

2.14 Obstetrical Emergencies

Recognition:

- 3rd trimester bleeding: vaginal bleeding occurring \geq 28 weeks of gestation.
- Preterm labor: onset of labor/contractions prior to the 37th week of gestation
- Malpresentation: presentation of the fetal buttocks or limbs.
- Prolapsed umbilical cord: umbilical cord precedes the fetus.
- Shoulder dystocia: failure of the fetal shoulder to deliver shortly after delivery of the head.
- Postpartum hemorrhage: >500 ml estimated blood loss or blood loss with hemodynamic instability.
- Pre-eclampsia/Eclampsia: BP $>$ 160/100, severe headache, visual disturbances edema, RUQ pain, seizures

EMR & EMT STANDING ORDERS



- Routine Patient Care
- Do not delay transport for patients with obstetrical emergencies, provide early notification to the receiving facility.
- If gestational age is known to be $<$ 20 weeks, transport to closest hospital.
- If gestational age is known to be $>$ 20 weeks or fundus is palpable at or above the umbilicus, contact **Medical Control** and follow local OB diversion protocol, if available.

For third trimester bleeding

- Suspect placenta previa (placenta is implanted in the lower uterine segment)
- Suspect placental abruption (placenta is separated from the uterine wall before delivery); because hemorrhage may occur into the pelvic cavity, shock can develop despite relatively little vaginal bleeding.
- Do not perform digital examination
- Place patient in the left lateral position
- Monitor hemodynamic stability (see [Shock Protocol 2.19](#))

For breech birth (presentation of buttock):

- Do not pull on newborn. Support newborn and allow delivery to proceed normally.
- If the legs have delivered, gently elevate the trunk and legs to aid delivery of the head.
- If the head is not delivered within 30 seconds of the legs, place two fingers into the vagina to locate the infant's mouth. Press the vaginal wall away from the infant's mouth to maintain the fetal airway.

For limb presentation:

- Place mother in knee-chest or Trendelenberg position.
- Do not attempt delivery; transport emergently as surgery is likely.

For prolapsed cord:

- Discourage pushing by the mother
- Place mother in knee-chest or Trendelenberg position.
- If umbilical cord pulse is absent, place a gloved hand into the mother's vagina and decompress the umbilical cord by elevating the presenting fetal part off of the cord.
- Wrap cord in warm, sterile saline soaked dressing.

For shoulder dystocia:

- Suspect if newborn's head delivers normally and then retracts back into perineum because shoulders are trapped.
- Discourage pushing by the mother
- Support the baby's head, do not pull on it.
- Suction the nasopharynx and oropharynx, as needed
- Position mother with buttocks dropped off end of stretcher and thighs flexed upward (Extreme knee-chest position/McRobert's maneuver). Apply firm pressure with an open hand immediately above pubic symphysis.
- If the above method is unsuccessful, consider rolling the patient to the all fours position.

Policy Continues



EMR & EMT STANDING ORDERS

E

For postpartum hemorrhage:

- Vigorously massage fundus until uterus is firm.
- If possible initiate breast feeding
- If blood loss is > 500 mL or patient is hemodynamically unstable, treat according to [Shock Protocol 2.19](#)

For cardiac arrest in the pregnant patient (regardless of etiology)

- See [Cardiac Arrest Protocol 3.2A](#)
- For patient ≥ 20 week gestation or if the fundus is palpable at or above the level of the umbilicus, apply left lateral uterine displacement (LUD) with the patient in the supine position to decrease aortocaval compression. LUD should be maintained during CPR. If ROSC is achieved, the patient should be placed in the left lateral decubitus position.

ADVANCED EMT STANDING ORDERS

A

- Establish IV access above the diaphragm.
- For preterm labor:
 - 20 mL/kg 0.9% NaCl, may repeat once

PARAMEDIC STANDING ORDERS

P

- After delivery:
 - Oxytocin 10 Units IM.
 - Note: In multiple pregnancy, do not give until all placentas are delivered.

PEARL:

The amount of bleeding is difficult to estimate. Menstrual pad holds between 5 - 15 mL depending on type of pad. Maternity pad holds 100 mL when completely saturated. Chux pad holds 500 mL. Estimate the amount of bleeding by number of saturated pads in last 6 hours. Consider transporting the soiled linen to the hospital to help estimate blood loss.

PRE-ECLAMPSIA / ECLAMPSIA

Pre-eclampsia/Eclampsia is most commonly seen in the last 10 weeks of gestation, during labor, or up to 48 hours post-partum. It also may occur up to several weeks post-partum.

EMT/ADVANCED EMT STANDING ORDERS

E

- Routine Patient Care.
- Ensure quiet environment / dim lights / limited use of siren.
- If pregnant, place patient in left lateral recumbent position.

ADVANCED EMT STANDING ORDERS

A

- Establish vascular access.

PARAMEDIC STANDING ORDERS

P

For patients in the third trimester of pregnancy or post-partum who are seizing or who are post-ictal:

- Magnesium sulfate, 4 grams IV (mix in 100 mL 0.9% NaCl) bolus over 10 minutes, then consider 1 gram/hr continuous infusion see [Seizure Protocol 2.17A](#).
- Contact **Medical Control** and follow local OB Diversion Protocol.

