

# DELAY IN LABOUR

## INTRODUCTION

This document gives guidance to all midwives and obstetric staff on how to identify and manage suspected delay in progress of first and second stages of labour in a low risk woman<sup>1</sup>.

Labour is monitored by observing progressive effacement and dilatation of the cervix, and descent of the presenting part against time in conjunction with the frequency and duration of uterine contractions.

## DEFINITIONS

### ACTIVE LABOUR

- A period of time characterized by regular painful uterine contractions, a substantial degree of cervical effacement and more rapid cervical dilatation from 5 cm until full dilatation for first and subsequent labours<sup>2</sup>.

### DELAY IN FIRST STAGE

- cervical dilatation of less than 2 cm in four hours for first labours<sup>1</sup>
- cervical dilatation of less than 2 cm in four hours or a slowing in the progress of labour for second or subsequent labours<sup>1</sup>

### NOTE

Slow progress in the active phase of labour is described as 'primary dysfunctional labour' whereas 'cessation of cervical dilatation following a normal portion of active phase dilatation' is termed 'secondary arrest of labour'.

### DELAY IN SECOND STAGE

- Birth would be expected to take place within three hours of the start of the active second stage in most nulliparous women, or within two hours for multiparous women<sup>1</sup>.
- If epidural analgesia is present and there is no urge to push then an hour of passive descent is included in the total time<sup>1</sup>.

### NOTE

Delay should be suspected if progress (in terms of rotation and descent of presenting part) is not evident after one hour of active 2<sup>nd</sup> stage in a nulliparous woman, or 30 mins in a multiparous woman.

## BACKGROUND

Delay in progress of labour is common, and it is now one of the leading indications for caesarean section worldwide. Historic criteria for normal progress in labour (as outlined by Friedman in 1950s) are increasingly being challenged in contemporary practice<sup>3</sup>. Some evidence suggests that up to one third of first labours experience a delay in progress in the first stage of labour.

A recent local audit<sup>4</sup> showed that 45% of non-elective caesarean sections had failure to progress listed as an indication for operative delivery, this represented 13.4% of all deliveries in that period. In the same audit instrumental delivery for failure to progress in the second stage accounted for 44% of all instrumental deliveries, which represented 12.3% all deliveries in that period.

Slow progress in labour may arise due to:

- Inefficient uterine contractions
- Fetal malpresentation or malposition
- Inadequate bony pelvis
- Pelvic soft tissue abnormalities

Where a delay in labour has been recognized interventions such as amniotomy and/or oxytocin infusion are offered with the aim to progress labour to prevent complications and to avert caesarean section<sup>1</sup>.

As long as there is evident progress of labour in terms of cervical dilatation, with descent and/or rotation of the presenting part and reassuring fetal status, there is no maximum length of time for either first or second stage of labour. RANZCOG guidelines state that instrumental delivery is not indicated for delay in second stage alone<sup>5</sup>.

There is evidence that correlates increasing length of second stage with increased maternal and fetal morbidity, however it concludes that the second stage of labor does not need to be terminated for duration alone<sup>6</sup>.

## MANAGEMENT OF SUSPECTED DELAY IN FIRST STAGE OF LABOUR

If delay in first stage of labour is suspected complete full assessment to include:

- Dilatation and rate of change < 2 cms in 4 hours, or slowing of rate in a multigravida
- Contractions – strength, duration and frequency
- Station, descent
- Presentation
- Position
- Rotation
- Fetal wellbeing

### Consider

- Parity
- Emotional status
- Hydration – oral and/or intravenous
- Bladder cares

## Offer

- Support – give consideration to birth plan
- Appropriate and effective pain relief – non-pharmacological, for example, hydrotherapy; IM opioids (IV/PCA, but not likely in low risk); epidural – medical consultation<sup>7</sup>

## Do

- Complete Partogram (Ref.2668) as a visual representation of progress
- Artificial Rupture of Membranes (ARM) (consider descent of presenting part and contraindications)

Repeat a full assessment of labour progress in 2 hours.

## MANAGEMENT OF CONFIRMED DELAY IN FIRST STAGE OF LABOUR

Refer for medical consultation as per the MOH, Guidelines for consultation with obstetric and related medical services (2012)<sup>7</sup>. By phone if in a primary unit/home.

