

OB High Risk Obstetric Patients-Premature Labor

PURPOSE:

To define the policy and protocol for OB / High Risk OB / Premature Labor transports

DEFINITIONS:

- **Premature labor:** Defined as gestational age < 37 weeks with cervical change and more than (1)contraction every (10) min and may occur with or without spontaneous rupture of membranes.
- **Precipitous Delivery:** classifies the pregnant patient at the stage where birth is considered imminent.

PROVISIONS (POLICY / CONTENT / PROCEDURAL STEPS):

- **Delivery during transport should be avoided.**
- Patients with threatened precipitous delivery will NOT be transported via helicopter
- See Laboring Patient Transport Algorithm for additional information

Basic Life Support Provider [EMR/EMT/AEMT]

- I. Initial Assessment & General Standing Orders.
 - A. Assess and document maternal history:
 - i. Last Menstrual Period, EDC (Estimated Date of Confinement)
 - ii. Pregnancy history, (G#,P#,Ab#)¹
 - iii. Problems during this or previous pregnancies
 - iv. Diabetes
 - v. Pre-eclampsia, eclampsia
 - vi. Hypertension
 - vii. Edema (peripheral, pulmonary)
 - viii. Protein in urine
 - ix. Prior ultrasonographic examinations and results
 - x. Bleeding during pregnancy or labor
 - xi. Past medical and surgical history, medications, and allergies
 - xii. Prenatal care
 - xiii. Blood type (if Rh negative: when, if any RhoGAM² received)

Paramedic / Critical Care Paramedic / RN Provider

- I. Assess patient's symptoms/physical exam
 - A. Rupture of membranes
 - B. Bleeding
 - C. Document cervical dilation within one hour of transport (if patient having contractions).
Note: internal cervical exam is not routinely done by MedEvac staff. If internal cervical exam is needed, then sending personnel or Neonatal transport team RN/MD should perform the exam.
 - D. Fetal Heart Tones
 - E. Fetal movements
 - F. Palpate Uterus (assess for fundal height, contraction, tenderness)

Treatment:

- I. All pregnant mothers should have prophylactic O₂ placed (at very least 2-4L NC). Monitor pulse oximetry closely.
- II. Patient should be positioned on left side to displace uterus off IVC. Monitor closely for hypotension and maternal comfort.
- III. If eclamptic, treat seizures per **Protocol – OB/Eclampsia**.
- IV. If not already given, give 500 ml bolus of NS/LR, followed by 250 ml/hr x 2 hours.
- V. If tocolysis is recommended: consider **Terbutaline³ 0.25 mg SQ, [PARA/Inter-Facility]** may repeat every (20) minutes until uterine contractions subside or a total of 4 doses has been administered.
 - A. Hold if maternal heart rate > 120 bpm, or Fetal HR > 200 bpm or maternal SBP < 90 mmHg or pulmonary edema occurs.
 - B. Do not give terbutaline if patient receiving Ritodrine (Yutopar).
 - C. Contraindicated in the eclamptic patient.
- VI. Consider Terbutaline infusion [PARA/Inter-Facility] after discussion with **Medical Control**. Infusion rates of 2.5 – 5 mcg/min are recommended.
- VII. If contractions persist, consult medical control for the consideration of **Magnesium Sulfate⁴ [PARA] 4-6 gm/250 ml D5W over 30 min then 2 - 4 gm/hr IV infusion (10 gm/250 ml D5W = 1 gm/25 ml)**.
 - A. If patient's reflexes diminish or patient develops respiratory depression, cease bolus/drip immediately.
 - B. Magnesium Sulfate toxicity is reversed w/**Calcium 1-3 gram IV [PARA]**
- VIII. OB kit must be readily accessible during transport.
- IX. Consider loading patient feet first if delivery is likely.

Footnotes:

1 Written as "(gravida,#, para, #, Ab, #)," where gravida is the total number of pregnancies (including the present one), para is the number of deliveries after 20 weeks of pregnancy, and Ab is the number of abortions.

2 Rho (D) Immune Globulin is used to suppress Rh isoimmunization (Prevents the Rh(-) mother from developing antibodies to this Rh(+) fetus blood, so if there is another Rh(+) fetus in the future it will not be attacked by antibodies from the mother).

3 Terbutaline Contraindications: hypersensitivity to Terbutaline. Adverse Reactions: Nervousness, trembling, decreases potassium, increases glucose, tachycardia, hypertension, nausea, vomiting, diaphoresis. Tocolytic therapy of an acute episode of idiopathic preterm labor often abolishes contractions only temporarily but does not remove the underlying stimulus that initiated the process of parturition or reverse the parturitional changes in the uterus. Crews **MUST** be prepared for precipitous delivery and make transport choices appropriately.

4 Magnesium Contraindications: heart block, serious renal impairment. Assess deep tendon reflexes every 30 minutes, cardiac monitor, respiratory rate, blood pressure and mental status. Adverse reactions: > 3mg/dL: depressed CNS, diarrhea, blocked peripheral neuromuscular transmission; > 5 mg/dL: flushing, somnolence; > 12.5 mg/dL complete heart block, respiratory paralysis