution providing a wide range of medical services and treatments, serving a large population in Mumbai and its surrounding areas. A day in Ward 12 Labor Ward at LTMMC and GH can be quite eventful and challenging.

We residents of the Dr. Niranjan Chavan unit have our emergency day every Thursday. As usual, we started our day with the induction of patients and the elective Lower Segment C-Section. A total of four inductions of labor were there and four elective lower segment cesarean section (LSCS). By the time, we finished our elective patients, more than three patients in labor were in active labor and were managed as required.

At 3 PM in the afternoon, we received a call on the labor room landline from a peripheral hospital regarding a 28-year-old G2A1 woman at 36-week gestation with severe pre-eclampsia and impending eclampsia, along with intrauterine fetal demise. The patient was referred to Sion Hospital from the peripheral setup and arrived at our labor room by 4 PM. To our surprise, the patient weighed 120 kg, and her blood pressure was recorded as 200/120 mmHg. On admission, immediate interventions were initiated, including intravenous magnesium sulfate as per Pritchard's regimen, antihypertensive medications, neuroprotective drugs, and other symptomatic management strategies. Induction of labor was commenced using dinoprostone gel. After 6 h, due to the progression of impending eclampsia, an emergency LSCS was performed. The surgical procedure was conducted without complications, and following the operation, the patient was transferred to the surgical intensive care unit (ICU). Postoperatively, special attention was given to prevent complications related to obesity during the recovery period.

When this patient was getting operated on, another patient landed in ward 12 G2P1L1 at 40.4 weeks gestation. The previous normal delivery with intrauterine fetal death on ultrasound was 2 weeks ago. The patient was negligent about the scan and, hence, reluctant to seek medical help. The patient was already in active labor. Vitally, the patient was stable, and her DIC profile was normal. The patient was allowed to progress spontaneously. At around 7:30 a.m. in the morning, the patient was fully dilated. The macerated head was delivered without any difficulty, but the shoulder was impacted. With the Woodcork screw maneuver, the impacted fetus was delivered. Cervical tracing was done, which was normal; no tear was present.

The night is the favorite time to work in emergencies. The tranquility of the end of the day lures everyone's focus towards the task at hand. A weird yet calm energy flows throughout the room as we work with amazing concentration without any distraction.

At 2 a.m., the early morning G2P1L1 34-week gestation patient came in a gasping state with vitally unstable cold clampy extremities and SpO2 of 60% on room air in active labor. Intubation was done, and the patient was shifted to the ICU. In an emergency, an echocardiogram was done, which showed a reduced ejection fraction, and a diagnosis of peripartum cardiomyopathy was made. The patient was intubated and started on a nitroglycerine drip. Forceps application was done during the second stage due to inadequate maternal efforts. The patient was later extubated on day 4 and discharged on day 10 with medical management of peripartum cardiomyopathy.

At 4 a.m., a call was received from a casualty medical officer at the hospital that a fully dilated patient was delivering. The resident, accompanied by a staff nurse, rushed to the casualty. However, the patient was delivered before they could reach.

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The patient was brought to labor room, where an examination was done. A tear was noticed on the lateral fornix apex, which was not visualized. The patient was taken for emergency vaginal exploration under anesthesia in the operation theater. Under anesthesia, the apex was visualized, and suturing was done. The patient was transfused with two personalized response codes post-exploration.

Among this chaos, Dr. Ria Joglekar, an M.D. graduate from the University of South Florida Morsani College of Medicine, came for observer ship in our unit and was so terrified to see the variety of cases that we see here.

In conclusion, the successful management of these complex and urgent cases exemplifies our commitment to delivering high-quality care under challenging circumstances. Our multidisciplinary team's swift and decisive actions ensured optimal outcomes for both patients, highlighting our dedication to excellence in emergency obstetric and critical care. Our experienced team is equipped to handle complex cases with precision and compassion, reaffirming our commitment to delivering exceptional healthcare to every individual who walks through our doors.

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