BRIEF HISTORY:
A 28 year old G1 PO at 40 weeks gestation with no known risk factors was admitted to the Labor and Delivery Unit with SROM and contractions that were 4-5 minutes apart. After several hours with no progress per cervical dilatation, her labor was augmented with pitocin and active labor ensured. An epidural was placed. Her BP prior to the epidural was 118/70. Following epidural placement her BP was 95/32.

TRACINGS (EXTERNAL MONITORS):

Tracing 2A

Tracing 2B
Case Study #1 (continued)

QUESTIONS:

1. What is the contraction pattern? (interval, duration, resting tone if appropriate)  
   (2-3, 30-50 sec duration. Unable to determine resting tone—external monitor.)

2. What is the baseline fetal heart rate?  
   (125)

3. What is the baseline variability?  
   (Minimal)

4. Are there any periodic changes present?  
   (Late decelerations (2A))

5. Are there any episodic changes present?  
   (Acceleration (2B))

6. What are the probable causes of the changes present?  
   (Decelerations—epidural decreased blood pressure)

7. When was the last reassuring sign of fetal well-being?  
   (Acceleration (2B))

8. What is the FHR pattern observed following placement of the epidural?  
   (Late decelerations due to hypotension from epidural placement.)

9. What interventions would be appropriate for this FHR pattern?  
   (Turn to left side, increase IV fluids, discontinue pitocin, O₂ per mask, notify physician.)

OUTCOME:
Late decelerations were corrected resulting in a normal FHR pattern. Pitocin was restarted and the result was a NSVD of a viable 7 lb. 3 oz. female infant; Apgars were 8/9.
CASE STUDY #2

BRIEF HISTORY:
A 24 year old G3 P1 at 39 weeks is in active labor. Her cervix is presently 5 cm. dilated.

TRACINGS (EXTERNAL MONITORS):
Tracing 4A

![Tracing 4A Image]

Tracing 4B

![Tracing 4B Image]
Case Study #2 (continued)

QUESTIONS:

1. What is the contraction pattern? (interval, duration, resting tone if appropriate)
   (1 ½, 40-60 sec duration. Unable to determine resting tone—external monitor.)

2. What is the baseline fetal heart rate?
   (170)

3. What is the baseline variability?
   (Minimal)

4. Are there any periodic changes present?
   (Late decelerations. Prolonged deceleration.)

5. Are there any episodic changes present?
   (None noted)

6. What are the probable causes of the changes present?
   (Rule out fever; rule out possible early hypoxia.)

7. When was the last reassuring sign of fetal well-being?
   (None noted)

8. What is the FHR pattern?
   (Late decelerations. Prolonged deceleration.)

9. What interventions would be appropriate to follow for this pattern?
   (O₂, IV started, patient was turned to left side.)

10. What other interventions might you consider?
    (Take temperature. Adjust toco and/or palpate. Consider I UPC. Notify provider.)

OUTCOME:
Late decelerations were corrected with position change and resulted in a NSVD of a 5 lb. 12 oz. male with Apgars of 9/9.
CASE STUDY #3

BRIEF HISTORY:
A 31 year old G2 P0 at 40 weeks was admitted to the Labor and Delivery Unit in active labor. An epidural was placed and ephedrine was given at frame #32417 for a low BP.

TRACINGS (INTERNAL MONITORS):
Tracing 19A

Tracing 19B
Case Study #3 (continued)

Tracing 19C

QUESTIONS:

1. What is the contraction pattern? (interval, duration, resting tone if appropriate)
   (1 ½- 4 minutes, 60-80 sec duration. Resting tone: 20 mmHg. Strength: 50-100 mmHg.)

2. What is the baseline fetal heart rate?
   (155 (19A), 165 (19B), unable to determine (19C), and 155 (19D))

3. What is the baseline variability?
   (Minimal to marked)

4. Are there any periodic changes present?
   (Late, prolonged decelerations)

5. Are there any episodic changes present?
   (None noted)
Case Study #3 (continued)

6. What are the probable causes of the changes present?  
   (Decelerations, R/T low BP)

7. When was the last reassuring sign of fetal well-being?  
   (Accelerations (19D))

8. What is the FHR pattern?  
   (Late decelerations from low BP. Prolonged decelerations.)

9. What interventions are appropriate?  
   (Increase IV fluids, turn to side, \(\text{O}_2\) per mask, notify anesthesiologist and OB physician. Ephedrine was given by anesthesiologist or RN, per protocol. If on oxytocin, consider decreasing due to frequency of contractions)

10. What was the resulting FHR pattern after ephedrine administration?  
    (Marked variability. Medications can have an effect on FHR patterns, just as ephedrine caused marked variability in this scenario. Demerol and other analgesics can decrease variability.)

OUTCOME:

FHR pattern became reassuring and after pitocin augmentation, a C-section was performed for failure to progress. An 8 lb. 8 oz. male was born with Apgars of 7/9.
CASE STUDY #4

BRIEF HISTORY:
A 23 year old G1 P0 who is a known cocaine abuser before and during her pregnancy enters the Labor and Delivery Unit with PROM and a moderate amount of vaginal bleeding at 35 weeks gestation. Upon vaginal exam by the physician, the patient is found to be 4 cm. dilated at 1645 and an IUPC is placed. She is examined at 1715 (45 minutes later) and is found to be completely dilated. Delivery occurs at 1729.

TRACINGS:
Tracing 30A

Tracing 30B
Case Study #4 (continued)

Tracing 30C

Tracing 30D
Case Study #4 (continued)

QUESTIONS:

1. What is the contraction pattern? (interval, duration, resting tone if appropriate)
   (Difficult to discriminate as the patient appears to be changing position. Contractions should be palpated manually to accurately assess strength, frequency, duration, and resting tone.)

2. What is the baseline fetal heart rate?
   (Approximately 135, which is difficult to ascertain as we need at least 2 minutes of consistent FHR between contractions to determine a baseline.)

3. What is the baseline variability? (STV/LTV)
   (Moderate)

4. Are there any periodic changes present?
   (No)

5. Are there any episodic changes present?
   (No)

6. What are the probable causes of the changes present?
   (Fetal oxygenation)
7. When was the last reassuring sign of fetal well-being?  
   (This strip is reassuring.)

8. Based on the patient’s history, what is probably the cause of her rapid labor?  
   (Abruptio placental from cocaine use.)

OUTCOME:
The patient delivered a 6 lb. 9 oz male with Apgars of 6/7.