** Online Registration for REMAC Refresher Exam – see below **

** From the Editor **

** New Online Registration for REMAC Refresher Exam **

Go to [www.planetReg.com/E31112555131510](http://www.planetReg.com/E31112555131510) (or [www.nycremsco.org](http://www.nycremsco.org) & click the REGISTER link under “News & Announcements”).

*See the last page of this journal for details.*

** July 1, 2012 REMAC Protocol revisions in effect **

Only the July 1, 2012 protocols are in effect in the field and on certification exams. (See page 2 for outline of changes.)

Always see [nycremsco.org](http://nycremsco.org) for the current approved protocols.

*REMEMBER: the protocols on the street are the protocols on the exam!*

** Mandatory REMAC Credentialing Fee **

A $25 fee has been instituted by NYC REMAC for all new or recertifying paramedic credentials. **No fee is collected at the exam.** After successfully completing a REMAC exam, candidates will receive an email directly from NYC REMSCO requiring a completed application and credentialing fee by money order only. On receipt, a permanent NYC REMAC certification card will be issued.

*Please direct inquiries on this process to NYC REMSCO at 212-870-2301*
Outline of July 2012 NYC REMAC protocol changes
see REMAC Advisory 2012-01 at nycremsco.org

General Operating Procedures

• Transport: changes stroke criterion to $3\frac{1}{2}$ hours from onset

BLS Protocols

• 400 WMD: updates language of evaluation and autoinjector configuration

ALS Protocols

• 500-A Smoke Inhalation: changes name of protocol and indication for its use

• 500-A Smoke Inhalation & 500-B Cyanide Exposure: adds Table 2 to clarify different hydroxocobalamin bottle configurations; removes administration time per individual bottles

• 503-A V-fib/V-tach: removes dilution of amiodarone

• 511 AMS: adds glucagon to note specifying glucometer levels for treatment

• 513 Seizures: clarifies that seizures must be generalized; adds glucagon to note specifying glucometer levels for treatment; adds glucagon option for diabetic patients

• 553 Peds Non-Traumatic Arrest: updates endotracheal intubation to advanced airway management

• 557 Peds Seizures: adds glucagon to note specifying glucometer levels for treatment; moves midazolam to Standing Orders for initial administration, increases dose, and specifies preference for intranasal route; defers rectal diazepam until all other options are exhausted

• 559 Peds Traumatic Arrest: updates endotracheal intubation to advanced airway management

Appendices

• Appendix R - Stroke Criteria: changes criterion to $3\frac{1}{2}$ hours from onset
REMAC Exam Study Tips

REMAC candidates have difficulty with:
* Epinephrine use for peds patients
* 12-lead EKG interpretation
* ventilation rates for peds & neonates

REMAC Written exams are approximately:
15% Protocol GOP
40% Adult Med. Emerg.
10% BLS
10% Adult Trauma
10% Adult Arrest
15% Pediatrics

Certification & CME Information

- Of the 36 hours of Physician Directed Call Review CME required for REMAC Refresher recertification, at least 18 hours must be ACR/PCR Review (which may include QA/QI Review). The remaining 18 hours may include ED Teaching Rounds and OLMC Rotation.
- Failure to maintain a valid NYS EMT-P card will invalidate your REMAC certification.
- By the day of their refresher exam all candidates must present a letter from their Medical Director verifying fulfillment of CME requirements. Failure to do so will prevent recertification.
- FDNY paramedics, see your ALS coordinator or Division Medical Director for CME letters.
- CME letters must indicate the proper number of hours, per REMAC Advisory # 2000-03:
  - 36 hours - Physician Directed Call Review
    - ACR Review, QA/I Session (minimum 18 hours of ACR/QA review)
    - Emergency Department Teaching Rounds, OLMC Rotation
  - 36 hours - Alternative Source CME - **Maximum of 12 hours per venue**
    - Online CME - Clinical rotations
    - Lectures / Symposiums / Conferences - Associated Certifications:
    - Journal CME

REMCO: www.NYCREMSCO.org
Online CME: www.EMS-CE.com
www.EMCert.com
www.WebCME.com
www.EMINET.com

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www.EMCert.com
www.WebCME.com
www.EMINET.com

REMAC Refresher Written examinations are held monthly, and may be attended up to 6 months before your expiration date. See the exam calendar at the end of this Journal. To register, call the Registration Hotline @ 718-999-7074 by the last day of the month prior to your exam.

