OB/GYN EMERGENCIES

- **Routine Medical Care**
- Level of distress:
- Estimate blood loss (if any)
- Is the patient in shock? If yes, Go to the Shock: Hypovolemia/Cardiogenic protocol page 154
- Consider immediate transport or prepare for delivery
- Determine stage (trimester) of pregnancy
- Any patient that is ≥ 20 weeks pregnant who has sign(s)/symptom(s) that may be pregnancy related (e.g. ABD
- pain), should be preferentially triaged to a receiving facility with a Labor and Delivery department.

1. **VAGINAL BLEEDING** (Abnormal bleeding between menses, during pregnancy, postpartum or post operative)
   1.1 If postpartum, gently massage the fundus to decrease bleeding
   1.2 Monitor vital signs frequently
2. **SPONTANEOUS ABORTION**
   2.1 If fetus is > 20 weeks or 500 grams, see neonatal resuscitation protocol (**page 73**). If non-viable, save and transport any tissue or fetal remains
   2.2 Have patient place a sanitary napkin or bulky dressing material over vaginal opening - **Do not pack the vagina *with anything***
3. **SEVERE PRE-ECLAMPSIA / ECLAMPSIA**
   3.1 Inclusion Criteria:
      3.1.2 More than 20- weeks' gestation, presenting with hypertension
      and evidence of end organ dysfunction including renal insufficiency, liver
      involvement, neurological, or hematological involvement
   3.2 May occur up to 6 weeks postpartum but is rare after 48 hours post-delivery
   3.3. Often the presenting symptom of postpartum pre-eclampsia is headache or SOB
   3.4. Severe Features of pre-eclampsia include:
      3.4.1. Severe hypertension (SBP greater than 160, DBP greater than 110)
      3.4.2. Headache
      3.4.3. Confusion/altered mental status
      3.4.4. Vision changes including blurred vision, spots/floaters, loss of vision (these
      symptoms are often a precursor to seizure)
      3.4.5. Right upper quadrant or epigastric pain
   3.5. Shortness of breath/pulmonary edema
   3.6. Ecchymosis suggestive of low platelets (bruising, petechiae)
   3.7. Vaginal bleeding suggestive of placental abruption
   3.8. Focal neurologic deficits suggesting hemorrhagic or thromboembolic stroke
   3.9. Observe for seizures, hypertension or coma, if seizing, go to the appropriate seizure protocol
4. **BREECH DELIVERY**
   4.1 Allow delivery to proceed passively until the baby's waist appears. Gently rotate the baby to a face down position and continue with the delivery
   4.2 If the head does not readily deliver insert a gloved hand into the vagina to relieve pressure on the cord and create an air passage for the infant. Transport. Monitor vital signs and infant condition frequently
5. **PROLAPSED CORD**
   5.1 Place the mother supine position with head lower than hips
   5.2 Insert a gloved hand into the vagina and gently push the presenting part (e.g.: the neonate's head or shoulder off the cord. **DO NOT TUG ON THE CORD**

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5.3 Place fingers on each side of the neonate's nose and mouth, split fingers into a "V" to create an opening. **Do not** attempt to re-position the cord. **Do not** remove your hand. Cover the exposed cord with saline soaked gauze

6. **LIMB PRESENTATION**

6.1 Defined as the presentation of a single limb - arm or leg

6.2 It is unlikely that the baby will deliver and immediate transport should be initiated

6.3 Place the mother supine position with head lower than hips

7. **SHOULDER DYSTOCIA**

7.1 Hyperflex mother's hips by firmly pressing knees to hips (McRoberts Maneuver).

7.2 Second provider applies suprapubic (not fundal) pressure with fist directed downwards to dislodge anterior shoulder

7.3 Third provider providers gentle downward traction on fetal head. Do NOT pull fetal head.

7.3.1 If unsuccessful, initiate immediate transport and communicate issue of concern over ring down "shoulder dystocia".

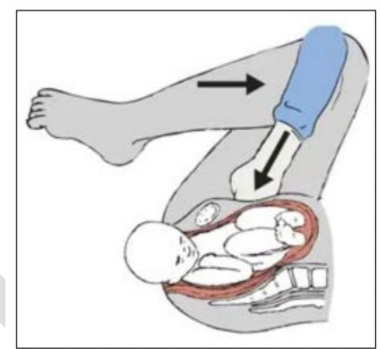

Figure 3. The McRoberts Maneuver: Hyperflexion of Hips & SUPRAPUBIC Pressure
(Adapted from: teachmeobgyn.com)

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