Protocol

OB-01

SECTION: OB-01

PROTOCOL TITLE: GENERAL OB Care

REVISED: November 1, 2017

GENERAL COMMENTS: This is a general protocol for non-specific OB emergencies, including contractions of non-specific etiology and vaginal bleeding (other than post partum). When possible this protocol should supplement other, more specific protocols based on clinical assessments and judgment.

BLS SPECIFIC CARE: *See Adult General Care protocol M-1*

- Any pregnant patient with direct blunt trauma to the abdomen should be encouraged to seek medical evaluation
- In case of vaginal bleeding (second or third trimester) assess for imminent delivery of fetus or other tissue with **VISUAL** inspection of the perineum.
- Rapid transport to an ***appropriate*** facility
- All patients in second and third trimester who are transported in the supine position should be placed in the left lateral recumbent position
- If amniotic sac has ruptured, determine time of rupture and try to ascertain if meconium was present in the fluid (determine color, odor and consistency)
- IF ACTIVE LABOR and CROWNING:
  - Follow **Childbirth Procedure** (Appendix 23)
  - Expedite transport for:
    - <36 weeks gestation AND crowning
    - Abnormal fetal presentation
    - Severe vaginal bleeding
    - Multiple gestations
- IF ACTIVE LABOR and NO crowning:
  - Monitor, reassess. Document duration/frequency of contractions
  - Notify receiving facility

AEMT/O.M. SPECIFIC CARE: *See Adult General Care protocol M-1*

ALS SPECIFIC CARE: *See Adult General Care protocol M-1*

GENERAL O.B. CARE

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PHYSICIAN PEARLS:

Manual exams of the vagina are not done in the field. Do not delay transport with high risk deliveries. Remember that maternal blood volume increases up to 45% with a relative anemia developing by the increase in circulating plasma. Therefore a pregnant patient may lose up to 35% circulating volume prior to showing severe S/S shock. If the pregnant patient is showing s/s of shock, in severe respiratory distress, altered in her mental status, or otherwise in extremis, transport to a facility with emergent surgical capability.

General considerations:

- Blood pressure usually decreases by 10-15 mm Hg by end of first trimester
- Heart rate increases 10-15 beats per minute
- Signs and symptoms of shock are delayed in these patients
- Transport all second or third trimester patients on left side
- Manually displace the uterus of third trimester patients to left side during CPR
- Angioedema and swelling may reduce the size of the airway, be prepared to use a smaller size ET Tube. (AHA 2010 recommendations)
- If CPR is required, do so while another responder manually pulls (externally) the uterus to the left. **Remove any fetal monitors prior to defibrillation**

Key history:

- Gestational age
- Expected due date
- How many pregnancies (gravida)
- How many live births (para)
- How many abortions or miscarriages
- Pre-natal care
- Number of fetuses
- Recent trauma
- Last fetal movement felt
- Other identified problems
- OB/primary physician & hospital choice
- Amount and type of bleeding/discharge (if applicable)

* Do not delay transport in active labor situations to obtain history.