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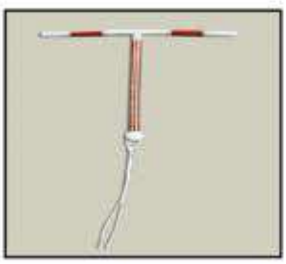



A must for undergraduate students

Exam Preparatory Manual for Undergraduates

Obstetrics & Gynecology

As per the Competency Based Medical Education Curriculum (NMC)

Punit S Bhojani

3rd Edition

Forewords
Geeta M Niyogi
Vinita S Salvi
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CHAPTER 13

Labor

Q. What are the stages of labor? Differences between true and false labor.

DEFINITION

Series of events that take place in genital organs in an effort to expel the viable products of conception out of womb through vagina into outer world is called as labor.

STAGES OF LABOR

Labor has four stages:

First Stage of Labor

- Begins with **regular uterine contractions and ends with complete cervical dilatation at 10 cm**
- Traditionally, divided into a **latent phase** (till cervix is 3–4 cm dilated) and an **active phase** (4–10 cm)
- **As per WHO 2020 Labor Care Guide, active phase is cervical dilatation of 5 cm or more**
- The latent phase begins with mild, irregular uterine contractions that soften and shorten the cervix
- Contractions become progressively more rhythmic and stronger
- The active phase usually begins at about 4 cm of cervical dilation and is characterized by rapid cervical dilation and descent of the presenting fetal part
- Its average duration is 12 hours in primigravida and 6 hours in multiparous woman.

Second Stage of Labor

- Begins with complete cervical dilatation and ends with the **delivery of the fetus**
- In nulliparous women, the second stage should be considered prolonged if it exceeds 3 hours if regional anesthesia is administered or 2 hours in the absence of regional anesthesia
- In multiparous women, the second stage should be considered prolonged if it exceeds 2 hours with regional anesthesia or 1 hour without it.

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Third Stage of Labor

- The period between the delivery of the fetus and the **delivery of the placenta** and fetal membranes.
- Delivery of the placenta often takes less than 10 minutes, but the third stage may last as long as 30 minutes.
- The duration is reduced to 5 minutes with active management of third stage of labor (AMTSL).

Fourth Stage of Labor

At least 1 hour observation after the expulsion of placenta and membranes. General condition of the mother and behavior of uterus are carefully to be monitored.

Differences between True and False Labor

True labor	*False labor*
Contractions occur at regular intervals	Contractions occur at irregular intervals
Intervals gradually shorten	Intervals remain long
Intensity gradually increases	Intensity remains unchanged
Discomfort is in the back and abdomen	Discomfort is chiefly in the lower abdomen
Progressive effacement and dilatation of cervix	**Cervix does not dilate**
Discomfort is not stopped by sedation	Discomfort usually is relieved by sedation
Associated with show and formation of bag of forewaters	Not associated
Associated with descent of the presenting part	No descent

Q. Partogram/partograph.

DEFINITION

Partogram is a composite graphical record of key data (maternal and fetal) during labor entered against time on a single sheet of paper.

It provides an accurate record of the progress of labor and any delay or deviation from normal may be detected quickly and treated accordingly. It was first devised by **Freidman in 1954**.

COMPONENTS

- **Patient identification:** Name, gravida, and parity
- **Time:** It is recorded at an interval of one hour. Zero time for spontaneous labor is time of admission in the labor ward and for induced labor is time of induction
- **Fetal heart rate:** It is recorded at an interval of **thirty minutes**
- State of membranes and color of liquor: "I" designates intact membranes, "C" designates clear, and "M" designates meconium stained liquor
- **Cervical dilatation** and descent of head
- *Uterine contractions:* Squares in vertical columns are shaded according to duration and intensity
- Drugs and fluids given to patient during labor
- *Blood pressure:* It is recorded in vertical lines at an interval of 4 hours

