Clinical Practice Guidelines:
Obstetrics/Shoulder dystocia

All feedback and suggestions are welcome, please forward to: Clinical.Guidelines@ambulance.qld.gov.au

Date	April, 2017
Purpose	To ensure consistent management of Shoulder dystocia.
Scope	Applies to all QAS clinical staff.
Author	Clinical Quality & Patient Safety Unit, QAS
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Information security	This document has been security classified using the Queensland Government Information Security Classification Framework (QGISCF) as UNCLASSIFIED and will be managed according to the requirements of the QGISF.
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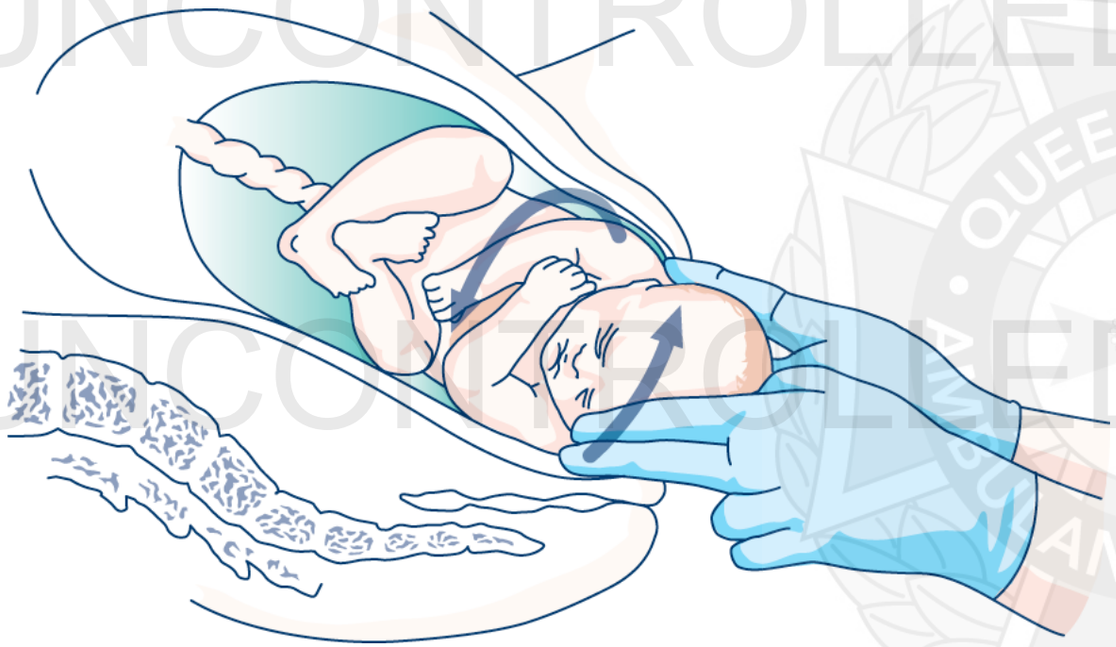
Shoulder dystocia

In **shoulder dystocia**, disproportion occurs between the bisacromial diameter of the foetus and the antero-posterior diameter of the pelvic inlet, resulting in impaction of the anterior shoulder of the foetus behind the symphysis pubis.[1] Difficult delivery ensues, requiring the use of additional manoeuvres beyond the downward traction of the foetal head. It is relatively uncommon, occurring in 1 in 300 births.

Shoulder dystocia – woods screw manoeuvre



Shoulder dystocia is associated with serious complications for both the mother and baby.[1] Perinatal morbidity includes asphyxia, birth trauma such as brachial plexus injury and fractured clavicles, and permanent neurological damage. Foetal death can also occur if not recognised immediately and treated promptly.[2]

Clinical features

Shoulder dystocia usually becomes obvious after the foetal head emerges and retracts up against the perineum, failing to undergo external rotation *(turtle sign)*.[3]

Shoulder dystocia is confirmed when the standard delivery manoeuvres (traction in a lengthwise trajectory) fail to deliver the foetus and the head to body delivery interval is prolonged ≥ 60 seconds.[4]

Risk assessment

An increased risk of shoulder dystocia is reported in association with:

