WOMEN'S HEALTH AND PAEDIATRICS

MATERNITY UNIT

MANAGEMENT OF CORD PROLAPSE AND PRESENTATION

Amendments			
Version	**Date**	**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
Feb 2022	Complete document review	Updated in line with RCOG Green Top guideline	

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In Consultation with: **Obstetric Consultants and Senior Midwives**

Ratified by: **Perinatal Guidelines Group**

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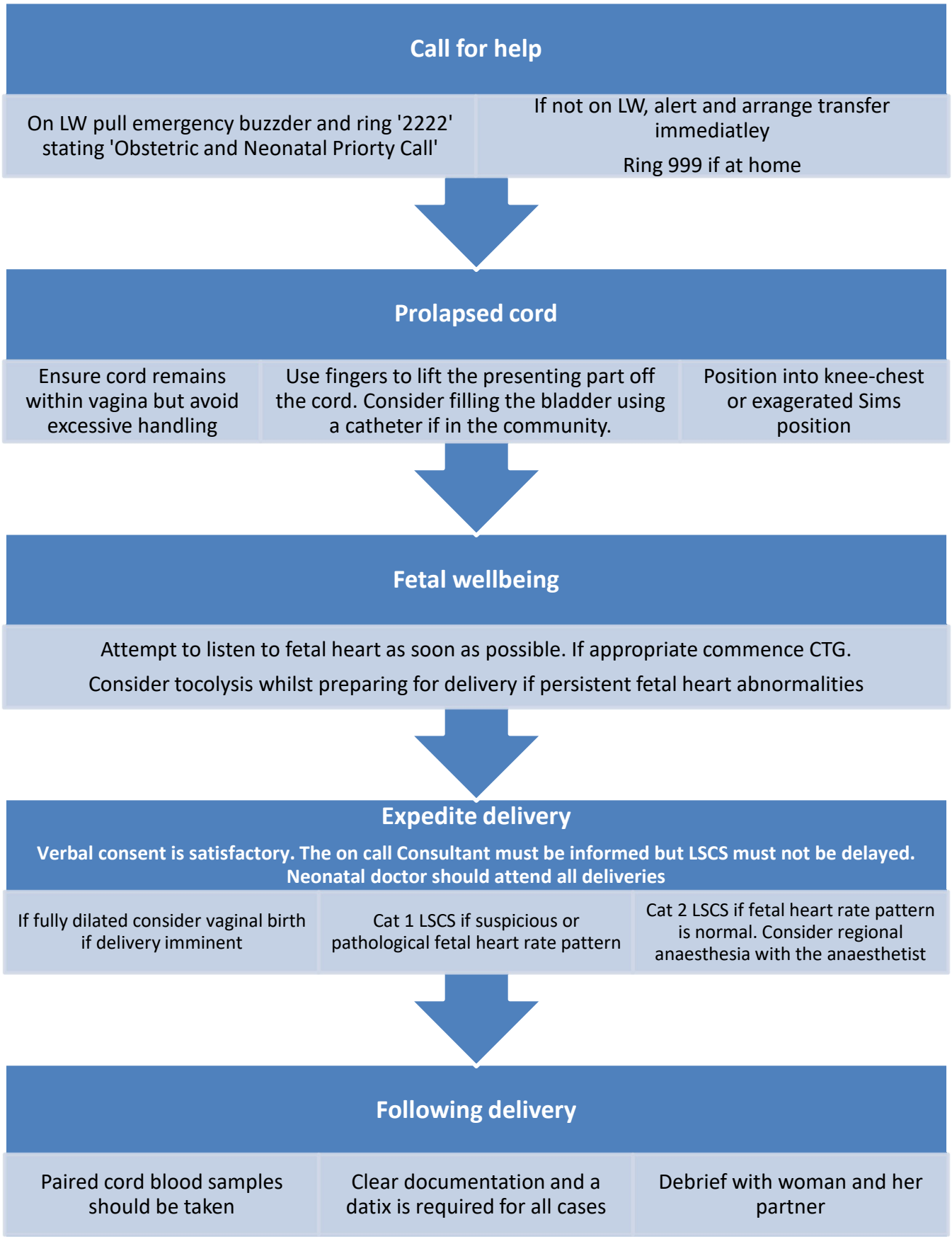
Target audience: **All health professionals within the maternity services**

Equality impact assessment: **Perinatal Guidelines Group**

Comments on this document to: **Perinatal Guidelines Group**

Contents

1.0 Flow diagram of the management of cord prolapse



2.0 Cord Prolapse

2.1 Definition

Cord prolapse has been defined as the descent of the umbilical cord through the cervix alongside (occult) or past (overt) the presenting part in the presence of ruptured membranes. It is considered an emergency requiring prompt action. The fetus is at risk of becoming acutely hypoxic when the presenting part compresses the cord.

2.2 Incidence

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 more predisposed than females to cord prolapse. The incidence is influenced by population characteristics and is higher where there is a large percentage of multiple gestations (RCOG 2014).

2.3 Risk Factors

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

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 and with arrangements in place for immediate caesarean.

3.0 Management of cord prolapse

3.1 Management of cord prolapse in hospital- see flow diagram 1.0

3.2 Management of cord prolapse in the community

If in the community setting women should be advised over the telephone to assume the knee–chest face-down position while waiting for hospital transfer. They should be transferred to the nearest consultant-led unit for birth, unless vaginal examination by a competent professional reveals a spontaneous vaginal birth is imminent. The presenting part should be elevated during transfer either manually or by using bladder distension. It is recommended that community midwives carry a Foley catheter for this purpose and equipment for fluid infusion.

3.3 Management of cord prolapse before viability

Expectant management should be discussed for cord prolapse complicating pregnancies with a gestational age at the threshold of viability (23^{+0} to 24^{+6} weeks). There is no evidence to support replacement of the cord into the uterus when prolapse occurs at, or before the threshold of viability. Women should be counselled on both continuation and termination of pregnancy following cord prolapse at this stage.

4.0 Cord presentation

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

If 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 on-call Consultant Obstetrician.

5.0 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.

6.0 References

Umbilical Cord Prolapse, Green Top Guideline No 50 2014