

## Miracle Baby

A Labor/Delivery Ward

I remember the gray November day during my second year of family practice residency. The medicine wards were full, as was every minute of my day, when a female patient arrived in the labor/delivery ward for a routine non-stress test. She was from the inner city community health center that served as my continuity clinic. Over the patient's prenatal course, we had become familiar and relaxed with each other. She frequented the office every 1 to 2 weeks because her pregnancy was complicated by oligohydramnios and intrauterine growth retardation.

A fellow resident called to inform me that the results of the patient's non-stress test were flat. An ultrasound demonstrated no amniotic fluid and a biophysical profile of 2 out of 10. The patient was 37 weeks pregnant.

I felt both a rush of excitement that accompanies medical emergencies and terror knowing that this baby would need delivery very soon and was likely to be very sick. Fortunately, our residency program included an excellent obstetrician/gynecologist who was dedicated to education and respectful of the resident's role as primary caregiver. He carefully allowed me to execute most steps of the procedure as we performed an urgent Cesarean section. The experience was both a birth for the newborn and a birth for me into a new realm of professional responsibility. We delivered a mottled and floppy newborn girl, with a 1 minute APGAR score of 3.

Instead of assisting with closure of the patient's abdomen, I attended to the newborn. Despite stimulation, she did not breathe. Her color was blue. We bagged her and saw some improvement in color. We started chest compressions because her heart rate was less than 100 bpm. Her heart rate recovered, and she made some gasping respiratory attempts but clearly was unable to breathe on her own. The on-call pediatrician arrived and helped me intubate her. The newborn

required high pressures to inflate her lungs, and we suspected persistent fetal circulation or perhaps pulmonary hypoplasia. Despite 100% oxygen, her oxygen saturation never exceeded 50%, and the arterial blood gas value demonstrated hypoxia and hypercapnia. Chest radiography, electrocardiography, and four limb blood pressure assessments revealed no obvious etiology for her respiratory distress. At this point, the neonatal intensive care unit team from the nearby tertiary care center arrived. Umbilical arterial and venous lines were put in place, and antibiotics and fentanyl were administered.

The code went on for 2 more hours without change in the newborn's status. I knew that the baby was likely to die or at least suffer neurologic compromise. My patient and her husband wanted to know what was happening and to see their daughter. Perhaps the most important thing I did that night was to serve as a trusted, familiar person who could provide a calm explanation, hold their hands, and assure them that I would be present no matter what happened.

In the neonatal intensive care unit, the newborn suffered congestive heart failure, ascites, hypotension caused by presumed sepsis, and multisystem organ failure. Despite dozens of tests, no etiology was found to explain her illness. Gradually all her systems recovered, she was successfully extubated, and she was discharged home 5 days after birth without detectable abnormalities by physical examination or laboratory tests.

By the time I left my family practice residency, this very sick newborn had grown into an adorable, smart, and, by all available measures, developmentally advanced 18-month old baby girl.

She is my miracle baby.

—John Bray-Morris, MD  
Ganado, AZ

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