## What to do if cord prolapse happens

### Recognize the emergency without delaying care

Umbilical cord prolapse usually becomes relevant after the membranes have ruptured, either spontaneously or after amniotomy. The cord may descend through a partially or fully dilated cervix and may be felt in the vagina or even seen outside the vulva. Sometimes it is not visible; the first sign may be an abnormal fetal heart rate pattern, especially sudden fetal bradycardia after waters break or recurrent variable decelerations due to cord compression in labor.

For a medically literate reader, the key pathophysiology is straightforward: pressure on the umbilical cord can occlude venous return first and then arterial flow, reducing oxygen delivery and risking fetal hypoxia and acidosis. This is why the clinical response is immediate and highly coordinated. It is not a situation where reassurance alone is appropriate.

If you are outside a hospital and suspect cord prolapse because you can feel or see a soft, pulsing loop of cord after the waters break, call emergency medical services immediately. Tell the dispatcher that you suspect an umbilical cord prolapse. Do not drive yourself if emergency transport is available, because positioning and urgent obstetric communication may be needed en route.

## Immediate actions before the obstetric team arrives

The safest first step is to get professional help urgently and follow the instructions of the emergency dispatcher or maternity unit. If the cord is visible, avoid pushing it back inside and avoid unnecessary handling. Direct manipulation can irritate the cord and may contribute to vasospasm, which can further reduce blood flow.

While waiting for help, the goal is to reduce pressure on the cord. If you have been instructed by a clinician or dispatcher, a position that uses gravity to move the baby away from the pelvis may be used. Common options include the knee-to-chest position, where the chest is lowered and hips are elevated, or a steep head-down position if this can be done safely. These positions are temporary bridges to definitive obstetric care, not treatments that solve the problem.

If the cord is outside the body, it should generally be kept from drying out while avoiding compression or rubbing. In clinical settings, staff may cover it with warm sterile saline-soaked gauze. At home, do not delay ambulance transfer trying to improvise supplies. The priority is rapid contact with emergency services and the receiving maternity unit.

If contractions are strong or there is an urge to push, tell the emergency team immediately. Pushing can increase compression unless birth is truly imminent and being actively managed by a qualified clinician.

## What clinicians do to relieve cord compression

Once healthcare professionals are present, their immediate aim is to restore or preserve fetal oxygenation while arranging the fastest safe birth. A clinician may insert a hand into the vagina and manually elevate the presenting part, lifting the baby’s head or breech away from the cord. This can be physically demanding and may need to be maintained until delivery in the operating room.

Maternal positioning is another common maneuver. The knee-to-chest position or steep Trendelenburg position can reduce gravitational pressure on the cord. If a vaginal examination confirms cord prolapse, staff will usually avoid repeated

examinations and avoid direct handling of the cord itself unless absolutely necessary.

In some settings, the bladder may be filled with sterile saline through a urinary catheter. This can elevate the presenting part and reduce cord compression while the team prepares for cesarean birth or transfer. Tocolysis, medication to reduce uterine contractions, may be considered by clinicians in selected circumstances if contractions are worsening compression and delivery is not immediate; this is a medical decision based on the situation.

Continuous or frequent fetal heart rate assessment guides urgency but does not make the situation non-urgent. A temporarily normal tracing does not remove the need for rapid delivery planning, because cord compression can recur abruptly.

**Delivery decisions: cesarean, vaginal birth, and timing**

Definitive management of cord prolapse is birth. In most cases, when vaginal birth is not imminent, emergency cesarean delivery is recommended. Guidelines commonly treat this as a Category 1 cesarean when there is fetal heart rate concern, meaning there is an immediate threat to fetal wellbeing and the team aims to deliver as quickly as safely possible, often within a 30-minute decision-to-birth framework where feasible.

Vaginal birth may be appropriate if it is clearly imminent, such as full dilation with the presenting part very low and delivery achievable faster than cesarean. Depending on circumstances, this may involve spontaneous birth or assisted vaginal birth using forceps or vacuum by an appropriately skilled clinician. The decision is situational: the fastest safe route for the baby and birthing parent is the guiding principle.

