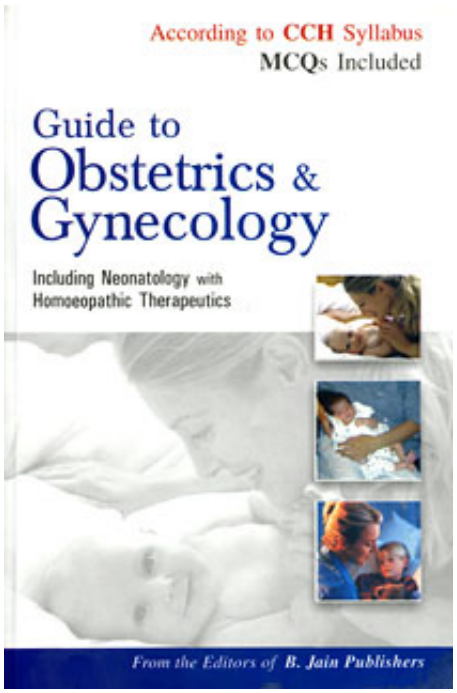
B. Jain
Guide to Obstetrics & Gynecology

Leseprobe

Guide to Obstetrics & Gynecology
von B. Jain
Herausgeber: B. Jain



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Management of Normal Labor

1. Aseptic environment: Labor should be conducted under strict antiseptic and aseptic precautions. Maintenance of strict asepsis is necessary because the woman in highly susceptible to infection due to:
   - Any trauma like perineal tears, etc. provide the site of entry.
   - The placental site is raw and organisms can easily gain entry into the blood stream through it.
   - Genital tract serves as a good culture medium for growth of micro organisms, after the delivery.

2. Cleansing the Vulva: The pubic hair are shaved and the vulva is washed with a detergent.

3. Vaginal Examination: Patient lies down in the lithotomy position. Area is cleaned with an antiseptic lotion. Two fingers of the right hand are introduced into the vagina while the labia majora are separated by two fingers of the other hand. Vaginal examination should be made every 4 hours. Points to be noted on vaginal examination are:

(i) Length of cervix,
(ii) Thickness of cervical lips,
(iii) Dilatation,
(iv) Presenting part,
(v) Locate the sutures and fontanelles.
(vi) Status of membranes, whether ruptured or intact; if ruptured look for color of liquor.

(vii) Caput or moulding of head,
(viii) Assessment of pelvis.

Since there is always some chance of introducing infection despite adequate aseptic measures, the number of vaginal examinations should be restricted to minimum.

MANAGEMENT OF THE FIRST STAGE

(i) Progress of labor is carefully monitored.
(ii) Vulval area is washed and cleaned .
(iii) Bowels are evacuated by giving an enema. This prevents the soiling of the perineal area during the second stage, (iv) No food to be given oraly, however water may be given, (v) Ask the patient to empty the bladder frequently, (vi) Adequate analgesia.
(vii) Note the progress of labor using a partogram. (viii) Monitor the general condition, hydration, blood pressure, temperature, pulse, etc. of the woman. (ix) Monitor the fetal well being by noting the fetal heart rate.

MANAGEMENT OF THE SECOND STAGE

It is important to recognize the transition from the first stage to the second stage.

Signs of Second Stage

Positive Sign

Complete cervical dilatation as seen on vaginal examination.

Probable Signs

- Increased intensity, duration and frequency of uterine contractions.
- Appearance of bearing-down efforts by mother.
- There is a feeling of defecation and the anus gapes.
- Bulging of perineum.

The aim of management in 2nd stage should be to facilitate the natural expulsion of fetus and to prevent permeal tears.

- Woman is shifted to the labor room.
- She lies down on the bed in a dorsal position with knees flexed and widely separated.
- Bladder should be emptied at the end of first, on the beginning of 2nd stage. Catheterization may be required if the woman has not passed urine for 6 hours and the bladder is clearly distended.
- The external genitalia and side of thighs is cleaned with savlon solution.
- The fetal heart rate is monitored.
- Uterine contractions should be monitored if they are not sufficiently strong. They can be augmented with oxytocin.

Delivery of the Head

- The woman is asked to increase the bearing-down effort during uterine contractions. She should be told to relax in between the contractions.
- After the crowning has occurred, flexion of the head is maintained by pushing the occiput downwards and backwards with one hand while giving perineal support with a vulval pad with the other hand (this is known as Ritgen's manoeuvre). The purpose of maintaining flexion of the head is to ensure that the smaller suboccipito-frontal diameter (10 cms) distends the vulval outlet instead of the larger occipito-frontal diameter.
- Prevent sudden escape of head during contractions.
- During subsequent contractions, the forehead, nose, mouth and chin are born successively by extension.

Note: When the perineum gets fully stetched and is bulging and there is risk of perineal tear, episiotomy is done after infiltrating the perineal area with 10 ml of 1% lignocaine.

- Immediately following the delivery of the head, any mucus or blood in the baby's mouth should be wiped out with a sterile gauze piece.
- In about 25% cases the umbilical cord is looped around the baby's neck usually once but sometimes two or three times. The cord should be slipped over the head if it is sufficiently loose.

