

CMG 26(b) - COMPLICATED BIRTH

(Revised: May 2017)

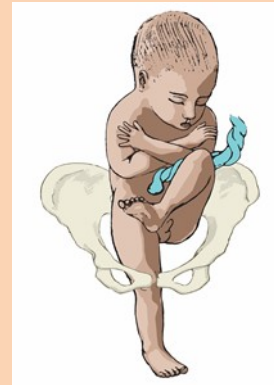


COMPLICATED BIRTH – breech births

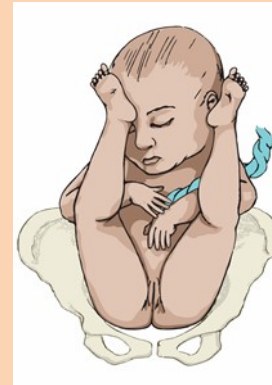
BREECH PRESENTATION:

Breech presentations occur in 3 – 4% of all deliveries, and are ideally delivered by caesarean section. Breech delivery has a high incidence of fetal mortality and morbidity, and as such the primary focus of pre-hospital management is rapid recognition of a breech birth and limiting manipulation of the neonate until required, being gentle but timely with the necessary techniques.

Field delivery is possible, but not preferable, for breech babies presenting buttocks first. Field delivery should not be attempted for footling or kneeling breech presentations. In this situation, do not attempt delivery, transport the mother urgently and notify the receiving obstetric unit as soon as possible.



Footling breech



Frank breech



Full breech

DELIVERY **NOT IMMINENT**, or if footling/kneeling presentation:

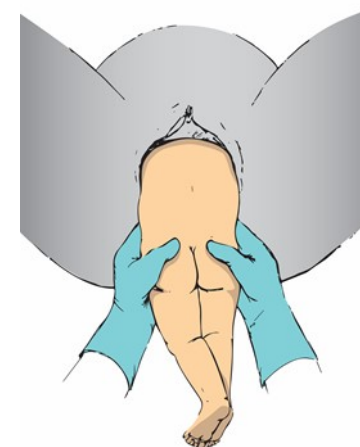
ICP	Notify and urgently transport to hospital.	AP
ICP	Where possible, do not encourage the woman to push, but rather to breathe through her contractions	AP

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COMPLICATED BIRTH

breech birth – DELIVERY IMMINENT, buttocks presenting

DELIVERY IMMINENT – breech presentation, buttocks presenting:

ICP	Have the mother adopt a position that allows the neonate to hang freely (e.g., standing or squatting, etc.)	AP	
ICP	Assess the cord to ensure it will allow the neonate to descend freely – treat as per ‘prolapsed cord’ guideline if necessary	AP	
ICP	Once the buttocks have entered the vagina, encourage the mother to push hard with contractions.	AP	
ICP	<p>The buttocks and legs should deliver spontaneously. If the legs do not deliver spontaneously, deliver one leg at a time:</p> <ul style="list-style-type: none">• push behind the knee to bend the leg• grasp the ankle and deliver the foot and leg• repeat for the other leg.	AP	
ICP	<p>Hold the neonate gently at the hips, but DO NOT pull.</p> <p>Support gently to ensure that the neonate’s back stays uppermost throughout.</p>		AP

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COMPLICATED BIRTH

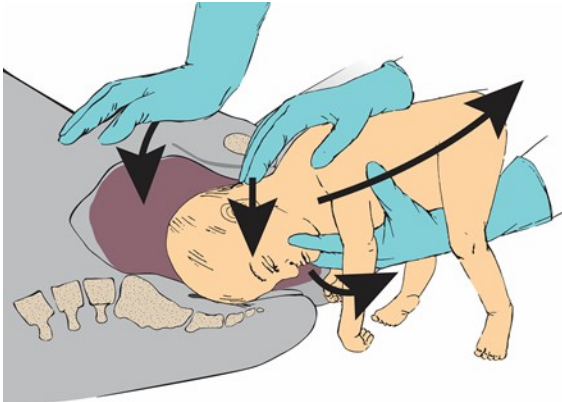
breech birth – DELIVERY IMMINENT, buttocks presenting (continued)

