STANDARD OPERATING PROCEDURE

Shoulder Dystocia

Special Region (1)

Union of Myanmar

Version: (1)

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Approved by: Internal Medicine Unit

Shoulder Dystocia

Introduction

- a vaginal cephalic delivery that requires additional obstetric manoeuvres to release the

shoulders after gentle downward traction has failed

- anterior or, less commonly, the posterior fetal shoulder impacts on the maternal

symphysis or sacral promontory

- Significant morbidity for both the mother and the fetus

Risk Factors

- maternal obesity
- macrosomia
- poorly controlled gestational and insulin-dependent DM
- previous shoulder dystocia, instrumental

Complications

Maternal complications

- increased perineal trauma (third- and fourth-degree tear)
- PPH
- psychological trauma

Fetal complications

- brachial plexus injury (weakness or paralysis)
- fractured clavicle or humerus
- birth asphyxia
- death (rare)

Warning Signs

- difficulty with delivery of the face and chin
- the head remaining tightly applied to the vulva or even retracting (Turtle-neck sign)
- failure of restitution of head following delivery of the head
- failure of the shoulders to descend

Management

- Should be managed systematically
- The HELPERR mnemonic is used as a memory aid
- H= Help
- E= Episiotomy
- L= Legs (McRoberts’ Manoeuvre)
- P= Pressure (Suprapubic pressure)
- E= Enter manoeuvres (internal monoeuvres)
- R= Remove or Delivery the posterior arm
- R= Roll the patient on to all- four position

H= Help

- call for help
- maternal pushing should be discouraged
- fundal pressure should not be applied

E= Episiotomy

- episiotomy to assist with later fetal manoeuvres
- allow optimal flexion and may help delivery

L= Legs (McRoberts’ Manoeuvre)

- Lie mother flat
- Bring her to the edge of the bed
- using one assistant on each of the mother’s legs

- Hyperflexion and abduction of the maternal hips
- positioning the maternal thighs on her abdomen

P= Pressure (Suprapubic pressure)

- with heel of hand
- constant or rocking pressure for 30 seconds in a downward and lateral direction
- apply over the posterior aspect of the anterior fetal shoulder just above the maternal

symphysis pubis

- McRoberts' manoeuvre and suprapubic pressure can be combined together to improve

success rate E= Enter manoeuvres (internal monoeuvres)

- done by senior obstetrician
- the whole hand should be entered posteriorly to perform internal rotation
- aim is to rotate the shoulders into an oblique lie or by a full 180 degree
- Woods' screw manoeuvres and Reverse Woods' screw manoeuvre

Woods' screw manoeuvres

- insert the fingers of the opposite hand vaginally to approach the posterior shoulder from

the front of the fetus

- press on the anterior or posterior aspect of posterior shoulders
- if pressure on the posterior shoulder is unsuccessful
- an attempt should be made to apply pressure on the posterior aspect of the anterior

shoulder Reverse Woods' screw manoeuvre

- Place fingers on the posterior shoulder from behind the fetus
- rotate in the opposite direction
- two handed-technique may be tried with any of these manoeuvres

R= Remove or Delivery the posterior arm

- reduces the diameter of the fetal shoulder
- inserting a hand into the posterior vagina
- fetal wrist should be grasped
- posterior arm should be gently withdrawn from the vagina in a straight line

R= Roll the patient on to all- four position

- When failed to deliver the shoulder
- roll the woman on to all four limbs position
- placing the patient onto her hands and knees
- try to deliver the baby or repeat stages above

Persistent failure of first and second line manoeuvres,

- third-line manoeuvres (cleidotomy, symphysiotomy and Zavanelli manoeuvres) should be

considered. After shoulder dystocia

- Birth attendants should be alert to the possibility of PPH and severe perineal tears.
- The baby should be examined for injury by a neonatal clinician.
- An explanation of the delivery should be given to the parents.

Documentation

It is important to record within the birth record:

- time of delivery of the head and time of delivery of the body
- anterior shoulder at the time of the dystocia
- manoeuvres performed, their timing and sequence
- maternal perineal and vaginal examination
- estimated blood loss
- staff in attendance and the time they arrived
- general condition of the baby (Apgar score)
- umbilical cord blood acid-base measurements
- neonatal assessment of the baby

It is particularly important to document the position of the fetal head at delivery as this facilitates identification of the anterior and posterior shoulder during the delivery.

References

1. Obstetrics by Ten Teachers, 21st Edition

2. Obstetrics and Gynaecology Myanmar management guidelines, 2024

3. Shoulder Dystocia (Green-top Guideline No.42)