INTRAPARTUM COMPLICATIONS

Reading Assignment:
Wong, Chapter 19

Objectives
• Identify risk factors for preterm labor.
• Discuss the current interventions and medications to treat preterm labor and birth
• Describe the physiologic effects of bed rest on the pregnant women
• Define preterm premature rupture of membranes and the complications associated with it.
• Discuss the causes and nursing interventions related to labor dystocia

Objectives
• Describe the difference between induction and augmentation of labor, use of oxytocin and the nursing role in their management
• Name the various reasons for cesarean section and the nurse’s role during the preoperative, intraoperative, and immediate postpartum periods.
• Describe the contraindications to vaginal birth after c/section and the nurse’s role.
Objectives

- Discuss the care of the women experiencing post-term pregnancy
- Name obstetric emergencies and their appropriate management and the nurse’s role.

Preterm Labor and Birth

- Preterm Labor- cervical changes and uterine contractions occurring between 20-37 weeks gestation.
- Preterm Birth- birth that occurs before the completion of 37 weeks gestation.

Preterm Birth

- Serious complication of labor and birth leading to 75% of the perinatal mortality today.
- Affect infant mortality rates and are second only to congenital anomalies as leading causes of infant mortality in the U.S.
- Preterm birth rates continue to rise despite treatments available.
Preterm Birth Vs. Low Birth Weight

• Preterm birth describes length of gestation < 37 weeks. More dangerous health condition because body systems of fetus are still developing.
• Low birth weight describes only weight at the time of birth <2500 gm. Can be but not necessarily, preterm. Can be caused by conditions other than preterm labor, such as IUGR, PIH, etc.

Risk Factors for Preterm Labor and Birth

• Demographic Risks
  African-American race (doubles the risk)
  Below 17 or above 34 years of age
  Low socioeconomic status
  Unmarried
  Low level of education

Risk Factors

• Medical Risks Predating Pregnancy
  History of previous preterm birth (triples the risk)
  Multiple abortions (miscarriage or elective)
  Uterine anomalies
  Low pre-pregnancy weight for height
  Parity (0 or >4)
  Diabetes
  Hypertension
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<thead>
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<th>Risk Factors</th>
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<tr>
<td><strong>Medical Risks in Current Pregnancy</strong></td>
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<tr>
<td>Multiple gestation</td>
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<tr>
<td>Infection</td>
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<tr>
<td>Incompetent cervix</td>
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<td>Short interval between pregnancies</td>
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<tr>
<td>Urinary tract infection</td>
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<tr>
<td>Bleeding in first trimester</td>
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<td>Placenta Previa or abruption</td>
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<tr>
<td>Anemia</td>
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<tr>
<td>Fetal anomalies</td>
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<tr>
<td>Premature rupture of membranes (PROM)</td>
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<th>Risk Factors</th>
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<tr>
<td><strong>Behavioral and Environmental Risks</strong></td>
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<tr>
<td>DES exposure</td>
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<td>Smoking</td>
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<td>Poor nutrition</td>
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<td>Alcohol or other substance abuse, esp. cocaine</td>
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<td>Late or no prenatal care</td>
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<thead>
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<th>Risk Factors</th>
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<tr>
<td><strong>Other Risks</strong></td>
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<tr>
<td>Stress</td>
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<tr>
<td>Uterine irritability</td>
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<td>Long working hours</td>
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<td>Inability to rest</td>
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Biochemical Markers for Preterm Labor

- Fetal Fibronectins
  Glycoproteins found in plasma and produced during fetal life
  Appear in the cervical canal early in pregnancy and then again in late pregnancy.
  Appearance between 24 and 34 weeks gestation predicts labor. A negative fetal fibronectin test is reliable to 95% that preterm labor will not occur.
  Done by vaginal swab, cannot have had a vaginal exam done within 24 hours of swab.

Biochemical Markers

- Salivary estrol
  Form of estrogen produced by the fetus that is present in plasma at 9 weeks gestation.
  Levels increase before preterm birth.
  Expensive and rarely used even though it has a high predictive value.

