

South Australian Perinatal Practice Guideline

Cord Presentation and Prolapse

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Note:

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate, and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Note: The words woman/women/mother/she/her have been used throughout this guideline as most pregnant and birthing people identify with their birth sex. However, for the purpose of this guideline, these terms include people who do not identify as women or mothers, including those with a non-binary identity. All clinicians should ask the pregnant person what their preferred term is and ensure this is communicated to the healthcare team.



“Aboriginal and Torres Strait Islander recognition statement: We use the term ‘Aboriginal’ to refer to people who identify as Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander. We do this because the people indigenous to South Australia are Aboriginal and we respect that many Aboriginal people prefer the term ‘Aboriginal’. We also acknowledge and respect that many Aboriginal South Australians prefer to be known by their specific language group(s).”



Australian Aboriginal Culture is the oldest living culture in the world, yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2–5 times more likely to die in childbirth and their babies are 2–3 times more likely to be of low birth weight. The accumulative effects of stress, low socio-economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services, and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics, the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation, and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectfully manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.

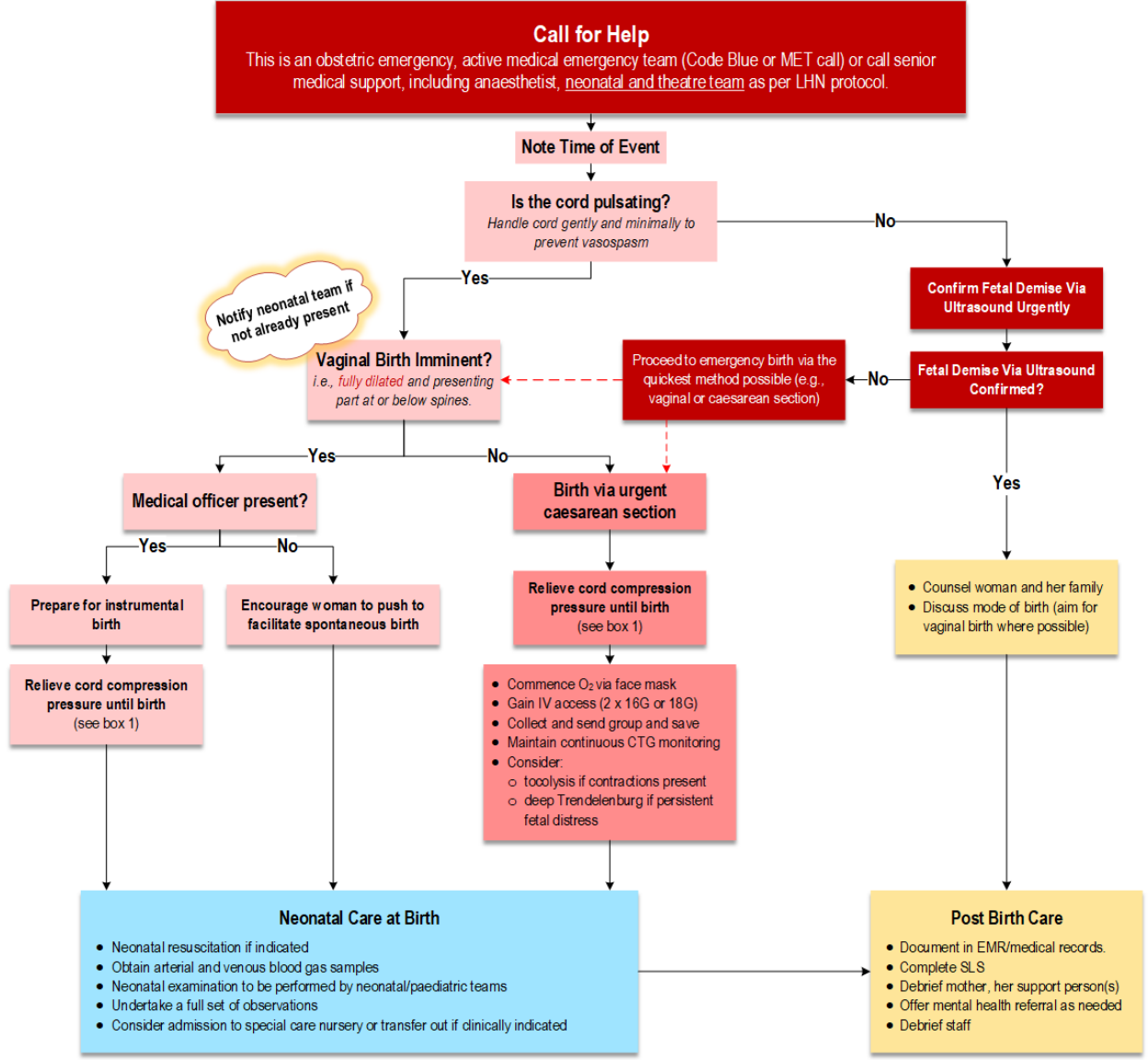
Explanation of the Aboriginal artwork: The Aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the Aboriginal culture. The horseshoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horseshoe shape depicts a pregnant woman. The smaller horseshoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.