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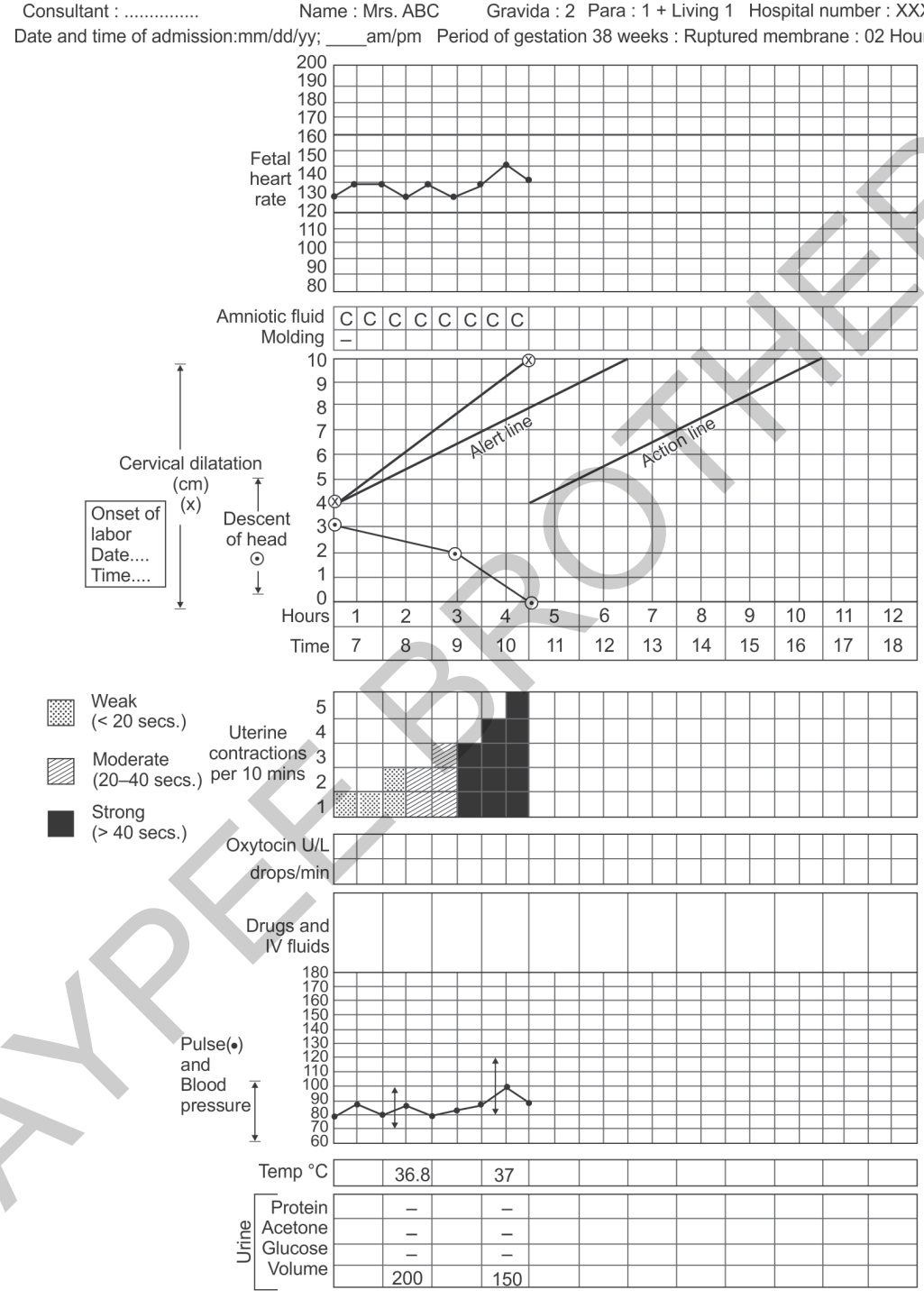

Fig. 13.1: Partograph (modified WHO) representing graphically the important observations in labor. The cervical dilatation and descent of head are shown in relation to alert and action lines. Intensity and duration of uterine contraction are shown with shades.

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- *Pulse rate:* It is also recorded in vertical lines at an interval of 30 minutes
- *Oxytocin:* If it is used then concentration (U/L) is noted down in upper box; while dose (drops/minute) is noted in lower box
- Urine analysis (quantity albumin, acetone)
- Temperature record (every 2 hours).

The concept of **"alert line" and "action line" was introduced by Philpott and Castle in 1972**. The action line can be placed at 2–4 hours interval, to the right and parallel to alert line. In partograms recommended by **"WHO",** the distance between the alert and action lines is **4 hours (Fig. 13.1)**.

ADVANTAGES

- Provides all important information and details on single sheet of paper
- No need to record labor events repeatedly
- **Early prediction** of any deviation from normal progress of labor, so appropriate steps can be taken
- Facilitates handover procedure
- Partograph has **reduced the incidence of prolonged labor and LSCS rates**
- Improvement in **maternal and perinatal morbidity and mortality**.

