Women's Health Interest Society of Monash

MUMUS

WHISM

Practice OSCEs in Obstetrics & Gynaecology

2020

Disclaimer

These OSCE stems have been written by Year 4C and 5D Monash medical students who are members of WHISM. They are intended as a study aid for students undertaking their Women's Health rotation and/or preparing for their Women's Health exams. Any relevance to faculty released OSCE stations is purely coincidental.

Title sheet

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Reviewer (if applicable):

Date reviewed (if applicable):

Station title: *Baby Sammy is stuck*

Topic covered: *Obstetric emergency - shoulder dystocia*

Station type: *Management*

Candidate instructions

Stem

You are the obstetrics registrar in birthing suite. The midwife calls out for you to come to see Miss Jane Smith who is currently in second-stage labour. She reports that the foetal head is retracting into the perineum.

Tasks

1. *State your step-wise management of this situation (5 minutes)*
2. *Answer the examiner's questions (3 minutes)*

Patient and examiner instructions/Marking sheet

Patient name: Jane Smith
Patient age: 27
Patient occupation: Nurse

MANAGEMENT

Introduction

Candidate should state that:

- This is an obstetric emergency due to shoulder dystocia
- I would elicit a quick history from the nurse in charge, examine and begin management simultaneously in the case of this obstetric emergency. For the purpose of this assessment, I will discuss this separately

History – assess for any risk factors, spontaneous vs. induced vaginal delivery, contractions, use of epidural and other analgesics

Principles:

- Do not apply fundal pressure (increases impaction of anterior shoulder)
- Stop mother pushing
- Specialised manoeurvres are necessary
- Each step and manoeuvre should be attempted for maximum 30 seconds

Step-Wise Management

Help (call for help)

- Put some information here as to how – Code ?? – call for more senior staff/midwife/obstetrician

Episiotomy:

- Should be considered to improve access for internal manoeuvres

Legs:

- McRoberts manoeuvre – Buttocks to end of bed and support the thighs hyperflexed to chest (knees to nipples) – *this step often corrects 90% of cases*

Pressure:

- Assistant performs suprapubic pressure over the posterior aspect of the anterior shoulder of the foetus
- Either constant pressure or a rocking motion is used

Enter:

- Rubins 2 manoeuvre (pressure is applied to the posterior aspect of anterior shoulder)
- Woods' screw manoeuvre (add anterior pressure to posterior shoulder in addition to the posterior pressure on the anterior shoulder from the Rubin 2 manoeuvre)
- Reverse Woods' screw manoeuvre (opposite to the Woods'screw – anterior pressure to the anterior shoulder and posterior pressure to the posterior shoulder

Remove posterior arm:

- Apply pressure to posterior arm cubital fossa to encourage flexion
- Then sweep arm along chest to deliver
- Anterior shoulder may drop for delivery

Roll onto all fours

- Can repeat internal manoeuvres once in this position

Last line manoeuvres:

- Cleidotomy - surgical division of the clavicle or bending with a finger
- Symphysiotomy dividing the anterior fibres of symphyseal ligament
- Zavanelli's manoeuvre - vaginal replacement of the head and then delivery by caesarean section

Debrief

- Ensure the patient and family understand the nature of the obstetric emergency
- Use a model to explain the obstruction

