

## Shoulder dystocia

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Shoulder dystocia is a failure of the baby's shoulders to spontaneously rotate and descend in the maternal pelvis after delivery of the baby's head and failure to deliver the baby when standard downward traction by the midwife or doctor has been applied.

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Shoulder dystocia occurs most commonly when the baby's shoulders get impacted on the bones of the mother's pelvis. The incidence in the UK is about 1 in 200 deliveries. Despite correct management, there is still the possibility that there may be temporary or permanent damage to the mother or baby. These may include nerve damage to the baby's face or arms, fracture to arm or collar bone, or more seriously, a disruption to the oxygen supply to the baby. There is also an increased chance of maternal complications, which may include excessive blood loss after delivery (1 in 9) and substantial perineal tears which may even involve damage to the anal sphincter (about 1 in 26).

Some mothers are slightly more at risk for having a shoulder dystocia and you may have been warned about the potential of this complication either in the antenatal period or when you are in labour. However, quite often there was no warning that the baby's shoulders were more likely to become stuck.

Factors associated with shoulder dystocia may be detected antenatally or when a woman is in labour.

### Antenatal factors:

- Previous shoulder dystocia (reoccurrence 1 in 6).
- Suspected large baby (although 1 in 2 cases of shoulder dystocia occurs in babies weighing less than 4000g. (Fetal weight estimation has about 1 in 10 error margin.)
- Diabetes.
- Maternal BMI higher than 30.
- Induction of labour.

### Factors during labour:

- Prolonged first stage of labour once properly established. Established labour is diagnosed when there are regular painful contractions, and there is progressive cervical dilatation from 4 cm. The length of the established first stage of labour varies between women. First labours last on average 8 hours and are unlikely to last over 18

hours. Second and subsequent labours last on average 5 hours and are unlikely to last over 12 hours. Progress in labour should be maintained at a rate of at least 2cms in 4 hours.

- Prolonged, active second stage of labour (when the cervix is fully dilated and the mother is pushing). Birth would be expected to take place within 3 hours of active second stage if it is your first baby and 2 hours if you have had a baby before.
- The use of instruments, either forceps or ventouse by the doctor to assist with the birth of your baby.
- Use of the hormone drip to help advance the labour.

If a shoulder dystocia is anticipated, there may be extra people in the room to assist should it occur. In cases where it does occur, there are several different manoeuvres that the midwives and/or doctors may try during the birth of the baby. All or some may be used. If it is unexpected, an emergency bell might be sounded to obtain further assistance. You will be asked to get onto the bed if you are not there already, and the bed will be put down flat.

- Your legs will be pulled up onto your chest to help open up the bones of the pelvis, allowing more room for the baby's shoulders to pass through.
- It may be possible to perform an episiotomy (a cut to the perineum – area between the vagina and anus).
- You may be asked to stop pushing while the midwife doctor tries to move your baby into a different position internally and release its shoulder to allow the birth of your baby.
- An assistant may apply pressure externally above your pubic bone. This is to try and push the baby's shoulder underneath the pubic bone.
- You may be asked to turn onto the all-fours, as a simple change in position can sometimes help.

A neonatologist (baby doctor) may be present at the birth of your baby and your baby will be fully examined by medical staff prior to discharge home, or sooner if there are any concerns.

### References:

1. Confidential Enquiry into Stillbirths and Deaths in Infancy. (1998). 5th Annual Report. London: Maternal and Child Health Research Consortium. Available at: [www.cemach.org.uk](http://www.cemach.org.uk)
2. Confidential Enquiry into Stillbirths and Deaths in Infancy. (1999). 6th Annual Report. London: Maternal and Child Health Research Consortium. Available at: [www.cemach.org.uk](http://www.cemach.org.uk)
3. King's Fund. (2008). Safe Births: Everybody's business – Independent Inquiry into the Safety of Maternity Services in England. London: King's Fund. Available at: [www.kingsfund.org.uk](http://www.kingsfund.org.uk)

4. Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. London. RCOG Press. Available at: [www.rcog.org.uk](http://www.rcog.org.uk)
5. Royal College of Obstetricians and gynaecologists, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Paediatrics and Child Health. (2008). Standards for Maternity Care: Report of a Working Party. London: RCOG Press. Available at: [www.rcog.org.uk](http://www.rcog.org.uk)
6. Royal College of Obstetricians and Gynaecologists. (2012). Shoulder Dystocia. Guideline number 42. London: RCOG. Available at: [www.rcog.org.uk](http://www.rcog.org.uk)

### Contact information

If you have any concerns or queries please either contact your GP or speak to your Community Midwife.

### Further information

Further information can be obtained from the following Royal College of Obstetricians website pages:

[www.rcog.org.uk/womens-health/clinical-guidance/shoulder-dystocia-green-top-42](http://www.rcog.org.uk/womens-health/clinical-guidance/shoulder-dystocia-green-top-42)

More information is available on the Trust website:

[www.royalberkshire.nhs.uk](http://www.royalberkshire.nhs.uk)

This document can be made available in other languages and formats upon request.

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