

Labor Procedures and Interventions

What would your best-case childbirth scenario look like? Chances are, it would go something like this: a manageably short labor, little pain, a few pushes, and then a beautiful baby to welcome into the world. And happily, many labor and deliveries end up pretty close to that scenario (well, except maybe for the little pain part). But sometimes, despite the hopes and plans of expectant women and their health care providers, things don't go quite that smoothly – or naturally. If this happens, your provider may decide an “intervention” is necessary.

A labor intervention is an action taken by your caregiver to identify, prevent, or treat a medical problem. Labor interventions include tests, procedures, and medications. These actions are called “interventions” because your caregiver is “intervening” with the natural progression of your labor.

Sometimes an intervention is the only possible option for your health and for your baby’s health. But many times your doctor will suggest an intervention and give you a choice. That’s why it’s important for you and your labor partner to be familiar with the interventions that are available. If you are informed, you will be able to discuss them with your provider ahead of time and decide your preferences, and you will be more prepared for making decisions about interventions during labor. Also, understanding what these procedures entail takes the mystery and anxiety out of them, which can make undergoing one less unsettling.

If you are presented with an option for an intervention during labor, here is a simple way to remember what questions to ask to help you make your choice. Use your **BRAINN!**

- **B enefits:** What are the benefits of this intervention?
- **R isks:** What are the risks of this intervention?
- **A lternatives:** What are my alternatives to this intervention?
- **I nterventions:** What other “companion interventions” will be required?
- **N ow:** Do I have to have this intervention now? Can I wait a little while to see if my labor progresses?
- **N othing:** What will happen if I do nothing?

Routine IV

In some hospitals it's routine to give all women in labor an IV (a thin flexible tube placed in your vein, usually in your hand or lower arm). The IV is used to drip fluids and medication into your bloodstream. IVs are mostly a precaution to prevent dehydration (since drinking fluids is discouraged during labor), and to save a step later on should an emergency arise that would necessitate medication. But in more and more hospitals these days, routine IVs are no longer the routine, especially if an expectant mom specifies in her birth plan that she wants to avoid one. Instead, the provider will wait until there is a need for an IV to insert one

If you plan to get an epidural, you will have to get an IV. IV fluids are given before the placement of an epidural to reduce the chance of a drop in maternal blood pressure, which is a very common side effect of epidurals. The IV also allows for easier administration of Pitocin should labor need to be augmented, as is sometimes the case following an epidural.

But for many women choosing an unmedicated birth, the placement of an IV isn't a welcome addition. An IV effectively tethers the laboring woman to the bed or a rolling IV pole, limiting her movement, possibly increasing her discomfort, and making it a lot harder to get to the bathroom.

If your practitioner requires a routine IV or if hospital policy dictates that you receive one despite your desire to avoid it, you may be able to compromise. A heparin lock, in which a catheter is placed in the vein and then locked off, is an option that gives hospital staff an open vein should an emergency arise, but doesn't hook you up to that IV pole unnecessarily.

Electronic Fetal Monitoring

Labor is no cakewalk for you – and it isn't for your baby either. During labor, your baby will be squeezed by your strong uterine muscles, then pushed and molded as he or she makes the journey through your narrow pelvis and down the tight birth canal. While most babies weather the storm of childbirth fine, others find the stress of labor too difficult, and respond with a drop in heart rate, rapid or slowed down movement, or other signs of fetal distress.

Periodically assessing how your baby is handling the stresses of labor is important to ensure the safety of your baby. The latest research shows that for low risk, unmedicated deliveries, intermittent fetal heart checks using a Doppler or fetal monitor is an effective way to assess fetal condition. So if you fit in that category, you probably won't have to be attached to a fetal monitor for the entire duration of your labor.

On the other hand, if you're being induced, have opted for an epidural, or have other risk factors at work, chances are you'll be hooked up to an electronic fetal monitor throughout your entire labor. There are two main types of continuous fetal monitoring:

External monitoring: An ultrasound transducer is strapped over your abdomen to pick up the baby's heartbeat. A second detector is strapped to the top of your abdomen to record the frequency and power of your contractions. Both are connected to a monitor, and the measurements are recorded on a paper readout. These two measurements give your provider detailed information about how your baby is handling labor.

