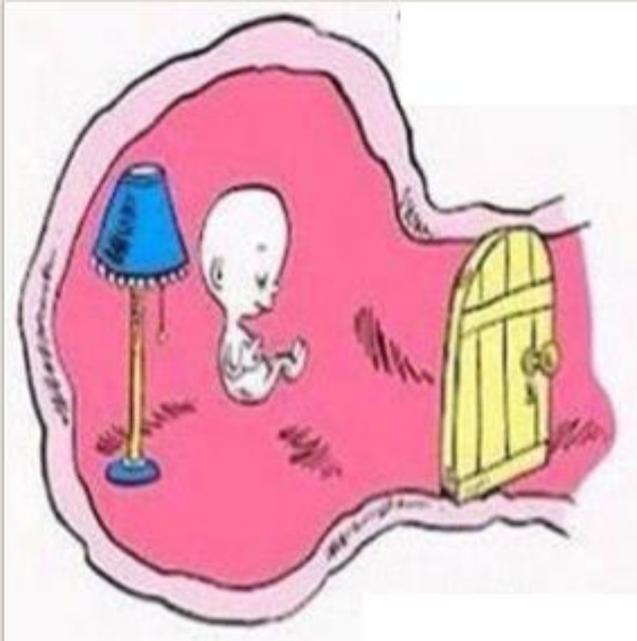


2025

SHOULDER DYSTOCIA

Dr Seuss Explains Pregnancy

What is a womb?
Well a womb is a room
A womb is a room
Where a kid'll be soon

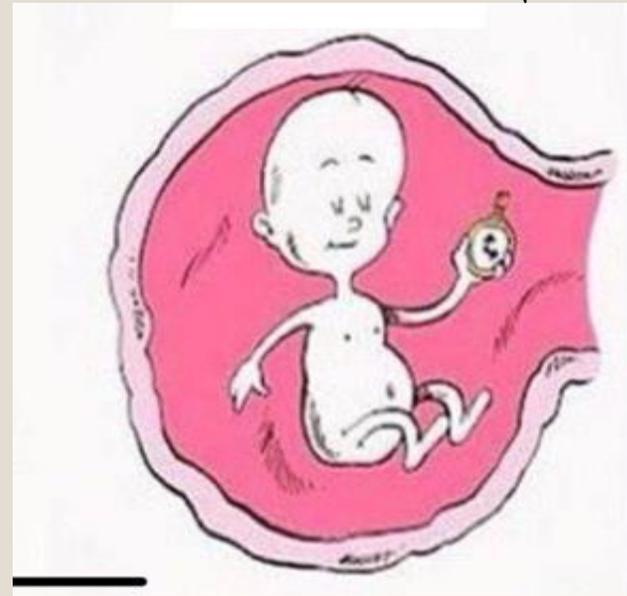


A womb is all squishy
All moist and magenta
And if there's a kid
Then its full of placenta

But the kid must be small
If there's one there at all
Just the size of a bean
Or the size of a ball

When the kid gets too big
Then its time to get out
When it happens to you
You will probably shout

You will shout, you will yell
You will roll on the floor
Cos the kid must come out
Of a very small door



What Is Shoulder Dystocia?

- **Most commonly diagnosed as failure to deliver the fetal shoulder(s) with gentle downward traction on the fetal head, requiring additional obstetric maneuvers to effect delivery.**
 - **ACOG, 2017 (reaffirmed 2019)**

There are differences in reported rates due to clinical variation in defining shoulder dystocia

- **Reported incidence among vaginal deliveries in vertex presentation is 0.2% to 3%**

**Incidence
of
Shoulder
Dystocia**

Risk Factors

Maternal diabetes

Maternal obesity

Several other associated factors

- Lack high predictive value

Associated Risk Factors

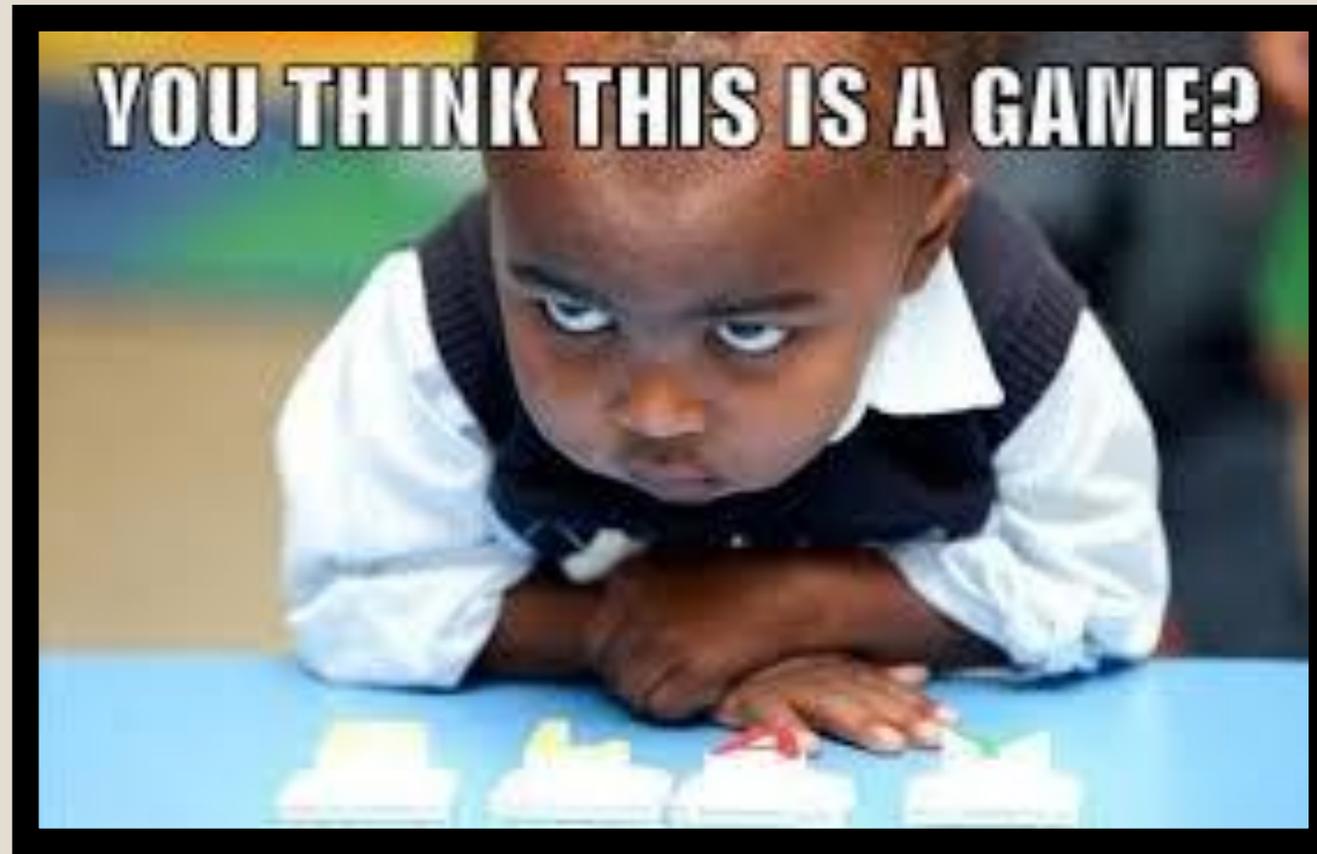
**Suspected fetal
macrosomia**

**History of prior shoulder
dystocia**

**Mid-pelvic operative
birth with an EFW of 4000
grams**

- Baird & Kennedy, 2017, p. 448

Game Time!