- Consider oxytocin (for continuous Electronic Fetal Monitoring (EFM) if oxytocin and/or epidural)
- Make a full assessment of labour progress in 4 hours
  - If dilatation > 2 cms in 4 hours, continue and reassess in 4 hours
  - If dilatation < 2 cms in 4 hours, request a further medical consultation
- Consider caesarean section

## NOTE

\*Multiparous women – **must** have a full assessment including abdominal palpation and vaginal examination by the on call medical staff member prior to a management plan being made with the woman and LMC/Midwife.

## MANAGEMENT OF SECOND STAGE OF LABOUR

A full assessment of labour progress must be made at the start of second stage of labour.

Allow a minimum of one hour for passive descent.

Primiparous women – medical consultation and consideration should be given to the use of oxytocin if contractions are inadequate at the beginning of second stage (for continuous EFM if oxytocin and/or epidural).

Ongoing assessment of:

- Position
- Hydration
- Pain relief needs
- Contractions
- Fetal wellbeing
- Advancement of presenting part



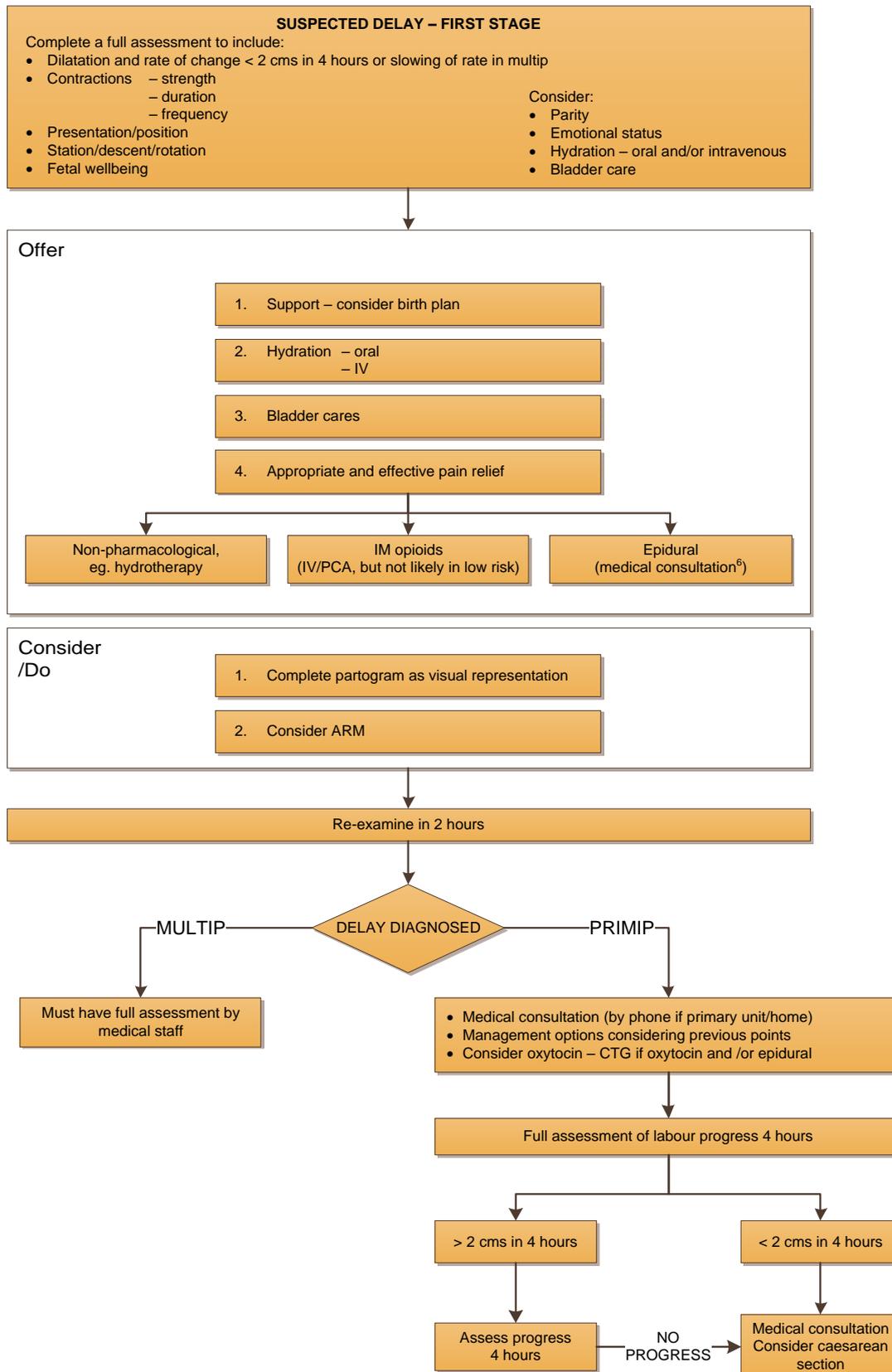
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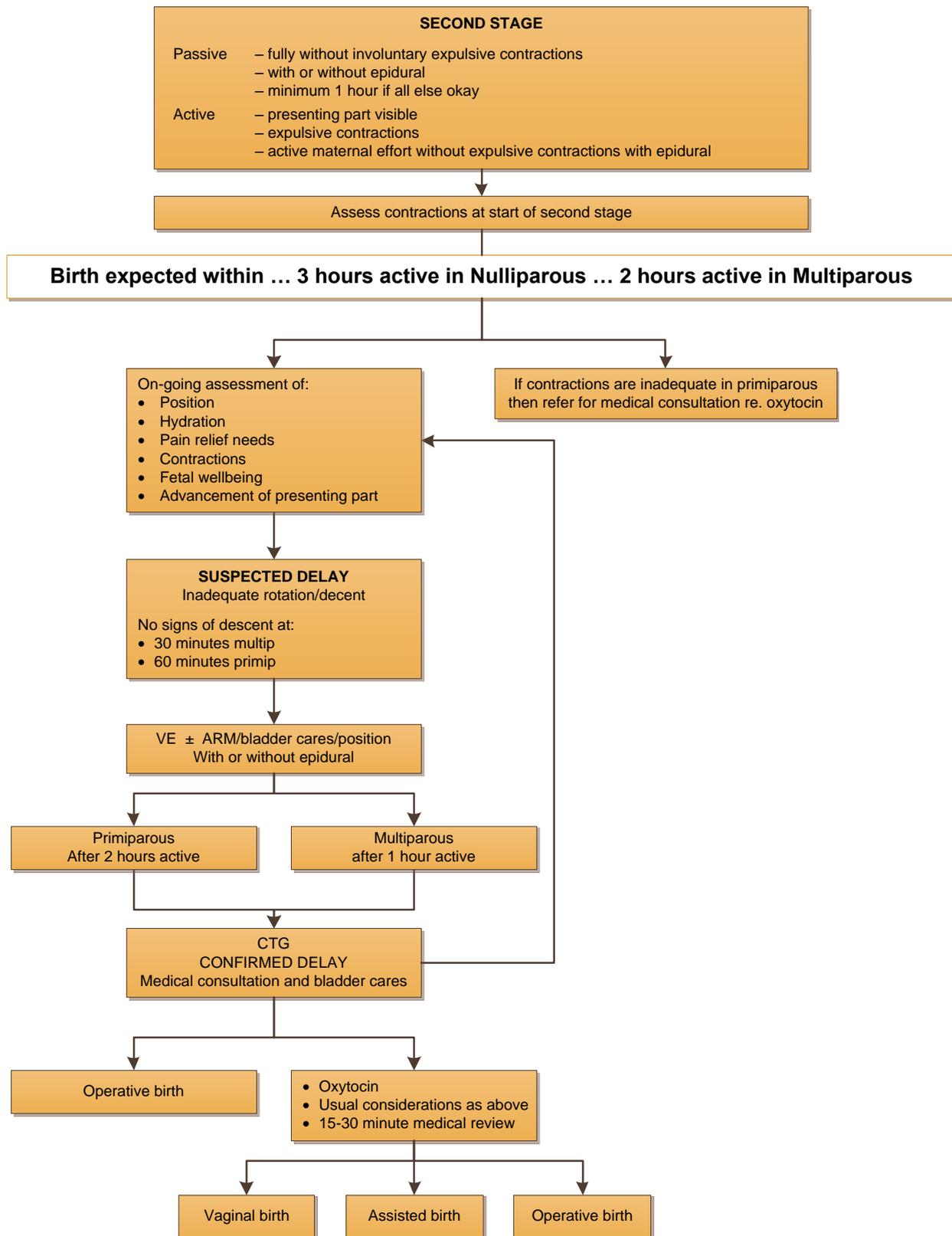
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**APPENDIX 1 MANAGEMENT OF LABOUR FOR SUSPECTED AND CONFIRMED DELAY IN LABOUR**





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