In the Name of God

Polyhydramnios

Presented by:

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Labor management

- Check fetal position frequently
- Monitor the fetal heart rate continuously
- Prophylactic gradual abdominal or trans-cervical amnioreduction with a needle when the head is engaged

The risk of cord prolapse should be considered;

Controlled amniotomy in the operating room is performed by using a small gauge needle, while a second operator is stabilizing the fetus in longitudinal lie/cephalic presentation.

Amniotomy should be performed between, not during, uterine contractions, if possible.

Timing of delivery

Mild to moderate polyhydramnios

In patients with mild to moderate idiopathic polyhydramnios and normal BPPs, induce labor at 39 to 40 weeks of gestation, as the risk of fetal death appears to increase signifcantly at term.

SMFM: ✓ Labor should be allowed to occur spontaneously at term for women with mild idiopathic polyhydramnios.

ACOG: ✓ Delivery at 39+0 to 39+6 weeks unless additional pregnancy complications warrant earlier delivery

Severe Polyhydramnios

Severe idiopathic polyhydramnios:

Induction of labor at 37 weeks:

Minimize the risk of umbilical cord prolapse and/or abruption in the event of spontaneous prelabor rupture of membranes

Earlier delivery on a case-by-case basis to patients between 34 and 37 weeks whose symptoms are intolerable and who have not responded to amnioreduction procedures.

Delivery at a *tertiary center* is recommended for women with severe idiopathic polyhydramnios since clinically important fetal abnormalities may not have been identified prenatally.

No absolute contraindication to use of oxytocin or prostaglandins for cervical ripening and labor induction .

These drugs should be used with caution

There is a marked increase in the incidence of postpartum hemorrhage related to atony in patients with polyhydramnios; use of uterine stimulants may increase this risk and that of amniotic fluid embolism.

Thank You for Your

Attention!

Any Question?