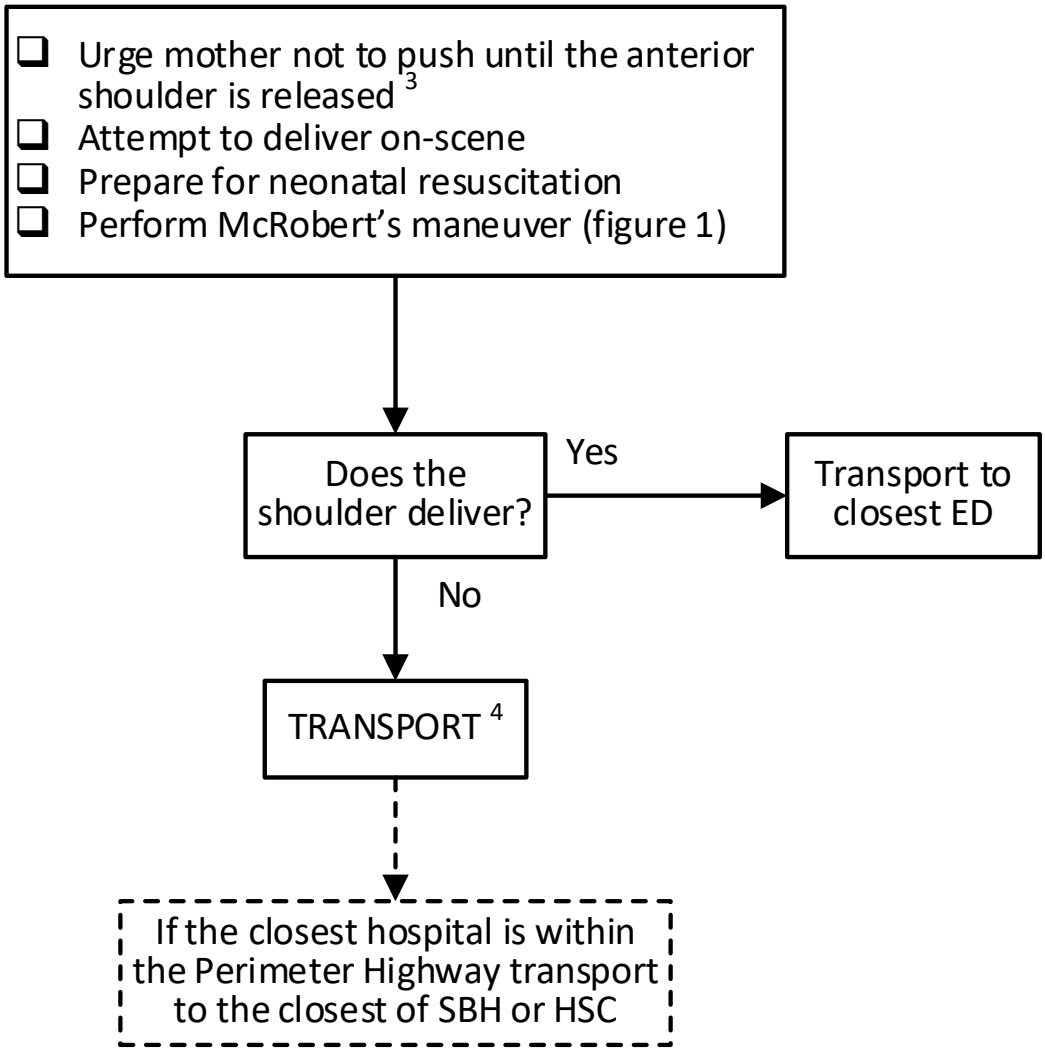
Shared health Soins communs Manitoba	**D05 - SHOULDER DYSTOCIA**
	MATERNAL & NEWBORN CARE
Version date: 2023-07-10	Effective date: 2024-02-13 (0700)



IDENTIFIER:	**EMR:** EMR only	**PCP:** PCP & ICP	**ICP:** ICP only	None - All providers

QRG: OBSTETRICAL FACILITIES

(*) Paramedics should call ahead to confirm that normal obstetrical services are currently available.

- Bethesda Regional Health Centre (Steinbach)
- Boundary Trails Health Centre (Winkler)
- Brandon Regional Hospital
- Dauphin Regional Health Centre
- Health Sciences Centre (Winnipeg)
- Lake of the Woods District Hospital (Kenora, ON) *
- Neepawa Health Centre
- Portage District General Hospital (Portage La Prairie)
- Selkirk Regional Health Centre (Selkirk)
- St. Anthony's General Hospital (The Pas)
- St. Boniface Hospital (Winnipeg)
- Thompson General Hospital
- Yorkton Regional Health Centre (Yorkton, SK) *

INDICATIONS

- Known or suspected shoulder dystocia during delivery [2]