Q. Physiology and management of third stage of labor.

INTRODUCTION

Third stage of labor is the period starting after the delivery of the fetus and till the delivery of the placenta and fetal membranes.

PHYSIOLOGY OF THIRD STAGE

It comprises of placental separation, its descent and finally expulsion with the membranes.

- After the baby is born, the muscles of the uterus contract, helping the placenta to separate from the uterine wall
- The amount of blood lost depends on how quickly this happens, since the uterus can contract more effectively after the placenta is expelled
- If the uterus does not contract normally (such as in uterine atony), the blood vessels at the placental site stay open and hemorrhage results. Because the estimated blood flow to the **uterus is 500–800 mL/minute at term**, most of which passes through the placenta, severe postpartum hemorrhage can happen within just a few minutes
- The muscle fibers of the uterus are in a **crisscross pattern** surrounding maternal blood vessels **(living ligature)**. After the birth of the baby, these muscle fibers begin to **contract and retract**
- During the third stage, uterine contractions continue causing the placenta to separate from the uterine wall. Placental separation happens by contraction and retraction of the uterine muscles, **reducing the surface area at the placental site to about its half**. This reduction in size of the uterus is caused by **retraction** of the uterine muscle, a unique characteristic that helps maintain its shortened length after each contraction. As the placental area becomes smaller, the placenta begins to separate from the uterine wall because, unlike the uterus, it is not elastic and cannot contract and retract

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- A shearing force is instituted between the placenta and the placental site which brings about the separation
- The plane of separation runs through **deep spongy layer of decidua basalis**
- At the area where the placenta separates from the uterus, a clot forms. This clot—known as a retroplacental clot—collects between the uterine wall and the placenta, and it further promotes separation.

Methods of Placental Separation

There are two ways of placental separation **(Figs. 13.2A and B)**:

1. **Schultze (more common)**
2. **Matthews Duncan.**

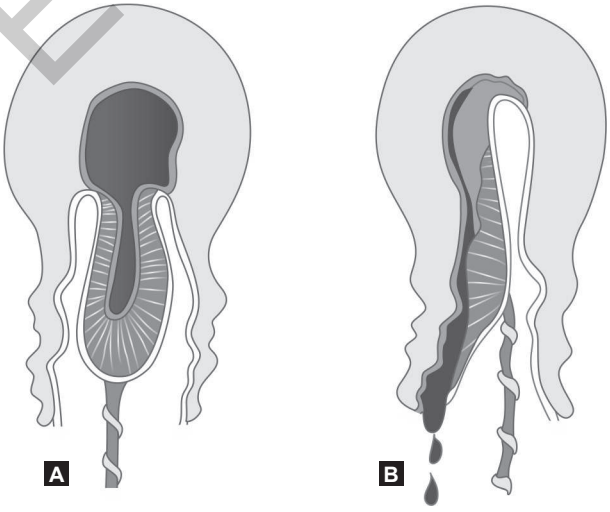
Schultze Mechanism

By far the most common mechanism of placental expulsion.

- Delivery of the placenta with the fetal side presenting. Results when separation begins **centrally** with corresponding formation of a central retroplacental clot, which weights the placenta so the central portion descends first.
- This then inverts the placenta and amniotic sac and causes the membranes to peel off the remainder of the decidua and trail behind the placenta. Bleeding associated with Schultze mechanism is not visible until the placenta and membranes are delivered, since the inverted membranes hold and catch the blood.

Duncan Mechanism

Delivery of the placenta with the maternal side presenting. Results when separation first takes place at the **margin or periphery of the placenta**. The placenta descends sideways and the amniotic sac, therefore, is not inverted but trails behind the placenta for delivery. Blood escapes between the membranes and uterine wall and is visible externally.



Figs. 13.2A and B: Types of separation of the placenta: (A) Schultze method; (B) Matthews Duncan method.

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Memory aid for remembering Schultze vs Duncan: It is based on the appearance of the two different sides of the placenta. Fetal side is shiny and glistening because it is covered by membranes, therefore **"shiny Schultze"**. Maternal side is rough and red-looking, thus **"dirty Duncan".** Remember: **SSC = Shiny Schultze Central**.