Causes of Preterm Labor and Birth

- Mostly unknown and assumed to be multifactorial.
- Infection is thought to be a major etiologic factor, ex. UTI's, cervical, vaginal.
- 25% of preterm deliveries intentionally delivered secondary to health of mother.
- 25% secondary to premature rupture of membranes and cannot be prevented
- 50% caused by preterm labor that may be treatable if early treatment is sought.
Care Management

- Early Education and prevention
  Women should be taught early symptoms of preterm labor especially if risk factors have been identified.
  Signs and symptoms – pelvic pressure, low dull backache, menstrual like cramps, change or increase in vaginal discharge, uterine contractions (with or without pain), intestinal cramping (with or without diarrhea).

Care Management

- Assessment of status of labor
  Cervical Change
  Presence of contractions – assess for frequency and intensity.
  History of preterm deliveries - increases risk of preterm labor for each subsequent pregnancy.

Care Management

- Bed rest
  Most common treatment for preterm labor. Cessation of all but most basic needs to decrease the chance of physical activity exacerbating preterm labor. (Has not been proven effective.)
  Risks of bed rest – after 3 days of bedrest - decreased muscle tone, weight loss, calcium loss, glucose intolerance. Can lead to bone demineralization, constipation, fatigue, isolation, anxiety and depression.
Care Management

- Pharmacologic Management-Tocolytics
  Medications used to suppress uterine activity. The best reason to use tocolytic therapy is to allow for the use of glucocorticoids to accelerate fetal lung maturity.

Care Management

- Commonly Used Tocolytics
  Terbutaline (Brethine) –
  Action – Beta Adrenergic receptor stimulant that relaxes smooth muscle.
  Dosage - .25mg SubQ q 30 min x 3 doses. Then switch to po dose of 2.5mg-5mg q 4-6 hours.

- Terbutaline
  - Adverse reactions
    - Tachycardia
    - Flushing
    - Palpitations
    - Tremors
    - Headache
    - Nausea and vomiting
    - Hypokalemia
    - Altered glucose metabolism
    - Fetal tachycardia
Nursing interventions –
Initially may need one on one care
Vital signs per protocol
Hold dose and notify MD if pulse exceeds 120
Assess lung sounds for signs of pulmonary edema.
Monitor electrolytes and glucose levels.

• Magnesium Sulfate
  Action – CNS depressant, relaxes smooth muscle.
  Dosage – Initially bolus of 4-6 gms over 30 minutes. Then maintenance dose of 1-3 gms/hr until contractions stop or decrease to less than 4-5 per hour.

• Magnesium Sulfate
  – Adverse Reactions
    • Hot flashes
    • Sweating
    • Nausea and vomiting
    • Drowsiness and lethargy
    • Decreased respirations
    • Decreased deep tendon reflexes
    • Decreased urinary output
    • Decreased blood pressure
Nursing interventions –
Assess for side effects
Monitor Magnesium levels
Assess vital signs, esp. BP, respirations, and DTR’s
Monitor FHR and uterine activity
Have Calcium gluconate readily available

• Indomethacin
  – Action – prostaglandin inhibition, relaxes smooth muscle.
  – Dosage – 100mg (rectal or po) initially then 25-50 mg q 4-6 hours up to 48 hours.
  – Adverse reactions – Nausea and vomiting, dyspepsia, dizziness, can cause premature closure of ductus arteriosus in fetus, oligohydramnios.

Nursing interventions –
Do not use with women with any potential for bleeding.
Ultrasound assessment for fetal compromise with serial ultrasounds for amniotic fluid and changes in ductus arteriosus.
• Ritodrine (Yutopar)
  – Not widely used, but is the only FDA approved medication for tocolytic use. See page 415 in textbook.

• Nifedipine (procardia)
  – Action – calcium channel blocker, relaxes smooth muscle.
  – Dosage – Initially 10mg, then 10-20mg po q 6 hours.
  – Adverse reactions – dizziness, headache, nervousness, palpitations, peripheral edema, hypotension.
  – Nursing interventions – Do not use with magnesium sulfate, assess BP and pulse before administration (vasodilation). Monitor I&O. Do not crush, open, break or chew XI tabs.

Nursing Care for Preterm Labor
  – Note frequency and intensity of all contractions and how mother’s perception of changes in contractions.
  – Encourage bed rest.
  – Monitor I & O.
  – Assess heart and lung sounds and DTR's.
  – Notify all personnel necessary if preterm birth suspected.
Monitor fetal heart rate for fetal well-being and signs of distress. Provide emotional support by answering questions and supplying information on preterm labor and birth, have staff from NICU visit, promote atmosphere that allows the woman to express concerns, worries and fears about premature labor and birth. If extended bed rest is anticipated, provide diversionary activities.

