Yukon-Kuskokwim HEALTH CORPORATION

Guideline Protocol

Labor Patient in Village

Pregnant patient with symptoms suggestive of labor.

23w0d to 33w6d

34w0d to 36w6d

≥ 37 weeks

Consult HROB with any questions or concerns at any point.

Preterm labor suspected? — No

Past Be-In-Bethel date? — No

Problems threatening maternal or fetal life? — Yes

Yes

- Bolus 1 L LR or NS by IV
- Initiate tocolysis
- Consider steroid and antibiotic
- Reassess after bolus and Q30min

Did contractions decrease? — Yes

No

- Continue tocolysis
- Consider NSAID if not yet given
- Administer steroid and antibiotic if not yet given

Did contractions decrease? — No

Yes

Complete evaluation per CHAM and RMT guidance. Observe in clinic at least 1 hour.

Send the patient on the next commercial flight to Bethel for evaluation in L&D Triage.

Activate medevac. Send pediatric and family doctor if in labor.

Yes

No medevac. Advise over phone or video. Consider involving pediatrician and OB RN.

Life-threatening problems from childbirth? — Yes

No

Routine postpartum and newborn care. See box.

Postpartum hemorrhage?

No

Send the patient and newborn on the next commercial flight to Bethel.

Yes

PPH resolved?

No

- Activate medevac.
- Additional uterotonics.
- Bolus and elevate legs if BP low.
- Consider bimanual compression based on CHA/provider comfort.
- Recommend PRBC and TXA to LM.

Yes

- Position supine and keep warm.
- Monitor SpO2 and BP closely.
- Establish two large bore IV if able and consider fluid bolus.
- Transabdominal fundal massage.
- Administer uterotonics if available.
- Consider bimanual compression based on CHA/provider comfort.
- Consider vaginal packing for lacerations/obstetric trauma.
- Encourage breastfeeding or nipple stimulation for endogenous oxytocin.

Things to Consider

- Parity
- Past or current pregnancy complications
- Placental location

If late-to-care/no BIB agreement, consider medevac even at term.

Tocolysis does not stop preterm labor; it can delay enough for commercial flight or to get medevac crew to the scene.

Do not place a patient on a commercial flight if she could deliver en route regardless of gestational age.

Blood loss is difficult to quantify. Request photos of pads/clots.

If activating a medevac for village labor

- Do not send a resident.
- Ensure that all Tiger Connect roles are covered by back-up physician.
- Notify ED Doctor On Duty since they are medical control.
- Gather **Village Delivery Backpack** from OB and Butterfly/iPad for US.
- Discuss with pediatrician the need to bring surfactant.
- Bring warm clothing (extra gear in peds call room under the bed), snacks, drinks, money, motion sickness medication, etc.
- Coordinate with pediatrician and plan to meet at LifeMed hangar at 3600 Tower Road. Tell LifeMed (LM) Dispatch if delayed more than 20 minutes.

Postpartum and Newborn Care

Mother: Check vital signs and fundal checks q15 min x 1 hour, then q30 min x 2 hours, then q1h x 3 hours. If all is well, may leave clinic to await travel with instructions to return immediately for return of bleeding or passing clots.

Baby: Check vital signs with axillary temperatures q30 minutes x 2 hours, then q1h x 4 hours. Low threshold to check blood glucose after first feed. Ensure vitamin K, erythromycin, and hepatitis B vaccine are given when able. If all is well, may leave clinic with instructions to return immediately for any concerns, especially trouble breathing, fast breathing, pauses in breathing, etc.

Tocolytics

1. Nifedipine (as BP permits)
   0 min: 30 mg PO
   90 min: 20 mg PO
   180 min: 10 mg PO
2. Terbutaline 0.25 mg SC q5 min x 4 PRN
3. Ketorolac 60 mg IM or ibuprofen 800 mg PO

Steroids

- Betamethasone 12 mg IM q24h x 2 (preferred); OR
- Dexamethasone 6 mg IM q12h x 4

Antibiotic (if no allergy)

- Ceftriaxone 1 g IM

Uterotonics

1. Oxytocin 10 units IM, 10-40 units IV bolus (SRC only)
2. Misoprostol 800 mcg PO/PR/SL
3. Methergine 0.2 mg IM q2h

In the village

- Help the crew, follow their instructions, and expect to carry equipment.
- Assess fundal height and Leopold maneuvers; consider dating accuracy versus polyhydramnios if size greater than dates.
- If EGA<34 weeks, perform a sterile speculum exam, obtain FFN, swab for GBS and GC/CT, and obtain urine sample for culture.
- If low risk for placenta previa (e.g., not noted on prior formal or Butterfly POCUS), check cervix after obtaining cultures.
- Make decision about disposition based on cervical exam, possible complications, and risk/benefit of travel.
- Discuss with HROB if any uncertainty about plan.
- Notify OB charge RN of plan as soon as possible from village clinic or Subregional Center (SRC) so they can prepare.
- If village delivery is anticipated, see **Village Deliveries (Pediatrics) Resource** for newborn care and preparation.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by Guideline Committee 8/23/23.
Click here to see the supplemental resources for this guideline.
If comments about this guideline, please contact William_Guerin@ykhc.org.