

Obstetric Emergencies

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Abstract

No specialty of medicine is more inundated with emergencies than obstetrics. This paper describes a number of the more common obstetric emergencies from a practical and rural practitioner standpoint. Obstetrics is unique in that there are two patients to consider and care for. This paper discusses basic emergency care, obstetric and fetal assessment, preterm labor, premature rupture of membranes, severe preeclampsia, eclampsia, prolapsed umbilical cord, antepartum hemorrhage, abortion with hemorrhagic shock, ectopic pregnancy with shock, acute abdominal pain during pregnancy, DIC, uterine inversion, postpartum hemorrhage, retained placenta, abdominal pregnancy, shoulder dystocia, amniotic fluid embolism, trauma, CPR during pregnancy, postmortem cesarean section, cesarean section with local or no anesthesia, and transport of the obstetric patient.¹

Introduction

In obstetrics there are two patients to care for instead of one, a mother and a baby or fetus. The management of one patient heavily affects the management of the other. Sometimes the decision has to be made to care for one patient at the expense of the other; i.e., care for the mother first. The second patient (the fetus) may be viable or not.

Basic Emergency Care

Basic care of the patient(s) includes the ABCs of resuscitation: airway, breathing, and circulation. The patient should be quickly assessed, as much history obtained as possible, and a quick physical examination performed. Are vital signs stable? Is the patient in shock? IV access should be obtained, and two large bore IVs placed, if there is active bleeding. Does the patient (and baby) need oxygen? What laboratory and radiographic studies are needed? How much blood does the blood bank have at this institution?

Obstetric Assessment

Did anyone come with the patient? Is the patient conscious? Are there signs of external trauma? Is there active bleeding? Is the patient in pain? Is the patient in labor? How far along is

the pregnancy? Most patients receiving prenatal care can tell their due date, if conscious. If not, does the patient look term or preterm? Are there fetal heart tones? A bedside ultrasound, if available, can provide gestational age, viability, if the pregnancy is alive, presentation, placental localization, number of fetuses, etc. If there is only one fetus, measuring the fundal height should correspond to weeks of gestation.¹

Fetal Assessment

If the pregnancy is viable, can the patient and baby be cared for at this institution or does the patient need to be transferred to a higher level of care? Are obstetric services available at all at this institution? What is the availability of someone to care for the baby if it needs to be delivered? Are there pediatricians and a nursery or neonatologists and a high-risk nursery available? Is anesthesia available? Does the patient need tocolysis, Betamethasone, or Group B Strep prophylaxis? Can the baby be monitored?

Preterm Labor and Delivery

The number one obstetrical problem worldwide is preterm labor and delivery. Preterm delivery is defined as delivery before 37 weeks gestation. No other single problem costs healthcare systems worldwide more healthcare dollars. Preterm deliveries comprise about 10% of all deliveries but comprise 85% of neonatal morbidity and mortality. Preterm labor demands an aggressive approach to stop labor, determine the cause, and prevent delivery. An effort should be made to determine the cause, although 50% of the time the etiology is not determined.

Preterm labor is treated with tocolysis, usually Magnesium sulfate or terbutaline. If the gestation is less than 34 weeks, Betamethasone is given to accelerate lung maturity should the tocolysis fail. Prophylaxis for Group B Strep is given. The decision should be made if the patient is stable and needs to be transferred to a higher level of care or because no obstetrics services are available. Often the decision will need to be made as to stabilize and transfer the patient or stabilize and deliver the patient, then transfer mother and baby. Pregnant women in labor should be transferred by ambulance or helicopter, depending on the availability and weather.

If the patient is in labor, a labor and delivery nurse should accompany the patient in the ambulance. If delivery is imminent or likely en route, the obstetrician or a physician capable of performing a vaginal delivery should ride with the patient. For helicopter transports, there is usually not room for a physician or even a nurse to accompany the patient. Most helicopter transports will be equipped with a physician and nurse capable of managing a vaginal delivery aboard.

Sometimes delivery is imminent in an institution in which there are no obstetric services at all. A physician capable of performing a vaginal delivery and a nurse should accompany the patient in transport. Today, most tertiary and quaternary institutions will not accept the transfer of a pregnant laboring patient without both physician accompanying the patient and the patient signing a waiver of liability to the accepting institution. Many accepting institutions require that the patient be stable prior to transfer.