<https://encrypted-tbn0.gstatic.com/images?q=tbn:ANd9GcShllKeDwtoZxfYVMf55ae700Ot6FRxszycgw&s>

Shoulder dystocia cannot be reliably predicted or prevented

- Baird & Kennedy, 2017, p. 448

BE PREPARED AT EVERY DELIVERY!!

Recommendation:
**Prepare with every
delivery!**

Nurses Role: Prepare the Room & Communication

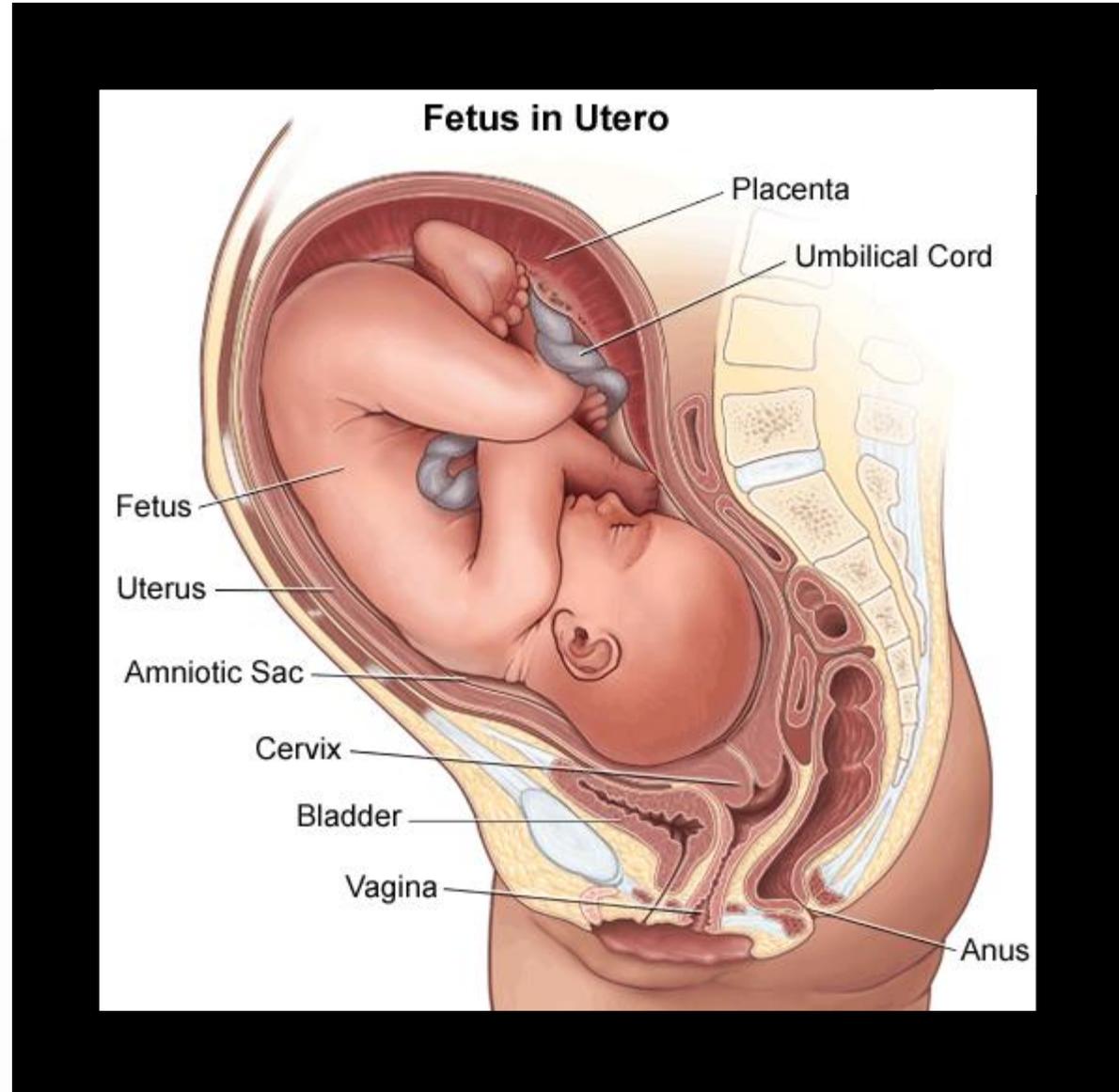


**Step stools
readily available
for all deliveries**

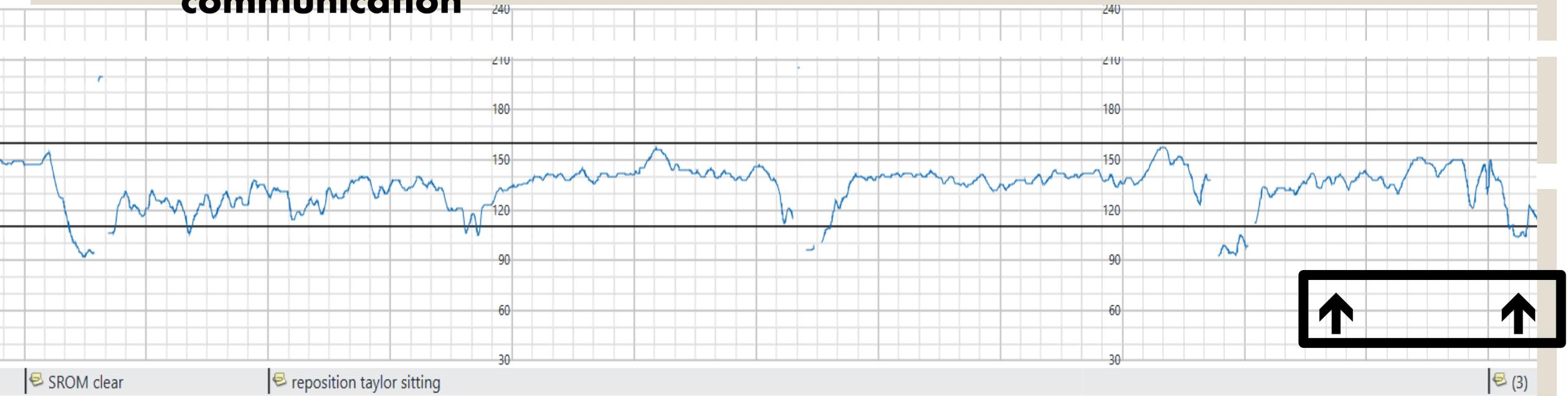
- **Rationale: to use when performing suprapubic pressure**