Premature Rupture of Membranes

- Definition – leaking of amniotic fluid that begins at least 1 hour before the onset of labor at any gestational age.

- Infection is most serious side effect of PROM. Another side effect could be prolapsed cord.

Premature Preterm Rupture of Membranes

- Definition – rupture of membranes before 37 weeks gestation.
  - Occurs in 25% of preterm labor.
  - Most likely cause is infection.
  - Expectant management continues as long as there are no signs and symptoms of infection or fetal distress. Sometimes treated with tocolytics until 24 hours after administration of steroids for fetal lung maturity. (Steroids can cause a transient elevation of WBC's)
Dystocia

- Definition – long, difficult or abnormal labor.
- Causes
  - Dysfunctional Labor – abnormal uterine contractions that prevent the normal progress of cervical dilation, effacement or descent.
    - Uterine factors – hypertonic or hypotonic uterine dysfunction, abnormal contraction patterns that cause ineffective labor.
  - Pelvic factors – reduced capacity of the bony pelvis including the inlet, midpelvis, outlet or any combination of these planes. The most common cause of pelvis dystocia is when the interschial spinour and posterior sagittal diameters of the midpelvis is 13.5 cm or less and fetal descent is arrested because the head cannot rotate internally.
  - Fetal causes –
    - Anomalies – gross ascites, tumors, open neural tube defects and hydrocephalus.
    - Cephalopelvic disproportion (CPD) – size of fetus is disproportionate to size of pelvis. (Ex. Large fetus with a normal maternal pelvis or normal fetus in a woman with a small pelvis.
    - Malposition - Most common is persistent occiput posterior.
    - Malpresentation – most common is breech. Also can be face or brow presentation, shoulder, hand, etc.
    - Multifetal pregnancy
– Position of the woman – restricting the woman to bed during labor. Should allow ambulation if possible to allow gravity to work.

Dystocia

• Care management
  – Assessment – Risk assessment is continuous during labor
    • Initial assessment on admission
    • Monitor contraction patterns
    • Labor progress – once labor established, progress should be 1cm per hour.
    • Fetal well-being

– Plan of care and implementation
  • Collaborative care with other health care professionals.
  • Assist with interventions that may include
    – External cephalic version
    – Internal cephalic version
    – Induction or augmentation with oxytocin
    – Amniotomy
    – Operative procedures
• External cephalic version
  – Definition – the attempt to turn the fetus from a breech or shoulder presentation to a vertex presentation for birth. It may be attempted in a labor and birth setting after 37 weeks gestation. Accomplished by gentle, constant pressure on the abdomen.

• Internal Version
  – Definition – fetus is turned by the physician, who inserts a hand into the uterus and changes the presentation to cephalic. May be used in multifetal pregnancies to deliver the second fetus.

• Induction of Labor
  – Definition of induction – the chemical or mechanical initiation of uterine contractions before their spontaneous onset.
  – Augmentation of labor – initiation of oxytocin in patient who is having inadequate contractions.
  – Indications
    • PIH
    • Diabetes
    • Postdates
    • Suspected fetal jeopardy – IUGR
    • History of rapid labor and mother living a distance from hospital
    • IUFD – intrauterine fetal death
– Medications –
  • Cervical ripening agents – ripens the cervix by causing softening and starting dilation and effacement, stimulates uterine contractions. Most common drug used is dinoprostone. Adverse reactions include headache, nausea and vomiting, diarrhea, fever, hypotension and hyperstimulation.

– Oxytocin – hormone produced normally for the posterior pituitary that stimulates uterine contractions.
  • Indications for use – induction or augmentation of labor
  • Contraindications
    – CPD
    – Non-reassuring fetal heart rate patterns
    – Placenta previa or vasa previa
    – Prior classical uterine incision or uterine surgery
    – Active genital herpes infection or know herpes lesion within last month.

