SUNDHEDSSTYRELSEN

National clinical guideline concerning primiparous women with dystocia (lack of progress)

Quick guide

Indication for oxytocin augmentataion of labour, the active stage of first stage

Consider oxytocin augmentation within an hour after diagnosing dystocia in the active phase of the first stage, if the membranes have ruptured and there are <5 contractions in 10 minutes.

Week recomendation

Updating the recommendation is not considered necessary in 2017

It is good practice to review the progress with an experienced colleague in case of suspected dystocia in the active phase.

In case of dystocia in the active phase, it is good practice – if the membranes have not ruptured – to perform amniotomy and await progress for another 1-2 hours before deciding whether to initiate oxytocin augmentation.

Pratice statement

Updating the recommendation is not considered necessary in 2017

Experienced colleague means, e.g., a senior staff midwife or a doctor, depending on the local conditions.
A review of the progress includes, among other things, assessing the following (cf. the childbirth checklist and the labour augmentation drip package of the Danish safe childbirth ('Sikre Fødsler') project (5)):

- Fetal heart rate, including indication for CTG
- The perspective of the parturient woman**
- Risk factors • Presence of mechanical mismatch (cephalopelvic disproportion)
- Descent and rotation of the fetal head
- Rupture of mebranes
- Pattern of contractions
- Cervical progress (assessed, e.g., by means of a partogram).

Prior to diagnosing dystocia review the situation carefully when the cervix has only dilated to 4-6 cm.

**Perspective of the parturient means: preferences, need for pain relief and physical and mental condition.

Indication for oxytocin augmentataion of labour, the second stage

It is good practice to review the progress with an experienced colleague in case of suspected dystocia in the descending phase.

It is good practice to review the progress with an experienced colleague in case of suspected dystocia in the expulsive phase – after 1 hour at the latest.

It is good practice to consider oxytocin augmentation in the second stage in case of dystocia and <5 contractions in 10 minutes.

It is good practice to consider forced delivery (caesarean section or instrumental vaginal delivery) when the expulsive phase has lasted 2 hours. Forced delivery should be considered earlier if the parturient woman so desires or if the estimated duration of the expulsive phase exceeds 2 hours.

Pratice statement

Updating the recommendation is not considered necessary in 2017

Experienced colleague means, e.g., a senior staff midwife or a doctor, depending on the local conditions.

A review of the progress includes, among other items, to assess the following (cf. the childbirth checklist and the labour augmentation drip package of the Danish safe childbirth ('Sikre Fødsler') project (5)):

- Fetal heart rate, including indication for CTG
- The perspective of the parturient woman
- Risk factors
- Presence of mechanical mismatch (cephalopelvic disproportion)
- Descent and rotation of the fetal head
- Ruptured membranes
- Pattern of contractions
- Cervical progress (assessed, e.g., by means of a partogram)
- Micturition/bladder emptying.

Perspective of the parturient woman means preferences, need of pain relief and physical and mental condition.

Dosage regimes for oxytocin

When initiating oxytocin augmentation, consider a starting dosage of 3.3 mU/min = 20 ml/h when using a solution of 10 IU of oxytocin in 1,000 ml of isotonic sodium chloride solution for infusion.

Week recommendation

Updating the recommendation is not considered necessary in 2017

In case of satisfactory progress at <5 contractions in 10 minutes, further increase of the infusion rate is not indicated.

Prior to initiating oxytocin augmentation, the checklist in the labour augmentation drip package of the safe childbirth ('Sikre Fødsler') project should be reviewed (5).

It is good practice to increase the dose with 3.3 mU/min = 20 ml/h every 20 minutes until reaching a maximum of 5 contractions in 10 minutes.

It is not good practice to let the dosage exceed 180 ml/h = 30 mU/min.*

Pratice statement

Updating the recommendation is not considered necessary in 2017

The assessment report for Syntocinon® indicates a maximum infusion rate of 120 ml/h (20 milliunits/min, 40 drops/min), but also mentions that a higher rate may be needed on rare occasions (6). From clinical experience and the literature review, the working group finds that it may be relevant to increase the infusion rate up to 180 ml/h for special cases and based on a professional judgment, provided the foetal heart rate is normal and the frequency of contractions does not exceed 5 in 10 minutes. The indication for increasing the infusion rate must always be recorded.

Second-stage dystocia in parturients with an epidural

It is good practice to allow the same duration of the descending phase in primiparous women with and without an epidural.

Pratice statement

Updating the recommendation is not considered necessary in 2017

In case of dystocia in parturients with an epidural, other possible reasons for slow progress should always be considered.

