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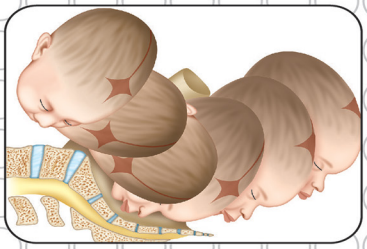

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JAYPEE

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3

Labor and Delivery

CHAPTER OUTLINES

- Labor Progress, Vaginal Delivery Notes
- Assessing a Patient in Labor
- Rupture of Membranes
- Vaginal Examinations
- Digital Cervical Examination
- Labor Pain Control
- Stages of Labor
- Labor Movements
- Postpartum Note

LABOR PROGRESS, VAGINAL DELIVERY NOTES

Labor Admission and Progress Notes

S: Comfortable (Y/N), epidural (Y/N), complaints (e.g. leakage of fluid, vaginal bleeding, contractions, etc.) in _____ stage of labor.

HPI: _ yo G_P__ @ ___ weeks by LMP consistent with 1st trimester US (or by US alone) presents for _____. Patient reports +/–FM, LOF, VB, or contractions (Y/N). +/– HA, vision changes, RUQ pain. Pregnancy complicated by _____. Prenatal care @ _____.

LMP: _____

EDD: _____

OB Hx: G_P____ (T- term, P- preterm, A- abortions, L-living children); mention all deliveries (year; term or preterm, if preterm - why; vaginal or cesarean delivery, type of cesarean and why; male of female; weight; complications.

Abortions: SAB (spontaneous) vs. EAB (elective), note GA and if D&C performed).

GYN Hx: h/o STDs, abnormal Paps, etc.

*PMH (past medical history):*_____

PSH (past surgical history): For example, D&C___, appendectomy

Meds: _____

Allergies: _____(always note reaction, e.g. PCL rash)

Family Hx: Mother___, Father___ (DM, HTN). +/– birth defects, mental retardation, bleeding or clotting disorders

Social Hx: +/– tobacco, EtOH, drugs. Living situation. Occupation. Feels safe? +/– Depression.

ROS

- *Gen:* +/- Fever/chills
- *HEENT:* Vision changes, sore throat, rhinorrhea
- *CV:* Palpitations, chest pain
- *Pulm:* SOB, prolonged cough
- *GI:* Abdominal pain, nausea, vomiting, diarrhea, constipation
- *GU:* Dysuria, hematuria, frequency, abnormal vaginal discharge
- *MS:* Joint pain, swelling

- *Neuro:* Severe headache, weakness
- *Heme:* h/o anemia or blood clots
- *Psych:* Depression or anxiety
- *Physical exam:*
- *VS:* BP___, HR __, RR __, O_2 Sat __
- *FHT (baby's vitals):* Baseline, variability (absent, minimal, moderate, marked), accelerations, decelerations (state type-early, late, variable)
- *Toco:* q 5 minutes (or 2 in 1 hour, or none)
- *Gen:* A/O (alert and oriented), NAD (no acute distress) or appears uncomfortable, etc.
- *CV:* RRR (regular rate and rhythm), + SEM (systolic ejection murmur)
- *Pulm:* CTAB (clear to auscultation bilaterally)
- *Abd:* 'gravid' Fundal Height = ___cm. EFW (estimated fetal weight)__ kg/lbs. Leopolds = presentation
- *Ext:* +/– edema, calves (tender, nontender)
- *Neuro:* DTRs (deep tendon reflexes) ___, clonus Y/N *(needed if any concern about pre-eclampsia)*
- *SSE (sterile speculum exam):* No bleeding or pooling; cervix visually dilated to ___cm

SVE (sterile vaginal exam): Cervix (dilatation, e.g. 3 cm)/ effacement (in %, e.g. 50%), membranes (intact, rupture of membranes, ROM time), station (e.g. -1)

- *Wet Prep:* +/– yeast, clue cells, or trich. Nitrazine and Ferning +/–
- *Urine Dip:* +/–

- *PNL (prenatal labs):* BG/Rh/HIV/HepB/RPR/GC (gonorrhea/chlamydia)/CF (cystic fibrosis)/Hgb/glucose tolerance test/GBS status

(e.g. O+/Ab–/HIV–/HepB–/RPR NR /CF–/GC–/Hgb 13.2/Pap NIL (negative for intraepithelial lesion/1 hour 72/GBS– (GBS negative)

- *GBS +:* Antibiotics (Y/N)
- *Premature labor:* Steroids given (Y/N)
- *Level II US:* EFW ___ g (__%), presentation, 3VC (Y/N), placenta (anterior, posterior, etc.), normal/abnormal fetal anatomy, BPP (biophysical profile)__ , Doppler __
- *FWB (fetal wellbeing) reassuring:* FHT (fetal heart tracing category)
  - Admit to L&D, anticipate vaginal delivery
  - NPO, IVF (nothing per os/intravenous fluids).

