



HEALTH HOLDING

HAFAER ALBATIN HEALTH
CLUSTER
MATERNITY AND
CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (L&D)		
Document:	Departmental Policy and Procedure		
Title:	Shoulder Dystocia		
Applies To:	All Obstetrics and Gynecology Staff		
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1. PURPOSE:

- 1.1 To define shoulder dystocia in order to clarify steps this should be followed at time of event.

2. DEFINITONS:

- 2.1 **Shoulder dystocia-** is a complication that occurs during delivery when an infant's shoulders become lodged in the mother's pelvic, often because the baby is proportionately too big for the birth canal (cephalopelvic disorder, known as CPD).

3. POLICY:

- 3.1 Shoulder dystocia occurs when after delivery of the fetal head, impaction of the shoulders within the maternal pelvis prevents further expulsion of the fetus.
- 3.2 Clinicians should be aware of existing risk factors but must always be alert to the possibility of shoulder dystocia with any delivery.
- 3.3 Elective caesarean section should be considered for women who have gestational diabetes and whose fetus weighs more than 4500 grams as this reduces the risk of brachial plexus injuries greatly.
- 3.4 An experienced obstetrician should be available on the labour ward for the second stage of labor when shoulder dystocia is anticipated.

4. PROCEDURE:

- 4.1 On admission:
 - 4.1.1 Usual admission procedure.
 - 4.1.2 Clinical assessment:
 - 4.1.2.1 Review the Antepartum risk factors:
 - 4.1.2.1.1 Fetal Macrosomia.
 - 4.1.2.1.2 Maternal Diabetes.
 - 4.1.2.1.3 Maternal Obesity.
 - 4.1.2.1.4 Multiparity.
 - 4.1.2.1.5 Post Term gestation.
 - 4.1.2.1.6 Prior History of Shoulder Dystocia.
 - 4.1.2.2 Intrapartum Risk Factors:
 - 4.1.2.2.1 Labor Induction.
 - 4.1.2.2.2 Epidural Anesthesia.
 - 4.1.2.2.3 Operative Vaginal Delivery.
 - 4.1.2.2.4 Abnormal Labor Pattern.
 - 4.1.2.2.5 Prolonged Second Stage.
- 4.2 Management:
 - 4.2.1 Intrapartum:

- 4.2.1.1 An experienced obstetrician should be available.
- 4.2.1.2 All birth attendants should be ready with the techniques required to facilitate delivery complicated by shoulder dystocia.
- 4.2.2 Prediction and Anticipation:
 - The attendant health-care should routinely observe for:
 - 4.2.2.1 Difficulty with delivery of the face and chin.
 - 4.2.2.2 The head remaining tightly applied to the vulva or even retracting.
 - 4.2.2.3 Failure of restitution of the fetal head.
 - 4.2.2.4 Failure of the shoulders to descend.
- 4.2.3 After the recognition of shoulder dystocia, immediately:
 - 4.2.3.1 Call for help.
 - 4.2.3.2 This should include further assistance, an obstetrician, a pediatric resuscitation team and an anaesthetist.
 - 4.2.3.3 Maternal pushing should be discouraged.
 - 4.2.3.4 The woman should be move to bring the buttocks to the edge of the bed.
 - 4.2.3.5 Evaluate.
- 4.2.4 Do Episiotomy (in order to provide extra room for vaginal manoeuvres however it is not mandatory for all cases).
 - 4.2.4.1 Legs:
 - 4.2.4.1.1 Perform McRoberts manoeuvres by lying woman flat and flexing her legs onto her abdomen. Delivery should be attempted in this position for 30-60 seconds using normal traction.
 - 4.2.4.2 Pressure:
 - 4.2.4.2.1 Do external manual directed Suprapubic pressure and dislodge the anterior shoulder from behind the symphysis.
 - 4.2.4.3 Enter (Internal Manoeuvres):
 - 4.2.4.3.1 Ruben Manuever: Approach anterior fetal shoulder from behind. Exert pressure on scapula to adduct most accessible shoulder and rotate to oblique position. Continue with McRoberts.
 - 4.2.4.3.2 Wood screw manoeuvre; Approach posterior fetal shoulder from the front. Gently rotate shoulder towards symphysis. Combine with (Rubin), previous maneuver.
 - 4.2.4.3.3 Reverse Wood Screw manoeuvre: Approach posterior shoulder from behind. Rotate fetus in opposite direction from Rubin or word screw maneuver.
 - 4.2.4.4 Remove: The posterior arm (inform physician and anesthetist) if failed.
 - 4.2.4.5 Roll: If above maneuver failed, consider all four position (if appropriate), roll the woman who onto hands and knees and attempt to deliver posterior shoulder first or repeat all manoeuvre.
 - 4.2.4.5.1 In extreme cases other manoeuvre such as cleidotomy, zavenelli maneuver or symphysiotomy may be considered. Decision to be taken by the physician.
- 4.3 Documentation:
 - 4.3.1 The shoulder dystocia was diagnosed.
 - 4.3.2 Time help was called for.
 - 4.3.3 Names of personnel who responded.
 - 4.3.4 Description and order of maneuver used.
 - 4.3.5 Patient was asked to stop pushing.
 - 4.3.6 Fetal assessment.
 - 4.3.7 Time of Birth.
 - 4.3.8 Position of fetal head at time of impaction.
 - 4.3.9 Neonatal interventions.
 - 4.3.10 Maternal and infant assessment.