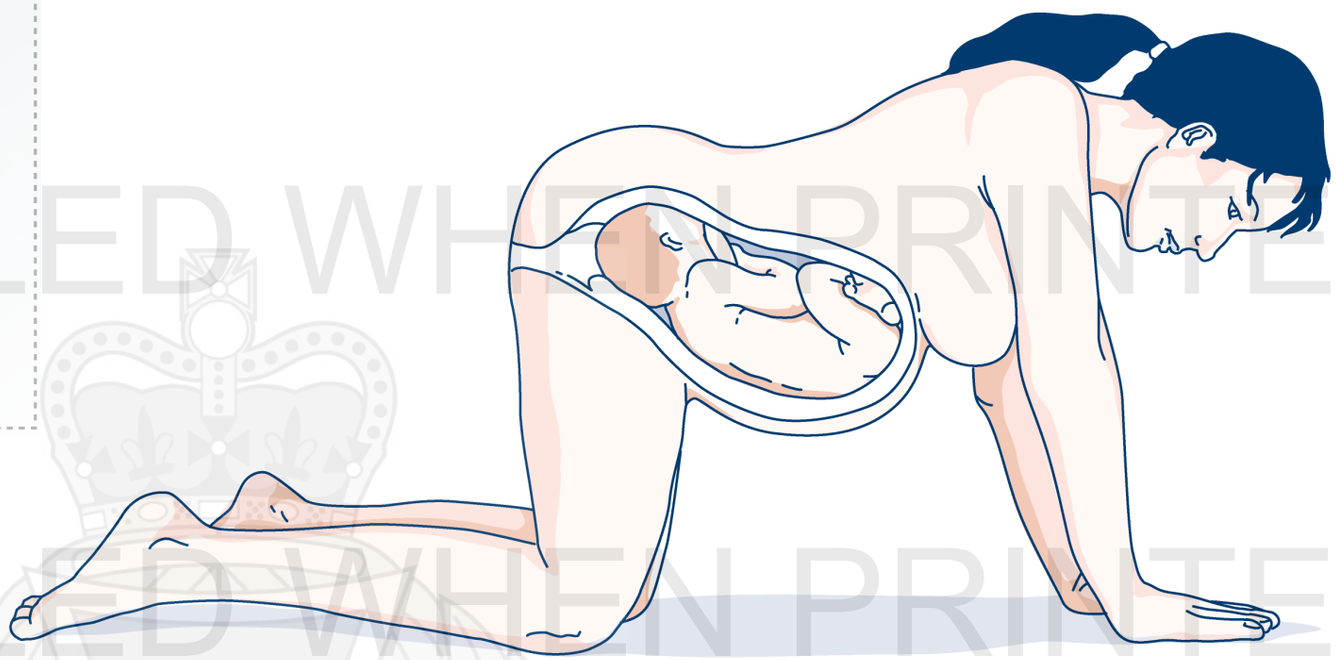
- prolonged second stage of labour
- assisted delivery
- maternal diabetes with or without macrosomia
- previous shoulder dystocia
- a large foetus > 4.5 kg (macrosomia)
- history of a large foetus
- maternal obesity
- multiparity.

Any combination of the above factors may significantly increase the risk of shoulder dystocia.[5]

Additional information

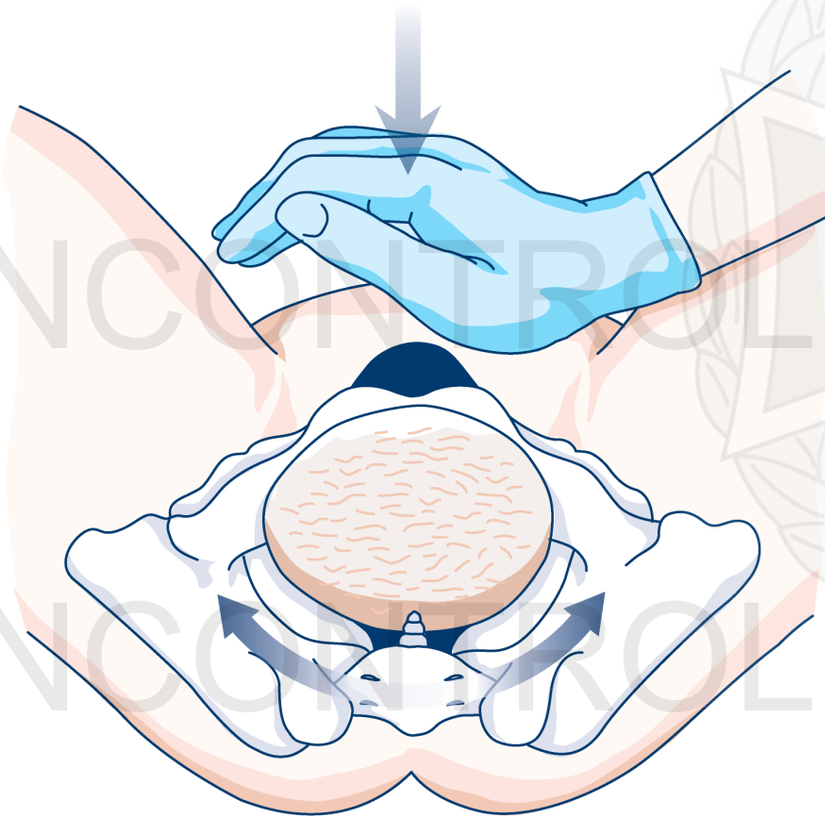
External manoeuvres include the following:

- McRoberts manoeuvre
- Rubin I manoeuvre (supra pubic pressure)
- Rotation onto all fours

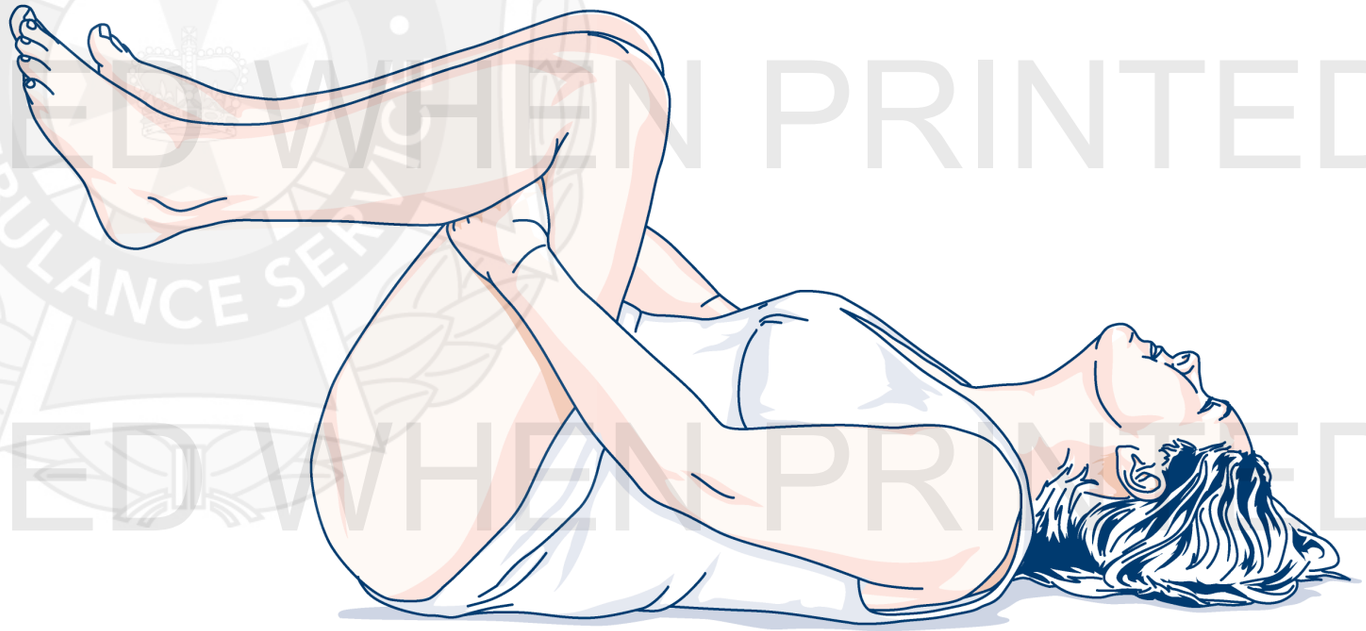


Rotation to all fours

Apply downward pressure
just superior to the symphysis pubis
in a continuous or rocking motion



Rubin I manoeuvre (supra pubic pressure)