ICP	Once the neonate has descended to where the shoulder blades are visible, assess to see if the arms are extended, or are felt on the chest.	AP
ICP	<p>ARMS EXTENDED (above head or folded around neck) use Loveset's manoeuvre:</p> <ul style="list-style-type: none"> • Hold the neonate by the hips and turn half a circle, keeping the back uppermost and applying downward traction at the same time, so that the arm that was posterior becomes anterior and can be delivered under the pubic arch. • Assist delivery of the arm by placing one or two fingers on the upper part of the arm. Draw the arm down over the chest as the elbow is flexed, with the hand sweeping over the face. • To deliver the second arm, turn the neonate back half a circle, keeping the back uppermost and applying downward traction, and deliver the second arm in the same way under the pubic arch. <div data-bbox="156 957 1299 1220"> </div>	AP
	<p>ARMS FELT ON CHEST:</p> <ul style="list-style-type: none"> • Allow the arms to disengage spontaneously one by one – only assist if necessary. • After delivery of the first arm, lift the buttocks toward the mother's abdomen to enable the second arm to deliver. • If an arm does not spontaneously deliver, place one or two fingers in the elbow and bend the arm, bringing the hand down over the neonate's face. <div data-bbox="1355 957 2072 1220"> </div>	

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COMPLICATED BIRTH

breech birth – DELIVERY IMMINENT, buttocks presenting (continued)

ICP	<p>Once arms are free, allow the neonate freely deliver until the occipital region is visible, then deliver the head: use the Modified Mauriceau-Smellie-Veit (MSV) manoeuvre:</p> <ul style="list-style-type: none"> • lay the neonate face down with the length of its body over your hand and arm • place the first and second fingers of this hand on the neonate's cheekbones and flex the head toward the chest • use the other hand to grasp the neonate's shoulders • with two fingers of this hand, gently press on the neonate's occiput to flex its head down toward its chest until the hairline is visible • pull gently to deliver the head (an assistant can help keep the neonate's head flexed by applying pressure just above the mother's pubic bone as the head delivers) • raise the neonate, still astride the arm, until the mouth and nose are free, and place neonate on the mother's abdomen. 	AP
ICP	<p>Provide maternal and neonate care as per normal birth guideline. Expect a "stunned" neonate upon delivery.</p>	AP

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COMPLICATED BIRTH

prolapsed umbilical cord

PROLAPSED UMBILICAL CORD:

Cord prolapse is a rare obstetric emergency that is associated with a high perinatal mortality rate. It occurs after the membranes have ruptured, when the umbilical cord slips down in front of the presenting part of the fetus and protrudes into the vagina.

The principles of pre-hospital management are to monitor the cord for pulsations, and use maternal positioning to prevent cord compression. If the cord stops pulsating, the pressure from the presenting part will need to be alleviated, either indirectly using gravity (maternal knee-chest position) or directly, by gently pushing the fetus off the cord.

ICP	URGENT TRANSPORT without delay, and early hospital notification	AP
	Assess if the cord is pulsating:	
ICP	<p>If PULSATING –</p> <ul style="list-style-type: none"> • MINIMAL HANDLING of the cord, to prevent vasospasm • position mother in 'exaggerated Sims' position' (left lateral with pillow under hip) • gently place the cord back into the vagina • if unable to place cord into vagina, support the cord with warm, moist pads. 	AP
ICP	<p>If NON-PULSATING –</p> <ul style="list-style-type: none"> • MINIMAL HANDLING of the cord, to prevent vasospasm • position mother in 'exaggerated Sims' position' (left lateral with pillow under hip) • using fingers, gently apply manual pressure on the fetal presenting part to alleviate compression of cord. 	AP
ICP	An alternative posture for a mother with a prolapsed cord is the knees-to-chest, head down position, however this is not ideal for transport. If possible, have the mother lay in the 'exaggerated Sims' position' for transport.	AP

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COMPLICATED BIRTH

shoulder dystocia

SHOULDER DYSTOCIA:

Shoulder dystocia occurs when the anterior shoulder of the neonate becomes impacted behind the symphysis pubis of the mother, which prevents delivery, either spontaneously or with gentle traction. The aim should be to resolve this obstetric emergency urgently as neonatal asphyxiation will occur very rapidly. It is also possible that the mother will suffer from a postpartum haemorrhage if shoulder dystocia is not managed efficiently and correctly.

ICP	Request urgent backup as neonate resuscitation may be required	AP
ICP	If possible, move mother so that her buttocks are at the edge of the bed, and apply gentle downward traction to the neonate's head, aiming to release the anterior shoulder	AP
ICP	If delivery of the neonate's body takes longer than 60 seconds (following delivery of the neonate's head) , it must be presumed the neonate's shoulder is caught behind the pelvis	AP
ICP	Maternal pushing should be discouraged, as this may further impact the shoulders. Fundal massage/pressure is CONTRAINDICATED.	
ICP	Immediately perform the McRoberts manoeuvre (hyperflexion of the maternal hips – “knees to nipples”): With the mother on her back, ask her to grasp her knees and pull them as far as possible onto her chest/abdomen. Assist the mother to achieve and maintain this position (this position should be maintained until delivery).	AP
ICP	If no delivery after 30 – 60 seconds : apply suprapubic pressure (either continuous or in a rocking motion) in combination with McRoberts manoeuvre and gentle traction. Use both hands to apply moderate pressure downward and laterally, aiming to slightly rotate the neonate	AP
ICP	If no delivery after a further 30 – 60 seconds , and IF POSSIBLE/PRACTICAL: rotate mother to be on hands and knees, then apply gentle downward traction, attempting to dis-impact the shoulder	AP