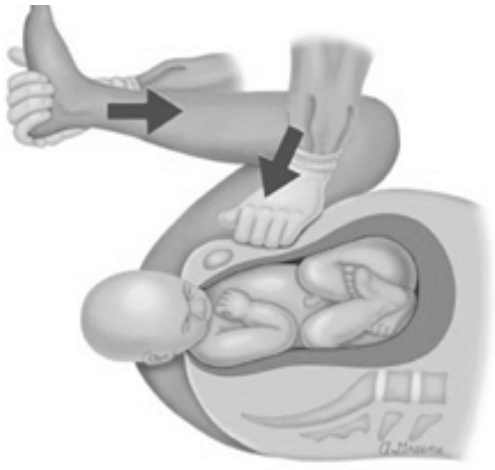
CONTRAINDICATIONS

- None

NOTES

1. Obstetrical emergencies are fortunately rare but can be very stressful. Be prepared and call early for assistance or intercept. Consult on-line medical support (OLMS).
2. Shoulder dystocia is a clinical diagnosis that should be suspected when any of the following occurs:
   a. The fetal body fails to deliver within 60 seconds of the head delivering (normally this takes under 30 seconds).
   b. The fetal head is expulsed during a contraction, but then retracts into the perineum between compressions (turtle sign).
   c. The usual gentle downward traction on the fetal head fails to accomplish delivery of the shoulders.

2. Delivery will not complete until the anterior shoulder is released from behind the pubic symphysis. Pushing by the mother, excessive traction on the fetus, or fundal pressure may worsen dystocia by wedging the shoulder against the maternal pelvis.
3. If unable to deliver with the McRobert's procedure, the preferred destination is an obstetrical facility where staff have expertise and resources to manage shoulder dystocia and experience with neonatal resuscitation (QRG). However, if the transport time is excessive initial care may have to be provided at a non-obstetrical facility. Ensure pre-arrival notification.
4. Paramedics with advanced care paramedic (ACP) registration, prior training, and competency *may* be able to deliver the posterior arm (appendix A) or shoulder (appendix B) with a delegation from and direct supervision by OLMS. This may be life saving for the fetus.
5. Clavicular or humeral fractures can occur (20%) but generally heal without compromise in function.

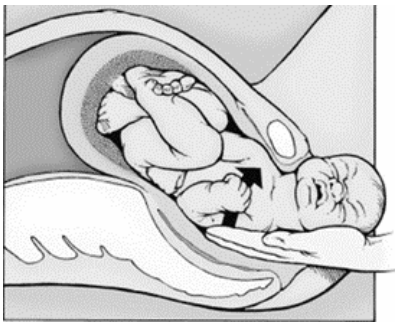
FIGURE 1 - McROBERT'S MANEUVER
 This is best accomplished by two or more providers. Step #1: **Flex the maternal hips well back onto the abdomen to achieve a "knees-to-chest" position.** This improves pushing efficiency and will often relive shoulder dystocia by rotating the maternal symphysis up over the fetal shoulder and flattening the sacrum. Step #2: **Apply suprapubic pressure with the palm of your hand directing the anterior shoulder down and laterally.** This will bring the shoulders into an oblique plane, which is the widest diameter of the pelvis. Avoid fundal pressure as this will force the anterior shoulder further under the pubic symphysis. Step #3: **Provide gentle in-line traction on the fetal head.** Excessive traction will force the shoulder against the symphysis and may cause fetal injury. After release of the shoulder, normal traction should allow delivery.

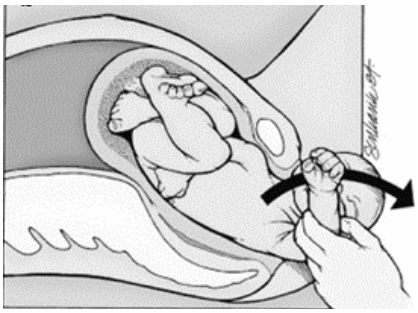
LINKS
D03 - NEWBORN CARE & RESUSCITATION

APPROVED BY	
	
EMS Medical Director	EMS Associate Medical Director

VERSION CHANGES (refer to X04 for change tracking)
• Identifier legend at bottom of flow chart replaces work scope statement in header

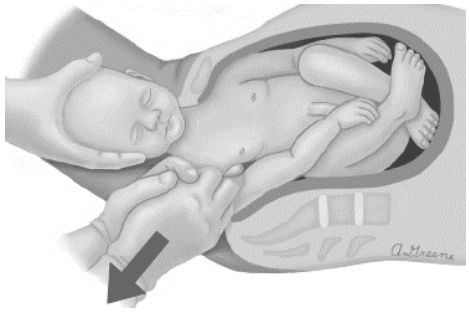
APPENDIX A - DELIVERY OF THE POSTERIOR ARM





1. Place one hand into the vagina along the posterior arm.
2. Grasp the forearm or elbow.
3. Ensure the elbow is flexed.
4. Sweep the arm across and up the fetal chest.
5. Deliver the posterior arm and shoulder. This should allow the anterior shoulder to slip out from under the maternal symphysis pubis.
6. If unable to reach the arm because it remains above the pelvic brim, it may be possible to deliver the posterior shoulder by axillary traction (appendix B).

APPENDIX B - AXILLARY TRACTION FOR DELIVERY OF THE POSTERIOR SHOULDER



1. Have another provider gently flex the fetal head towards the anterior shoulder.
2. Overlap the middle fingers of each hand in the posterior fetal axilla.
3. Pull the posterior shoulder downward along the curve of the maternal sacrum and then out.
4. The posterior arm can then be delivered.