

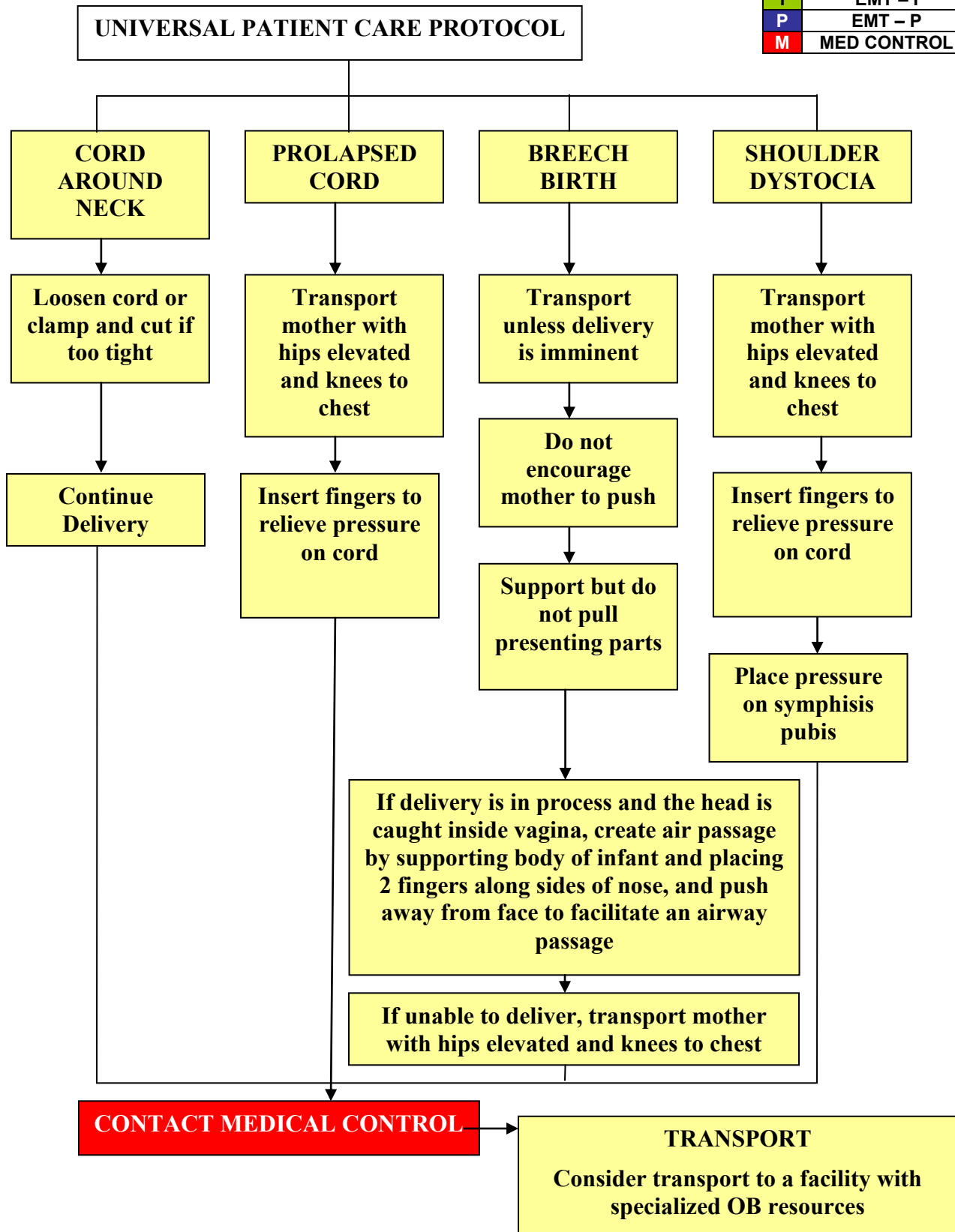
**CHILDBIRTH / OBSTETRICAL EMERGENCIES**

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# CHILDBIRTH / OBSTETRICAL EMERGENCIES

