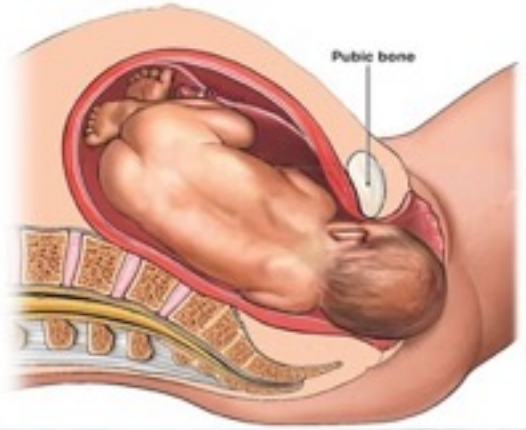
Getting practical about shoulder dystocia and breech birth

Else Vooijs

Shoulder dystocia

- A ‘bone-on-bone’ obstruction - the anterior shoulder gets stuck under the symphysis pubis after the birth of the baby’s head, and the posterior shoulder may become lodged in th



- Can not diagnose or prevent it
- It is rare (0.58-0.7% of vaginal births)
- Every midwife need to know how to manage it

Minimising shoulder dystocia

- Upright birth position
- Undisturbed birth – free mobilisation
- Instinctive (pelvic) movement and pushing
- Patience

Five warning signs

- Slow advancing of the head in second stage
- Looking like the head is retracting into the vagina after being born, and turning red and puffy
- Inability or difficulty in the chin sweeping over the perineum
- Inability to feel the baby's neck area
- Failure of gentle traction on the head, when the mother is in the supine position

Getting practical about shoulder dystocia

- Know the risks and signs
- Stay calm
- Ask for help (but don't rely on it)
- You have time to manage this calmly
- Continually reassures and comforts the mother and partner!
- Encourages her to assist by bearing down at the right time
- Encourage her to breath well

“Natural midwifery techniques, which take inherent anatomy and physiology into account, have been shown to prevent and solve shoulder dystocia, potentially reducing even this low incidence.”

