Pregnancy - obstetric emergencies

Summary

- Obstetric emergencies are health problems that are life-threatening for pregnant women and their babies.
- An obstetric emergency may arise at any time during pregnancy, labour and birth.
- Hospital care is needed for all obstetric emergencies, as the woman may need specialist care and an extended hospital stay. This may be because of the risk of a premature birth, the loss of a baby or increased risk to the woman’s health.
- If you think you or your unborn baby are at risk, call your doctor, midwife or hospital, or call 000 for an ambulance.

Obstetric emergencies during pregnancy

Obstetric emergencies that may arise during pregnancy include:

- **miscarriage** – the loss of a baby before 20 weeks gestation. A miscarriage cannot be stopped once it has started. The mother may need treatment for infection, or to remove remaining tissue
- **ectopic pregnancy** – where the fertilised egg implants in one of the fallopian tubes rather than the uterus (womb). The pregnancy cannot continue and treatment usually means the loss of the tube. If the pregnancy causes a split in the tube, this can result in pain and serious bleeding. Loss of or damage to the tube may affect the woman’s ability to become pregnant in the future
- **placental abruption** – where the placenta separates from the uterus before birth, causing bleeding, pain and contractions
- **placenta praevia** – where the placenta attaches to the lower part of the uterus and partly or completely blocks the neck of the womb. As a result, the mother may suffer vaginal bleeding during pregnancy
- **pre-eclampsia and eclampsia** – pre-eclampsia (or pregnancy-induced high blood pressure) causes severe swelling from water retention. It can lead to kidney and liver failure. If it progresses to eclampsia (convulsions), it can be fatal for the mother and her baby
- **premature rupture of membranes (PROM)** – where the bag of amniotic fluid breaks before contractions or labour begin. This is an emergency if the waters break before 37 weeks of pregnancy and lead to a major leak of amniotic fluid or infection of the amniotic sac.

Obstetric emergencies during labour

Obstetric emergencies that may arise during pregnancy include:

- **shoulder dystocia** – where the baby’s shoulders wedge in the birth canal after the birth of the baby’s head. Depending on its position, the baby may start to lose oxygen
- **prolapsed umbilical cord** – where the umbilical cord is pushed down into the cervix or vagina before the baby is born. If the cord becomes compressed, the fetus does not receive enough oxygen. The result may be brain damage or even death
- **placenta accreta** – where the placenta is implanted too deeply in the uterine wall and cannot come out after the baby is born
- **rupture of the uterus** – where a weak spot in the uterus tears
- **inversion of the uterus** – where a portion of the placenta remains attached to the uterine wall, and pulls the
uterus out

- **amniotic fluid embolism** – where fluid moves from the amniotic sac (bag of waters) and ends up in the mother’s blood. This very rare complication can happen during pregnancy but usually occurs during strong contractions in labour and causes serious complications including death of the mother.

**Why things may go wrong during pregnancy**

An early pregnancy complication usually occurs because the developing baby has not properly attached or formed. This means the baby will not grow and a miscarriage occurs.

Sometimes, often for unknown reasons, a miscarriage may occur many weeks into a seemingly healthy pregnancy.

Other obstetric emergencies can be caused by a number of factors, such as trauma or for genetic reasons. Sometimes a woman’s experience in earlier pregnancies can help her doctor identify possible complications and prepare for them.

**What to look for – signs of an obstetric emergency**

Most symptoms of pregnancy are nothing to worry about but there are some symptoms that need immediate medical attention. If you experience any of the following symptoms, call your doctor, midwife or hospital immediately. Don’t wait until your next prenatal visit.

- **Any bleeding** during pregnancy is not normal – be sure to call your doctor or midwife
  - Heavy bleeding with severe stomach pain in the first three months of pregnancy – could be a sign of ectopic pregnancy
  - Heavy bleeding with cramping in the first three to four months of pregnancy – could be a sign of miscarriage
  - Bleeding with abdominal pain in the last three months of pregnancy – could be a sign of placental abruption
- **Stomach cramps** – could be a sign of ectopic pregnancy
- **Dizziness** – could be a sign of ectopic pregnancy or pre-eclampsia
- **Severe vomiting or sickness** – could be a severe symptom of pregnancy, or could be due to an infection
- **Severe stomach pain** – could be a sign of pre-eclampsia
- **Lower back pain** – could be a sign of pre-eclampsia
- **Rapid increase in blood pressure**, possibly signalled by nose bleeds, headache or dizziness – could be a sign of pre-eclampsia
- **Blurry vision and headaches** – could be a sign of pre-eclampsia
- **Sudden and significant swelling of hands, face and feet** – could be a sign of pre-eclampsia
- **Fever** – could be a sign of an infection
- **A decrease in your baby’s normal daily movements**, or if you are worried about how frequently your baby moves
- **Regular, increasingly intense contractions before 37 weeks of pregnancy** – might be a sign of premature labour
- **If your waters break before labour begins** – you may feel a gush or continual trickle of fluid that has a slightly sweet smell
- **Blackouts** (loss of consciousness) or fits (convulsions) – must be taken seriously. Call an ambulance (000) for anyone who fits and for anyone who faints or blacks out and has not recovered in a few minutes.

