20 Questions – Childbirth and Pregnancy Complications

1. You are called for a vaginal bleed. The patient is a 33 week pregnant woman with sudden onset of blood from the vagina. What are some possible causes?
2. If the bleeding was dark, and she had severe pain, what is the most common diagnosis?
3. The patient tells you that on an ultrasound done at 16 weeks she had a placenta previa. Is this helpful information?
4. What therapy should you provide to all pregnant patients?
5. If the patient must be placed supine to get her down the fifteen flights of stairs, how should she be positioned?
6. Following this call, you respond to an imminent delivery. How do you know when a delivery is imminent?
7. You find the patient pale and diaphoretic. Her BP is 60/P and HR 130. The abdomen is tender and distended. She has had seven other children, the most recent two by C-section. She is in terrible pain. What could be happening?
8. Responding on a seizure, you find your patient is 34 weeks pregnant. She had a witnessed generalized seizure. She has no history of seizures, but has been having headaches recently. Her VS are BP 160/95, HR 100, RR 16, sats 96%. What is the most probable diagnosis?
9. Called to another maternal labor (quite a night!), you find the mother in bed. The baby is crowning. You notice thick green secretions that came out when her water broke 15 minutes ago. What does this mean and what do you need to be prepared for?
10. On a subsequent call, you find the mother in bed. The umbilical cord is visible, but no baby is seen. What should you do?
11. Called to a PI, you extricate and are transporting a critical trauma patient, a female in her 20s. A few minutes from the ED, she has a cardiac arrest. You noted a low abdominal mass previously, and believe she may be pregnant. Can anything be done?
12. You are going to do a home delivery on a patient that is crowning. What do you need to do to help minimize vaginal tears as the head is delivered?
13. Once the head is out, what should you do next?
14. After checking for this, what should be done next?
15. How should you guide the baby once the head is out?
16. After the anterior shoulder delivers, how do you position the infant?
17. Following delivery of the body, where should the infant be placed?
18. How much room should you leave between the baby and the first cord clamp?
19. If the head delivers, but the shoulder does not, and the head seems to retract back into the vagina (turtle sign), what is potentially happening?
20. How do you deliver the placenta?

20 Answers – Childbirth and Pregnancy Complications

1. Placenta previa, placental abruption, bloody show (usually limited pink blood and mucus from the cervix-often occurs soon before labor starts), cervical bleeding (cervix is boggy and bleeds easily), polyps, and trauma are the most common causes of third-trimester bleeding.
2. Placental abruption typically presents with pain, dark vaginal bleeding (though bleeding may be absent in at least 20% of patients), and uterine contractions. This occurs when the placenta prematurely separates from the uterus. It is often related to trauma (even minor trauma), and occurs in about 1% of pregnancies. It can be extremely dangerous to the baby since the placenta is the source of oxygen for the fetus.
3. Maybe. 90% of placenta previas diagnosed on ultrasound early in pregnancy resolve by the time of delivery. However, if you have a bleeding patient that tells you this, it's certainly something to have on the list. Previa is when the placenta covers the cervical opening. Rupture of blood vessels in the placenta can cause heavy vaginal bleeding, usually bright red. The risk to the baby is much less than with abruption. 70% of previa are painless bleeds.
4. Oxygen. Regardless of the mother's oxygen saturations, the baby may be distressed and require supplemental O2.