The Bladder

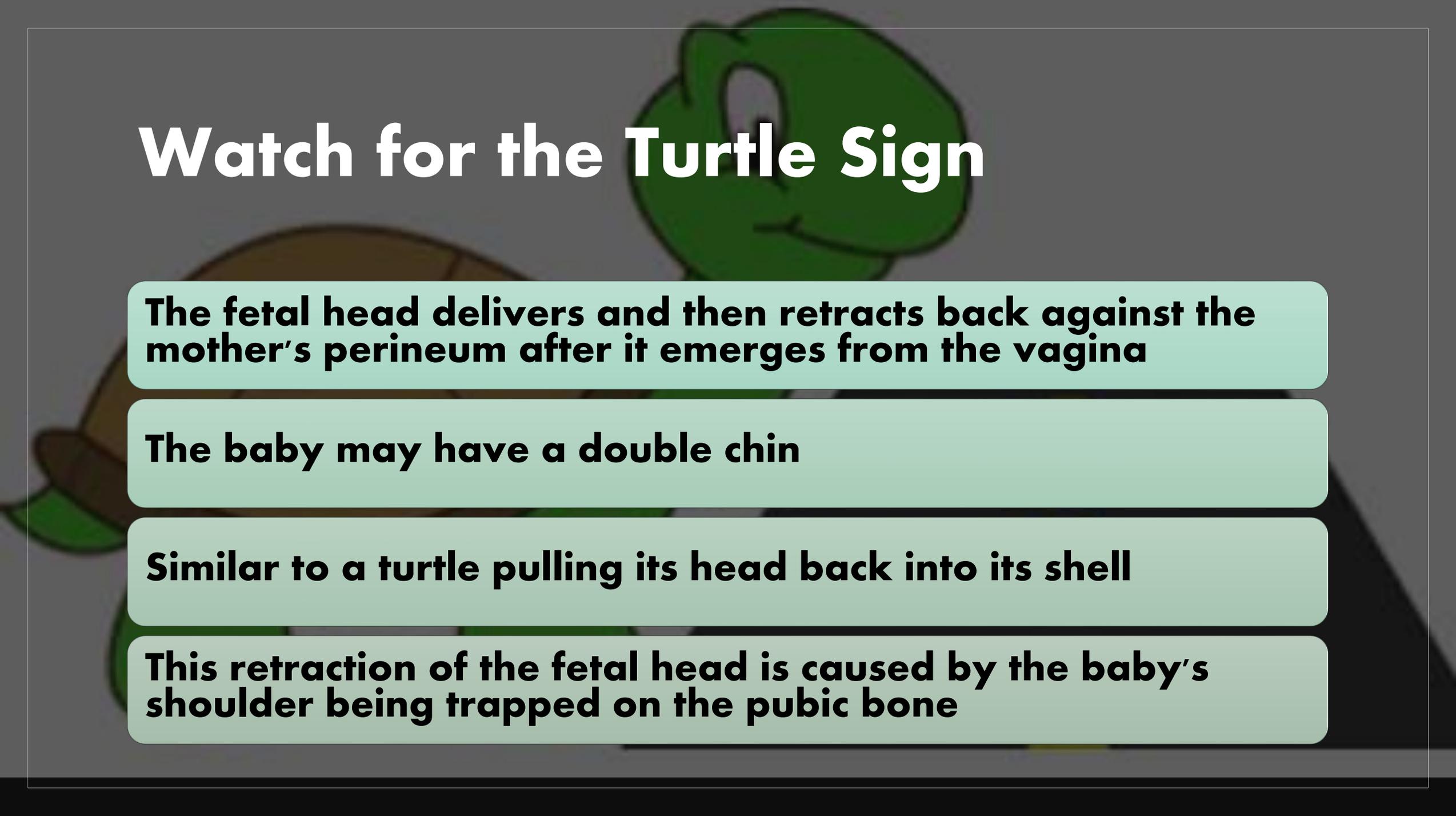
Promote the emptying of the bladder throughout the labor process



Note: Time of head to delivery of body interval is noted by pressing the mark button on the fetal monitor and closed loop communication



Watch for the Turtle Sign



The fetal head delivers and then retracts back against the mother's perineum after it emerges from the vagina

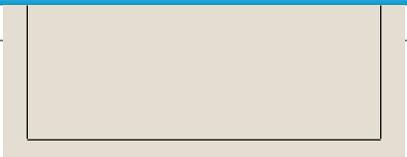
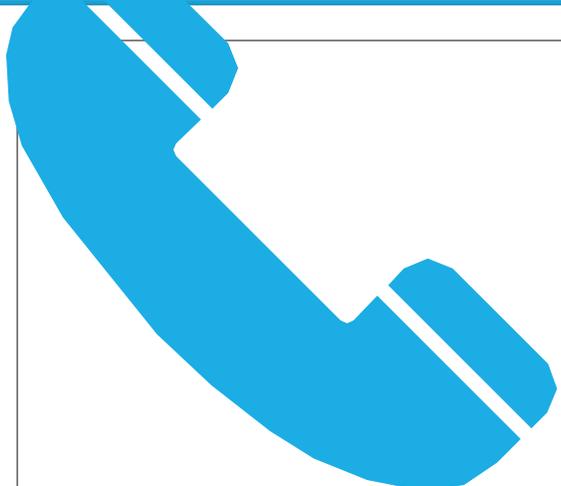
The baby may have a double chin

Similar to a turtle pulling its head back into its shell

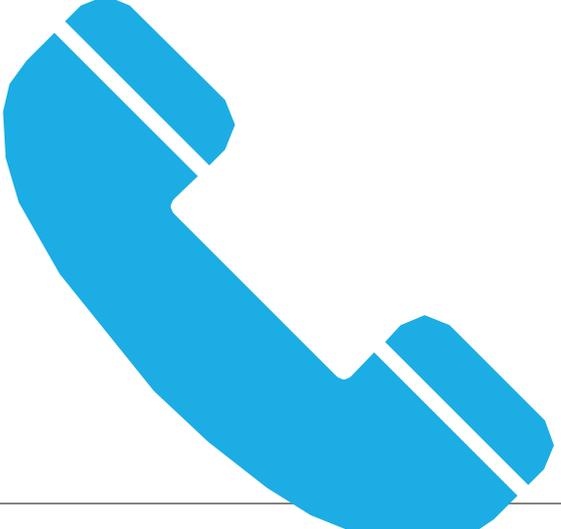
This retraction of the fetal head is caused by the baby's shoulder being trapped on the pubic bone



The Turtle Sign



CALL FOR HELP!