**What to do in an obstetric emergency**

If you are having an obstetric emergency, call triple zero (000) immediately.

If you are unsure whether your situation is an emergency, you can call your doctor, midwife or hospital and explain what is happening. Or just call 000.

**When to call an ambulance during a home birth**

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You may have arranged a home birth but then changed your mind. It is absolutely fine to decide to go to hospital. You can make that decision at any point during your pregnancy or labour, right up to the actual birth.

Your midwife may recommend you transfer to a hospital if your home birth is not going to plan or because your labour is not progressing. The midwife might call an ambulance or agree that you can travel to hospital in a car (not driving yourself). At hospital, your midwife will stay with you as much as possible, but the hospital midwives and doctors will take over your care.

In addition to the obstetric emergencies mentioned above, a hospital birth may be necessary if you need:

- epidural pain relief (which must be administered by an anaesthetist)
- control of any bleeding that the midwife cannot stop
- assistance with the birth of your baby because you cannot push your baby out yourself
- help with the labour because it is too slow, or because of concerns about your baby’s heartbeat or the colour of the amniotic fluid (if it contains meconium, which is baby’s first poo)
- assistance because the placenta is stuck (retained placenta)
- repair of a serious tear
- special care for your baby, often because the baby has breathing problems.

**Obstetric emergencies – what happens at hospital**

If you are sent to hospital with pregnancy complications, a specialist will take your medical history and perform a pelvic and general physical examination.

You may have blood and urine tests (to look for infection), and you will have your heart rate and blood pressure monitored (if pre-eclampsia is suspected). Your baby’s heartbeat will also be monitored.

A scan (abdominal ultrasound) may help identify whether the placenta is out of position (placenta praevia or placental abruption). It can also provide information on your baby’s size, movements and heart rate, and the amount of fluid around your baby.

A hospital is the safest place for dealing with any obstetric emergency.

**Treatment of emergencies during pregnancy**

Obstetric emergencies during pregnancy are treated as follows:

- **miscarriage** – there is no treatment, other than ensuring the mother is not at risk of excessive bleeding or infection. Sometimes a procedure may be necessary to treat infection or remove pregnancy tissue
- **ectopic pregnancy** – the fertilised egg is removed by keyhole surgery (laparoscopy). If the fallopian tube has burst or been damaged, further surgery is needed
- **placental abruption** – bed rest may prevent further separation of the placenta and stop the bleeding. If the bleeding is very heavy or cannot be stopped, the baby may need to be born immediately. Some women and babies may need a blood transfusion
- **placenta praevia** – most babies will be born by caesarean section before their due date, however this will depend on how low the placenta is.
- **pre-eclampsia and eclampsia** – birth of the baby and delivery of the placenta is the only known cure for the condition. Medication may be used to control blood pressure and prevent convulsions. A woman near full term who has been diagnosed with mild pre-eclampsia may be advised to have her labour induced. If the baby is under 28 weeks, the mother may be admitted to hospital and given steroids to build the lungs of the baby, in case it needs to be born early. If the life of the mother or baby is at risk, the baby is delivered immediately, usually by caesarean
- **premature rupture of membranes (PROM)** – treatment depends on the number of weeks of pregnancy at which this happens. If PROM occurs before 37 weeks the mother is given intravenous antibiotics. If the baby is close to term, the mother is usually advised to have her labour induced. Induction of labour is not always needed if contractions start within 24 hours of rupture (unless the mother has had a test during the pregnancy that is positive for a bug called GBS that can make babies very unwell).

**Treatment of emergencies during labour**
Obstetric emergencies during labour are treated as follows:

- **shoulder dystocia** – the mother sits or lies with her knees to her chest, to free the child's shoulder. An episiotomy is also performed to widen the vaginal opening. Different manoeuvres (external and internal) can be tried to free the baby
- **prolapsed umbilical cord** – if the cord has come out the vaginal opening an immediate delivery by caesarean section is usually needed
- **placenta accreta** – the placenta is usually surgically removed after the baby is born. Other treatments and medications may be used to try to save the uterus but most commonly, a hysterectomy is needed
- **rupture of the uterus** – a ruptured uterus is repaired if possible, although a hysterectomy (removal of the uterus) may be performed if the damage cannot be fixed. The mother may need a blood transfusion
- **inversion of the uterus** – an inverted uterus is moved back (either by hand or surgically) to the proper position
- **amniotic fluid embolism** – the mother is given emergency care and the baby is delivered as soon as possible.

**Where to get help**

- In an emergency, call 000 for an ambulance
- Your midwife or obstetrician
- Your **GP (doctor)**
- Your hospital's emergency unit or maternity unit

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