Reference Number: *UHBOBS125* **Version Number:** 3	**Date of Next Review:** *Nov 2020* **Previous Trust/LHB Reference Number:**

Shoulder Dystocia

Introduction and Aim

Objectives

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Scope
All births affected by Shoulder Dystocia in the CLU and MLU.

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	
Approved by	*Maternity Professional Forum*

Accountable Executive or Clinical Board Director	*Ruth Walker, Executive Nurse Director*
Author(s)	*Pina Amin, Consultant Obstetrician and Gynaecologist* *Henry Cole, Senior Trainee Obstetrician*

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	*June 2011*	*June 2011*	
2	June 2014	June 2014	

3	27/11/2017	15/01/2018	Updated and amended by Henry Cole and Pina Amin

PRINTED DOCUMENTS MUST NOT BE RELIED ON

Contents Page

SHOULDER DYSTOCIA Overview

Defined as: "Shoulder dystocia is defined as a vaginal cephalic delivery that requires additional obstetric manoeuvres to deliver the fetus after the head has delivered and gentle traction has failed" There is wide variation in the reported incidence of shoulder dystocia but it occurs between 0.58 and 0.70% of vaginal births.[1-2]

Risk factors:

Pre-labour	**Intrapartum**
Previous shoulder dystocia	Prolonged first stage of labour
Macrosomia >4.5kg	Secondary arrest
Diabetes Mellitus	Prolonged second stage of labour
Maternal obesity	Oxytocin augmentation
Induction of Labour	Instrumental delivery

Aetiology Failure of the fetal shoulder(s) to enter the pelvic inlet.

Management: There are numerous manoeuvres that can be used to resolve shoulder dystocia. The most commonly used algorithms are those advocated by the RCOG and ALSO (Advanced Life Support in Obstetrics). These can be found in appendix 1 and 2 respectively.

OBJ

1. Shoulder Dystocia in the CLU and MLU

1. Recognise the problem and don't panic.

2. Note delivery time of the fetal head.

3. Summon assistance, midwifery, obstetric, paediatric and anaesthetic staff. Use the emergency buzzer if on CLU or if on the MLU then phone 2222. Avoid fundal pressure and extensive traction on the fetal neck as this increases morbidity(2).

4. Try the McRoberts manoeuvre Use an exaggerated lithotomy position with the mothers' thighs flexed and abducted almost touching the maternal abdomen. *See appendix 3.*
   Explain the procedure to the mother. Flatten the bed and bring the buttocks to the edge of the bed.

5. Apply pressure suprapubically (**not** fundal) aiming to displace the fetal anterior shoulder to one side under the pubic symphysis and reducing the presenting diameter of the shoulder girdle. An assistant should apply suprapubic pressure from the side of the fetal back (if this is known). There is no evidence that rocking is better than continuous pressure when performing suprapubic pressure, or that it should be performed for 30 seconds in order to be effective.(1) *See appendix 4.*

6. Perform an episiotomy. Although this doesn't increase space for delivery it allows other manoeuvres to be attempted more easily.

   There is no evidence demonstrating that internal rotational manoeuvres are superior to delivering the posterior arm in order to deliver the shoulders of the baby or that one should be attempted before the other.

7. Internal rotational manoeuvres. Rotation can be achieved by pressing on the anterior or posterior aspect of the posterior shoulder. Rotation should move the shoulders into the wider oblique diameter, this resolving the shoulder dystocia. If pressure on the posterior shoulder is unsuccessful then apply pressure on the anterior fetal shoulder.

8. Attempt to deliver the posterior shoulder by inserting your hand into the sacral hollow and identify the posterior humerus. Follow this up and grasp the forearm, bringing it down over the fetal chest and use this arm to rotate the baby in the direction it is facing, bringing the anterior shoulder into the pelvis. If necessary, repeat this with the other arm.

