POET 2e manual updates

The following are changes made following publication of the POET 2e manual. Some of these may be incorporated in reprints, but a full list is included here for completeness.

Chapter	Dates of changes noted below
Chapter 1 – Obstetric Services	
Chapter 2 – Legal and Ethical issues	
Chapter 3 – When things go wrong	
Chapter 4 – Getting it right – non-technical skills and communications	
Chapter 5 – Anatomical and physiological changes in pregnancy	November 2018
Chapter 6 – Structured approach to the obstetric patient	
Chapter 7 – Collapse, cardiac arrest and shock in pregnancy	December 2021, February 2025, June 2025
Chapter 8 – Emergencies in early pregnancy (up to 20 weeks)	
Chapter 9 – Emergencies in late pregnancy (from 20 weeks)	
Chapter 10 – Trauma, surgical and medical emergencies	December 2021
Chapter 11 – Normal labour and delivery	
Chapter 12 – Complicated labour and delivery	November 2018
Chapter 13 – Emergencies after delivery	December 2021
Chapter 14 – Resuscitation of the baby at birth	February 2025, June 2025
Chapter 15 – Assessment and management of the post-gynaecological surgery patient	

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Chapter 5 – Anatomical and physiological changes in pregnancy

Page	Change	Date
46	Text alteration There is a range of opinion on the amount of left lateral tilt that should be achieved and maintained. Around 15 degrees is usually sufficient to reduce vena caval compression, and around 30 degrees to reduce aortal compression. However, the latter may be difficult to achieve. In the absence of custom-made wedges, the unresponsive patient should be placed in a full left lateral position, or her uterus should be manually displaced. Where a patient requires full spinal immobilisation, it is important to ensure that the orthopaedic stretcher or rescue board is tilted to 15-30° to the left, with adequate strapping to secure the woman.	November 2018
46	Change to second Top Tip 2. If the woman is unconscious, e.g. in eclampsia, left lateral tilt or manual uterine displacement will relieve aortocaval pressure.	November 2018

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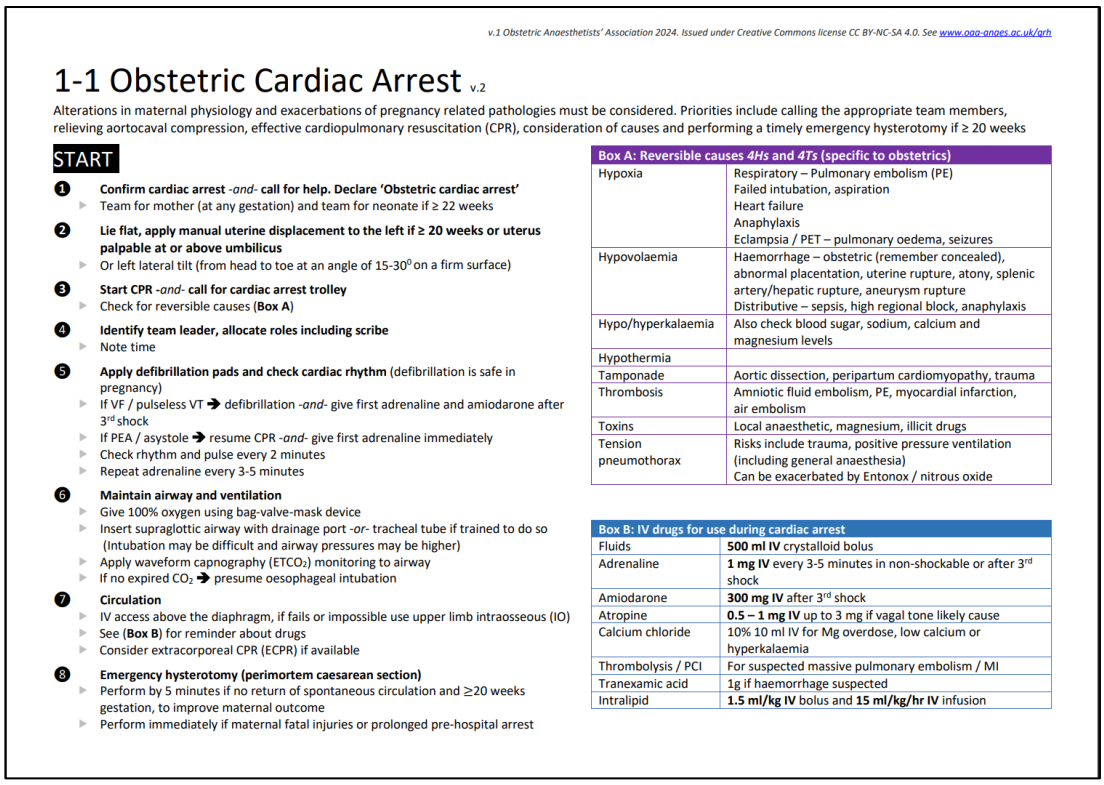
Chapter 7 - Collapse, cardiac arrest and shock in pregnancy

