

TREATMENT:

A. General

1. Treat per Universal Patient Care. Start O2 in all abnormal deliveries.
2. If multiple, or abnormal birth, consider second transport unit.
3. If in second trimester or third trimester, transport patient on the left side (pillow under right hip or, if on backboard, tilt right side of board up 20 degrees) to keep uterine pressure off inferior vena cava unless delivery is imminent.
4. Vital signs may not be a reliable indicator of shock or respiratory distress in the pregnant patient. BP does not change until significant blood loss occurs due to physiologic changes in pregnancy.

B. Toxemia of Pregnancy

1. If in seizure (eclampsia) follow Seizure protocol.
2. Contact OLMC for consideration of use of **Magnesium Sulfate**.

C. Normal Childbirth

1. Use sterile or clean technique.
2. Guide/control but do not retard or hurry delivery.
3. Check for cord around neck and gently remove if found. If unable to remove, place clamps 2 inches apart and cut cord if needed.
4. Suction mouth, then nose with bulb syringe after head is delivered. Keep infant level with perineum.
5. Guide head upward to deliver lower shoulder, then downward to deliver upper shoulder.
6. Place clamps 2 inches apart and cut umbilical cord about 8 inches from navel and then dry infant. Keep infant level with mother's heart until cord is cut.
7. Assess and treat ABC's. Follow Neonatal Resuscitation protocol if needed.
8. Assess infant using APGAR at time of birth and five minutes later. (The Pre-hospital Care Report should describe the infant using criteria rather than giving a numerical score.)
9. Dry infant and place against mother's skin. Cover both with a clean, dry blanket to maintain warmth.
10. If child does not need treatment, place on mother's chest for transport.
11. Gently but firmly massage fundus to encourage contraction and prevent excessive bleeding.
12. Transport
 - a. Monitor vital signs of mother and infant enroute.
 - b. Do not delay transport to deliver the placenta.
 - c. Severe bleeding following placental delivery, contact OLMC for treatment with **Oxytocin 10 units (10 mg) IM**.

D. Abnormal Childbirth

1. General
 - a. Transport to nearest appropriate hospital.
 - b. Give receiving hospital earliest possible notification.
 - c. Contact OLMC for advice.
 - d. Transport in position as described in General treatment above.
 - e. If extended transport consider Air Resources

2. Breech Presentation (buttocks first)
 - a. If delivery is imminent, prepare the mother as usual and allow the buttocks and trunk to deliver spontaneously then support and lower the body to help the head pass. As the hairline appears, raise the body by the ankles upward to fully deliver the head.
 - b. If the head does not deliver within three minutes suffocation can occur.
 1. Place a gloved hand into the vagina, with your palm toward the baby's face.
 2. Form a "V" with your fingers on either side of the baby's nose and push the vaginal wall away from the baby's face to create airspace for breathing.
 3. Assess for the presence of pulse in umbilical cord, if presenting.
 3. Shoulder Dystocia:
 - a. Shoulders will not pass through the pelvis
 - b. Apply gentle traction to back while applying suprapubic pressure
 - o McRoberts Maneuver: Pulling the women's knees towards her chest, applying suprapubic pressure.
- E. Prolapsed Cord
1. With a gloved hand, gently attempt to push the baby back up the vagina several inches.
 2. Do not attempt to push the cord back.
 3. Assess for the presence of pulse in umbilical cord.
 4. Use saline soaked gauze to prevent cord from drying
 5. Move mother to Trendelenburg position or knees to chest. This will help with cord pressure and increase fetal circulation
- F. Limb Presentation
1. The presentation of an arm or leg through the vagina is an indication for immediate transport to the hospital.
 2. Assess for presence of pulse in umbilical cord, if presenting.
 3. Do not pull on limb.
- G. Abruptio Placentae – Occurs in the third trimester of pregnancy when the placenta prematurely separates from the uterine wall leading to intrauterine bleeding.
1. The patient experiences lower abdominal pain and the uterus becomes rigid.
 2. Shock may develop without significant vaginal bleeding.
- H. Placenta Previa – Occurs when the placenta covers the cervical opening and can result in vaginal bleeding and prevents delivery of the infant through the vagina. The infant needs to be delivered via caesarian section.

OB/GYN & Childbirth Emergencies – 10.170

NOTES & PRECAUTIONS:

Always consider the possibility of ectopic pregnancy in a woman of child bearing age (13 – 55) with abdominal pain or vaginal bleeding. The patient may decompensate quickly due to internal blood loss.

KEY CONSIDERATIONS:

Due date/prenatal care, last menstrual period, previous childbirth history, single or multiple birth, fetal heart tones, ruptured membranes, vaginal bleeding, contractions, cramping, edema or hypertension, abdominal pain, seizures

APGAR SCORE:	0	1	2
Appearance	Blue/Pale	Body pink, blue extremities	Completely pink
Pulse	Absent	Slow (< 100 bpm)	≥ 100 bpm
Grimace	No response	Grimace	Cough or sneeze
Activity	Limp	Some flexion	Active motion
Respirations	Absent	Slow, irregular	Good, crying

Normal Maternal Changes:

- HR increases 15-20 BPM
- B/P decreases 5-15mmHg 2nd tri
- Plasma increases 40%
 - Increase in clotting factors, increased risk of Pulmonary Embolus (PE)
- Hormones Progesterone and Relaxin relaxes sphincters
 - Increased risk of aspiration in intubation and RSI

Newborn Target Spo2 after birth:

1 min	60-65%
2 min	65-70%
3 min	70-75%
4 min	75-80%
5 min	80-85%
10 min	85-95%