Factors influencing the decision include cervical dilation, station of the presenting part, fetal presentation, fetal heart rate, availability of an operating room, anesthesia readiness, and clinician expertise. A cephalic fetus high in the pelvis usually points toward urgent cesarean. A baby already crowning may be delivered vaginally. Malpresentation, including breech presentation or transverse lie, can increase complexity and often makes operative delivery more likely.

For the birthing parent and support person, the rapid shift can feel shocking. You may hear urgent language, see multiple staff enter, be moved quickly, and be asked for consent under pressure. This urgency reflects the physiology of cord compression, not a lack of care or compassion.

**If it happens in different birth settings**

In hospital, the response usually involves calling an obstetric emergency, moving rapidly to theater if needed, maintaining manual elevation or maternal positioning, alerting anesthesia and neonatal teams, and preparing for immediate delivery. Intravenous access, blood pressure monitoring, urinary catheterization, and fetal monitoring may happen in quick succession.

In a freestanding birth center or home birth setting, suspected cord prolapse requires emergency transfer unless birth is already unavoidable and a qualified clinician is managing it. The attending midwife or clinician may position the birthing parent to reduce compression and may communicate directly with the ambulance crew and receiving hospital. Transport should not be delayed for nonessential tasks.

During ambulance transfer, the same principle applies: reduce pressure on the cord and get to a facility capable of urgent operative birth and neonatal resuscitation. If manual elevation of the presenting part has been started by a trained professional, it may need to continue during transfer. This is one reason cord prolapse is so logistically intense; the temporizing maneuver and the definitive delivery plan must happen at the same time.

If you are planning birth outside an obstetric unit and have risk factors such as an unengaged presenting part, unstable lie, malpresentation, polyhydramnios, multiple pregnancy, or preterm labor, discuss emergency transfer pathways in advance with your maternity team. Planning does not prevent every emergency, but it can shorten response times.

**After birth: newborn care, parental recovery, and debrief**

After delivery, the neonatal team will assess the baby’s transition, breathing, tone, heart rate, and need for resuscitation. Some babies recover quickly after cord compression is relieved; others may need oxygen, ventilation support,

blood gas assessment, or admission for closer observation. The level of care depends on the baby's condition at birth and local protocols.

The birthing parent's recovery depends on the mode of delivery and the circumstances. After emergency cesarean, there may be surgical recovery, anesthesia after-effects, pain management, wound care, and the emotional impact of a sudden operative birth. If vaginal birth occurred, care may focus on perineal trauma, bleeding, bladder function, and monitoring after an intense emergency.

Emotionally, cord prolapse can be traumatic even when the outcome is good. It often involves alarms, rapid consent, physical repositioning, separation from a partner, and fear for the baby's life. A postnatal debrief with the obstetric or midwifery team can help reconstruct the timeline: when the prolapse was recognized, what fetal heart rate changes occurred, which maneuvers were used, why the chosen route of birth was safest, and how the baby responded.

Seek additional support if you experience intrusive memories, panic, sleep disturbance unrelated to normal newborn care, guilt, or persistent fear about future pregnancies. These reactions are understandable and treatable. A compassionate review of the event can be part of both medical and psychological recovery.

**Risk awareness without self-blame**

Cord prolapse is uncommon, and when it happens it is rarely because a parent did something wrong. It is associated with situations where the presenting part does not fill the pelvis well, allowing space for the cord to slip past. Examples include malpresentation and cord prolapse risk with breech or transverse lie, an unengaged presenting part, prematurity, polyhydramnios, multiple pregnancy, and some procedures such as artificial rupture of membranes when the presenting part is high.

Risk factors guide clinical vigilance, but many cases occur unexpectedly. If your waters break and you have been told the baby's head is high or the lie is unstable, contact your maternity unit promptly and follow their instructions about assessment. If you feel something in the vagina after membrane rupture, treat it as urgent until a professional says otherwise.

For future pregnancies, ask for a review of your previous records. The discussion may include presentation scans, timing and setting of membrane rupture, place of birth planning, and what to do if membranes rupture before labor. The goal is not to create fear, but to make a rapid plan visible to everyone involved in your care.