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ACOG addressed via committee opinion (endorsed by ACNM) the JAMA publication that assessed immediate vs delayed pushing in women who have opted for neuraxial analgesia. Previous ACOG guidelines recommended that in the 2nd stage of labor Women can be offered a period of rest for 1-2 hours before pushing Delayed pushing is only appropriate in the absence of a reason for ‘expeditious’ delivery Resting can be offered ‘particularly’ in nulliparous patients with neuraxial anesthesia However, in light of the JAMA publication, ACOG now states that Collectively, and particularly in light of recent high-quality study findings, data support pushing at the start of the second stage of labor for nulliparous women receiving neuraxial analgesia Delayed pushing has not been shown to significantly improve the likelihood of vaginal birth and risks of delayed pushing, including infection, hemorrhage, and neonatal acidemia, should be shared with nulliparous women receiving neuraxial analgesia who consider such an approach KEY POINTS: Summary of the JAMA Publication (Cahill et al., 2018) Methods Randomized Controlled Trial (RCT) Participants Nulliparous pregnant women ≥37 weeks’ with neuraxial analgesia Admitted for spontaneous or induced labor 6 academic and community medical centers across the United States Exclusion Multiparous patients | Scheduled cesarean deliveries | Multiple gestations | Major fetal anomalies | Nonreassuring fetal status Patients randomized (after 10 cm dilation) to Immediate pushing: Told to start pushing at randomization Delayed pushing: Told to wait 60 minutes prior to pushing unless instructed to do otherwise or ‘irresistible’ urge to push Follow up: To 6 weeks postpartum (mothers and infants) Primary outcome: Spontaneous vaginal delivery Secondary outcomes Total duration of the second stage |Duration of active pushing | Operative vaginal delivery | Cesarean delivery | Several individual maternal morbidity assessments | A composite outcome of neonatal morbidity Adverse Events (prespecified by the data and safety monitoring board) Neonatal acidemia | Chorioamnionitis during the second stage of labor | Severe postpartum hemorrhage NICU admission for>12 hours Serious adverse events included maternal death, ICU admission, unplanned hysterectomy, serious neonatal birth injuries Results 2,414 women (75% of recruitment target) were randomized before the study was stopped following a planned interim analysis by the data and safety monitoring board Stopped due to futility (even if study continued unlikely to show difference) and increased morbidity in the delayed pushing group Rate of spontaneous vaginal delivery was not different between groups Immediate group: 85.9% Delayed group: 86.5% Absolute difference, –0.6%; 95% CI, –3.4% to 2.1% Relative risk (RR) 0.99; 95% CI, 0.96 to 1.03 Secondary outcomes There were no significant differences in Composite outcome of neonatal morbidity Perineal lacerations The immediate group had significantly Shorter mean duration of the second stage compared with the delayed group (102.4 vs 134.2 minutes) Lower rate of chorioamnionitis (6.7% vs 9.1%) Fewer postpartum hemorrhages (2.3% vs 4.0%) Conclusions No significant difference in rate of vaginal delivery between immediate and delayed pushing groups in nulliparous women with neuraxial anesthesia Consistent with a previous meta-analysis of RCTs Learn More – Primary Sources: ACOG Committee Opinion 766: Approaches to Limit Intervention During Labor and Birth Effect of Immediate vs Delayed Pushing on Rates of Spontaneous Vaginal Delivery Among Nulliparous Women Receiving Neuraxial Analgesia Take a post-test and get CME credits TAKE THE POST TEST Related OBG Topics: What does breastfeeding look like in the first week of a baby’s life? Sometimes as new parents we keep thinking feed the baby, feed the This blog is filled with our top Yoga | Birth | Babies breastfeeding podcast episodes & lactation resources because August is National Breastfeeding Month! This The first trimester, wow. It can be a bear for some of us. I know my first trimesters were rough, and many of us go When I was pregnant with my first, instead of asking for clothes, onesies, and all of the stuff babies come with I asked for hours This episode is one of my favorite things we do on the podcast, share community birth stories. We have different members of our online or The American Congress of Obstetricians and Gynecologists recently updated their recommendations to limit intervention during birth. Since these recommendations were released, natural birth advocates have been talking about the impact these changes will have on women’s experiences in birth. While many