Royal Hospital for Women (RHW)

BUSINESS RULE

COVER SHEET

NAME OF DOCUMENT	**Cord Presentation and Prolapse – identification and management**
TYPE OF DOCUMENT	Clinical Business Rule
DOCUMENT NUMBER	RHW CLIN127
DATE OF PUBLICATION	31/3/2025
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EXECUTIVE SPONSOR	Maternity co-directors
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SUMMARY	Identification and management of a cord presentation/prolapse in an antenatal or labouring woman
KEY WORDS	Cord presentation, prolapse

This Clinical Business Rule (CBR) is developed to guide safe clinical practice at the Royal Hospital for Women (RHW). Individual patient circumstances may mean that practice

Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1 BACKGROUND

The aim of this CBR is to guide in the prompt detection and appropriate management of cord presentation/prolapse.

2 RESPONSIBILITIES

2.1 Staff (medical, midwifery, Nursing, Allied health)

Identify, escalate and manage cord presentation/prolapse in a woman antenatally or intrapartum (see appendix.1)

3 PROCEDURE

3.1 Clinical Practice

Cord Presentation

- Identify cord presentation on vaginal examination by:
  - sensation of pulsation behind membranes
  - felt beside presenting part with ruptured membranes
- Inform medical team
- Confirm on ultrasound scan where appropriate
- Confirm fetal viability
- Monitor continuously with CTG
- Consider tocolysis if the woman is contracting
- Cease any oxytocin infusion
- Do **NOT** perform an artificial rupture of membranes with a viable fetus
- Expedite delivery in the viable fetus. Mode of delivery will depend on stage of labour but should be within one hour. Urgency will depend on gestational age, and CTG

Cord Prolapse

- Identify cord prolapse (cord lying in front of presenting part) by visual inspection or vaginal examination (see appendix 1 flow chart)
- Call for immediate obstetric team review, activate a Rapid Response
- Confirm fetal viability
- Monitor fetal heart rate continuously with CTG
- Consider placing woman in exaggerated Sims position, knee chest, or Trendelenburg (see appendix 2)
- Cease any oxytocin infusion
- Consider tocolysis if the woman is contracting
- Consider instrumental vaginal birth if appropriate
- Call 2222 and ask for '30 minute Caesarean Section' and organise urgent transfer to the operating theatre
- Ascertain cord pressure from presenting part and consider elevation by:
    - Digitally elevating the presenting part until bladder is filled
    - Consider filling bladder if immediate vaginal birth not possible and/or delay in theatres
        - insert 14 gauge urinary catheter
        - allow bladder to drain
        - inflate balloon with 10mls of sterile water for injection so catheter remains insitu
        - connect intravenous (IV) giving set and fill bladder with 500-750mls of normal saline and spigot
    - It is the responsibility of the person who fills the bladder to communicate directly with the operating obstetrician about the full bladder and need to empty prior to commencement of surgery
- Reassess once in operating theatre around urgency, mode of birth, mode of anaesthesia and need for bladder to be emptied prior to commencement of caesarean
- Remove spigot and attach urinary catheter bag prior to the commencement of surgery, to ensure bladder is emptied
- Notify neonatal team and request team to be present for birth
- Keep woman and family informed of events to ensure emergency management occurs quickly and with cooperation
- Collect cord blood gases at time of birth
- Debrief woman and family at an appropriate time during postnatal stay
- Debrief staff involved at an appropriate time

3.2 DOCUMENTATION

- Electronic Medical Record (EMR)

3.3 EDUCATIONAL NOTES

- Incidence is 0.1% - 0.6%[1]
- Most widely accepted risk factor is where the presenting part is not engaged in the maternal pelvis[1]
- Cord presentation and prolapse A woman in labour
    - with intact membranes where the umbilical cord lies in front of the presenting part
    - with ruptured membranes where the umbilical cord lies beside the presenting part
    - with ruptured membranes where the umbilical cord lies in front of the presenting part
- Cord vasospasm from the cooler temperature may occur which may lead to perinatal hypoxic ischaemic encephalopathy (HIE) or death[1]
- Other risk factors[1,2,3]:
    - Malpresentation
    - Prematurity
    - Multiple pregnancy
    - Abnormal placentation
    - Grand multiparity
    - Fetal anomaly
    - Polyhydramnios
    - External Cephalic Version (at time of procedure)
- Bladder filling is the preferred method for elevation of the presenting part
- Bladder filling is more practical if there is an anticipated delay in delivery[1]
- Simulation training in all clinical areas should be undertaken regularly to maintain skills
- Current beds used in birth unit have a weight limit of 150 kilograms, which may preclude staff from being on the bed for transfer to theatre at the same time as woman

3.4 CBR should include implementation, communication and education plan

The revised CBR will be distributed to all medical, nursing and midwifery staff via @health email. The CBR will be discussed at ward meetings, education and patient quality and safety meetings. Education will occur through in-services, open forum and local ward implementation strategies to address changes to practice. The staff are asked to respond to an email or sign an audit sheet in their clinical area to acknowledge they have read and understood the revised CBR. The CBR will be uploaded to the CBR tab on the intranet and staff are informed how to access