Non-medicinal options, intravenous fluid therapy

Consider offering intravenous therapy using isotonic Ringer's lactate as an addon to free oral fluid intake in case of suspected dehydration or slow progress (i.e., without waiting for 4 hours and before the criteria for dystocia have been met).

Week recommendation

Updating the recommendation is not considered necessary in 2017

The parturient's fluid balance should be assessed (intake, vomiting and micturition) in case of slow progress of labour.

It is important to ensure that any intravenous fluid offered to the parturient is an isotonic electrolyte solution (such as isotonic Ringer's lactate).

Until additional documentation indicates otherwise, the working group suggests to use an infusion rate of 125-250 ml/h upon assessing the parturient woman's fluid balance.

In a woman with an epidural, special attention should be paid to bladder emptying if she is receiving intravenous fluid.

Non-medicinal options, accupuncture

Acupuncture should only be used as an intervention in case of dystocia upon due consideration. The available evidence neither demonstrates beneficial nor adverse effects.

Week recomendation against

Updating the recommendation is not considered necessary in 2017

Use of acupuncture in case of dystocia should be documented for quality follow-up describing group of patients and beneficial and adverse effects.

The diagnosis code for acupuncture used in case of uterine inertia is BKXA31.

It is not good practice to delay relevant options such as amniotomy and oxytocin augmentation in favour of acupuncture.

It is good practice to inform the parturient about the lack of scientific documentation for beneficial as well as for adverse effects from the use of acupuncture in case of dystocia.

Pratice statement

Updating the recommendation is not considered necessary in 2017

Non-medicinal options, rebozo

Due to the lack of evidence of the beneficial and/or adverse effects of the intervention, the DHMA gives neither a recommendsation for or against rebozo.

If rebozo is offered, it is good practice to document the use for quality follow-up.

When offering rebozo, it is good practice to inform the parturient woman that the effects of the treatment and potential adverse effects are undocumented.

Updating is not considered necessary in 2017

The diagnosis code for rebozo iis BKXA9A

Non-medicinal options, amniotomy

In case of dystocia in the active phase of the first stage (the dilatation phase), it is good practice to perform amniotomy and await progress for another 1-2 hours before initiating oxytocin augmentation.

In case of dystocia in the descending phase, it is good practice to perform amniotomy and await progress for 1 hour before initiating oxytocin augmentation.

In case of dystocia in the expulsive phase, it is good practice to perform amniotomy and await progress for 20 minutes before initiating oxytocin augmentation.

Pratice statement

Updating the recommendation is not considered necessary in 2017

An individual assessment of the risk factors for umbilical cord prolapse (unengaged or high fetal head, polyhydramnois) should be carried out prior to performing amniotomy.

In case of prolonged rupture of membranes, the parturient should be observed for signs of infection according to applicable local guidelines.

Duration of oxytocin augmentation of labour

It is good practice that the midwife responsible for the childbirth reviews the progress after 4 hours of oxytocin augmentation in the active phase of the first stage (the dilatation phase).

In case of a cervical dilatation of <2 cm after 4 hours of oxytocin augmentation, it is good practice to review the progress with an experienced colleague.

It is good practice to consider an additional 2 hours of oxytocin augmentation if a satisfactory pattern of contractions (a maximum of 5 contractions in 10 minutes) has not been reached within 4 hours.