## ABNORMAL BIRTH EMERGENCIES

B	EMT - B	B
I	EMT - I	I
P	EMT - P	P
M	MED CONTROL	M



# CHILDBIRTH / OBSTETRICAL EMERGENCIES

## ABNORMAL BIRTH EMERGENCIES

**CONTACT MEDICAL CONTROL IMMEDIATELY WHEN ANY ABNORMAL BIRTH PRESENTATION IS DISCOVERED**

HISTORY	SIGNS AND SYMPTOMS	DIFFERENTIAL DIAGNOSIS
<ul style="list-style-type: none"> <li>Past medical history</li> <li>Hypertension meds</li> <li>Prenatal care</li> <li>Prior pregnancies / births</li> <li>Gravida / Para</li> <li>Ultrasound findings in prenatal care</li> </ul>	<ul style="list-style-type: none"> <li>Frank Breech (buttocks presents first)</li> <li>Footling Breech (one foot or both feet presenting)</li> <li>Transverse Lie (fetus is on his/her side with possible arm or leg presenting)</li> <li>Face First Presentation</li> <li>Prolapsed Cord (umbilical cord presents first)</li> </ul>	<ul style="list-style-type: none"> <li>Miscarriage</li> <li>Stillbirth</li> </ul>

## KEY POINTS

### General Information

- DO NOT pull on any presenting body parts.
- These patients will most likely require a c-section, so immediate transport is needed.
- Prolonged, non-progressive labor distresses the fetus and mother. Be sure to reassess mother's vital signs continuously.

### Cord Around Baby's Neck

- As baby's head passes out of the vaginal opening, feel for the cord. Initially try to slip cord over baby's head; if too tight, clamp cord in two places and cut between the clamps.

### Breech Delivery

- Footling Breech (one or both feet delivered first)
- Frank Breech (buttocks first presentation)
  - When the feet or buttocks first become visible, there is normally time to transport patient to nearest facility.
  - If upper thighs or the buttock have come out of the vagina, delivery is imminent.
  - If the child's body has delivered and the head appears caught in the vagina, the EMT must support the child's body and insert two fingers into the vagina along the child's neck until the chin is located. At this point, the two fingers should be placed between the chin and the vaginal canal and then advanced past the mouth and nose.
  - After achieving this position a passage for air must be created by pushing the vaginal canal away from the child's face. This air passage must be maintained until the child is completely delivered.

### Prolapsed Cord

- When the umbilical cord passes through the vagina and is exposed, the EMT should check cord for a pulse.
- The patient should be transported with hips elevated or in the knee chest position and a moist dressing placed around the cord.
- If umbilical cord is seen or felt in the vagina, insert two fingers to elevate presenting part away from cord, distribute pressure evenly when the occiput presents.
- DO NOT attempt to push the cord back. High flow oxygen and transport IMMEDIATELY.

### Shoulder Dystocia

- Following delivery of the head, the shoulder(s) become "stuck" behind the symphysis pubis or sacrum of the mother.
- Occurs in approximately 1% of births.

### Excessive Bleeding Pre-Delivery

- If bleeding is excessive during this time and delivery is imminent, in addition to normal delivery procedures, the EMT should use the Hypovolemic Shock Protocol.
- If delivery is not imminent, patient should be transported on her left side and Shock Protocol followed.

