



اسم السياسة /الخطة: سياسة إدارة مضاعفات الحبل السري / تدلي الحبل السري Funic Complication / Cord Prolapse Management
رقم السياسة/ الخطة: 07- OSD-PP

المعنيين بالسياسية: كوادر قسم النسائية والتوليد		المجموعة: رعاية المرضى
توقيع مسؤول صالات الولادة:	تاريخ الاعداد: 2025/8/12	إعداد: قسم النسائية والتوليد
التوقيع:	تاريخ التدقيق: 2025/11/1	دققت من قبل: مدير قسم الجودة
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Purpose:

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- 1.1 To institute, emergency procedures quickly to prevent or minimize impairment of fetal circulation.

2. Policy:

- 2.1 Vaginal examination and pattern of periodic irregular fetal bradycardia must be assessed by midwife, resident doctor and referred to obstetrician immediately.
- 2.2 Fetal heart rate must be recorded immediately after the rupture of membrane.
- 2.3 Continuous Cardiotocography as possible.
- 2.4 Cord outside the vagina must not be reposition back.
- 2.5 Never leave the client unattended she should be treated with consideration.
- 2.6 Consent for surgical intervention is a must.
- 2.7 Explain what happened to mother and her accompanied and answer their question

3. Scope:

- 3.1 This policy is applicable to all patients in Labor department.

4. Responsibility:

- 4.1 It is responsibility of head department unit to assure applied this policy.
- 4.2 It is responsibility of Midwives who interact with patient.
- 4.3 It is responsibility of Resident doctor who interact with patient

5. Definitions:

- 5.1 **Funic Complication:** It is the prolapse of the cord, alongside or in front of the presenting part. As the head comes down, the compression of the cord between the fetal skull and the pelvic brim will shut off its circulation completely, Commonly occurs after rupture of the membrane during labor and be classified into:
 - 5.1.1 Occult prolapse-cord lies along side.
 - 5.1.2 Concealed prolapse-cord felt during vaginal examination.
 - 5.1.3 Apparent prolapse-cord visibly protruding from the vagina.

6. Equipments/Forms/Attachments:

- 6.1 Standard equipment to prepare mother for Emergency Cesarean Section.
- 6.2 Standard equipment for Vacuum Extraction.

7. Procedure:

7.1 Know the causes and clinical manifestation of cord prolapsed.

7.1.1 Causes:

7.1.1.1 Adoption of the presenting part to the maternal pelvis which include:

7.1.1.1.1 Breech and transverse presentation.

7.1.1.1.2 Unengaged presenting part and hydramnious.

7.1.1.1.3 Twin gestation.

7.1.1.1.4 Prematurely or small fetus.

7.1.1.2 Placenta Previa.

7.1.1.3 Flat pelvis and tumors in the pelvis.

7.1.2 Clinical Manifestations:

7.1.2.1 Fetal heart rate pattern may be irregular with periodic fetal bradycardia.

7.1.2.1.1 hand washing technique.

7.1.2.1.2 Assess existing condition of the patient and refer any abnormalities.

7.1.2.1.3 Fetal heart continues monitoring by Cardiotocography.

7.1.2.1.4 Administration of oxygen as ordered

7.1.2.1.5 Positioning of the client.

7.1.2.1.5.1 Knee-chest position.

7.1.2.1.5.2 Lateral sim's position.

7.1.2.1.5.3 Trendelenburg position.

7.1.2.1.5.4 Elevate the hips with pillow

7.1.2.1.5.5 Presenting part may be push upward by pressure from a sterile gloved hand in the vagina.

7.1.2.1.6. If the cord has prolonged outside the vagina, no attempt should be made to reposition it to the vagina, just cover with sterile towel moistened with warm saline.by resident doctor and in charge midwife

7.1.2.1.7 most expert midwife or obstetrical resident doctor do vaginal exam to elevate the presenting part from the cord until delivery of the baby by normal vaginal or caesarean section

7.1.2.1.8 Prepare patient for urgent delivery by:.

7.1.2.1.8.1 Cesarean section for incomplete dilation of the Cervix.

7.1.2.1.8.2 Vacuum extraction or forceps delivery. Occasional cases such as vertex presentation with nearly Complete dilation.

7.1.2.1.9 Documentation:

7.1.2.1.9.1 All assessment and intervention must be documented accurately for the continuity of care of the health team

8. References:

8.1 NICE 2024