Purpose and Scope of PPG

This guideline provides clinicians with information on risk factors, prevention, diagnosis and management of cord prolapse and/or presentation.



Flowchart 1| Cord Prolapse Management



Box 1
 The following techniques may assist in relieving cord compression pressure, however, they should not be undertaken if they delay birth.

- Manually elevate presenting part off the umbilical cord by vaginal digital examination
- Alternative fill maternal bladder with 500 ml normal saline (warm if possible) via IDC
- Position woman in deep knees-chest (A) or left lateral position with head down and elevated foot of the bed (B)



Regional Considerations

- Situational awareness: who is available? how long will it take for extra staff to arrive?
- Contact senior obstetric doctor promptly
- Call theatre team early
- Contact PAL/MedStar
- Delegate scribe

Umbilical Cord Presentation and Prolapse PPG v6 (09/07/2025)

For a printable version see [Appendix 1| SAPPG Cord Prolapse Management Record](#)

Cord Presentation and Prolapse

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Cord Presentation and Prolapse

Summary of Practice Recommendations

Perform a vaginal examination to exclude or confirm the presence of cord presentation/prolapse if sudden appearance of persistent, deep, fetal variable decelerations or prolonged fetal bradycardia.

If the cord is felt on vaginal examination below the presenting part in the presence of intact membranes, artificial rupture of membranes (ARM) should **not** be performed.

Once cord prolapse is diagnosed, treat as an obstetric emergency and call for help.

If the woman's cervix is fully dilated, expedite vaginal birth.

If the woman's cervix is not fully dilated, the priority is to relieve pressure on the cord by elevating the presenting part, while preparations are made for an emergency caesarean section.

A practitioner experienced in neonatal resuscitation should be present at all births where cord prolapse has occurred.

If the cord is not pulsating, confirm fetal demise with ultrasound urgently, in particularly in cases where fetal heart rate was previously auscultated.

Abbreviations

>	Greater than
≥	Equal to or greater than
<	Less than
≤	Equal to or less than
+/-	Plus or minus
ARM	Artificial rupture of membranes
CTG	Cardiotocograph
FHR	Fetal heart rate
g	Gram(s)
IV	Intravenous
mL	Millilitre(s)
O ₂	Oxygen

Definitions

Cord Presentation	The presence of the umbilical cord between the cervix and the fetal presenting part with or without intact membranes.
Cord Prolapse	The descent of the umbilical cord through the cervix and alongside the presenting part (occult cord prolapse) or past the presenting part (overt cord prolapse) in the presence of ruptured membranes. ¹
Shared decision making	Shared decision making involves discussion and collaboration between a consumer and their healthcare providers. It is about bringing together the consumer's values, goals, and preferences with the best available evidence about benefits, risks and uncertainties of screening, investigations, and treatment, to reach the most appropriate healthcare decisions for that person.



Cord Presentation and Prolapse

Literature Review

Cord prolapse is an unpredictable obstetric emergency that requires a high level of clinical vigilance and expedited birth to minimise fetal morbidity and mortality.² Cord prolapse occurs in approximately 0.1–0.9%, or 1 to 9 per 1000 pregnancies. In South Australia, the incidence is approximately 0.2%, equating to 2 cases per 1000 pregnancies.²⁻⁴ Optimal fetal outcomes are achieved through rapid emergency response, expedited birth combined with interventions to relieve cord compression.²

