Obstetrical Emergencies

Purpose: To provide the process for the assessment and management of the patient with an obstetrical related emergency.

1. Follow **General Pre-hospital Care Protocol**
2. Assessment Information
    A. History:
        a. Past Medical History: previous births, previous complications
        b. Current History: duration of gestation (weeks), whether single or multiple births are expected.
    B. Specific Objective Findings: vital signs, assess contractions
    C. Determine whether to transport or remain at scene due to imminent delivery. Indications of impending imminent delivery may include:
        a. Multiple pregnancy, strong regular contractions, every 2 minutes or less; ruptured membrane, bloody show, need to push or bear down, crowning
    S D. Obtain vascular access, if time permits.

3. Management of Normal Delivery
    A. Have oxygen and suction readily available for care of the newborn.
    B. **If signs of newborn delivery are imminent, and there is no time to transport, prepare for delivery.**
        a. Try to find a place for maximum privacy and cleanliness.
        b. Position patient on back, on stretcher if time permits or on bed.
            i. Monitor patient for signs of hypotension. If signs develop, position patient so weight of uterus is to patient's left side.
        c. Drape if possible, using clean sheets.
        d. Encourage mother to relax and take slow deep breaths through her mouth.
        e. Reassure her throughout procedure.
        f. As baby's head begins to emerge from vagina, support it gently with hand and towel to provide a controlled delivery.
        g. After head is delivered look and feel to see if cord is wrapped around baby's neck.
            i. **If the cord is around neck and loose**, slide gently – over the head **DO NOT TUG.**
            ii. **If the cord is around neck and snug**, clamp the cord with 2 clamps and cut between the clamps.
        h. As the shoulders deliver, carefully hold and support the head and shoulders as the body delivers, usually very suddenly – and the baby is very slippery! **Note the time of delivery**.
        i. Place the baby on its side with head lower than the body. (Suction with a bulb syringe should be reserved for infants with obvious obstruction)
        j. Prevent heat loss.

i. Place baby in warm environment
ii. Dry baby off and remove all wet linen.

k. Evaluate respirations
   i. **If the baby does not breathe spontaneously**, stimulate by gently rubbing its back or slapping the soles of its feet. If still no response, initiate ventilation with 100% high flow oxygen per **Neonatal Assessment and Resuscitation Protocol.**
   ii. If spontaneous breathing begins, administer oxygen for a few minutes until baby's color is pink.

l. When infant is delivered and breathing normally, cord should be tied or clamped 8 inches from the infant with 2 clamps (ties) placed 2 inches apart. Cut the cord between the clamps, and assure that no bleeding occurs.
   i. If child is being resuscitated or is in distress, the cord may be cut and clamped and kept moist with a small dressing. (In case Umbilical Vein IV is needed.)

m. Score **APGAR** at **one minute** and **five minutes** after delivery.
   i. A – appearance (color)
   ii. P – pulse (heart rate)
   iii. G – grimace (reflex irritability to slap on sole of foot)
   iv. A – activity (muscle tone)
   v. R – respiration (respiratory effort)
   vi. Each parameter gets a score of 0 to 2.

APGAR SCORING

Sign	0	1	2
Appearance – skin color	Bluish or paleness	Pink or ruddy; hands or feet are blue	Pink or ruddy; entire body
Pulse – heart rate	Absent	Below 100	Over 100
Grimace – reflex irritability to foot slap	No response	Crying; some motion	Crying; vigorous
Activity – muscle tone	Limp	Some flexion of extremities	Active; good motion in extremities
Respiratory effort	Absent	Slow and Irregular	Normal; crying

n. If **APGAR** is less than 6, refer to **Neonatal Assessment and Resuscitation Protocol**.
o. When delivery of baby is complete, prepare for immediate transport. Placenta can be delivered in route or at the hospital
p. Delivery of placenta generally takes place within 20 minutes.
q. Following placental delivery, massage the uterus to aid in contraction of the uterus.
r. Place placenta in basin or plastic bag and transport with mother.


s. Contact medical control.

4. If there are signs of airway obstruction or respiratory distress, suction and refer to **Neonatal Assessment and Resuscitation Protocol.**
5. Abnormal Deliveries
   A. Contact Medical Control as soon as appropriate.
   B. **Breech position**
      a. Allow buttocks and trunk to deliver spontaneously.
      b. Once legs are clear, support body on the palm of your hand and surface of your arm, allowing head to deliver.
      c. If the head doesn't deliver immediately, transport rapidly to the hospital with mother's buttocks elevated on pillows with baby's airway maintained throughout transfer.
         i. Place **gloved** hand in the vagina with your palm towards the baby's face. Form a "V" with your fingers on either side of the baby's nose and push the vaginal wall away from baby's face until the head is delivered.
   C. **Prolapsed Cord – Life Threatening Condition**
      a. Place mother in a supine position with hips supported on a pillow.
      b. Evaluate and maintain airway, provide oxygen.
      c. **With sterile gloved hand, gently push** the baby up the vagina several inches to release pressure on the cord.

d. **DO NOT ATTEMPT TO PUSH CORD BACK!**
e. Transport maintaining pressure on baby's head.

D. **Arm or limb presentation – Life threatening condition**.
a. Immediate transportation
b. Delivery should not be attempted outside the hospital.
c. Place mother in position of comfort or with hips elevated on pillow.
d. Evaluate and maintain airway, provide oxygen.

E. **Multiple births**
a. Immediate transportation
b. Multiple birth infants are typically small birth weight and will need careful management to maintain body heat.
c. After first infant is delivered, clamp cord and proceed through airway, drying and warming procedures while awaiting delivery of other births, (See step 3a.)
d. Prepare additional supplies for subsequent births.
e. There may be time to transport between births.

6. **Pre-eclampsia/Eclampsia**
A. Signs of preeclampsia
a. BP 160/110 or higher
b. Marked peripheral edema
c. Diminished level of consciousness
d. Seizure (eclampsia)
B. Immediate transport
C. If seizure occurs
a. Administer Magnesium Sulfate 2 gm over 10 minutes IV/IO until seizure stops**.** Administration of Magnesium Sulfate is best accomplished by adding Magnesium Sulfate 2gm to 100 or 250 ml of NS and infusing over approximately 10 minutes.
b. If eclamptic seizure does not stop after magnesium, then refer to **Seizure Protocol**