Head to Body Delivery Interval

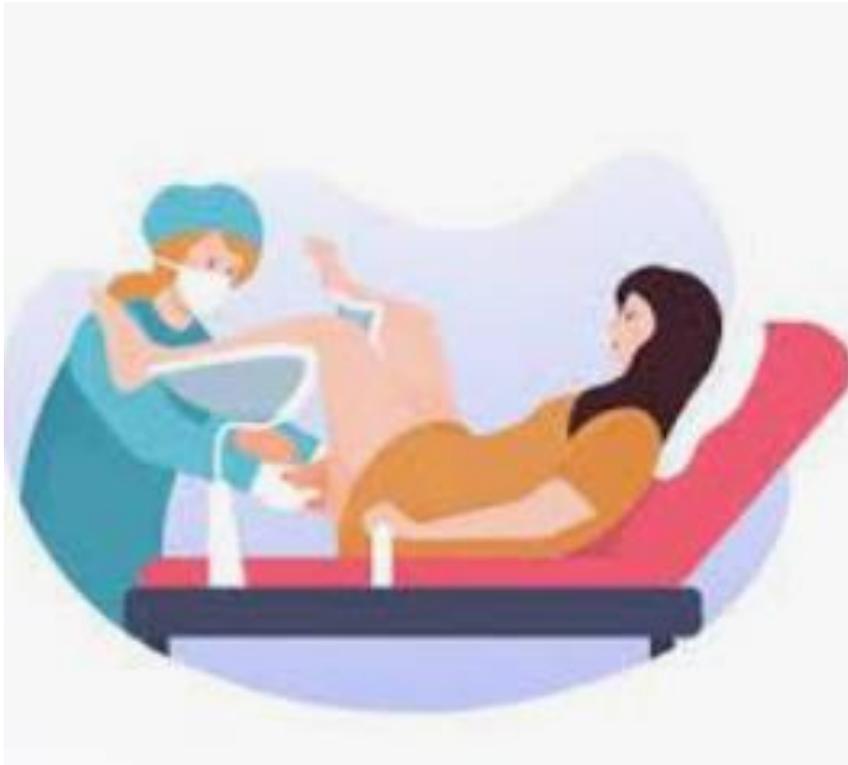
Note time of delivery of fetal head

Note time of diagnosis of shoulder dystocia

- **Provider makes the diagnosis and communicates it to the team**
- **What term do you use at your facility to communicate there is a shoulder dystocia?**

Note time of delivery of fetal body

**If Provider communicates
there's a shoulder**



**Pushing (Bearing
Down Efforts)**

**Follow the
provider's
instructions
regarding when to
have the patient
push and when to
request she not push**

Lower head of bed and side rails when providers states “We have a shoulder” or uses the term identified in your organization



- **To make room for the nurse to perform suprapubic pressure**

McRoberts Maneuver



**Hyperflexion
of woman's
thighs against
her abdomen**

**Considered
the first-line
maneuver**

McRoberts Maneuver

- **McRoberts position alone has successfully alleviated shoulder dystocia in as many as 42 percent of patients**

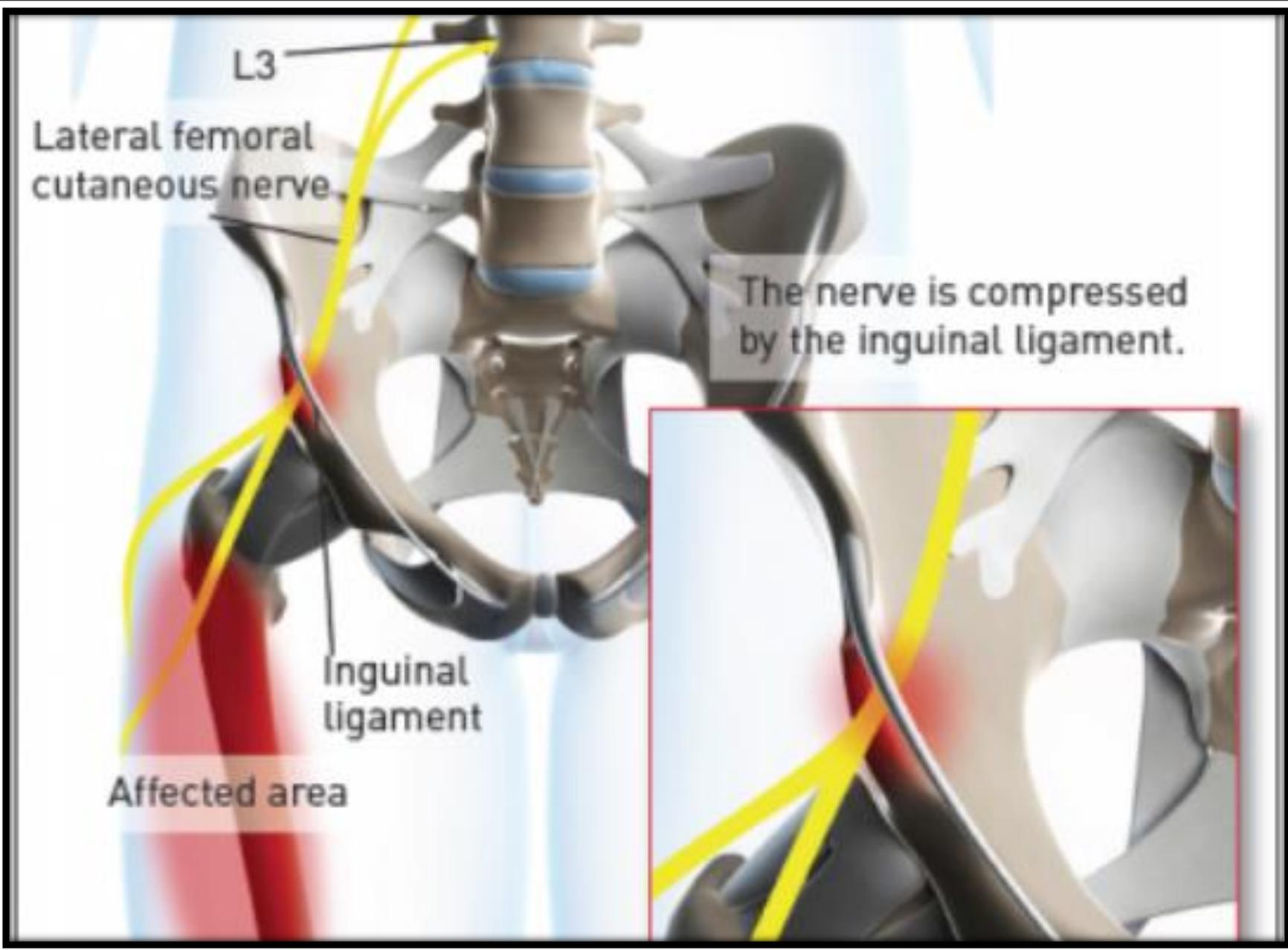
Use Caution with McRoberts

Avoid prolonged or overly aggressive application of the McRobert's maneuver

- **Gabbe, 2017, p. 389**

Symphyseal separation and lateral femoral cutaneous neuropathy has been shown to be associated with aggressive hyperflexion of the maternal legs