**New March 2013:** REMAC Basic Written and Scenario examinations are held monthly. Registration is limited to the first 25 applicants. See the exam calendar at the end of this journal.

REMAC CME and Protocol information is available, and suggestions or questions about the newsletter are welcome. Call 718-999-2671 or email swansoc@fdny.nyc.gov
FDNY ALS Division Coordinators

Citywide ALS  718-999-1738  Division 4  718-281-3392  
Lt. George Kroustallis  
Mike Romps

Division 1  212-964-4518  Division 5  718-979-7175  
Patrick O’Neil  
Joseph D’Agosto

Division 2  718-829-6069  Bureau of Training  718-281-8325  
Juliette Arroyo  
Hector Arroyo / Lisa Desena

Division 3  718-968-9750  EMS Pharmacy  718-571-7620  
Gary Simmonds  
Cindy Corcoran

FDNY EMS Medical Directors

Dr. Glenn Asaeda  718-999-2790  Dr. Dario Gonzalez  718-281-8473  
Chief Medical Director  Field Response Division 2  
OLMC Director, REMAC Coordinator  USAR/FEMA Director, OEM Liaison

Dr. David Ben-Eli  718-999-0404  Dr. Doug Isaacs  718-281-8428  
Field Response Division 4  Field Response Division 1  
Haz-Tac, PASU & EMS Resident Director  EMS Fellowship & Rescue Medic Director

Dr. Bradley Kaufman  718-999-1872  
QA, EMD & EMS Training Director

EMS Fellows - Field Response Divisions 3 & 5  
Dr. Ryan Bayley  718-999-0364  Dr. Matt Friedman  718-999-0351

FDNY OLMC Physicians and ID Numbers

<table>
<thead>
<tr>
<th>Name</th>
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<th>Name</th>
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<td>Van Voorhees, Jessica</td>
<td>80310</td>
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Birth is the final destination of the gestational journey into being, and like death, it is shared by all individuals on earth. Historically, it has been a precarious time for both mother and child. Gynecology and obstetrics are medical specialties created to study female reproductive organs and pregnancy, with the goal of lessening the dangers and improving survival rates.

For centuries women gave birth without anesthetics, antibiotics, or antiseptics, risking infection and contributing to high mortality rates. Most gave birth at home, sometimes alone. Often they were attended by the women of the community and the event was treated as a social gathering. Some women were assisted by untrained but experienced midwives. It was usually an exclusively female occasion, with the males of the family nervously loitering in another room waiting for the first signs of new life. By the 18th century medical professionals began to seek solutions to the problems associated with this very special process. In 1800, British chemist Humphry Davy began experimenting with nitrous oxide and, unfortunately became addicted to the laughing gas. But others, following his lead, later developed anesthetics to alleviate the pain associated with childbirth. The year 1846 saw the introduction of ether followed by chloroform in 1847. During the same period, in Austria, Ignaz Semmelweis realized that cleanliness reduced infection rates and by 1865 Joseph Lister was using carbolic acid as an antiseptic. The introduction of penicillin in the 1940s was a giant step forward. Today, in the 21st century, the risk of death for the mother during pregnancy and childbirth is less than 1 in 10,000.

Female Anatomy and Physiology Overview

In order to properly assess a patient it is important to understand the female reproductive system. This month's journal will review the basic anatomy and physiology of the nonpregnant and pregnant patient, the stages of labor and delivery, and post-delivery care of the mother and newborn. It will also include the gynecological emergencies and complications of pregnancy which often challenge the pre-hospital care provider.

Reproductive Structures

The structures of the female reproductive tract include the external female genitalia, uterus, vagina, fallopian tubes, ovaries, and the perineum.

- Ovaries- Are a pair of organs that release eggs and reproductive hormones.
- Fallopian tubes – Paired structures extending from each side of
the uterus to each ovary. They provide pathways to the uterus for the egg. Fertilization normally occurs inside the fallopian tubes.

- Uterus – Muscular organ approximately the size of a pear; grows with the developing fetus. The upper portion is termed the fundus. The lower portion is called the cervix the neck of the uterus, it joins with the top end of the vagina, which leads to the outside of the body.

Together, the lower portion of uterus, the cervix and the vagina are referred to as the birth canal.

The uterus consists of layers.

