DELAY IN LABOUR

FIRST STAGE

Latent phase
- Painful contractions
- Some cervical change, including effacement – up to 4 cm dilated

Management of latent phase
- Advise woman that latent phase of labour is normal and that she can choose to remain active or rest
- Eat and drink regularly
- Warm baths, wheat bags, paracetamol 1 g oral 6-hrly and TENS machine may be helpful

First stage
- Regular painful contractions
- Progressive cervical dilatation from 4 cm

Management of first stage
- Inform woman that:
  - length of first stage varies between women
  - first labours last an average of 8 hr and are unlikely to last >18 hr
  - second and subsequent labours last an average of 5 hr and are unlikely to last >12 hr

DELAY IN FIRST STAGE

Assessment of progress
- Include:
  - parity
  - rate of cervical dilatation
  - woman's emotional state

Delay in first stage
- Take into account:
  - cervical dilatation <2 cm in 4 hr in first labours
  - cervical dilatation <2 cm in 4 hr, or slowing in progress of labour for second or subsequent labours
  - descent and rotation of baby's head
  - changes in strength, duration and frequency of uterine contractions

Interventions
- Give support, hydration and appropriate and effective pain relief

Amniotomy
- Advise this will shorten labour by approximately 1 hr but may increase strength and pain of contractions
- Two hours after amniotomy, perform vaginal examination. Delay confirmed if cervix has dilated <1 cm
- Amniotomy alone is not an indication for electronic fetal monitoring (EFM)

Oxytocin
- Once diagnosis of delay made by vaginal examination 2 hr after amniotomy, consider oxytocin
- in a nulliparous woman, after discussion with obstetric team, midwife may start oxytocin
**Delay in labour 2013–15**

**Before commencing oxytocin, obstetric registrar must review parous woman.**
*If previous caesarean section, discuss use of oxytocin with obstetric consultant.*
*Perform at least an abdominal palpation*
*Repeat vaginal examination may also be appropriate*

- Advise woman that oxytocin will increase frequency and strength of contractions and, where anaesthetist available, offer epidural before oxytocin started

**Monitoring**
- Perform vaginal examination 4 hr after commencing oxytocin
- if at least 2 cm progress, repeat vaginal examination 4-hrly
- if <2 cm progress after 4 hr of regular contractions, further review by obstetric medical team and possible caesarean section

**SECOND STAGE**

**Definition**

*Passive second stage*
- Full dilatation of cervix without involuntary, expulsive contractions

*Active second stage*
- Full dilatation of cervix
- Expulsive contractions
- Active maternal effort in absence of expulsive contractions

**DELAY IN SECOND STAGE**

**Assessment of progress**
- Include:
  - maternal behaviour
  - effectiveness of pushing
  - fetal wellbeing
  - fetal position and station
- These factors help determine timing of vaginal examinations and need for obstetric registrar review

**Definition of delay**

*Nulliparous women*
- Active second stage is delayed if baby not delivered after 2 hr

*Parous women*
(Includes multipara women who have had previous caesarean section)
- Active second stage is delayed if baby not delivered after 1 hr

**Management**

*All women*
- In nulliparous women with inadequate contractions at *start* of second stage, consider oxytocin with epidural
- If woman excessively distressed, support, sensitive encouragement and adequate analgesia are particularly important
- Continue epidural top-ups in second stage
- Change position
- Ensure bladder empty
- Perform amniotomy
- If contractions adequate, there is no advantage to starting oxytocin
Delay in labour 2013–15

**Women who have received an epidural**
- Following diagnosis of full dilatation, delay active pushing (active second stage) for 1 hr unless:
  - head visible
  - woman has urge to push
  - concern about fetal wellbeing
  - Oxytocin is not routinely required in second stage

**Nulliparous women**
- Allow up to 1 hr passive second stage (with or without epidural)
- Then, after 1 hr of active second stage, perform a repeat vaginal examination to assess progress. Inform midwife co-ordinator
- in absence of any progress, consider asking obstetric registrar to expedite delivery
- If delivery not occurred in a nulliparous women within 2 hr of start of active second stage, call obstetric registrar. See **Timing of delivery** below

**Parous women**
- Allow up to 1 hr passive second stage (with or without epidural)
- After 1 hr of active second stage, call obstetric registrar – see **Timing of delivery** below

**Monitoring**
- Monitor every 15–30 min until delivery

**TIMING OF DELIVERY**
- Delivery should occur within 3 hr for a nulliparous and within 2 hr for a parous woman of the active second stage

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The time taken to perform a caesarean section or instrumental delivery (especially if a trial in theatre indicated) must be taken into account when timing decision for operative delivery