Information to accompany O_V_1_B

Case Study Mrs. C

Step 1

Mrs. C. is brought to the emergency department of the district hospital by her husband after she complained of a severe headache this morning.

The following information is available from Mrs. C.'s antenatal record

- She is 20-years old
- This is her first pregnancy
- She is 37 weeks of gestation
- She had two antenatal care visits during this pregnancy at 20 and 33 weeks gestation and there was nothing that indicated a problem

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Case Study Mrs. C

Step 2

Mrs. C. reports onset of severe headache and blurred vision six hours prior to coming to the clinic. She denies upper abdominal pain or decreased urine output, and fetal movement is normal.

Further information:

- BP 160/120 mm Hg
- Pulse 84/minute
- Temp 37.2°C
- Respirations 18/minute
- Fetal Heart Tones 140 beats per minute
- Fundal Height Appropriate for gestational age
- Abdomen Non-tender
- Patellar reflexes Normal
- Urine 3+ protein
- Contractions Two in ten minutes lasting 20 seconds by palpation

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Case Study Mrs. C

Step 3

One hour after the treatment, Mrs C has a moderate headache but she has no further convulsions.

Further information:

- BP: 140/100 mm Hg
- Pulse: 84/minute
- Temp: 37.2°C
- Respirations: 18/minute
- Lungs: Clear to auscultation
- Fetal heart tones: 130-140 beats per minute
- Fundal height: Appropriate for gestational age
- Abdomen: Non-tender
- Patellar reflexes: Normal
- Urine output: 40ml per hour
- Contractions: Three in ten minutes lasting 40-60 seconds by palpation
- Cervix: Soft, 4 cm dilation
- Fetus: Cephalic presentation, head not palpable above the symphysis pubis