Contraindications to tocolysis include cardiac disease, severe fetal anomalies, hyperthyroidism, severe migraine headache, uncontrolled diabetes, advanced cervical dilatation and fetal distress.¹ Fetal distress should be managed prior to transfer, if at all possible. Prophylactic tocolysis is often used during transfer, if not contraindicated, to minimize the risk of delivery en route.¹

Premature Rupture of Membranes

Premature rupture of membranes is a second important obstetric emergency. Fluid coming from the vagina is ruptured membranes until proven otherwise. The diagnosis is made by sterile speculum examination with nitrazine, pooling, ferning and/or ultrasound estimation of amniotic fluid volume. Amniocentesis with instillation of methylene blue may also be used to make the diagnosis. At sterile speculum examination, dilatation of the cervix should be noted. A closed cervix as opposed to a completely dilated cervix with impending delivery will affect management.

Is delivery imminent? What is the presenting part? Is the fetus viable? What is the gestational age? Ultrasound can be used to answer these questions. Much the same as preterm labor, can this patient be cared for in this institution or does she need to be transferred? Will she need to be delivered and stabilized first, then transferred?

Severe Preeclampsia

Severe preeclampsia is also an obstetric emergency demanding immediate treatment. A systolic blood pressure of 160 mm Hg or diastolic of 110 mm Hg needs immediate intervention. The diagnosis of severe PIH is also made by proteinuria of 5 grams on a 24-hour collection or +3 on a dipstick of a random specimen. Oliguria of <500 cc urine output over 24 hours, any CNS symptoms, pulmonary edema or cyanosis, impaired liver function tests, low platelets, intrauterine growth restriction, or right upper quadrant abdominal pain also confirm the diagnosis.¹

The cure for severe preeclampsia is delivery, regardless of gestational age. Magnesium sulfate is used to prevent seizures, hydralazine to control blood pressure after the loading dose of magnesium, and Lasix reserved for pulmonary edema. Diuretics are used only for pulmonary edema and congestive failure, due to their increased risk of precipitating a pulmonary embolus. A vaginal delivery is hoped for, and cesarean section is used for failed inductions, malpresentations, or worsening blood pressures.²

Magnesium is continued for at least 24 hours postpartum and often 48 hours. Preeclampsia can develop up to two weeks postpartum. Therapeutic levels of magnesium are in the 4-6 range with levels obtained every six hours usually. If the creatinine is 1.3 or above, reduce the magnesium infusion rate by 50%.² The higher the infusion rate of magnesium, the more frequently magnesium levels are checked.

Eclampsia

Eclampsia is generalized seizures occurring usually with preeclampsia. They are antepartum 50% of the time and 91% occur after 28 weeks. The differential diagnosis includes epilepsy, uncontrolled hypertension, lupus, intracranial hemorrhage, brain tumors, aneurysms, ITP, Metabolic Disorders, Cerebral Vasculitis, Cavernous Vein Thrombosis, Postdural Puncture, CVA, and inadvertent vascular injection of anesthetic used for epidural anesthesia.² The latter is usually accompanied by a metallic taste, an aura, and "strange feeling" before seizing.

Cerebral imaging is not always necessary unless there are focal changes, the seizures recurrent, deterioration of the patient's condition, or the need to exclude other etiologies.² Usually the cure is delivery, and it should not be withheld for Betamethasone. Avoid diuretics unless there is pulmonary edema. Restrict fluids to reduce the incidence of cerebral edema. The treatment is magnesium sulfate. If the patient is on magnesium and seizing, then more magnesium is needed. Rarely, is a second line anticonvulsant needed. Hydralazine and labetalol are used to treat blood pressure. Nitroglycerine may be necessary postpartum. Systolic blood pressures > 160 mm Hg and diastolic > 110 mm Hg increase the likelihood of stroke.

Prolapsed Umbilical Cord

A prolapsed umbilical cord is an obstetric emergency in which compression of the umbilical cord can have fatal results if not relieved quickly. If the membranes are not ruptured, a cord presentation, as it is called, is a disaster waiting to happen. Compression of the cord by the presenting part compresses umbilical vessels, causing hypoxia. The diagnosis is made by fetal heart rate tracing and vaginal examination. While a prolapsed cord can occur spontaneously, most often it occurs after artificial rupture of membranes from a high station before the head is engaged. Basically, the loose umbilical cord is washed out of the vagina with the flow of amniotic fluid and the effect of gravity. While most obstetricians have at one time or another

tried replacing the cord into the uterus, it is not successful. It is important to know if the baby is alive, gestation age if viable, and if there are anomalies.¹

The cord compression is relieved by elevating the fetal head vaginally while preparing for cesarean section. Elevation may be assisted by placing the mother in deep Trendelenburg position or knee-chest. An operative vaginal delivery may be considered if the cervix is completely dilated and the head is low in the pelvis.