Expulsion and Control of Bleeding

- After complete separation, the placenta is pushed into the flabby lower segment or upper vagina by effective contraction and retraction of uterus
- Thereafter, it is expelled out either by voluntary contraction of abdominal muscles or by manual procedure
- The placental site is rapidly covered by a fibrin net and clots form
- The muscle fibers of the uterus (interlacing intermediate layer of myometrium) compress the blood vessels where the placenta was attached, helping to control bleeding at the placental site **(living ligature principal of hemostasis)**
- Also, thrombosis occurs to occlude the torn sinuses
- **Apposition of walls of uterus (myotamponade)** also contribute.

LENGTH OF THIRD STAGE

- Fifty percent of placental deliveries occur within 5 minutes, and 90% are delivered within 15 minutes
- When the third stage of labor lasts longer than 30 minutes, PPH occurs six times more often than it does among women whose third stage lasted less than 30 minutes.

MANAGEMENT OF THIRD STAGE

Third stage is the most crucial stage of labor. Its most important and most dangerous complication is PPH.
Two methods of management are:
1. Expectant management
2. Active management (preferred) **(Flowchart 13.1)**.

	Physiologic (expectant) management	*Active management*
Uterotonic	Uterotonic is not given before the placenta delivered	Uterotonic is given within one minute of the baby's birth (after ruling out the presence of a second baby)
Signs of placental separation	**Wait for signs of separation:** • Gush of blood • Lengthening of cord • Uterus becomes rounder and smaller as the placenta descends	**Do not wait for signs of placental separation. Instead:** • Palpate the uterus for a contraction • Wait for the uterus to contract • Apply CCT with counter traction
Delivery of the placenta	Placenta delivered by gravity assisted by maternal effort	Placenta delivered by CCT while supporting and stabilizing the uterus by applying counter traction
Uterine massage	Massage the uterus after the placenta is delivered	Massage the uterus after the placenta is delivered

Contd...

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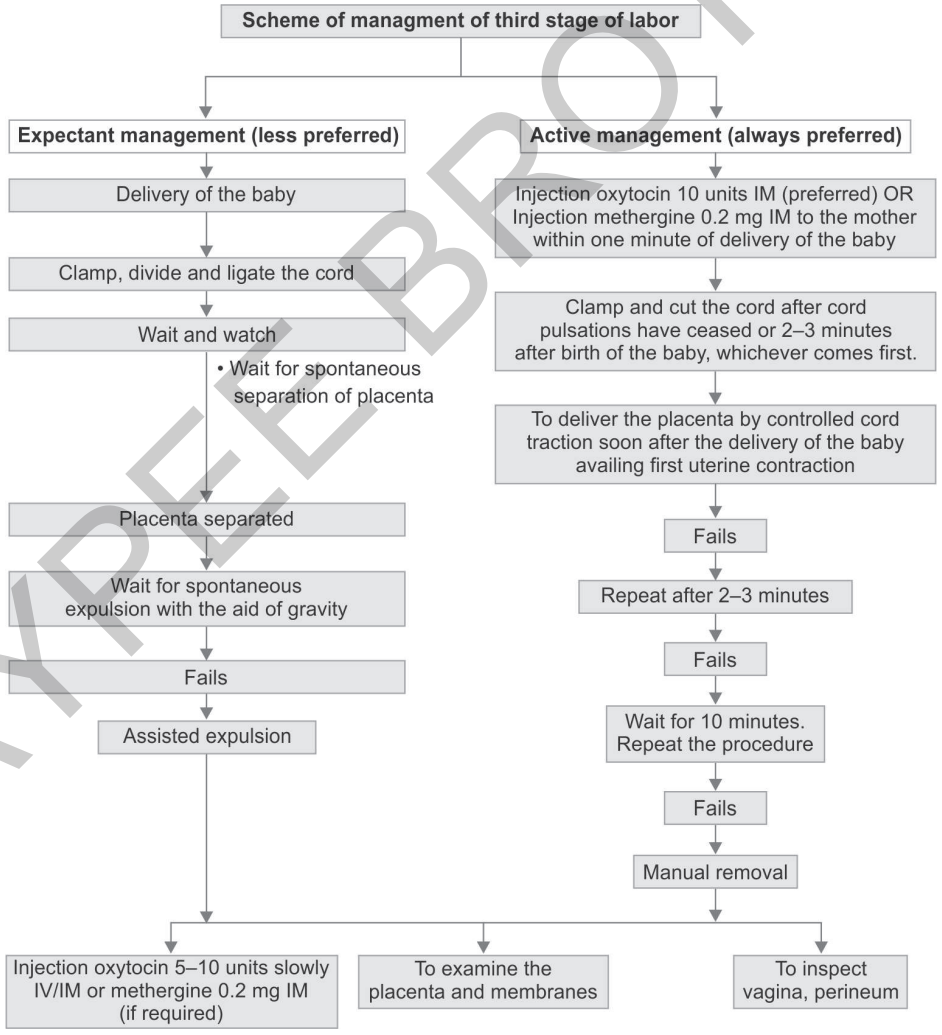
Contd...

