

CLINICAL PRACTICE GUIDELINE UPDATE

In line with new medical guidance the following update is issued to supplement the UK Ambulance Service Clinical Practice Guidelines 2013

Birth Imminent: Normal Delivery and Delivery Complications

Table 5.3 – ASSESSMENT and MANAGEMENT of:

Delivery complications

8. Shoulder dystocia^f

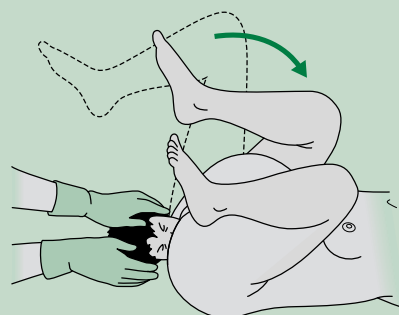
ASSESSMENT

An arrest of spontaneous delivery; when delivery of the baby's shoulders is delayed because the baby's anterior shoulder is stuck behind the symphysis pubis.

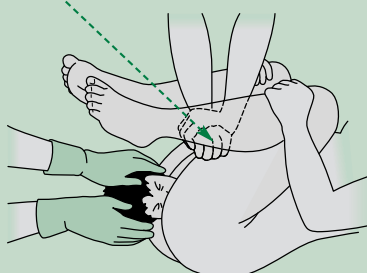
MANAGEMENT

- **DO NOT** cut the cord before the baby's head is delivered.
- **DO NOT** press on the uterine fundus.
- If the shoulders are not delivered within two contractions following the birth of the head a further attempt must be made to deliver the shoulders using the McRobert's manoeuvre (see below).

McRobert's Manoeuvre (increases the pelvic diameters/alters the angle of the pelvis)



location of
symphysis pubis



1. Ask the mother to lie flat with only one pillow under her head.
2. Bring the mother's knees up towards her chest and outwards slightly.
3. During the next two contractions attempt to deliver the baby's shoulders with gentle traction applied to the baby's head (both outward and downward), while the mother is encouraged to push.
4. **If after two contractions the shoulders have not delivered attempt surapubic pressure.**

Suprapubic Pressure

1. Identify the side where the fetal back lies. This will often be the opposite side to the direction the baby is facing. NB The mother should be flat with a maximum of one pillow under her head.
2. Ask the assistant to:
 - Stand on the side of the baby's back (if the baby is facing left, stand on the mother's right or vice versa).
 - Use their hands in CPR grip and place the heel of their hand two finger breadths above the symphysis pubis behind the baby's shoulder.
 - Use suprapubic pressure in conjunction with gentle traction of the baby's head (pressure alone is unlikely to be successful).
 - Apply moderate pressure on the baby's shoulder pushing downwards and away from them.
 - This will hopefully dislodge and rotate the shoulder from behind the symphysis pubis.
3. Encourage the mother to push and during the next two contractions attempt to deliver the baby's shoulders with gentle traction applied to the baby's head (both outward and downward while the mother continues to push), while the assistant simultaneously applies suprapubic pressure.
4. **If after two attempts the shoulders have not delivered, apply intermittent pressure.**

^f This is when delivery of the baby's shoulders is delayed. The baby's anterior shoulder is stuck behind the symphysis pubis.

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Table 5.3 – ASSESSMENT and MANAGEMENT of:

Delivery complications

8. Shoulder dystocia^f *continued*

ASSESSMENT

MANAGEMENT

Intermittent Pressure

1. Encourage the mother to empty her bladder.
2. Ask the assistant to apply intermittent pressure on the shoulder by rocking gently backwards and forwards.
3. Encourage the mother to push and during the next two contractions attempt to deliver the baby's shoulders using gentle traction applied to the baby's head (both outward and downward).
4. **If after two attempts the shoulders have not delivered, place the mother in the all-fours position.**

All-Fours Position

1. Position the mother on her hands and knees with her hips well flexed, bottom elevated and her head is as low as possible (see diagram below).
2. While the mother pushes, apply gentle traction to the baby's head (both outward and downward towards the floor), to try and deliver the shoulder nearer the maternal back first.
3. **If after two attempts, if the shoulders have not delivered:**
 - Undertake a **TIME CRITICAL** transfer to a **CONSULTANT-LED UNIT**.
 - Administer high levels of supplemental oxygen.
 - In this situation do not await the arrival of the midwife.
 - Provide an alert/information call.
 - Ideally, the mother should be removed from scene using the ambulance stretcher. However, if necessary, the mother may be helped to walk a **SHORT** distance to the nearest point of access for the stretcher, but crews should be prepared to deliver the baby as this may precipitate birth. Once on the stretcher and during transportation the mother should be placed on her side with padding placed under her hips to raise the pelvis.



Methodology

For details of the methodology used in the development of this guideline refer to the guideline webpage.

KEY POINTS

Birth Imminent: Normal Delivery and Delivery Complications

- For a patient experiencing an abnormal labour or delivery, transfer to further care without delay.
- Undertake a rapid assessment of the patient to ascertain whether there is anything abnormal taking place.
- If the mother presents with an obvious medical or traumatic condition that puts her life in imminent danger treat appropriately.
- The period of gestation is important in informing the appropriate course of action.
- Severe vaginal bleeding, prolapsed cord, continuous severe abdominal/epigastric pain and presentation of part of the baby other than the head (e.g. an arm or leg) warrant IMMEDIATE transfer to the CONSULTANT-LED UNIT.
- Do not allow the baby to become cold during transfer.
- Using McRobert's manoeuvre (+/- suprapubic pressure) will also require gentle traction on the baby's head while the mother pushes, to complete delivery.