Peripartum Complications

- The recommended actions/interventions may not always be feasible, and most OB complications cannot be anticipated or managed in the field.
- This guideline should be considered to be "best advice" for rare, difficult scenarios.
- In every case, initiate immediate transport to definitive OB care.

Umbilical cord around the infant's neck → **Nuchal Cord** *(below)*

Umbilical Cord at vaginal opening → **Prolapsed Cord** *(below)*

Abnormal fetal part at the vaginal opening *(head not presenting)* → **Abnormal Presenting Part** *(below)*

Head gets "stuck" during delivery → **Shoulder Dystocia** *(below)*

Actively Seizing
(Eclampsia can occur up to 2 months postpartum)

Eclampsia Treatment

P — **Magnesium Sulfate 2 grams IV/IO**
Give over about 30 min

AND

Seizure Guideline **Including Benzo Use — M-07

Severe Vaginal Bleeding
(pre- or postpartum)
→ Vaginal Bleeding Hemorrhagic Shock — OB-04 T-03

M — **If any question, always contact online medical control -- discuss with OB if available.**

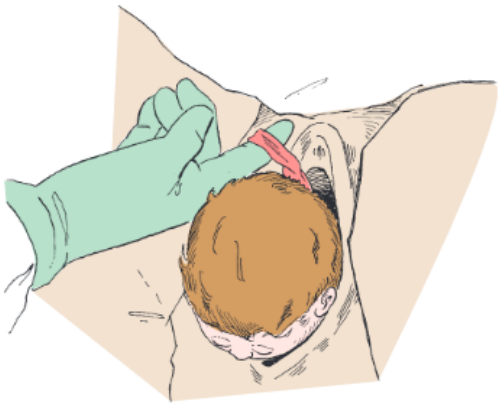
OB-03 OBSTETRICAL EMERGENCIES		First Responder EMT AEMT Paramedic

NUCHAL CORD

Indication: Umbilical cord wrapped around the infant's neck.

Procedure:

1. As the head is delivered, use a finger to determine if the cord is encircling the neck.
2. If able, loosen it and slip the intact cord over the infant's head.
3. If unable to remove the cord:
    a. Clamp the cord (*twice*).
    b. Carefully cut the cord between the clamps.
    c. Proceed with delivery.



Notes:

PROLAPSED UMBILICAL CORD

Indication: Umbilical Cord presenting at the vaginal opening before or without a fetal part.

Procedure:

1. Discourage pushing by mother
2. Position mother supine with hips elevated (knees to chest).
3. Place gloved hand in mother's vagina and elevate the presenting fetal part off of cord until relieved by physician
    a. Do NOT attempt to push inwards.
    b. Feel for cord pulsations.
4. Keep exposed cord moist and warm

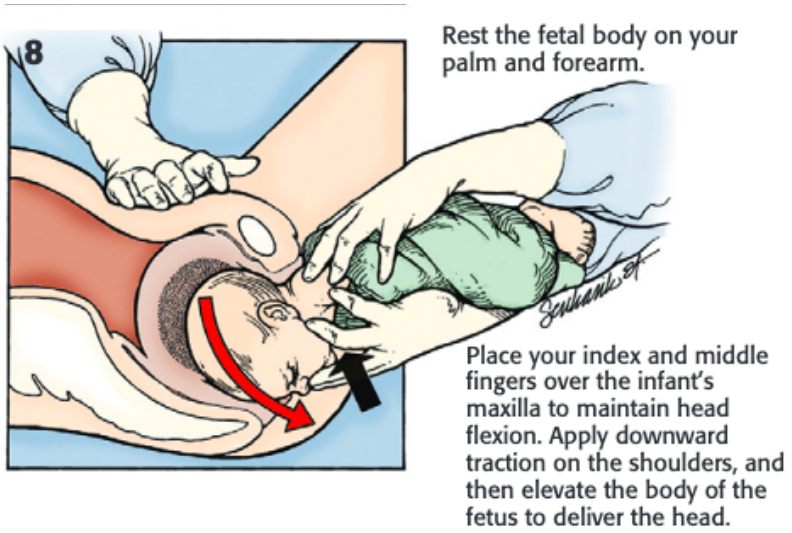
Notes:

ABNORMAL PRESENTING PART (i.e. Breech or Limb Delivery)

Indication: Fetal part other than the head presenting at the vaginal opening.