Document

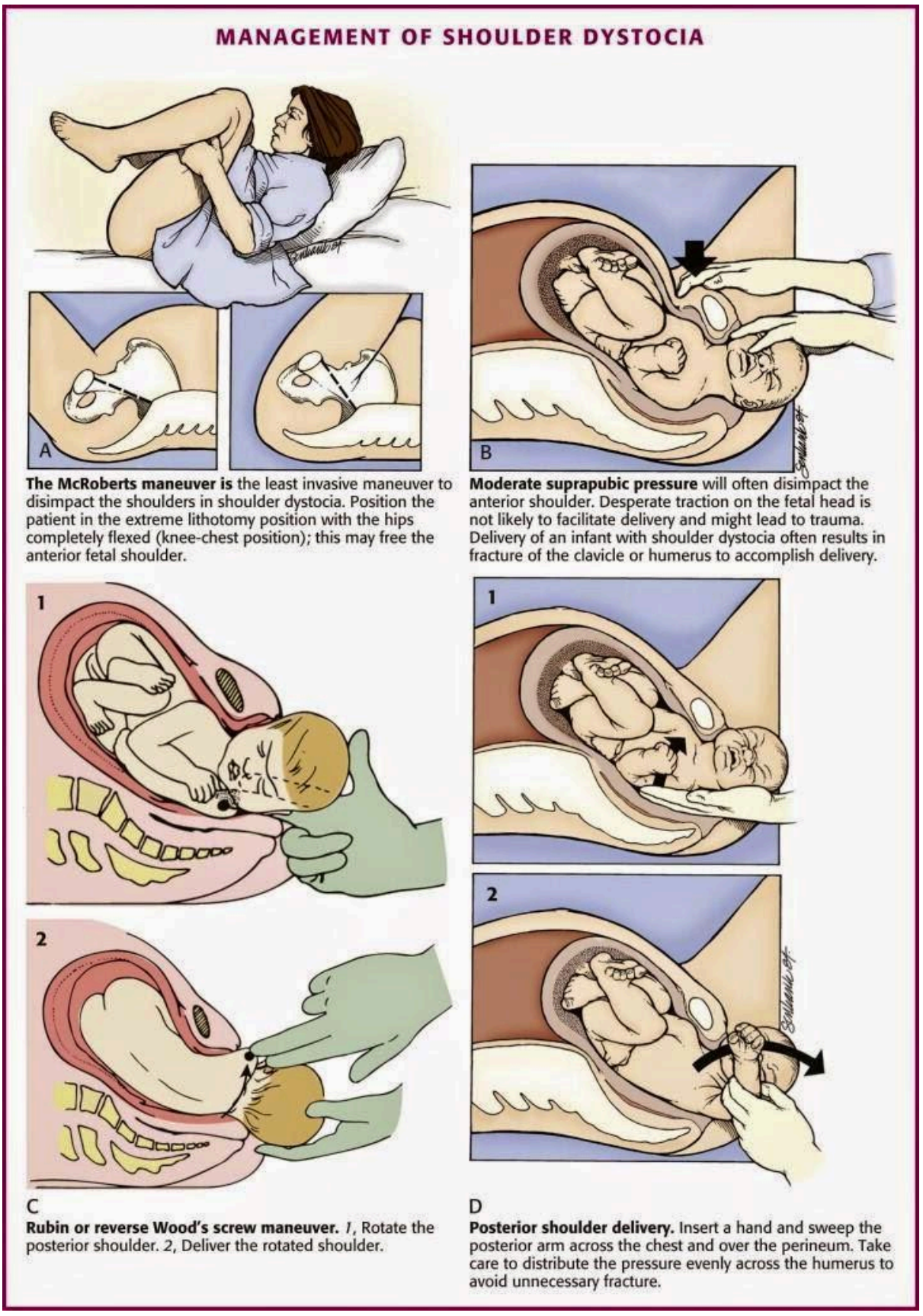
- This includes which shoulder (L or R) was impacted – important when following up any complications to the fetus

QUESTIONS

1. What are some risk factors for shoulder dystocia?
    - Maternal obesity
    - Macrosomia
    - Short stature
    - Prolonged pregnancy
    - Microcephaly/ anencephaly
    - Prolonged labour

2. What are some possible foetal complications of shoulder dystocia?
    - Brachial plexus injury
    - Fractured clavicle
    - Facial purpuric rash
    - Birth asphyxia

3. What are some possible maternal complications of shoulder dystocia?
    - Perineal tears
    - PPH
    - Uterine rupture
    - Psychological effects



The McRoberts maneuver is the least invasive maneuver to disimpact the shoulders in shoulder dystocia. Position the patient in the extreme lithotomy position with the hips completely flexed (knee-chest position); this may free the anterior fetal shoulder.

Moderate suprapubic pressure will often disimpact the anterior shoulder. Desperate traction on the fetal head is not likely to facilitate delivery and might lead to trauma. Delivery of an infant with shoulder dystocia often results in fracture of the clavicle or humerus to accomplish delivery.

C

Rubin or reverse Wood's screw maneuver. *1*, Rotate the posterior shoulder. *2*, Deliver the rotated shoulder.

D

Posterior shoulder delivery. Insert a hand and sweep the posterior arm across the chest and over the perineum. Take care to distribute the pressure evenly across the humerus to avoid unnecessary fracture.

http://www.emcurious.com/blog-1/2015/3/28/shoulder-dystocia

Resources:

PROMPT Guideline: Shoulder Dystocia (Maternal Emergency)
https://system.prompt.org.au/Search/SearchLibrary.aspx

RCOG GreenTop Guideline: Shoulder Dystocia No. 42
https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg42/