Page	Change	Date
	Chapter has been updated and is compliant with ILCOR 2021 Chapter 7 PDF is available here	**June 2025**
55	Addition of figure 1-1 Obstetric Cardiac Arrest) from the Quick Response Handbook from the OAA	**February 2025**



1-1 Obstetric Cardiac Arrest v.2

Alterations in maternal physiology and exacerbations of pregnancy related pathologies must be considered. Priorities include calling the appropriate team members, relieving aortocaval compression, effective cardiopulmonary resuscitation (CPR), consideration of causes and performing a timely emergency hysterotomy if ≥ 20 weeks

START

1. **Confirm cardiac arrest** *-and-* **call for help. Declare 'Obstetric cardiac arrest'**
   - Team for mother (at any gestation) and team for neonate if ≥ 22 weeks
2. **Lie flat, apply manual uterine displacement to the left if ≥ 20 weeks or uterus palpable at or above umbilicus**
   - Or left lateral tilt (from head to toe at an angle of 15-30^0 on a firm surface)
3. **Start CPR** *-and-* **call for cardiac arrest trolley**
   - Check for reversible causes (**Box A**)
4. **Identify team leader, allocate roles including scribe**
   - Note time
5. **Apply defibrillation pads and check cardiac rhythm** (defibrillation is safe in pregnancy)
   - If VF / pulseless VT → defibrillation *-and-* give first adrenaline and amiodarone after 3rd shock
   - If PEA / asystole → resume CPR *-and-* give first adrenaline immediately
   - Check rhythm and pulse every 2 minutes
   - Repeat adrenaline every 3-5 minutes
6. **Maintain airway and ventilation**
   - Give 100% oxygen using bag-valve-mask device
   - Insert supraglottic airway with drainage port *-or-* tracheal tube if trained to do so (Intubation may be difficult and airway pressures may be higher)
   - Apply waveform capnography ($ETCO_2$) monitoring to airway
   - If no expired CO_2 → presume oesophageal intubation
7. **Circulation**
   - IV access above the diaphragm, if fails or impossible use upper limb intraosseous (IO)
   - See (**Box B**) for reminder about drugs
   - Consider extracorporeal CPR (ECPR) if available
8. **Emergency hysterotomy (perimortem caesarean section)**
   - Perform by 5 minutes if no return of spontaneous circulation and ≥20 weeks gestation, to improve maternal outcome
   - Perform immediately if maternal fatal injuries or prolonged pre-hospital arrest

Box A: Reversible causes *4Hs* and *4Ts* (specific to obstetrics)

Hypoxia	Respiratory – Pulmonary embolism (PE) Failed intubation, aspiration Heart failure Anaphylaxis Eclampsia / PET – pulmonary oedema, seizures
Hypovolaemia	Haemorrhage – obstetric (remember concealed), abnormal placentation, uterine rupture, atony, splenic artery/hepatic rupture, aneurysm rupture Distributive – sepsis, high regional block, anaphylaxis
Hypo/hyperkalaemia	Also check blood sugar, sodium, calcium and magnesium levels
Hypothermia	
Tamponade	Aortic dissection, peripartum cardiomyopathy, trauma
Thrombosis	Amniotic fluid embolism, PE, myocardial infarction, air embolism
Toxins	Local anaesthetic, magnesium, illicit drugs
Tension pneumothorax	Risks include trauma, positive pressure ventilation (including general anaesthesia) Can be exacerbated by Entonox / nitrous oxide

Box B: IV drugs for use during cardiac arrest

Fluids	**500 ml IV** crystalloid bolus
Adrenaline	**1 mg IV** every 3-5 minutes in non-shockable or after 3rd shock
Amiodarone	**300 mg IV** after 3rd shock
Atropine	**0.5 – 1 mg IV** up to 3 mg if vagal tone likely cause
Calcium chloride	10% 10 ml IV for Mg overdose, low calcium or hyperkalaemia
Thrombolysis / PCI	For suspected massive pulmonary embolism / MI
Tranexamic acid	1g if haemorrhage suspected
Intralipid	**1.5 ml/kg IV** bolus and **15 ml/kg/hr IV** infusion