9. All fours position (if appropriate) or repeat the above.

10. If all else fails then the following can be considered:

    -Cleidotomy, fracturing the clavicle in order to decrease the bisacromial diameter.

    -Zavanelli manoeuvre. If all else fails and the baby is still alive flex and replace the head in the vagina and proceed to emergency caesarean section. Consider giving Tocolysis-Terbutlaine.

    -Symphysiotomy

    There is no evidence that each manoeuvre should be attempted for a set amount of time before moving on to the next. If one technique is not working, then move on to the next.

    Fundal pressure and excessive downward traction of the fetal head should be avoided as these are both associated with high rates of brachial plexus injury.[2]

A documentation sheet should be used during the emergency and to record important details of the delivery. An example scribe sheet can be found in appendix 5

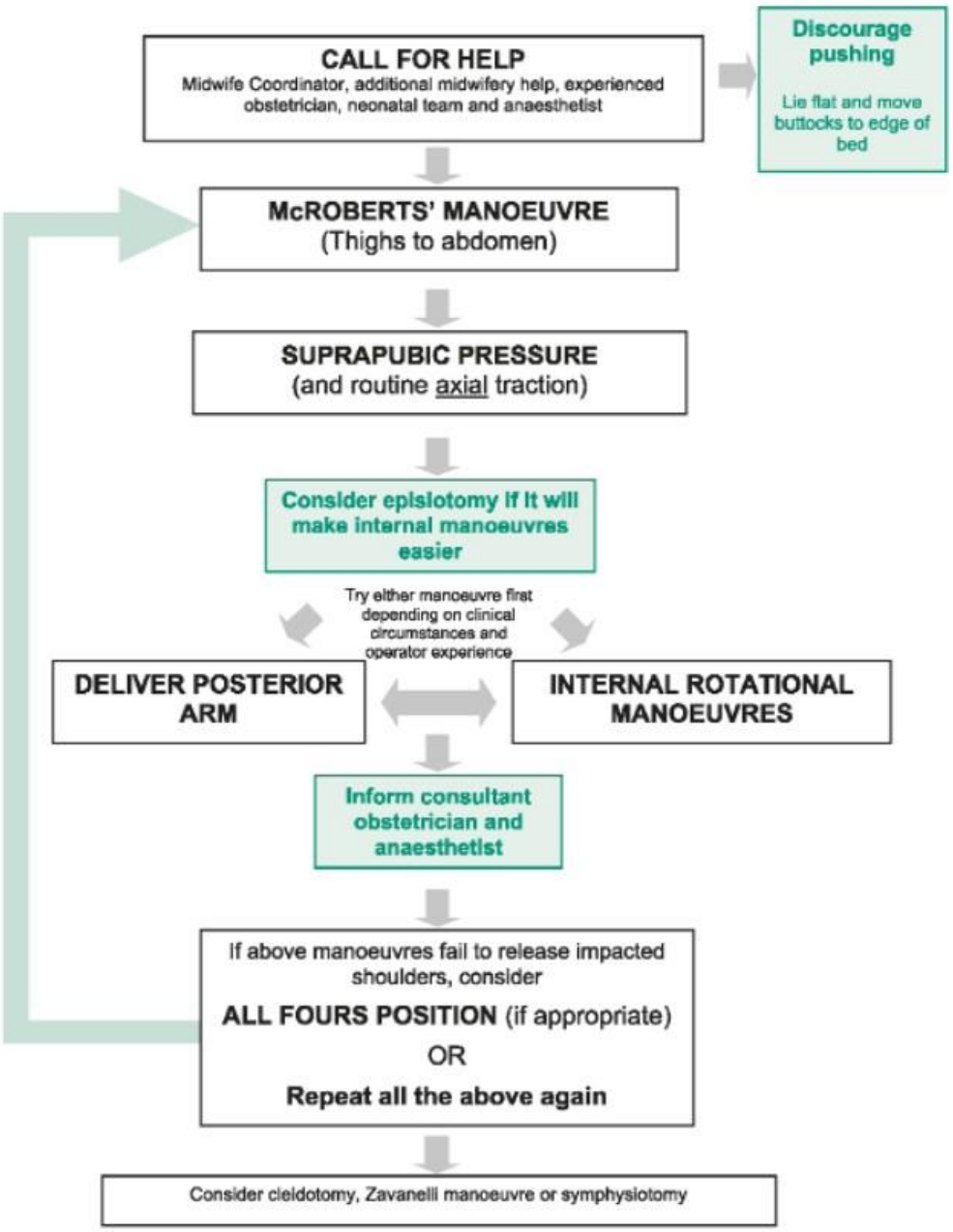
All attendants must be prepared for PPH/neonatal resuscitation. If on the MLU then follow guidelines for obstetric / neonatal transfer to Consultant Led Unit.

