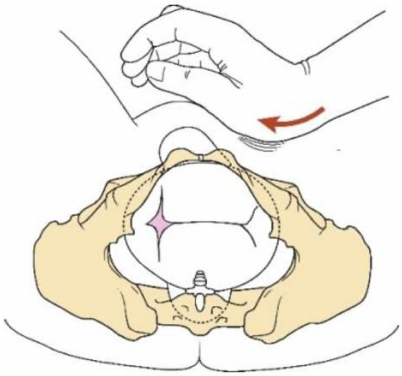
Sir Charles Gairdner Emergency Department Obstetric Guidelines

Shoulder Dystocia

Maternal pushing should be discouraged until shoulder displacement is achieved as it may lead to further impaction of the shoulders

Birth manoeuvres (first line)

McRobert's manoeuvre- perform first Position the woman in the Mc Robert's position: • Flex and abduct the maternal hips • Position the thighs up onto her abdomen This position is successful in up to 90% of cases of SD	 Image © North Metropolitan Health Service 2021
Suprapubic pressure Simultaneously, while the woman is placed in the McRobert's position: • Place both hands suprapubically over the posterior aspect of the fetal shoulder with the heel of the hand and apply continuous pressure in a downward lateral motion just above the maternal symphysis pubis. • If continuous pressure is not successful, apply the pressure in a rocking intermittent motion. • Only moderate traction should be applied	 Image © North Metropolitan Health Service 2021

If the above are not successful- (second line manoeuvres)

Rotation of the woman onto all- fours

- Rotation of the woman onto all-fours may also facilitate birth by increasing the pelvic diameters and allowing better access to the posterior shoulder.
- Note: In a woman who is less mobile proceeding with internal manoeuvres first may be more appropriate before considering 'all fours'.

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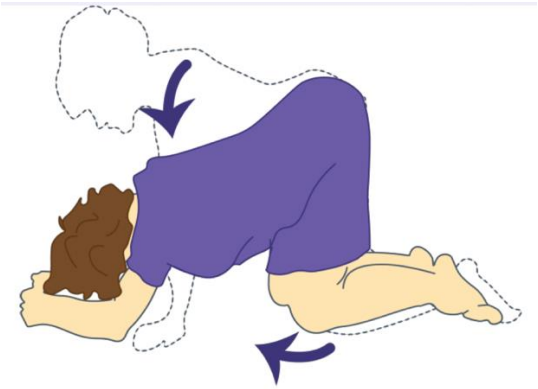


Image © North Metropolitan Health Service 2021

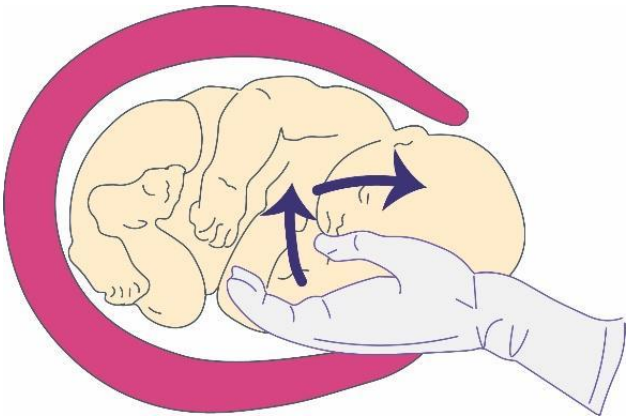
Evaluate the need for episiotomy

Perform an episiotomy to facilitate internal rotational manoeuvres as required.

Shoulder dystocia is a bony impaction, so episiotomy will not release the shoulders.

Deliver the posterior shoulder and arm

- Insert the hand into the vagina along the sacral curve and locate the posterior arm or hand.
- Grasp the fetal wrist or apply pressure to the cubital fossa to flex the elbow in front of the body and remove the forearm in a sweeping motion over the fetal anterior chest wall and fetal face.



