Low-lying placenta not identified during ultrasound
16HDC01486, 8 August 2019

District health board ~ Radiology service ~ Radiologist ~ Obstetrician ~ Sonographer ~ Placenta praevia ~Placenta accreta ~ Right 4(1)

A woman had an ultrasound scan when she was 19 weeks pregnant. On the hard-copy worksheet, the sonographer noted that the placenta was anterior. However, she did not comment that the placenta appeared to be low lying.

A radiologist then reviewed the sonographer's worksheet and the sonography images. The radiologist completed a written report of the scan, which stated: "Placenta: anterior, not low lying." The default for placental position in the ultrasound report template was "not low lying", ie, if nothing abnormal was noted in the sonographer's worksheet at the time of the scan, or if nothing was noticed on the images provided at the time of the radiologist's review, the radiologist could leave the placental position as the default.

At 35 weeks + 6 days' gestation, the woman was taken to hospital by ambulance. Initially, the woman thought that she had had a spontaneous rupture of membranes, but she found that she had substantial vaginal bleeding. The ambulance records note that the woman was experiencing severe intermittent pain.

At 6.45pm the woman was seen by a consultant obstetrician, who said that as the placenta was not low lying (according to the 19-week ultrasound scan) and the presenting part was engaged, she ruled out placenta praevia, which had been her initial suspicion. Her provisional diagnosis was that the woman had a mild abruption, and she made a plan to manage the woman in line with this diagnosis.

At 11pm the woman was seen by an obstetric registrar, who discussed the woman's presentation with the obstetrician. The registrar then inserted Cervidil to induce labour. The woman continued to report vaginal bleeding overnight.

The following morning, the woman was seen by another consultant obstetrician. The information she had at the time fitted with the diagnosis of mild placental abruption, and she planned to continue with Cervidil for up to 24 hours.

At 10.45am, the woman experienced further vaginal bleeding of about 200ml. She was reviewed by an obstetric registrar and the obstetrician, and a digital vaginal examination revealed that the edge of the placenta could be felt. The obstetrician undertook an ultrasound scan using a portable scanner, and found that the placenta was low and anterior, and the fetal heart rate was low. The woman underwent an urgent Caesarean section. The procedure was complicated by difficulty delivering the placenta, which was abnormally adherent (placenta accreta) and low lying (placenta praevia).

The DHB's policy on placenta praevia and placenta accreta states that clinical suspicion of placenta praevia should be raised in any woman with vaginal bleeding after 20 weeks of gestation, with a high presenting part or an abnormal lie, and painless and unprovoked bleeding, irrespective of previous imaging results.

Findings

The Deputy Commissioner was critical that the sonographer worksheet and electronic ultrasound report template did not reflect the requirements of the Australasian Society for

Ultrasound Medicine standard. In addition, the paper-based system of documentation that was used to summarise and report scans was fallible, and the default for placental position in the electronic ultrasound report template, to be completed by the radiologist, was "not low lying". This left the reports open to the type of human error that occurred in relation to the 19-week anatomy scan. For this reason, it was found that the radiology service did not provide services with reasonable care, and breached Right 4(1).

Because the radiologist concluded that the woman's placenta was not low lying, when in fact it was, he breached Right 4(1).

The sonographer apparently recognised that the placenta was low, but forgot to return to look at this at the end of the scan. The Deputy Commissioner was critical that the appropriate placental position was not documented on the sonographer worksheet.

There was a missed opportunity for the obstetrician to confirm the woman's diagnosis with an ultrasound scan before undertaking a digital examination and inducing labour.

It was held that the DHB did not breach the Code.

Recommendations

It was recommended that the DHB (a) provide a training session for obstetric staff on placenta praevia and placenta accreta; (b) update its policy on antepartum haemorrhage to reflect more clearly the need to be suspicious of the accuracy of radiological reports, and to include a definition of mild abruption; and (c) provide a copy of its updated policy on placenta praevia and placenta accreta.

It was recommended that the radiology service and the radiologist provide apologies to the woman.