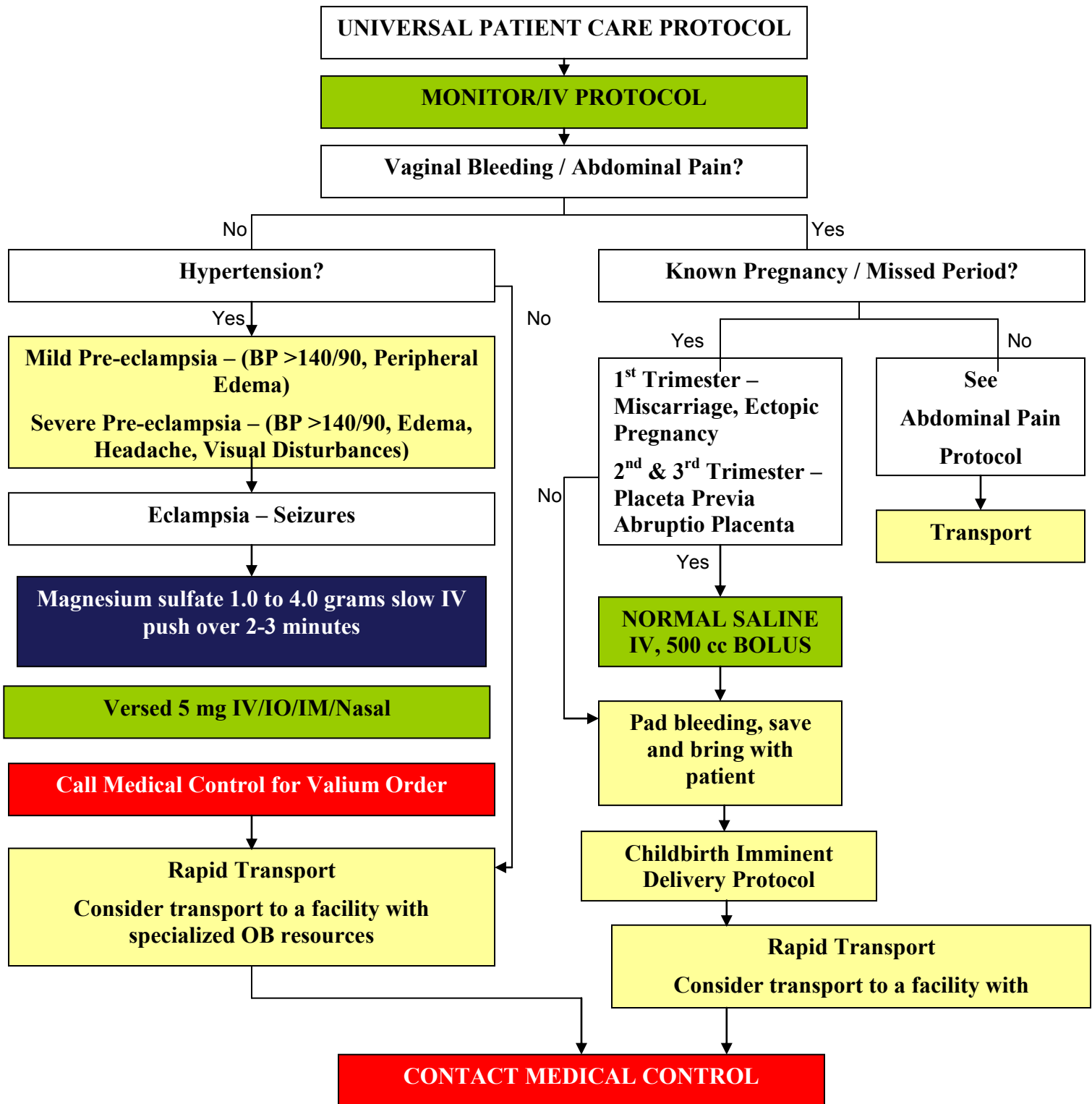
### Excessive Bleeding Post-Delivery

- If bleeding appears to be excessive, start IV of saline.
- If placenta has been delivered, massage uterus and put baby to mother's breast.
- Follow Hypovolemic Shock Protocol.

# CHILDBIRTH / OBSTETRICAL EMERGENCIES

## OBSTETRICAL EMERGENCIES

<b>B</b>	EMT - B	<b>B</b>
<b>I</b>	EMT - I	<b>I</b>
<b>P</b>	EMT - P	<b>P</b>
<b>M</b>	MED CONTROL	<b>M</b>



# CHILDBIRTH / OBSTETRICAL EMERGENCIES

## OBSTETRICAL EMERGENCIES

HISTORY	SIGNS AND SYMPTOMS	DIFFERENTIAL DIAGNOSIS
<ul style="list-style-type: none"> <li>• Past medical history</li> <li>• Hypertension meds</li> <li>• Prenatal care</li> <li>• Prior pregnancies / births</li> <li>• Gravida / Para</li> </ul>	<ul style="list-style-type: none"> <li>• Vaginal bleeding</li> <li>• Abdominal pain</li> <li>• Seizures</li> <li>• Hypertension</li> <li>• Severe headache</li> <li>• Visual changes</li> <li>• Edema of hands and face</li> </ul>	<ul style="list-style-type: none"> <li>• Pre-eclampsia / Eclampsia</li> <li>• Placenta previa</li> <li>• Placenta abruptio</li> <li>• Spontaneous abortion</li> </ul>

### KEY POINTS

#### General Information

- Exam: Mental Status, Abdomen, Heart, Lungs, Neuro.
- May place patient in a left lateral position to minimize risk of supine hypotensive syndrome if in late 2<sup>nd</sup> or 3<sup>rd</sup> trimester.
- Ask patient to quantify bleeding - number of pads used per hour.
- Any pregnant patient involved in a MVC should be seen immediately by a physician for evaluation and fetal monitoring.
- DO NOT apply packing to the vagina.
- Be alert for fluid overload when administering fluids.
- Consider starting a second IV if the patient is experiencing excessive vaginal bleeding or hypotension.
- Transport to an appropriate OB facility if the patient is pregnant.

