Complicated birth – the time-honored midwifery way

A Sensitive Midwifery Workshop

THE SYMPOSIUM FOR ALL MIDWIVES AND ASSOCIATED PROFESSIONALS

Slow progress of labour, fetal distress & occipito-posterior position

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Slow progress of labour

Rule of thumb

As long as the labouring woman and baby are healthy and labour length doesn't meet criteria of 'labour arrest', labouring women should be treated as if they are progressing normally.

Keeping the mom feeling relaxed is the golden rule!

WHO recommendations, now in RSA

- Duration of latent phase: 24 hours instead of 8 hours (most with ‘prolonged latent phase’ will enter active phase if … ?)
- Start of active phase of labour - 5cm dilation
- Current partogram: 1cm/hour alert line, 2-hour refer line but bear in mind:
  - Research - prolonged labour as per partogram – minimal contribution to perinatal deaths from intrapartum asphyxia
  - Cervical dilatation alone is a poor predictor of adverse neonatal outcomes
  - From 4–6cm, nulliparous and multiparous women dilate at essentially the same rate
  - Beyond 6cm, multiparous women dilate more rapidly

Cesarean delivery for active-phase arrest - ACOG

Should be reserved for women with:

- Greater than 6cm dilatation
- Ruptured membranes
- Failure to progress despite four hours of adequate uterine activity, *OR*
- At least six hours of oxytocin administration with inadequate uterine activity and no cervical change

The Ps at play in labour

- Power – contractions/surges/waves:
  - When surges slow, look at hydration, food, energy levels, etc.
  - When fetal heart normal, allow to rest and wait for contractions to ↑
- Passage - birthing channel:
  - Ensure optimal outlet with different upright positions

The Ps at play in labour

- Passenger – baby:
  - Fetal skull anatomical changes
  - Wellbeing of unborn baby
- Position - lie of baby:
  - Midwife tricks for positional challenges
- Don’t forget the other P’s: Psyche, Preparation…!

Fetal distress

Consensus document by ACOG & Society for Maternal-Fetal Medicine:

- Most intrapartum non-reassuring fetal heart rate tracings (aka abnormal or indeterminate FHR) only require evaluation, surveillance, appropriate corrective measures, re-evaluation, not immediate C/S

- C/S should be reserved for FHR decelerations >2 mins, <10 mins - can occur after rapid cervical change, regional analgesia hypotension, abruptio placentae, umbilical cord prolapse, uterine rupture

Fetal distress

- Uterine tachysystole (>5 contractions in 10 mins over 30 mins) also linked to prolonged or late decelerations
- Can occur spontaneously
- Uterotonics like oxytocin/prostaglandins – Medical Rx: reduction or cessation of uterotonics or administer a uterine relaxant

Midwives must also know

- Agreement between experienced caregivers about FHR patterns mean, can be as low as 42%
- Biased towards Baby having a problem, when one does not really exist
- Continuous EFM may lead to ↑ false positives for fetal hypoxaemia… unnecessary C-sections!
- No evidence of benefit for admission CTG in low-risk women in labour - increases C-section rate by ±20%

Recommendation

- Admission CTG not be used for low-risk women…!
- Women should be informed of increase in C-section without evidence of benefit

Fetal heart rate know-how

- BASELINE FHR: 110-160bpm
- VARIABILITY: Peak to trough fluctuations in FHR baseline 2 cycles per min or greater
- ACCELERATIONS: Abrupt increase in FHR above baseline
- DECELERATIONS:
  - Early decelerations associated with a contraction
  - Late decelerations found after contraction

Best CTG technique

- Semi-sitting position with lateral tilt
- Auscultate the baby's heart rate
- Locate the baby's heart rate and secure the transducer
- Apply the contraction belt over the upper segment of the uterus
- Run the paper at 1cm/minute
- Label the tracing with name, number, date, time

Best CTG technique

- If no acceleration after 10-20 minutes administers acoustic stimulation with an electric toothbrush or use an empty soft drink can
- Stop the test as soon as one acceleration is noted, provided there are no abnormal features
- Baby sleeping pattern – wait and repeat

Fetal physiological adaptation to labour

- There is reduced fetal movement
- The baby will display reduced breathing movements
- Cord compression causes a vagal bradycardia which protects the fetus from hypertension (variable decelerations)
- There is some hypoxia during contractions due to vasoconstriction in non-essential organs; this is called vagal bradycardia (late decelerations)
- Late decelerations can be detected by auscultation

Preventing & managing fetal distress – the midwife way

- Pay heed to the ‘stress’ in fetal distress …
- In latent and active stage, supported, skilled, midwifery-led labour almost always results in a good second stage
- Kindness, encouragement, mobilisation, reassurance, and respect are the ‘treatments’ that labouring women often need most, and can help to minimise stress that could lead to distress.

