

CORD PRESENTATION AND PROLAPSE

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Prompt detection and appropriate management of cord presentation/prolapse

2. PATIENT

- A woman in labour, with intact membranes where the umbilical cord lies in front of the presenting part
- A woman with ruptured membranes where the umbilical cord lies in front of or beside the presenting part

3. STAFF

Medical, midwifery and operating theatre staff

4. EQUIPMENT

- Ultrasound machine
- Cardiotocograph (CTG) machine
- Cord prolapse box

5. CLINICAL PRACTICE

Cord Presentation in Labour.

- Identify cord presentation by sensation of pulsation behind membranes on vaginal examination
- Inform medical team
- Monitor continuously with CTG
- Confirm on ultrasound scan where appropriate
- Confirm fetal viability or fetal death
- Do **NOT** perform an artificial rupture of membranes with a viable fetus
- Expedite urgent delivery in the viable fetus. Mode of delivery will depend on stage of labour. Urgency will depend on gestational age, and CTG indication

Cord Prolapse

- Identify cord prolapse by visual inspection or vaginal examination
- Call for immediate obstetric and neonatal assistance (Rapid Response System)
- Monitor continuously with CTG
- Confirm fetal viability or fetal death
- Attempt instrumental vaginal delivery in the viable fetus, if the cervix is fully dilated and the presenting part is cephalic and below the ischial spines
- Notify operating theatres (OT) of 'urgent delivery within 30 minutes' if vaginal delivery not appropriate. Immediate delivery is necessary when the fetus is viable

CLINICAL POLICIES, PROCEDURES & GUIDELINES

Approved by Quality & Patient Care Committee
6/10/16

CORD PRESENTATION AND PROLAPSE cont'd

- Decrease pressure on cord by:
 - Digitally elevating the presenting part out of the pelvis until delivery. If possible, replace cord into the vagina with minimal handling
 - Placing woman in knee chest or exaggerated Sims position
 - Consider bladder filling if delivery is not immediate. Insert urinary catheter, drain the bladder then connect intravenous (IV) giving set and fill bladder with 500-750 mls normal saline
- Administer tocolysis if the woman is contracting
- Expedite transfer to OT
- Keep woman and family informed of events to ensure emergency management occurs quickly and with cooperation
- Ensure bladder is emptied just prior to delivery
- Ensure cord blood gases are collected at time of delivery
- Debrief woman and family at an appropriate time during postnatal stay
- Debrief staff involved at an appropriate time

6. DOCUMENTATION

- Integrated Clinical Records
- Partogram
- ObstetriX

7. EDUCATIONAL NOTES

- Incidence is 0.1% - 0.6%.
- Most widely accepted risk factor is where the presenting part is not engaged in the maternal pelvis.
- Cord vasospasm from the cooler temperature may occur which may lead to perinatal hypoxic ischaemic encephalopathy(HIE) or death
- Other risk factors.
 - Malpresentation
 - Prematurity
 - Multiple pregnancy.
 - Abnormal placentation
 - External cephalic version
 - Grand multiparity
 - Fetal anomaly
 - Polyhydramnios
- Bladder filling may be more practical if there is an anticipated delay in delivery

8. RELATED POLICIES/PROCEDURES/LOCAL OPERATING PROCEDURES

- Emergency Caesarean section
- Instrumental vaginal delivery
- Terbutaline (bricanyl) – subcutaneous injection for uterine hypertonus or acute fetal distress
- Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating ADULT and MATERNITY Inpatient

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CORD PRESENTATION AND PROLAPSE cont'd

9. RISK RATING

- Low

10. NATIONAL STANDARD

- CC – Comprehensive Care

11. REFERENCES

1. Lin, Monique G.MD. Umbilical Cord Prolapse. *Obstetrical and Gynaecological Survey Volume 61(4,)* April 2006, pp269-277.
2. Module 10. Cord Prolapse. In: Winter C, Crofts J, Laxton C, Barnfield S, Draycott T, editors. *PROMPT: PRactical Obstetric Multi-Professional Training. Practical locally based training for obstetric emergencies. Course Manual*. 2nd ed. Cambridge: Cambridge University Press; 2012. p.169–78.
3. SA Maternal & Neonatal Clinical Network. South Australian Perinatal Practice Guidelines – Cord presentation and prolapse 10 June 2014
Royal College of Obstetricians and Gynaecologists (2014). *Umbilical Cord Prolapse Green Top Guideline Number 50*.

REVISION & APPROVAL HISTORY

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