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New shoulder dystocia guidelines

Published in Midwife Practice Vol. 23 Issue 8 September 2020 Dystocia Combs is a life-threatening maternity emergency that has been recognized by midwives and obstetricians for centuries. When Leslie Ansel experienced severe shoulder dystocia that led to a fractured fetal humerus bone, she knew there had to be a change in operation. Here, he has a travel chart that leads him to discuss, review and research the idea of stretching underneath as a shoulder dystocia settlement method. Shoulder dystocia is a maternity emergency that can lead to significant maternal and infant trauma, and even infant death. Shoulder dystocia is defined as anterior, posterior or both fetal shoulder failures to enter the pelvic cavity after the birth of the fetal head vagina.1 This potentially life-threatening emergency is one of the most worrying problems midwives face, but the relative rarity of shoulder dystocia means there is little opportunity to become an 'expert' in dealing with the problem.1 This article presents my personal and research journey, which led to the change. In practice when presented with shoulder dystocia. This journey leads to recommendations and adoptions then to act that the pivotal stretch of the first internal maneuver attempts when shoulder dystocia occurs. This change in action is presented along with an explanation of how the 'do' stretch of the armpit, which makes in our previously published article 'Shoulder Dystocia Success Rate Managed by Internal Rotational Maneuvers and Posterior Arm Delivery: Literature Review'.2 My Journey Saw Severe Shoulder Dystocia Where The Failure of The McSubberts, Sutopubik Pressure, Internal Rotational Maneuvers and Then Attempts to Deliver the Posterior Arm Led to Complete Arm Fractures. The baby was literally born by 'stretched' by a broken arm and needs a full resuscitation. Following this traumatic experience, I spent many hours reflecting on the events of that birth. I thought about trying to deliver the posterior arm and the shock I felt when I heard an arm bone fracture. The midwife, who eventually delivered the baby, explained the problem she had in trying to find the fetus's elbow because both fetal shoulders were left above the pelvic bribe. In an attempt to find the elbow he had only managed to understand the upper arm and stretch afterwards against the arm had caused a fracture. The stretch had caused some movement in the shoulder, which is why he continued to pull the damaged arm until the shoulder eventually descended under the pelvic bribe and he was able to pull the baby through the pelvis. I asked him why he didn't understand the fetus's shoulder and use it to pull the baby down (my thought was that if every child was trapped anywhere, the natural reaction would be to secure the child under their armpits to try to free them). His response was 'This is not what we This comment was fair - it was what we were taught. I started to question what I would do if I was in the same situation again. It was evident that the maneuvers trained in our days of emergency skills had failed in this situation and I noticed the lack of practice problems we faced. Discussions with colleagues and the start of the research journey began to discuss the management of shoulder dystocia with other colleagues, and a number of people had been in similar situations with the failure of internal rotational maneuvers and posterior arm delivery. I reflected on the need to move the fetus's shoulders through the pelvis. This made me think more about the possibility of using fetal axylella but in a manner that would secure the arm tightly against the body so as to avoid stretching to the humerus, which can lead to fractures. The stretch can then be driven through the embryo's excel to move the shoulder through the pelvis. It also seemed reasonable that if a hand is placed in the pelvic cavity, the fetus's shoulder is first located before the fetus's elbow. I started to question why we would bypass Acusilla, which is a more accessible and tangible place to secure the fetus, and then apply the stretch to get the shoulder through the pelvis? I researched the management of shoulder dystocia and found that HELPERR's menonic literature and internal rotational maneuvers promoted rubins II, Woods screws or posterior arm delivery.3 I also examined the natural birth mechanism of the shoulders. When the fetus's head is born, the shoulders enter the pelvic cavity through a pelvic bribe in the mile or transient diameter (larger diameters inside). The shoulders then rotate to the anterior-posterior diameter (A-P) of the pelvis and the anterior shoulder is located behind the symuffis pobis. Retaking occurs when the fetus's head rotates externally and the shoulders rotate forward in the pelvic cavity.4 This causes the shoulders to be born with a double-saccharum diameter in the diameter of the A-P pelvic outlet.5 Shoulder delivery is therefore facilitated by using the widest diameter in the outlet. The occasional arch acts as