Cord prolapse a timely reminder

11pm a labouring women arrives at a health centre. The nurses who attend to her make their diagnosis. The cervix is 9cms dilated, fetal heart 134bpm, membranes are absent and an umbilical cord presents, they recognise a cord prolapse.

For any midwife the response to the above scenario would be immediate delivery (Dilbaz *et al,* 2006), however, this case is in a remote health centre in Rwanda.

To help you understand the logistics of this scenario I will attempt to build a picture of the difficulties which now face the woman and her family. To access the necessary help needed an attempt was made to contract the local ambulance, this is a run down vehicle with none of the modern equipment associated with our current health care provision in the UK. Unfortunately despite their efforts and the urgency of the situation there was no vehicle available. The only option now was for her family to carry her on a stretcher through the night, a six hour walk up a steep mountainside, to the nearest hospital at Shyira where myself and two other midwives were working.

9am the next morning, unaware of what had proceeded her emergency arrival at Shyira Hospital, the midwifery team approached the situation as though it had just happened. Our midwifery training triggered us to respond immediately when we were made aware of a possible cord prolapse, implementing emergency obstetric management (Goswami, 2007) whilst trying to establish the facts. As a team we applied a co-ordinated approach to try and facilitate the best outcome for the mother and fetus.

We tried to explain to the woman that we needed her to lie on her left side while we assessed the situation, but this was frustratingly difficult due to the language barrier and the general practice in Rwanda of lying women on their backs for delivery, no matter what the circumstances were.

I attempted to establish if there was a fetal heart but her abdomen was tense making if difficult to assess abdominally. The loop of cord protruding from the vagina confirmed we were dealing with a cord prolapse and the questions flashed through my mind how long ago did this happen and was there a fetal heart? My colleague proceeded to perform a vaginal examination to establish

cervical dilatation and help us determine the management, additionally applying counter pressure to the presenting part to reduce cord compression (Goswami, 2007).

Although we continued to manage the situation I became increasing aware of the mêlée of raised voices around us in the labour room, amongst the different languages I discerned the words, caesarean section and is there a fetal heart. The obstetrician had arrived and was attempting to establish what had happened.

To complicate the case further a compound presentation was diagnosed during the vaginal examination, the head and hand were both trying to traverse through the vagina at the same time. On reflection this may have been a causative factor relating to the cord prolapse, as there is evidence to support links with malpresentation and the increased incidence of cord prolapse (Dilbaz, *et al,* 2006, Qureshi *et al*, 2004). With this additional complication the obstetrician became quite insistent now that the woman should have a caesarean section, without first establishing if there was a fetal heart.

Within seconds we had confirmed that there was no fetal heart but the issue remained how to deliver the woman, the obstetrician still wanted to do a caesarean section due to the compound presentation. Our intuition and experience lead us to believe we could safely deliver the woman vaginally, despite the presentation, as the presenting parts were already below the ischeal spines and the pelvic outlet felt adequate. The obstetrician finally consented to us conducting the delivery; however, he remained in the delivery room to watch over the proceedings.

During the deliver the nurses kept attempting to turn the woman back into the supine position but our experience told us that the left lateral position would offer the woman the best opportunity to deliver safely. The position would allow posterior rotation of the coccyx which would increase the anteroposterior diameter of the maternal pelvis, and as the labour rooms only had half beds in them, it was also the safest option open to us.

The delivery took place over the next few minutes with the nurses and obstetrician watching over us; it was conducted in a calm and sensitive manner encouraging the woman to push with each contraction, thereby, allowing a slow and controlled delivery of the baby. At delivery it was immediately evident that her son had died some hours before; his arm was swollen, mottled and oedematous where it had obviously been trapped for some time. He was carefully taken, wrapped in a cloth and placed on a table in the delivery room as the woman did not want to see him, it all felt so final. I felt the need to examine him to confirm that there was nothing else wrong with him, a tentative attempt to consol myself that this had not been a life lost unnecessarily, externally he was perfect; cause of death prolonged cord prolapse.

Despite the gulf between us in respect of language and culture we felt we had achieved the best outcome for the woman. This was reinforced when she thanked us for our care.

Throughout this whole scenario I had acted as a professional midwife, however, as the reality of the situation hit me and the realisation of the unnecessary loss of life my emotions overwhelmed me, fortunately my colleague was on hand with a hug and a tissue. The one thing I was acutely aware of at that time was the response of the Rwandan nurses, who carried on with their duties laughing, joking and sending texts as though nothing had happened, a stark contrast to how I was feeling.

On reflection I was trying to make sense of the situation by placing it in the context of my own experience and how the outcome of this event may well have been different in the UK. However, what it did show me was how you cannot always apply your own expectations and experience in a different country and culture. The response to loss was markedly different from the UK possibly due to the aftermath of the genocide. From my observation the Rwandan people appear to more readily accept death as part of the natural order of life.

Some time after the delivery a set of written records were discovered by the staff. They had been sent by the health centre staff that had initially assessed the woman, contained within them were all the details I started this piece with. The discovery was shocking but it also placed the event in context making me realise that we had indeed achieved the best outcome for the woman. The notes also raised a question for me; if I had been in full knowledge of the facts at the beginning of the scenario would I have done anything differently. I think the only difference would be to spend more time preparing the woman for the delivery, by maintaining a calm atmosphere.

Although the experience had a sad outcome for the fetus there are a number of positive aspects which can be drawn from the situation. Unlike the UK the women in Rwanda have to pay for their deliveries a normal delivery is £2 and a caesarean section £35 a small amount in our throw away society when we would probably spend more than that on a pair of shoes. However, when you put this in perspective, with the average wage of £3 per week for unskilled labour and £10 per week for skilled labour it is easy to see the financial burden experienced by the families. By achieving a normal delivery for the woman in this scenario we were able to help her financially in two ways, by reducing her delivery cost and helping her to return to work quicker to earn money for her family. There is also the physical element no only for her recovery but also for any future pregnancies.

The whole experience of working in Rwanda has shown me how small acts can pay huge dividends and has reinforced my belief that midwives really do make a difference to the lives of women.

References

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