A large retrospective study involving over 100,000 births, including 130 intrapartum cord prolapse events, demonstrated favourable neonatal outcome when timely, protocol-driven responses were implemented—regardless of the preceding fetal heart rate (FHR) pattern.⁵ However, another study found a significant correlation between the interval from bradycardia onset to birth and umbilical cord arterial pH specifically in cord prolapse cases complicated by fetal bradycardia. This relationship was not observed when the FHR was normal or showed decelerations.⁶ Furthermore, the risk of perinatal mortality, along with neonatal morbidity and mortality, increases significantly when cord prolapse occurs outside of a health facility.⁷

Introduction

Cord prolapse occurs where there is descent of the umbilical cord through the cervix, either alongside the presenting part (occult cord prolapse) or past the presenting part (overt cord prolapse), in the presence of ruptured membranes.^{1, 7-9}

Cord presentation or cord prolapse can occur in any situation where the presenting part does not fit well into the maternal pelvis. In the case of cord presentation and prolapse, blood flow through the umbilical vessels may be compromised from the compression of the cord between the fetus and the uterus, cervix or pelvic inlet, umbilical vein occlusion, and umbilical artery vasospasm, which can compromise fetal oxygenation.⁸ Caesarean section is the safest birth option for the viable fetus, especially in the first and early second stage of labour.

 **Cord prolapse is an obstetric emergency that may result in fetal asphyxia or death.**

Common issues in the management of cord prolapse include:¹

- lack of recognition of cord prolapse
- inappropriate handling of the cord
- delay in the woman adopting a position that will relieve the pressure on the cord
- not calling for help
- delays in transfer to theatre
- difficulty with equipment for bladder filling
- omission of collection of cord blood gases.

Regional Considerations

Cord prolapse in a regional setting provides a unique set of challenges. Staff working at these sites require appropriate knowledge and expertise to expediate birth and mobilise appropriate personnel.

Once a cord prolapse has been identified, staff must ensure theatre are called in promptly and the emergency is declared appropriately, for example, “*I am calling a category 1 caesarean section for cord prolapse*”.

Early planning for transfer should be considered, dependant on local resources and the condition of the neonate at birth.



Cord Presentation and Prolapse



Consider the need for calling in senior obstetric and midwifery staff for neonatal resuscitation and notify MedStar as required.

Note: Not all staff attending a cord prolapse in regional settings will have had experience with obstetric emergencies. Appropriate debriefing of the team involved, along with an opportunity to ask questions should be provided.

Management of a Prolapse in the Community

- Women with a known or suspected cord prolapse should be advised to assume the knee-chest/face-down position ([figure 1](#)) whilst waiting for an emergency transfer to hospital.⁷
- Expecting obstetric units should prepare for an emergency caesarean.
- When the woman arrives at the health facility, she should be reviewed by senior medical staff and urgent birth plan implemented based on stage of labour, where the fetus has not demised (see [intrapartum management](#) section of this guideline).

Risk Factors

Cord prolapse occurs most frequently after the amniotic membranes rupture (spontaneous or via ARM) and the fetal presenting part is not well applied.

Maternal risk factors include:^{1, 7, 8, 10}

- multiparity
- polyhydramnios
- abnormal placentation
- pre-term labour, +/- low birth weight < 2500 g
- pelvic deformities
- prolonged labour
- previous cord prolapse
- second twin.

Fetal risk factors include:^{1, 7, 8}

- breech/malpresentations
- transverse, oblique and unstable lie
- high head at onset of labour, +/- artificial rupture of membranes (ARM)
- fetal congenital anomalies
- abnormally long umbilical cord.

Obstetric interventions that increase the risk of cord prolapse include:^{1, 4, 5, 7, 8}

- amniotomy (especially ARM with high fetal head, or for second twin during vaginal birth)
- internal podalic version
- disimpaction of fetal head during rotational assisted birth
- fetal scalp electrode application
- external cephalic version
- expectant management of premature rupture of membranes
- cervical ripening with a balloon catheter
- induction of labour
- footling breech with SROM
- manual rotation of the fetal head
- application of forceps or vacuum
- amnioinfusion.



