

Common Variations in Labor and Birth

Pre-term Labor

What is it? Onset of rhythmic contractions that produce cervical dilation before 37 full weeks of gestation.

How common is it? 6-10% of births are premature.

Why is it a problem? Although modern medicine has greatly improved the survival rates of premature babies, they do have more health complications than term babies.

What increases my risk of pre-term labor? Lack of prenatal care, multiple fetuses, age under 16 or over 40, obesity or very low weight, cigarette smoking, alcohol or drug abuse, maternal medical illness, high blood pressure, strenuous physical work, unusual emotional stress or anxiety, current infection of vagina or urinary tract.

What can you do about it? Consult with caregiver. Drink several glasses of water, bed rest on your left side, avoid nipple stimulation and sexual activity.

What can your caregiver do? Prior to 37 weeks, they might suture cervix closed, recommend bedrest, or give medication to stop or slow labor. After 37 weeks, usually labor will be allowed to progress; caregiver may recommend amniocentesis to determine lung maturity, or may recommend birthing in a hospital with a newborn intensive care unit.

Post-date Pregnancy

What is it? A pregnancy lasting 42 or more weeks from the start of the last menstrual period. (see handout on How accurate is your due date; under misc.)

How common is it? 4-14% of pregnancies.

Why is it a problem? Going past the due date can carry these risks: the placenta may become less able to provide baby with enough oxygen and nutrients, chance of a pinched umbilical cord increases as amount of amniotic fluid decreases, higher possibility of fetal distress, higher chance of baby inhaling meconium from a bowel movement in utero, and chance that the baby will grow too large.

However, only a small percentage of “late” babies display postmaturity syndrome. According to ACOG, 95% of babies born between 42 and 44 weeks are born safely.

Post-date pregnancy can also be frustrating and discouraging for women who are “sick of being pregnant” and who are impatient to see their babies.

What can you do about it? Stay calm, having faith in your body’s wisdom, rather than focusing on dates on the calendar. Take good care of yourself; be active for part of the day, but also rest. Indulge in your last few days of having only yourself to take care of.

What can caregivers do for it? Labor induction. (see induction handouts)

The benefits of induction are that it starts a labor which has not begun on its own. The risks of induction are that all of the forms of induction can lead to stronger, more painful, and more frequent

contractions for mom. These powerful contractions may also limit oxygen supply to the baby, so increase the risk of fetal distress and related interventions, including cesarean. It's important to clearly discuss these issues with your caregiver. If the induction is being done for convenience, or for unclear medical issues, then the benefits of induction may not outweigh the risks.

A few caregivers recommend labor induction shortly after the 40 week mark to avoid post-date babies; however, research indicates that typically the risks would outweigh the benefits at that point. Most caregivers recommend routine induction at 42 weeks.

Studies cited in Simkin (1993) indicate that an appropriate response might be to monitor "post-date" for fetal well-being twice a week, and inducing only if problems arise.

Tests for fetal well-being: Fetal movement counting, ultrasound, non-stress test, and contraction stress test. There is a risk of false positives with these tests, so consult with your caregiver about whether multiple tests should be used before intervening.

Precipitous Labor

What is it? A labor that is less than 3 hours from start of contractions through birth.

How Common is it? Probably less than 5% of births (I do not have exact statistics). The rates for first time moms are much lower than the rates for women who have given birth before.

Why is it a problem? Emotionally stressful for the family: panic, fear, sense of being out of control. Intense contractions can be very painful, and there's often no time for medication. Some risk of damage to the baby's head and to the mother's perineum.

What can you do to help prevent it? Cocaine use is clearly associated with precipitous labor. Poor nutrition might be associated. Beyond those, it appears to be a combination of anatomical issues: small babies, large bony pelvises, or soft, pliable genital tissue.

What can you do about it? If your labor begins with very rapid, intense contractions that cannot be managed with comfort techniques, call your caregiver. Go to the hospital immediately. Whenever possible, lie on your side, rather than standing or sitting.

If you feel your body pushing and you cannot stop it, or if you or your partner can see the baby's head at the vaginal opening, call 911 and request assistance and advice.

Prolonged Labor

How common is it? More common than precipitous labor.

If labor is moving slowly, it is probably the result of:

Powers: Insufficient strength and/or frequency of contractions.

Passages: The shape and flexibility of the mother's pelvis and soft tissues.

Passenger: Baby is in a non-optimal position.

Pain: If mother is very tense because of pain, muscular tension can slow labor.

Psyche: Maternal stress and anxiety.

Keep these in mind as you consider solutions; look for ideas that work on each of these areas.

