

OBSTETRICAL EMERGENCIES

1. Vaginal bleeding (1st or 2nd trimester):
 - a. History – should include information on last menstrual period, quantity of blood loss, trauma. Assume ectopic pregnancy may exist.
 - b. If vital signs normal, obtain orthostatics.
 - c. Place patient supine.
 - d. Administer **oxygen**.
 - e. Establish large bore **IV** of **NS or LR**; infuse wide open if orthostatic or history of significant blood loss.
 - f. **Contact Medical Control**.
 - g. Transport, if needed.
2. Vaginal bleeding (3rd trimester): All 3rd trimester bleeding should be considered an abruption or previa, with treatment aimed at minimizing shock and transporting quickly.
 - a. Administer **oxygen**.
 - b. Establish large bore **IV** and infuse **NS or LR**.
 - c. **Contact Medical Control**
 - d. Transport on left side.
3. Preeclampsia: Characterized by hypertension (blood pressure greater than 130/80) and/or edema, in 3rd trimester or postpartum.
 - a. Position on left side and keep calm and quiet.
 - b. Administer **oxygen**.
 - c. Establish **IV** of **NS or LR** TKO.
 - d. **Contact Medical Control**.
 - e. Transport gently, without lights and siren.
4. Eclampsia: Seizures with hypertension (blood pressure greater than 130/80) and/or edema, in 3rd trimester or postpartum.
 - a. Position on left side.
 - b. Administer **oxygen**, assist ventilations as necessary.
 - c. Establish **IV** of **NS or LR** TKO.
 - d. **Midazolam**: Draw 0.2 mg/kg up to 10mg of 5mg/ml solution for delivery by atomizer device, ½ in each nostril, or 0.2 mg/kg up to 10mg I.M., or 0.1 mg/kg I.V up to 5 mg I.V.
 - e. **Contact Medical Control**
 - f. Transport to closest appropriate hospital.
5. Trauma in pregnancy:
 - a. Treat mother as any other trauma patient with the following exceptions:
 - i. In 3rd trimester position on left side after spinal immobilization is in place.
 - ii. All pregnant trauma victims should be evaluated at a hospital, even if minor trauma.
 - iii. In 3rd trimester traumatic arrest, continue resuscitative measures until patient arrives at hospital.
 - iv. **Contact Medical Control**
 - v. Transport to closest appropriate hospital.
6. Delivery (normal cephalic presentation):
 - a. Obtain quick history.
 - b. Determine if adequate time is available to transport (consider number of previous births, contraction frequency, ruptured amniotic sac, and/or if crowning has occurred).
 - c. If not imminent:
 - i. Place patient on left side.
 - ii. Administer **oxygen**.
 - iii. Establish **IV** of **NS or LR** TKO.
 - iv. **Contact Medical Control**.
 - v. Transport.
 - d. If delivery is imminent, prepare to deliver on scene.
 - i. Deliver child in controlled manner, checking for umbilical cord around neck, suctioning

- immediately at perineum, and keep infant warm.
 - ii. Begin resuscitation of infant, if necessary (APGAR _ 7 at one minute).
 - iii. **Contact Medical Control**
 - iv. Transport and prepare for delivery of placenta enroute.
- 7. Delivery (abnormal presentation):
 - a. Breech (buttocks first)
 - i. If imminent, allow buttocks and trunk to deliver, supporting baby with arm and palm, and then allow head to deliver.
 - ii. If head does not deliver, push vaginal wall away from baby's face.
 - iii. **Contact Medical Control**
 - iv. Transport to closest hospital.
 - b. Limb presentation: DO NOT ATTEMPT DELIVERY.
 - i. **Contact Medical Control**
 - ii. Transport to closest hospital.
- 8. Prolapsed umbilical cord:
 - a. Administer **oxygen**.
 - b. Elevate mother's hips (knee-chest position or on pillows).
 - c. Apply gentle pressure to baby's head without disturbing umbilical cord.
 - d. **Contact Medical Control**
 - e. Transport to closest hospital.