Antepartum Hemorrhage

Antepartum hemorrhage is the newer term applied to what used to be called third trimester bleeding. By definition, antepartum hemorrhage is bleeding during the second half of pregnancy. Other definitions include bleeding after viability, often after 24 weeks. The most common cause of mild bleeding is sexual intercourse and is usually self-limited. Significant causes of bleeding include placenta previa, placental abruption, vasa previa, and uterine rupture.

Vasa previa is presentation of umbilical vessels lacking Wharton's Jelly below the presenting part. Rupture of a vessel causes bleeding from the baby. Placental abruption is premature separation of the placenta due to bleeding, characterized by significant pain, uterine tetany and shock, with or without external bleeding. Placenta previa is characterized by painless bleeding from the placenta covering the cervix. Cesarean section is usually the required method of delivery. Bleeding may occur in conjunction with uterine rupture from a previous cesarean section or uterine surgery, such as a myomectomy. Uterine rupture is characterized by a fetal heart rate abnormality.

The degree of vaginal bleeding or the fetal heart rate abnormality will dictate the delivery, regardless of gestational age. Ultrasound is helpful making the diagnosis. If ultrasound is unavailable, a double set-up in the operating room may be helpful.

Abortion With Hemorrhagic Shock

Abortion with hemorrhagic shock may occur with any type of abortion: complete, incomplete, septic, induced or missed. Fortunately, illegal abortions have been reduced with Roe vs. Wade. A patient presenting with hemorrhagic shock from an abortion needs a quick clinical assessment, two large-bore IV lines, a complete blood count, coagulation studies, and a type and cross-match for blood. Rhogam will need to be given for Rh negative patients. A pelvic exam should reveal uterine size, lacerations, cervical dilatation, and the degree of active bleeding. An ultrasound should reveal any retained products of conception. Patients with septic abortions are at high risk for disseminated intravascular coagulation, acute renal failure, and adult respiratory distress syndrome.

An empty uterus can be managed with pitocin, methergine, antibiotics, massage, and blood transfusion with correction of any clotting abnormalities. Retained products of conception will

require dilatation and curettage and occasionally evacuation of the uterus with dilatation and evacuation. The uterus is soft during pregnancy and very easy to perforate. Uterine perforation should be a consideration in a patient with significant bleeding who has already had a dilatation and curettage. For a patient with a septic abortion, triple antibiotics should be given.

Ectopic Pregnancy with Shock

An ectopic pregnancy with shock demands expedient surgical management, not medical or conservative. A patient with a positive pregnancy test and abdominal or pelvic pain is an ectopic pregnancy until proven otherwise. Abdominal ultrasound should visualize the site of a pregnancy in a normal size patient at a level of 5,000 to 6,000 mIU. A transvaginal ultrasound should be able to identify a pregnancy at a level of 1200-1500 mIU. A patient with an ectopic pregnancy in shock needs a complete blood count, quantitative Beta HCG, coagulation studies, and a type and cross-match for blood. Two large bore IV lines should be placed. If the patient is Rh negative, she will require Rhogam.

Acute Abdominal Pain During Pregnancy

Anything causing pain in a woman not pregnant can also cause pain during pregnancy. The number one cause of abdominal pain during pregnancy is uterine contractions due to labor. Other causes include acute appendicitis, ruptured liver, ruptured spleen, acute cholecystitis, pyelonephritis, ovarian torsion, trauma, placental abruption, uterine rupture, small bowel obstruction, infarcted fibroid, round ligament pain, renal stone, ureteral obstruction due to an enlarging uterus, ruptured aneurysm, and pelvic abscess. Management depends on the diagnosis. Practitioners should bear in mind that any abdominal or pelvic surgery will almost always cause uterine contractions. For this reason, exploratory laparotomy after 35 weeks gestation should include a cesarean delivery.

Disseminated Intravascular Coagulation

Disseminated Intravascular Coagulation, or DIC, is a consumptive coagulopathy due to some cause including preeclampsia, eclampsia, massive blood loss, abruption, intrauterine fetal demise, septic abortion, amniotic fluid embolism, ruptured uterus, hypovolemic shock, massive blood transfusion, sepsis, gestational trophoblastic disease, or saline abortion.¹ There is massive bleeding from multiple sites including IV sites, incisions, uterus and mucous membranes. PT, PTT, and Bleeding Time are prolonged. Platelets and fibrinogen are low. FSP and FDP are elevated. There is hemolysis with hemoglobinuria and elevated LDH.

