## CASE STUDIES AND STUDY QUESTIONS

Mrs. C. is a 22-year-old gravida 3, para 2 (G3, P2) woman. She delivered her first child spontaneously at 34 weeks' gestation, and the child has subsequently done well. Her second child underwent cesarean delivery at 29 weeks and died 10 days later from complications of prematurity.

Mrs. C. is at 25 weeks' gestation and has been feeling pelvic pressure and a vague sense of cramping since 7 AM. It is now 11 AM, and she has called the labor and delivery unit because of concerns about her cramping.

1. Your best response to her is:
   a. Maintain bedrest in the lateral position and drink plenty of fluids.
   b. Go to the hospital immediately for further evaluation.
   c. Do not be concerned because the cramping is probably Braxton Hicks contractions and is normal at this gestational stage.
2. Mrs. C. is at risk for preterm labor because:
   a. She is a young multipara.
   b. She has previously undergone cesarean delivery.
   c. She has had previous preterm labors and births.
   d. She is not at risk for preterm labor.

### Postterm Pregnancy

Ms. H. is a 26-year-old G1, P0 patient. She has had no prenatal care, but her LMP puts her at 42 weeks' gestation. She came into the hospital with possible ROM. She is not sure whether her membranes have ruptured because, although she felt a gush, she saw only a small amount of brownish fluid.

3. The labor and delivery nurse is concerned about Ms. H. because:
   a. She is probably in preterm labor.
   b. Her history indicates the risk for oligohydramnios and the probable presence of meconium.
   c. She is at risk because she is an older primipara.
   d. She is in active labor at this time.

After Ms. H. has been on the external fetal monitor for 40 minutes, the tracing shows minimal FHR variability but no evidence of decelerations. No fetal movement and no spontaneous FHR accelerations are present.

4. Appropriate nursing interventions at this time include:
   a. Preparing her for emergency cesarean delivery
   b. Allowing her to ambulate to stimulate the onset of contractions
   c. Maintaining her on bedrest in lateral position, starting an IV, and continuing the FHR monitoring
   d. Discharging her home to return when contractions are 5 minutes apart

### Premature Rupture of Membranes

Mrs. L. is a 30-year-old G3, P2 woman at 31 weeks' gestation. She presents to the labor and delivery suite complaining of leaking fluid for the last couple of hours. Her vital signs are blood pressure 108/60 mm Hg, pulse 70 bpm, respirations 20, and a 36.4° C (97.6° F) temperature. She is monitored for 1 hour, and the FHR tracing is in the range of 130 to 145 bpm, reactive with no decelerations. No uterine contractions are perceived by Mrs. L. or recorded on the monitor.

5. Mrs. L. is a candidate for expectant management because:
   a. She is afebrile and has no other symptoms of infection.
   b. Her fetus is in the vertex position.
   c. A normal amount of amniotic fluid by ultrasound examination is present.
   d. She is not a candidate for expectant management.
6. In your initial assessment of Mrs. L. you note that she is nitrazine-negative but positive for vaginal pooling and ferning. These findings would lead you to believe that she is:
   a. Probably not ruptured because nitrazine is the most accurate test
   b. Most likely ruptured because many factors may interfere with nitrazine testing
   c. Definitely ruptured because ferning is 100% accurate
   d. Most likely infected because that causes a positive fern test result

### Multiple Gestation

Mrs. D. is a 30-year-old G1, P0 patient. She has a history of infertility for 4 years and conceived while taking fertility drugs. She is carrying twins at 33 weeks' gestation and presents to the labor and delivery unit with complaints of cramping and a feeling of pelvic pressure. After 30 minutes on the fetal monitor, you note that Mrs. D. has mild uterine contractions every 5 to 6 minutes. Her cervical examination reveals a long, closed posterior cervix.