	Physiologic (expectant) management	*Active management*
Advantages	• Does not interfere with normal labor process • Does not require special drugs/supplies • May be appropriate when immediate care is needed for the baby (such as resuscitation) and no trained assistant is available • May not require a birth attendant with injection skills	• Decreases length of third stage • Decrease likelihood of prolonged third stage • Decreases average blood loss • Decreases the number of PPH cases • Decreases need for blood transfusion
Disadvantages	• Length of third stage is longer compared to AMTSL • Blood loss is greater compared to AMTSL • Increased risks of PPH	• Requires uterotonic and items needed for injection/injection safety • Requires a birth attendant with experience and skills giving injections and using CCT

Flowchart 13.1: Scheme of management of third stage of labor.



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Q. Active management of the third stage of labor (AMTSL).

INTRODUCTION

Third stage of labor is the period starting after the delivery of the fetus and till the delivery of the placenta and fetal membranes.

DEFINITION

Active management of the third stage of labor (AMTSL): A combination of actions performed during the third stage of labor to **prevent PPH**. AMTSL speeds delivery of the placenta by increasing uterine contractions and prevents PPH by minimizing uterine atony.

The components of AMTSL are:

- Administration of a **uterotonic drug** at the time of delivery of the **anterior shoulder or afterward within one minute after the baby is born (oxytocin is the uterotonic of choice)**
- **Controlled cord traction** (CCT)
- **Uterine massage** immediately after delivery of the placenta.

STEPS

1. WHO recommends oxytocin as the drug of choice for AMTSL.
2. Give a uterotonic drug (oxytocin or methergine) within one minute of the baby's birth.
3. Before performing AMTSL, gently palpate abdomen **to rule out the presence of another baby**. At this point, do not massage the uterus.
4. If there is not another baby, begin the procedure by giving the woman **10 IU of oxytocin IM** in the upper thigh. This should be done within one minute of childbirth. **In case of twins, do it after the delivery of second baby.**
5. Clamp and cut the cord following strict hygienic techniques after cord pulsations have ceased or approximately 2–3 minutes after birth of the baby, whichever comes first.
6. Perform controlled cord traction.
   Controlled cord traction (CCT): Brandt Andrew's maneuver
   Traction on the cord **during a contraction** (in downward and backward direction holding the clamp) combined with counter traction upward on the uterus toward umbilicus with the provider's hand placed immediately above the symphysis pubis approximately at the junction of upper and lower segment. CCT facilitates expulsion of the placenta once it has separated from the uterine wall **(Fig. 13.3)**.
7. **Massage the uterus** immediately after delivery of the placenta and membranes until it is firm. Massaging the uterus stimulates uterine contractions and helps to prevent PPH.

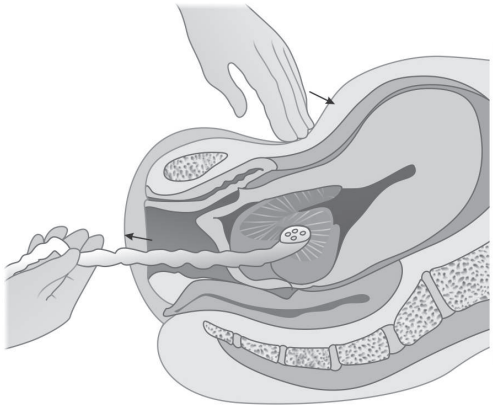

Fig. 13.3: Expression of the placenta by controlled cord traction.

