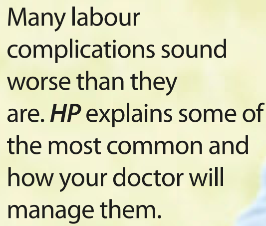

Many labour complications sound worse than they are. ***HP*** explains some of the most common and how your doctor will manage them.

WORDS **JOANNA ONG**

Complications in Labour

Your due date has arrived and excitement is mounting up! We all know that giving birth rarely happens like it does on movies: Your water breaks; you gasp and exclaim, "He's coming!" Then, a few seconds later, you cradle your chubby newborn as your handsome husband looks on. Nevertheless, we hope your experience isn't going to be traumatic either: A swarm of doctors sprinting into the delivery room, shouting, "Get her ready for emergency C-sect! And the NICU team! Baby is in foetal distress!". More than likely, labour and delivery will be somewhere between the two scenarios. However, problems may sometimes develop suddenly and unexpectedly and it is good to be informed. Serious problems are relatively rare, and most can be anticipated and treated effectively by your doctor.

Here are a few of the most common labour complications and how your doctor will manage them.

Foetal Distress

According to Dr Ann Tan, OBGYN at Women Fertility & Fetal Centre in Mount Elizabeth Medical Centre, during the labour, when there is low volume of amniotic fluid or when the umbilical cord is being compressed repeatedly during the process of labour, the foetal heart rate will slow due to the decrease in oxygen that the baby is receiving. This can be observed by abnormal heart rate patterns detected on the CTG (cardiotocography) which is used to monitor foetal well-being during labour. These decelerations are common when the baby is coming down through the pelvis and out of the mother's body. However, if these decelerations occur over a prolonged period and the delivery is not imminent, this heart beat irregularities could be detrimental to the baby's well-being and delivery would commonly need to be expedited.

Another evidence for potential foetal distress is the presence of meconium (baby's stool) in the liquid. When the amniotic fluid is green in colour, this implies that the baby has passed motion within the uterus. Dr Christopher Ng, OBGYN at GynaeMD Women's & Rejuvenation Clinic at Camden Medical Centre adds that if the cervical os (entrance to the cervix leading into the cervical canal and uterine cavity) is fully dilated and imminent delivery is possible, vacuum or forceps assisted vaginal delivery can be attempted. Failing which an emergency caesarean section should be performed.

Abnormal Foetal Lie in Labour

Occasionally, even though the baby's head appears to be at the lower abdominal region in the late stage of the pregnancy, at the time of labour, the baby could still have turned especially if the baby's head is "unengaged", Dr Tan describes. If the baby is present in the oblique lie (the baby's body and head are diagonally down but not vertical or horizontal) in an established labour, then this a situation which calls for an emergency caesarean section. If it is a breech presentation (bottom's down), most obstetricians would prefer to do a caesarean section unless the breech is already descending into the pelvis and an easy vaginal birth can be anticipated. However, as vaginal breech delivery is considered more dangerous than a caesarean birth, most patients would opt for a caesarean section.

Cephalopelvic Disproportion (CPD)

This is the result of the foetal head being too big to pass through the mother's birth canal, Dr Ng states. This may then result in prolong labour, foetal distress and failure to progress in which the cervix fails to dilate any further despite optimal

Did you know?
An epidural is sometimes given to help labour along.

uterine contractions. It occurs in 0.4 per cent of births. The risk factors include large babies, small maternal pelvis, abnormal maternal pelvis, abnormal foetal positions, postdate deliveries and mothers with poorly controlled gestational diabetes resulting in overweight babies. An emergency caesarean section should be performed.

Shoulder Dystocia

According to Dr Ng, this can also occur when the baby's head safely passes out through the vagina but one of the shoulders is stuck behind the pubic bone of the mother. This is more likely to happen if the baby's weight is above average. This occurs in 0.7 per cent of births. Certain emergency manoeuvres will need to be performed in order to dislodge the stuck shoulder and to deliver the baby vaginally. 10 per cent of babies who have shoulder dystocia will have some over-stretching of the nerves in the neck resulting in brachial plexus injury, which may lead to loss of movement to the arm. This is usually temporary and rarely permanent. Unfortunately, other babies may fracture their arms or shoulder and a paediatrician needs to attend to these babies immediately.