- Myometrium- Muscular layer of the uterine wall
- Endometrium- Nutrient rich inner layer of the uterine wall which is shed during menstruation. Under normal circumstances if fertilization occurs the egg will implant itself in the endometrium. The endometrial lining allows for changes in thickness and structure during menstruation.
- Uterine cavity- Innermost region of the uterus.

In the United States the average age of menarche is 12.5 years and the average age of menopause is between 51-52 years. Menarche is the onset of menstruation during puberty, whereas menopause is the expiration of ovarian function and the menstrual cycle. There are three phases of the menstrual cycle. The cycle starts with the proliferative phase; estrogen stimulates the endometrium to thicken. Once the proliferative phase ends ovulation begins when an egg is released from the ovarian follicle. This event normally occurs 14 days after the start of the previous menstrual cycle. Once the egg is released, the ovarian follicle secretes progesterone which starts the secretory phase. Throughout this phase estrogen and progesterone are secreted to maintain the endometrium. If fertilization occurs the endometrium is ready to accept the fertilized ovum. If fertilization is not successful, menstruation occurs and the endometrial lining is shed. During menstruation approximately 25-60 ml of blood are lost, with menstruation lasting from 4-6 days.
Gynecologic Emergencies: Assessment and Management

Gynecological emergencies can manifest as vaginal bleeding, abdominal pain, fever, vomiting, diaphoresis, and syncope. Patients may describe symptoms of dyspareunia (pain during intercourse) or other urinary symptoms. A complete gynecological history is paramount. This history should include an examination of the chief complaint, as well as associated symptoms. Information about the date and normalcy of the last menstrual cycle should be obtained. The patient should be asked if the possibility of pregnancy exists.

The emergency care provider may encounter specific gynecological emergencies that present with nontraumatic abdominal pain, such as the following: pelvic inflammatory disease (PID), ovarian disorders, bladder infections, and uterine disorders. Uterine disorders may present as endometritis, endometriosis, uterine prolapse, or vaginal bleeding. It is important to remember that gynecological conditions may mimic an acute appendicitis.

When conducting a physical assessment of a patient with a gynecologic emergency be aware of indications of conditions such as tachycardia, hypotension, fever, abdominal tenderness, or bleeding from the vagina. A maternal history should note if the patient is currently pregnant, the number of previous pregnancies carried to term, the number of miscarriages or abortions, a history of prior gynecological problems or surgeries, and a history of sexually transmitted diseases. The following formats should be used when obtaining a maternal history: gravida (pregnancies), para (number of births after 20 weeks of gestation, regardless of outcome), and abortus (spontaneous or induced). A documentation of G3P2A0 would indicate a woman who is pregnant and has two prior pregnancies with two living children and no abortions. Be aware that the case of twins still equals one birth.

The management of the gynecological patient before hospitalization can present unique challenges. It should include the following: assessment of the ABCs, a physical exam, and an awareness of the potential for hemorrhagic shock, particularly with the patients complaining of vaginal bleeding. The patient should be kept warm, given oxygen, be placed on cardiac monitoring and administered fluids as indicated. If transport to the hospital is necessary, the patient should be in a comfortable position. Many of these patients report relief when using the knee chest position. The watchful eyes of the paramedic who continues to monitor the patient's vital signs and identifies early warning signals are life-saving and reassuring.

EMS Provider Pearl

- Always assume that women of childbearing age with vaginal bleeding have a potentially life-threatening condition until proven otherwise.

Patients may not always give reliable information to the EMS responder. According to one study, women with abdominal pain or vaginal bleeding often stated that there was "no chance" of pregnancy. Yet the result was
11.5% had a positive pregnancy test. Remember to protect the patient's privacy and modesty at all times, always using proper medical and anatomical terms. A professional image is reassuring when discussing very personal matters with the patient.

**Anatomy and Physiology of Pregnancy**

In order to properly assess and treat the pregnant patient the dynamic changes in anatomy and physiology must be understood. Fertilization normally occurs in the distal third of the fallopian tube and the egg implants itself within the uterus. During the first eight weeks of pregnancy the egg is called an embryo and beyond that it is referred to as a fetus.

**Specialized Structures of Pregnancy**

The placenta is a disc like organ composed of interlocking material and fetal tissues. The placenta is considered an organ of exchange between mother and fetus. The placenta has **5 main functions:**

1. Transfer of the gases oxygen and carbon dioxide.
2. Transport of nutrients such as glucose, fatty acids, potassium, sodium, and chloride.
3. Excretion- waste products such as urea, uric acid, and creatinine diffuse from fetal blood into maternal blood.
4. Temporary secretion of the hormones estrogen and progesterone to maintain the uterine lining and prepare for delivery and lactation.
5. Formation of a partially selective barrier which protects against harmful substances (certain medications such as steroids and narcotics can cross the barrier).