Pratice statement

Updating the recommendation is not considered necessary in 2017

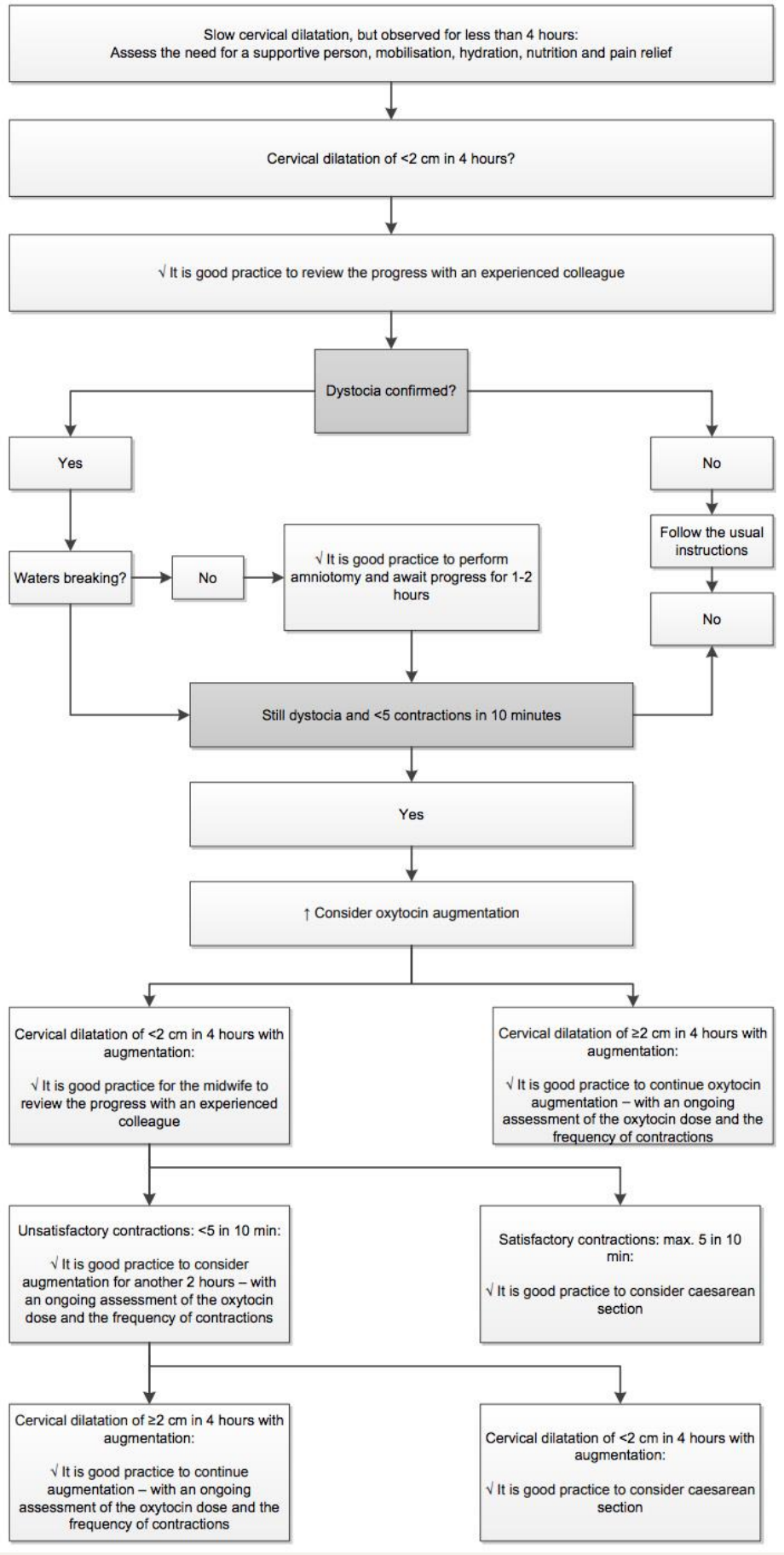
Experienced colleague means, e.g., a senior staff midwife or a doctor, depending on the local conditions.

A review of the progress includes, among other things, assessing the following (cf. the childbirth checklist and the

