DELIVERING A BABY IN THE WILD!

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A LITTLE ABOUT ME..

- Born in Arkansas
- MD from University of Arkansas for Medical Sciences, Residency in Obstetrics and Gynecology at University of Texas Southwestern (Parkland Hospital), Fellowship in Robotic and Advanced Pelvic Surgery with North Texas Gynecologic Oncology
- Enjoy running, rugby, reading, cooking
- Why Idaho? It's supposed to snow! Skiing, fishing, outdoors

GETTING DOWN TO BUSINESS..

READY OR NOT HERE I COME!

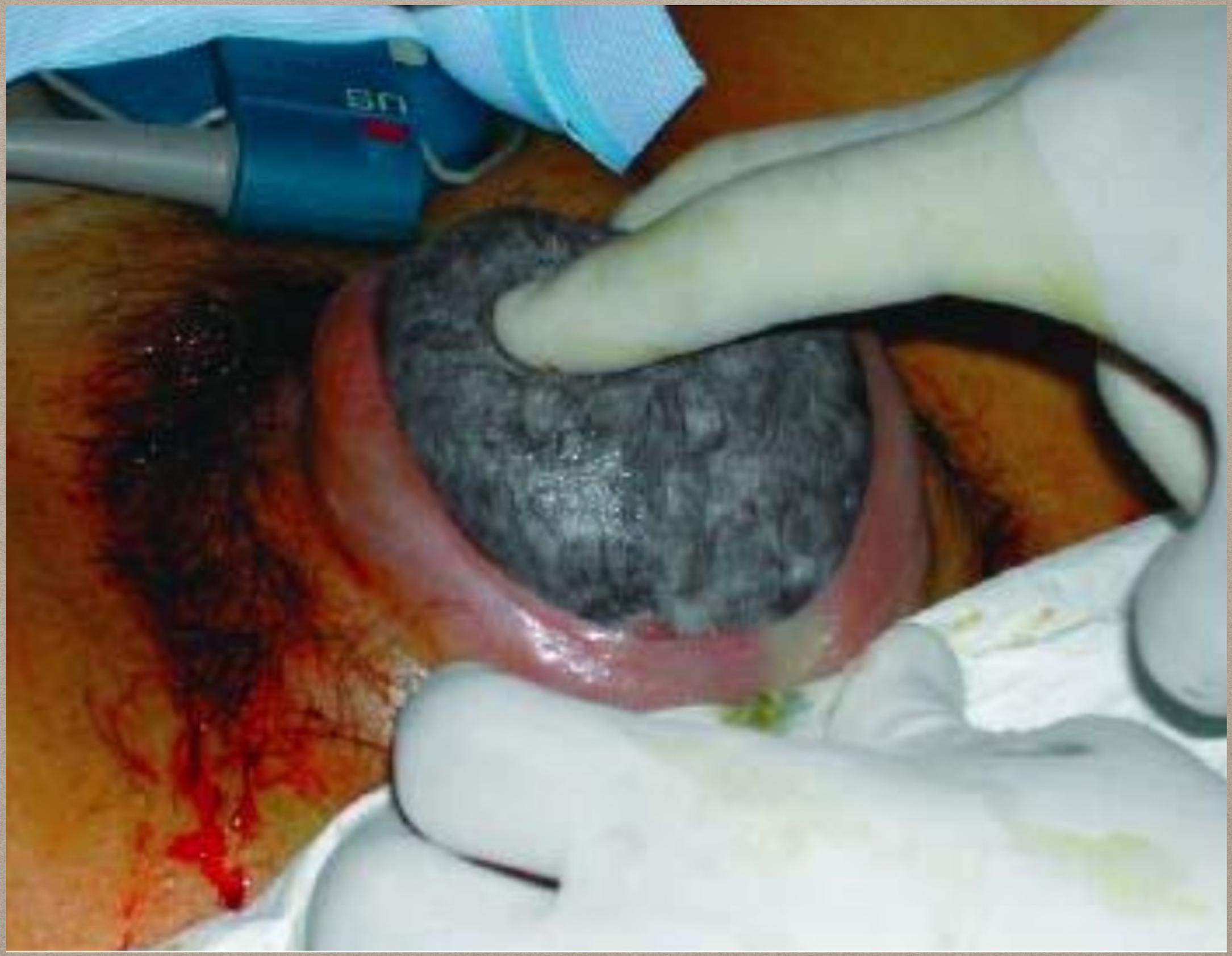
WHAT TO DO WHEN THE BABY IS COMING

- Remind the patient (and yourself) to breathe
- Is this a false alarm? An obstetrician will generally check the cervix to assess dilation. 10cm is fully dilated. If you see a head (or butt that isn't mom's), then you can skip this step.
- Preferably, mom should deliver in the hospital, and she should be advised not to push if delivery isn't imminent.