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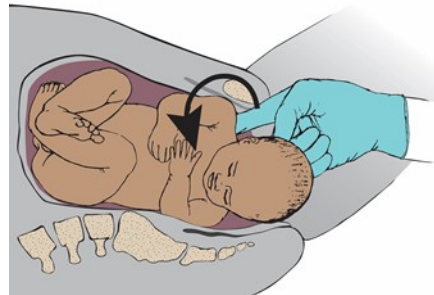
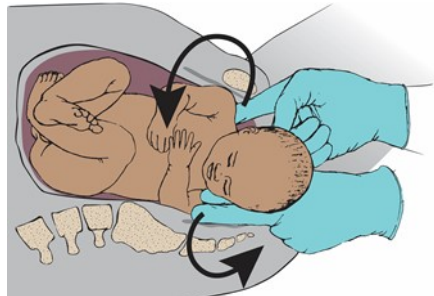
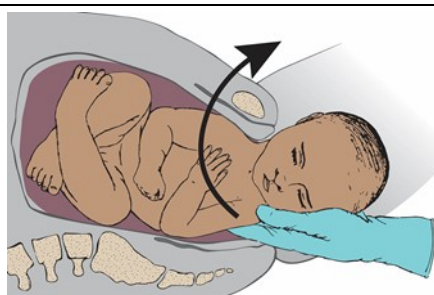
CMG 26(b) - COMPLICATED BIRTH cont.

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COMPLICATED BIRTH

shoulder dystocia (continued)

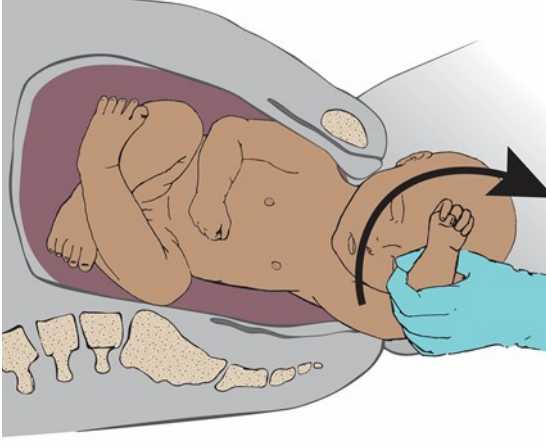
If all appropriate external options are exhausted, proceed to **internal manipulation** on the neonate:

ICP	<p>Rubin II manoeuvre:</p> <p>The fingers of one hand are inserted into the vagina and used to apply pressure behind the anterior (top) shoulder, pushing the shoulder towards the neonate's chest. (May be used alongside suprapubic pressure, if practical)</p>		AP
ICP	<p>Woods screw manoeuvre:</p> <p>If the Rubin II manoeuvre fails to deliver the neonate, the fingers of the first hand remain in position, while the fingers of the second hand are inserted in front of the posterior (lower) shoulder and used to add further pressure to rotate the neonate's shoulders (do not rotate head).</p>		AP
ICP	<p>Reverse Woods screw manoeuvre:</p> <p>Failure of the previous technique requires this attempt to turn the neonate 180° in the opposite direction, applying pressure to the back of the posterior shoulder.</p>		AP

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COMPLICATED BIRTH

shoulder dystocia (continued)

ICP	<p>Delivery of the posterior (lower) arm:</p> <p>The elbow of the posterior (lower) arm is located and flexed, sweeping the arm across the neonate's chest and out of the vagina to lie beside the head. This often allows the anterior shoulder to be displaced and delivered.</p>		AP
ICP	AT NO TIME should the neonate's head be rotated – rotate ONLY the shoulders		AP
ICP	Continue procedures if required; if neonate is still not delivered initiate URGENT TRANSPORT		AP
ICP	Note that if the shoulder is released, delivery of the rest of the body will follow quickly		AP
ICP	Mother should be transported in McRoberts position, with 30° left pelvic tilt		AP

OTHER PRESENTATIONS:

ICP	Recognise!	AP
ICP	Normal, unassisted delivery may not always be possible.	AP
ICP	Notify and urgently transport to nearest appropriate hospital.	AP