OBSTETRICAL/GYNECOLOGICAL EMERGENCIES/CHILDBIRTH

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Vaginal Bleeding

Subjective Findings:

- Abdominal Pain
- Estimate Blood Loss
    - Duration of bleeding
    - Quality of bleeding
    - Number of pads per hour
- Last menstrual period
- For known pregnancy – How many weeks/months?
- Estimated due date

Objective Findings:

- Blood Pressure
- Vaginal bleeding
    - with possible products of conception: Collect and transport with the patient
- Observe for signs of shock

  Treatment:
    - Consider second IV access
    - If hypotensive (SBP<90 or signs of poor perfusion), fluid challenge of 250-1000 ml NS IV. If SBP remains <90 continue fluid resuscitation. Titrate to SBP of 90 or symptoms of improved perfusion
    - Keep NPO
    - Place pad or large dressing over vaginal opening if bleeding
    - Save and transport all tissue or fetal remains
    - If pregnant and over 20 weeks, transport to facility with OB capabilities and don't encourage delivery

Pre-eclampsia or Eclampsia

Objective Findings:

- Hypertension (BP > 140/90, or SBP > 30 mm Hg above baseline, or DBP >15 mm Hg above baseline)
- Over 20 weeks pregnant
- Altered mental status, blurred vision, headache, or seizures
- Pedal edema

  Treatment:
    - High flow oxygen
    - IV access
    - Minimize stimulation (lights, noise, other stressors)

- Left lateral decubitus position
- For seizures, midazolam (Versed®):
  - 1-2 mg IV/IO. May repeat every 5 minutes, up to a maximum dose of 10 mg
  - 1-5 mg IN. May repeat in 10 minutes up to a maximum dose of 10 mg.
  - Monitor the patient's EKG monitor and pulse oximetry after administration.

Childbirth

Information Needed:

- Estimated due date, last menstrual period
- Anticipated problems (multiple fetuses, premature delivery, placenta previa, lack of prenatal care, use of narcotics or stimulants, etc.)
- Gravida/para
- Onset of regular contractions
- Rupture of membranes, color of fluids, time of rupture
- Frequency and duration of contractions
- Urge to bear down or have bowel movement

Objective Findings:

Observe perineal area for:

- Fluid or bleeding
- Crowning (check during contraction)
- Abnormal presentation (breech, extremity, cord)

Treatment:

- Routine medical care
- Oxygen as indicated
- If birth is not imminent, place patient in left lateral position
- IV access when appropriate

Normal Delivery

Treatment:

- Assist with delivery
- Clean, preferably sterile technique
- Control and guide delivery of baby's head and body
- Check for nuchal cord - slide overhead if possible: If tight, double clamp and cut, unwind, then deliver baby quickly
- Keep the baby at or below the level of the mother until the cord is clamped
- Suction mouth, then nares
- Double clamp and cut cord
- Dry and wrap infant for warmth (especially the head); if possible place with the mother for shared body heat
- Note time of delivery

- Assess infant's status, respirations and pulse rate (APGAR if possible)
- Evaluate mother post-delivery for excessive bleeding

Post-partum hemorrhage

Treatment:

- Fundal massage
- Fluid challenge, 250-1000 ml Normal Saline

Breech Delivery

Treatment:

- Provide airway with gloved hand for baby if needed
- If unable to deliver or delivery is not imminent, place patient in left lateral Trendelenburg position and transport rapidly
- In the setting of a limb presentation, do not pull on the delivered extremity

Prolapsed Cord

Treatment:

- Left lateral Trendelenburg position and elevate hips when possible
- If the cord is pulseless, manually displace presenting part above the cord
- Avoid manipulation of the cord, cover with a moist sterile dressing, and try to keep cord warm by keeping it close to the patient's body
- Rapid transport

Precautions and Comments:

- Ectopic pregnancy should be considered in all women of childbearing age with either abdominal pain or vaginal bleeding.
- Eclampsia can occur up to a week after delivery
- The first priority in childbirth is assisting the mother with delivery of the child
- The primary enemy of a newborn is hypothermia and can occur within minutes
- Consider early suctioning after delivery of the infant with evidence of meconium
- Do not pull on the cord
- Do not delay transport for delivery of placenta. If placenta delivers, then place it in a plastic bag for transport with the mother
- If hemorrhage is present prior to delivery in a patient who is near term, consider emergencies such as placental abruption, placenta previa, and uterine rupture. Treat with IV fluids (consider a second IV) and rapid transport to an appropriate hospital
- Massage fundus after delivery of placenta