

Shoulder Dystocia

Stillborn

This section is on the definition of stillbirth and the definition of stillbirth in the UK, the US and the WHO.

1. Background

Stillbirth is the death of a foetus or infant before or during delivery, or the death of a foetus or infant after delivery but before the child has reached a certain age. An objective diagnosis of stillbirth is made when the foetus or infant is found to be dead after delivery. The WHO defines stillbirth as a foetus or infant that is born dead after 28 weeks of gestation. The WHO also defines stillbirth as a foetus or infant that is born dead after 20 weeks of gestation and weighs at least 400g.

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There can be significant personal or cultural differences in the way that stillbirth is defined. The WHO defines stillbirth as a foetus or infant that is born dead after 28 weeks of gestation and weighs at least 1000g. The WHO also defines stillbirth as a foetus or infant that is born dead after 20 weeks of gestation and weighs at least 400g.



The McRoberts manoeuvre is done by flexing the knees on the hips, pulling the feet up towards the chest and the knees up towards the chest. This manoeuvre is used to relieve the pressure on the fetal head during a breech presentation. It is often used in conjunction with the Trendelenburg position.

The Trendelenburg position is used to relieve the pressure on the fetal head during a breech presentation. It is often used in conjunction with the McRoberts manoeuvre. The Trendelenburg position is done by tilting the table so that the head of the patient is lower than the feet.

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Internal manoeuvres or 'all-fours' position should be used if the McRoberts' manoeuvre and suprapubic pressure fail.

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Shoulder dystocia has been suggested as a potential preventable complication of the birth process. However, the degree of prevention of shoulder dystocia is not obvious. Neonatal outcomes should be considered when giving an explanation of the fact that it is a preventable complication.

Evidence

Other findings relating to the possibility of this being a preventable complication are few.

6.4 What is the optimal management of the woman and baby after shoulder dystocia?

Birth attendants should be alert to the possibility of postpartum haemorrhage and severe perineal tears.



The significant neonatal morbidity associated with shoulder dystocia is not postpartum haemorrhage or severe perineal tears. Other potential complications include bruising, pelvic bone fracture, postpartum haemorrhage, and neonatal hypoxia.

Evidence
Level +
Evidence
Level

The baby should be examined for injury by a neonatal clinician.



It is one of the most important complications of shoulder dystocia, and of the other complications.

Other potential complications associated with shoulder dystocia include fractures of the ribs and the humerus.

Evidence
Level

An explanation of the delivery should be given to the parents (see section 9).



7. Risk management

7.1 Training

Shoulder dystocia training

All maternity staff should participate in shoulder dystocia training at least annually.



The RCOG CESD report recommends the development of awareness and training for all birth attendants to be observed. An annual training programme is recommended for all staff. The College of Midwives (COMA) is one of the recognised educational institutions for the CESD training.

Evidence
Level

The training has been associated with a reduction in neonatal outcomes and is a key element of training.

Evidence
Level

One of the key elements of training for postpartum haemorrhage following training is the ability to manage the risk of shoulder dystocia following training. The ability to manage the risk of shoulder dystocia is one of the key elements of training.

Evidence
Level

Shoulder dystocia training

For shoulder dystocia training to be effective, it is important to have a good understanding of the risk of shoulder dystocia. Training should be given to all staff, including parents, upon the risk of shoulder dystocia.

Evidence
Level

...shoulder distance (9.5% pre-training, 2.5% DC, 5% training) ...



Figure 1. Gait characteristics over time for DC, Training, and Control groups.

...the training group showed a significant increase in the parameter over time compared to the DC and Control groups.

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- macrocytes & deformed RBCs in urine suggest renal
- maternal perineal and vaginal examination
 - estimated blood loss
 - staff in attendance and time they arrived
 - general condition of the baby (APGAR 1 & 5)
 - umbilical cord blood acid base measurement

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APPENDIX 2

Algorithm for the management of Shoulder Dystocia

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