- **The Umbilical cord** contains two arteries and one vein, blood flows from the fetus to the placenta through the two umbilical arteries, these arteries carry deoxygenated blood. Oxygenated blood returns to the fetus through the umbilical vein. Wharton’s Jelly is a substance in the umbilical cord which provides protection and cushions the arteries and vein avoiding cord compression due to fetal movement.
• **The amniotic sac** is a fluid filled cavity which completely surrounds and protects the fetus. The fluid within the sac develops from fetal urine and secretions from the respiratory tract, skin, and amniotic membranes. It functions to maintain body temperature and prevent cord compression. By the time of birth, the amniotic sac contains about one liter of fluid.

The term of gestation usually is 40 weeks long and fetal development is divided into trimesters.

![Diagram of Fetal Development by Trimester](image)

**Physiological changes of pregnancy Overview**

• **Blood**

During pregnancy the change in blood volume and composition is dramatic. The blood volume increases by approximately 1500 ml, or 40% to 50% above non-pregnancy levels. This increase acts as a protective mechanism which hydrates the fetal and maternal tissues and provides a fluid reserve to compensate for blood that will be lost during delivery. The production of red blood cells is accelerated during pregnancy and cardiac output is also stimulated due to increased stroke volume and heart rate. This is a normal response to satisfy increased tissue demands for oxygen. During the first trimester the mother's heart rate increases by 10-15 beats/minute. In the second trimester the blood pressure decreases 10-15 mm hg before gradually increasing again.

• **Pulmonary**

The respiratory system too undergoes adaptations to meet the demands of pregnancy. The diaphragm is displaced as much as 4 cms and residual capacity decreases by 25%, which may cause respirations to increase. Elevated estrogen levels increase the vascularity of the upper respiratory tract.

• **Gastrointestinal**

The woman's gastrointestinal system also experiences changes. Increased levels of progesterone, decreasing muscle tone, and peristalsis cause the stomach to empty its contents more slowly. Heartburn and constipation are common during pregnancy.
• **Genitourinary**

There are also changes in the genitourinary system during pregnancy as the pressure of the expanding uterus causes the need for frequent urination.

Assessment of the obstetrical patient always includes an initial measurement of the ABCs, followed by present and past medical histories, and a physical exam noting general appearance of the skin color, temperature, and moisture. Examine the abdomen and note the height of the fundus to abdominal structures such as the umbilicus and xiphoid process, which can indicate an approximate gestational age. Check the hands and feet to identify edema and monitor vital signs looking for indications of dehydration or shock. The increased respiratory rate is due to stimulation of the respiratory centers of the brain by the hormone progesterone. During the assessment it is important to understand some of the normal readings which appear on the EKG. In addition to an accelerated heartbeat of 10-15 beats/minute, it may display flat or negative T waves in lead 3. This is caused by the elevation of the diaphragm displacing the heart to the left and slightly upward. As the uterus grows it becomes heavy while the patient is supine. It compresses the inferior vena cava in the abdomen and reduces the return of blood to the heart resulting in hypotension. This is called supine hypotensive syndrome and transport of the patient in the left lateral recumbent position is recommended. The obstetrical patient presents many challenges for the prehospital provider.

**Complications of Pregnancy**

- Ectopic pregnancy is one that occurs outside the uterus, usually in the fallopian tube.
- Hyperemesis Gravidarum is a severe form of morning sickness that can persist throughout pregnancy.
- Abortion (miscarriage) is defined as the ending of a pregnancy for any reason before 20 weeks gestation.
- Placental Abruption occurs when part of the placenta separates from the inner wall of the uterus.
- Placental Previa is the abnormal placement of the placenta which causes it to cover the cervical opening.
Other Complications: Preeclampsia and Eclampsia