7. Uterine activity at 33 weeks is particularly significant for Mrs. D. because:
   a. She is at high risk for preterm labor.
   b. She has been contracting and her cervix has not changed.
   c. She is at high risk for chorioamnionitis.
   d. No reason for concern exists; uterine contractions are common at this gestational age.
8. Mrs D. is also at high risk for which other pregnancy complications?
   a. Preeclampsia
   b. Antepartum hemorrhage
   c. Preterm PROM
   d. All of the above

### Stillbirth

Ms. T. is a 34-year-old G3, P1 woman with class C diabetes. She had a previous stillborn at 36 weeks' gestation with an undetermined cause of fetal death. She is at 35 weeks' gestation. She has had an uneventful pregnancy so far but now calls the labor and delivery unit because she has not felt the infant move since early this morning. It is now 1 PM.

9. Your best response to Ms. T. is to tell her:
   a. Go to Labor and Delivery as soon as possible for further evaluation.
   b. Wait at least 10 to 12 hours, then call her physician if she still has not felt movement.
   c. Her anxiety is most likely related to her previous loss at this gestation and therefore no need for concern exists.
   d. Maintain bedrest in the left lateral position.
10. When Ms. T. arrives in the labor and delivery unit, you are unable to auscultate a fetal heart rate. You suspect she may have experienced intrauterine fetal death. The most definitive way to confirm this diagnosis is to:
    a. Document the absence of fetal cardiac activity by ultrasonography.
    b. Send her for pelvic radiographs.
    c. Find an elevation in serum fibrinogen.
    d. Obtain an L/S ratio.

### Anaphylactoid Syndrome of Pregnancy

Ms. N. is a 25-year-old primigravida at term who arrives in the labor and delivery unit at 2 AM. Her contractions started at midnight, and their frequency and intensity increased so rapidly that she was no longer able to tolerate the pain and came to the hospital. On examination, her cervix is 6 cm dilated and completely effaced. The presenting part is at zero station. She continues in very active labor with uterine contractions every 1 to 2 minutes over the next 30 minutes, at the end of which she is completely dilated and effaced. She pushes for 10 minutes and is prepared for delivery.

11. Immediately after the delivery of the infant, Ms. N. complains of dyspnea and shortness of breath. Within minutes, she becomes cyanotic and lethargic and seems to be losing consciousness. Recognizing this clinical picture as most likely an anaphylactoid syndrome of pregnancy, appropriate nursing actions are to:
    a. Prepare a loading dose of magnesium sulfate for seizure precaution.
    b. Open her IV line and administer oxygen at high concentrations.
    c. Notify the NICU and prepare for possible neonatal transfer because the newborn is at great risk for RDS.
    d. Perform an abdominal shave and skin preparation to get Ms. N. ready for emergency surgery.
12. Ms. N. is intubated and ventilated by the anesthesiologist for 10 minutes. She is fighting the endotracheal tube and breathing on her own. Blood for laboratory work is drawn, and her arterial blood gas values are within normal limits. She is extubated and resumes spontaneous respirations. Her color is good, but nasal oxygen is kept on at 10 L/min. Her oxygen saturation is 96% to 97%. She has survived the initial insult of anaphylactoid syndrome of pregnancy. Ms. N. is still at great risk for which subsequent complications?
    a. Preeclampsia
    b. ARDS
    c. Postpartum endometritis
    d. Deep vein thrombosis

### Uterine Rupture

Mrs. P. is a 30-year-old G2, P1 woman with class B diabetes who is at term. She had a previous cesarean delivery at 27 weeks' gestation for an abruptio placentae 6 years earlier.

13. Mrs. P. is not a candidate for trial of labor because:
    a. This infant is likely to be much bigger than her previous one.
    b. She has diabetes and therefore requires another cesarean delivery.
    c. A cesarean delivery at 28 weeks' gestation was likely to have involved a classical incision.
    d. She is a good candidate for trial of labor.

14. If Mrs. P. arrived in the labor and delivery unit and told you she had been having contractions for the last 8 hours, and now the pain "just won't go away," you might consider the possibility of uterine rupture. Other assessment parameters consistent with uterine rupture are:
    a. Systolic hypertension
    b. Bleeding
    c. Fetal bradycardia
    d. Excess fetal movement

## ANSWERS TO STUDY QUESTIONS

| | | | |
|---|---|---|---|
| 1. b | 5. a | 9. a | 13. c |
| 2. c | 6. b | 10. a | 14. c |
| 3. b | 7. a | 11. b | |
| 4. c | 8. d | 12. b | |

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