References:

1 ROCG Guideline No. 42 March 2012.
2 PROMPT, Practical Obstetric Multi-Professional Training Course. Manual, 2nd edition, published 2016 by Cambridge University Press
3 ALS Advanced Life Support Obstetrics (2000) Provider Training Manual p 149-155.
4 http://www.shoulderdystociainfo.com

Appendix 1(1)

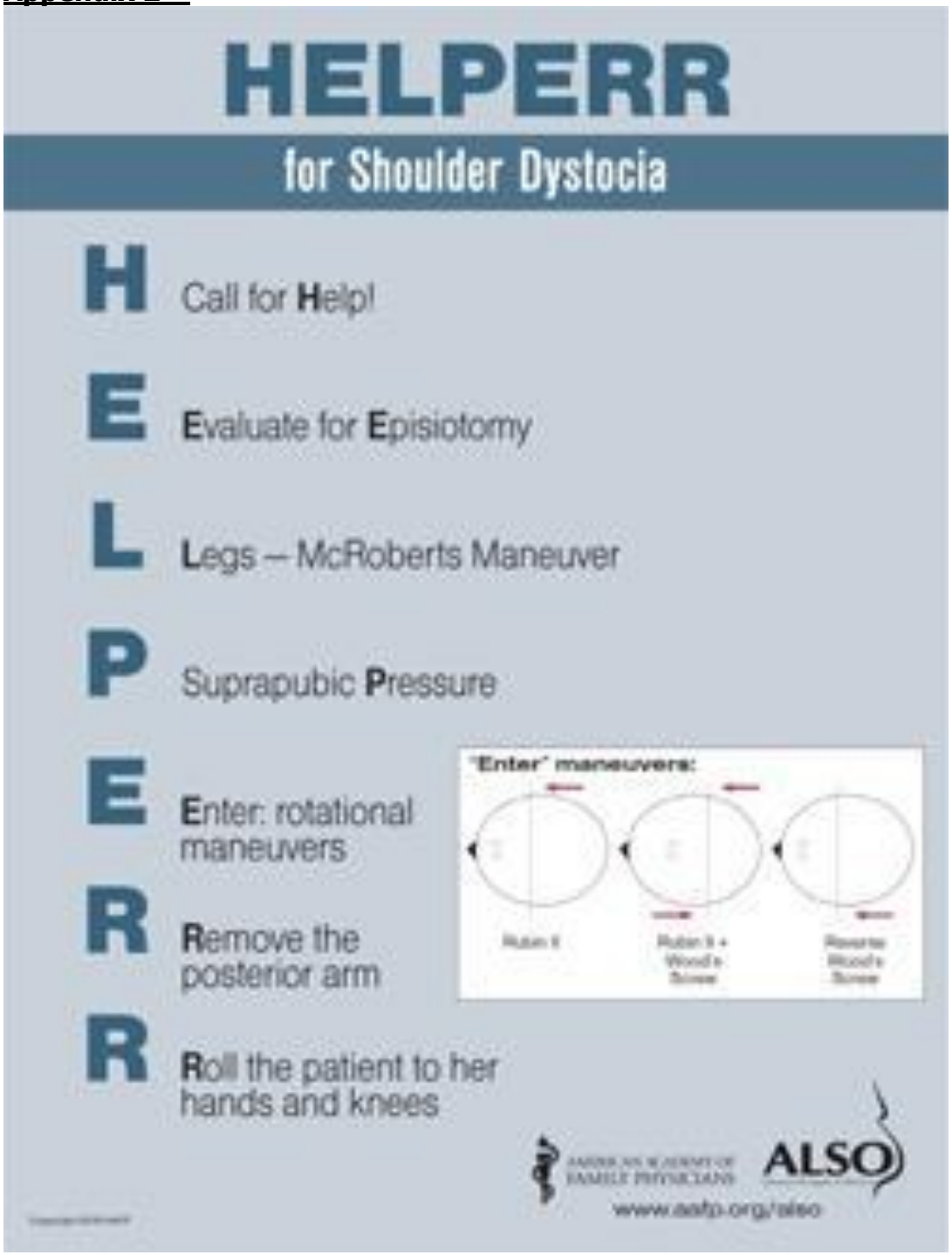
Algorithm for the management of Shoulder Dystocia