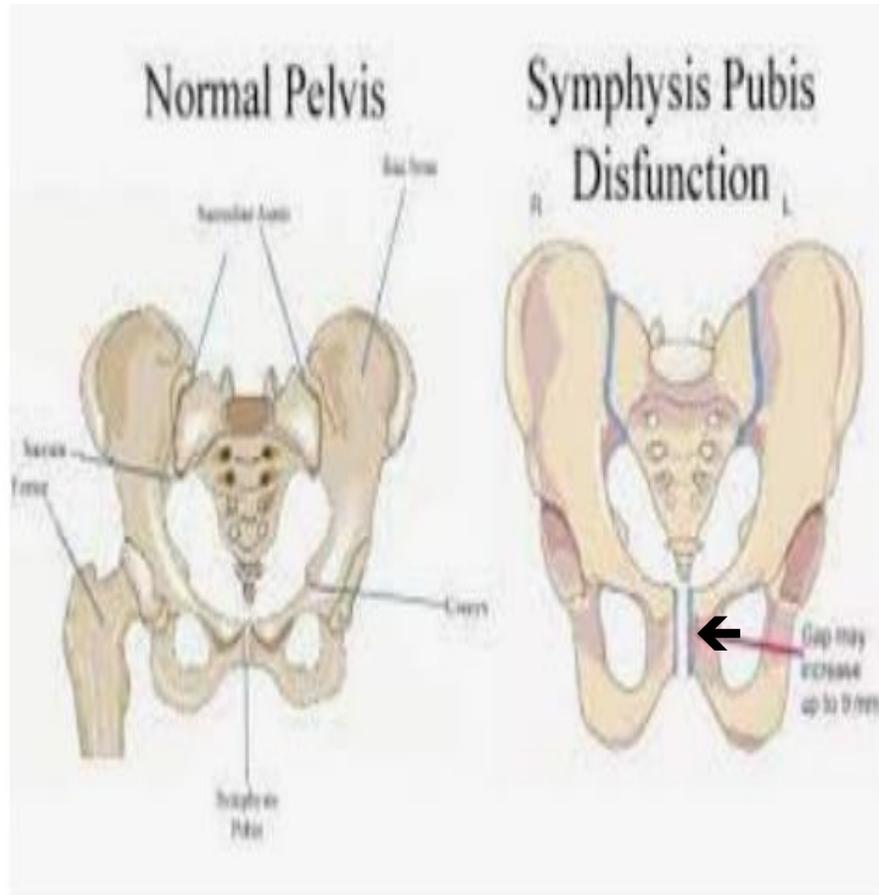
- **ACOG, Shoulder Dystocia, Number 178, May 2017**



- One potential complication is that of lower extremity neuropathy. Lower extremity neuropathy results from prolonged compression of the femoral nerve beneath the inguinal ligament, which can lead to decreased hip flexion and knee extension

Symphyseal Separation

An overly exaggerated lithotomy position and thigh abduction stretches the articular surfaces of the symphysis pubis



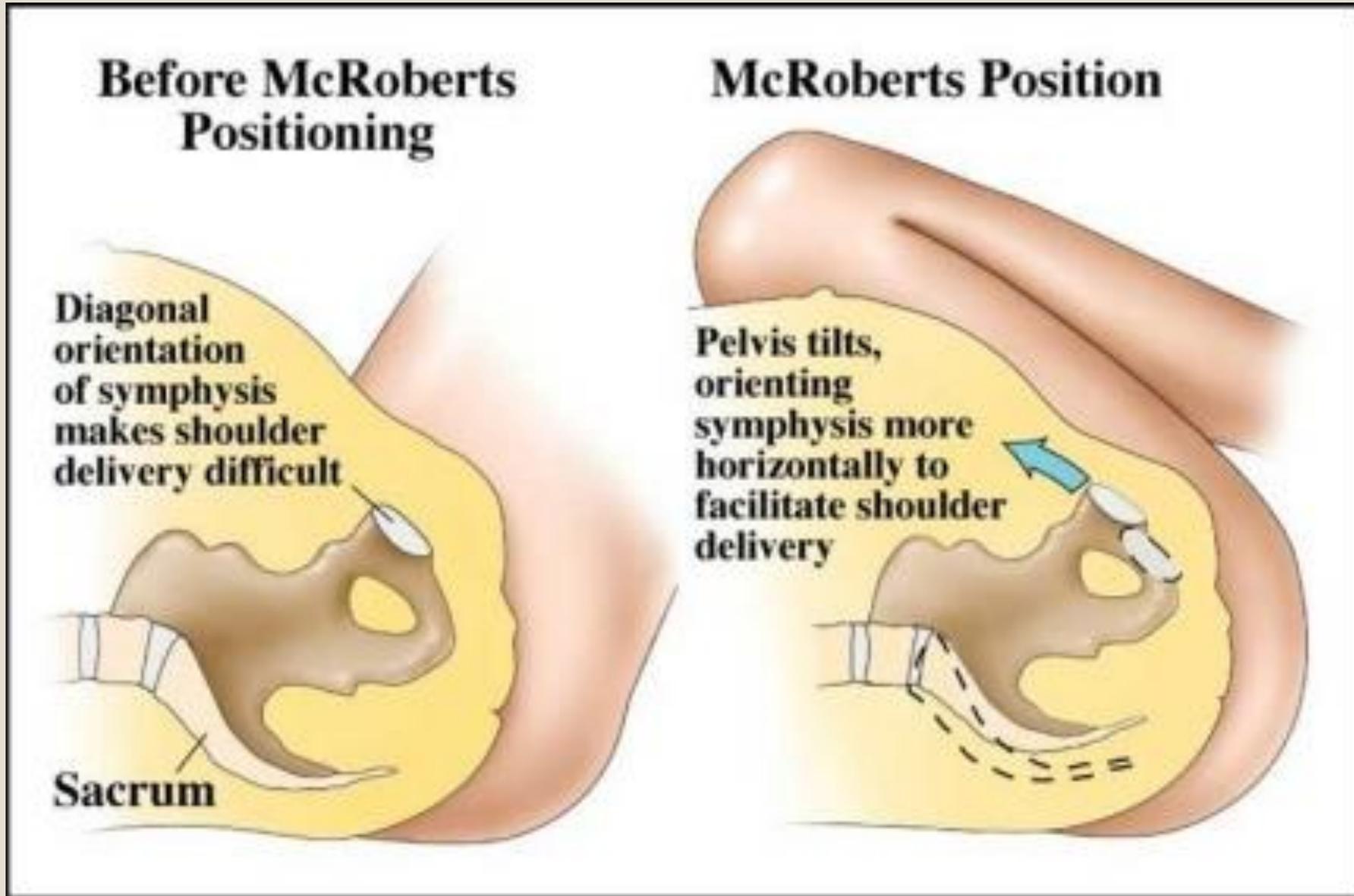
Before McRoberts Positioning

Diagonal orientation of symphysis makes shoulder delivery difficult

Sacrum

McRoberts Position

Pelvis tilts, orienting symphysis more horizontally to facilitate shoulder delivery



Suprapubic Pressure

MD or CNM may request nurse to apply suprapubic pressure using either a posterior or lateral technique

- **Posterior pressure used to dislodge the anterior shoulder and push it under symphysis**
- **Lateral pressure to the back surface of the fetal anterior shoulder**
 - **used to push fetal anterior shoulder toward the fetal chest**