Obstructed Labour

During the progress of labour, regular vaginal examination helps determine how a woman's labour is progressing by assessing the cervical dilation. During active labour, the cervix should dilate 1 cm per hour and the uterine contractions should be optimally at approximately one every two to three minutes in frequency. The baby's head should be felt to drop deeper into the pelvis and this is described as the station of the foetal head. Dr Tan explains that should there be a situation where the cervix stops dilating despite adequate contractions and/or there is no descent of the baby's head, this is called obstructed labour or secondary arrest in labour. In this situation, if the foetus is handling the labour well and the uterine contractions are deemed to be less than adequate, adding medications to increase the power of the contractions may be considered. Sometimes ensuring adequate pain relief especially in the form of epidural analgesia may seem to help. However, if the contractions are already very strong and all other assistance have been given, then the obstetrician will have to perform an emergency caesarean section to deliver the baby.

3rd / 4th Degree Vaginal Tear

A 3rd degree tear is from the vaginal down to the anal sphincter and a 4th degree tear extends from the vagina all the way into the anus or rectum, Dr Ng explains. They occur as a result of traumatic tears following difficult vaginal births. The risk is higher in primips (first time delivery), instrumental vaginal assisted deliveries, birth of above average size babies and shoulder dystocia. Besides discomfort, women may develop

A word of advice
It is important to keep calm and trust your obstetrician and midwives should any complication arise during your delivery.

faecal incontinence and this is usually temporary until healing is complete. In severe cases, an anovaginal or rectovaginal fistula (abnormal connection between vagina and anus or rectum respectively) may develop if healing is poor. A good episiotomy repair can prevent this. Women are given ice packs to reduce the swelling and stool softeners to reduce excessive straining when passing motion along with antibiotics to prevent secondary infections.

Post-partum Haemorrhage (PPH)

Post-partum haemorrhage is excessive loss of blood of more than 500 ml after delivery. Up to 5 per cent of women will experience PPH, Dr Tan states. There is Primary or Immediate PPH which occurs at the time of the birth or within 24 hours. Secondary or delayed PPH is bleeding that occurs after the first 24 hours or up to six weeks of post-delivery. Secondary PPH is commonly associated with similar issues of primary PPH as well as a possibility of retained placenta or membranes. Primary PPH occurs following a prolonged labour and usually of bigger babies. It can also happen to a mother who has had three or more deliveries, multiple pregnancies, when there is an infection or when there is sudden separation of the placenta. Dr Ng adds that in the event of PPH, intravenous (IV) or intramuscular (IM) injections (to the muscle) of medication can be given to contract the uterus rapidly. Blood transfusions may also be required to prevent shock.

Retained Placenta

For the majority of women, the placenta spontaneously expels itself within 30 minutes. If the whole placenta or parts of it fail to do so, this is called retained placenta which can lead to life threatening haemorrhage (PPH) and infections. Once recognised, a manual removal of the placenta (MRP manoeuvre) can be performed in the labour ward or in operating theatre with antibiotic cover, Dr Ng explains. He further adds that by recognising the risk factors and anticipating the dangers, certain measures can be taken to prevent these labour complications from happening, for example in the case of potential PPH, IM/IV medications can be administered prophylactically to prevent PPH from occurring. In the case of potential retained placenta, IM/IV medications can also be administered to help expel the placenta along with controlled cord traction manoeuvre to deliver the placenta completely.

It is important to keep calm and trust your obstetrician and midwives should any of these events happen to you. Everyone has the best intentions towards you and your baby, advises Dr Tan. You should be kept informed of what's happening but in the state of emergency, trust is highly important and lengthy explanations may not always be possible in acute emergencies. Here's wishing you a safe and speedy delivery!