Cord Presentation and Prolapse

Note: *Obstetric procedures account for approximately 50% of cases of cord prolapse.*⁸

Prevention

- In the presence of risk factors cord presentation or prolapse should be excluded at every vaginal examination.⁷
- If the cord is felt on vaginal examination below the presenting part in the presence of intact membranes, ARM should **not** be performed.⁷
- Where ARM is indicated it should only be performed by senior medical or midwifery staff in the following circumstances (consider the need to exclude cord presentation on ultrasound before ARM):
 - high, ill-fitting presenting part
 - unstable lie
 - polyhydramnios.
- In the above circumstances, arrangements should be in place for an immediate caesarean section.⁷
- Any upward displacement of the presenting part should be minimised once the membranes have ruptured.⁷
- When the fetal lie is transverse, oblique or unstable consider elective admission to hospital after 37 weeks gestation.⁷
 - Women with a transverse, oblique or unstable fetal lie not admitted to hospital should be counselled as to the urgency of presenting should labour commence or they experience rupture of membranes.⁷

Presentation and Diagnosis

Cord prolapse is an obstetric emergency

Call for help immediately

- Cord prolapse can present with sudden bradycardia or decelerations of the fetal heart rate (FHR) where there has previously been a normal trace.⁸ The abnormal FHR changes will typically occur after rupture of membranes or an obstetric intervention that disengages the presenting part.⁸
- The presence of cord should be excluded during all routine vaginal examinations in labour and after spontaneous rupture of membranes where risk factors are present or if fetal heart rate abnormalities commence soon thereafter.⁷
- Diagnosis can be made when a soft, usually pulsatile structure is felt during routine vaginal examination or where on examination, the cord may be presenting (alongside the presenting part), or prolapsed (into the vagina or at the introitus).

Antepartum Management

- Obstetric emergency management will depend on gestation, viability and discussion with the woman.
- In the setting of an incidental finding of a cord presentation on a routine ultrasound, appropriate antenatal counselling should be arranged with a senior obstetrician to discuss potential risks and plan mode of birth.
 - Further ultrasounds to assess the status of the cord presentation may be appropriate depending on the gestation.
 - Women should be counselled regarding the risk of cord prolapse and immediate management to undertake in the event of labour or rupture of membranes.



Cord Presentation and Prolapse

- If unexpected rupture of membranes occurs in the antenatal period, perform a speculum examination immediately for women with a high risk of cord prolapse or if cord prolapse is suspected.
 - If prolapse is diagnosed, **call for immediate medical assistance**.
 - Ensure immediate assessment of clinical circumstances:
 - gestation
 - presentation
 - cervical dilatation
 - fetal wellbeing.
 - If cord not pulsating or fetal heart not heard, confirm presence or absence of fetal heart with portable ultrasound **urgently**.
 - If fetal demise confirmed, counsel women and her family/support person(s) and discuss mode of birth (aim for vaginal birth where possible)
 - If fetal bradycardia identified expedite birth via Category 1 caesarean section.

Intrapartum Management

- The sudden appearance of FHR decelerations or prolonged fetal bradycardia on the cardiotocograph (CTG) or as part of intermittent FHR auscultation in labour or after spontaneous rupture of the membranes is an indication to perform a vaginal examination with consent to exclude or confirm the presence of cord presentation/prolapse.
- Once cord presentation/prolapse is diagnosed, treat as an obstetric emergency and **call for immediate medical assistance/activate local emergency** procedures to expedite birth.
- Discontinue oxytocin infusion if in progress.
- The mode of birth will depend on whether a FHR is present and the stage/progress of labour.
- Explain the findings to the woman and support persons including the emergency measures that may be needed.
- Aim to maintain the fetal circulation by preventing/minimising cord compression until birth occurs.

Note: *the time of diagnosis of cord presentation/prolapse and maintain a contemporaneous record of events until birth occurs.*
- A practitioner experienced in neonatal resuscitation should be present at all births where cord prolapse has occurred.

Cord Pulsating

- Determine the stage of labour by vaginal examination.
- Management will depend on the stage of labour or cervical dilatation.

Cord not Pulsating

- If the cord is not pulsating, fetal demise should be confirmed via an ultrasound scan by appropriately trained staff **urgently**.
 - A lack of pulse does not necessarily indicate fetal demise, especially if fetal heart rate was auscultated on admission.
- If fetal bradycardia is detected on ultrasound proceed to birth via the fastest and safest mode of birth e.g., vaginal, or emergency caesarean section.
- If fetal demise is confirmed via ultrasound:
 - counsel the woman and discuss mode of birth explaining that the preferred management is by vaginal birth in the case of fetal demise.⁷



