WELLINGTON

OBSTETRICS

LABOUR AND BIRTH
INFORMATION FOR WOMEN AND FAMILIES

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LABOUR AND BIRTH—INFORMATION FOR WOMEN AND FAMILIES

AM I IN LABOUR?

As you enter the final stages of your pregnancy, your body will give signs that labour is approaching. The following information should help you to understand these signs and make it easier for you to determine whether you are in labour.

Some of the signs and symptoms of going into labour may include:

- period-like cramps
- backache
- diarrhoea
- mucous discharge or 'show'
- gush or trickle of water as the membranes break
- contractions

Engagement

As you move closer to delivery, your baby's head may drop and become engaged in your pelvis in preparation for labour. If you are expecting your first baby, you may notice pressure in your groin and on your bladder beginning up to four weeks before the birth. You may also notice that you can breathe a little easier and have a little more appetite as your baby drops, and is not pushed up against your diaphragm and stomach quite so much. This is sometimes known as "lightening", as women generally feel lighter.

Show

During your pregnancy a mucous plug fills your cervix. Towards the end of pregnancy, the cervix becomes softer and this mucous plug may become loosened and start to come away. The process of discharging this mucous is called a 'show' and might often contain streaks of blood or may also be brownish in colour. This is different from any flow of fresh blood which you would report immediately to your doctor or the hospital. The show may continue over a period of hours or even days. It is one of the signs that your body is preparing for birth. Labour may begin in the next few days, hours or weeks following a show. There is no need to phone the hospital if you have had a show.

Water Breaking (Rupture of Membranes)

This may occur at any time prior to the start of labour, or at any time during labour. The break may be low, near the opening of the uterus, and will produce a gush of amniotic fluid. If this occurs, place a sanitary pad on and note the colour of the fluid. Ring the hospital and tell the midwife that this has occurred. You will usually be asked to come in to the hospital.

Another type of amniotic fluid leak may occur higher up in the amniotic sack, or top of the uterus. This will be less obvious to you and you may only notice a trickle of fluid. Since many women have a heavy vaginal discharge or leak a small amount of urine towards the end of their pregnancy and it is often difficult to tell the difference. Urine is often yellow, where amniotic fluid is usually clear, or has a pink tinge, and has a "sweet" odour. If you are unsure, ring the hospital.

If the colour of the fluid is green or brownish, it indicates that your baby has passed a bowel motion (meconium) inside the uterus. It is very common to have meconium-stained amniotic fluid in a pregnancy over 41 weeks, but this may also be a sign that your baby is distressed. You will need to ring the hospital immediately and then come into the hospital.

CONTRACTIONS

Braxton Hicks Contractions

Braxton Hicks contractions are sometimes mistaken for labour. These “practice” contractions usually start halfway through the pregnancy and continue right through to the end.

These contractions are often irregular and can be uncomfortable and tight. Braxton Hicks contractions usually increase in regularity and strength towards the end of your pregnancy, preparing your uterus for the birth. Sometimes it is difficult to distinguish between these Braxton Hicks contractions and labour contractions. Below are the common differences between the two.

Labour Contractions

True labour contractions usually increase in strength and duration. In order to time your contractions, time the interval between the start of one contraction to the start of the next. Early labour contractions are often likened to period cramps with or without backache.

Braxton Hicks Contractions

- contractions usually irregular and short
- do not get closer together
- do not get stronger
- walking does not make them stronger lying down may make them go away uncomfortable and tight—not painful

Labour Contractions

- become regular with time
- get closer together with time
- become stronger
- walking makes them stronger
- lying down does not make them go away painful

HOW DOES LABOUR START?

Labour can start in different ways. You may be start experiencing some period like pains or contractions. You might notice that these tightenings/contractions start to get stronger, closer and last longer than before. Or you might start with some back ache or a stomach upset that gets stronger and develops into regular contractions. In approximately 10–15% of women, labour will start when your membranes rupture. Contractions usually follow.

SHOULD I CALL THE HOSPITAL?

You should call the hospital when:

- your waters break
- you have bright blood loss
- your contractions are regular and five minutes apart
- you are ready to come into hospital

BIRTH PLANS

Many women develop and share their plan for labour and birth with their maternity team. We encourage you to consider your preferences for this special time, and to discuss them with your Obstetrician during your pregnancy. This will help us to discuss any details, risks or concerns before labour begins. Because labour and birth involve so many variables, it is not possible to predict exactly what will happen and you should be reassured that we are committed to providing the best care which is safe for both you and your baby. Sometimes in emergency situations this may mean your preferences may not be able to be followed exactly. Wherever possible we would endeavour to discuss the reasons for this with you to facilitate informed consent and your understanding of events.

