While the QAS has attempted to contact all copyright owners, this has not always been possible. The QAS would welcome notification from any copyright holder who has been omitted or incorrectly acknowledged.

All feedback and suggestions are welcome. Please forward to: Clinical.Guidelines@ambulance.qld.gov.au

Disclaimer

The Digital Clinical Practice Manual is expressly intended for use by appropriately qualified QAS clinicians when performing duties and delivering ambulance services for, and on behalf of, the QAS.

The QAS disclaims, to the maximum extent permitted by law, all responsibility and all liability (including without limitation, liability in negligence) for all expenses, losses, damages and costs incurred for any reason associated with the use of this manual, including the materials within or referred to throughout this document being in any way inaccurate, out of context, incomplete or unavailable.

**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.[4]
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:** Clinicians 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.
EVIDENCE OF SHOULDER DYSTOIA:
• Turtle sign – the foetus fails to undergo external rotation due to the shoulders being too large to enter the pelvis or have entered at an unfavourable angle/diameter
• Failure to deliver – this timing is vital as sometimes contractions cease, manoeuvres should be initiated at 60 seconds after birth of the head

COMMENCE EXTERNAL MANOEUVRES – ATTEMPT EACH PROCEDURE FOR 30 SECONDS, IF THE FOETUS FAILS TO DELIVER, PROGRESS TO THE NEXT STEP.
• McRoberts manoeuvre (knees to chest)
• Rubin’s I manoeuvre (supra pubic pressure)

Note 1: 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 CPG: Shoulder dystocia.
Always consider appropriate pain relief as required.

Note 2: Clinicians must only perform procedures for which they have received specific training and authorisation by the QAS.

SUCCESSFUL?

COMMENCE INTERNAL MANOEUVRES – ATTEMPT EACH PROCEDURE FOR 30 SECONDS.
• Request the mother to stop pushing
• Rubin’s II manoeuvre
• Wood screw manoeuvre
• Reverse wood screw manoeuvre
If the mother is already on all fours, assist the mother into the running start position (Gaskin manoeuvre) and attempt to deliver the posterior arm

SUCCESSFUL?

Newborn is breathing effectively/crying with good muscle tone and HR > 100?

CONDUCT POST-DELIVERY ASSESSMENT AND CARES.
Newborn
• Dry the newborn
• Encourage skin to skin contact
• Assess APGAR (at 1 and 5 minutes)
• Clamp and cut the cord (when pulsations have ceased)
• Encourage breastfeeding
• Provide ongoing patient assessments and management

Birthing parent
• Manage the third stage of labour (active management preferred due to increased risk of PPH)
• Provide ongoing patient assessments and management

Newborn and birthing parent assessment and management should ideally occur simultaneously if this does not interfere with treatment priorities and sufficient resources are available.

Manage as per:
CPG: Resuscitation – Newborn

Transport to hospital
Pre-notify as appropriate