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Abnormal Labour and Obstetrical Interventions

Midwifery & Obstetrical Nursing

Prolonged labour, obstructed labour, malpresentation, malposition, breech presentation, shoulder dystocia, induction and augmentation of labour, assisted vaginal birth and caesarean section.

For educational purposes only.

CHAPTER 16 / MIDWIFERY AND OBSTETRICAL NURSING 16. Abnormal Labour and Obstetrical Interventions

1. Abnormal labour concepts

Prolonged labour means progress longer/slower than expected in clinical context; obstructed labour means mechanical inability of presenting part to descend despite contractions. Causes include ineffective powers, cephalopelvic disproportion, malpresentation/malposition and fetal or pelvic factors. Assess maternal exhaustion, pain, contraction pattern, descent/dilatation, fetal well-being, membranes and signs of rupture/infection. Avoid rigid time-only decision; obstruction/fetal compromise requires immediate review.

Malpresentation and malposition

Definition and pathophysiology: Non-vertex presentation (breech, shoulder/transverse, face/brow) or unfavourable vertex position (e.g., persistent occiput posterior).

Clinical features and investigations: Abdominal/authorized vaginal exam and ultrasound as needed; possible poor progress, cord prolapse or fetal compromise.

Management and nursing care: Specialist assessment for external cephalic version, suitable assisted vaginal birth or caesarean depending condition. No forceful manipulation; monitor fetal/maternal status and prepare appropriate facility.

Breech and shoulder dystocia

Definition and pathophysiology: Breech presents buttocks/feet; shoulder dystocia occurs after head birth when shoulders impacted.

Clinical features and investigations: Breech identified before labour; dystocia is sudden obstetric emergency.

Management and nursing care: Planned mode of birth by trained team according to eligibility; for dystocia call help, document head/body times, trained manoeuvres per protocol, no fundal pressure/excessive traction; newborn/maternal injury assessment.

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Induction and augmentation

Definition and pathophysiology: Induction initiates labour before spontaneous onset; augmentation strengthens inadequate labour after onset. Methods may include cervical ripening, amniotomy or oxytocin.

Clinical features and investigations: Assess indication, gestation, cervix/Bishop score, fetal lie/status, scar and contraindications to vaginal birth.

Management and nursing care: Obtain consent, verify regimen and infusion pump, continuous/appropriate

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monitoring with oxytocin, assess contractions and FHR. Excessive contractions or abnormal FHR require immediate protocol actions and escalation. Do not augment suspected obstruction.

Assisted vaginal birth

Definition and pathophysiology: Vacuum or forceps used by trained clinician for selected indications when prerequisites met.

Clinical features and investigations: Full dilatation, known presentation/position, engaged head and other prerequisites as determined clinically.

Management and nursing care: Prepare consent, analgesia, bladder care, fetal monitoring, backup surgical/newborn team; postbirth assess maternal trauma, bleeding and neonatal scalp/head injury.

Caesarean section

Definition and pathophysiology: Surgical birth via abdominal/uterine incisions for indicated maternal/fetal circumstances.

Clinical features and investigations: Planned or emergency; assess indication and surgical/anaesthetic preparation.

Management and nursing care: Verify identity/consent, checklist, prescribed antibiotics/VTE measures, readiness. Postoperative airway, bleeding, pain, wound, urine, mobility, breastfeeding and maternal/newborn contact; future birth counselling.

2. Other emergencies

Cord prolapse: palpable/visible cord or sudden fetal bradycardia after membrane rupture; call help, relieve pressure by trained protocol, minimize cord handling and prepare urgent birth. Suspected uterine rupture: severe pain, fetal heart abnormality, haemorrhage/shock or loss of station; emergency surgical response. Document clearly, maintain maternal stabilization and transport readiness.

3. Important Examination Questions

Long Answer Questions

1. 1. Discuss abnormal labour, induction/augmentation and caesarean nursing care.

Short Answer Questions

1. 1. Define obstructed labour
2. 2. describe assisted vaginal birth prerequisites and shoulder dystocia precautions.

Very Short Answer Questions (with answers)

1. 1. What is Bishop score used for? - Cervical favourability assessment before induction.
2. 2. Can oxytocin be used routinely in mechanical obstruction? - No.

4. Quick Revision

- Assess cause of abnormal progress.

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- Oxytocin needs uterine/fetal monitoring.
- Obstetric interventions require trained teams.

5. Conclusion

Assess cause of abnormal progress. Oxytocin needs uterine/fetal monitoring. Obstetric interventions require trained teams.

Practice questions

Choose one best answer. The answer key and explanations follow the questions.

1. How does augmentation differ from induction?

A. Augmentation strengthens inadequate labour after it has begun
B. Augmentation initiates labour before spontaneous onset
C. Augmentation suppresses contractions to delay birth
D. Augmentation only assesses cervical favourability

2. Which definition describes obstructed labour?

A. Any labour slower than one centimetre per hour
B. Mechanical inability of the presenting part to descend despite contractions
C. Irregular contractions without cervical change
D. A normal variation in latent-phase duration alone

3. Which finding after membrane rupture should raise concern for cord prolapse?

A. A steady fetal rate with progressive descent
B. Clear fluid alone with stable observations
C. Sudden fetal bradycardia or a visible or palpable cord
D. Normal maternal pulse without fetal changes

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Answer key and explanations

1. A - Augmentation strengthens inadequate labour after it has begun

Induction initiates labour; augmentation strengthens labour already underway.

2. B - Mechanical inability of the presenting part to descend despite contractions

Obstructed labour involves a mechanical barrier to descent.

3. C - Sudden fetal bradycardia or a visible or palpable cord

Cord prolapse may present as a visible or palpable cord or sudden fetal bradycardia.

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