Suprapubic Pressure

Posterior suprapubic pressure

- Place hands just above pubic bone
- Apply pressure straight down

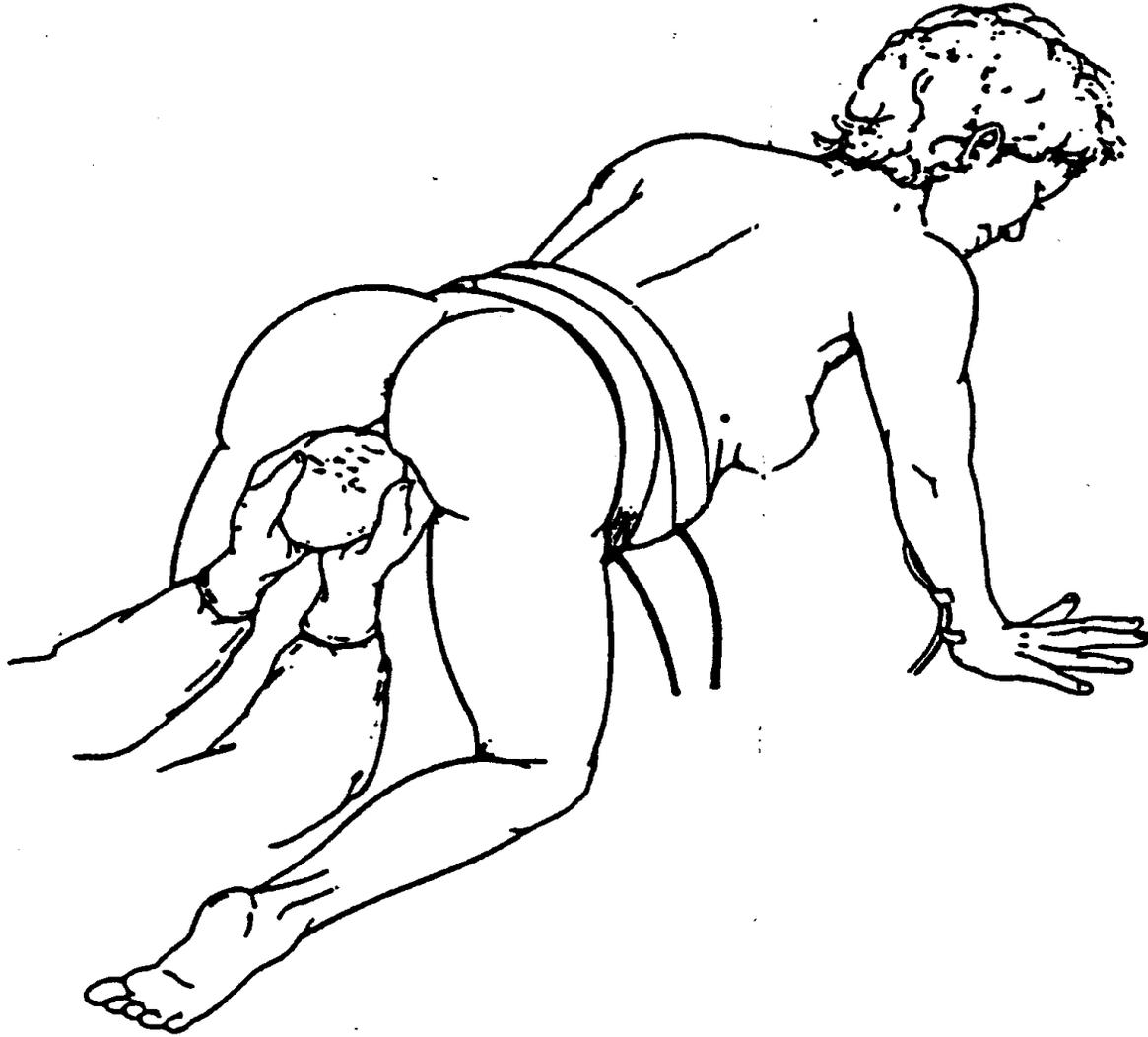
Laterally, to either the right or left side

- Apply pressure on the side of the mother where the fetal back is located and toward the direction of the fetal face



Fundal Pressure

Generally regarded as contraindicated for shoulder dystocia



Gaskin Maneuver

**Delivery in all-
fours Position
change & gravity
may dislodge the
shoulder**

From Bruner, J. P., Drummond, S. B., Meenan, A. L., & Gaskin, I. M. (1998). All-fours maneuver for reducing shoulder dystocia during labor. *Journal of Reproductive Medicine*, 43, Figure 1, p. 440.

Provider Maneuvers

Episiotomy

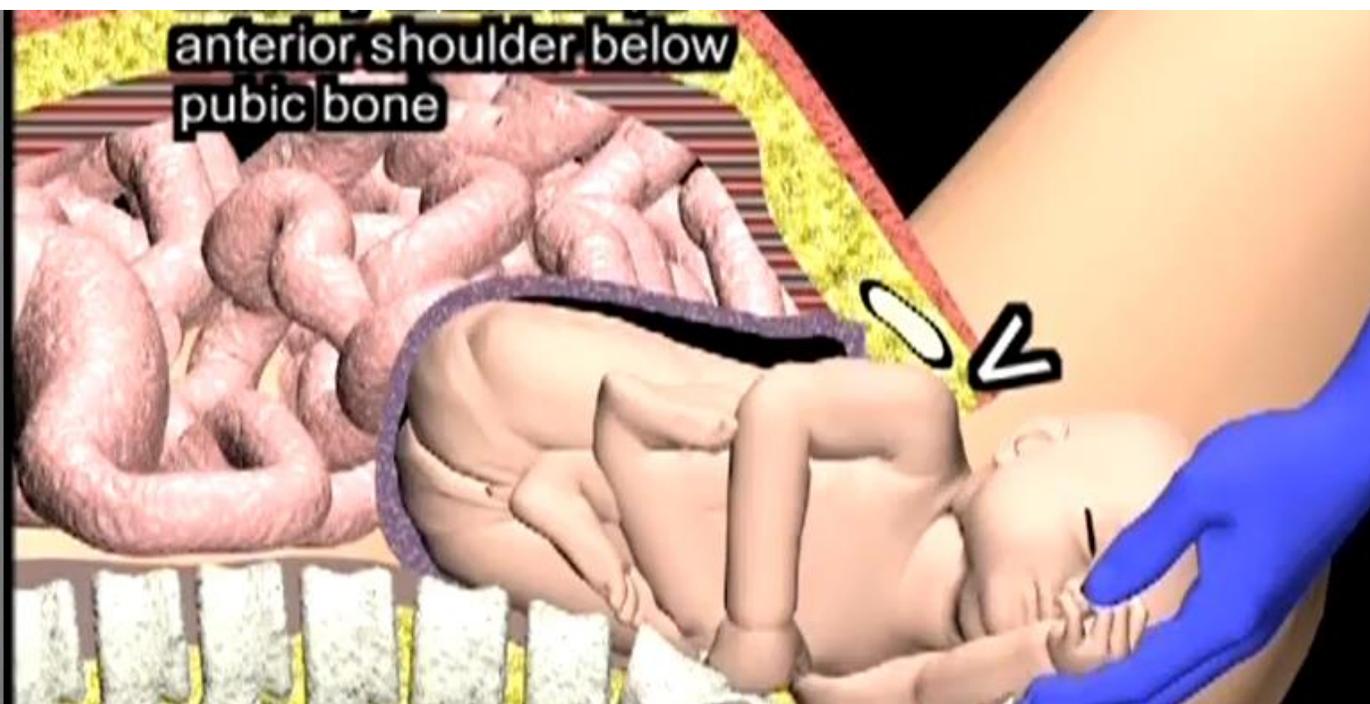
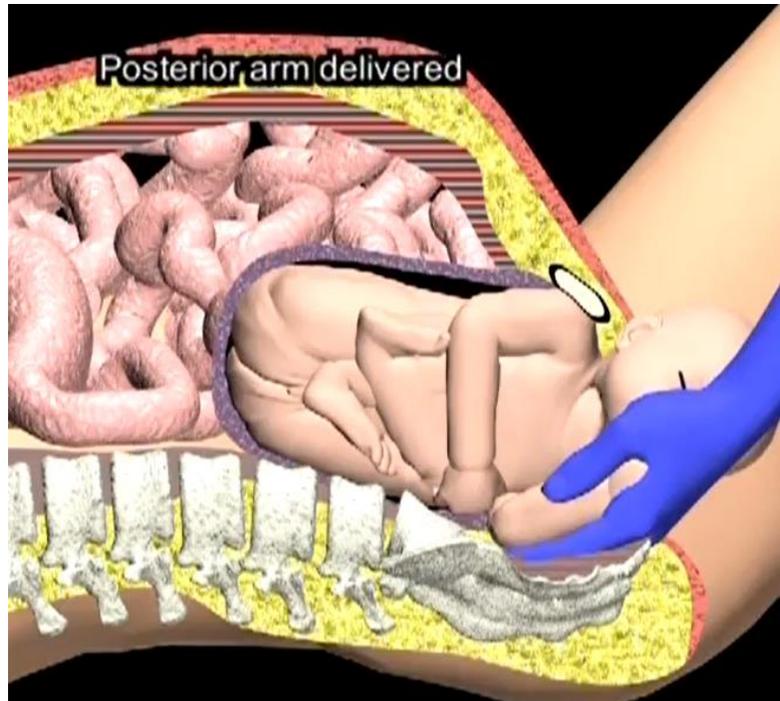
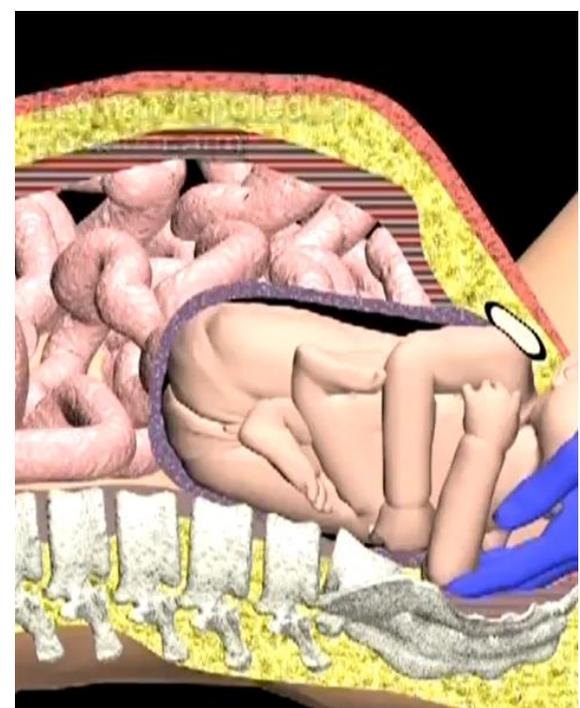
- **Based on clinical circumstances**