SOMETIMES MOM DOESN'T LISTEN

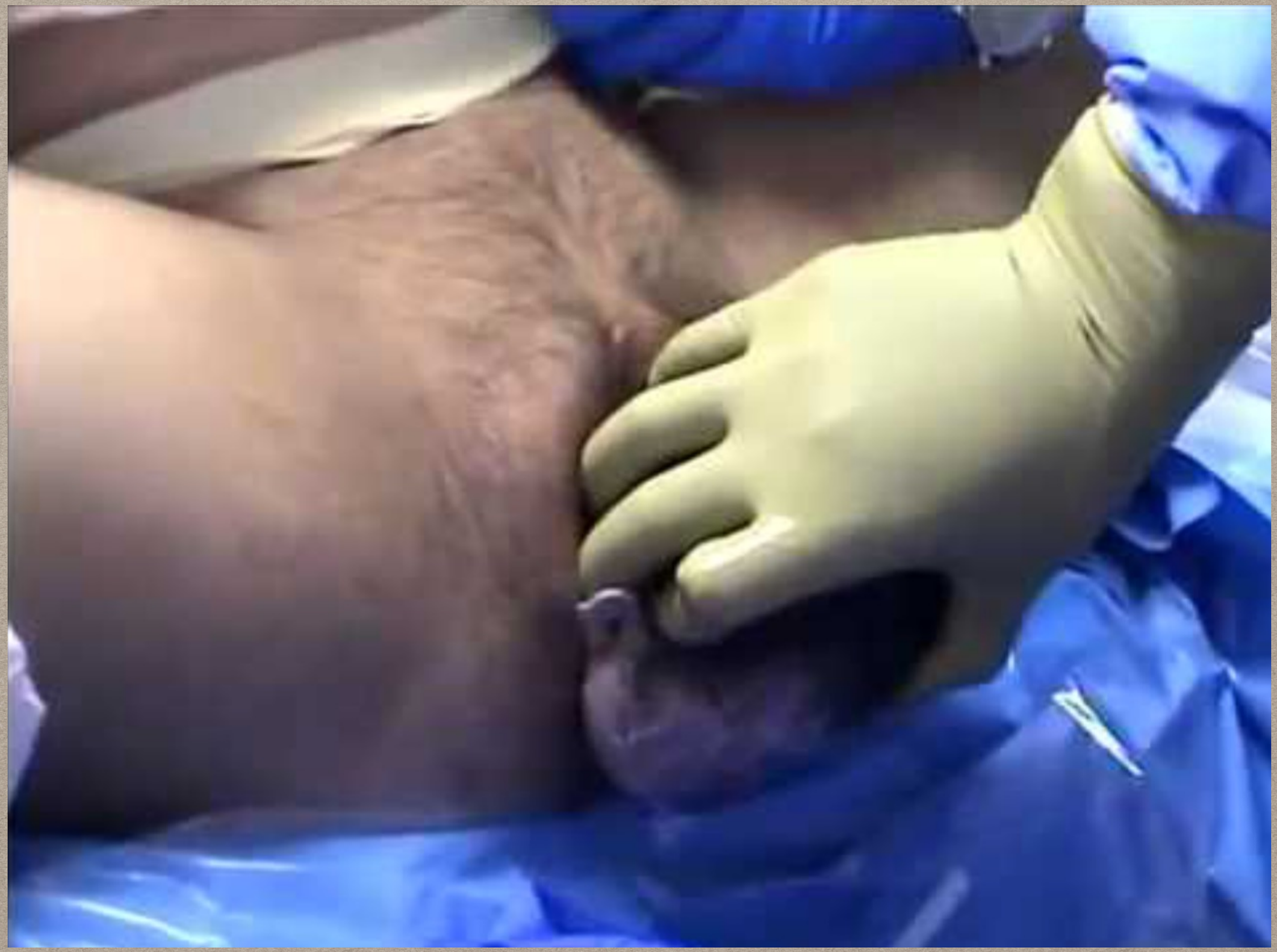
WHEN MOMMY HAS TO PUSH

- PLEASE (from all of your ob/gyn friends), support the perineum and control the baby's head. This will minimize tearing and lacerations.
- When mom is pushing, help guide her as follows: at the peak of her contraction, have her push for 10 seconds, take a deep breath, push for 10 seconds, take a deep breath, and push for 10 seconds.
- As crowning happens, push gently AGAINST the baby's head to slow its expulsion and use the other hand to squeeze gently against the perineum.