Midwifery techniques

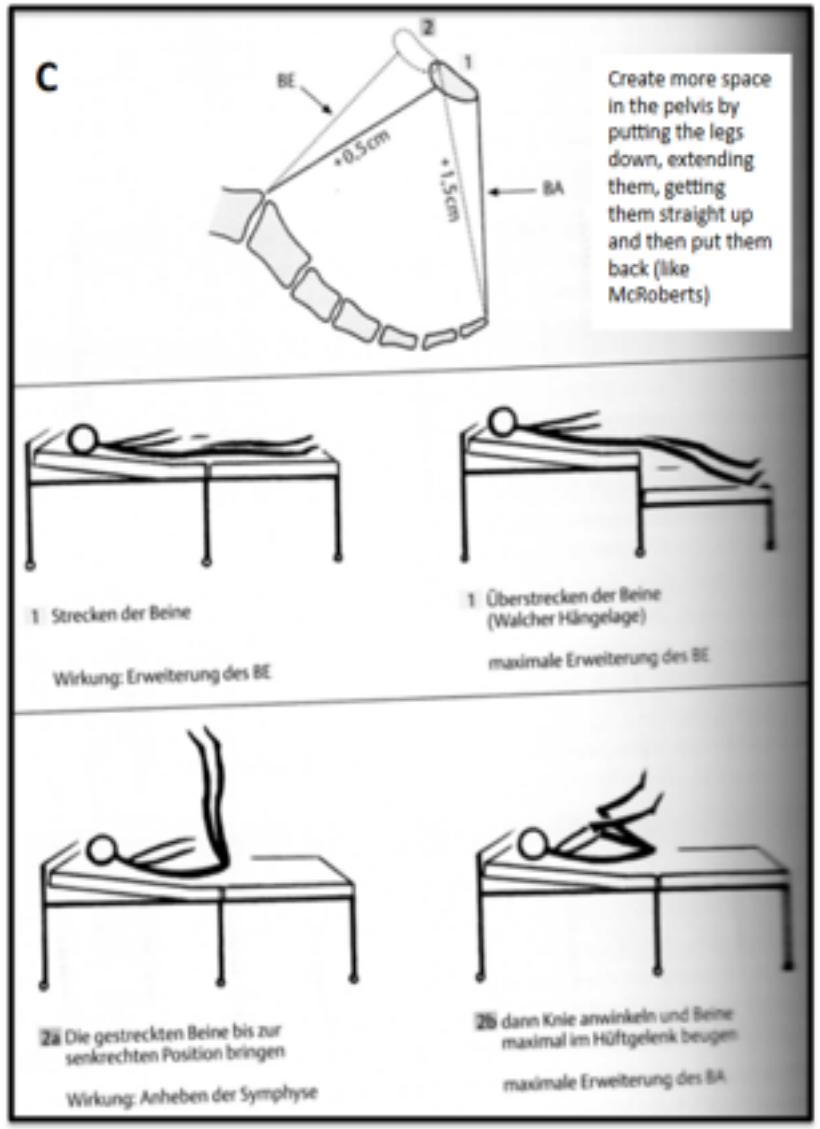
- Change position – might be enough

- Stand alongside the bed and raise first one leg with bended knee at a 45 degree angle to her midline, until her thigh is at right angles to her body, then the other leg; she should repeat this at least five times

Midwifery techniques (2)

- Turn into an all fours position on her bed and roll her hips, followed by flexing her spine into a convex and then concave curve, then splaying her knees about 60cm apart and rocking backwards onto her heels and forwards onto all fours again
- Crouch on her bed or the floor with her knees splayed as wide as possible to pull at the pelvic bones, followed by rocking forward

McRoberts - hyperflexion

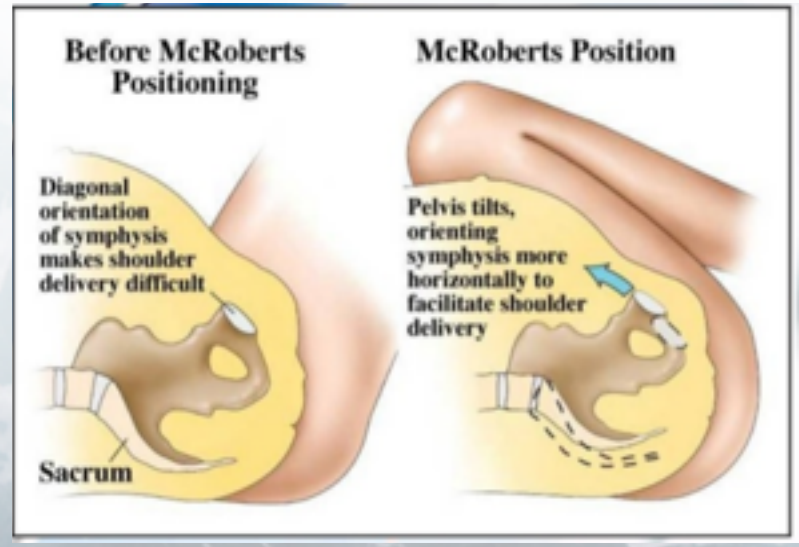


Put legs down

Extend the legs

Get the legs straight up

Bend the legs back

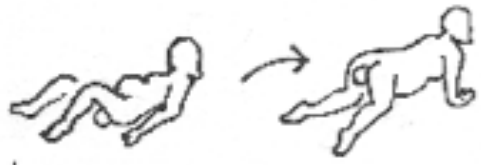


Spinning Baby's:

- Gaskin's (flip your mother to all fours)
- Running Start (lift one leg to the front, preferable the side of the back of the baby)
- Rotation shoulder into oblique
- Bringing out a posterior arm

Flip

F



Gaskin's

Flip the mom over

Over to Gaskin's The movement is the point here.

L

Running Start

Lift the leg(s)

On H & Ks. lift Rt. leg , or, if known, the leg on side of baby's back.

O

Rotate the shoulder into the Oblique

Posterior arm is easier to move.

