

Intrapartum – Labor

Pelvic anatomy

Want broad pubic arch, curved sacrum, blunt ischial spines, and moveable coccyx

True pelvis – fetus must pass through this

pelvic inlet – from sacral promontory to top of pubic symphysis

pelvic outlet – from bottom of sacrum to bottom of pubic symphysis

Ischial spines = ground zero in staging fetus

Diameters:

Pelvic inlet:

True conjugate = anterior/posterior diameter – from sacral promontory to top of pubic symphysis

Pelvic outlet:

Diagonal conjugate – from sacral promontory to bottom of pubic symphysis

Transverse – from ischial tuberosity to ischial tuberosity

Attitudes - Relationships of fetal parts to each other

Lie – Relationship of long axis of fetus to long axis of mother

Longitudinal or vertical

Presentation – the body part of fetus that engages in true pelvis

Cephalic: vertex, brow, face

Breech: frank (hips flexed, knees extended, butt engaged), complete (knees & hips flexed, butt engaged), single or double footling (1 or both feet folded under buttocks at pelvic inlet)

Shoulder: C-section would be needed

Position – relationship of presenting parts to mom's pelvic quadrants.

Letters:

1st: R or L = mom's right or left

2nd: O (occiput), M (mentum – chin), S (sacrum) - fetal part

3rd: A, P, or T = mom's anterior, posterior, or transverse (side)

Ex: ROA = fetal head is presenting with occiput facing forward on mom's right

Station – relationship between presenting part & ischial spines

Floating – fetal parts above true pelvic inlet

Engaged – suboccipitobregmatic diameter fixed in pelvic inlet

Station 0 = presenting part at level of ischial spines this is why the ischial spine are important

Stations -1, -2, -3 are cm above ischial spines

Stations +1, +2, +3 are below ischial spines

Changes Before Labor

Lightening – fetus drops into true pelvis so mom can breathe better

Braxton-Hicks contractions – practice labor that doesn't progress

Increased vaginal secretions

Cervical ripening (softens)

Rupture of Membranes (ROM) – Now mom's risk of infection is high. Check with nitrazine paper

(turns dark blue because fluid is alkaline)

Bloody show – loss of mucus plug in cervix

The Process of Labor

Contractions increase in frequency, strength, & duration
 Effacement – thinning of cervix
 Progressive dilation of cervix

Stages of Labor

First Stage

Latent Phase – cervix dilates 0 – 3 cm; mom happy
 Active Phase – cervix dilates 4 – 7 cm; contractions 5 min apart; Keep mom relaxed & comfortable
 Transition Phase – cervix dilated 7 – 10 cm; contractions strong & 1 – 2 min apart; mom irritable

Second Stage Starts when the cervix is dilated to ten and fully effaced

Expulsion of infant
 Perineum bulges; may have bowel movement
 Mom focused

Third Stage

Expulsion of placenta (afterbirth)
 Occurs within 30 minutes of birth
 Check “dirty Duncan” or “shiny Shultz”

Fourth Stage

1 – 2 hours post partum
 Fundus firm at umbilicus
 Lochia rubra
 Mom tired, thirsty, chilled, may be nauseous

Watch Outs During Labor

Mom:

Supine hypotension
 Hyperventilation
 Hemorrhage - bright red bleeding
 Increased pulse rate or elevated temperature → = infection?
 Uterine tetany – If mom is on an oxytocin drip, stop it ASAP!
 Uterine atony → hemorrhage
 Bladder distention → hemorrhage

Fetus/Infant:

Fetal heart rate (FHR) should be 120 – 160 bpm
 Early deceleration – early in contraction – 100 bpm = head compression, normal → no worries
 Late decelerations – after peak of contraction – 60 - 100 bpm = uteroplacental insufficiency = bad
 Variable decelerations – changes in duration, intensity, & time = cord compression = bad
 Meconium-stained amniotic fluid – indicated fetal distress; check vocal folds for aspiration

Normal Postpartum

Normal Psych of 1st 2 – 3 days:

Taking in phase – ponder new role as mom, but self-focused; not into taking care of baby
 Taking hold phase – mom begins to start doing for herself & new baby

Letting go phase – New mom redefines new role, accepting reality of baby & her being the mom
Post-partum Blues

Assessments

Uterus

Involution stages:

1st hour post delivery: fundus at level of umbilicus where stays for 24 hours

Decreases 1 cm per day --> by 10 day postpartum into pelvis so can't palpate

Must have empty bladder when measure as bladder keeps uterus from contracting

Delay of uterine involution by: multiparity, prolonged labor, multiple fetuses, hydramnios, full bladder

Lochia

Lochia rubra – red – day 1 – 3

Lochia serosa – pink/brown – days 3 – 10

Lochia alba – creamy white – days 10 – 14

Perineum

Episiotomy Hemorrhoids

Breasts

Colostrum – start secreting mid-way through pregnancy; secrete 1st 2 days postpartum

Oxytocin release during suckling --> helps uterine involution

Breast-feeding versus Not Breast feeding

Circulation

Orthostatic Hypotension

Thrombus formation

Rh Sensitivity – RhoGAM

Urinary

Urinary Output increases – massive shift of excess fluid (up to 3L/day) out so that by 1st or 2nd week post partum have normal blood volume

Diaphoresis adds to rapid loss of fluid