STAGES OF LABOUR

Every labour is different and individual for each woman. For first time mothers, labour takes approximately 12 to 24 hours. Women who are having their second or subsequent baby can expect labour to last approximately seven hours. Labour can be broken down into three stages.

First Stage

The first stage of labour is generally the longest, taking an average of 8 to 16 hours for a first baby and 3 to 10 hours for a second or subsequent baby. Labour contractions are responsible for the softening and thinning of the cervix (effacement) and its dilation to around 10cm. Your cervix starts out firm and long like your nose (feel your nose), and must become soft, stretchy and flat, like your lips (now feel your lips) before the birth of your baby. There are three phases in first stage of labour and they include:

- The latent or early phase—generally, this stage is the longest and can be the least painful part of labour. The cervix may take weeks, days or hours to thin out and may come with mild contractions. The contractions may be regularly or irregularly spaced, or else you might not even notice them at all.

Labour is said to be “established,” when the cervix is 3 cm dilated and contractions are regular and strong.

- The active phase—or established labour is marked by strong, painful contractions that tend to occur around three or four minutes apart and last up to a minute or so. This phase continues until the cervix dilates to approximately 7 cm, usually at the rate of 1 cm per hour in the presence of strong contractions.
- The transition phase—the contractions become more intense, painful and frequent. You may feel like the contractions are no longer separate but are running into each other. Or you might feel none of these things. Others find that their contractions are lasting one to one-and-a-half minutes and occur every two to three minutes. You might feel shaky, shivery and sick. The cervix may still take around 1 cm per hour to dilate the final 3 cm.
- It is not unusual to feel a strong urge to go to the toilet as your baby’s head pushes against the rectum. The midwife may check your cervix to ensure it is fully dilated before you start to push. You may feel a strong urge to push at this time.

The muscles at the top of your uterus are pressing down on your baby’s bottom and their head is pressing against your cervix. As the baby’s head descends, it exerts pressure on the cervix, assisting further dilation. Dilatation of the cervix may not occur at a constant rate and usually, the dilatation from 1 to 5cm takes much longer than from 5 to 10 cm. Generally, the stronger and longer the contractions, the more responsive the cervix will be in dilating.

If your labour is slow, your Obstetrician may recommend further treatment to help labour progress. You will be given a clear explanation of why this is proposed, what is involved with augmentation of labour and your informed consent will be obtained. Your waters may be broken during a vaginal examination if this has not already happened. This is often enough to get things moving. If not, you may be offered a drip in your arm containing a hormone called Syntocinon which will encourage contractions. The Syntocinon is increased every 30 minutes until your contractions are effective. When the cervix is 10 cm or ‘fully dilated’ the second stage begins.

Second Stage

This stage begins when the cervix is fully dilated and lasts until the birth of your baby. Most women feel a strong urge to push. Your Obstetrician and midwife will guide you if needed.

Find a position that you find comfortable and which will make labour or pushing easier for you. You might want to be in bed with your back propped up with pillows, or stand, sit, kneel or squat. Squatting will take practice if you are not used to it. If you are very tired, you might be more comfortable lying on your side rather than sitting up. If you have experienced backache in labour, kneeling on all fours might be helpful. It’s up to you.

You will probably now feel like pushing each time you have a contraction. Your body will most likely tell you how. This stage is hard work but your midwife and obstetrician will help you by making suggestions and encouraging you. Your partner can also give you lots of support. This stage can take up to two hours, so it helps to know how you’re doing.

As the baby's head moves closer, you can put your hand down to feel it, or look at it in a mirror. When the baby's head is nearly born, your obstetrician or midwife will may ask you to stop pushing, to push very gently, or to puff a couple of quick short breaths, blowing out through your mouth. This is so that your baby's head can be born slowly, giving the skin and muscles of the perineum (the area between your vagina and anus) time to stretch without tearing. There will be a burning sensation as the skin is stretching. Sometimes the skin of the perineum won't stretch enough and may tear, or there may be a need for the baby to be born sooner, in which case, the midwife or doctor will then ask your permission to give you a local anaesthetic and cut the skin to make the opening bigger. This is called an episiotomy. Afterwards the cut or tear is stitched up again and heals quickly.

Once your baby's head is born, most of the hard work is over. With one more gentle push the body is born quite quickly and easily. Your baby will usually be lifted straight on to your tummy before the cord is cut so that you can feel and be close to each other immediately. Your baby will be covered with a warm towel and you will be able to hold and cuddle your baby properly. Skin to skin contact is encouraged for all babies.