Cord Presentation and Prolapse

Cervix not Fully Dilated

- Arrange immediate Category One caesarean section. (See *Standards for the Management of Category 1 Caesarean Section in SA* available at www.sahealth.sa.gov.au/perinatal).
- Ensure intravenous access is in place and obtain and send group and save (may occur in theatre and should not delay transfer).
- Administer O₂ via non-rebreathing mask at 8 litres per minute.
- Ensure continuous CTG until in theatre and commencing caesarean section or until after vaginal birth.
- The priority is to relieve pressure on the cord by elevating the presenting part while preparations are made for emergency caesarean section. This can be achieved by:
 - Positioning the woman in the deep knee-chest position ([figure 1](#)) or on the left side with head down ([figure 2](#)). Elevate the foot of the bed where possible. The knee chest position provides the greatest elevation effect and can be implemented whilst preparing for a caesarean.¹¹



Figure 1: deep knee-chest position (source: A. Brown. 2025. UniSA)



Figure 2: left side, head down position (source: A. Brown. 2025. UniSA)

- Manually elevating the presenting part is reasonable if there is immediate access to theatre. The clinician should insert sterile gloved fingers into the vagina to elevate the presenting part off the cord. Avoid excessive handling of the cord. Cover the woman and expedite birth.
- Acute intravenous tocolysis (using either subcutaneous or intravenous (IV) Terbutaline, IV salbutamol, glyceryl trinitrate) may be an effective adjunct treatment whilst preparing for theatre or if a delay is experienced.
- In cases where a delay in transfer to theatre for caesarean section is expected, consider elevation of the presenting part through rapid instillation of sodium chloride to the bladder.
 - 0.9 % Sodium Chloride (at least at room temperature) into the maternal bladder (by inserting the end of a blood giving set into a Foley catheter). Position head down in left lateral position before passing the urinary catheter. Clamp the catheter once 500 – 750 mL has been instilled. **Ensure the woman's bladder is emptied before any birth attempt.**
- If a delay in transfer to theatre is expected and the pulsating cord is prolapsed outside of the vagina, the cord may be replaced in the vagina, or a pad soaked in warm saline (sodium chloride 0.9 %) may be used to cover the cord. There is insufficient data to prove the benefits of either method.
- Any of the methods above (tocolytics, bladder filling, positioning) should **not** be used if they will delay the birth of the baby.
- Immediate resuscitation of the neonate should take priority over delayed cord clamping with compromised neonates.⁷

Note: For dosing information and tocolytic alternatives, see *Tocolysis for Uterine Hypercontractility PPG* available in the A–Z listing at www.sahealth.sa.gov.au/perinatal.



Cord Presentation and Prolapse

Anaesthetic and Theatre Management

- The management aim should be to deliver the baby **as soon as possible** in a manner that provides for safe anaesthesia for the woman.
- There is poor correlation between the decision-to-delivery interval and umbilical cord pH.⁷ The 30-minute decision-to-delivery interval is the acknowledged target for category 1 caesarean section in tertiary settings, with level 3-6 hospitals aiming for a 30-60 minute decision-to-delivery interval.¹²
- A focused anaesthetic assessment of the woman must be conducted before anaesthetising the woman.
- If the woman has a working epidural in place, there may be time for this to be topped up, by the anaesthetist, either before or en-route to theatre, avoiding general anaesthesia.⁷
- The majority of caesarean sections, where there is a cord prolapse and there is no epidural in-situ, are performed under general anaesthesia. However, expeditious spinal anaesthesia performed in a lateral position can be performed in cases of cord presentation, particularly when the fetal heart rate is acceptable.
- It is a high priority to move the woman to the operating room:
- Depending upon local circumstances, some procedures e.g., IV cannulation, obtaining group and save and urinary catheterisation can be delayed until the woman is in the operating theatre.
- The usual prophylaxis to prevent the adverse effects of the aspiration of gastric contents should still be given to the woman.
- Perform “Surgical Team Safety Checklist” as per SA Health Policy before commencing surgery. In many cases, the immediacy of the situation leaves little time for documentation of consent before surgery. However, documentation of the woman’s verbal consent can be completed.
- It is important that staff counsel any support persons who are unable to be present in theatre in cases of emergency caesarean section regarding the need for immediate intervention to optimise fetal outcomes.