Management involves correcting the inciting cause and treating empirically with crystalloid and colloid, fresh whole blood, if available, packed red blood cells, oxygen, fresh frozen plasma for every 2-3 units of packed cells and platelets. Cryoprecipitate may also be given when the fibrinogen < 100. One unit

of platelets will raise the platelet count 5,000-10,000. Usually give a 12 pack of platelets prior to operating to raise the platelet count above 100,000. PCV should be kept above 30 and urine output 30-60 cc/hr. CVP should be monitored.

Uterine Inversion

Uterine inversion appears as a hemorrhagic mass at the introitus after pulling on the umbilical cord to remove the placenta. Massive bleeding, shock, and pain follow. Inversion is associated with too much traction on the cord, fundal pressure, a short cord, or too rapid removal of the placenta. Manual replacement should be attempted immediately before the development of a cervical ring and edema. Manual replacement may require halothane anesthesia or tocolysis followed by pitocin. Surgical treatment with hysterectomy may be required in difficult cases.

Postpartum Hemorrhage

Postpartum hemorrhage is defined as blood loss > 500 cc for a vaginal delivery or >1,000 cc for a cesarean section. Causes include uterine atony, retained placenta, fibroids, prolonged labor, multiple gestation, infection, ruptured uterus, precipitate labor, full bladder, or DIC. Treatment involves vaginal exploration, exploration of the uterus, pitocin, methergine, bimanual compression, Hemabate, IV fluids, D&C, uterine packing, hypogastric artery ligation, O'Leary-O'Leary ligation of uterine arteries, uterine compression sutures, or cesarean hysterectomy.

Retained Placenta

A placenta is not retained until after 30 minutes. A retained placenta may be due to atony or a constriction ring, such that it is hard to get out. Retention may be due to an abnormally adherent placenta due to a defective decidua in which the placenta will not come out. Manual removal may require piecemeal removal under anesthesia but usually requires a hysterectomy. If the placenta is left to slough, it will usually cause bleeding and infection. The only situation in which the placenta is left undelivered is in an abdominal pregnancy, and the cord is tied off with absorbable suture.

Abdominal Pregnancy

An abdominal pregnancy is rare, usually occurring only once in a practitioner's career. Abdominal pregnancies arise from a ruptured ectopic pregnancy with reimplantation on another organ, usually the bowel or other abdominal viscera. In an average size woman the fetal parts can be felt "unusually well." These pregnancies may go to term but never go into labor because they are not inside the uterus. They are occasionally diagnosed at attempted cesarean section for failed induction nearing post-dates. All abdominal pregnancies must be delivered by laparotomy. ***An abdominal pregnancy is the only type of pregnancy in which the placenta is left undelivered.*** The umbilical cord is tied off with absorbable suture. Current thought is that placental resorption can be accelerated with postpartum Methotrexate.

Shoulder Dystocia

The greatest fear in obstetrics is a shoulder dystocia. The second greatest fear is massive hemorrhage. Immediate retraction of the head after it is delivered with inability to deliver the shoulders is the classical description of a shoulder dystocia. The first thing to do is get help! The second is to stay calm. Although numerous maneuvers have been described to relieve shoulder dystocias, McRobert's Position, suprapubic pressure, and a generous episiotomy will relieve most.

McRobert's Position involves hyperflexing the thighs against the mother's abdominal wall, which increases the AP diameter of the pelvis and gives more room laterally. A generous episiotomy is also helpful. An episiotomy, as described in older texts, is usually not necessary. Newer trained obstetricians are reluctant to cut an episiotomy early. Whether this is for fear of cosmetics or a difficult repair, neither is justified. Suprapubic pressure involves identifying the anterior shoulder and pushing it laterally; there is no room to simply push directly posteriorly.

Delivery of the posterior arm, Wood's Corkscrew Maneuver, Gaskin's Maneuver, and many other procedures have been described. The Zavanelli Maneuver involves replacing the head into the pelvis and performing a cesarean section. This is easier said than done, because elevating the head is difficult, and it must be held in that position until delivered from above at cesarean section. The Avery Modification of the Zavanelli Maneuver involves elevating the head and internal version to a breech presentation, so that a breech extraction can be performed from above.³ This reduces the pressure required to keep the head elevated, but at the same time prevents the presenting part from falling back into the pelvis.

