The Management of Normal Labour

1st Stage

Principles:

i. Continuity of care and emotional support to the mother.

ii. Observation of the progress of labour with intervention if becomes abnormal.

iii. Monitoring of foetal wellbeing.

iv. Appropriate pain relief.

v. Adequate hydration.

Membranes may be: intact, have ruptured artificially (ARM) or ruptured spontaneously.

Management:

→ Intermittent monitoring of her (BP, pulse, temp) and foetus by CTG.

→ Encourage to mobilize and eat light diet.

→ Vaginal examinations every 4 hours – progress plotted on a partogram.

→ If epidural then an indwelling catheter should be positioned or the bladder emptied every few hrs by an ‘in and out’ catheter.

2nd Stage

First sign of 2nd phase is an urge to push.

↓ Confirm full dilation of cervix by vaginal examination.

↓ Women will get an expulsive reflex with each contraction, and will generally take a deep breath, hold it, and strain down – pushing needs to be organized to be effective.

↓ Position to push effectively – well propped up with head upright and hands behind knees. Variations: left lateral position, in water.

↓ When head crown’s the midwife should control it to prevent it being born suddenly.

↓ Check that the cord is not wound tightly around neck.

↓ If meconium staining then perform naso-pharyngeal suction to prevent aspiration.

↓ With next contraction body can be delivered – to aid delivery head should be pulled downwards and forwards until anterior shoulder appears beneath pubis.

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Foetal Assessment in Labour

- Abdominal and vaginal examination.
- CTG and intermittent auscultation of foetal heart.
- Monitor colour, consistency and amount of amniotic fluid.
- Partogram – allow visual assessment of rate of cervical dilation against expected norm, according to parity of the women.
Immediate Care of Neonate

- No need for immediate cord clamping – about 80mL of blood will be transferred from placenta to baby before cord pulsations cease.
- Baby’s head should be kept dependant to allow mucus in respiratory tract to drain – apply oropharyngeal suction if necessary.
- Clamp cord.
- APGAR score assessment for one min.
- Place baby on mothers abdomen – will encourage bonding and release of oxytocin will encourage uterine contractions.
- Give vit K.
- General examination for abnormalities.
- Wrist label.

**APGAR Score**

Usually done at 1 and 5 minutes.

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Appearance – central trunk colour</td>
<td>Pale</td>
<td>Blue</td>
</tr>
<tr>
<td>P</td>
<td>Pulse rate</td>
<td>Absent</td>
<td>&lt;100</td>
</tr>
<tr>
<td>G</td>
<td>Grimace</td>
<td>Nil</td>
<td>Grimace</td>
</tr>
<tr>
<td>A</td>
<td>Activity (muscle tone)</td>
<td>Limp</td>
<td>Some flexion</td>
</tr>
<tr>
<td>R</td>
<td>Respiratory effort</td>
<td>Absent</td>
<td>Gasping/irregular</td>
</tr>
</tbody>
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**3rd Stage**

Separation of placenta occurs due to: ↓ in vol. of uterus and shortening of lattice-like arrangements of myometrial fibres.

**Signs of separation:**
- Lengthening of the cord protruding from the vulva.
- A small gush of blood from placental bed.
- A rising of uterine fundus above umbilicus.
Management – Controlled cord traction:

1. Synthetic oxytocin 10iu IM following delivery of anterior shoulder. This will cause uterus to contract soon after delivery of baby.

2. After delivery of baby, midwife should place left hand on uterus to identify when contraction has occurred – check for any signs of haemorrhage.

3. Double clamp the cord 1-2 mins after delivery of baby.

4. When contraction felt move left hand suprapubically – at same time right hand should grasp cord and exert steady traction – use twisting motion to ensure placenta peels off all the membranes.

5. Placenta separates and is delivered.

If placenta retains try same methods 10 mins later – If still unsuccessful will require manual removal by operation under general or regional anesthesia.

Inspect placenta for missing cotyledons or succenturiate lobe – if suspected arrange manual removal of placenta as postpartum risk is high.

Inspect vulva of mother for tears or lacerations – If extensive tears into perineal muscle, or an episiotomy, then repair.

Bibliography