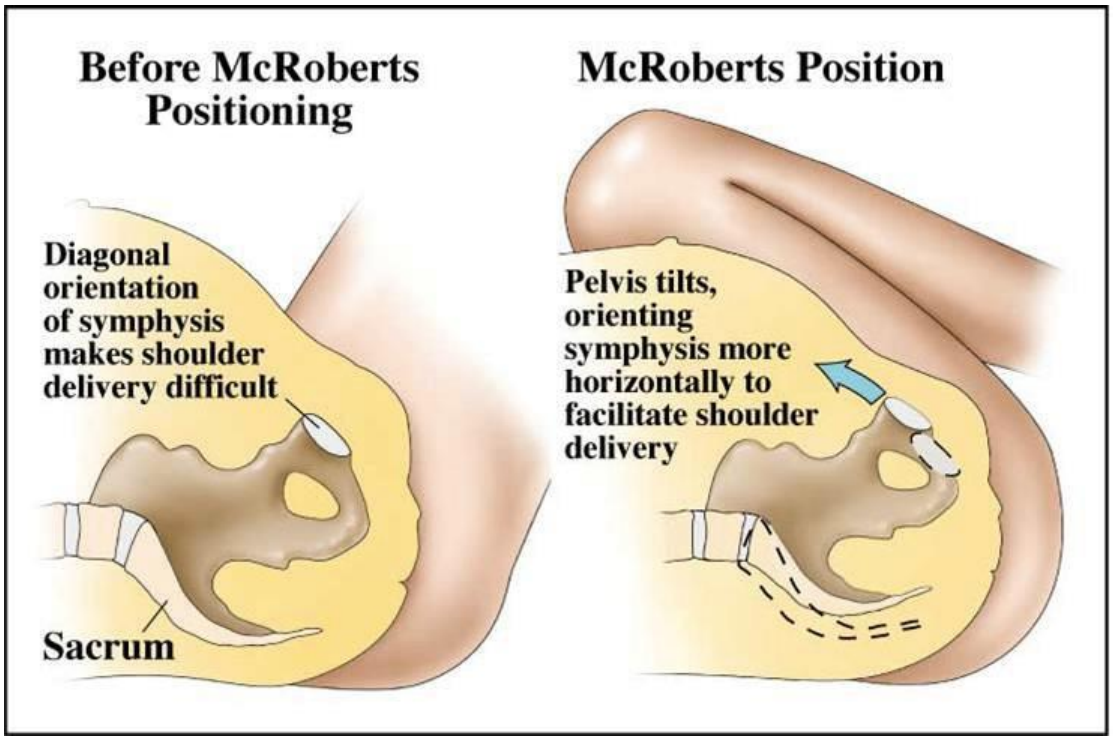
Baby to be reviewed by neonatologist after birth and referred for Consultant Neonatal review if any concerns

DOCUMENT ALL ACTIONS ON PROFORMA AND COMPLETE CLINICAL INCIDENT REPORTING FORM.

