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Shoulder dystocia

In shoulder dystocia, disproportion occurs between the bisacromial diameter of the foetus and the antero-posterior diameter of the pelvic inlet, resulting in impaction of the anterior shoulder of the foetus behind the symphysis pubis.[1] Difficult delivery ensues, requiring the use of additional manoeuvres beyond the downward traction of the foetal head. It is relatively uncommon, occurring in 1 in 300 births.

Shoulder dystocia – woods screw manoeuvre

Shoulder dystocia is associated with serious complications for both the mother and baby.[1] Perinatal morbidity includes asphyxia, birth trauma such as brachial plexus injury and fractured clavicles, and permanent neurological damage. Foetal death can also occur if not recognised immediately and treated promptly.[2]

Clinical features

Shoulder dystocia usually becomes obvious after the foetal head emerges and retracts up against the perineum, failing to undergo external rotation (turtle sign).[3]

Shoulder dystocia is confirmed when the standard delivery manoeuvres (traction in a lengthwise trajectory) fail to deliver the foetus and the head to body delivery interval is prolonged ≥ 60 seconds.[4]

Risk assessment

An increased risk of shoulder dystocia is reported in association with:
- prolonged second stage of labour
- assisted delivery
- maternal diabetes with or without macrosomia
- previous shoulder dystocia
- a large foetus > 4.5 kg (macrosomia)
- history of a large foetus
- maternal obesity
- multiparity.

Any combination of the above factors may significantly increase the risk of shoulder dystocia.[5]
Additional information

External manoeuvres include the following:

- McRoberts manoeuvre
- Rubin I manoeuvre (supra pubic pressure)
- Rotation onto all fours

Apply downward pressure just superior to the symphysis pubis in a continuous or rocking motion.
Additional information (cont.)

Internal manoeuvres: manipulation of the foetus within the birth canal includes:

- Rubin II manoeuvre
- Woods Screw manoeuvre
- Reverse woods screw manoeuvre
- Deliver of posterior arm

**NOTE:** Paramedics must exhaust all external manoeuvres first before undertaking the manipulation of the foetus within the birth canal. A description of each of these techniques is given in CPP: Shoulder dystocia. Always consider appropriate pain relief as required.
RECOGNISE SHOULDER DYSTOCIA:
- Turtle sign: foetal shoulders fail to deliver because anterior shoulder is struck behind maternal symphysis pubis
- Failure to deliver head to body delivery interval is > 60 seconds

MATERNAL POSITION:
- Ask mother to lie flat, then assist to move into running start position, then alternate to all fours

EXTERNAL MANOEUVRES: MAINTAIN URGENCY WHEN CARRYING OUT MANOEUVRES
- McRoberts manoeuvre (bring her knees up towards her chest, thighs to abdomen)
  - If shoulders do not release after 30 seconds move to the next step
- Rubin’s I manoeuvre, (Suprapubic pressure applied in downwards and in lateral direction)
  - If shoulders do not release after 30 seconds move to next step
- All fours position (move mother onto ‘all fours’, encourage mother to push to release shoulders)
  - If shoulders do not release after 30 seconds move to next step

INTERNAL MANOEUVRES
- Rubin II (using fingers apply pressure behind the anterior shoulder, pushing the shoulder towards the baby’s chest)
  - Do not pull downwards or twist foetal neck
  - Woods screw
  - Reverse woods screw
  - Delivery of posterior arm

CONDUCT POST-DELIVERY ASSESSMENT AND CARES:
- Dry baby
- Maintain warmth
- Provide maternal and neonate skin to skin contact
- Clamp and cut the cord, when it stops pulsating
- APGAR score at 1 & 5 minutes
- Encourage breastfeeding

SUCCESSFUL?

Transport to hospital
Pre-notify as appropriate