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Obstetric Hemorrhage in Intensive Care Unit

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Introduction: Nowadays the maternal obstetric hemorrhage remains a cause of morbidity and mortality. Pregnancy-associated hemorrhagic shock that could cause serious bleeding, ruptured ectopic pregnancy, the placenta detachment, placenta previa, placenta accreta, uterine rupture, atony or inversion is as a result of the birth of the placenta or lacerations originate from rest. In this study, we present massive obstetrical hemorrhagic cases followed our reanimation unit throughout the year 2014

Material and Method: Demographic data of the patients that is, diagnosis, gestational age, blood products used in the intensive care unit length of stay, mortality rates were evaluated

Results: in this study all of 10 patients followed in the intensive care unit. The means age of the patients was 34.3 years old. The mean gestational age of the patients was 34±4 weeks. Length of stay in the intensive care unit of patients is 5 days. All patients are used red blood cell (avg. 2.66) and fresh frozen plasma (avg. 2.88). Additionally three patients took fibrinogen, and one patient is used 11 units platelet and 3 units apheresis platelets. Maternal mortality was observed in one case due to (12.5%) DIC.

Conclusion: It should be noted that appropriate approach and correct blood and blood products transfusion done timely in intensive care unit may be life-saving at obstetric hemorrhage patients

Key words: Obstetric hemorrhage, intensive care unit

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Treatment of Severe Methanol Intoxication: Case Report

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Introduction: Methanol intoxication comes out with severe metabolic and neurological dysfunctions. In this case report, a successful treatment of severe methanol intoxication with hemodialysis (HD) and intravenous (iv) ethanol infusion was described.

Case: A 58 years old male patient admitted to hospital with a history of drinking three bottles of spirit. He didn't have further problems except alcoholism. Arterial blood gas analyze showed high anion and osmolar gap, metabolic asidosis with pH: 7.00 and anion gap 40 mEq/L. He also had nausea, vomiting and dizziness. Intravenous sodium bicarbonate 1 mEq-kg-1 was administered. Ethanol infusion and HD was initiated. Pyridoxine and folic acid 50 mg-kg-1 six times per day and thiamine 100 mg were administered. Ethanol infusion was adjusted according to blood ethanol concentrations. Due to technical limitations, test for methanol blood concentration couldn't been performed. Dextrose 5% infusion was administered and blood glucose levels was followed. The pH were 7.10, 7.19, 7.30 and 7.35 during the HD and ethanol infusion for the first three hours respectively. Ethanol therapy was terminated due to arterial blood gas analyzes and clinical condition of the patient. On the 72th hour of admittance the patient was totally recovered and no further problems observed in neurological examinations and the patient discharged.

Conclusion: Methanol intoxication has dramatic outcomes like putaminal necrosis and blindness. Increased anion gap and serum osmolar gap metabolic acidozis may ocur. Conventional HD and iv ethanol infusion to prevent formation of toxic methanol metabolites, formaldehyde and formic acid is recommended in the guidelines and literature for the management of the intoxication. Also, fomepizol is another antidote, but there is no evidence that it's superior to ethanol. Conventional HD and spesific antidote therapy must be considered immediately for methanol intoxication to avoid neurological sequelaes.

Key words: Methanol intoxication, ethanol, hemodialysis, fomepizol