Your baby may be born with some of your blood and perhaps some of the white, greasy vernix which acts as a protection in the uterus still on the skin. Sometimes some mucus has to be cleared out of a baby's nose and mouth or some oxygen given to encourage your baby to breathe effectively. If your baby requires more assistance, your baby will not be kept away from you any longer than necessary.

Third stage

After your baby is born, more contractions will push out the placenta. This stage usually takes about 10 minutes but can take up to an hour. After discussion with you, your midwife or obstetrician may give you an injection in your thigh, just as the baby is born, or very soon after birth—this is called active third stage. The injection makes the uterus contract and therefore helps to prevent a postpartum haemorrhage which is very heavy bleeding. You may prefer not to have the injection at first, but to wait and see if it is necessary. You should discuss this in advance with your obstetrician or midwife and make a note on your birth plan.

SUPPORTING BREASTFEEDING WITH SKIN TO SKIN CONTACT

Ask to have skin to skin contact as soon as possible after birth. Your baby should have warmed blankets placed over his/her back and a hat placed on their head. The rest of your baby should be in direct contact with your skin. This will help them to stabilise their temperature and start to initiate an instinctive feeding response that will enhance bonding and breastfeeding establishment. Your baby's instinctual responses to breastfeed are heightened in the first two hours after birth. Skin to skin contact during this time increases those responses and the likelihood that your baby will attach and feed well at the breast. It will also help to stop some of the shaking you may experience directly after birth.

FETAL HEART RATE MONITORING DURING LABOUR

During each contraction the blood supply to the placenta, and to your baby, decreases but resumes rapidly once the contraction is over. A normal healthy baby will cope well during this natural process. Every baby's heartbeat is monitored, in some way, throughout labour. Your midwife or doctor is watching for any marked change in the heart rate, which could indicate that closer monitoring and care is required.

There are different ways of monitoring the baby's heartbeat:

- Your midwife may listen to the baby's heart intermittently with a hand-held ultrasound monitor called a Doppler. This method allows you to be free to move around in labour if you wish. It can also be used in water if you wish to use warm water immersion for pain relief.
- The heartbeat and contractions may also be measured through a monitor called a Cardio tocograph (CTG). This gives a print-out of the baby's heartbeat and your contractions. The monitor will be strapped to your tummy with two belts. This can make it more difficult to be mobile during your labour, but is sometimes essential, i.e. when being induced (with a Syntocinon infusion) or with an epidural.
- Sometimes it may be suggested that a clip is put on your baby's head so that their heart rate can be monitored more exactly. The clip is put on during a vaginal examination and the waters are broken if they have not already done so. The midwife or doctor will explain why they feel the clip is necessary for your baby and gain your consent.

PAIN MANAGEMENT

Although everybody is different, most women experience some pain during the birthing process. Your doctor and midwife are there to help you through this and will discuss with you a number of pain management options in the development of your birth plan. Below are some of the pain management techniques and options available to women.

Try all the coping strategies you feel comfortable with, but if these are not enough feel happy and confident with any decision you make regarding pain relief.

Breathing and Relaxation

During labour contractions, being aware of how you are breathing can be helpful. Aiming to breathe as slowly as is comfortable and as low down in your lungs as you can gives a central focus and promotes an even rhythm of breathing. This reduces feelings of panic (from breathing too high and fast), and allows your body's natural endorphins to be released.

If you have practised and can apply the skills of physical relaxation, especially of your "trigger points" during contractions, you will conserve enormous amounts of energy and feel much more in control of your body.

Try to stay focussed on the positive outcome of this work, your confidence in your body's ability to do this job and the incredible "experience" of labour.

Relaxation is very important and most useful in early to mid first stage. It also helps to coordinate uterine contractions, saves your energy for second stage, spares oxygen for your baby and uterus, and can break the panic cycle. Relaxation is useful throughout your labour.

Start and finish contractions with a deep cleansing breath then breathe in through your nose and blow out through your mouth. Use a focal point (not a clock) or close your eyes and focus inwardly on breathing. As the contractions intensify, your body naturally wants to respond to the increased discomfort by breathing faster. To avoid breath holding or hyperventilating, try faster, shallower breathing, in the same manner. Once the peak of the contraction has passed, try to slow your breathing down, take a longer breath in and gradually aim for low,

slow breathing.