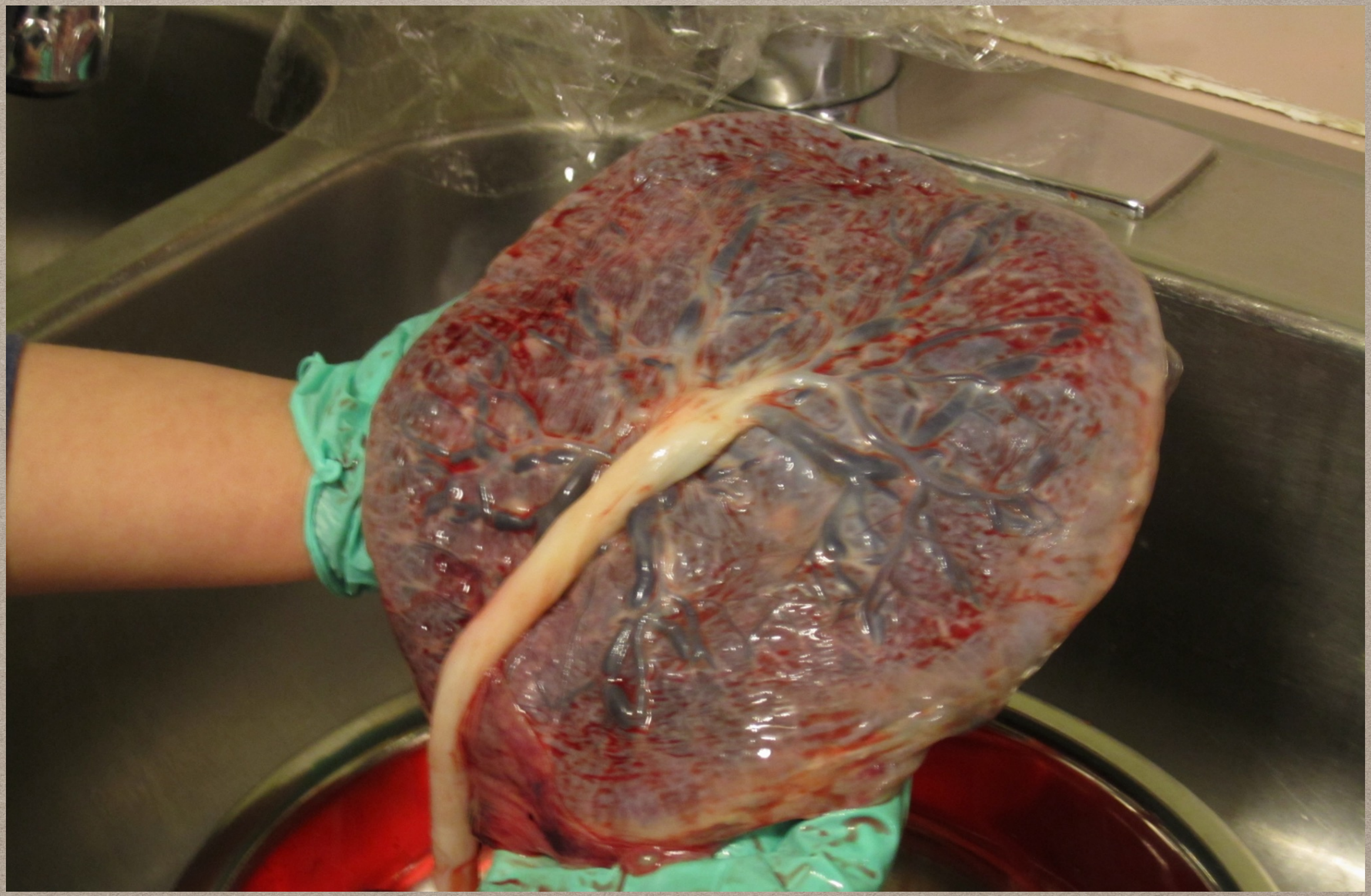
ALMOST THERE

- Once the head is out, check the neck for a nuchal cord. If present, then sweep over the infants head until reduced.
- Then, provide gentle downward traction to free the anterior shoulder, and then pull upward to free the posterior shoulder.
- Suction the baby's mouth until breathing adequately, and then place the infant on mom's abdomen to have her hold the baby (put her to work!).



NOW FOR THE UGLY TWIN

- Clamp and cut the umbilical cord.
- Sometimes there is minimal bleeding after delivery and the placenta may remain in-situ until the patient is brought to the hospital.
- However, if bleeding persists, then apply GENTLE downward traction on the umbilical cord until the placenta releases.