4.3.11 Conversations between the provider and the woman and her family.

5. MATERIALS AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

- 6.1 Obstetrician and Gynaecologist
- 6.2 Neonatologist
- 6.3 Radiologist
- 6.4 Nurses
- 6.5 Midwives








7. APPENDICES:

- 7.1 Shoulder Dystocia Documentation Form

8. REFERENCES:

- 8.1 Guidelines for Obstetrics and Gynecology, Ministry of Health, General Directorate of Health Centers- Riyadh, 2013

9. APPROVALS:

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APPENDIX 7.1 Shoulder Dystocia Documentation Form

Kingdom of Saudi Arabia
Hafar Al Batin Health Cluster
Maternity and Children Hospital



المملكة العربية السعودية
التجمع الصحي بحفر الباطن
مستشفى الولادة والأطفال

SHOULDER DYSTOCIA DOCUMENTATION FORM

Date: _____ Time: _____
MRP: _____
Designation: _____
Signature: _____

Mother's Name: _____
Date of Birth: _____
Hospital Number: _____
Consultant: _____

Called for help at:		Emergency call via overheard page at:			
Staff present at birth of head		Additional staff attending for birth of shoulders			
Name	Role	Name	Role	Time arrived	
Maternal position when shoulder dystocia occurred please circle (i.e prior to any procedures to assist)	Semi-recumbent	Lithotomy	Side lying	All forms	
	Kneeling	Standing	Squatting	others	
Procedures used to assist birth	By whom	time	order	details	Reason if not performed
McRoberts position					
Suprapubic pressure				From maternal left/right (circle as appropriate)	
Episiotomy				Enough access/hear present/already performed (Circle as appropriate)	
Delivery of posterior arm				Right/left arm (circle as appropriate)	
Internal rotational maneuver					
Description of rotation					
Description of traction	Routine (as for normal vaginal birth)		Other -	Reason if not routine	
Other man oeuvres used					
Mode of birth of head	spontaneous		Instrumental-vacuum/forceps		
Time of birth of head	Time of birth of baby		Head-to-body birth interval		
Fetal position during dystocia	Head facing maternal left Left fetal shoulder anterior		Head facing maternal right Right fetal shoulder anterior		
Birth weight	Apgar	1 min:	5 mins:	10mins:	
Cord gases	Art pH:	Art BE:	Venous pH:	Venous BE:	
Explanation to parents	yes	By:	Risk incident form completed if clinical concerns	Yes	N/A
Neonatologist called	Yes/No	Time arrived:	neonatologist name:		
Baby assessment at birth (maybe done by M/W): Any sign of arm weakness.	Yes	No	If yes to any these questions, for review and follow up by consultant neonatologist		
Any sign of potential bony fracture?	Yes	No			
Baby admitted to Neonatal Care unit?	Yes	No			