Clinical Practice Guidelines:
Obstetrics/Umbilical cord rupture

<table>
<thead>
<tr>
<th>Policy code</th>
<th>CPG_OB_UCR_0518</th>
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<tr>
<td>Date</td>
<td>May, 2018</td>
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<tr>
<td>Purpose</td>
<td>To ensure consistent management of umbilical cord rupture.</td>
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<tr>
<td>Scope</td>
<td>Applies to Queensland Ambulance Service (QAS) clinical staff.</td>
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<tr>
<td>Health care setting</td>
<td>Pre-hospital assessment and treatment.</td>
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<tr>
<td>Population</td>
<td>Applies to all ages unless stated otherwise.</td>
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<tr>
<td>Source of funding</td>
<td>Internal – 100%</td>
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<tr>
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Umbilical cord rupture

The tensile strength of the umbilical cord is directly proportional to the weight of the baby by approximately 2.5 times. A pre-term lower weight baby’s umbilical cord will possess less tensile strength. Cord rupture can cause significant haemorrhage, hypovolemic shock and even exsanguination of the newly born.[1]

Risk factors include:

- short cord
- precipitous unassisted delivery of the baby dangling by cord
- premature delivery (friable cord)

**Clinical features**

- deteriorating condition of the newly born
- visible blood loss between cord and clamp
- visible tear in the umbilical cord

**Risk assessment**

- umbilical cord rupture represents a life-threatening emergency to the newly born
- a small amount of blood loss from the newly born represents a significant proportion of their total circulating volume

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**CPG: Clinician safety**

- CPG: Standard cares

**Apply direct pressure to tear with sterile dressing**

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**Tear close to newly born abdominal wall?**

- **Y**
  - Position clamp proximal to tear
  - Newly born HR < 100?
    - **Y**
      - Manage as per:
        - CPG: Resuscitation
          - Newly born
    - **N**
      - Consider:
        - IV/IO fluid
        - Transport to hospital
        - Pre-notify as appropriate
  - **N**
    - Note: Clinicians are only to perform procedures for which they have received specific training and authorisation by the QAS.