Shoulder Dystocia

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<th>Guideline</th>
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1. Purpose of guideline

This guideline establishes the importance of recognition of the risk factors associated with shoulder dystocia and the emergency management when it occurs within Auckland District Health Board (ADHB).

2. Definitions

Shoulder dystocia is widely defined as a delivery that requires additional obstetric manoeuvres to deliver the foetus after gentle downward traction has failed. Shoulder dystocia occurs when either the anterior or less common the posterior foetal shoulder impacts on the maternal symphysis or the sacral promontory respectively.

3. Background

Although the occurrence of shoulder dystocia is uncommon it is not rare with an incidence ranging from 0.58% to 0.70% of all deliveries. There are predisposing factors but largely it is an unpredictable event.

Maternal morbidity is also increased, particularly post partum haemorrhage, 3rd and 4th degree tears and post traumatic stress syndrome.

Infant morbidity includes brachial plexus injuries around 2.3% to 16% a minority of these being permanent. Other injuries include fractures of clavicles or humerus, hypoxia, neurological damage or death.

4. Risk factors associated with shoulder dystocia

<table>
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<th>Pre labour</th>
<th>Intra-partum</th>
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<td>Previous shoulder dystocia (10 times higher)</td>
<td>Prolonged first stage of labour</td>
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Key points

- The majority of cases of shoulder dystocia occur in women with no risk factors
- Shoulder dystocia is therefore unpredictable and largely unpreventable
- All clinicians should be aware of the methods for diagnosing shoulder dystocia and the techniques required to facilitate birth
- Clinicians should be aware of existing risk factors but must always be alert to the possibility of shoulder dystocia with any birth
- Simulation training with models is recommended

5. Intrapartum: high risk cases

If shoulder dystocia is anticipated then pre-emptive preparation may help:

- An experienced obstetrician should be in the labour and birthing suite for the second stage
- All practitioners delivering must be conversant with the techniques required to facilitate delivery complicated by shoulder dystocia

6. Delivery

Timely management of shoulder dystocia requires prompt recognition:

- Difficulty with delivery of the face and chin
- Failure of restitution of the head
- The head remains tightly applied to the vulva and may even retract (“turtle-neck”) sign
- Failure of the shoulders to deliver with routine traction
7. Shoulder dystocia management flowchart

**Call for help**
- Push emergency bell
- Call an obstetric emergency
- Call a neonatal code blue

**McRoberts Manoeuvre**
Position knees to nipples or thighs to abdomen

**Suprapubic pressure (Rubins I)**
External suprapubic pressure is applied in a downward and lateral direction to push the posterior aspect of the anterior shoulder towards the foetal chest

**Consider episiotomy**
If it will make internal manoeuvres easier

**Deliver Posterior Arm**
**Internal rotational manoeuvres**

**Inform Consultant Obstetrician**

**Move onto all-fours position**
(if appropriate)
Or
Repeat all of the above again

**Consider fracturing clavicle or Zavanelli manoeuvre**
It is rare that these are required

**Baby to be reviewed by neonatologist**
Complete documentation and risk pro if required

Discourage pushing. Move buttocks to edge of bed or put in lithotomy

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8. Documentation

Accurate and comprehensive documentation of a difficult and potentially traumatic birth is essential. It is important to record:

- Time of delivery of the head
- The manoeuvres performed; the timing and sequence
- Which was the anterior shoulder
- The time of delivery of the body
- The condition of the baby
- Umbilical cord lactates or gases
- Estimated blood loss
- Maternal perineal and vaginal examination
- The staff members who attended

9. Debriefing

- Parents – as soon as possible after the birth with an explanation of the birth and prior to discharge home and document discussion
- Staff members involved as soon as convenient

10. Supporting evidence

11. Associated ADHB documents

Intrapartum Care - Normal Labour & Birth
Perineal Tears - 3rd & 4th Degree
Postpartum Haemorrhage
Resuscitation of Newborns

12. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this ADHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

13. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed before the scheduled date, they should contact the owner or the Clinical Policy Advisor without delay.