hospitals and healthcare professional already follow some of these practices, we’re thrilled with the expected changes and wanted to share our five favorite recommendations. What they said: “Admission to labor and delivery may be delayed for women in the latent phase of labor when their status and their fetuses’ status are reassuring. The women can be offered frequent contact and support, as well as nonpharmacologic pain management measures.” What it means: Moms who haven’t be determined at risk for complications during delivery can spend the first phase of labor in the comfort of their own homes, waiting until they’ve moved to “active labor” to head to the hospital. Why we love it: Staying at home during this phase of labor can help moms relax, which allows labor to progress more quickly. Sometimes labor can stall when a mom goes to the hospital this early. This is also a great time to rest, eat, and drink plenty of fluids. What they said: “For women with normally progressing labor and no evidence of fetal compromise, routine amniotomy need not be undertaken unless required to facilitate monitoring.” What it means: If everything is proceeding naturally, and mom & baby are both doing well, the medical staff won’t break mom’s water for her. Why we love it: This allows mom to labor as long as she needs to provided she and baby are doing well. Once the bag of waters is broken it is recommended that the baby is delivered within 24 hours. Breaking water unnecessarily puts mom and baby “on the clock.” What they said: “To facilitate the option of intermittent auscultation, obstetrician-gynecologists and other obstetric care providers and facilities should consider adopting protocols and training staff to use a hand-held Doppler device for low-risk women who desire such monitoring during labor.” “Frequent position changes during labor to enhance maternal comfort and promote optimal fetal positioning can be supported as long as adopted positions allow appropriate maternal and fetal monitoring and treatments and are not contraindicated by maternal medical or obstetric complications.” What it means: Rather than be hooked up to fetal heart rate monitors, baby will be monitored by a Doppler, allowing mom greater freedom of movement Why we love it: This helps mom labor in whatever position she feels comfortable in rather than in bed on her back. Moms will be encouraged to labor on a birthing ball, walk around, be on their hands and knees, or any other position works for them. What they said: “Use of the coping scale in conjunction with different nonpharmacologic and pharmacologic pain management techniques can help obstetrician-gynecologists and other obstetric care providers tailor interventions to best meet the needs of each woman.” What it means: This method, which uses a list of questions to determine how well the mom is coping, allows for more personalization of care. Why we love it: Every mom will be treated as an individual rather than all laboring women being treated the same, it may also allow moms to focus on how their bodies are working rather than on the negative aspect of “pain.” What they said: “In the absence of an indication for expeditious delivery, women (particularly those who are nulliparous with epidural analgesia) may be offered a period of rest of 1–2 hours (unless the woman has an urge to bear down sooner) at the onset of the second stage of labor.” What it means: After her cervix has fully dilated, moms who DON’T feel the need to push will be offered a chance to rest for a few hours (laboring down) before trying to push. Why we love it: Since new moms are often exhausted from labor, this gives them a chance to rally/conservr some energy for the next leg of labor. This will also allow moms to work with their bodies’ natural urges rather than try to “force” something to start happening. We want to hear from you! Did your labor & delivery team follow practices like this? Might your delivery have been different if they had? Are you excited to see hospitals implement these recommendations? Additional Resources: Tags: ACOG C-Section Cesarean delivery Healthcare Professionals hospitals labor labor and delivery Maternity Wards pregnancy pregnant moms ACOG Releases Report on Dystocia and Augmentation of Labor The American College of Obstetricians and Gynecologists (ACOG) recently published a clinical practice guideline on dystocia and augmentation of labor. The complete guideline, ACOG Practice Bulletin no. 49, appeared in the December 2003 issue of Obstetrics and Gynecology. The report provides a review of the definition of dystocia, the risk factors associated with dystocia, the criteria that require delivery, and the approaches to clinical management of labor