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<tbody>
<tr>
<td>Twin or multiple gestation</td>
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<tr>
<td>Hypertension</td>
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<td>Excessive amniotic fluid</td>
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<td>Diabetes</td>
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<td>Renal Disease</td>
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<td>Obesity</td>
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<td>Maternal age &gt;35</td>
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<td>History of preeclampsia</td>
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The other usual suspects that may challenge the EMT/Paramedic are preeclampsia and eclampsia. These are defined as the occurrence of hypertension during pregnancy in the absence of other causes of elevated blood pressure. The etiology of these complications is not understood completely, however metabolic disturbances or disruptions in hormonal activity by the developing placenta may be involved. Some evidence links these complications to abnormal blood vessel constriction, which can lead to other problems. Preeclampsia can manifest as hypertension, edema, proteinuria, blood clotting, and vasospasms. Severe preeclampsia is classified by a systolic blood pressure reading of 160 mm hg or higher and a diastolic blood pressure reading of 110 mm hg or higher. It may be accompanied by severe headaches, visual disturbances, and pulmonary edema. During physical examination the emergency caregiver may encounter other changes such as glistening retina, hepatomegaly, severe swelling of the face, hands, and feet, epigastric discomfort, nausea, and vomiting. The presence of seizures indicates a diagnosis of eclampsia.

Diabetes may also complicate pregnancy causing a plethora of maternal effects. Infections (e.g., urinary tract infection), preterm labor and premature rupture of membranes may occur. Hydramnios/ polyhydramnios (excessive amniotic fluid), macrosomia (big baby syndrome), delayed lung maturity, and congenital abnormalities can also develop. If the patient cannot increase insulin production periods of hyperglycemia will occur. At times the patient will experience hypoglycemia between meals and during the night because the fetus is constantly drawing glucose from the mother. In the second and third trimesters of the pregnancy, the fetus faces the risk of organ damage from hyperglycemia because of the increased resistance of fetal tissue to maternal insulin.

Management of Patients with Complications

Always approach the management of a patient with complications by performing initial assessment and the critical care ABCs. Provide high concentration oxygen and monitor vital signs closely. On the ALS end, begin cardiac monitoring, obtain IV access and transport. Magnesium sulfate is the treatment of choice for seizures.
caused by eclampsia but remember that this is a medical control option and watch out for respiratory depression during its administration. The antidote for magnesium toxicity is calcium gluconate.

Labor refers to the process of moving the fetus, placenta, and membranes out of the uterus and through the birth canal. There are 3 stages.

![Image of a newborn]

### Stages of Labor

**Stage 1** The dilation stage is the onset of regular uterine contractions to complete cervical dilation.

**Stage 2** The expulsion stage is from full dilation of the cervix to the delivery of the newborn.

**Stage 3** The placental stage is the period between delivery of the baby and expulsion of the placenta (usually 5-20 minutes after delivery of the newborn).

The decision to transport the patient to the hospital or to assist the patient on site should be based on the clinical presentation of the patient. If time permits, it is best to begin transport. However, the prehospital care provider must be ready to assist in the birthing process when imminent birth is probable. Signs and symptoms that indicate delivery at the scene are regular contractions of 45-60 seconds in duration at 1-2 minute intervals. An interval is measured from the beginning of one contraction to the start of the next. Telltale signs that the patient is about to deliver include the following:

- The patient expresses an urge to bear down.
- The patient reports that she feels the need to have a bowel movement.
- There is a copious amount of bloody show.
- The patient states she is about to deliver.
- Crowning occurs.
The emergency care provider should only provide assistance in the natural event of childbirth. The goal is to prevent an uncontrolled delivery and to transition the infant into its new environment and protect it from the elements. Both the mother and infant should be monitored after the stress of delivery.

**Preparation for Delivery**

Always seek to provide a private area for the patient to deliver. Prepare the mother and yourself and the surrounding area. Always use standard precautions, using gloves, a mask, and a gown and eye protection. Prepare your commercially available obstetrical kit. When the baby’s head begins to crown the following steps should be followed to assist in the delivery:

- To allow for gradual, controlled delivery apply gentle pressure to the infant's head during crowning.
- Notice if the umbilical cord is around the neck and if present use your index finger to slip it over the head; if unable to slip over the head then carefully clamp and cut the cord.

- If the amniotic sac has not already broken, use a clamp or gloved finger to puncture it and push it away from the infant's head and mouth as they emerge.
- After delivery of the infant's head, support it and use a bulb syringe to suction the mouth and then the nose to clear the airway.
- Continue to support the infant's head as it aligns with the shoulders.
- Guide the infant's head gently downward to deliver the anterior shoulder.
- In order to deliver the posterior shoulder and the rest of the body, gently guide the infant's head upward.
- Carefully grasp and support the infant as it emerges. The newborn is very slippery so it is important to always use caution.

