Obstructed labor

- Abnormalities of vagina
  - Transverse or longitudinal septa
  - scarring from caustic traditional medication
- Abnormalities of Ux
  - myoma
  - Congenital malformation

Clinical presentation

- prolonged labor often extending to days rather than hours
- prolonged Rom
- painful contractions eventually might cause Ux hypotonia or rupture
- fever

P/E

- exhausted , tired and anxious (by sever pain , lack of sleep)
- dehydrated and acidotic- due to muscular activity in absence of intake
- Rapid pulse & often febrile
- Hypotension or shock (septic or hgic due to infection or Ux rupture)
- Distended hypoactive bowels due to electrolyte deficit

- Hypotonic or hypertonic Ux contractions depending on the progress of labor
- The cause of the obstruction may be evident on abdominal examination (abnormal lie , big baby etc..)
- In the presence of Ux rupture the abdomen will be tender, fetal parts are easily felt, lie and presentation may be difficult to detect as the baby has been displaced into the peritoneal cavity

- Sepsis is more common in primigravid

  women, and uterine rupture in parous women
- Sepsis results from the prolonged state of an open cervix often with ruptured membranes

impairing natural, mechanical barriers to ascending infection from the vagina
- The major immediate causes of death in obstructed labour are sepsis, and haemorrhage from uterine rupture

PV - oedematous vulva (kanula sign) and Cx

- Foul smelling meconium stained liquor, sever caput and moulding
- The Cx may or may not be fully dilated and the station may be high or low depending on the level of obstruction
- Catheterization is often difficult b/s of the impacted presenting part necessitating inserting of two fingers behind symphysis pubis to pass F. Catheter.

Management

- Resuscitation
  - If delivery is not imminent or likely to be so shortly, resuscitation is the first Step before facilitating transfer of the Pt to higher institution.
- In H/L admit the Pt straight to the delivery unit or operating theater
- Update HCt, blood group & RH type, WBC

- Start IV fluid (crystalloids if hypotensive or dextrose water otherwise) to correct dehydration.
- v/s should be checked regularly
- O2 5 li /min if there is fetal distress or maternal distress
- Broad spectrum a.bs (Ampicilin, CAF, Gentamicin)

- Clindamycin and metronidazol IV alternatives to CAF
- Insert F. catheter into the bladder
- avoid metal catheter-devitalized urethra is very easy to be injured
- If C/S planned empty stomach with NGT
- If Ux rupture is strongly suspected , prepare 2 unit of blood

- Operative delivery
  - Obstructed labor has to be relieved wot delay
  - Choice of the operative intervention should depend on
- Fetal condition (dead or alive)
- Station or descent of the presenting part
- The presence or absence of evidence of imminent or overt Ux rupture
- Fetal presentation

- Extent of cervical dilatation
- The cause of obstruction

  Episiotomy
- May be the only intervention required in a Pt with the presenting part in the Perineum
- This is often the case when obstruction is due to tight perineum
- Obstructed labor due to CPD at the out let level eg. OP could be effected by generous episiotomy

- Vacuums and Forceps Delivery
  -No definite CPD
  -Descent not more than 1/5 above brim
  -Other conditions for forceps and vacuum are met
  -The procedure preferably should be a lift out never be a difficult procedure
  -The fetus must be alive

C/ Section

Indicated if

- The fetus is alive and exceptional conditions for instrumental delivery are not satisfied
- The fetus is dead and conditions for vaginal operative deliveries are not met
- Repeat C/S almost always required
- Next baby is larger, sepsis during peurperium produce weak scar

Destructive operations

1. ***Craniotomy***

- Destructive operation for cephalic presentation if
- *The fetus is dead*
- *The head is the presenting part*
- *2/5 or less of the head is above the brim*

(Head should be fixed)

- *The cervix is fully dilated*
- *No uterine rupture or imminent rupture*

2. *Destructive delivery for transverse lie*

- **Decapitation**
- *The fetal neck is divided & the body & head are delivered separately*
- **Evisceration**
- *Fetal chest or abdomen is opened & all intestinal organs are removed. The trunk collapses & delivery becomes easier*
- **Preconditions**
- *The same with that of craniotomy*
- ***Cleidotomy***
- *Reduction of the size of the shoulder girdle after delivery of the head*
- *Indicated in shoulder dystocia & dead fetus*

Rx after relieve of obstruction

1. IV therapy for 24 hrs
   - correction of DHN with electrolyte imbalance
2. a.b for at least 5 days
   - puerperal sepsis inevitable
3. Keep catheter for 10 days

Complications of obstructed labor

- ***Rupture of uterus & its sequele***
- ***Intrpartum /puerperal sepsis* ,Infertility**
- ***Lower genital tract injuries (VVF, RVF etc.)***
- ***Osteitis pubis***
- ***Urinary incontinence***
- ***Peripheral nerve injury-foot drop***
- ***Amenorrhea***
- **Fetal Asphyxia**
- **Cerebral birth trauma**
- **Clotting defect**
- **Contracture and stenosis of vagina ,Dysparunia**
- **Peritonitis with abscess formation**
- **Atonic PPH,Psychological trauma**

- Fistula - is more common in the primigravid
- VVF- mainly result from the ischaemic necrosis of vaginal and bladder tissues, trapped between the fetal head and the mother's pubic symphysis during prolonged, obstructed labour.
- RVF- less common B/S of absence of maternal bony surface in close proximity, posteriorly.

Prevention

- Good obstetric care (ANC, intrapartum care)
  - obstructed labor should never occur
- Risk assessment(ANC)

  - past Hx of difficult deliveries

  -short stature

  - mal presentation , big baby

  - pelvic assessment antenataly for selected pts

  - use of partograph during labor

  help in recognition of slow cervical dilatation to predict and detect mechanical problems

Ruptured uterus

- Is a life threatening situation
- Peak incidence is in the 3rd & 4th pregnancies
- Anterior rupture is common & the tear is often L-shaped
- The bladder is often torn & extend sometimes in to the vagina

Dx

- Palpation of the abdomen causes severe pain
- Often vaginal bleeding
- The shape of the uterus changes & fetal parts may be easily palpable
- Sudden circulatory collapse, mostly shock develops slowly
- Cessation of contraction

Mx

- Improve circulation rapidly
- Prepare immediately > 2 units of blood
- Give broad spectrum antibiotics
- Catheterize the patient
- Insert N-G tube
- Laparotomy
  - Repair + tubal ligation or
  - Hysterectomy

THANK YOU