But if the cord is tight then it can be cut after clamping it with two pairs of Kochers forceps.

Delivery of Shoulders and Trunk

Allow the movements of restitution and external rotation of the head to occur. The anterior shoulder rotates forwards so that the shoulders come to lie in the antero-posterior diameter of the outlet. This will be evident by the external rotation of the head. During subsequent contractions the anterior shoulder is delivered. However if there is some delay, the expulsion of the anterior shoulder may be facilitated by gently depressing the head towards the anus. Thereafter the posterior shoulder is delivered by drawing the head in an upward direction. It is important that traction exerted should be minimal because of the risk of injury to the brachial plexus causing Erb's paralysis. The rest of the body can be gentally pulled out by lateral flexion.

Immediately after the delivery of the baby, the cord is clamped and cut and the baby is handed over to the pediatrician.

MANAGEMENT OF THE THIRD STAGE OF LABOR

Third stage of labor involves separation and expulsion of placenta and membranes. Usual duration of this stage is between 5 to 15 minutes. The main objective of management in this stage is to prevent any complications such as post-partum hemorrhage.

- It is necessary to maintain thorough asepsis as the chances of contracting infection are maximum at this time.
- Keep a constant watch for signs of placental separation which include
  - u Sudden gush of blood per vagina
  - u Permanent langthening of the cord.
  - D Fundus is globular on abdominal palpation.

Expulsion of Placenta

Woman lies in a dorsal position with both knees flexed and well separated.

Methods of placental expulsion:

(i) Bearing-down by woman, (ii) Fundal pressure application. (iii) Controlled cord traction.

Bearing-down by Woman

Patient is told to bear down. The raised intra-abdominal pressure is usually adequate to expel the placenta. After the placenta is delivered, it is given a gentle traction so as to strip off the membranes completely. However if some part of the membranes is left behind, exploration of the uterus with fingers is required. However if bearing-down efforts of the woman don't expel the placenta for up to 10 minutes then other methods for delivery of placenta can be used.

Fundal Pressure

Fundal pressure is applied by placing a hand over the fundus per abdomen and then pushing it downwards and backwards. Pressure must be applied after the uterus has hardened. This method is preferred over controlled cord traction when the tensile strength of the cord is low and it is likely to break. For example, premature delivery, macerated fetus, etc.

Controlled Cord Traction

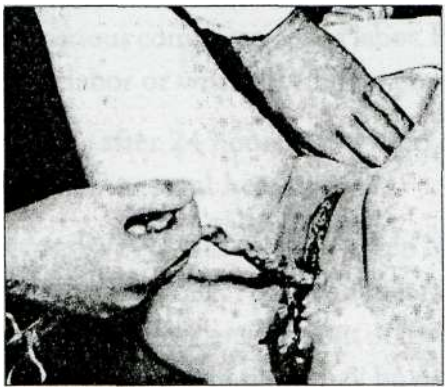


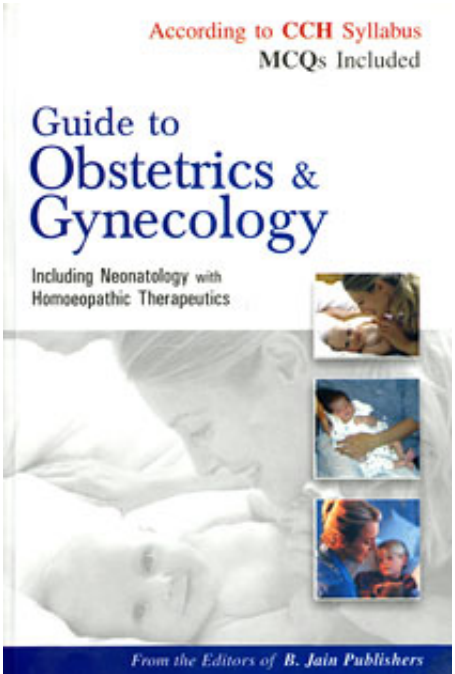
Fig. 13.1 Controlled cord traction. One hand pushes the contracted uterus upwards.

The left hand is placed on the lower abdomen so as to displace the body of the uterus upwards towards the umbilicus to prevent inversion of uterus. The other hand is used to apply gentle traction to the cord with a clamp in the downward and backward direction. If the cord breaks, sterile gloved hand is introduced into the vagina and the placenta is grasped and extracted.

Administration of Oxytocic Drugs

Injection of Ergometrine 0.25 mg or Methergin 0.2 mg intravenously after the birth of the anterior shoulder shortens the duration of the third stage, reduces blood loss and the incidence of hemorrhage.

- After the deliver of placenta and membranes, they should be carefully examined to rule out any missing lobes or parts of the membrane. Absence of a lobe or part of membranes requires immediate exploration of the uterus.
- Inspect the vagina, vulva and perineal area to rule out any tears on lacerations. If present they are to be repaired, also if episiotomy was done if should be repaired.
- Post-delivery condition of the mother including the general condition, hydration, vitals (pulse, B.P., respiratory rate and temperature), condition of the uterus, and any vaginal bleeding should be monitored for atleast 1 hour after the delivery.



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