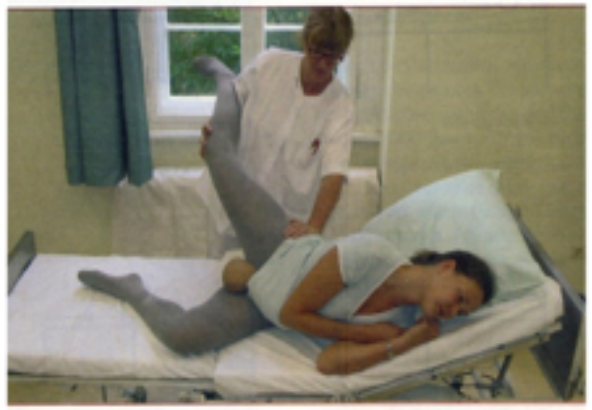
P

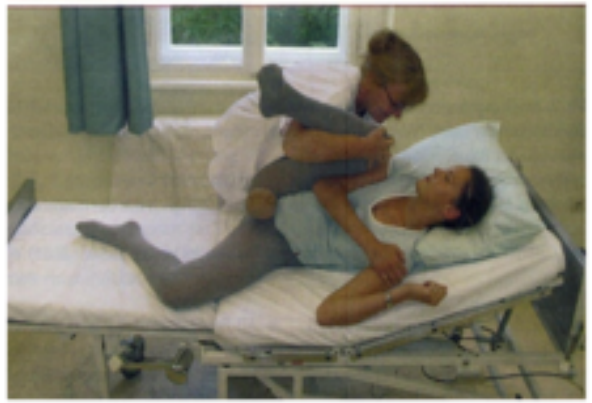
Bring out the Posterior arm

Bend elbow first. If needed rotate baby and repeat.

German ways

A



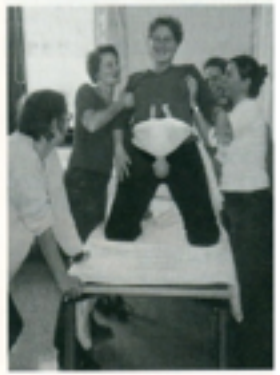


B

1. Upright in the kneeling position.

2. With straight upper legs tilting the pelvis forwards until the mother feels traction at the symphysis.

3. Going back onto the all four position and then shake the pelvis sidewards.



Harder, SofortmaBnahman bei Schulterdystokie, Die Hebamme 2005: 18: 138-145

D

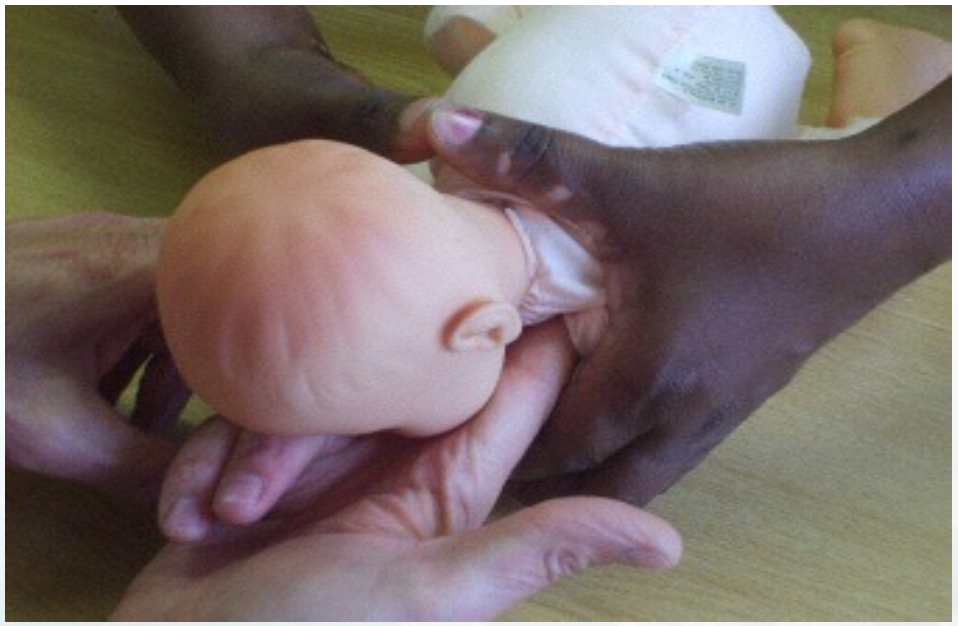
When the woman is in the bath, shower or in a standing or sitting position ask her to:
- get upright (if not already)
- rock her pelvis
- sit down again

