Guideline for the Management of Cord Prolapse

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Specialty: Maternity
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GUIDELINE FOR THE MANAGEMENT OF CORD PROLAPSE

Definition

Cord prolapse is when a loop of umbilical cord descends through the cervix either alongside the presenting part (occult) or below the presenting part (overt) in the presence of ruptured membranes.¹

Incidence

Occurs in 0.1-0.6% cases. 50% are preceded by an obstetric intervention.

Risk factors

Fetal

- Congenital anomaly
- Prematurity <37 weeks
- Polyhyramnios
- Multiple pregnancy (second twin)
- Breech presentation
- Transverse, oblique or unstable lie
- Unengaged presenting part
- Low birth weigh <2.5kg

Maternal

- Grand multip
- Placenta praevia
- Long cord/cord presentation

Procedure related

- Artificial rupture of membranes/stabilizing induction
- Vaginal manipulation of the fetus in the presence of ruptured membranes
- Internal podalic version

Patients with transverse/oblique/unstable lie should be offered admission after 37+6 weeks gestation.

Patients with a non-cephalic presentation and preterm pre-labour rupture of the membranes should be offered admission.

Avoid artificial rupture of membranes if presenting part is mobile.

Diagnosis

Can occur in the presence of a normal fetal heart rate pattern.

If risk factors are present as above and a spontaneous rupture of the membranes occurs +/- acute change in fetal heart rate pattern a vaginal examination should be performed to exclude cord prolapse.

Ultrasound may be required to confirm ongoing fetal heart activity.
Management

- Call for help – emergency buzzer, dial 2222 stating Obstetric emergency and the location
- Using sterile gloves keep a hand in the vagina to elevate the presenting part and relieve the pressure on the cord
- Minimise handling of the cord to avoid vasospasm. If outside vagina gently replace into vagina.
- Place patient into head down tilt or knees to chest position ideally in left lateral position.
- Consider filling the bladder (500ml normal saline via Foley catheter and blood giving set and clamp. Remove and drain bladder prior to an attempt at delivery.
- Consider tocolysis (0.25mg terbutaline s/c)
- Category 1 LSCS recommended in the presence of fetal heart rate abnormalities.
- Operative delivery can be considered if fully dilated and quick delivery anticipated.
- Breech extraction can be performed in some circumstances ie. After internal podalic version of the second twin.
- Category II LSCS may be appropriate if normal fetal heart rate
- A practitioner competent in neonatal resuscitation should be present at delivery.
- Paired cord blood samples should be taken.
- Post natal debriefing should be offered to patient
- Complete a trigger incident from

References

2. MOET course manual
Obstetric management:

CALL FOR HELP - 2222

Is fetal heartbeat present?

Yes

Is cervix fully dilated?

Yes

Consider Ventouse delivery

No

Elevate the presenting part to relieve pressure

Patient in head down tilt or knees to chest in left lateral

Consider filling the bladder with 500ml normal saline using Foley's Catheter

Monitor fetal heart with CTG

Normal CTG

C-Section / Consider Reg Anaesthesia

Suspicious / pathological CTG

Consider tocolysis if contracting

Grade 1 C-Section

At skin incision, release clamp and drain bladder

No

Confirm IUD with Ultrasound

Await spontaneous delivery
**Directorate of Women & Child Health**

**Checklist for Clinical Guidelines being Submitted for Approval**

**by Quality & Safety Group**

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* To be completed by Author and submitted with document for ratification to Clinical Governance Facilitator