#### Abortion/Miscarriage

- The patient may be complaining of cramping, nausea, and vomiting.
- Be sure to gather any expelled tissue and transport it to the receiving facility.
- Signs of infection may not be present if the abortion/miscarriage was recent.
- An abortion is any pregnancy that fails to survive over 20 weeks. When it occurs naturally, it is commonly called a "miscarriage."

#### Abruptio Placenta

- Usually occurs after 20 weeks.
- Dark red vaginal bleeding.
- May only experience internal bleeding.
- May complain of a "tearing" abdominal pain

#### Ectopic Pregnancy

- The patient may have missed a menstrual period or had a positive pregnancy test.
- Acute unilateral lower abdominal pain that may radiate to the shoulder.
- Any female of childbearing age complaining of abdominal pain is considered to have an ectopic pregnancy until proven otherwise.

#### Pelvic Inflammatory Disease

- Be tactful when questioning the patient to prevent embarrassment.
- Diffuse back pain.
- Possibly lower abdominal pain.
- Pain during intercourse.
- Nausea, vomiting, or fever.
- Vaginal discharge.
- May walk with an altered gait due to abdominal pain.

#### Placenta Previa

- Usually occurs during the last trimester.
- Painless.
- Bright red vaginal bleeding.

#### Post Partum Hemorrhage

- Post partum blood loss greater than 300-500 ml.
- Bright red vaginal bleeding.
- Be alert for shock and hypotension.

#### Uterine Inversion

- The uterine tissue presents from the vaginal canal.
- Be alert for vaginal bleeding and shock.

#### Pre-Eclampsia/Eclampsia

- Severe headache, vision changes, or RUQ pain may indicate pre - eclampsia.
- In the setting of pregnancy, hypertension is defined as a BP greater than 140 systolic and greater than 90 diastolic, or a relative increase of 30 systolic and 20 diastolic from the patient's normal (pre-pregnancy) blood pressure.

#### Uterine Rupture

- Often caused by prolonged, obstructed, or non-progressive labor.
- Severe abdominal pain.

#### Vaginal Bleeding

- If the patient is experiencing vaginal bleeding, DO NOT pack the vagina, pad on outside only.

# CHILDBIRTH / OBSTETRICAL EMERGENCIES

## UNCOMPLICATED DELIVERY

UNIVERSAL PATIENT CARE PROTOCOL

B	EMT - B	B
I	EMT - I	I
P	EMT - P	P
M	MED CONTROL	M

Observe Head Crowning

Contact Medical Control to Notify of Delivery

Prepare Patient for Delivery  
Set-Up Equipment

IV Protocol if Time  
Run Normal Saline at 150 ml/hour

### Delivery of Head

Firm, gentle pressure with flat of hand to slow expulsion.  
Allow head to rotate normally, check for cord around neck, and wipe face free of debris.  
Suction mouth and nose with bulb syringe.

### Delivery of Body

Place one palm over each ear with next contraction gently move downward until upper shoulder appears.  
Then lift up gently to ease out lower shoulder Support the head and neck with one hand and buttocks with other.  
**REMEMBER THE NEWBORN IS SLIPPERY**

### Newborn and Cord

Keep newborn at level of vaginal opening. Keep warm and dry.  
After 10 seconds, clamp cord in two places with sterile equipment at least 6-8" from newborn. Cut between clamps.

Allow placenta to deliver itself but do not delay transport waiting.  
**DO NOT PULL ON CORD TO DELIVER PLACENTA.** Take placenta to hospital with patient.

