Abnormal labour

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

ESMOE

2030
NDP

MENTAL HEALTH AND RESPECTFUL CARE MATTERS

• Encourage one companion during labour (doula, staff, partner, family or friend or the woman's choice)

- Support
- choice
- information
- permission
- Calm staff
- debriefing

Prolonged latent phase of labour

- 24 hours from the time of **confirmed** labour
- Management of apparent prolonged latent phase
  - Exclude other causes of abdominal pain
  - Consider false labour (no cervical changes, no increase in pains) – discharge home if well
- If **certain** of prolonged latent phase:
  - exclude fetal distress and CPD
  - ‘stretch and sweep’ the cervix, rupture the membranes and/or start an oxytocin infusion

Poor progress in the active phase of labour

- Start active phase partogram only when sure (Cx 5cm dilated, fully effaced, strong regular contractions). We will in time move to the WHO Labour Care guide which allows specific evidence-based time for each cm of progress.
- Remember COPE: Companions, Oral fluids, pain relief and Eliminate supine position
- For poor progress: consider Patient, Powers, Passage, Passenger
- Ensure adequate hydration:
  - Sodium Chloride 0,9% 200-300 mL IV, then 120 mL/hour, plus oral fluids
- bladder empty
- Exclude malpresentation
- Exclude fetal distress
- Support and reassure the woman
- ○ Encourage mobilisation
- ○ Offer analgesia
- ○ Rupture the membranes if still intact
- ○ Continue labour observations and reassess progress in two hours
- ○ If progress crosses the two hour action line: transfer from CHC to hospital

Poor progress in the active phase of labour

- Evidence of CPD in a multipara, arrange CD or transfer from CHC to hospital.
- If no CPD in a primigravida and no evidence of fetal distress, start oxytocin infusion
- Continue with two hourly assessments: if progress in cervical dilatation is still less than one cm/hour, consider caesarean delivery or discuss with an experienced doctor for a second opinion on the need for CS

- Thick meconium in the amniotic – monitor with a CTG

PROLONGED SECOND STAGE OF LABOUR

- More frequent monitoring in second stage: Fetal heart, maternal condition, descent. **Avoid the supine position**
- • If not bearing down after one hour of full dilatation:
  - re-examine to make sure the cervix is truly fully dilated
  - rupture the membranes if they are intact
- if still no urge to bear down, refer to hospital
- Failure of the head to descend despite maternal pushing
- At a CHC: If baby not born after 45 minutes of pushing in a nullipara, or after 30 minutes in a multipara: Use fifths palpable above the brim to assess descent of the head
- Perform ventouse delivery if the head is 0/5 palpable above the brim or transfer to hospital
- Can attempt to do ventouse in hospital with 1/5 palpable head

- • At hospital: allow for 2 hours of pushing for primigravida and 1 hour for multigravida if fetal and maternal condition stable

VACUUM EXTRACTION

- • May be performed at CHCs by (skilled) advanced midwives
- • Disposable vacuum cups are preferred because they are easy to use and reliable.
- Conditions for safe vacuum extraction …..

- Technique …..

- See https://www.youtube.com/watch?v=GthnX-jYT5s for a video demonstration on ventouse delivery

FORCEPS DELIVERY

- Should only be performed in hospitals,
- by experienced operators,
- where all conditions for forceps delivery are met.

Thank you