A Case of Suspected Unconsciousness in a Parturient: Does Psychiatric Disorder Come to the Mind of an Anesthesiologist?

Sir,

In many ways, the field of obstetrics has always carried immense importance in terms of managing and saving two lives; mother and the baby. It is not an exaggeration to say that, when call is given to anesthesiologist for an acute emergency involving an obstetric patient, he would be on the toes with lot of adrenaline rush in his body. Vasovagal syncope is characterized by bradycardia, marked hypotension, and loss of consciousness. It has a mean prevalence of 22% with parturient in labor at higher risk,[1] with main predisposing factors being emotional stress and pain. Here, we describe a case of primi, 27 years, admitted in the labor room whose clinical scenario on the first look mimicked a vasovagal syncope but turned out to be a psychiatric disorder on the detailed evaluation retrospectively. Call was given to the anesthesiologist for sudden unresponsiveness of the patient in labor room. The patient was in active stage of labor and unresponsive with a blank stare and absence of any voluntary movements. There was response neither to call nor to the uterine contractions. Immediately, vitals were checked and crash cart kept ready suspecting a vasovagal syncope. Vitals were normal with a heart rate of 64/min, blood pressure of 130/80 mmHg, and a normal electrocardiogram tracing with a saturation of 100%. Unlike syncope where there is transient loss of consciousness often associated with hemodynamic instability,[2] our patient had none. In about 8 min, she returned to normal state and responded to call. Over the next half an hour, several such episodes occurred each lasting for a few minutes with full recovery of consciousness between the episodes. This on and off episodes of unresponsiveness with no hemodynamic instability or airway obstruction left us unclear with no diagnosis to fit in the clinical symptom nor requiring any emergency intervention from us. We remained by the side of patient with continuous monitoring till she delivered a healthy baby. The immediate postpartum period was uneventful. On gathering more information after the delivery, family members reported that the patient had several similar episodes of stupor during her board examinations several years back and not very long ago during some interpersonal conflicts in the family. Cardiac and neurology evaluation revealed a normal study in echocardiography and computed tomography brain. In view of the past history and absence of diagnosable organic cause for the stupor, a diagnosis of dissociative stupor was entertained in consultation with the psychiatrist. As defined in international classification of diseases (ICD) 10,[3] dissociative stupor is diagnosed on the basis of a profound diminution or absence of voluntary movement and the individual sits or lies motionless with no speech or purposeful movements.[4] The muscle tone, posture, breathing, and eye opening in our patient were such that it was clear she was neither asleep nor unconscious. Hence, in a suspected case of unconsciousness, where there is no hemodynamic instability or airway obstruction, this experience provides us with fresh perspectives to consider other rare conditions which can mimick unconsciousness, say a psychiatric disorder and hence manage appropriately. Having said that arranging for crash cart with vigilant monitoring and preparedness for resuscitation, however, carries prime importance in such scenarios.

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Conflicts of interest

There are no conflicts of interest.

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