Learn simply

Cord Prolapse

Passion profession same

Cord prolapse[1]

Prevent iatrogenic cord prolapse[2]

- Anticipate the diagnosis[3]
- Confirm the diagnosis[4]
- Document fetal wellbeing
- Confirm gestational age

Further management depends on gestational age

Previable fetus[5]

- Consider ultrasound to confirm the diagnosis, confirm the gestational age, and document fetal wellbeing
- Consider neonatology consult, if appropriate
- Consider MFM and anesthesia consults
- Consider clerical consult, if appropriate

Expectant management[6]

If fetal heartbeat is present

- Inpatient management
- Discuss options of expectant management versus induction of labor

If fetal heartbeat is absent

- Recommend augmentation/induction of labor
- Expedite delivery for excessive bleeding, infection, coagulopathy
- Check CBC, T&S, coagulation studies

Viable fetus[5]

- **Immediate MFM, anesthesia, and neonatology consults**
- **Continuous fetal heart rate monitoring**
- Check CBC, T&S, coagulation studies
- Cross-match PRBC, platelets, and/or FFP, if indicated
- Obtain maternal consent for emergency cesarean delivery[7]

Immediate and emergency cesarean delivery[8]

1. Cord prolapse is an obstetric emergency characterized by prolapse of the umbilical cord into the vagina after rupture of the fetal membranes.

2. To prevent iatrogenic cord prolapse, perform amniotomy (artificial rupture of the membranes) only once the vertex is well applied to the cervix and always with fundal pressure.

3. The diagnosis should be anticipated in the setting of rupture of the fetal membranes if any of the following risk factors are present:
   (i) prematurity;
   (ii) a small fetus;
   (iii) funic (cord) presentation on ultrasound examination; and
   (iv) fetal malpresentation.

4. (Incidence at term is 0.4% of cephalic pregnancies, 0.5% of frank breech pregnancies, 4–6% of complete breech pregnancies, 15–18% of footling breech pregnancies, and up to 25% with transverse lie.)

5. Cord prolapse is a clinical diagnosis made by palpation of the umbilical cord on vaginal examination with or without fetal bradycardia. In the acute setting with a viable fetus, there is no place for ultrasound to confirm the diagnosis

1. Fetal viability is variably defined. In the United States, most obstetric care providers regard the limit of fetal viability as being between 23 and 24 weeks of gestation.

2. Given the urgency of the situation, verbal consent for emergency cesarean delivery is adequate. However, the surgeon should consider having a second provider witness and document the verbal consent and getting written consent from the patient once she has fully recovered from anesthesia. If this is done, it should be made clear that the written consent was obtained after the procedure.

3. Contraindications to emergency cesarean delivery include intrauterine fetal demise, maternal hemodynamic instability (shock), coagulopathy, and failure to secure maternal consent.

1. Once the diagnosis of cord prolapse has been made in a viable pregnancy with confirmation of a live fetus (usually by palpation of a pulsatile umbilical cord), subsequent management should include the following:

- CALL FOR HELP.
- Manual replacement of the umbilical cord into the uterus by the obstetric care provider, who should continue manual replacement until the infant is delivered.
- Place the patient in the knee–chest position.
- Establish intravenous access.
- O2 supplementation by facemask.
- Transfer the patient immediately to the operating room.
- Notify anesthesia, neonatology, and/or high-risk obstetrics.
- Check CBC, T&S, coagulation studies.
- Continued assessment of fetal well-being (usually confirmation of a pulsatile umbilical cord is adequate).
- Emergency cesarean delivery, usually under general endotracheal anesthesia (epidural analgesia may be used only if it is already in place and has been tested).