complicated by dystocia. It focuses on labor subsequent to entering the active phase, diagnosis of active-phase abnormalities, clinical considerations, and management recommendations for the active phase and the second stage of labor. Dystocia is characterized by the slow and abnormal progression of labor and is the leading indication for primary cesarean delivery in the United States. Because dystocia rarely can be diagnosed with certainty, the imprecise term “failure to progress” has been used, which includes lack of progressive cervical dilation or lack of descent of the fetal head, or both. Dystocia should not be diagnosed until an adequate trial of labor has been achieved. According to ACOG, a more practical classification is to categorize labor abnormalities as slower-than-normal (protraction disorders) or complete cessation of progress (arrest disorders). In the report, ACOG lists parameters for defining when labor becomes prolonged and intervention should be considered. In nulliparous women, the diagnosis should be considered when the second stage of labor exceeds two hours without regional anesthesia and three hours if anesthesia was used. In multiparous women, the time limit is one hour without anesthesia and two hours if it was administered. A prolonged second stage of labor warrants clinical reassessment of the patient, fetus, and expulsive forces. According to ACOG, risk factors for dystocia include epidural analgesia, occiput posterior position, longer first stage of labor, nulliparity, short maternal stature, birth weight, and high station at complete cervical dilation. Chorioamnionitis, pelvic contractions, and macrosomia also may affect the progression of labor. The guideline includes the following clinical considerations and recommendations: Dystocia cannot be predicted with certainty. According to ACOG, risk factors (see accompanying table) for difficult delivery in nulliparous women in the second stage of labor include short stature (less than 5 ft [150 cm]), age greater than 35 years, gestational age greater than 41 weeks, interval between epidural induction and full cervical dilation for more than than six hours, fetal station above +2 cm at full cervical dilation, or occiput posterior fetal position.Epidural anesthesia is associated with increases in duration of the first and second stages of labor, incidence of fetal malpositions, use of oxytocin, and operative vaginal delivery. Epidural anesthesia was not shown to increase the cesarean delivery rate for dystocia.No evidence supports routine use of intrauterine pressure catheters for labor management. They may be beneficial when the evaluation of contractions is difficult because of obesity, there is a lack of one-on-one nursing care, or response to oxytocin is limited.Walking during labor has not been shown to enhance or impair progress in labor. It is not harmful, and mobility may result in greater comfort and ability to tolerate labor.Not enough evidence is available to support the use of x-ray pelvimetry in patients whose fetuses have cephalic presentations. Additional prospective studies are necessary to establish the usefulness of this diagnostic modality to predict dystocia, so it is not recommended at this time.Continuous support during labor from caregivers (nurses, midwives, or lay persons) has several benefits to the patients and newborns without any evidence of harmful effects.Active management of labor is not associated with unfavorable maternal or neonatal outcomes. It may lead to shortened labor in nulliparous women, but it has not led to a consistent reduction in cesarean deliveries.Current data do not support the theory that doses oxytocin regimens are superior to high-dose regimens for augmentation of labor. Low-dose regimens are associated with less uterine hyperstimulation and lower maximum doses. High-dose regimens may be used for multiparous women, but no data support the use of high-dose oxytocin regimens for augmentation in a patient with a previously scarred uterus.Twin gestation does not preclude the use of oxytocin for labor augmentation. Augmentation is not a significant risk factor for cesarean delivery or adverse outcomes.Amniotomy may enhance progress in the active phase and negate the need for oxytocin augmentation, but it may increase the risk of chorioamnionitis.No definitive evidence has identified the most effective method of fetal heart rate surveillance when oxytocin is used for augmentation. Intermittent auscultation is equivalent to continuous electronic fetal monitoring when performed at specific intervals with a one-to-one nurse-to-patient ratio. No data indicate the optimal frequency for intermittent auscultation in the absence of risk factors.