3.5 Related Policies/procedures

- Caesarean Birth – Maternal Preparation and Receiving the Neonate(s)
- Assisted vaginal birth guideline – SESLHD GL/050

- Terbutaline for uterine hypertonus or acute fetal distress
- Clinical Emergency Response System (CERS) – Management of the deteriorating patient
- Australian Commission on Safety and Quality in Health Care. Clinical care standard. Stillbirth. (under consultation for publishing October 2022)

3.6 References

1. Royal College of Obstetricians and Gynaecologists (2014) updated 2017. Umbilical Cord Prolapse Green Top Guideline Number 50.
2. SA Maternal & Neonatal Clinical Network (2019). South Australian Perinatal Practice Guidelines – Cord presentation and prolapse
3. The Royal Women's Hospital (2020). Cord Prolapse guideline. Victoria Australia

4 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal liaison officers, health workers or other culturally specific services

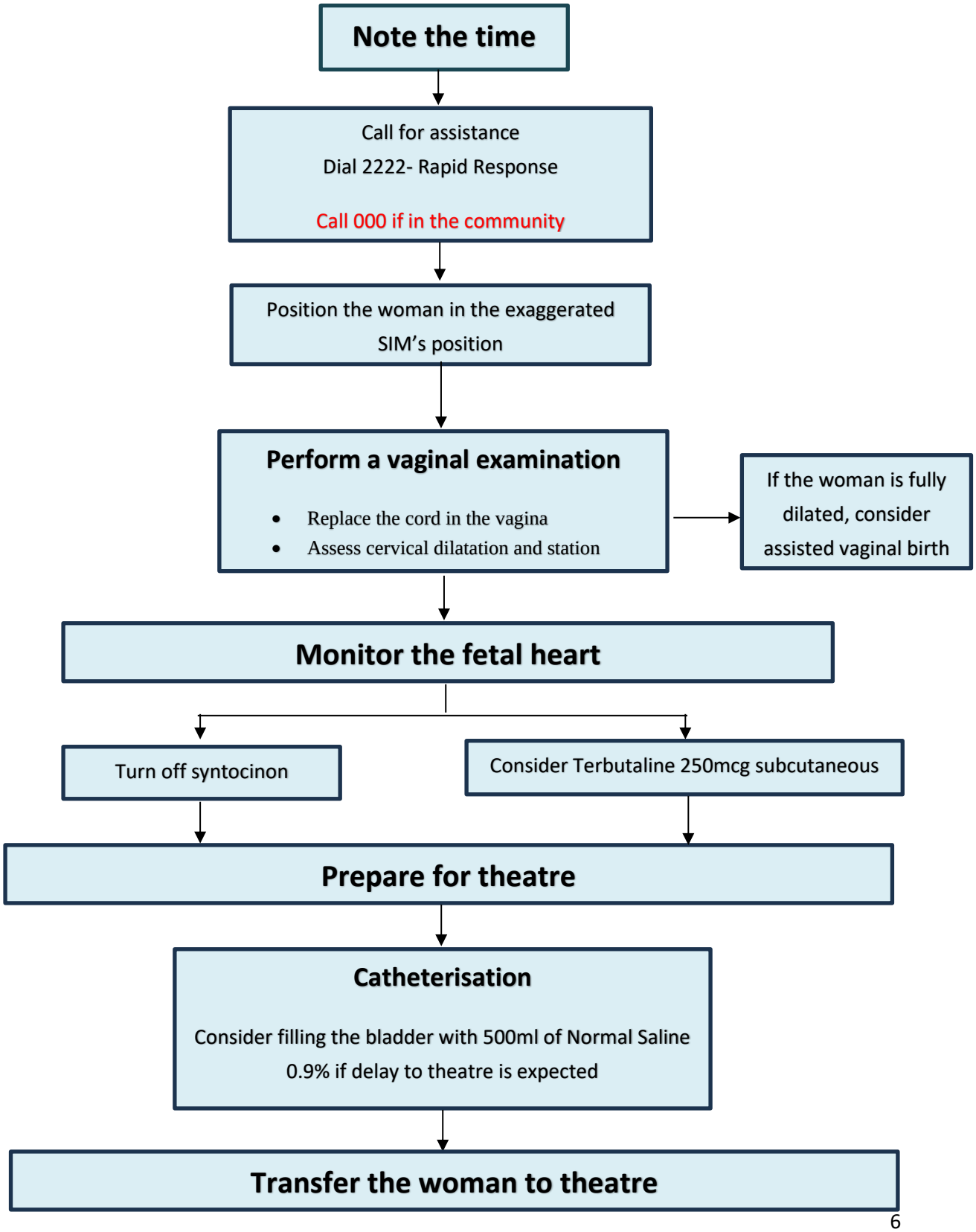
5 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: NSW Ministry of Health Policy Directive PD2017_044-Interpreters Standard Procedures for Working with Health Care Interpreters.

6 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
20/12/2024	V1	Amended to state "consider" filling the bladder if a delay to OT for birth- O&G request
10/2/2025	V2	Addition of flowchart (appendix1) for cord prolapse
31/3/2025	V2	BRGC

Appendix 1 CORD- Cord Prolapse



Appendix 2

Figure 1. Exaggerated Sims' position

Figure 2. Knee Chest position

Figure 3. Trendelenburg position