Vaginal Delivery Note

- NSVD of viable (male/female) infant over an intact perineum @ (time)
- Apgars _&_, wt __g. Position (e.g. LOA), bulb suction, (nuchal cord × ?, reducible).
- Spontaneous delivery of intact 3-vessel cord placenta @ (time), fundal massage and Pitocin initiated, fundus firm.
- __-degree perineal laceration repaired under local anesthesia with __-0 vicryl.
- Estimated blood loss (EBL) = ___ cc. Mom and baby stable Y/N). Doctors were ___

ASSESSING A PATIENT IN LABOR

- *False labor (Braxton Hicks contractions):* Irregular contractions, same intensity throughout, cervix not dilated, discomfort relieved by medications.
- *True labor:* Regular contractions with increase in intensity and dilated cervix. Signs are bloody show, rupture of membranes (diagnose by Nitrazine, Fern Tests).
- Maternal blood pressure and pulse should be evaluated and recorded every 10 minutes. Oral intake is limited to small sips of water, ice chips, or hard candies.
  - *If no prenatal care check:* CBC, blood group and Rh typing, rapid HIV, urine testing.
  - *Those with prenatal care require:* Urine test for protein or glucose, CBC, blood for cross matching.
- Always obtain from a laboring patient:
  - Time of onset and frequency of contractions, rupture membranes, presence of vaginal bleeding, regularity of fetal activity, last food intake, use of medications, allergies to medications. Determine if high- or low-risk pregnancy.
- Monitor uterine contractions by internal or external uterine pressure monitors. Pressure is calculated by increases in uterine pressure above baseline (8–12 mm Hg) multiplied by frequency of contractions per 10 minutes.
  - Uterine contractions in the first stage of labor increase progressively in intensity from 25 mm Hg to 50 mm Hg, and the frequency increases from three to five contractions per 10 minutes.

- Contractions in the second stage increase further (aided by maternal bearing down) to 80–100 mm Hg, and the frequency increases to 5–6 per 10 minutes.

RUPTURE OF MEMBRANES

- A digital examination should not be performed, as it increases the risk of infection:
  - *Sterile speculum examination (SSE):* Visualize extent of cervical effacement and dilation, and exclude prolapsed cord or protruding fetal extremity.
  - *Pool test:* Identify fluid coming from the cervix or pooled in the posterior fornix of the vagina → supports diagnosis of PROM.
  - *Nitrazine test (NT):* Put fluid on nitrazine paper, which turns blue if fluid is alkaline. Alkaline pH indicates fluid is amniotic.
  - *Ferning test:* A swab from the posterior fornix is smeared on a slide, allowed to dry, and examined under a microscope for "ferning" → + for amniotic fluid.
- *ROM:* Rupture of membranes.
- *PROM:* Premature rupture of membranes (ROM before the onset of labor).
- *PPROM:* Preterm (<37 weeks) premature rupture of membranes
  - If <24 weeks, increased risk of oligohydramnios that may cause pulmonary hypoplasia.
  - Increased risk of premature birth.

- *Prolonged rupture of membranes:* Membranes ruptured >18 hours before delivery
  - Increased risk of chorioamnionitis, neonatal infection and umbilical cord prolapse.
  - *Etiology:* Unknown but hypothesized—vaginal and cervical infections, incompetent cervix, abnormal membranes, and nutritional deficiencies.

VAGINAL EXAMINATIONS

- Vaginal examinations should be kept to the minimum required for the evaluation of a normal labor pattern, for example, every 4 hours in latent phase and every 2 hours in active phase. Sterile gloves and lubricant should be utilized.
- Perform a sterile speculum examination prior to a digital examination if you suspect rupture of membranes, preterm labor or placenta previa. Otherwise, a digital cervical examination may be performed.
- To assess vaginal fluid to determine if membranes have already ruptured:
  - Use a sterile speculum to assess fluid in the posterior vaginal fornix (pool test).
  - Fluid may be collected on a swab if the source of fluid is unclear:
    - *Ferning test* (high estrogen content of amniotic fluid causes fern pattern on slide when air dried). Confirms ROM in 85–98% of cases.

- *Nitrazine test:* Nitrazine paper is pH sensitive and turns blue with amniotic fluid as it is more alkaline than vaginal secretions (pH = 7.15) 90–98% accurate.

– Fluid should also be examined for vernix or meconium.
  - The presence of meconium in the amniotic fluid may indicate fetal distress. Meconium staining more common in term and post-term pregnancies than preterm.
  - Meconium aspiration syndrome is seen as infant tachypnea, costal retractions, cyanosis, coarse breath sounds.

DIGITAL CERVICAL EXAMINATION

- Effacement describes the length of the cervix which usually thins and softens in labor. The normal length is 3–4 cm. 50% is around 2 cm length. When the cervix becomes as thin as the areas surrounding the cervix, it is 100% effaced.
  – Palpate with finger and estimate the length from the internal to external os.
- Dilation is the size of the opening of the cervix. Ranges from closed (zero) to fully dilated (10 cm).
  – Sweep a finger from the margin of the cervix on one side to the opposite side.
- Cervical position describes the location of cervix with respect to the fetal presenting part, usually progresses from posterior to anterior during labor.