Removing the posterior arm shortens the diameter of the fetal shoulders by the width of the arm.

There is a risk of humoral fractures (reported incidence 2-12%) however trauma may reflect the refractory nature rather than the procedure.

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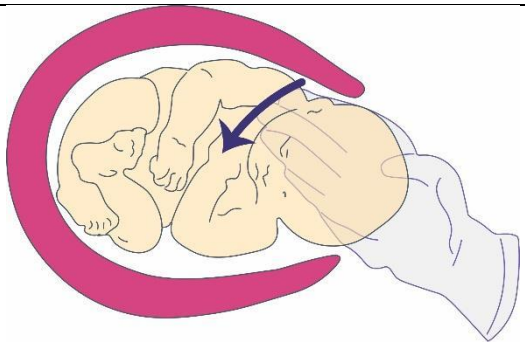
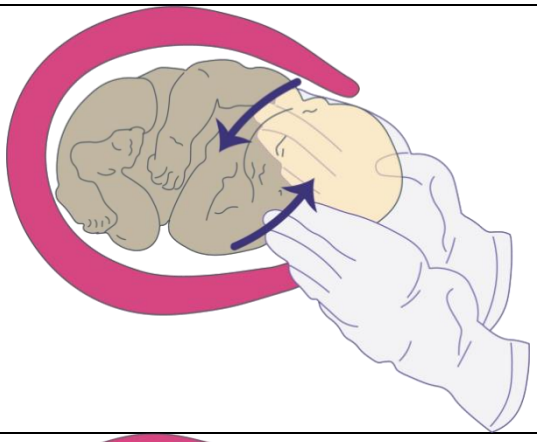
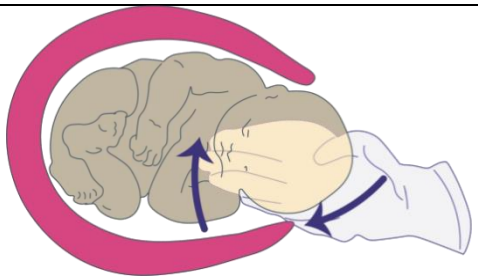
Internal rotational manoeuvres

(Described by Woods and Rubin)

One hand, fingers behind anterior shoulder: Insert the hand into the vagina posteriorly and sweep two fingers up to the posterior aspect of the anterior shoulder and push it towards the fetal chest into the oblique diameter of the pelvis. - *If this is not successful, move onto the manoeuvre below*	
Two hands: While one hand is performing the above, enter the vagina and apply pressure with two fingers to the anterior aspect of the posterior shoulder i.e. maintaining rotation in the original direction. - *If this manoeuvre is unsuccessful then the accoucheur moves onto the reverse manoeuvre below.*	
Reverse direction of posterior shoulder: Apply pressure to the posterior aspect of the posterior shoulder and attempt to rotate it through 180° in the opposite direction to the previous manoeuvre.	 Image © North Metropolitan Health Service 2021

Repeat

If previous manoeuvres are not successful, try repeating them all.

Key points regarding shoulder dystocia

Use the HELPERR mnemonic:

H = Help

E = Evaluate for episiotomy

L = Legs (McRoberts Manoeuvre)

P = Pressure (Suprapubic)

E = Enter the vagina (Internal Manoeuvres)

R = Remove the posterior arm

R = Roll onto all fours

- Throughout these manoeuvres the shoulders must be rotated using pressure on the scapula or clavicle. NEVER ROTATE THE HEAD.
- **Avoid excessive traction at all times.** Strong downward traction or jerking without disimpacting the shoulder is associated with neonatal trauma and brachial plexus injury.
- Avoid fundal pressure. This is associated with high rate of brachial plexus injury, uterine rupture and haemorrhage from potential detachment of fundal placenta.
- Third and fourth degree perineal trauma and PPH are possible complications resulting from shoulder dystocia.