– Administration of oxytocin–
  • Administered IVPB via infusion pump.
  • Measured in mU/min.
  • Titrated until uterine contractions are 2-3 minutes apart lasting 60-90 seconds and of the intensity to produce cervical change.
• Conditions that warrant close supervision with oxytocin use.
  – Multiple gestation
  – Breech presentation
  – Presenting part above the pelvic inlet
  – Abnormal fetal heart rate pattern not requiring emergency birth
  – Polyhydramnios
  – Grand multiparity
  – Maternal cardiac disease, hypertension

• Adverse Reactions
  – Tetanic contractions
  – Placental abruption
  – Uterine rupture
  – Lacerations of the cervix
  – Postpartum hemorrhage
  – Hyperstimulation of the uterus with resulting decreased blood flow to placenta, causing fetal compromise.

• Nursing Interventions
  • Be familiar with and follow all written protocol within the institution where you work.
  • Explain the procedure and expected course of the induction or augmentation to the patient and significant other.
  • Assess uterine activity and fetal heart rate with electronic fetal monitoring. Requires continuous fetal monitoring.
  • Document according to hospital standards and notify the appropriate personnel as needed.
  • Intervene with measures to promote comfort as appropriate.
– Interventions for hyperstimulation of the uterus or non-reassuring fetal response.
  • Maintain side lying position
  • Turn off oxytocin
  • Increase mainline IV rate
  • Start O2 per face mask at 8-10 L
  • Notify primary health care provider

Cesarean Section
• Definition – birth by surgical intervention to preserve the life and well-being of the mother and infant.
  – Increase in c/section rate from 5% in 1965 to >20% in 1997. Probably related to increased use of electronic fetal monitor and epidural anesthesia, increase in pregnancies of older mothers, higher incidents of repeat c/sections and increase in lawsuits against MD’s and hospitals.

Cesarean Section
• Indications – complications associated with labor and birth such as fetal distress, malpresentation, CPD, and obstetrical emergencies.
• Techniques –
  – Classical – incision made vertically in the main body of the uterus. Associated with increased blood loss, infections and likelihood of rupture of the uterine scar in subsequent pregnancies. Not commonly used.
- Low cervical transverse – incision made horizontally through the lower uterine segment. Associated with less blood loss, decreased postoperative infections and decreased risk of rupture of uterine scar. May attempt vaginal delivery with subsequent pregnancies.

• Complications
  – Maternal
    • Aspiration
    • Pulmonary embolism
    • Wound infection
    • Wound dehiscence
    • Thrombophlebitis
    • Hemorrhage
    • Urinary tract infections
    • Injuries to surrounding organs
    • Complications from anesthesia

• Complications
  – Fetal
    • Risk of prematurity
    • Trauma
• Anesthesia
  – General – used for emergency situation when time of intervention is critical. Also used when unable to place regional anesthesia or when regional anesthesia is contraindicated.
    • Complications
      – Risk of aspiration
      – Medications cross the placenta and affect the fetus. Reach the fetus within 3 minutes from time of induction of anesthesia.

• Regional – spinal or epidural anesthesia.
  • Advantages
    – Decreased risk of aspiration
    – Mother is awake and can be alert during delivery
    – Support person may stay in room

• Disadvantages
  – Anesthetic block may not be as profound as with general anesthesia.
• Preoperative Care
  – Informed consents must be obtained.
  – IV access must be obtained with 18 g needle
  – Pre-op meds
  – Abdominal prep
  – Insertion of Foley catheter
  – Maternal vital signs
  – Fetal heart tones in pre-op and in OR
  – Pre-op teaching

• Intraoperative Care
  – Circulating responsibilities
    • Displace weight of mother’s body off vena cava to perfuse uterus. (left wedge)
    • Assist with gowning and gloving
    • Note time entering OR, time of anesthesia start, time of start and finish of operation, name and titles of personnel in room, etc.
    • Count instruments prior to surgical incision when body cavities closed and at any other time requested by physician or other medical personnel.

• Note time of birth, sex, time of delivery of placenta.
• Assist with or do neonatal care and resuscitation as consistent with institution’s protocols and procedures.
• Maintain sterility and obtain all additional items needed during surgery
• Inform patient and support of infant status.
• Assist with transfer to recovery area.
• Immediate Postoperative Care
  – Maintain patent airway
  – Obtain vital signs, O2 saturation level, apply EKG monitor.
  – Assess level of consciousness and ability to respond to commands.
  – Assess level of regional anesthesia.
  – Assess level of pain

  – Assess dressing and bleeding from wound site and vaginally.
  – Assess fundal height and firmness.
  – Assess IV site for patency and fluid status.
  – Assess urinary output.
  – Promote breastfeeding if appropriate.
  – Promote bonding.