Posterior arm release

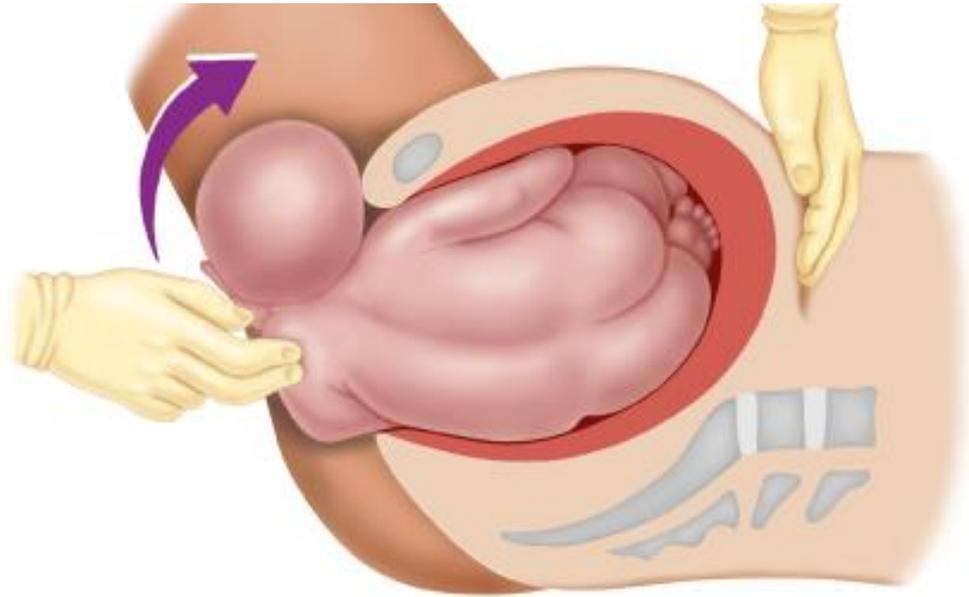
Rubins Maneuver

Woods Maneuver

Gaskin Maneuver

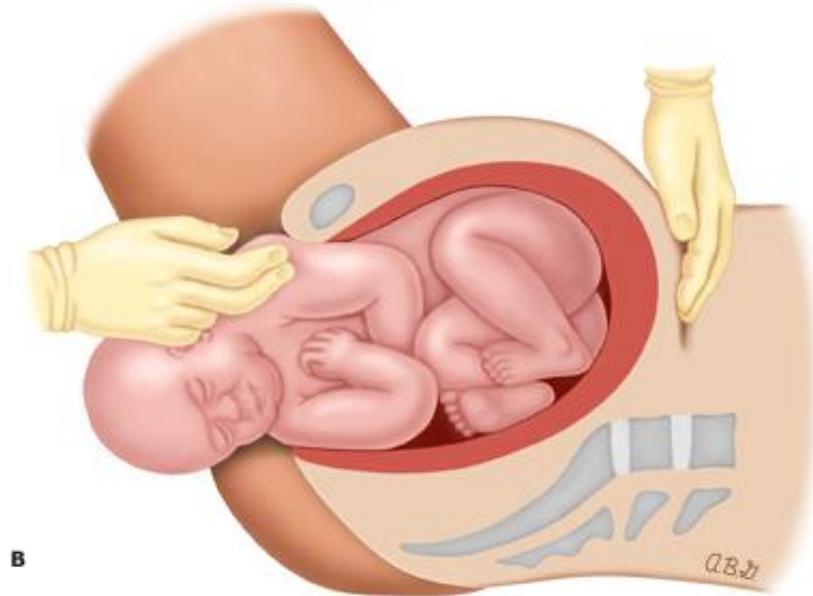
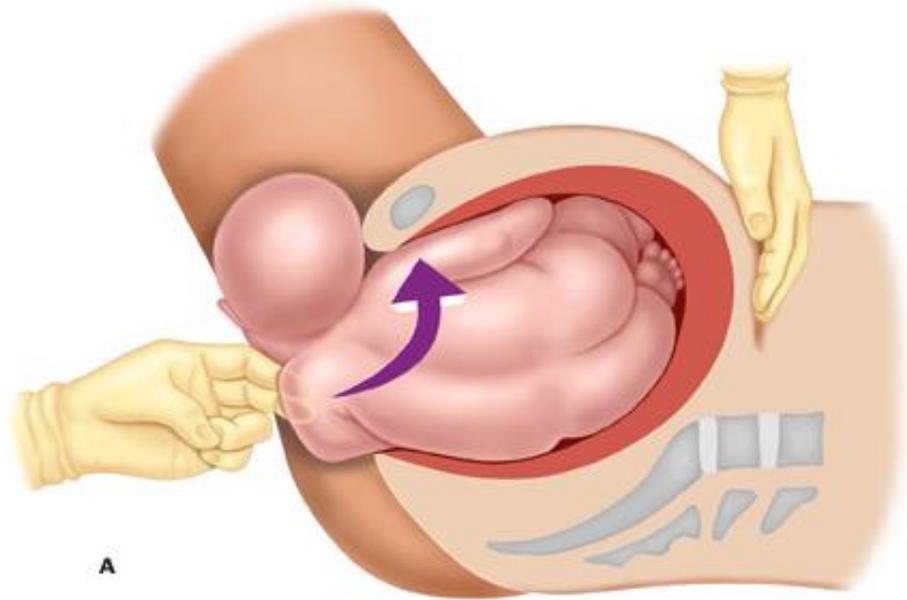