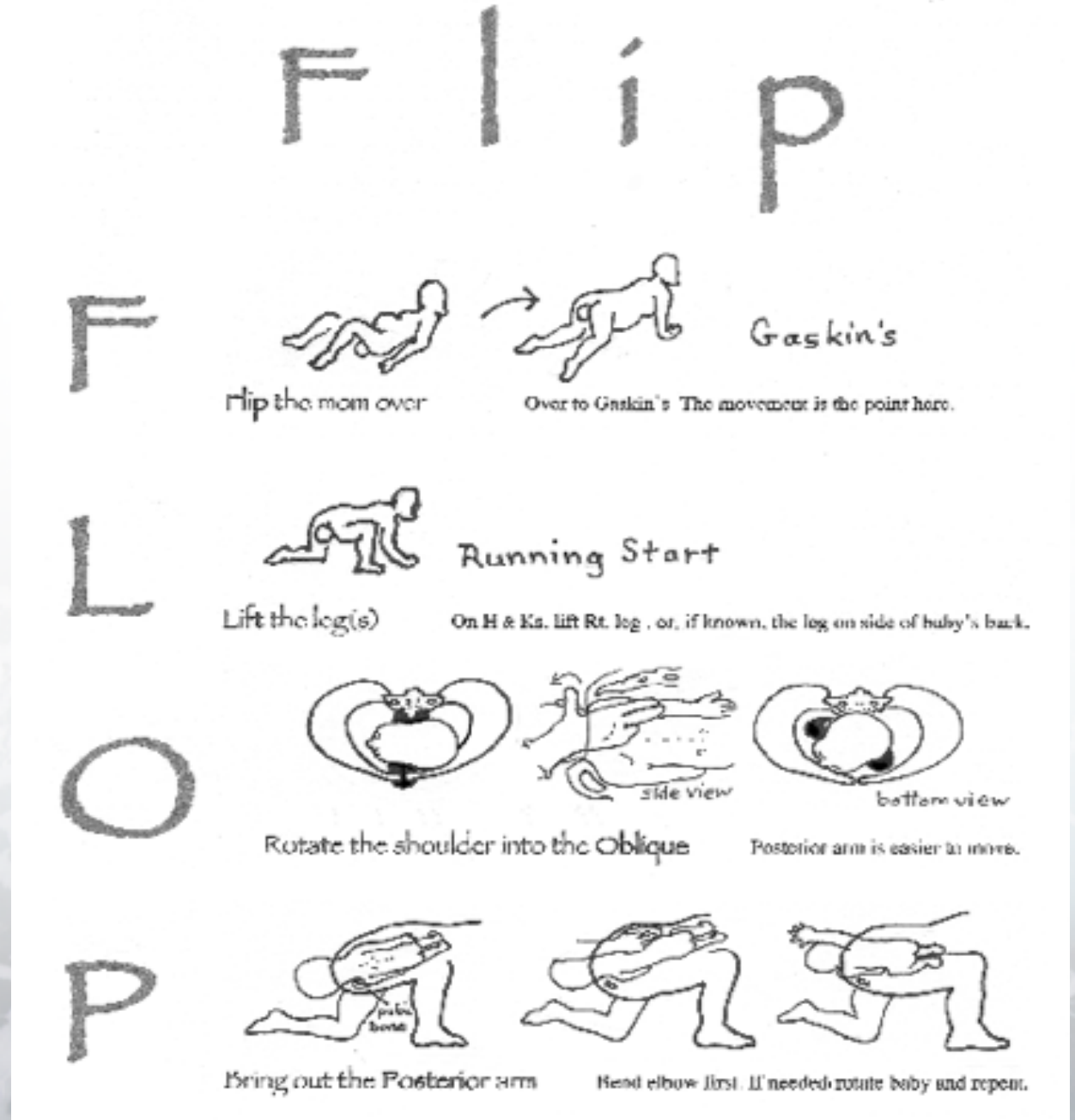
Repeat this three times. If this doesn't work use HELPERR

Re-cap on the 'classic' way HELPERR

H Call for Help
E Evaluate for Episiotomy … or Explain
L Legs: McRoberts maneuver
P Subrapubic Pression
E Enter: Rotational maneuvers
R: Remove the posterior arm
R: Roll the patient to her hands and knees