a 'pivot' for the anterior shoulder and the posterior shoulder is born first.6 literature since the early 1990s supports that if the birth is allowed to progress normally and without help, the posterior shoulder in most cases automatically born first.7 Using this principle, it seemed reasonable to locate and understand the posterior shoulder and apply stretching it through the pelvis (while the axis The anterior shoulder around the symphys in the same way as normal birth) can achieve birth during shoulder dystocia. I started working as a clinical midwifery instructor at Auckland University of Technology (AUT) and during that time there was a lot of discussion about the management of shoulder dystocia. These discussions often included the use of a doll Hips with demonstrations of how to 'do' stretch axillary. As a result, I was encouraged to examine the viability of the axillary stretch as a method for solving shoulder dystocia. Then dystocia comb became the subject of my master's degree in health sciences (MHSc) at AUT. The study identified 8 problems that doctors had with both recalling and performing internal maneuvers described in HELPERR, as well as their lack of effectiveness at times. When attempting internal rotational maneuvers, doctors - without being aware - had often used axial pull by 'accident', successfully dissolving shoulder dystocia. The underlying stretch in practice during the master's course, other doctors I worked with be aware of the Ackmillian stretch and saw the use of stretching with a good deal of success. They requested maneuver training and started using it themselves in action, again with a good degree of success. Stretching Axillary began to 'creep' into action. Senior medical officers (SMOs), resident medical officers (RMOs) and midwives working in the area embraced the use of Izmili stretching. Often doctors contact me to tell me that they had used it and how effective it was. As a result, a subsorricular stretching method for the management of shoulder dystocia was examined by the Obstetrics and Gynecology Quality Forum in Manukaw Health (CMH) (Auckland New Zealand) in 2009 and a new guideline including subsorricular stretching was adopted. As a result of that directive, subseparal stretching was also included in emergency skills training courses and multi-professional obstetrics and gynecology (PROMPT) practical training. The original instruction only included a description of how to stretch underneath, but the most recent updated version (2018) includes photos to help with the description. BELOW ARE EXCERPTS FROM THE 2018 GUIDELINES SHOWING HOW TO 'DO' THE UNDERARM STRETCH: STRETCHING THE ARMPIT SLIDES ALONG THE NECK OF THE POSTERIORLY EMBRYO TO COMPREHENSION SHOULDER POSTERIOR WITH A THUMB AND FIRST FINGER PLACE THE SECOND FINGER ON TOP OF THE ARM AND HOLDING TIGHTLY APPLYING ARMPIT STRETCHES FOLLOWED BY SACRUM CURVES. The anterior fetus shoulder will be 'axial' around semphyse and posterior shoulder will be delivered for the first time. The degree of elasticity required may be very significant. Stretching through Axias only and not against the fetal arm is unlikely to cause injury. The hand slides along the posterior fetus's neck to the shoulder comprehension posterior shoulder with thumb and first finger place second finger on top of the arm applying armpit stretching followed by the curve of the anterior shoulder sacrum 'axis' around the Sphiphis shrine - posterior shoulder delivery id document first: A2794 version 4.0 Section: Obstetrics and Gynecology Last Updated: 8/03/2018 Document Owner: Clinical Leader of Obstetrics and Gynecology Next review date: 8/03/2021 Approved by: Women's Health Document Control First issued date: 01/02/2004 Manukau Health cities spread word word about the use of underlying stretching below began to spread. In September 2010, I presented at the New Zealand College of Midwives 11 biennial national conference highlighting the pivotal pull 'as an alternative and effective strategy for managing this obstetrics and gynecology emergency...' The session was very well attended, and I started receiving requests from midwives and midwifery educators to offer PowerPoint used shoulder dystocia as a teaching resource in midwifery schools across New Zealand. The presentation was repeated at Waitakere Hospital (Auckland New Zealand) the following month at the request of clinical midwifery instructors. An application to the New Zealand College of Midwives (NZCOM) to have the underlying underlying stretch included in the clinical skills training program was mandatory for midwives, however, it declined in 2010 (Anonymous, Personal Communications, February 1, 2010) on the basis that the maneuver was not evaluated. Further research on my behalf led me to understand that internal rotational maneuvers (Rubins II, Bolt Woods) or posterior arm delivery were not objectively evaluated either, but despite this, these maneuvers were still taught in New Zealand. In 2012 the findings of a qualitative study to manage shoulder dystocia were published by stretching the sub-bezer