Preventing & managing fetal distress – the midwife way

- Create as peaceful an atmosphere as possible
- Home-like birth environments, in which low risk women are looked after mainly by professional midwives, have shown benefits such as:
  - Increased maternal satisfaction
  - Decreased augmentation, use of analgesia, rate of operative deliveries and FHR abnormalities

In-utero resuscitation techniques – the midwife way

- Reassure the mother and communicate to her that working with a more natural approach will often resolve worrying heart rates in her unborn baby
- Move the mother into the lateral or upright position, or mobilise her
- Ensure that the mother is hydrated, preferably orally

In-utero resuscitation techniques – the midwife way

- Stop oxytocin administration if possible, as this often contributes to fetal and maternal distress
- Let the unit manager or doctor know of all the interventions you've taken
- Record them, and keep colleagues informed of the mother's progress subsequent to these

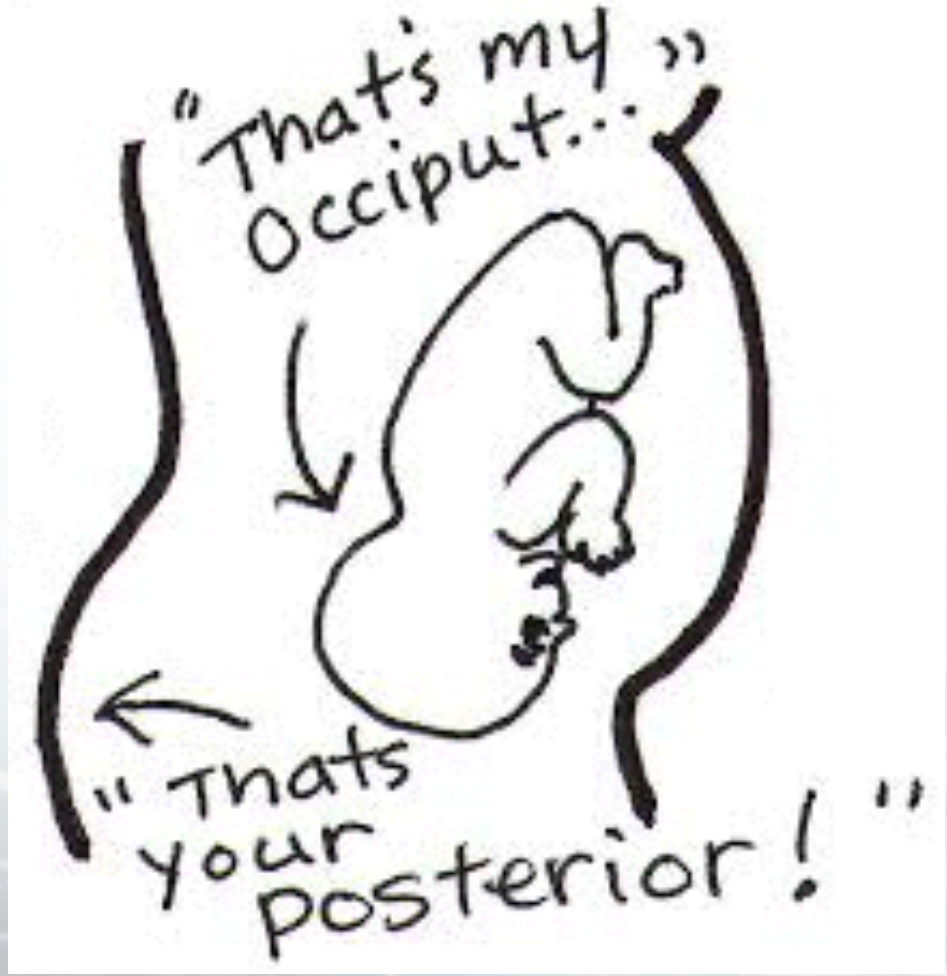
Medical intervention and management

This may include:

- Beta-stimulants might be ordered if contractions strong
- Avoid dextrose/Sodium bicarbonate
- Possibly amnioinfusion for decelerations/meconium

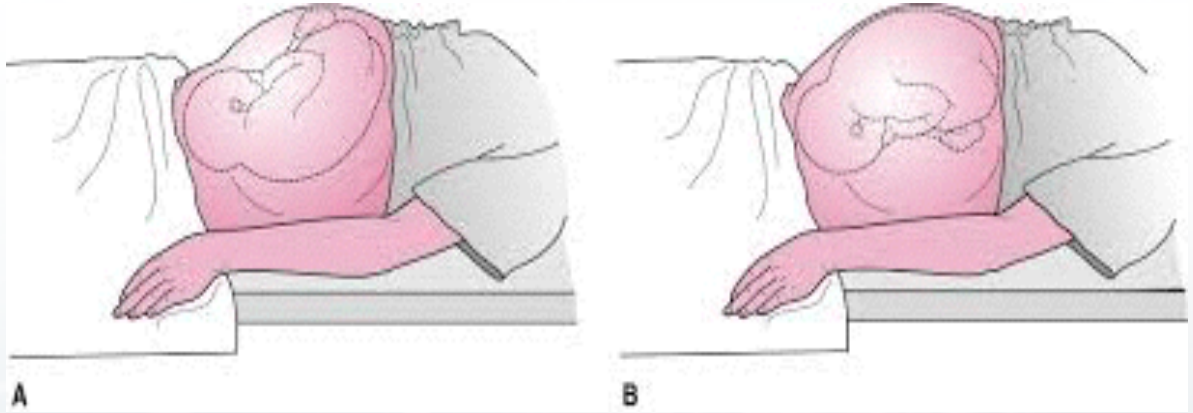
Occipito-posterior position (OP)

- OP positions (back to back) ± 15-20% at start of labour
- Only 5% OP at birth as most babies rotate to OA



Characteristics

- Buttocks high against ribs
- Sub umbilical flattening
- Movement on both sides of abdomen
- Head often high with late engagement
- Difficult to palpate baby's back



Characteristics

- FH heard best on midline
- Backache worse with contractions
- Urge to push quite early in labour as occiput presses against the rectum
- Longer, more uncomfortable labour, especially transition phase

Midwifery help for OP position

- Offer mother and birth partner extra emotional support and encouragement
- Encourage mother to eat and drink in labour, to prevent exhaustion and dehydration
- Get her to mobilise in labour and squat a few times between contractions - helps turn fetal head into anterior position

Midwifery help for OP position

- To relieve backache and reduce the premature urge to push - on all fours on knees and elbows
- Encourage birthing in upright position - less uncomfortable
- Open knee chest position (spinningbabies.com)

Open knee chest position

- Start with knee chest position. Mother's chest is on the floor. Her face is on the floor (or a cloth covering the floor).
- Now move the chest and shoulders forward. Way forward. The knees stay put. Slip a pillow under the chest (not the face). See how the thighs and spine make a letter "A"?
- The helper in the back holds a long cloth, like reigns, wrapped across the mother's upper thighs. This cloth is not on her abdomen at all. The helper leans back to take the weight of the mother's lower body off her chest during the Open-knee Chest.
- A helper at the front sits so that the mother can put her shoulders up on their ankles. This is very comforting during this position.

Open knee chest position

- The Open-Knee-Chest means mothers knees are away from her pubic bone.
- Her knees are only as far open as her belly needs them to be, not more. About hip-width apart is ideal.
- A pillow under the chest helps the head come down to rest on her cheek. This is nice for the neck.
- It is intense. Make sure you are doing this because you are backing a stuck baby back out and not for just any labor.
- It is good to do a complete sidelying release first (see instructions, this is NOT laying on your side!!!).

“Women-centred care has the potential to drastically transform maternity units and therefore maternal health outcomes, in South Africa!”

How incredible is Mother Nature!

SENSITIVE MIDWIFERY

Inspiring midwives, influencing midwifery!