POSTERIOR ARM RELEASE



Rubin Maneuver

- **The clinician places one hand in the vagina behind the posterior fetal shoulder and then rotates it anteriorly (toward the fetal face). If the fetal spine is on the maternal left, the operator's right hand is used. Alternatively, the Rubin maneuver can be attempted by placing a hand behind the anterior shoulder, if it is more accessible**



Wood's Maneuver

- **The posterior shoulder is rotated counterclockwise until (B) it becomes anterior. The anterior shoulder rotates out from under the symphysis pubis and descends during this process.**

What About Fetal Assessment?

Once the head has been delivered the focus of the team should be on maneuvers to resolve the shoulder dystocia

“Continued attempts to find or record the FHR once the vertex is delivered are unnecessary and could delay important nursing actions such as patient positioning or suprapubic pressure”



Communication

**Communication
is vital**

- **With patient**
- **Between provider
and nurse**

Documentation

Recommend that provider and nurse document events together after the delivery...

Consistency in documentation is important

Some institutions use a checklist

- **The checklist sample shown in the next slide shows specific actions and interventions for provider and nurse documentation**

**SHOULDER DYSTOCIA DELIVERY NOTE
ADDENDUM**

Head-to-body delivery time _____ (min/sec)
(time interval between delivery of head and body)

Initial Traction:

Gentle attempt at traction, assisted by maternal expulsive forces

Explain if above box not checked _____

Any/all maneuvers that apply and the order in which they were utilized. The order is not specified by the standard of care

Maneuvers utilized	In which order (circle)	By whom
<input type="checkbox"/> McRoberts	1 2 3 4 5 6 7 8	_____
<input type="checkbox"/> Suprapubic pressure	1 2 3 4 5 6 7 8	_____
<input type="checkbox"/> Episiotomy	1 2 3 4 5 6 7 8	_____
<input type="checkbox"/> Episiotomy extension	1 2 3 4 5 6 7 8	_____
<input type="checkbox"/> Posterior arm release	1 2 3 4 5 6 7 8	_____
<input type="checkbox"/> Rubin's Maneuver	1 2 3 4 5 6 7 8	_____
_____	adduction of anterior shoulder (forward roll)	_____
_____	adduction of posterior shoulder (forward roll)	_____
<input type="checkbox"/> Woods maneuver	1 2 3 4 5 6 7 8	_____
_____	abduction of anterior shoulder (backward roll)	_____
_____	abduction of posterior shoulder (backward roll)	_____
<input type="checkbox"/> Gaskin (all fours)	1 2 3 4 5 6 7 8	_____
<input type="checkbox"/> Other (list)	1 2 3 4 5 6 7 8	_____

Verify that fundal pressure was not applied after the head delivered:

_____ Not Applied
_____ Applied

If applied, by whom: _____

If applied, reason: _____

The arm under the symphysis at the point the head was delivered was: Right Left

List other items of note _____

Primary Care Provider Signature Date/Time

Registered Nurse Signature Date/Time

Other Care Providers in attendance Signature Date/Time

Other Care Providers in attendance Signature Date/Time

**Sample
Checklist
Form**

**Assess for possible
neonatal and maternal
complications**

Possible neonatal complications

Brachial Plexus Injury (C4-6 nerve roots)

- **Approximately 50% of injuries NOT a result of SD**

DuChenne-Klumpke

- **Involves entire brachial plexus**

Klumpke's (C8-T1)

- **affects forearm and small muscles of hand**

Clavicular fracture

Humerus fracture

Contusions

Horner's Syndrome

- **Damage of sympathetic nerves traversing T₁ due to a brachial plexus injury**
 - **Depression of eyelid, drooping of mouth on affected side**

Possible neonatal complications

Hypoxic ischemic encephalopathy

Death

Possible maternal complications

Hemorrhage

- **Uterine atony**
- **Lacerations**
- **Uterine rupture**

Postpartum bladder atony

- **Usually temporary**

Femoral nerve damage

- **Lerner, 2017**

Summary

The healthcare team should be prepared for a shoulder dystocia at every delivery

Communication and teamwork is vital whenever a shoulder dystocia occurs

The nursing role includes assisting with maternal maneuvers, closed loop communication and documentation

- **McRobert's, suprapubic pressure, Gaskin**

Summary

Team documentation following a shoulder dystocia delivery is important for an accurate and consistent record of events

It is important to assess for maternal and neonatal complications following a shoulder dystocia

Videos for learning

- https://www.hopkinsmedicine.org/gynecology_obstetrics/education/training/shoulder-dystocia
- **McRoberts, Suprapubic, and drill (scroll forward to 4:10 on the video to the start of the scenario)**

References

- **American College of Obstetricians and Gynecologists (2017) [Reaffirmed 2020]. Shoulder dystocia. *ACOG Practice Bulletin Number 178, May 2017.***
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- **Baird, S. M., & Kennedy, B. B. (2017). Obstetric Emergencies in Betsy B. Kennedy & Suzanne McMurtry Baird (eds.) *Intrapartum Management Modules, 5th ed.*, Philadelphia: Wolters Kluwer. Bruner, J. P.,**
- **Resnik, R., Lockwood, C.J., Moore, T.R., Greene, M.F., Copel, J.A., & Silver, R.M., (2019) Chapter 43: Clinical Aspects of Normal and Abnormal Labor in Creasy & Resnik's *Maternal-Fetal Medicine Principles and Practice 8th ed.*, Philadelphia, PA: Elsevier**
- **Lerner, H. (Copyright © 2004 – 2023) Shoulder Dystocia: Facts, evidence, and conclusions. www.shoulderdystociainfo.com**
- **Lowdermilk, D. L., Cashion, K., & Alden, K. R., Olshansky, E.F., Perry, S.E. (2024) Chapter 32: Labor and Birth at Risk in *Maternity and Women's Health Care 13th ed.* St. Louis, MO: Elsevier.**
- **Simpson, K. R. & Creehan, P. A., O'Brien-Abel, N. & Rohan, A.J. (2021). *AWHONN Perinatal Nursing 5th ed.* Chapter 14 Labor and Birth. Philadelphia, PA: Wolters Kluwer/Lippincott Williams & Wilkins**