5. She should have a pillow or other support placed under her right side, to prevent gravity from compressing the uterus against the vena cava, which would result in hypotension…15 degrees is adequate. (remember 'up-right' if you can't position them upright)
6. A good indicator is when mother says the baby's coming or she needs to push. The vast majority of pre-hospital deliveries will be in multiparous patients, so they will have been through it before. Other signs are a need to move the bowels, and obviously, the presentation of the head (or other parts).
7. Uterine rupture occurs extremely rarely, usually during labor. The mother dies in up to 40% of cases. Weakness of the uterus, often due to prior surgery and births, is common. The vaginal blood loss is usually only a fraction of the total lost, as most is intra-abdominal. Oxygen, IV fluids, and emergent transport for a C-section are all you can do.
8. Eclampsia is the occurrence of seizures in pregnancy associated with hypertension. The hypertension is sometimes severe. Seizures are treated with the usual benzodiazepines, and you may want to call to see if the doc wants you to start magnesium (usually 4 grams over 10 minutes). Pre-eclampsia is hypertension in pregnancy that is probably related to some dysfunction in the vessels of the placenta. It is present in 5-10% of all pregnancies. It is common for these patients to have headaches, visual changes, swelling of the legs, and sometimes abdominal symptoms. Generally, delivery of the baby is recommended to prevent progression to eclampsia.
9. The presence of meconium may mean that the infant is stressed. It usually occurs in post-dates babies (after 40 weeks). Thick meconium MAY require tracheal suctioning emergently after delivery if the baby is apenic on delivery. If the baby delivers and is not crying, do NOT stimulate the baby in this case. Proceed to tracheal suctioning until no more meconium is recovered from the airway, then dry, stimulate, and assess the infant as you usually would.
10. Umbilical cord prolapse is a major problem. Since the cord is preceding the baby, as the baby delivers it may cut off its own blood supply. First, check GENTLY to see if the cord has a pulse (do not pinch the cord to do this, lay your fingers against it gently- pinching may cause arterial spasm). Then, insert a gloved hand into the vagina and push up on the baby. Give oxygen to mom. Place her in reverse Trendelenburg if possible (head down). Transport Code 3 to the nearest hospital able to perform a C-section.
11. Perhaps. Even though this is a blunt trauma arrest an extraordinary effort may be made in which a thoracotomy is done on the mother at the same time an ED C-section is performed. A patient with a uterus at or above the umbilicus who can receive this intervention within 15 minutes of arrest is a candidate. Sometimes both baby and mother can be salvaged (but more often baby gets the better deal).
12. Place a hand against the head to apply just a slight amount of counter-pressure as the head delivers (do not hold the head in, however). This will limit explosive delivery and thus tearing.
13. Check to see if the baby has a nuchal cord (umbilical cord around the neck). If it does, see if it can be eased over the head. If it is too tight to do this, clamp and cut the cord before proceeding with delivery. Have mom breathe through the contractions until this is done.
14. Suction each nostril with the bulb suction (we used to do mouth first, but now we do nose first).
15. After the head delivers, place a hand on each side of the head and guide the head downwards (posteriorly), this will help the anterior shoulder deliver.
16. As soon as the anterior shoulder is out, bring the baby upwards to help deliver the posterior shoulder. This may happen fast, and the baby will be VERY slippery, so have a good grip!
17. Place the infant on a clean towel between mom's legs. If the baby is moved much above or below the uterus before the cord is cut they may lose blood to the placenta if they are placed above it (or gain too much blood if placed below) due to gravity.
18. At least 3 inches. If the baby is distressed, this will allow room to place umbilical central lines in the hospital.
19. Shoulder dystocia is quite rare, more common in babies born to diabetics and late (post-dates) babies (larger babies). One of the shoulders doesn't make it under the pelvis, and the baby is stuck. Get moving for the hospital! This will result in fetal death if not corrected soon. Try to have mom bring her legs up to her chest and hold her knees (like squatting) and apply pressure to the suprapubic area while guiding the head down. If this works, go ahead with delivery. If not, call a doc for more ideas…
20. You shouldn't need to worry about delivering the placenta in the field. If it does deliver, save it and bring it along to the hospital. Too much traction on the cord before the placenta

separates can invert the uterus or cause retained portions of the placenta (requires a trip to the OR). If you are at a fishing camp in the middle of nowhere, try gentle massage of the uterus and just slight traction on the umbilical cord to encourage delivery. Watch for post-delivery bleeding!

Even if not pregnant how about some State Fair pickles – or maybe a deep fried candy bar!