

Obstetrical Emergencies

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

Pre-Medical Control

MFR/EMT/SPECIALIST/PARAMEDIC

1. Follow **General Pre-hospital Care Protocol**
2. Assessment Information
 - a. History:
 - i. Past Medical History: previous births, previous complications
 - ii. 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:
 - i. Multiple pregnancy, strong regular contractions, every 2 minutes or less; ruptured membrane, bloody show, need to push or bear down, crowning
3. General Management
 - a. Utilize universal precautions
 - b. Evaluate and maintain airway, provide oxygen and support ventilation as needed.

SPECIALIST/PARAMEDIC

- c. Obtain vascular access, if time permits.

4. Management of Normal Delivery

MFR/EMT/SPECIALIST/PARAMEDIC

- 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.**
 - i. Try to find a place for maximum privacy and cleanliness.
 - ii. Position patient on back, on stretcher if time permits or on bed.
 1. Monitor patient for signs of hypotension. If signs develop, position patient so weight of uterus is to patient's left side.
 - iii. Drape if possible, using clean sheets.
 - iv. Encourage mother to relax and take slow deep breaths through her mouth.
 - v. Reassure her throughout procedure.
 - vi. As baby's head begins to emerge from vagina, support it gently with hand and towel to prevent an explosive delivery.
 1. If practical, mouth and nose should be suctioned.
 - vii. After head is delivered look and feel to see if cord is wrapped around baby's neck.
 1. **If the cord is around neck and loose**, slide gently – over the head **DO NOT TUG.**
 2. **If the cord is around neck and snug**, clamp the cord with 2 clamps and cut between the clamps.

- viii. 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.**
- ix. Place the baby on its side with head lower than the body and **gently** suction mouth and then nose making sure the airway is clear.

SPECIALIST/PARAMEDIC

- 1. If evidence of meconium, the baby should be immediately intubated and the lower airway suctioned via the ET tube (with suction to the tube.) Repeat suction with new ET tube each time.

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- x. Prevent heat loss.
 - 1. Place baby in warm environment
 - 2. Dry baby off and remove all wet linen.
- xi. Evaluate respirations
 - 1. **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 Resuscitation Protocol.
 - 2. If spontaneous breathing begins, administer oxygen for a few minutes until baby's color is pink.
- xii. 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.
 - 1. 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.)
- xiii. Score APGAR at one minute and five minutes after delivery. Refer to Neonatal Resuscitation Protocol if APGAR is less than 6.
- xiv. When delivery of baby is complete, prepare for immediate transport. Placenta can be delivered in route or at the hospital
- xv. Delivery of placenta generally takes place within 20 minutes.
- xvi. Following placental delivery, massage the uterus to aid in contraction of the uterus.
- xvii. Place placenta in basin or plastic bag and transport with mother.

EMT/SPECIALIST/PARAMEDIC

- xviii. Contact Medical Control.

5. Abnormal Deliveries

- a. **Contact Medical Control as soon as appropriate.**

MFR/EMT/SPECIALIST/PARAMEDIC

- b. **Breech position**

- i. Allow buttocks and trunk to deliver spontaneously.
- ii. Once legs are clear, support body on the palm of your hand and service of your arm, allowing head to deliver.

- iii. 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.
 - 1. 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

- i. Place mother in a supine position with hips supported on a pillow.
- ii. Evaluate and maintain airway, provide oxygen.
- iii. **With sterile gloved hand, gently push** the baby up the vagina several inches to release pressure on the cord.
- iv. **DO NOT ATTEMPT TO PUSH CORD BACK!**

EMT/SPECIALIST/PARAMEDIC

- v. Transport maintaining pressure on baby's head.

d. Arm or limb presentation – Life threatening condition.

- i. Immediate transportation
- ii. Delivery should not be attempted outside the hospital.
- iii. Place mother in position of comfort or with hips elevated on pillow.
- iv. Evaluate and maintain airway, provide oxygen.

e. Multiple births

- i. Immediate transportation
- ii. Multiple birth infants are typically small birth weight and will need careful management to maintain body heat.
- iii. After first infant is delivered, clamp cord and proceed through airway, drying and warming procedures while awaiting delivery of other births, (See steps 3a.)
- iv. Prepare additional supplies for subsequent births.
- v. There may be time to transport between births.

6. Pre-eclampsia/Eclampsia

- a. Signs of preeclampsia
 - i. BP 160/110 or higher
 - ii. Marked peripheral edema
 - iii. Diminished level of consciousness
 - 1. Seizure (eclampsia)
- b. Immediate transport

PARAMEDIC

- c. If seizure occurs, administer **midazolam** 0.05 mg/kg, max of 5 mg IVP, (adult or peds) (if IV unsuccessful administer midazolam 0.1 mg/kg, to max of 10 mg IM).

EMT/SPECIALIST/PARAMEDIC

- d. Contact Medical Control

Post-Medical Control

PARAMEDIC

1. Possible orders post-radio contact

- a. For persistent seizure, consider:

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- i. **Magnesium sulfate** 2 gms IVP over 1-2 minutes with IV running wide open. Additional 2 gms IVP may be repeated.
- ii. **Diazepam** 2 -10 mg IVP slowly.

Medication Options (Choose One):

- Magnesium Sulfate 2 gms IVP over 1-2 minutes with IV running wide open. Additional 2 gms IVP may be repeated.
- OR**
- Diazepam 2 – 10mg IVP slowly

MFR/EMT/SPECIALIST/PARAMEDIC

1. APGAR Scoring

- a. Procedure for immediately evaluating a newborn baby.
 - i. Based on:
 1. A – appearance (color)
 2. P – pulse (heart rate)
 3. G – grimace (reflex irritability to slap on sole of foot)
 4. A – activity (muscle tone)
 5. R – respiration (respiratory effort)
 - ii. Each parameter gets a score of 0 to 2.

APGAR SCORING

Sign	0	1	2
Heart Rate	Absent	Below 100	Over 100
Respiration (effort)	Absent	Slow & Irregular	Normal; crying
Muscle Tone	Limp	Some flexion of extremities	Active; good motion in extremities
Irritability	No response	Crying; some motion	Crying; vigorous
Skin color	Bluish or paleness	Pink or ruddy; hands or feet are blue	Pink or ruddy; entire body