Mechanically Assisted Birth
• Definition – delivery of the infant head with the use of mechanical devices that guide the fetal head through the birth canal and out of the body. Currently two types of mechanical devices used, forceps and vacuum suction.
– Forceps – two metal curved blades with handles that fit around the fetal head.

• Indications
  – Fetal distress
  – Certain types of abnormal presentation
  – Arrest of rotation
  – Assist with delivery of the head after breech delivery of the body.

– Standards for forcep application

  • Full dilation
  • Known fetal part presenting, preferably vertex
  • Presenting part engaged
  • Membranes ruptures
- Types of forceps
  - Outlet – appropriate when fetal scalp is visible on the perineum without manually separating the labia
  - Low – application of forceps to a fetal head that is at least at a +2 station.
  - Midforceps – application of forceps to the fetal head that is engaged (no higher than 0 station) but above the +2 station.

- Nursing interventions during forcep use
  - Monitor fetal heart rate throughout procedure
  - Ensure empty bladder to avoid trauma
  - Obtain type of forceps requested by MD and document.
  - Explain procedure to woman and provide support

- Assure that adequate anesthesia is available for patient.
- Inform proper personnel of assisted birth
- Assess infant after delivery for signs of trauma, ex. Bruising, abrasions, facial palsy, subdural hematoma.
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<th>Vacuum Extraction</th>
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<tr>
<td><strong>Definition</strong> – application of a plastic cup on the fetal head and the use of negative pressure to assist with the delivery of the head. The infant must be in a vertex presentation and membranes must be ruptured.</td>
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<tr>
<td><strong>Indications</strong> – same as for forceps</td>
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<th>Nursing interventions</th>
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<tr>
<td>Same as above except must also document the amount of pressure used with the vacuum and if any popup occurred.</td>
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<tr>
<th>Vaginal Birth After Cesarean</th>
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<tr>
<td>Vaginal Birth after Cesarean is recommended for women with a history of one cesarean birth with a low cervical transverse incision on the uterus.</td>
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<tr>
<td>Relatively safe with only a 0.5% risk of uterine rupture through a lower uterine segment scar.</td>
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VBAC

• Contraindicated in women with a previous classic cesarean scar or evidence of CPD.
• Nursing interventions
  – Continuous fetal and uterine monitoring during active phase of labor.
  – IV access in case c/section is indicated.
  – Support and comfort measures to alleviate anxiety.

Postterm Pregnancies

• Definition- pregnancies that go beyond 42 weeks gestation calculated for the first day of the last menstrual period.
• Risks
  – Maternal
    • Dysfunctional labor
    • Trauma to birth canal secondary to difficult delivery of a large infant.
    • Postpartum hemorrhage
    • Forceps or vacuum assisted delivery or c/section

  – Fetal
    • Prolonged labor
    • Shoulder dystocia
    • Birth trauma
    • Meconium passage in utero
    • Asphyxia secondary to meconium aspiration
    • Problems associated with aging of the placenta
      – Calcification of the placenta
      – Oligohydramnios
      – Cord compression r/t oligohydramnios
      – Fetal distress
      – IUFD (intrauterine fetal death)
Postterm Pregnancies

• Management
  – Biophysical profiles
  – Weekly NST’s after 40 weeks and twice weekly after 41 weeks.
  – Amniotic fluid volume assessment
  – Daily fetal movement counts
  – Induction of labor with close fetal monitoring

Obstetric Emergencies

• Shoulder Dystocia
  – A rare obstetric emergency in which the anterior shoulder can not be quickly or easily delivered after delivery of the head.
  – Risk Factors
    • Macrosomia-large baby with small pelvic outlet
    • Inexperienced or nervous deliverer
    • Maternal tension and/or fear – the mother is too upset or uncooperative to assist with expulsion of the fetal body
    • Obesity - may not be able to fully abduct hips to increase birth canal angle.

• Management – to increase the diameter of the birth canal and assist with the rotation of the anterior shoulder under the symphysis pubis. Call for assistance.
  • Suprapubic pressure- direct pressure applied downward immediately above the symphysis attempting to rotate the anterior shoulder.
  • McRobert’s maneuver -Lower the head of the bed to less than 45 degrees and abduct hips and flex the knees toward the chest.
• Note time of delivery of head and anterior/posterior shoulder.
• Prepare for resuscitation of infant.
• Examine infant for fractured clavicles and movement and tone of upper extremities.