  - *Posterior:* Difficult to palpate because it is behind the fetus, and high in the pelvis.
  - *Anterior:* Easy to palpate, low down in pelvis.
- Cervical consistency ranges from firm to soft. Soft is favorable for labor.
- *Bishop score* rates if cervix is ready for delivery. If sum >8 is a favorable cervix
  - *1 pt:* Dilated 1–2 cm, effaced 40–50%, station -2, cervix mid position, medium consistency.
  - *2 pt:* Dilated 3–4 cm, effaced 60–70%, station -1 or 0, cervix anterior position, soft consistency.
  - *3 pt:* Dilated 5–6 cm, effaced >80%, station >+1, +2.
- Cervical ripening agents
  - Cervidil (prostaglandin E2/dinoprostone) 10 mg. Insert q 12 hours, maximum 3 doses.
  - Cytotec (prostaglandin E1/misoprostol) 25 mcg (1/4 of 100 mcg pill) vaginally q 4 hours.
  - Oxytocin.

LABOR PAIN CONTROL

- Innervation:
  - Early labor pain is from uterine contractions. Visceral sensory fibers from the uterus, cervix, and upper vagina run with T11-12 and L1.
  - Second stage of labor pain is from genital tract, along the pudendal nerve S2-4.
- Nonpharmacological methods of pain control:

  - Appropriate antepartum training in breathing. Psychological support (friend or family member). Considerate physicians and labor assistants (doulas) who instill confidence.
- Pain relief with a narcotic (Meperidine/Stadol/Fentanyl/Nalbuphine) plus an antiemetic (Promethazine) is both safe and effective.
  - Slight, bearable discomfort should still be felt at the height of a contraction.
  - *Phenergan + Meperidine IM:* Analgesia peak at 45 minutes. IV—effects are immediate.
  - *Naloxone hydrochloride:* Displaces the narcotic from receptors in the CNS. 0.1 mg/kg of body weight of the newborn injected into the umbilical vein and acts in 2 minutes.
- General anesthesia should be given as late as possible to minimize newborn respiratory depression. All anesthetic agents that depress the maternal CNS cross the placenta and depress the fetal CNS.
- Epidural anesthesia relieves pain of uterine contractions
  - *Lumbar block:* Abdominal delivery (T8-S1) or Caudal block vaginal delivery (T10-S5).
  - Risks of accidental spinal block, hypotension, convulsions, prolongation of labor.

STAGES OF LABOR

- *First stage* begins with onset of labor (uterine contractions of sufficient frequency, intensity, and duration to result in

effacement and dilation of the cervix), and ends when the cervix is fully/completely dilated to 10 cm. Two phases:
  - *Latent phase:* From onset of labor to 4 cm dilatation. Lasts 20 hours in nulliparous, 14 hours in multiparous.
  - *Active phase:* Rapid dilation from 4 to 10 cm dilation, takes nulliparous 1.2 cm/h, multiparous 1.5 cm/h. Fetal descent at 7–8 cm.
- *Second stage* begins with a fully dilated cervix and ends with delivery of the fetus.
  - Fetus descends in nulliparous women 1 cm/h, multiparous at 2 cm/h.
  - The modified Ritgen maneuver presents the smallest diameter for delivery. Place one hand over the perineum with upward pressure on the fetal chin, other hand pressing down on the fetal occiput during a contraction.
  - After delivery of the head, check for a nuchal cord by passing a finger along the neck. If felt remove with finger over the infant's head, unless tight, then clamp and cut.
  - Shoulders normally deliver spontaneously, grasp sides of head with both hands, gentle downward traction applied until anterior shoulder descends under the pubic arch, then upward traction to deliver posterior shoulder.
  - Typically, the rest of the body rapidly follows the delivery of the shoulders.
- *Third stage* is placental separation. Usually <10 minutes, prolonged if >30 minutes.

- Three signs are: Gush of blood, lengthening umbilical cord, uterine fundus firming.

LABOR MOVEMENTS

Cardinal movements are changes in the position of the fetal head during birth.

- *Engagement* is the descent of the biparietal diameter to the plane of the pelvic inlet (0 station). Often occurs before the onset of true labor, especially in nulliparous women.
- *Descent* is the fetal head passing down into the pelvis. It occurs in a discontinuous fashion. The greatest rate of descent occurs in the deceleration phase of the first stage of labor and during the second stage of labor.
- *Flexion* refers to the chin-to-chest position that the fetus takes to present the smallest possible diameter of the fetal head to the birth canal.
- *Internal rotation* refers to the fetal occiput gradually rotating toward the pubic symphysis.
- *Extension* occurs after the fetus has descended to the maternal vulva. This brings the base of the occiput into contact with the inferior margin of the symphysis pubis, where the birth canal curves upward. The fetal head is delivered by extension from the flexed to the extended position, curving under and past the pubic symphysis.
- *External rotation:* The fetus resumes its normal "face-forward" position with the occiput and spine in the same plane. External rotation is completed by rotation of the

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