



**Base Hospital Contact: Required for vaginal bleeding at > 20 weeks pregnancy and newborn delivery ① ② ③ ④**

1. Do not delay transport for treatment if suspected eclampsia; Manage delivery en route
2. Assess airway and initiate basic and/or advanced airway maneuvers prn ([MCG 1302](#))
3. Administer **Oxygen** prn ([MCG 1302](#))
4. Establish vascular access ([MCG 1375](#))  
Vascular access should not take precedence over controlled delivery or emergency transport
5. For poor perfusion ([MCG 1355](#)):  
**Normal Saline 20mL/kg IV/IO rapid infusion** per [MCG 1309](#)  
**CONTACT BASE** for persistent poor perfusion to obtain order for additional **Normal Saline 20mL/kg IV/IO** per [MCG 1309](#)
6. If crown is showing with amniotic sac intact, pinch sac and twist the membrane to rupture

**BREECH DELIVERY**

7. Support presenting part and allow newborn to deliver
8. If head does not deliver, place gloved hand inside mother and form "V" formed with fingers by baby's face to provide an opening for the airway

**PROLAPSED CORD**

9. Manually elevate presenting fetal part off the umbilical cord; maintain elevation of the presenting part until transfer of care ⑤
10. Wrap cord with moist gauze

**NUCHAL CORD**

11. If nuchal cord is loose attempt slipping the cord over the head prior to delivery
12. If the cord is too tight to easily slip over the head, clamp the cord in two places 1 inch apart and cut the cord with scissors

**SHOULDER DYSTOCIA**

13. Perform McRobert's maneuver with suprapubic pressure in order to deliver the anterior shoulder ⑥



**Treatment Protocol: PREGNANCY COMPLICATION**

Ref. No. 1217-P

MATERNAL HYPERTENSION (SBP  $\geq$ 140mmHg and/or DBP  $\geq$ 90mmHg) / ECLAMPSIA **7**

14. Place mother in left lateral decubitus position
15. For seizure, treat in conjunction with *TP 1231-P, Seizure*

POST-PARTUM HEMORRHAGE **8**

16. Massage the mother's lower abdomen (fundal massage)
17. Establish 2 IVs, large bore catheter (16g or 18g) preferred
18. **Normal Saline 20mL/kg IV/IO rapid infusion** per *MCG 1309*  
**CONTACT BASE** for persistent poor perfusion to obtain order for additional **Normal Saline 20mL/kg IV/IO** per *MCG 1309*



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**SPECIAL CONSIDERATIONS**

- ① Pediatric patients who are pregnant must be evaluated for child maltreatment and are at high risk for complications during delivery for the mother and the newborn.
- ② This protocol was intended for complications of pregnancy at the time of delivery; if patient is known to be pregnant and has complaints not associated with labor or delivery treat per *TP 1202-P, General Medical* or most applicable protocol.
- ③ If the patient has vaginal bleeding associated with known pregnancy >20 weeks, Contact Base and communicate signs and symptoms so that the receiving hospital can pre-notify OB consultants as needed.
- ④ Any delivery after the first trimester (12 weeks) should be considered childbirth for the purposes of this treatment protocol and paramedics should contact Base to discuss the management and transport. In general, delivery prior to 20 weeks gestation is nonviable and does not require resuscitation. However, dates can be incorrectly estimated, therefore, Base Contact is strongly encouraged. Any *potentially viable birth* should be resuscitated in the field and transported to a perinatal center that is also an EDAP (with a NICU if ≤34 weeks gestation). Births prior to 20 weeks do not necessarily require specialty center care and can be transported to the MAR.
- ⑤ In addition to manually elevating the presenting part from the umbilical cord, placing the patient in Trendelenburg position during transport can help to elevate the presenting part off the cord to maintain blood flow to the fetus. Do not attempt to push a prolapsed cord back in.
- ⑥ Shoulder dystocia is inability to deliver the anterior shoulder, which usually occurs in large newborns. If delivery fails to progress after head delivers, hyperflex mother's hips tightly in knee to chest position and apply firm suprapubic pressure in attempt to dislodge anterior shoulder (McRobert's maneuver).
- ⑦ Consider preeclampsia and eclampsia when evaluating patients at or beyond 20 weeks gestation and post-partum up to 6 weeks after delivery. Preeclampsia and eclampsia require immediate emergency and obstetric care. Patients in this group with SBP ≥140mmHg or DBP ≥90mmHg, or with new-onset seizure (with or without elevated blood pressure) should be transported to a Perinatal Center for evaluation.
- ⑧ Some bleeding is normal during delivery, typically up to 500mL. Bleeding is reduced with fundal massage, which promotes contraction of the uterus.