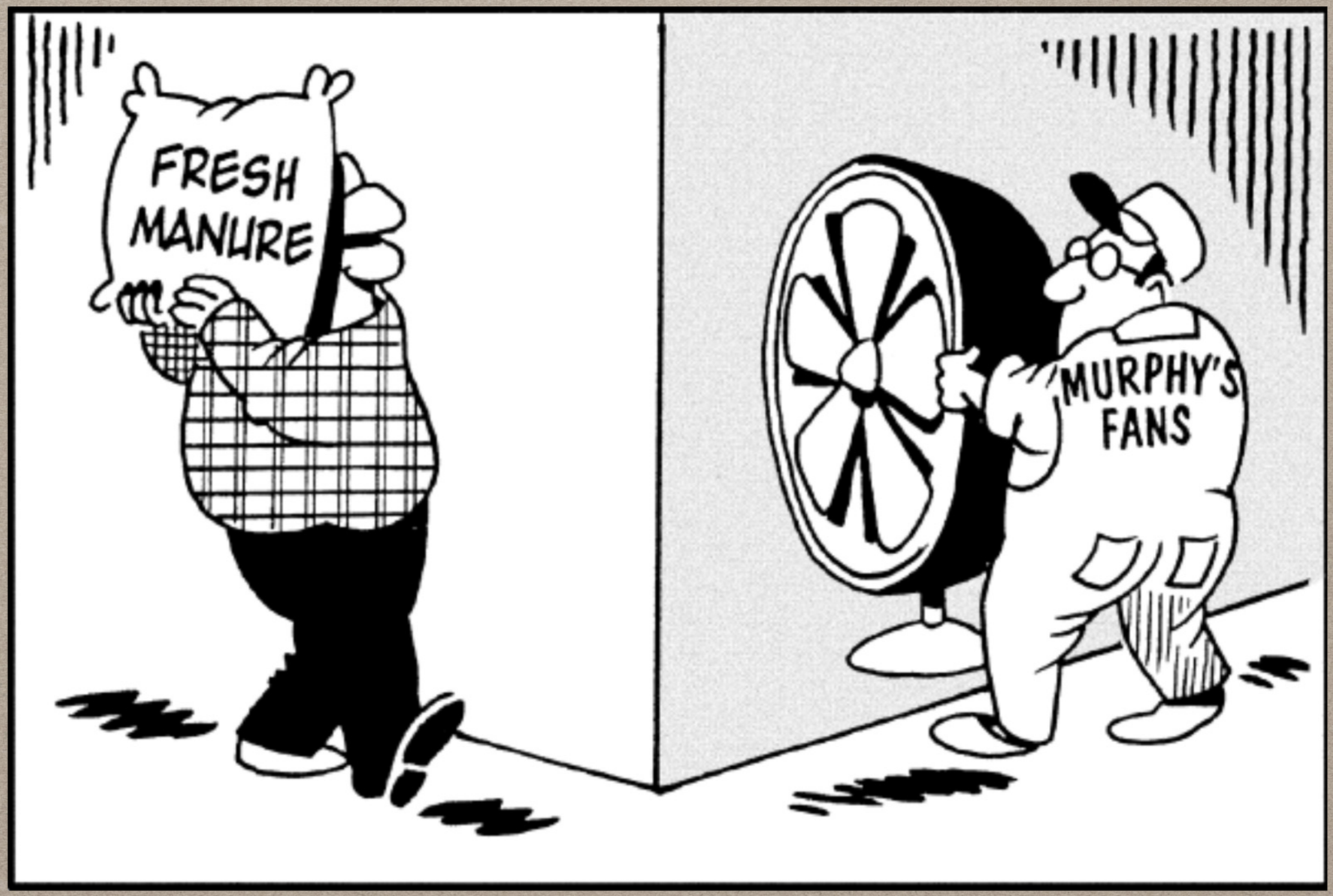
MAKE THE BLEEDING STOP!

- Use a bimanual exam for vigorous fundal massage.
- Drain the bladder if necessary.
- Nipple stimulation releases oxytocin (generally least awkward if done by a breastfeeding infant).
- Check the placenta to ensure it appears to be intact. If a portion (lobe) appears to be missing, manual removal from the uterus may be required to provide hemostasis.
- Once the uterus has good tone, a vaginal pack may be placed to control bleeding from lacerations.

You did it!