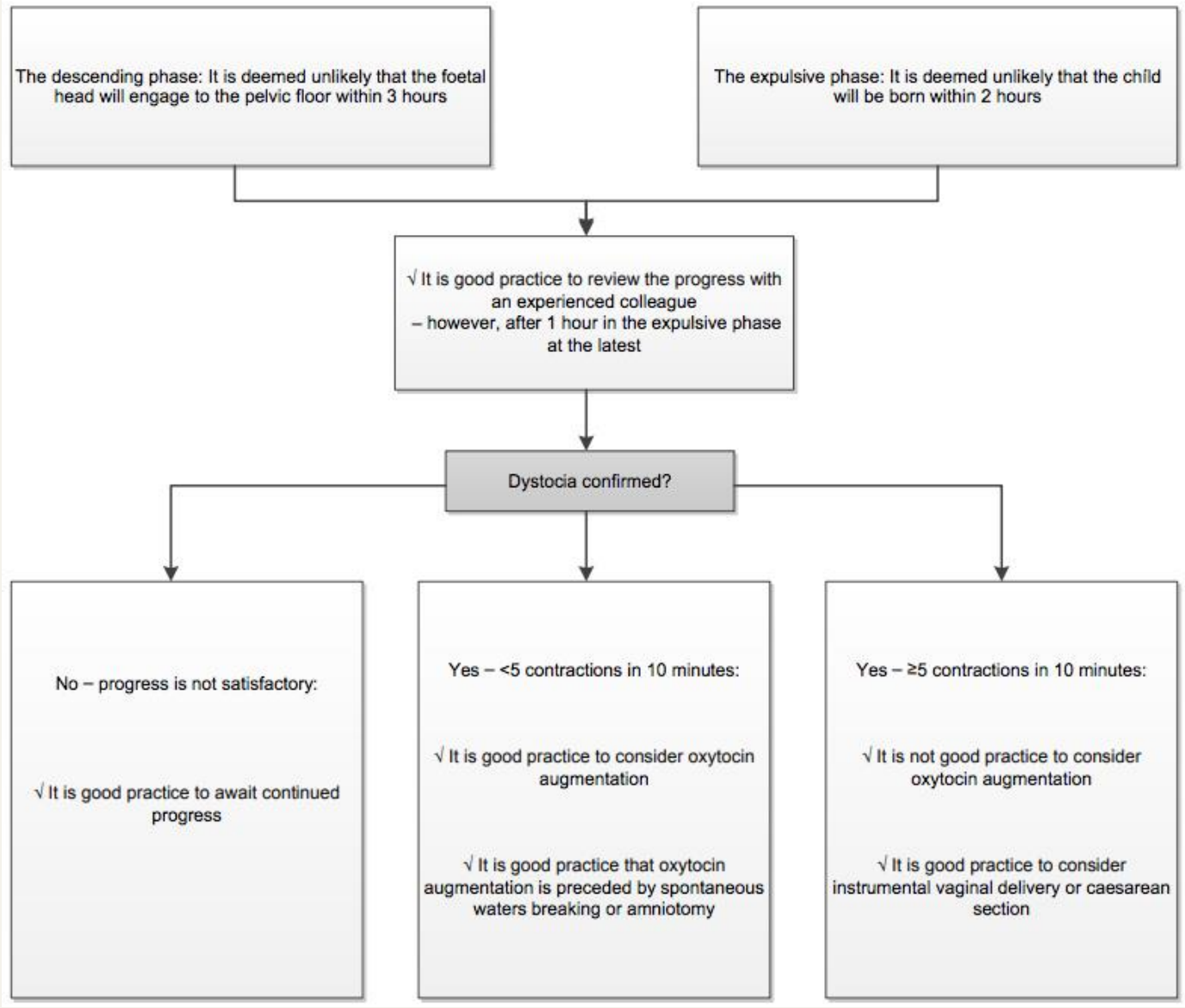
labour augmentation drip package of the Danish safe childbirth ('Sikre Fødsler') project (5)):

- Fetal heart rate, including indication for CTG
- The perspective of the parturient woman
- Risk factors
- Presence of mechanical mismatch (cephalopelvic disproportion)
- Descent and rotation of the fetal head • Rupture of membranes
- Pattern of contractions • Cervical progress (assessed, e.g., by means of a partogram)
- Perspective of the parturient means preferences, need of pain relief and physical and mental condition.

Flowchart for dystocia in the active phase of the first stage



Flowchart for dystocia in the second stage of labour



About the quick guide

The quick guide contains the key recommendations of the national clinical guideline concerning primiparous women with Dystocia (Lack of Progress).

The guideline has been prepared within the framework of the Danish Health and Medicines Authority.

The focus of the national clinical guideline on primiparous women with dystocia (lack of progress) is the indication and administration of oxytocin for augmentation of labour and on selected non-medicinal options that potentially can be used to prevent and treat dystocia.

Definition of dystocia:

In this guideline, dystocia in primiparous women with a fetus in cephalic presentation is defined as follows:

The active phase of the first stage (the dilatation phase):

• Cervical dilatation of < 2 cm assessed over 4 hours.

The descending phase:

• When deemed unlikely that the leading part of the fetus will engage to reach the pelvic floor within 3 hours after the start of the descending phase.

The expulsive phase:

• When deemed unlikely that the child will be born within 2 hours after the start of the expulsive phase.

Recent research indicates that the active phase may not start until the cervix has dilated to 6 cm (1-4). Therefore, evaluate the situation carefully prior to diagnosing dystocia when the cervix has only dilated to 4-6 cm.

The national clinical guideline contains recommendations for selected parts of the clinical pathway. It should not stand alone but should be seen in conjunction with local protocols and other guidelines etc. on the topic.

Supplementary material on sundhedsstyrelsen.dk

On www.sst.dk you can find the national clinical guideline in full (in Danish), including a detailed review of the underlying evidence for the recommendations.

About the national clinical guidelines

The national clinical guideline is one of 50 national clinical guidelines (NKR), which were developed under the framework of the Health and Medicines Authority in the period 2013-2016. In 2017-2020 the national clinical guidelines were assessed for need for updating.

Further information (in Danish) about topic selection, methods and process can be found on www.sst.dk.