QUICK REFERENCE CARD

retrieve
Adult Critical Care Transfer Service

Maternal Critical Care

v1.0

This QRF includes normal physiological parameters and information on drug use for common presentations and general pointers

General points for maternal critical care patients:

- Treat pregnant and postpartum women the same as non-pregnant women unless there is a clear reason not to
- Omitting treatments/intervention is generally more harmful than giving them in pregnant patients

Medications:

- UK Tetralogy Information Service Best Use of Medicines in Pregnancy (UKTIS/BUMPS) website is a reliable and useful resource regarding drugs
- Dose as you would for non-pregnant patient

Patients with cardiovascular disease:

- DC cardioversion can be carried out at any gestation, if needed

NORMAL PHYSIOLOGICAL PARAMETERS

- **Heart rate:** increased by 10–20bpm, particularly in third trimester
- **Blood pressure:** can decrease by 10–15mmHg by 20 weeks, but returns to pre-pregnancy levels by term
- **Respiratory rate:** unaltered. If RR >20, consider pathological cause
- **Oxygen saturation:** unchanged throughout pregnancy
- **Temperature:** unchanged throughout pregnancy

SPECIFIC DRUGS FOR MATERNAL CRITICAL CARE

- **Antiarrhythmics:** avoid amiodarone, others are safe
- **Antibiotics:** avoid tetracyclines
- **Anticonvulsants:** avoid sodium valproate (see hypertensive disorders card)
- **Opioids and antiemetics:** can be given safely
- **Steroids and nebulised bronchodilators:** can be given safely
- **Thrombolysis**: pregnancy not an absolute contraindication. Give where benefits > risk

SPECIFIC ADVICE FOR MANAGING PREGNANT WOMEN

- Where possible, position patient in left lateral position if >24/40
- During transfer, consider [TBC – waiting for Intensive Care Society guideline]

NORMAL ECG VARIANTS IN PREGNANCY

- Transient ST segment and T wave changes
- Q wave and inverted T waves in lead III
- Attenuated Q wave in lead AVF
- Inverted T waves in leads V1, V2, and, occasionally, V3