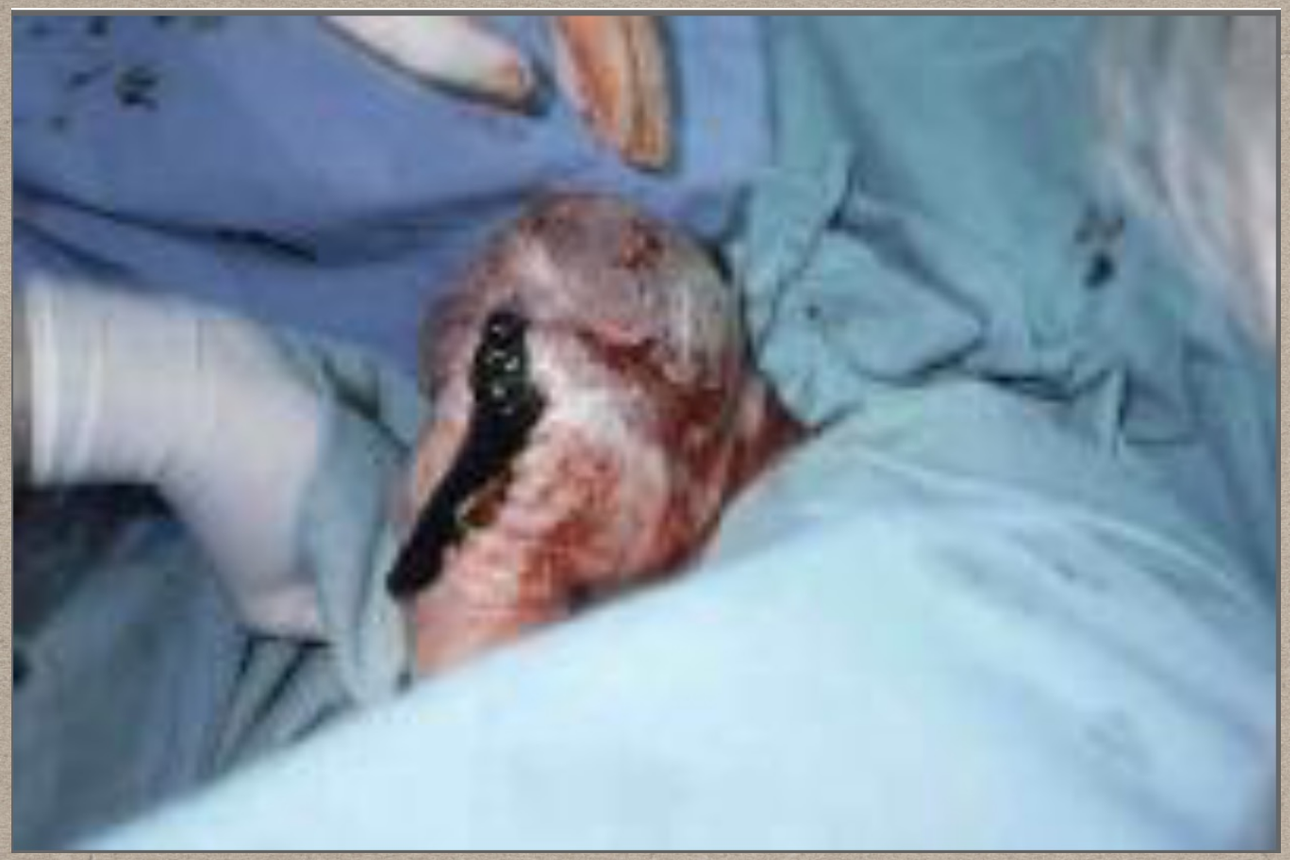
Congratulations

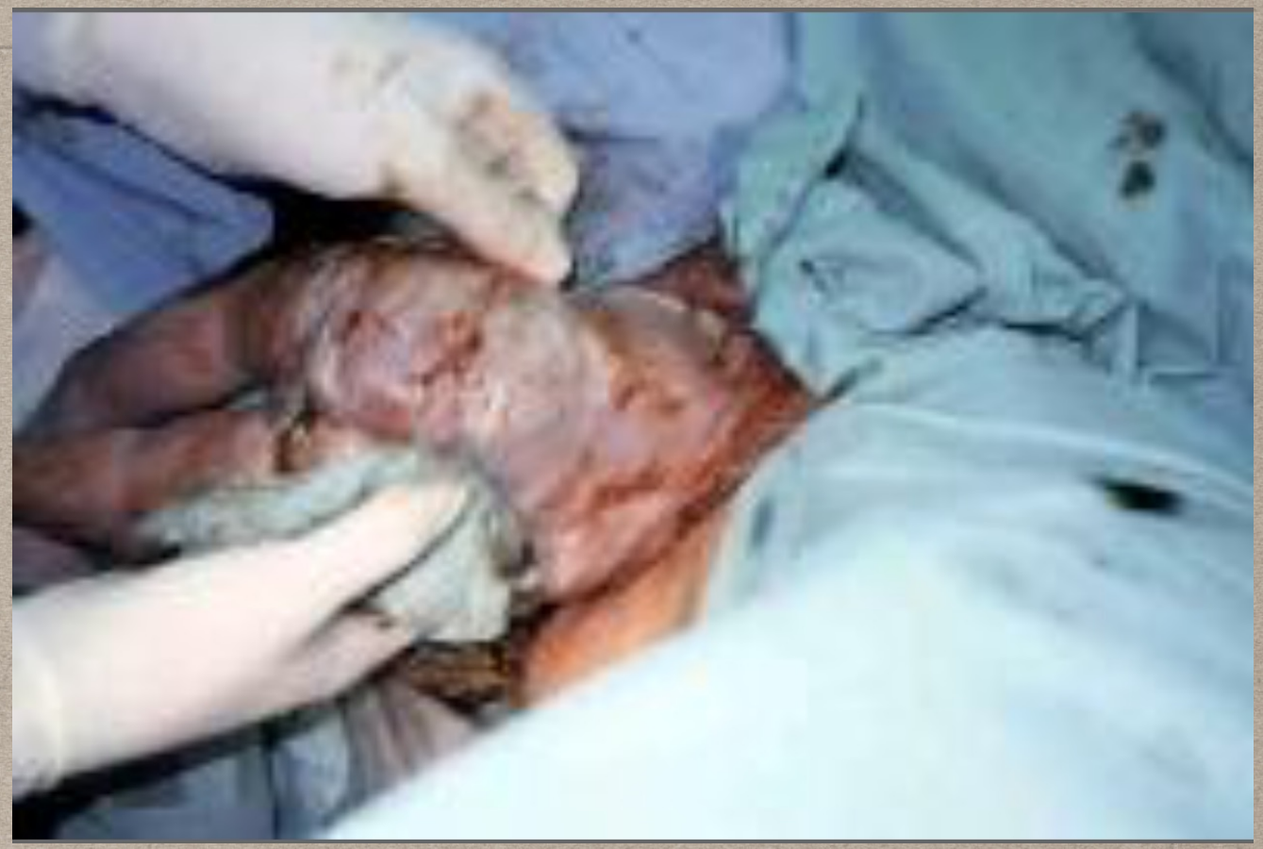
WHAT HAPPENS WHEN EVERYTHING DOESN'T GO AS PLANNED: TROUBLE-SHOOTING 101

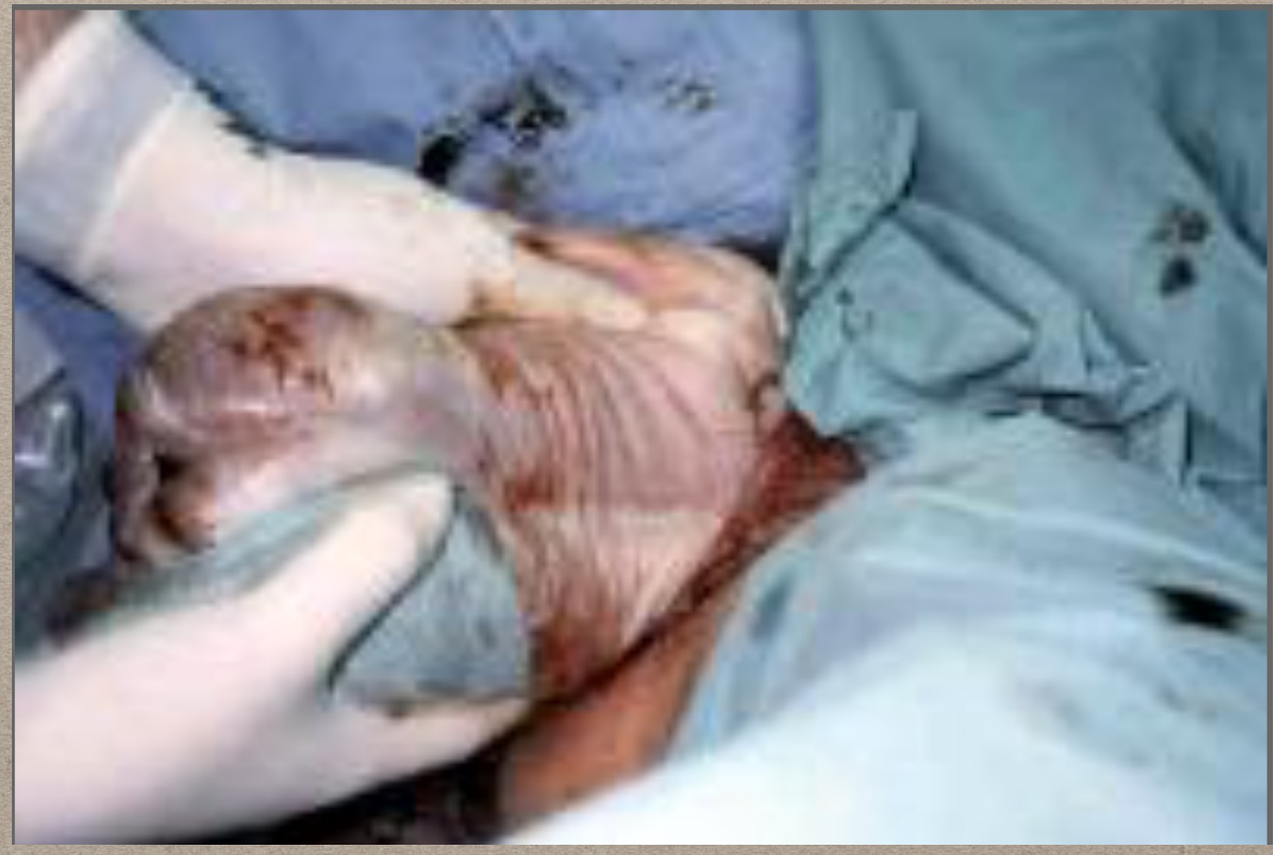


BASS-ACKWARDS: IS THAT A BUTT?!

- Occurs in 3-4% of all deliveries. May be frank, complete, or footling. 65-70% are frank breech.
- For frank breech, deliver the buttocks in a similar fashion to the head in a cephalic delivery.
- Apply gentle traction until the lower extremities are free. Wrap the lower extremities in a blue towel.
- Continue gentle downward traction applied to the ASIS (anterior superior iliac spine) at the tops of the hip bones.