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8. Examine the placenta and membranes to ensure they are complete. A small amount of placental tissue or membranes remaining in the woman can prevent uterine contractions and cause PPH.
9. Gently separate the labia and inspect the lower vagina and perineum for lacerations that may need to be repaired to prevent further blood loss. Suture the episiotomy.
10. Perform a comprehensive examination of the woman and newborn one and six hours after childbirth. During the first two hours after the delivery of the placenta, monitor the woman at least every 15 minutes (more often if needed) to:
    - Palpate the uterus to check for firmness
    - Massage the uterus until firm (ask the woman to call for help if bleeding increases or her uterus gets soft)
    - Check for excessive vaginal bleeding.

ADVANTAGES

AMTSL decreases:

- **Incidence of PPH by up to 60%**
- Duration of third stage of labor
- Percentage of third stages of labor lasting longer than 30 minutes
- Need for blood transfusion
- Need for uterotonic drugs to manage PPH.

DISADVANTAGE

The only disadvantage is **slightly increased incidence (1–2%) of retained placenta** and consequent manual removal of placenta. This is more likely to happen when methergine is used for AMTSL.

Q. Management of first stage of normal labor.

INTRODUCTION

First stage of labor starts from onset of true labor pains (regular uterine contractions) and ends with complete cervical dilatation at 10 cm.

GENERAL CONSIDERATIONS

- Labor events have got great psychological, emotional, and social impact to the woman
- Throughout labor, the patient is given **encouragement and emotional support**
- **Privacy** must be maintained
- She is explained about the events from time to time
- Comfortable environment, skill and confidence of the caregiver and the emotional support are all essential.

Management of normal labor aims at *maximal observation with minimal active intervention.* The idea is to maintain the normalcy and to detect any deviation from the normal at the earliest possible moment.

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ANTISEPTICS AND ASEPSIS

Strict asepsis has to be maintained. Antiseptic and aseptic precautions are to be taken during vaginal examination and during conduction of delivery.

PATIENT CARE

Shaving or hair clipping of the vulva is done.

The vulva and the perineum are washed liberally with soap and water and then with 10% Dettol solution or Hibitane (chlorhexidine) 1 in 2000.

VAGINAL EXAMINATION IN LABOR

First vaginal examination should be done by a **senior doctor** to be more reliable and informative and it is to be done taking all aseptic precautions.

Complete examination should be done before fingers are withdrawn. The following information is to be noted and recorded carefully:

- Cervical **dilatation** in centimeters
- Degree of **effacement** of cervix
- Status of **membranes** and if ruptured—color of the liquor: clear/meconium stained/blood stained
- Presenting part and its position
- Caput or molding of the head
- **Station** of the head in relation to ischial spines
- Assessment of the **pelvis** especially in primigravida is to be done and presence of vulval varicosity, if any, is to be noted.

Indications of Vaginal Examinations

Vaginal examinations should be restricted to a minimum.

- *At the onset of labor*: To confirm the onset of labor
- *The progress of labor* can be judged on periodic examinations at an interval of 3–4 hours
- *Following rupture of the membrane* to exclude cord prolapse especially where the head is not yet engaged
- *Whenever any interference is contemplated*
- To confirm the actual coincidence of bearing down efforts with complete dilatation of the cervix and to *diagnose precisely the beginning of second stage.*

FIRST STAGE MANAGEMENT

Principles

- Noninterference with watchful expectancy so as to prepare the patient for natural birth
- To monitor carefully the progress of labor, maternal conditions, and fetal well-being so as to detect any intrapartum complication early.

Preliminaries

- Enquiry is to be made about the onset of labor pains or leakage of liquor

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- Thorough general and obstetrical examinations including vaginal examinations are to be carried out and recorded
- Records of antenatal visits, investigation reports, and any specific treatment given are to be reviewed.