Internal monitoring: If your cervix is sufficiently dilated (1 to 3 centimeters), your bag of waters is no longer intact, and more accurate results are required (such as when there is reason to suspect fetal distress), you might be hooked up to an internal monitor. A tiny electrode is inserted through your vagina onto your baby's scalp and a catheter is placed in your uterus or an external pressure gauge is strapped to your abdomen to measure the strength of your contractions. Though internal monitoring gives a slightly more accurate record of the baby's heart rate and your contractions than an external monitor, it's only used when necessary since there is a slight risk of infection.

Labor Induction

There are many reasons a practitioner may decide to induce labor:

- A woman is overdue and there's no sign of action from the uterus.
- The mom has a condition like preeclampsia or diabetes and continuing the pregnancy would be problematic for both her and her baby.
- The baby isn't thriving inside the womb.
- The placenta isn't functioning properly.
- The amniotic fluid is infected or too low or has ruptured and the mom hasn't started having contractions within 24 hours.

The method of used to induce labor is based on how “ripe” the cervix is. If your cervix isn't ripe (i.e. it's not soft, nor dilated, nor effaced), your practitioner will apply a gel or a vaginal suppository with the hormone prostaglandin to your cervix to help it soften, thin, and dilate. Less often, your practitioner may use a device such as a catheter with an inflatable balloon to ripen the cervix.

- If your bag of waters (amniotic sac) is still intact, your practitioner may “strip the membranes” by swiping his or her finger across the fine membranes that connect the amniotic sac to the uterus to release prostaglandin, or break your water to get labor started.
- If neither the prostaglandin gels nor the stripping or rupturing of the membranes has brought on regular contractions, your practitioner will slowly administer intravenous Pitocin, a synthetic form of the hormone oxytocin, until contractions are well established. Contractions brought on by Pitocin are usually stronger, more regular, and more frequent than those of a labor that has begun naturally.
- Your baby will be continuously monitored to assess how he or she is dealing with the stress of induced labor.

Labor Augmentation

Sometimes, active labor starts on its own (you start getting regular, frequent contractions, you rush to the hospital, and find out your cervix is dilated to four centimeters), but then before you know it, your contractions peter out, start coming irregularly and infrequently (or even stopping completely), and your cervix stops dilating. Your labor may be “stalled.” This is a common side effect of getting an epidural: you receive the epidural, and all of a sudden your contractions weaken. Labor augmentation means helping a stalled labor along, and there are several possible methods:

Rupturing of the membranes: If your amniotic sac is still intact, your practitioner may rupture it in an effort to give your sluggish labor a boost.

Pitocin: Another way to get labor back on track is to administer Pitocin, a synthetic form of the hormone oxytocin, via an IV. The amount of Pitocin given will be carefully monitored; you'll get enough only to reinvigorate your contractions.

Nipple stimulation: Unfortunately, this isn't as fun as it sounds, but it could work to give your contractions the extra push they need. You or your partner will massage, twist, tweak, or rub your nipples to stimulate your own natural oxytocin to be produced.

Usually one (or all) of these interventions work well enough to get your labor back on track. But if your stopped labor is too stubborn to move along, you might end up needing a C-section.

Artificial Rupture of Membranes

The amniotic sac has been protecting your baby throughout his or her entire gestation in your womb. But by the time your baby is ready to make his or her appearance into the world, the bag of waters' time has come to an end. Often the contractions of active labor will provide enough pressure to rupture the membranes on their own (about 15 percent of women break their waters before any contractions at all), but other times your provider may opt to rupture them artificially:

- To augment a labor that has stalled
- To induce labor
- To allow for internal monitoring of the baby
- To allow for a forceps or vacuum assisted delivery
- To see whether your baby has passed meconium (the first bowel movement), which may be a sign of fetal distress

Luckily, you won't feel much if anything at all when your membranes are ruptured, especially if you're already in labor. Your practitioner will insert into your vagina an amniohook, a long plastic device that looks like a crochet needle with a sharp point at the end, and will puncture a hole in the amniotic sac. You may notice a gush of water after the rupture and usually your contractions will start coming stronger and faster after the procedure.