- Rotate so that the shoulders are anterior and posterior, then sweep the anterior shoulder free and wrap it. Turn 180 degrees and repeat with the other shoulder, which is now anterior.
- Continue gentle outward and slightly upward traction while utilizing the Mariceau maneuver (performed by placing the index and middle fingers over the maxillary prominence on either side of the nose to maintain flexion of the neck.
- If the presentation is footling breech, then gentle downward traction on the ankles may be used until the bilateral ASIS are visible. Then proceed as above.







IS SHE DELIVERING A TURTLE OR A BABY?! SHOULDER DYSTOCIA

- Occurs in 1% of births when either the anterior shoulder cannot pass below the pubic symphysis or requires significant manipulation to pass.
- Risk factors include maternal obesity, diabetes, and fetal macrosomia.
- Step one is gentle downward traction to relieve the anterior shoulder.
- If that fails to allow delivery, then hyperflexion of the legs (McRoberts maneuver) and suprapubic pressure may be utilized. NEVER use fundal pressure.
- Rubin maneuver (digital pressure applied to the posterior aspect of the anterior shoulder in order to rotate the baby to a more favorable position).
- Wood screw (use of the Rubin maneuver in conjunction with pressure on the anterior aspect of the posterior shoulder). If ineffective, then may use the reverse wood screw maneuver, which is pressure in the opposite direction to the wood screw maneuver.
- Deliver of the posterior shoulder first.
- Episiotomy
- Rotation of the patient onto all fours

HERE COMES THE CORD, WHERE IS THE PLACENTA? UMBILICAL CORD AVULSION

- If not bleeding heavily, the placenta may be left in-situ until the patient reaches the hospital or until spontaneous delivery.
- If the patient is bleeding heavily, then manual extraction of the placenta may be indicated.

ANY QUESTIONS?

This presentation is meant to provide general guidelines only and is no substitute for proper medical judgment.