Positioning

Experimenting by changing positions while you are in labour will help to ensure you are as comfortable as possible. Since different positions can work best at different times, feel free to change position if you find one is not helping for now. Supporting your pelvis in an “open” position with your hips apart and flexed comfortably can be done in kneeling, sitting, side lying or standing. Positioning yourself so that gravity helps you (e.g. in upright positions like leaning forward) can help your labour progress. Strategies such as straddling a chair, using a beanbag or birthing ball, pelvic rocking or leaning on your partner can be very useful. If you are uncomfortable at any time, try a different position. Avoid sitting on a painful tailbone and always maintain your posture by avoiding twisting and maintaining the curve in your lower back. It is best to avoid lying flat on your back or adopting one position for the whole of your labour.

Massage

Massage can be of great assistance for a woman in labour, providing physical comfort and focus, relief of muscle tension, or simply communicating support and commitment. Stroke relaxation techniques involve using smooth, predictable pressure in long continuous strokes with as much hand to skin contact as possible. Massage can be both physically and mentally calming when utilised during contractions and can also facilitate a relaxed rhythm of breathing.

Some popular massage techniques include:

Heel of the hand contact massage over the lower back, coccyx and sacrum—remember slow firm circular pressure—is helpful for back pain and can be a “counter irritant” as baby moves down through the pelvis. Stroke with firm hands from neck, down either side of the vertebral column and down around the hips. Start at the back of the neck and shoulders, apply firm even pressure—stroking across the back of shoulders and down the arms

- Heel of the hand contact massage or thumb-kneading down the muscles of the back - can help to relieve pain and tension. Shoulder and neck muscles massage—roll muscles between thumb and fingers being careful not to pinch. Inner thigh massage—firm pressure through the flat of the hand from groin to ankles.
- Massage thigh and calf muscles
- Temple massage
- Other forms of massage can be helpful for muscle fatigue or localised tension—muscle kneading, deep frictions and sacral pressure.

Work with your support person during the pregnancy, so that they know some strategies.

Warm water immersion

Warm water immersion can be very effective for comfort and pain relief during labour. Water provides support and buoyancy that enables labouring women to relax and take advantage of the weightless feeling it provides.

If you are well, your pregnancy has been uncomplicated, you have BMI of 35 or under, and you have progressed to 37 completed weeks of pregnancy, you may like to consider water immersion.

Sometimes, if you are in very early labour, the water can be so relaxing that your labour slows down so you need to wait until your labour is established before getting into the bath. It is a good idea to talk to your obstetrician or midwife about the appropriate time to consider getting into the bath.

Nitrous Oxide

Nitrous Oxide is a mixture of nitrous oxide and oxygen which acts as a relaxant when breathed in via a face mask or mouthpiece. Nitrous Oxide is used by many women during their labour as it allows them to control their pain management and acts quickly.

Advantages:

- acts as a relaxant takes the edge off contractions
- quick acting wears off in 15 seconds
- no known side effects to baby
- may be given in various doses
- you are in control

Disadvantages:

- may cause nausea
- give the feeling of being 'high'
- may cause difficulty with concentration
- can make your mouth very dry.

Pethidine

Pethidine is a narcotic drug given via injection into the buttocks. As pethidine crosses the placenta to the baby after approximately two hours, it is best to use pethidine earlier rather than later. For example, when you arrive to birth suite and your cervix is less than 6cm and you are tired or run down, a one off dose of pethidine may be helpful and allow you to get some sleep, after which you may feel more energised and labour more efficiently.

Advantages:

- act as a relaxant allows some rest between contractions
- takes the edge off contractions
- allows you to relax
- is stronger than nitrous oxide and oxygen

Disadvantages:

- can cause baby's breathing to slow down if given close to the birth—antidote is available, if required, for baby

- may cause nausea
- gives a feeling of being 'high'
- may give a feeling of being disorientated
- may cause baby to be too sleepy to breastfeed or latch correctly on the first day.

Epidural

An Epidural is an injection of local anaesthetic through a fine plastic tube which has been placed near the nerves in your spine. These nerves carry pain messages from the uterus and birth canal to the brain. When the epidural is working, the pain of labour or procedures associated with birthing may be completely or partially relieved. This procedure is performed by an anaesthetist.

You can ask for an epidural at any time during active labour. Remember that as it may take some time to organise an anaesthetist, it is usually too late to ask for an epidural once you are pushing.

When you have an epidural, you will need to have an IV inserted and will require continuous monitoring of your baby and you will be required to stay in bed.

An epidural has side effects for you and your baby. Your anaesthetist will provide you with information to enable you to make an informed choice and provide consent.

Adapted from:

Labour and Birth Information. Mater Mothers Hospital. 2012