

OBSTETRICS

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INTRODUCTION

UNLESS DELIVERY IS IMMINENT, TRANSPORT IMMEDIATELY TO A HOSPITAL with obstetrical capabilities. Remember, even skilled obstetricians sometimes have difficulty predicting how soon delivery will occur. Sometimes the membranes (bag of water) will be bulging down into the opening of the vagina and may suggest to the inexperienced EMT that the head is about to deliver. If delivery is not clearly imminent transport while observing perineal area.

The EMT should not place a gloved hand inside the vagina EXCEPT in the case of:

1. Prolapsed cord
2. Breech delivery with entrapment of the head

Placing of the hand in the vagina under other circumstances may cause fatal bleeding (with placenta previa), infection (with premature rupture of membranes) or even accidental rupture of membranes and possible cord prolapse. Physical examination information regarding the progress of labor must be obtained only by palpation of the abdomen and observation of the perineal area.

During delivery, controlling the expulsion of the head is a critical portion of the care. Gentle pressure with the flat of the hand against the crown of the head helps “control” the force with which the head is expelled. Gentle pressure results in a smooth, continuous delivery of the head during a contraction. If this maneuver is not used, the head may “pop out” and subject the newborn to an increased incidence of cerebral bleeding, or produce serious injury to the mother’s vagina.

“Gentle” pressure is recommended during a normal delivery when pulling down then up on the head and neck in order to deliver the shoulders. “Gentle” is a term which may mean different things to different people. For this reason, it is very important to observe an obstetrician doing several “normal” deliveries to understand what is meant by the term “gentle.” Too much pressure can damage the neck or nerves in the arm.

Delivery is best done on a couch, cart or floor. This way, there is no danger of the newborn falling after it is delivered.

Meconium passage - green/brown liquid or sticky particles may be passed in the amniotic fluid. The oral and nasal passages must be suctioned clear before the newborn takes the first breath. Suction must not be too deep or too strong as this has been associated with cardiac arrest.

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Questions Medical Control will need answered:

1. Has the mother had a baby before? (Gravida/Pregnancy & Para/with) Any complications?
2. How frequent are the contractions? How long do they last?
3. Has the mother's amniotic sac (bag of water) ruptured? When?
4. Signs of meconium?

PLACENTA PREVIA

UTERINE RUPTURE

THIRD TRIMESTER BLEEDING

ANTEPARTUM HEMORRHAGE

1. Maintain airway, breathing and circulation.
2. Pulse Oximetry, high flow oxygen.
3. Position patient, left lateral recumbent. **DO NOT LAY PATIENT SUPINE.**

*****MONITOR FOR SHOCK*****

4. IV normal saline Wide Open rate, blood draws
5. Rapid Transport
6. Monitor ABC's

NOTIFY HOSPITAL EARLY

DO NOT ATTEMPT TO EXAMINE THE PATIENT INTERNALLY

POSTPARTUM HEMORRHAGE

1. Maintain airway, breathing and circulation.
2. Pulse Oximetry, high flow oxygen.
3. Place newborn baby on mother's abdomen.
 - Refer to natural childbirth section for additional information
4. Keep baby warm and dry.
5. Begin Uterine massage.

MONITOR FOR SHOCK

6. IV Normal Saline Wide Open rate, blood draws
7. Rapid Transport
8. Monitor ABC's

NOTIFY HOSPITAL EARLY

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UTERINE INVERSION

1. Maintain airway, breathing and circulation.
2. Pulse Oximetry, high flow oxygen.
3. Position left lateral recumbent. **DO NOT LAY PATIENT SUPINE.**
4. IV Normal Saline Wide Open rate, blood draws.

DO NOT SEPARATE PLACENTA FROM UTERUS

5. Light moist vaginal dressing.
6. Rapid Transport
7. Monitor ABC's.

NOTIFY HOSPITAL EARLY

ECTOPIC PREGNANCY

RUPTURED TUBAL PREGNANCY

1. Maintain airway, breathing and circulation.
2. Pulse Oximetry, high flow oxygen.
3. IV Normal Saline Wide Open rate, blood draws. Consider placement of 2nd IV.
4. Treat for shock
5. EKG monitor (if dysrhythmias, begin ACLS protocols).
6. Rapid Transport.
7. Monitor ABC's.