Episiotomy

An episiotomy is a surgical cut in your perineum (the muscular area between your vagina and your anus) right before delivery to enlarge your baby's exit. Historically, episiotomies were performed routinely to prevent tearing of the perineum and to reduce the risk of fetal birth trauma, but these days it is recognized that laboring women who tear spontaneously during delivery recover in the same (or less) time and often with less pain and with fewer complications than those with episiotomies. What's more, research has shown that episiotomies are more likely than spontaneous tears to turn into serious third- or fourth-degree tears. Finally, studies also show that infants fare just as well without an episiotomy. The American College of Obstetricians and Gynecologists now recommends that episiotomies not be performed routinely.

Still, there are situations in which you might need an episiotomy, either for your well-being or that of your baby:

- When your baby is very large and needs a roomier exit route
- When forceps or vacuum extraction needs to be used
- When your baby's shoulder gets stuck in the birth canal during delivery
- When your baby's heart rate during the last minutes of labor shows he or she's in fetal distress and needs to be born right away

If you do need an episiotomy, you'll get an injection of local pain relief before the cut. Your practitioner will then take surgical scissors and make either a median incision (a cut made directly back toward the rectum) or a mediolateral incision (which slants away from the rectum). After delivery of your baby and the placenta, the practitioner will stitch up the cut.

You can reduce the possibility of needing an episiotomy by:

- Doing Kegel exercises throughout your pregnancy
- Doing perineal massage for six to eight weeks before your due date
- Placing (or having your doula, support person, or nurse place) a warm compress on your perineum during labor to soften the skin in the area, enabling it to better stretch
- Standing or squatting while pushing the baby out
- Pushing for only five to seven seconds at a time, bearing down gently, instead of pushing hard for ten seconds while holding your breath
- Asking your practitioner to apply gentle counterpressure to your perineum as the baby's head emerges so that the perineum has time to stretch slowly

Forceps

Forceps, a device that resembles a long pair of metal spoons or salad tongs, are used to help the baby make his or her descent down the birth canal to be born if he or she's having trouble. Forceps are used much less often these days than vacuum extraction, but your doctor may decide to use forceps:

- To help your baby out if your uterus is not contracting well enough to push the baby down
- If your baby needs to be delivered in a hurry because of fetal distress
- If your baby is in an unfavorable position during the pushing stage (the forceps can be used to rotate the baby's head so he or she can be born more easily)
- If your baby gets stuck in the birth canal
- To protect the baby's head if he or she is premature or in a breech position
- When a mother can't push well or at all (as from exhaustion or if the mother has a heart condition or very high blood pressure and pushing would be detrimental to her health)

Forceps are inserted one at a time, locked into position around the baby's head, and then used gently to pull the baby out of the birth canal. There may be some bruising or swelling on the baby's scalp from the forceps, but it will usually go away within a few days after birth. In fact, studies show that when forceps are used correctly by an experienced practitioner, the risks to the baby and to the mother are low.

Before the forceps are applied to the baby's head, you'll be numbed with a local anesthetic (unless you already have an epidural in place). You'll also likely receive an episiotomy to enlarge the vaginal opening to allow for the placement of the forceps. If your practitioner attempts delivery with forceps, but the attempt is unsuccessful, you'll likely undergo a C-section.

Vacuum Extraction

An alternative to forceps delivery is a vacuum extractor, which is a metal or plastic cup attached to the baby's head that uses suction to help guide him or her out of the birth canal. The vacuum extractor prevents the baby's head from moving back up the birth canal between contractions and can be used to assist the mother while she is pushing during contractions. Vacuum extraction is becoming more popular in obstetrical practices and offers a good alternative to both forceps and C-section under the right circumstances.

The indications for vacuum extraction are the same as forceps; and while both are safe if performed by experienced practitioners, vacuum deliveries are associated with less trauma to the vagina (and possibly a lower chance of needing an episiotomy) and less need for anesthesia. Babies born with vacuum extraction may experience some swelling on the scalp, but it is not serious, doesn't require treatment, and usually goes away within a few days. As with forceps, if the vacuum extractor isn't working successfully to help deliver the baby, a cesarean birth is recommended.