If the delivery is too slow, hypoxia and brain injury may occur. If the delivery is too fast, maternal or fetal injury may occur, such as Erb's Palsy. Develop a plan that works for you, practice, rehearse, drill, and anticipate. Personally follow up injuries, communicate with your patient, document comprehensively.²

Amniotic Fluid Embolism

Amniotic fluid embolism is a rare, but highly fatal, obstetric emergency with an estimated mortality of 70-90%.¹ The usual scenario is respiratory distress, then collapse after pushing or immediately after delivery. Amniotic fluid gains entry into the circulatory system and causes acute pulmonary vascular obstruction and hypertension, cor pulmonale, left ventricular failure, hypotension, shock, hypoxia, cyanosis, coma, and DIC.¹ Pulmonary thromboemboli and air emboli produce the same picture.

Treatment consists of cardiopulmonary resuscitation, mechanical ventilation, Dopamine, steroids, correction of acidosis, blood transfusion, and blood component therapy to correct DIC.¹ If the mother is undelivered, a decision must be made as to whether the baby can be delivered. If an epidural anesthesia is in place and working, it may be used to perform an emergency cesarean section to save the child. Otherwise, general anesthesia would be needed to perform a cesarean section. Because of DIC and time

requirements, regional anesthesia would be contraindicated. If the mother cannot be saved and the baby is still alive or has been alive within the last four minutes, a postmortem cesarean section may be performed at bedside with gloves and a knife. The baby will need resuscitating almost always.¹

Trauma During Pregnancy

Pregnant women are exposed to the same trauma as the rest of society. The treatment is the same as for non-pregnant women. Treatment should never be withheld because a woman is pregnant. Treatment involves two patients, not one; one of these, the baby, may be viable or not. Whatever is best for the mother is best for the baby. *Care for the mother first, then the baby.* If the mother dies, the baby will die without intervention. Fetal compromise is usually manifested within four hours, accounting for the prolonged observation of pregnant women subjected to trauma.¹

Because the abdomen can be shielded, radiographs to delineate trauma should be performed. Tetanus prophylaxis should be administered. Appropriate antibiotics should be used, avoiding sulfa, tetracycline, and chloamphenicol.¹ If the mother was the automobile driver, always consider a placental abruption. If vaginal bleeding is present, an Apt Test may tell if it is fetal in origin. If the patient is Rh negative, Rhogam must be administered after the appropriate dose is determined by a Kleihauer-Betke Test to quantify the amount of fetal blood in the maternal circulation. MAST trousers are rarely used today, but, if used on a pregnant woman, only inflate the legs. Assess the baby and determine gestational age and viability. A bedside ultrasound is very helpful.¹

Cardiopulmonary Resuscitation During Pregnancy

Cardiopulmonary resuscitation may be required during pregnancy. Ventilation can be difficult. Trendelenburg position makes ventilation even harder. Because of the risk of regurgitation and aspiration from increased abdominal pressure and a relaxed gastroesophageal sphincter, early endotracheal intubation should be considered. External chest compression should occur at a 15 degree left lateral decubitus angle to avoid aorto-caval compression.¹ Chest compression should also occur higher at midsternum.¹

Postmortem Cesarean Section

Postmortem cesarean section dates back to antiquity, when, as history has it, expired pregnant women were delivered by incising the abdomen to deliver a viable baby in hopes that it would be a male to serve as a soldier. From a practical standpoint, a fetus can exist inside the womb without maternal circulation and oxygenation only for a short period of time, currently thought to be four minutes. There are no reports of good results after ten minutes. When the time is unknown, results are usually not good. Often, it is best not to pursue delivery if the time is prolonged, although obstetricians always want to be heroic.

A postmortem cesarean section should never distract from maternal resuscitation. Viability and gestational age should be determined before embarking on a cesarean section. Viability may be determined by ultrasound, Doppler, or fetoscope. Should the baby be delivered, there needs to be someone to care for the baby. Evacuating the uterus may improve resuscitation efforts. Evacuating the uterus may also help resuscitation and hemodynamics in resuscitating a pregnant patient with pulseless electrical activity. The delivery is accomplished by taking a knife and opening the abdomen with a midline incision, and then opening the uterus with a midline classical cesarean section incision. The baby is delivered, airway suctioned clear, cord clamped, baby resuscitated, APGARs determined, and time of birth recorded. At this point, CPR should be stopped, time of death recorded, and abdominal skin incision closed for the funeral home or coroner/medical examiner's office.