Second Stage of Labour

- If the woman is in the second stage of labour and vaginal birth is feasible with the presenting part at or below spines, the doctor should prepare for operative birth (vacuum extraction or instrumental). Consideration for operative birth in theatre should be considered.
- The obstetrician should choose the instrument most appropriate to the clinical circumstances and the operator’s level of skill.⁷
- If immediate vaginal birth is not feasible, expedite birth with caesarean section.
- Obtain paired arterial and venous cord blood gases immediately after birth to exclude intrapartum-related hypoxic ischaemic brain damage.⁷

Neonatal Management

- Neonates born alive following cord prolapse are highly likely to require resuscitation.⁷
- Paired arterial and venous cord blood samples can provide clinicians with an accurate picture of fetal status at the time of birth and should be collected in the case of cord prolapse.⁷
- Ensure the baby is reviewed and/or managed by a paediatrician or appropriately trained medical officer at the time of birth (where possible) or as soon as possible.



Cord Presentation and Prolapse

Postpartum Management

Documentation

- Ensure documentation is completed in the woman's medical records including details of the birth, time help was called and arrived, methods used to alleviate cord compression (if relevant), outcome and follow-up.¹
- If a centralised CTG monitoring system was in use (such as OBTraceVu or Philips IntelliSpace Perinatal) the cord prolapse event should also be recorded in the system.
- Consider the use of a Cord Prolapse Management Form (see [Appendix 1| SAPPG Cord Prolapse Management Record](#))

Open Disclosure, Debriefing and Ongoing Support

All cord prolapse cases should be managed as per the [Clinical Incident Management Policy](#) found at www.sahealth.sa.gov.au.

Considerations include:

- Clear communication and instructions to the woman and support persons during the emergency.
- After the birth, the woman and her support persons should be offered opportunities to discuss the birth and the reason for the suggested management.
- Counselling should be offered.
- A social work referral should be offered.
- Arrange a clinical review postnatally to further debrief.



Aboriginal women should be referred to the Aboriginal Health Professional.

Staff Training and Support

All staff working in delivery and birth suites should participate in regular practical based simulated training in obstetric emergencies including cord prolapse.^{4, 13, 14} Attending a cord prolapse can be distressing for all staff involved. If possible, a counselling session should occur after the emergency to debrief regarding the events and discuss any issues with the case as a team.

Resources

SAPPGs Web-based App:

[Practice Guidelines \(sahealth.sa.gov.au\)](http://sahealth.sa.gov.au)

Medicines Information: (sahealthlibrary.sa.gov.au)

<https://sahealthlibrary.sa.gov.au/friendly.php?s=SAPharmacy>

SA Health Pregnancy:

[Pregnancy | SA Health](#)

Australian Government Pregnancy, Birth and Baby: (www.pregnancybirthbaby.org.au)

[Pregnancy, Birth and Baby | Pregnancy Birth and Baby \(pregnancybirthbaby.org.au\)](#)

Pathology Tests Explained: (<https://pathologytestsexplained.org.au/>)

[Pathology Tests Explained](#)



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South Australian Perinatal Practice Guidelines
Cord Prolapse Management Record

Facility/Unit:

UR Number
Surname
Given Name
D.O.B/...../..... Sex

Date:	Time:	Gestation:	Scribe:	Designation:
Call for Help (activate medical emergency team/support, including anaesthetics, neonatal/paediatric and theatre teams)				Time:
Place where cord prolapse diagnosed? <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Other:				
Time suspected cord prolapse first identified:		Time of confirmed diagnosis:		Cervical dilatation at diagnosis:
Actions: (tick (✓) all that apply)		Yes		No
1.	Cord pulsating? Handle cord gently and minimally to prevent vasospasm	<input type="checkbox"/> → Go to 2		<input type="checkbox"/> → Urgently confirm fetal demise via ultrasound → Go to 4
2.	Vaginal birth imminent? (i.e., fully dilated and presenting part at or below spines)	<input type="checkbox"/> → Go to 3		<input type="checkbox"/> → Go to 5
3.	Medical officer present?	<input type="checkbox"/> → Prepare for instrumental birth. → Relieve cord compression pressure until birth (See 6)		<input type="checkbox"/> → Encourage woman to push to facilitate spontaneous birth → Complete sections 7-9
4.	Fetal demise confirmed via ultrasound?	<input type="checkbox"/> → Counsel woman and her family/support person(s) → Discuss mode of birth (aim for vaginal birth where possible) → Go to 9		<input type="checkbox"/> (i.e., fetal bradycardia) → birth via quickest mode → Go to 2
Emergency Caesarean Section (tick (✓) when completed)				
5.	<input type="checkbox"/> Book Category 1 caesarean section <input type="checkbox"/> Relieve cord compression pressure until birth (See 6) <input type="checkbox"/> Oxygen: High flow via facemask <input type="checkbox"/> IV Access: 2 X 16G/18G	<input type="checkbox"/> Bloods: Group and Crossmatch <input type="checkbox"/> CTG monitoring: Continuous if gestation appropriate <input type="checkbox"/> Consider: Tocolysis if contractions present and/or deep Trendelenburg if persistent fetal distress		
Procedures Used to Manage Cord Prolapse: (tick (✓) all that apply)				
6.	<input type="checkbox"/> Manual elevation of the presenting part <input type="checkbox"/> Bladder filling <input type="checkbox"/> Tocolysis:	<input type="checkbox"/> Left lateral position with head down and elevated foot of the bed <input type="checkbox"/> Deep knees to chest		
Date of birth:		Time of birth:		
7.	Birth type: <input type="checkbox"/> Vaginal (unassisted)	<input type="checkbox"/> Instrumental: <input type="checkbox"/> Forceps <input type="checkbox"/> Ventouse		<input type="checkbox"/> Caesarean:
Analgesia: <input type="checkbox"/> Epidural <input type="checkbox"/> GA		<input type="checkbox"/> Spinal	<input type="checkbox"/> Pudendal	<input type="checkbox"/> Other:
8. Neonatal Outcome (tick (✓) all that apply)				
Cord Gases		Resuscitation		Birth Weight: grams
Venous	Arterial	<i>(if applicable)</i>		Appgars: 1 minute: 5 minutes: 10 minutes:
PH:	PH:	<input type="checkbox"/> Stimulation <input type="checkbox"/> T-piece device PEEP <input type="checkbox"/> IPPV <input type="checkbox"/> ETT IPPV duration:		<input type="checkbox"/> Neonatal examination by neonatologist/paediatrician <input type="checkbox"/> Observations: HR ____ RR ____ SpO ₂ ____ Temp.: ____
BE:	BE:	<input type="checkbox"/> Oxygen <input type="checkbox"/> Adrenaline <input type="checkbox"/> Volume expanders <input type="checkbox"/> Naloxone <input type="checkbox"/> External chest compressions		Transfer to higher care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Transfer: Time of Transfer: Receiving Facility:
Lactate:	Lactate:	Resuscitation Outcome: →	
9. Post Birth Care: (tick (✓) all that apply)				
<input type="checkbox"/> Document events in EMR/medical record		<input type="checkbox"/> Offer mental health referral, as needed		
Debrief:				
Debrief provided to parents: <input type="checkbox"/> Yes <input type="checkbox"/> No			Debrief organised for staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	
By whom:		Date:	By whom:	
Date:		Reported to O&G Consultant: <input type="checkbox"/> Yes <input type="checkbox"/> No		
SLS recorded: <input type="checkbox"/> Yes <input type="checkbox"/> No		Report Number		Date:
Attendance Record:				
Name		Designation		Name

Cord Presentation and Prolapse

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Cord Presentation and Prolapse

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Document Ownership & History

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Guideline history:	Is this a new perinatal practice guideline (V1)? N Does this perinatal practice guideline amend or update an existing perinatal practice guideline? Y If so, which version? V5 Does this perinatal practice guideline replace another perinatal practice guideline or policy with a different title? N If so, which perinatal practice guideline or policy (title)?

Approval Date	Version	Who approved New/Revised Version	Reason for Change
09/07/2025	V6	Clinical Guideline Domain Custodian	Formally reviewed in line with 1–5 yearly scheduled timeline for review. Addition of rural considerations.
20/12/2019	V5	SA Health Commissioning and Performance Unit	Reviewed in line with scheduled review date.
03/05/2018	V4.1	SA Health Safety and Quality Strategic Governance Committee	Review date extended to 5 years following risk assessment. New template.
17/06/2014	V4	SA Health Safety and Quality Strategic Governance Committee	Reviewed in line with scheduled review date.
26/07/2011	V3	Maternal and Neonatal Clinical Network	Reviewed in line with scheduled review date.
17/06/2008	V2	Maternal and Neonatal Clinical Network	Reviewed in line with scheduled review date.
28/11/2005	V1	Maternal and Neonatal Clinical Network	Original approved version.