Practice together



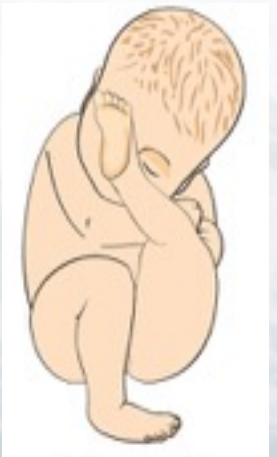


Getting practical about: Breech birth

- Incidence 3 - 4%
- Possible causes:
  - placenta previa,
  - uterine abnormalities,
  - multiple pregnancies,
  - preterm delivery,
  - polyhydramnios,
  - oligohydramnios.
- 85% of cases there is no known cause

Breech positions

- Frank breech, in which the hips are flexed and the knees extended, occurs in 50-70%
- Complete breech, in which both the hips and knees flexed, accounts for 5-10%
- Footling or incomplete breech, where one or both hips are extended, and the foot is the presenting part, is found in 10-30%



Breech birth

- Having a baby in breech position carries more risks no matter the choice of delivery
- The main concerns with a breech presentation are that the head has not undergone molding or shaping, and the cord could prolapse because the buttocks do not apply as well as the head to the cervix.

During pregnancy

Encourage Baby to turn by:

- Visualising baby turn
- Playing music on lower abdomen
- Hot or cold pack
- Gentle abdominal massage
- Chiropractor – webster technique
- Hypnosis / hypnotherapy

During pregnancy

Exercises

- To stretch ligaments and soft tissue
- Relax pelvic muscles
- Body balance
- Support baby to tuck the chin

During pregnancy

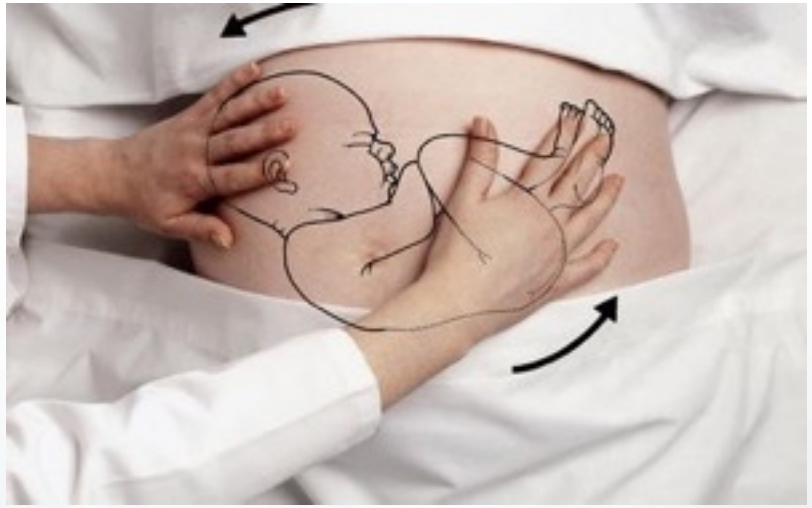
- Breech tilt

- The knee chest position

- Forward leaning

External Cephalic Version

- By a trained professional
- 40% succesful
- Not more than two attempts
- Complications rare
- Contraindications: a history of antepartum bleeding, ruptured membranes and a hypertensive mother



Studies – Vaginal breech birth vs C-Section

- 2000 - Term Breech Trial concludes that a C-section is preferred for a term breech baby.
- Follow up study concludes that C-section did not reduce the risk of death or neurodevelopmental delay at the age of 2

Safe vaginal breech delivery if:

- Fetal weight 2.5-4kg
- Frank or complete breech
- Placenta is not low-lying
- There should be no medical problems that can complicate birth
- No previous C-sections were performed
- Spontaneous labour occurring between 37 and 41 weeks of pregnancy
- A physically and mentally fit mother
- Experienced practitioner to assist the breech birth

Midwifery techniques

- Birthing on all fours to increase outlet
- Hour of patience - after it's believed that the cervix is fully dilated, wait another hour to make absolutely sure.
- If the birth progresses spontaneously, resist temptation to interfere, or pull baby down. Simply stand by and leave baby alone until the shoulders are delivered.

Midwifery techniques

- When the umbilical cord becomes visible, gently pull down a small loop to avoid tension of the cord.

- When baby's head is engaged in the pelvis and the hairline is visible, support baby's body with your right forearm and carefully assist with delivery of the head