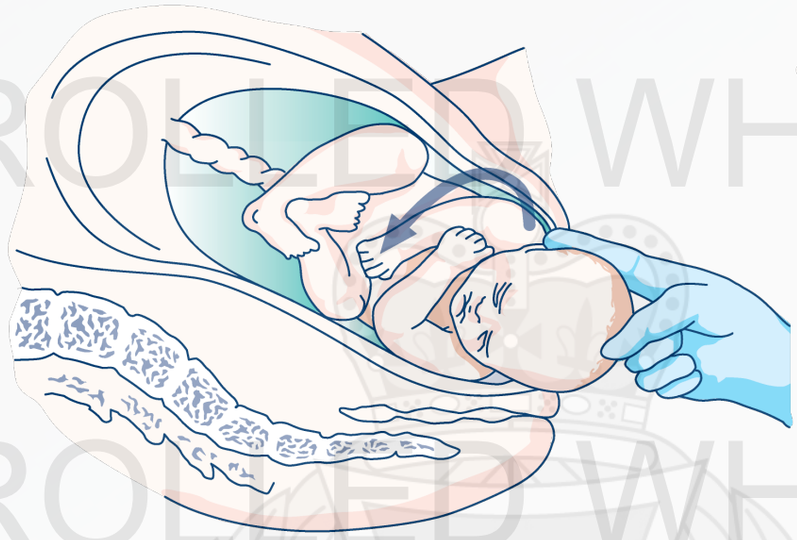
McRoberts manoeuvre

Additional information *(cont.)*

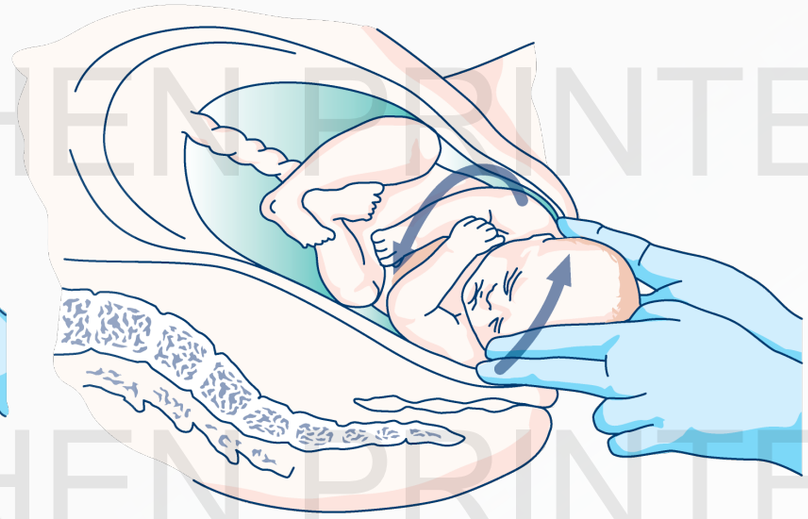
Internal manoeuvres: manipulation of the foetus within the birth canal includes:

- Rubin II manoeuvre
- Woods Screw manoeuvre
- Reverse woods screw manoeuvre
- Deliver of posterior arm

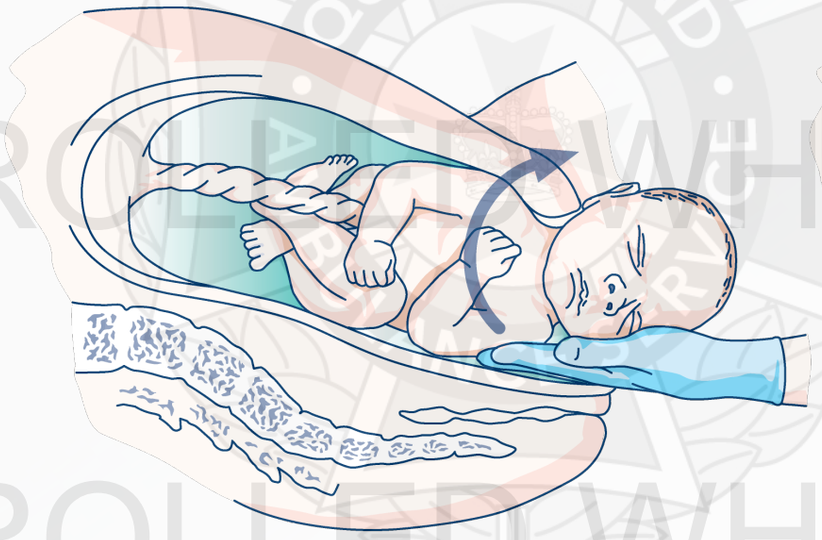
NOTE: *Paramedics must exhaust all external manoeuvres first before undertaking the manipulation of the foetus within the birth canal. A description of each of these techniques is given in* ***CPP: Shoulder dystocia****. Always consider appropriate pain relief as required.*