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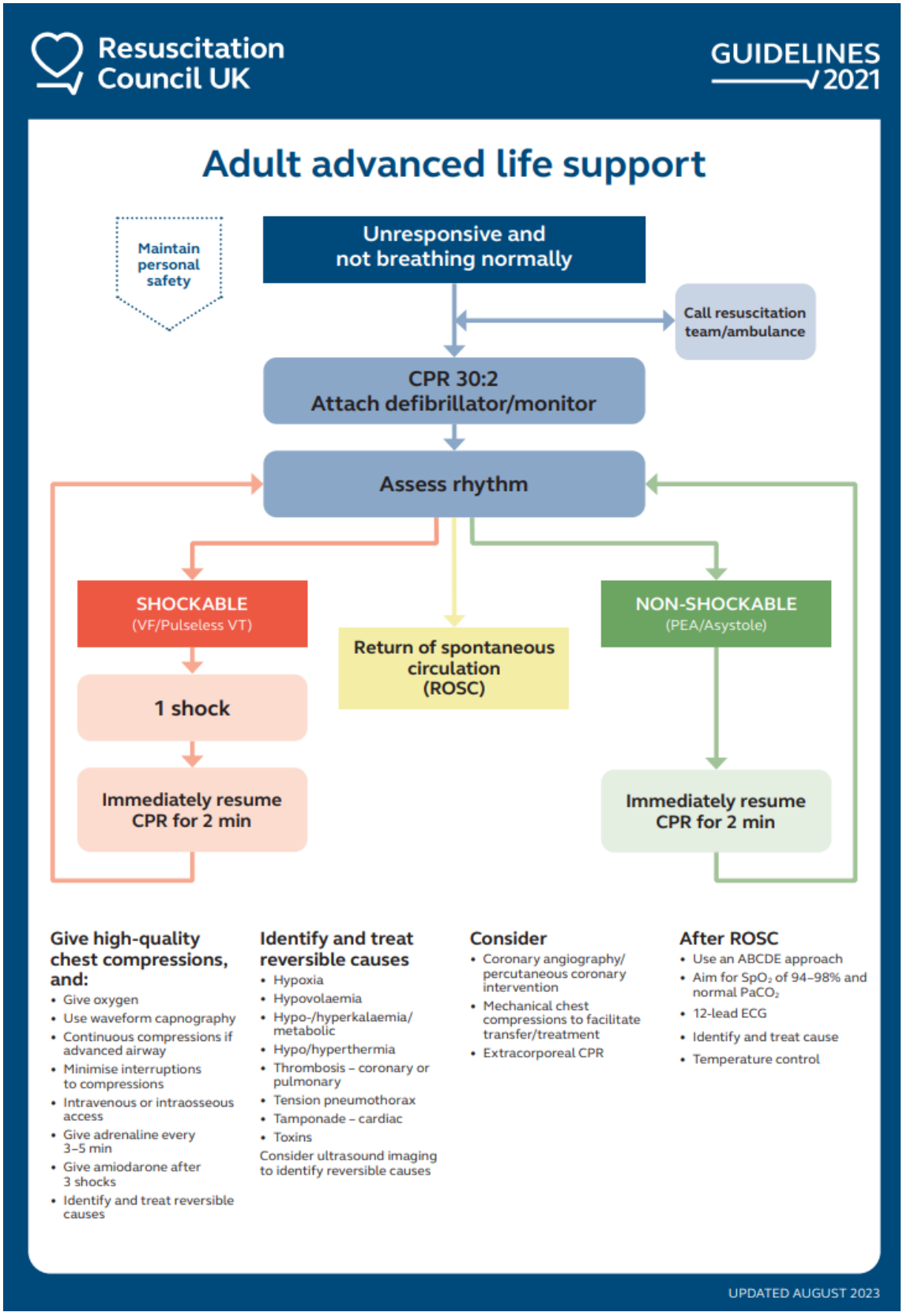
60	Figure 7.3 Adult advanced life support resuscitation algorithm updated to 2021 version.  	

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64	Under Specific management, Hypovolaemic shock the 3rd paragraph ("Consideration should be... dose") and 4th paragraph ("The use of... PPH") replaced as follows. The early administration of Tranexamic Acid (within 3 hours of delivery) has been shown to reduce mortality from PPH, following the initial administration of a uterotonic agent. The dosage of Tranexamic Acid is 1g IV, followed by a further dose if bleeding continues, or restarts after 30 minutes. We consider it advisable to administer Tranexamic Acid, where indicated, to both pregnant and post-natal women. Local guidelines will determine the route and dosage.	December 2021

Chapter 10 - Trauma, surgical and medical emergencies

Page	Change	Date
95	New bullet point 18: The use of Tranexamic Acid is recommended in the management of traumatic haemorrhage in pregnancy, as in the non-pregnant patient.	December 2021

Chapter 12 - Complicated labour and delivery

Page	Change	Date
118	Replace Top Tip "Remember the fetal back…" with Top Tip When the mother chooses a semi-recumbent position for vaginal breech delivery, ensure **the baby's back remains upwards** during the delivery.	November 2018
118	Replace Top Tip "Remember, if the mother is in the squatting position…" with Top Tip When the mother chooses an 'all fours' position for vaginal breech delivery, ensure **the front of the baby's abdomen remains upwards** during the delivery.	November 2018

Chapter 13 - Emergencies after delivery

Page	Change	Date
134	New bullet point: 12. The early administration of Tranexamic Acid (within 3 hours of delivery) has been shown to reduce mortality from PPH, following the initial administration of a uterotonic agent. The dosage of Tranexamic Acid is 1g IV, followed by a further dose if bleeding continues, or restarts after 30 minutes.	December 2021

	We consider it advisable to administer Tranexamic Acid, where indicated, to both pregnant and post-natal women.	