in midwifery.8 After that release, I was approached by more educators and midwifery managers than several regional health boards in New Zealand who wanted it included in their shoulder dystocia guidelines and emergency skills training days. As a result of the anecdotal success of underlying underlying stretching, the Pacific Women's Health Unit at the University of Auckland approached me to write a chapter on the management of shoulder dystocia, including the use of underlying underlying stretching for the Pacific Mothers and Infants Emergency Education Manual. I have received feedback that stretching axillary many times in the Pacific Islands had been used with great success. The word continued to spread. Student midwives, midwives from new staff and resident medical officers had heard about the maneuver and approached me to teach them how to do it. Many hours have passed in the clinical area with dolls and pelvises with doctors learning and practicing maneuvers. It was often referred to as the 'Leslie' maneuver and if the shoulder dystocia had occurred there would have been discussions about whether the 'Leslie' maneuver had been used and if it had worked. On practically every occasion, it seemed to have worked, and if it didn't work for a doctor, then it would usually do so if another doctor who had more experience using akmilli stretching would have done so. Anecdotal evidence for research with the growth of axial stretching anecdotal success, it was found that we needed more research to prove that the azoilial pull was effective in resolving. Dystocia. In 2014, I decided to conduct research to examine the success rate of maneuvers used to solve shoulder dystocia. Axelari's stretch was 'introduced' in 2009, so I decided to explore the stretch years before and after Akmilli. I applied to the hospital research department for permission to conduct an audit of the birth wrapped by Comb Dystocia from 2006 (three years before introduction) and 2012 (three years after introduction) to see if there is any evidence to support the use of foresea stretching. The hospital's research department was allowed to conduct the study. Ethics approval was searched and granted by the Southern Health and Disability Ethics Committee (reference: 14/STH/15) and dystocia shoulder became the subject of my doctoral work. The PhD study examined the effectiveness of axial stretching when shoulder dystocia occurs. This retrospective review of internal maneuvers used in shoulder dystocia management is the first to document the use of Azin stretching for a large number of women. Of the 422 women who experienced shoulder dystocia, a total of 226 (53.6%) needed internal maneuvers to solve the problem. The first internal maneuvers used were classified as aar stretching, posterior arm delivery or internal rotational maneuvers. The results showed a significant difference (p>0.001) in the success rate of the first internal maneuvers used. In 52.7% of cases, the first internal maneuver used was Azin stretching, which was successful in 95.8% of cases and no more maneuvers were needed. The success rate of armpit stretching as the first internal maneuver was significantly higher than that for rotary maneuvers (p<0.001) and posterior arm delivery (p 0.025).9 We presented the results of the study at the Royal Australian Conference and the New Zealand College of Obstetricians and Gynecologists in Brisbane in 2018. Sharing knowledge of the practice although this has been my journey, to date it has yet to be officially confirmed within the wider maternity community in New Zealand. In order to share this knowledge as widely as possible I have created a YouTube video, which outlines how to do the underlying stretch. The video can be found using the link below: . Conclusion Shoulder dystocia is a life-threatening complication of childbirth that has been recognized for centuries by midwives and obstetricians. My own personal experience led me to discuss this issue, investigate and research this as a way to solve shoulder dystocia. The results of both anecdotals and research evidences have shown the effectiveness of underlying stretching to solve shoulder dystocia. So the Axari stretch should be the first maneuver used when an internal maneuver is needed to solve shoulder dystocia. TPM Resources Gherman R. Shoulder Dystocia: Evidence-Based Assessment of Obstetrics and Gynecology Clinical Obstetrics & Gynecology 2002;45(2):345-362. Ansell L, McAra-Coupler J, Larmer P. Success rates of shoulder dystocia managed by internal rotational manoeuvres and delivery of the posterior arm: a review of the literature. 47-41 :(5)23;2020 . ماماي تمرين كننده (online). Royal College of Obstetricians & Gynaecologists (RCOG). 42 شماره دستورالعمل دیستوسیا شونه. London: RCOG; 2012. خواب J. فیزیولوژی و مدیریت مرحله دوم کار. In: Bennet V, Brown L, eds. کتاب درسی Myles 1993؛ چرچیل لیوینگستون: ادینبورگ. چاپ 12. برای ماماها. McEwan A, Johnson I. مشکل دیستوسیای شانه. Current Obstetrics & Gynaecology. 2004;14(1):62-67. Sutton J, Scott P. 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