NOTIFY HOSPITAL EARLY

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PRE-ECLAMPSIA

INDICATIONS

- a. Patient is in third trimester of pregnancy.
- b. BP > 130/90 without history of hypertension prior to pregnancy (frequently seen in first pregnancies).

PROCEDURE

1. Maintain airway, breathing and circulation.
2. Pulse Oximetry, high flow oxygen.
3. Obtain history (specific to pre-natal care and diagnosis of hypertension or pre-eclampsia).
4. Perform examination.
5. Place patient in position of comfort (if supine, elevate patient's right side).
6. EKG monitor (if dysrhythmias, begin ACLS protocol).
7. IV Normal Saline TKO rate, blood draws.
8. Rapid Transport.
9. Monitor ABC's.

WATCH FOR SEIZURES NOTIFY HOSPITAL EARLY

If seizures (Eclampsia):

1. Begin Seizure protocol.
2. Administer Magnesium Sulfate 1.0-4.0 grams SLOW IV PUSH over 2-3 minutes.
Repeat in 5 min up to maximum of 4.0 grams or until seizures stop
3. Administer Versed (Midazolam) 5mg IV/IM PUSH or Intranasal

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CHILDBIRTH

NATURAL CHILDBIRTH (WITHOUT COMPLICATIONS)

1. Maintain airway, breathing and circulation on mother
2. Pulse Oximetry, high flow oxygen via non-rebreather (if tolerated)
3. Place mother supine, legs spread, and knees bent
4. Remove all lower clothing
5. Assess for crowning
6. Transport immediately unless delivery is imminent
7. EKG monitor (if dysrhythmias, contact medical control)
8. IV Normal Saline Wide Open rate, blood draws
9. Monitor ABC's and reassess for crowning

**NOTIFY HOSPITAL EARLY
DO NOT ALLOW MOTHER TO GO TO TOILET
DO NOT ATTEMPT TO RESTRAIN DELIVERY**

If delivery is imminent:

1. Keep environment sterile. Reassure mother
2. Support baby's head while mother slowly pushing

DO NOT PULL ON HEAD

3. Watch for cord around the neck
4. Suction oral and nasal passages clear with bulb aspirator (squeeze bulb before inserting it)
5. Assist in shoulder delivery

BABIES ARE SLIPPERY! HOLD ON!

6. Hold baby's head slightly lower and gently stimulate breathing
7. Record time of birth
8. Maintain baby's airway, breathing and circulation
9. ****Dry baby off and keep warm****
10. Place baby on mother's abdomen and clamp cord (approximately 6" and 9" from the baby)

DO NOT FORCE DELIVERY OF PLACENTA

11. Obtain baby's heart rate and respiratory rate
12. Monitor mother's ABC's, monitor baby's ABC's
13. Rapid transport.

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CHILDBIRTH

CORD AROUND THE NECK

1. Try to slip the cord around the neck.
2. If no success, clamp cord and cut between clamps.
3. Continue Natural Childbirth protocol.

NOTIFY HOSPITAL EARLY

PROLAPSED CORD

NOTE IF PULSE IN UMBILICAL CORD

1. Position mother trendelenberg or supine with hips elevated.
2. Push presenting part off of the prolapsed cord until relieved by physician.

NOTIFY HOSPITAL IMMEDIATELY

3. Insert two gloved fingers and raise presenting part of the fetus off the cord.
4. Rapid transport.
5. Administer Oxygen via non-rebreather mask.

BREECH BIRTH

NOTIFY MEDICAL CONTROL IMMEDIATELY DO NOT PUSH OR PULL ON LEGS DO NOT TOUCH OR STIMULATE PRESENTING PART

1. Try to keep presenting part warm, do not encourage mother to push (unless advised by medical control).
2. Place gloved fingers in vagina to create airway passage for baby.
3. Rapid Transport.

SHOULDER DYSTOCIA

1. Support baby's head.

DO NOT PULL ON HEAD

CONTACT MEDICAL CONTROL IMMEDIATELY

2. Suction oral and nasal passages clear with bulb aspirator (squeeze bulb before inserting).
3. Maintain airway.
4. Rapid transport.