CONTACT MEDICAL CONTROL

TRANSPORT

Consider transport to a facility with specialized OB resources

# CHILDBIRTH / OBSTETRICAL EMERGENCIES

## UNCOMPLICATED DELIVERY

**CONTACT MEDICAL CONTROL IMMEDIATELY WHEN DELIVERY IS IMMINENT**

HISTORY	SIGNS AND SYMPTOMS	DIFFERENTIAL DIAGNOSIS
<ul style="list-style-type: none"><li>• Due date</li><li>• Time contractions started / how often</li><li>• Rupture of membranes</li><li>• Time / amount of any vaginal bleeding</li><li>• Sensation of fetal activity</li><li>• Past medical and delivery history</li><li>• Medications</li></ul>	<ul style="list-style-type: none"><li>• Spasmodic pain</li><li>• Vaginal discharge or bleeding</li><li>• Crowning or urge to push</li><li>• Meconium</li><li>• Left lateral position</li><li>• Inspect perineum (No digital vaginal exam)</li></ul>	<ul style="list-style-type: none"><li>• Abnormal presentation<ul style="list-style-type: none"><li>• Buttock</li><li>• Foot</li><li>• Hand</li><li>• Prolapsed cord</li></ul></li><li>• Placenta previa</li><li>• Abruptio placenta</li></ul>

### KEY POINTS

- Exam (of Mother): Mental Status, Heart, Lungs, Abdomen, Neuro.
- Document all times (delivery, contraction frequency, and length).
- If maternal seizures occur, refer to the Obstetrical Emergencies Protocol.
- After delivery, massaging the uterus (lower abdomen) will promote uterine contraction and help to control post-partum bleeding.
- Some perineal bleeding is normal with any childbirth. Large quantities of blood or free bleeding are abnormal.
- Prepare to deliver on scene (protecting the patient's privacy). If delivery becomes imminent while enroute, stop the squad and prepare for delivery.
- Newborns are very slippery, so be careful not to drop the baby.
- There is no need to wait on scene to deliver the placenta.
- If possible, transport between deliveries if the mother is expecting twins.
- Allow the placenta to deliver, but DO NOT delay transport while waiting.
- DO NOT PULL ON THE UMBILICAL CORD WHILE PLACENTA IS DELIVERING.

<b>MEDICATIONS</b>
<b>MAGNESIUM SULFATE</b>

P	EMT – P	P
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<i>ACTIONS</i>	Anticonvulsant Antiarrhythmic CNS depressant
<b>INDICATIONS</b>	Seizures secondary to eclampsia Ventricular ectopy refractory to Amiodarone Torsades Adjunct to alleviate acute asthma attack
<b>CONTRAINDICATIONS</b>	Renal disease Heart blocks
<b>SIDE EFFECTS</b>	Respiratory depression CNS depression Hypotension Cardiac arrest
<b>ADULT DOSAGE</b>	1.0 – 4.0 grams SLOW IVP over 2-3 minutes (Max dose 4 grams  Asthma dose 45mg/kg IV to a total of 75mg/kg
<b>KEY POINTS</b>	

Approx Mag Dose	
Child < 10	1 gram
Child 10 16	1 to 2

<b>MEDICATIONS</b>
<b>VERSED (Midazolam)</b>

I	EMT – I	I
P	EMT – P	P

<b>ACTION</b>	Sedative and hypnotic benzodiazepine Induces amnesia
<b>INDICATIONS</b>	Conscious sedation Seizure Facilitate intubation Facilitate pacing / cardioversion
<b>CONTRAINDICATIONS</b>	Intolerance to benzodiazepines Narrow-angle glaucoma Shock Coma
<b>SIDE EFFECTS</b>	<p><b>CNS</b> – amnesia, headache, dizziness, euphoria, confusion, agitation, anxiety, delirium, drowsiness, muscle tremor, ataxia, dysphoria, slurred speech, and paresthesia.</p> <p><b>Cardiovascular</b> – hypotension, PVC’s, tachycardia, vasocagel episode</p> <p><b>Eye</b> – blurred vision, diplopia, nystagmus, pinpoint pupils</p> <p><b>Respiratory</b> – coughing, bronchospasms, laryngospasm, apnea, hypoventilation, wheezing, airway, obstruction, tachypnea</p> <p><b>Skin</b> – swelling, burning, pain at the site of injection</p>
<b>ADULT DOSAGE</b>	2mg IV/IO max initial dose for sedation (may repeat as necessary) 5mg IV/IO max initial dose for seizures (may repeat as necessary) 5mg IV/IO for RSI and Violent Patients <b>Versed may be administered IM or nasally in actively seizing or violent patients whenever IV access is not achieved.</b>
<b>PEDIATRIC DOSAGE</b>	Seizures – 0.1mg/kg IV/IO/IM to a max dose of 5mg 0.2mg/kg Intranasal to a max dose of 10mg