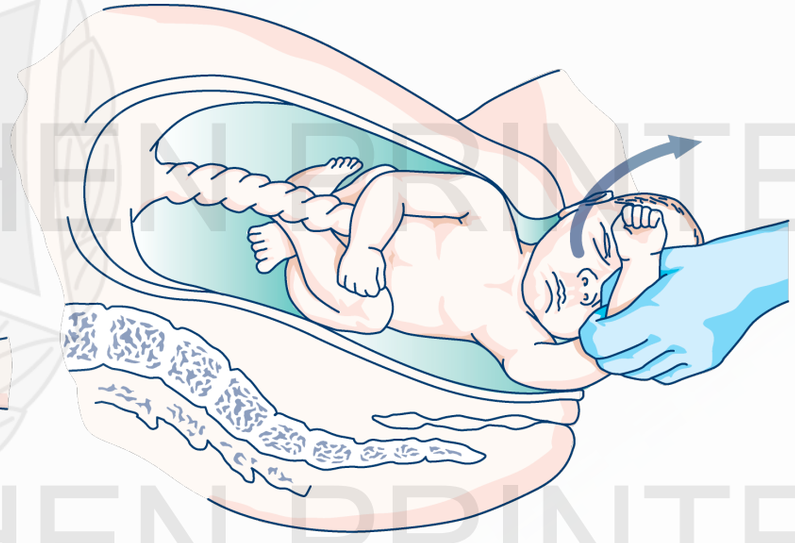
Rubin II manoeuvre



Woods screw manoeuvre



Reverse woods screw manoeuvre



Delivery of posterior arm

CPG: Paramedic Safety
CPG: Standard Cares

Recognise shoulder dystocia

- Turtle sign foetal shoulder fail to deliver because anterior shoulder is struck behind maternal symphysis pubis)
- Failure to deliver head to body delivery interval is > 60 seconds.

Note: *Officers are only to perform procedures for which they have received specific training and authorisation by the QAS*

Maternal Position:

- ask mother to lie flat, then assist to move into running start position, then alternate to all fours.

Consider:

- need for back up
- prepare for newly born resuscitation
- urgency
  - start time when shoulder dystocia is recognised
  - aim to birth baby within 4 minutes
- pain relief
- external manoeuvres **BEFORE** attempting internal manoeuvres
- contractions may stop, synchronise with interventions if still occurring

Note: *Paramedics must exhaust all external manoeuvres first before undertaking the manipulation of the foetus within the birth canal. A description of each of these techniques is given in CPP: Shoulder dystocia. Always consider appropriate pain relief as required.*

External Manoeuvres: maintain urgency when carrying out manoeuvres

- McRoberts manoeuvres (bring her knees up towards her chest, thighs to abdomen)
  - if shoulders do not release after 30 seconds move to next step
- Rubin's I manoeuvre, (Suprapubic pressure applied in downwards and in lateral direction)
  - if shoulders do not release after 30 seconds move to next step
- All fours position (move mother onto 'all fours', encourage mother to push to release shoulders)
  - if shoulders do not release after 30 seconds move to next step

Successful?

Y → Assess immediately post-delivery is the neonate breathing or crying with good muscle tone and HR > 100

Conduct post-delivery assessment and cares:

- dry baby
- maintain warmth
- provide maternal and neonate skin to skin contact
- clamp and cut the cord, whenstops pulsating
- APGAR score at 1 & 5 min
- encourage breastfeeding

N

Internal manoeuvres

- Rubin II (using fingers apply pressure behind the anterior shoulder, pushing the shoulder towards the baby's chest)
- do not pull downwards or twist foetal neck at any time
- woods screw
- reverse woods screw
- delivery of posterior arm

Consider:

- gaining consent
- timing
- do not spend too long on each manoeuvre
- code one transport to obstetrics unit

Manager as per:

CPP: Resuscitation newly born

Transport to hospital
Pre-notify as appropriate