Prodromal Labor: Prolonged Early Labor

What is it? Early labor that last 24 hours or longer, before reaching 4 cm dilation.

What can you do to help with it? Stay well-nourished, drink plenty of fluids, and stay as rested as possible. Encourage your partner to do the same. Try not to worry, and get anxious; this is a normal pattern of labor for some women. Alternate quiet relaxation, with distracting activities, shifting position frequently. Walking can be helpful, but don't exhaust yourself. Any of the non-medical induction methods (e.g. nipple stimulation, orgasm) can also help augment labor, but check with your caregiver before attempting to stimulate labor.

If you have slow progress, back pain, and/or irregular contractions (maybe "coupled" contractions), assume that your baby is occiput posterior (see back ache in labor handout).

What can your caregiver do for it? Caregiver may just recommend relaxing and self-care until your body goes into more active labor. Or, if you are exhausted, caregiver may recommend trying to stop contractions and help you rest, by using sedatives, tranquilizers, morphine, or alcohol. Or, caregiver may augment labor by rupturing your membranes, and/or using Pitocin.

Prolonged Active Labor

What is it? Labor that slows or stops after you have reached 4 cm dilation. Some caregivers diagnose dysfunctional labor if dilation averages less than 1 cm/hr; others say less than .5 cm/hour over a four hour period. One recent study says abnormal progress should not be declared unless a mother has taken more than 19.5 hours to go from 4 cm to 10 cm.

Basically, it's a labor that's taking longer than the people involved think it should take.

Possible causes? Exhaustion, lack of nourishment, dehydration, full bladder, anxiety, fear, cervix not effaced, baby's position.

What can you do to help with it? Rest, eat, drink, go to the bathroom, relaxation and comfort measures, plenty of reassurance and encouragement from partner, use positions and movements where gravity can help move the baby down. Voicing your fears.

What can your caregiver do for it? Your caregivers will regularly monitor baby's well-being, and may do more frequent vaginal exams. May recommend I.V. fluids for hydration, and pain medications for relaxation. May rupture membranes, or recommend Pitocin augmentation.

Prolonged Second Stage Labor

What is it? Labor progress that slows or stops after the cervix is fully dilated. Pushing for more than 3 hours; some caregivers say 2 hours.

What can you do to help prevent it? Use a variety of positions and movement in early labor to help the baby descend into position for birth.

What can you do to help with it? Try positions that open the pelvic outlet, and use gravity to help baby descend. Squatting, dangling, and sitting on the toilet can all help. You can also try standing, semi-sitting, and hands-and-knees.

What can your caregiver do for it? They will carefully monitor heart rate. If baby seems to be handling the contractions well, they may not intervene. They may use pitocin to augment your contractions or use vacuum extraction, forceps, episiotomy, or cesarean section to deliver the baby.

Back Labor with an Occiput Posterior Baby

What is it? Labor contractions that are felt mostly in the mother's back. May be very painful. Contractions may be irregular, sometimes "coupling" (two contractions come close together, then there's a break, then a cluster of two or three more). Also can cause a very long labor.

Back labor is usually due to a posterior baby. Baby's head is pressing on the mother's sacrum or tailbone. Once the baby rotates, labor usually returns to normal. A baby can be delivered in the posterior position, but sometimes posterior babies require forceps or c-section delivery.

How Common is it? 25% of babies begin labor occiput posterior. 70-90% of those will rotate on their own during labor.

What can you do to help prevent it? Simkin recommends 10 daily repetitions of the pelvic tilt (see exercise handout) in late pregnancy. Also, hip circles, like in belly dancing or hula dancing. Avoiding sitting for long periods of time in a reclined position.

Basically, the easiest answer is: if you have back pain, assume the baby is posterior. Any of the techniques in the handout 'Back Ache In Labor' will help relieve the pain, and will help the baby to rotate, if he is posterior, and won't cause any problems if he's anterior.

Compiled by Janelle Durham. Slight modifications made by Heather Ward.

Sources: Birth Education Northwest's handout on "Coping with Common Variations in Labor" by Sheri Feld. Pregnancy, Childbirth, and the Newborn by Simkin, Whalley, and Keppler (2001 edition). "How long is too long? The Dilemma of Post-dates Pregnancy" by Penny Simkin, *Childbirth Forum*, Spring 1993. Abstract for "The Length of Uncomplicated Human Gestation" by Mittendorf et al, *Obstetrics & Gynecology*, V.75, N.6, June 1990. "Pregnancy past your due date" by Terri Isidro-Cloudas on americanbaby.com. "The Occiput Posterior Baby" by Henci Goer, *Childbirth Instructor Magazine*, Summer 1994.