Chapter 14 Resuscitation of the baby at birth

Page	Change	Date
	Chapter has been updated and is compliant with ILCOR 2021 Chapter 14 PDF is available here	**June 2025**

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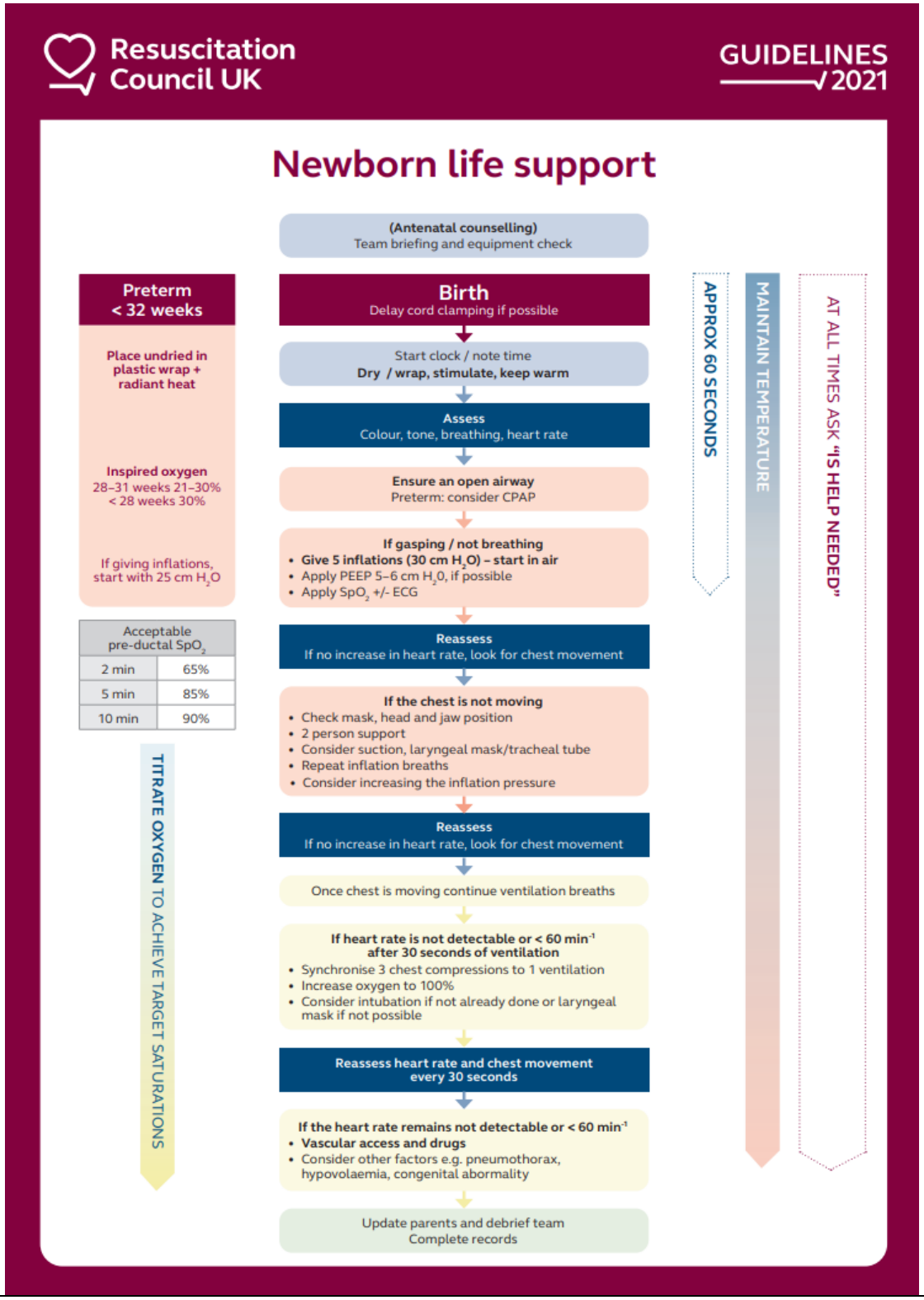
Chapter 14 - Resuscitation of the baby at birth

Page	Change	Date
160	Newborn resuscitation algorithm updated to 2021 version	February 2025



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