Procedure:

1. **Never attempt to pull the infant**
2. Once legs are delivered, gently *elevate trunk and legs* to aid in the delivery of the head
3. Head should deliver within 30 seconds. **If not:**
    a. Reach 2 fingers into vagina to locate infant's mouth.
    b. Press vaginal wall away from baby's mouth to access an airway
    c. Apply gentle abdominal pressure to uterine fundus



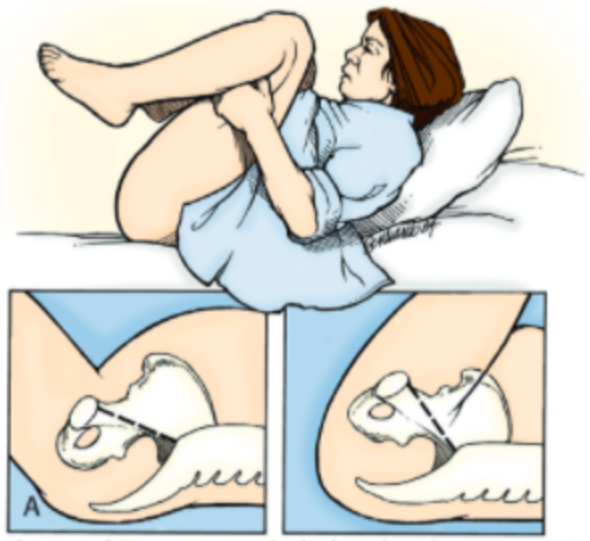
Notes:

SHOULDER DYSTOCIA

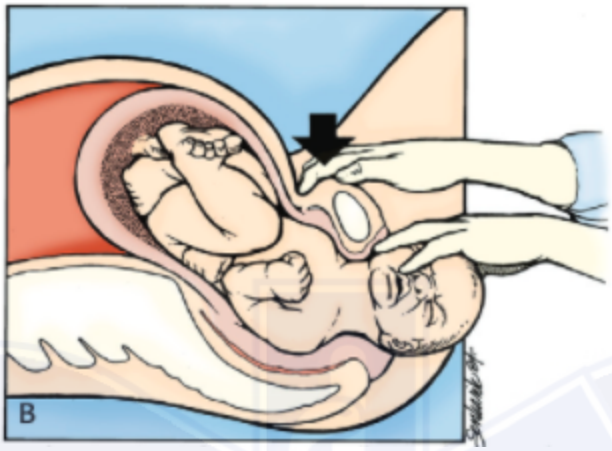
Indication: Normal appearing delivery that does not progress as expected after the head delivers as shoulder gets stuck at the pelvic brim. Commonly associated with the “turtle” sign (head bobs back into the vagina).

Procedure:

1. Support the infant’s head — DO NOT pull on the head
2. Position the mother with buttocks just off the end of bed and flex her thighs upward (knees to chest — a.k.a. McRoberts maneuver, *see right*).
3. Place ***gentle*** pressure above the pubic bone (not fundal pressure).



The McRoberts maneuver is the least invasive maneuver to disimpact the shoulders in shoulder dystocia. Position the patient in the extreme lithotomy position with the hips completely flexed (knee-chest position); this may free the anterior fetal shoulder.



Notes:

ECLAMPSIA

Indication: Eclampsia = **Seizures**/severe Altered LOC

Treatment:

- **Magnesium Sulfate 2 grams IV/IO over 30 minutes**
- See Seizure Guideline [**M-09**], and consider benzodiazepine (e.g. Versed) use for continued seizure activity.
- **If an IV cannot be quickly established, proceed directly to an IM Benzodiazepine (i.e. Versed 5-10 mg IM)** while access is obtained, *or* consider IO placement.

Notes:

- Preeclampsia signs: Hypertension (SBP > 140), peripheral edema, headache or vision changes. *If a patient has these symptoms, significant hypertension, and appears to be deteriorating,* ***consider Magnesium administration and contact online medical control*** *for approval.*
- Eclamptic seizures may occur up to 2 months postpartum.

Images courtesy of:

Lew, G.H. & Pulia, M.S. **Chapter 56: Emergency Childbirth**. *Roberts and Hedges' Clinical Procedures in Emergency Medicine - Sixth Edition*. Elsevier, 2013.