Pulling the Uterus Inside–Out with the Removal of the Placenta.

At age 24 this patient came into the Hospital in labor at 37 weeks on 7/15. She previously had two children and two abortions.

Her condition was normal, except for premature labor at 32 weeks treated with steroids and tocolytic (labor stopping) drug therapy. She was also borderline anemic.

Dr. #1 was treating her in the hospital. He ruptured her membranes (AROM) and inserted a monitor for uterine contractions and for fetal monitoring. He checked her at 1952.

She was encouraged to push, and delivered a healthy male baby at 2003. Who delivered the baby? Who tried to remove the placenta? How much delay was there between the delivery and the attempt of removal of the placenta? Who did it? The “Labor and Delivery Summary” shows that the delivery was at 2003 but that the placenta was delivered at 20--. The Nurses were #1 and #2. The Attending Physician was Dr. #2. The assistants were Dr. #3 and Dr. #1.

At 2012 Dr. #3 was in the room an ordered a narcotic injection. At 2020 the Nurses notes show that the “placenta 90% out. Dr. #3 noted uterine inversion. Dr. #4 paged (who is he?). Anesthesia paged.”

She was immediately taken to the Operating Room and placed under a light general anesthesia with the drug Ketamine at 2025. The operative report notes that the attending physician was Dr. #2. Was he there? He is responsible for supervising all her obstetrical care. Also noted were the Resident Surgeons Dr. #4 and Dr. #3.

They said: “We were called to see the patient in the third stage of labor (the “delivery” of the placenta), without the delivery of the placenta. The placenta was present in the vaginal vault (vagina). With gentle traction on the umbilical cord, the placenta was spontaneously delivered through the vaginal vault, at which time a uterine inversion was noted.

Rapid pelvic replacement of the uterus was made, however, reinversion of the uterus could not be obtained.” Then she was taken to the Operating Room where “The surgeon’s hand was placed in the vagina. Gentle steady manipulation was performed until the uterus reinverted.”

The Pathologist noted that this 456 gram placenta was totally removed (“intact cotyledons”).

The operative report is not accurate. Gentle traction would not invert the uterus. Excessive pulling would do it. Furthermore, the standard of care is to wait a few minutes between the delivery at 2003 until the pull on the umbilical cord is done, to allow the placenta to spontaneously separate. If it does not easily separate, a few more minutes delay should occur. If at that point it does not separate, the obstetrician uses their hand (covered by a sterile glove) to peel it off of the uterus.

Sometimes the placenta grows more deeply into the uterine muscle (placenta accreta) and when not recognized, and excessive (negligent) force is used to pull it loose, the uterus can invert (turn inside out like a sock). Since the placenta was removed intact in one piece, she most likely did not have placenta accreta.
Either way, the uterine inversion was from negligently used excessive force. Who did it? What was their level of training at the time? Who was at their side (if anyone), supervising and protecting their patient?

They say she lost 1000 c.c. (two pints) of blood. Her hematocrit (packed red blood cell volume) dropped from 35.1 to 21.8. That is a critical level of anemia and consistent with three to four pints (units) of blood loss. Although she was not in documented shock, there may be some kidney damage. This is best assessed by the creatinine clearance test which is a 24 hour urine collection and one blood test. Her Physician can order that inexpensive study at any time.

Otherwise she recovered physically. On 8/23 she was counseled for a tubal ligation operation which took place on 8/26 with the use of Hulka clips, in the standard manner. No pathology was seen in her abdomen or pelvis.

I suggest that the patient be evaluated by a local Clinical Psychologist with courtroom experience for any residual emotional (psychological) damages. Administration of standardized tests such as the M.M.P.I. (Minnesota Multiphasic Personality Inventory) which have been given to millions of people would further support that opinion before a jury.

For the reasons stated above, I believe those Physicians and the Hospital which is responsible for its Resident (trainee) Doctor employees were negligent and caused preventable injury including her uterine inversion, massive blood loss, psychological damages as well as potential kidney impairment. It did not cause other problems.

You may want to get a copy of the contracts between the Hospital and each Doctor, its existing published rules, regulations and standards regarding training and level of responsibility for patient care, particularly regarding obstetrical deliveries as they existed at the time of her delivery. Note that the Resident Doctor year begins on 7/1. How much delivery experience did each have after 15 days into their new year? Her Admitting (in charge) Physicians were Drs. #5 and #1. Dr. #4 (a Resident) was noted by the Anesthesiologist to be in the Operating Room although Dr. #2 was listed as the Attending Surgeon in the typed operative report. Dr. #3 dictated that report. Who was really there?

I would suggest that you authorize us to obtain an Expert review by a Board Certified Obstetrician now, or after you obtain answers to the questions I raised. We await your instructions.