Dry and wrap the infant in clean towels and blankets, then wrap in a silver swaddler, leaving the newborns face exposed. Be sure to note gender and the time of delivery. After the birth place the first clamp 8-10 inches
away from the newborn then place the second clamp approximately 4 finger widths from the new born. Cut the cord in between the clamps with sterile scissors. Assess the cut ends of the cord to ensure the bleeding has stopped. The cord is delicate and should be handled with care because it can tear easily. The placenta normally delivers within 20 minutes of the infant. Do not delay transport waiting for its arrival.

**Evaluation of the Newborn**

In 1953, anesthesiologist Virginia Apgar published a scoring system of neonatal assessment which is still in use throughout the world today. After the newborn has been dried and warmed, position and clear the airway and provide tactile stimulation. If resuscitation is unnecessary, use the Apgar score. It should be performed at 1 and 5 minutes to evaluate the infant and it is calculated from 0-2 in each category. The results are then totaled for a score.

![Apgar Score](image)

- 10 is the highest rating the infant can receive.
- 7-9 indicates slight depression (close to normal)
- 4-6 represents moderate depression
- 0-3 indicative of severe depression

This is the fourth stage of the labor and it is paramount to remember that there are two patients in need of care. Reassess the mother, monitoring her vital signs, and keep a vigilant watch for the development of symptoms of shock. Postpartum hemorrhage, which affects 5% of deliveries, occurs when more than 500 ml of blood is lost after a vaginal delivery. It may happen in the first few hours or it may be delayed up to 24 hours. The cause of hemorrhage is usually ineffective or incomplete contraction of the intertwined uterine muscle fibers. Women who are most at risk are those who have multiple births or experience long, stressful labors.

**Management**

Monitor the ABCs and vital signs, and provide oxygen and warmth to the patient. Use direct pressure to control external hemorrhage. Palpate the uterus for loss of tone and, if identified, massage the fundus until the uterus feels firm. The patient should be continuously monitored. ALS providers should gain IV access and administer fluid resuscitation as indicated by the patient's clinical picture and hemodynamic status. The location
of the fundus in comparison to the umbilicus, the degree of firmness, and the approximate loss of blood should be documented.

During delivery a multitude of complications may arise. The preceding situations require a unique approach to management and the emergency care provider should refer to REMAC protocols.

**Conclusion**

Childbirth in the twenty-first century Western world has become safer and less painful as science continues to make progress and pass its findings on to medicine. Emergency care providers, in some situations, may become an integral part of the process, and must be prepared for any emergency. The double responsibility of two patients, for whom treatment priorities are equal, has many challenges, and adequate training is very important to a successful outcome.

*Written by:* Jessica DeResto, RN, EMT-P
FDNY EMS BOT Certified Instructor Coordinator

Written by: Jessica DeResto, RN, EMT-P
FDNY EMS BOT Certified Instructor Coordinator

**References**

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The Regional Emergency Medical Services Council of New York City Inc. New York , New York ; 2012

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CME JOURNAL 2013  J06: PREGNANCY & CHILDBIRTH

(All providers must answer all 10 questions)

1. You are assisting with a vaginal delivery. The infant’s head has been delivered and the mouth and nose suctioned. To deliver the anterior shoulder, you should gently ___________.
   
   A. guide the infant’s head downward
   B. guide the infant’s head upward
   C. lift the infant’s head to a transverse position
   D. pull on the infant’s head
2. A 23 year old female who is in active labor complains that she needs to use the bathroom. The vaginal area is bulging outward and the top of the infant’s head is visible. In what stage of labor is the patient?
   A. crowning
   B. first
   C. second
   D. third

3. A 25 year old female in the seventh month of her first pregnancy complains of a severe headache, spots before her eyes, and upper abdominal pain. Edema of the face, feet and hands is present. Vital signs are BP 170/120 mm HG, Pulse 112 beats/min bounding; Respirations 22 breaths/min shallow, regular. The patient is at risk for what condition?
   A. cerebral accident
   B. myocardial infarction
   C. seizure
   D. spontaneous pneumothorax

4. The second stage of labor_______.
   A. begins with full cervical dilation and ends with the infant’s delivery
   B. begins with the expulsion of a mucous plug
   C. begins with the onset of the first contraction and ends with the delivery of the placenta
   D. usually lasts 8 to 12 hours in the primigravida patient