Obstetric Emergencies

• Prolapsed Cord
  – Definition – occurs when the cord lies below the presenting part of the fetus. Can occur when the presenting part is not engaged in the pelvis or is not well applied to the cervix and rupture of membranes occur.
Obstetric Emergencies

• Prolapsed Cord
  – Risk Factors
    • Long cord
    • Floating or unengaged presenting part
    • Breech presentation
    • Transverse lie
    • Multiple gestation
    • polyhydramnios

Obstetric Emergencies

• Prolapsed Cord
  – Management
    • Immediate care must be done
    • Call for help
    • Do not remove fingers from cord and vagina, holding the fetal presenting part off cord.
    • Place woman in trendelenburg, knee chest or with hips elevated.
    • Notify primary health care provider
    • Prepare for immediate delivery, usually c/section.

Obstetric Emergencies

• Rupture of the uterus
  – A rare but serious obstetric injury that occurs in every 1500 to 2000 births. Most common causes are separation of the scar from previous classical c/section birth, uterine trauma and congenital uterine anomaly.
Obstetric Emergencies

• Rupture of the uterus
  – Signs and Symptoms
    • Vary with the extent of the rupture
    • May be silent or dramatic
    • Fetus may or may not show non-reassuring signs on EFM
    • Woman may display signs of shock
    • May experience sudden sharp abdominal pain

• Care management depends on severity
  • Hysterectomy and blood replacement is the usual treatment for complete rupture.
  • A laparotomy and repair of the laceration, with blood transfusions for small rupture.

• Rupture of the uterus
  – Other causes during labor and birth
    • Intense uterine contractions
    • Labor stimulation with oxytocin
    • Overdistended uterus (twins, triplets, etc)
    • Malpresentation
    • External or internal version
    • Difficult forceps assisted deliver
    • More common in multigravidas
Obstetric Emergencies

• Rupture of the uterus
  – Associated fetal mortality rates are high >80%.
  – Maternal mortality rates may be as high as 50-75%.

Abruption

• Placental abruption occurs when the placenta shears away from the uterine wall before the delivery of the infant

Abruption

• Risk factors
  - Maternal HTN
  - Cocaine use
  - Abdominal trauma
  - Smoking
  - Poor nutrition
  - Uterine abnormalities
  - History of greater than 5 low cervical transverse incisions or 3 classical incisions
Abruption

• Management
  - Immediate delivery-usually by c/section.
  - Replacement of blood products

Obstetric Emergencies

• Amniotic Fluid Embolism
  – Definition – occurs when amniotic fluid containing particles of debris (ex. Vernix, hair, skin cells, or meconium) enters the maternal circulation and obstructs pulmonary vessels, causing respiratory distress and circulatory collapse. Can occur because fluid can enter the maternal circulation any time there is an opening in the amniotic sac or maternal uterine veins accompanied by enough intrauterine pressure to force the amniotic fluid into the veins.

Obstetric Emergencies

• Amniotic Fluid embolism
  – Estimated to be associated with a maternal mortality rate as high as 86% and fetal mortality rate of 50%.
  – More damaging if meconium is present, and maternal death is more frequent because it clogs the pulmonary veins.
  – Even if death does not occur coagulation problems such as DIC usually occur.
Obstetric Emergencies

- Amniotic Fluid Embolism
  - Signs and Symptoms
    - Respiratory distress
    - Circulatory collapse
    - Hemorrhage
  - Interventions
    - Oxygenate
      - O2 by face mask or resuscitation bag delivering 100% oxygen.
      - Prepare for intubation and mechanical ventilation
      - Initiate or assist with CPR; tilt pregnant woman 30 degrees to side to displace uterus
  - Maintain Cardiac output and replace fluid losses
    - Administer IV fluids
    - Administer blood; packed cells, fresh frozen plasma
    - Insert Foley catheter and measure hourly output
Obstetric Emergencies

• Amniotic Fluid Embolism
  – Interventions
    • Correct coagulation failure
    • Monitor fetal and maternal status
    • Prepare for emergency birth once woman’s condition is stabilized
    • Provide emotional support to woman, her partner and family