Actual Management

- **General:** Encouragement, emotional support, and assurance are given. *Constant supervision* is ensured.
- **Bowel:** An enema with soap and water or glycerin suppository is traditionally given in early stage.
- **Rest and ambulation:** If the membrane is intact, the patient is allowed to walk about. This attitude prevents vena cava compression and encourages descent of the head. Ambulation can reduce the duration of labor, need of analgesia.
  If, however, labor is monitored electronically or analgesic drug (epidural analgesia) is given, she should be in bed.
- **Diet:** There is delayed emptying of the stomach and low pH of the gastric contents in labor.
  So food is withheld during active labor **(to prevent Mendelson's syndrome)**. Fluids in the form of plain water or fruit juice may be given in early labor.
  Intravenous fluid with ringer solution is started where any intervention is anticipated or the patient is under regional anesthesia.
- **Bladder care:** Patient is encouraged to pass urine by herself (bed pan can be given) as full bladder often inhibits uterine contraction and may lead to infection.
  If the patient fails to pass urine especially in late first stage, catheterization is to be done with strict aseptic precautions.
- **Relief of pain:** Different options include—pethidine injections IM, Entonox inhalation (a mix of nitrous oxide 50% and oxygen 50%) and **epidural analgesia (considered the best and safe and should be offered if facilities are available)**.
- Assessment of progress of labor and **partograph** recording:
  - **Pulse** is recorded every 30 minutes.
  - **Blood pressure** is recorded at every four hours.
  - **Temperature** is recorded every two hours.
  - **Urine output** is recorded for volume, protein or acetone. Any drug (oxytocin or other) when given is recorded in the partograph.
  - **Abdominal palpation:**
    - *Uterine contractions:* As regard the frequency, intensity, and duration are assessed. *The number of contractions in 10 minutes and duration of each contraction in seconds are recorded in the partograph*. Partograph is charted every half an hour.
    - *Pelvic grip:* Gradual disappearance of poles of the head which were felt previously, usually occurs in labor. Abdominal palpation for descent of the fetal head in terms of fifths felt above the brim is to be used.
    - Shifting of the maximal intensity of the fetal heart beat downward and medially.
  - **To note the fetal well-being:**
    - Fetal heart rate (FHR) noted every half an hour in the first stage and every 15 minutes in second stage or following rupture of the membranes. *To be of value, the observation should be made immediately following uterine contraction. The count should be made for 60 seconds.*

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- Ordinary stethoscope is quite suitable. Doppler, however, is helpful in the case of obesity and polyhydramnios.
- Normal fetal heart rate ranges from 110–160 per minute.

❖ **Continuous electronic fetal monitoring/CTG:** Recording of fetal heart rate and uterine contraction. It is commonly used for high-risk pregnancies.
❖ **Vaginal examination:** (To get information as mentioned above).

To Watch for Maternal and Fetal Distress

Evidence of Fetal Distress

❖ **Loss of beat-to-beat variability**
❖ **Decelerations**
❖ **Tachycardia**
❖ **Bradycardia.**

Evidence of Maternal Distress

❖ Tachycardia (>100 beats/minute)
❖ Anxious look with sunken eyes
❖ Dehydration, dry tongue, acetone smell in breath
❖ Hot, dry vagina often with offensive discharge
❖ Scanty high colored urine with presence of acetone.

Q. Types of Pelves.

Q. Caldwell-Moloy Classification.

CALDWELL-MOLOY CLASSIFICATION OF PELVIC TYPES (1933)

Four types of female pelves were described. Actually, the majority of pelves are of mixed types:

1. **Gynecoid pelvis (50%):**
   - It is the normal female type
   - Shape: Round. Inlet is slightly transverse oval
   - Sacrum is wide with average concavity and inclination
   - Side walls are straight or slightly divergent, with blunt ischial spines
   - Sacro-sciatic notch is wide
   - Bituberous diameter: Normal
   - Subpubic angle is 85–100 degrees
   - No difficulty in vaginal delivery.
2. **Anthropoid pelvis (25%):**
   - It is ape-like type.
   - Shape: Anteroposteriorly oval. All anteroposterior diameters are long
   - Side walls: Straight or divergent, with blunt (non prominent) ischial spines
   - All transverse diameters are short
   - Sacrum is long and narrow
   - Sacrosciatic notch is wide

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- Bituberous diameter: Normal or short
- Subpubic angle is narrow
- More incidence of face to pubis delivery (vertex-occipito-posterior).

3. **Android pelvis (20%):**
   - It is a male type
   - Inlet is triangular or heart-shaped with anterior narrow apex
   - Side walls are converging (funnel pelvis) with projecting ischial spines
   - Sacro-sciatic notch is narrow and deep
   - Bituberous diameter: Short
   - Subpubic angle is narrow <90°
   - More chances of DTA, difficult delivery, perineal injuries.
4. **Platypelloid pelvis (5%):**
   - It is a flat female type
   - Shape: Transversely oval
   - All anteroposterior diameters are short
   - All transverse diameters are long
   - Side walls: Divergent, with blunt (non-prominent) ischial spines
   - Sacro-sciatic notch is narrow and small
   - Bituberous diameter: wide
   - Subpubic angle is very wide.

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