The usual scenario is CPR in progress with life-ending injuries, massive head trauma, or decapitation with fetal viability documented by fetal heart tones, Doppler or fetoscope or documentation of the same within a few minutes. It is rare for a baby to survive maternal cardiac arrest longer than 10 minutes; the standard is four minutes.

Cesarean Section Under Local Anesthesia

On rare occasions, it may be necessary to perform an emergency cesarean section under local anesthesia. Almost always, this occurs when anesthesia services are not available. "Field block" anesthesia is performed by infiltrating the skin, incising it, infiltrating the subcutaneous tissue, incising it, etc., until the peritoneum is entered. The peritoneum is the most painful layer to incise, followed by the uterus. Once the baby is delivered, sedation can be accomplished with narcotics, if anesthesia is still not available. Closure can then be performed. It is time consuming to perform a field block, and only infiltrated tissue can be cut.

Cesarean Section Without Anesthesia

Only on rare occasion, it may be necessary to consider a cesarean section without any form of anesthesia. When anesthesia is not available and time to accomplish the delivery will not allow field block anesthesia, cesarean section without any form of anesthesia may be offered to the mother. A motivated mother can tolerate incredible pain as a function of maternal instinct to save her baby. There must be permission from the mother with a clear explanation and expectation of survival of the baby. Without permission and informed consent, this procedure could easily be construed as battery.

Transport of the Obstetric Patient

An obstetric patient should be transported in the left lateral decubitus position, except for loading into an ambulance or helicopter in which the position is unstable. A paramedic or emergency medical technician should ride with the patient. If delivery is

a remote possibility, a labor and delivery nurse should accompany the patient. If delivery is imminent or patient unstable, transport imperative, and baby viable, an obstetrician or other physician capable of performing a vaginal delivery should accompany the patient.

A physician must accompany the patient if delivery is imminent or the patient unstable!

Sufficient equipment to perform a vaginal delivery should be available including IV fluids, pain medication, pitocin, methergine and oxygen. Checking fetal heart tones during transport is usually not helpful, other than to document that the baby is still alive. If there are decelerations or arrest of fetal heart tones, intervention by cesarean section is not possible in the back of an ambulance.

Transport of an obstetric patient in a helicopter usually has a patient weight limit. Most helicopter transports have their own crew. There is not room for an obstetrician, hospital staff, or family to ride with the patient. Helicopter transport is a quick way to transport any patient but is limited by weather conditions.

Conclusion

Most babies are delivered without complication. Many obstetric emergencies can arise and any practitioner who delivers babies needs to know how to manage these. Some emergencies arise frequently such as preterm labor, postpartum hemorrhage, and preeclampsia. Some only occur rarely such as amniotic fluid embolism, uterine inversion, and abdominal pregnancy.

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Medical Poetry

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AIDS

Cowering indoors, erect, seized by shame
 Overzealous libido, intransigent beast, unable to tame
 Night beckons: life a flickering, autumnal flame
 Delightful ecstasy, fleeting, useless to lay blame
 Of youth once fed, now a flower withered, lame
 Motionless, revolver spins, calmly taking aim.

Hypertension

Pain-stricken, full of dread
 Racing heart, slowed, then sped
 Anxiety, overcome by, heavier than lead
 Zzz's, seized by, in this hospital bed
 Obstinate, heeded not what the doctor said
 Smoking, gluttony I chose instead
 No hope left! Forlorn, guilt-ridden, soon I'll be.....

Diabetes

Mind about to burst
 Endless, agonizing thirst
 Type I, Type II: equally cursed
 Fought with needle first
 Optimistic, with insulin nursed
 Relentless pain unrehearsed
 Mind about to burst
 Intense, agonizing thirst
 Nearer, nearer comes the Hearst.

Obesity

Earth's black gold, chocolate, source of boundless delight
 Xtacy, dazzling pallet, with every radiant bite
 Ecstasy to the lips, engorges the hips, pants suddenly tight
 Rapture of lips, enlarging hips with no respite
 Chocolate: a devil in many forms: dull, glazed, bright
 Instant gratification yielding mounds of cellulite
 Spirit fierce, cellulite clings with rage and might
 Everywhere tires spare, exercise an angel, eradicates this blight.

Anxiety

Palpitations, bracing, expression stern
 Raging tempest, immobilizing me at every turn
 Open eyes, frozen stare, for control I yearn
 Zealous flames choke my veins in familiar pattern
 Abandoned by lifeless body, in vain, synapses burn
 Ceasing, Prozac rescue, normal functions return