5. Infants of diabetic mothers tend to be:
   A. small
   B. hypoglycemic
   C. large
   D. polydactyl

6. In ectopic pregnancies, the fertilized ovum is implanted:
   A. outside the uterus
   B. on the corpus luteum
   C. on the outer edge of an ovary
   D. in the fallopian tubes
7. Blood pressure above 160/110 in the third trimester may indicate:
   A. the onset of labor
   B. abruptio placenta
   C. placenta previa
   D. preeclampsia

8. Your patient is a 23 year old gravida 3, para 2 (G3P2) in the last trimester states when she lies down on her back, she becomes dizzy and “blacks out”. If she sits up or rolls onto her side, the symptoms subside. What is this condition called?
   A. vertigo
   B. hysteria
   C. supine hypotensive syndrome
   D. mittelschmerz

9. What drug will antagonize the toxic effects of magnesium sulfate?
   A. atropine
   B. dopamine
   C. calcium Gluconate
   D. proparacaine

10. What drug should be administered for a patient with severe pre-eclampsia or eclampsia?
    A. dopamine
    B. epinephrine
    C. amiodarone
    D. magnesium sulfate
Journal CME Credit Answer Sheet

Based on the CME article, place your answers to the quiz on this answer sheet. Respondents with a minimum grade of 80% will receive 1 hour of Online/Journal CME.

Please submit this page only once, by one of the following methods:
• FAX to 718-999-0119 or
• MAIL to FDNY OMA, 9 MetroTech Center 4th flr, Brooklyn, NY 11201

Contact the Journal CME Coordinator at 718-999-2790:
• three months before REMAC expiration for a report of your CME hours.
• for all other inquiries.

Monthly receipts are not issued. You are strongly advised to keep a copy for your records.

Note: if your information is illegible, incorrect or omitted you will not receive CME credit.

check one: □ EMT □ Paramedic □ other

Name

NY State / REMAC # or “n/a” (not applicable)

Work Location

Phone number

Email address

Submit answer sheet by the last day of this month

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<tr>
<th>June 2013</th>
<th>CME Quiz</th>
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June 2013 – Journal CME Newsletter
### Citywide CME - June 2013

*Sessions are subject to change without notice. Please confirm through the listed contact.*

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<td>TBA: call to inquire →</td>
<td>ED Conference Room</td>
<td>Dr Hew</td>
<td>Manny Delgado 718-363-6644</td>
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<td>Dr Brandler</td>
<td>Aaron Scharf 718-780-1859</td>
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<td>4th Wed</td>
<td>1730-1930</td>
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<td>Dr Chitnis</td>
<td>Dale Garcia 718-630-7230</td>
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<td><a href="mailto:dgarcia@lmcmc.com">dgarcia@lmcmc.com</a></td>
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<td>Ana Doulis 212-746-0885 x2</td>
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<td>Schwartz Lecture Hall 401 E 30 Street</td>
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<td>Jessica Kovac 212-263-3293</td>
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<td>Mt Sinai Qns</td>
<td>last Tues</td>
<td>1800-2100</td>
<td>Lecture or Call Review</td>
<td>25-10 30 Ave, conf room</td>
<td>Dr Dean</td>
<td>Donna Smith-Jordan 718-267-4390</td>
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<td>Thursdays</td>
<td>0800-0900</td>
<td>Call Review/Trauma Rounds</td>
<td>East bldg, courtyard flr</td>
<td>Dr Sample</td>
<td>Mary Ellen Zimmermann RN 718-670-2929</td>
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<td>William Amaniera 718-818-1364</td>
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<td>Regina McGinn Center 475 Seaview Ave</td>
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<td>346 Seguine Ave</td>
<td>Dr Barbara</td>
<td><a href="mailto:pbarbara.md@gmail.com">pbarbara.md@gmail.com</a></td>
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The REMAC Refresher Written examination is offered for paramedics who meet CME requirements and whose REMAC certifications are either current or expired less than 30 days. To enroll, go to the REGISTER link under “News & Announcements” at nycremsco.org before the registration deadline above. Candidates may attend an exam no more than 6 months prior to expiration.

The REMAC Basic Written & Scenario examination is for initial certification, or for inadequate CME, or for certifications expired more than 30 days. Seating is limited and registrations must be postmarked by the deadline above. A $100 exam fee by money order is required. Email swansoc@fdny.nyc.gov for instructions.