Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

CORD PROLAPSE / PRESENTATION MANAGEMENT

Amendments			
Date	Page(s)	Comments	Approved by
Sept 2007	2	Updated to include correct terminology for categorisation of caesarean sections to describe urgency of the operation	Women's health Clinical Governance committee
Oct 2014	Complete document review	Updated in line with RCOG Green Top guideline	Women's Health Guidelines Group
Feb 2018	Complete document review	No Changes	Head of Midwifery

Compiled by: Women's Health Guidelines Group

In Consultation with: Obstetric Consultants and Senior Midwives

Ratified by: Women's Health Guidelines Group

Date Ratified: November 2014

Date Issued: November 2014

Next Review Date: November 2021

Target Audience: Staff working within maternity services

Impact Assessment Carried Out By: Women's Health Guidelines Group

Comments on this document to: Women's Health Guidelines Group

CORD PROLAPSE / PRESENTATION MANAGEMENT

Cord prolapse has been defined as the descent of the umbilical cord through the cervix alongside (occult) or past the presenting part (overt) in the presence of ruptured membranes.

Cord presentation is the presence of the umbilical cord between the fetal presenting part and the cervix, with or without membrane rupture.

The overall incidence of cord prolapse ranges from 0.1% to 0.6%. In the case of breech presentation, the incidence is slightly higher than 1%. It has been reported that male fetuses appear to be predisposed to cord prolapse. The incidence is influenced by population characteristics and is higher where there is a large percentage of multiple gestations (RCOG 2008)

Both situations should be considered an emergency requiring prompt action. The fetus is at risk of becoming acutely hypoxic when the presenting part squashes the cord (ALSO 2012).

Risk Factors:

- Poorly fitting presenting part.
  - occipito posterior position
  - breech
  - face and brow presentation
  - high head
  - compound presentations
- Abnormal lie
  - transverse
  - oblique
- Polyhydramnios.
- Preterm labour.

When the presenting part is poorly applied or in the case of polyhydramnios, Artificial rupture of membranes should be performed with caution after discussion with a Consultant Obstetrician.

Management

1. **Cord Prolapse**

- Call for help using the emergency bell. (If at home call 999)
- Ring 2222 state 'Obstetric and Neonatal Priority call'
- If not on labour ward, alert LW and transfer immediately.
  If on labour ward - Allocate scrub duties to appropriate person
- Ensure cord remains within vagina, insert fingers to ensure presenting part off the cord as far as possible.
- Position the woman into knee chest position where possible. Avoid excessive handling of cord.
  DO NOT REMOVE FINGERS from the vagina until instructed to do so by attending obstetrician.

- Attempt to listen to Fetal heart as soon as possible. If appropriate commence CTG.

- Vaginal birth, in most cases operative, can be attempted at full dilatation if it is anticipated that delivery would be accomplished quickly and safely

- A category 1 caesarean section should be performed with the aim of delivering within 30 minutes or less if there is cord prolapse associated with a suspicious or pathological fetal heart rate pattern but without unduly risking maternal safety.

- Verbal consent is satisfactory

- The duty/on call Consultant must be informed but Caesarean section must not be delayed.

- Category 2 caesarean section is appropriate for women in whom the fetal heart rate pattern is normal.
  Regional anaesthesia may be considered in consultation with the anaesthetist

- Neonatal doctor should attend all deliveries with cord prolapse

- Paired cord blood samples should be taken for pH and base excess measurement.

- A datix is required to be completed for all cases.

If in community setting - Women should be advised, over the telephone if necessary, to assume the knee–chest face-down position while waiting for hospital transfer. During emergency ambulance transfer, the knee–chest is potentially unsafe and the left-lateral position should be used.

Postnatal debriefing should be offered to every woman with cord prolapse.

Management of cord prolapse before viability

- Expectant management should be discussed for cord prolapse complicating pregnancies with gestational age at the limits of viability.
- Uterine cord replacement may be attempted.
- Women should be counselled on both continuation and termination of pregnancy following cord prolapse at the threshold of viability.

2. Cord presentation

If a cord presentation is identified (membranes intact and cord felt through the membranes) then a planned Caesarean section will be required. Continuous fetal heart monitoring must be undertaken. If the registrar feels that delaying Caesarean section is appropriate this must be discussed with the duty/ on call Consultant Obstetrician.

Monitoring

Compliance with this guideline will be monitored by review of maternity records in all cases of Cord Prolapse. Where deficiencies are identified action plans will be developed and changes implemented and disseminated as required.

References

Advanced Life Support in Obstetrics (ALSO) 2012 *Provider course syllabus Revised 5th Edition* America Academy of Family Physicians Kansas USA. www.also.org.uk

Umbilical Cord Prolapse, Green Top Guideline No 50 2008

EQUALITY IMPACT ASSESSMENT TOOL

Name: Cord Prolapse/ Presentation Management

Policy/Service: Women's Health and Paediatrics

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
To ensure consistent high standard of evidence base care Women's Health Guideline Group
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
Policy widely circulated for comments within the Multidisciplinary Maternity Team.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
Accepted and understand the relevance of high standards of evidence based practice. Principles of equality have been adhered to.
Conclusion • Provide a summary of the overall conclusions
Improvement and consistency of maternity care provision in accordance with ALSO (2012) recommendations.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
none

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact, HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name: Policy	Cord Prolapse/Presentation management
Name of Person completing form:	Dianne Casey
Date:	October 2014

Author(s)	Dianne Casey and Jane Urben	
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Dianne Casey	
Date of final draft	October 2014	
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?		Yes
By whom:	Women's Health Guidelines Group	
Is this a new or revised policy/guideline?	revised	

Describe the development process used to generate this policy/guideline.
Women's Health Guidelines Group, Labour Ward Forum, Obs & Gynae Consultants, Supervisors of Midwives
Who is the policy/guideline primarily for?
Health Professionals working within the maternity service
Is this policy/guideline relevant across the Trust or in limited areas?
Maternity Services
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
Intranet, newsletters,
Describe the process by which adherence to this policy/guideline will be monitored.
See *monitoring section of policy*
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?
See *reference section of policy*
What (other) information sources have been used to produce this policy/guideline?
See *reference section of policy*
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
No impact
Other than the authors, which other groups or individuals have been given a draft for comment?
All obstetric Consultants, Women's Health Guidelines Group, SOM's
Which groups or individuals submitted written or verbal comments on earlier drafts?
Any comments received considered by Women's Health Guidelines Group
Who considered those comments and to what extent have they been incorporated into the final draft?
All comments considered
Have financial implications been considered?
Yes