UMBILICAL CORD PROLAPSE
Supporting information

This guideline has been prepared with reference to the following:


All staff involved in the management of obstetric emergencies (including cord prolapse) should receive at least annual training?

A retrospective cohort study (Siassakos, 2009) examined the case records of all 62 cases of cord prolapse occurring in a large tertiary maternity unit within a UK university hospital between 1993 and 2007. Thirty four cases occurred before the introduction of multidisciplinary simulation training and 28 after. After training, there was a statistically significant reduction in median diagnosis-delivery interval from 25 to 14.5 minutes (P < 0.001). There was also a statistically significant increase in the proportion of caesarean sections where recommended actions had been performed (from 34.78 to 82.35%, P = 0.003). The authors concluded that “…introduction of annual training, in accordance with national recommendations, was associated with improved management of cord prolapse”.


Evidence Level: IV

Prolapse of the umbilical cord is an independent risk factor for perinatal mortality?

A large population-based study (Kahanna, 2004) comparing all deliveries complicated by cord prolapse (n=456; 0.4%) to deliveries without this complication (n=120,771) noted higher rates of perinatal mortality in the cord prolapse group vs. the control group (OR=6.4, 95% CI 4.5-9.0).

A retrospective study of 132 babies born after the identification of cord prolapse at the John Radcliffe Hospital, Oxford, between 1984 and 1992 (Murphy, 1995), found that 12 babies died. There were 6 stillbirths and 6 neonatal deaths. Only 1 of the neonatal deaths was due to birth asphyxia. The authors commented that mortality in this group of babies was predominantly attributable to congenital anomalies and prematurity rather than birth asphyxia.

A population-based case-control study in 709 cases of cord prolapse and 2407 randomly selected controls (Critchlow, 1994) found an increased risk of mortality (RR 2.7, 95% CI 1.9 to 4.0), with mortality being less likely to occur among cases delivered by cesarean section (RR 0.4, 95% CI 0.2 to 0.6).


Evidence Level: IV

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