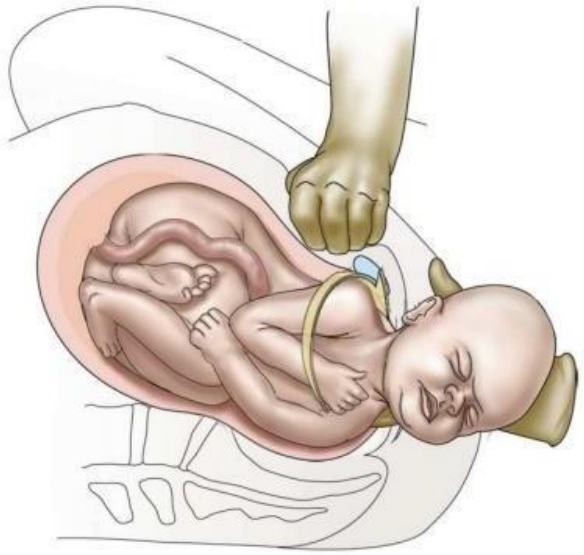
Appendix 2[3]


HELPERR
for Shoulder Dystocia
H Call for Help!
E Evaluate for Episiotomy
L Legs – McRoberts Maneuver
P Suprapubic Pressure
E Enter: rotational maneuvers
'Enter' maneuvers:
R Remove the posterior arm
R Roll the patient to her hands and knees
ALSO
www.aafp.org/also

Appendix 3[4]



Appendix 4[4]



Appendix 5(1)

SHOULDER DYSTOCIA DOCUMENTATION

Date .....
Time .....
Person completing form ..... **Designation**.....
Signature .....

Mother's Name _____
Date of birth _____
Hospital Number _____
Consultant _____

Called for help at:		**Emergency call via switchboard at:**		
Staff present at delivery of head:		**Additional staff attending for delivery of shoulders**		
Name	**Role**	**Name**	**Role**	**Time arrived**

Procedures used to assist delivery	**By whom**	**Time**	**Order**	**Details**	**Reason if not performed**
McRoberts' position					
Suprapubic pressure				From maternal **left** / **right** (circle as appropriate)	
Episiotomy				Enough access / tear present /already performed (circle as appropriate)	
Delivery of posterior arm **Internal rotational manoeuvre**				**Right** / **left** arm (circle as appropriate)	
Description of rotation					
Description of traction	Routine axial (as in normal vaginal delivery)	Other -		Reason if not routine axial:	
Other manoeuvres used					

Mode of delivery of head	**Spontaneous**		**Instrumental – vacuum / forceps**	
Time of delivery of head		**Time of delivery of baby**	**Head-to-body delivery interval**	
Fetal position during dystocia	Head facing maternal **left** **Left** fetal shoulder anterior 		Head facing maternal **right** **Right** fetal shoulder anterior 	
Birth weight kg	**Apgar**	**1 min :**	**5 mins :**	**10 mins :**
Cord gases	**Art pH :**	**Art BE:**	**Venous pH :**	**Venous BE :**
Explanation to parents	Yes	By	**Datix** **form completed**	Yes

Neonatologist called? Yes **Neonatologist arrived:** ..... **Name:** .....
If neonatologist not called or didn't arrive, give reason: .....

Baby assessment after birth (maybe done by M/W):			**If yes to any of these questions for review and follow up by Consultant neonatologist**
Any sign of arm weakness?	Yes	No	
Any sign of potential bony fracture?	Yes	No	
Baby admitted to Neonatal Intensive Care Unit?	Yes	No	
Assessment by			

Please copy x 2 copies: x1 maternal notes, x 1 attached to AIMS form.