Patient information

Labour and birth information

For most women being pregnant, experiencing labour and giving birth is a normal process. Where childbirth is allowed to occur naturally, where it starts and continues without any interference, it is more likely to result in a normal vaginal birth.

For most women, when labour starts it can be an anxious and apprehensive time, yet it can be welcoming, as it means the waiting is finally over. These feelings will be present whether this is your first time or you have experienced labour before. Regardless of how many times a woman has experienced labour, each labour is different.

Labour is divided into three stages:

- The first stage of labour is when the cervix softens, shortens and dilates to full dilatation (10cm)
- The second stage of labour is from full dilatation until your baby is born (pushing stage)
- The third stage of labour is where the placenta (afterbirth) and membranes (bag of fluid in which your baby was in) is delivered.

When labour starts

Labour contractions are different from the 'practice' ones (Braxton Hicks) experienced in the final months of pregnancy. Labour contractions cause the uterus (womb) to become hard and this gradually pushes the baby through the birth canal.

There are some factors that are more likely to lead to a normal vaginal birth. One of these is when labour contractions begin on their own, rather than being stimulated (induction). Other factors which can influence the way labour progresses include:

- The strength and regularity of labour contractions and how long each one lasts.
- The way your baby is lying inside the womb
- Positions during labour and delivery
- Sitting upright, standing, walking about and adopting a squatting position can all help towards a normal delivery.
- Lying down, especially quite flat on your back, is more likely to lead to slow progress and the need for assistance.

Progress in labour

When active labour starts, the midwife will record your observations and progress in labour on a special chart called a 'partogram'. The midwife will observe how frequently the contractions occur, their strength and how long they last for. The progress of labour is usually assessed by a vaginal examination. During the examination, the midwife is able to identify the position and dilation of the cervix and the position of the baby's head in the birth canal.

The midwife will also listen regularly to your baby's heartbeat to ensure the baby is coping well with the effects of the contractions. This may be done intermittently with a hand-held device for the baby may be monitored continuously if this is thought necessary. All of these observations help the midwife to assess the progress of labour and to monitor you and your baby's wellbeing.

Normal labour and birth

Towards the end of pregnancy, you may notice your uterus tightening from time to time. This may feel uncomfortable, but they shouldn't be painful. These are known as Braxton Hicks contractions and are quite normal.

Normal labour is when the contractions start spontaneously, without the need for stimulation (induction), the labour progresses to full dilatation and the baby is delivered spontaneously with maternal effort.

Labour contractions come in waves, with a gap in between when the pain subsides. In comparison to Braxton Hicks contractions, when labour starts contractions become more regular, closer together, last longer and are much stronger. In early labour you can continue your normal routine but it is advisable to rest occasionally and continue to eat and drink little and often to maintain your energy levels.

Some women may require help to start labour contractions (induction) or at certain points during their labour to ensure labour progresses, but birth can still be spontaneous and without the need for instrumental assistance. A separate leaflet giving full information about induction of labour is available from your midwife or on the hospital website.

Instrumental assisted delivery

Your midwife will give care and support in labour that promotes the normal birth of your baby however situations can arise where the midwife may need to refer concerns about the well-being of your baby or the progress of your labour to a doctor. About 10 - 15% of women in the United Kingdom give birth with the help of forceps or ventouse.

A ventouse delivery involves placing a plastic or silicone cup against the baby's head and applying suction pressure, which attaches the cup firmly to baby's head. Pushing will still be encouraged during a contraction, and as you push, steady traction (pull) will be applied by the doctor to the cup, which helps ease the baby out.

Forceps are two interlocking instruments (like two large spoons), which are curved to follow the shape of the baby's head and the shape of your pelvis. Forceps are used in the same way as the ventouse, where the doctor applies traction whilst you push with each contraction. Sometimes forceps are also used to correct the position of a baby's head when it is lying awkwardly in the birth canal. This then enables delivery to take place when a degree of traction is applied.

The doctor will assess you and your baby carefully and will always discuss the situation with you. The most common reasons why a doctor may recommend an instrumental delivery are:

- If you become too exhausted and/or distressed and have been pushing for a long time.
- If there is a concern about the baby's heart rate, or how the contractions are affecting the baby's general condition.
- There is a medical reason to avoid muscular exertion or strain.
- An instrumental delivery is generally undertaken using a local anaesthetic and you are likely to receive an episiotomy (cut to the perineum), to allow more room for the baby to deliver during the procedure.

Caesarean section

About 1 in 4 women in the United Kingdom give birth to their baby by caesarean section, the need for which only arises if there is a concern regarding the health and wellbeing of either you or your baby. Sometimes the decision to deliver your baby by caesarean section is planned and the reasons for this are discussed with you fully beforehand so that you are able to decide whether you are in agreement. You will be asked to sign a consent form after discussion with the obstetrician caring for you.

There are some risks associated with a caesarean section, and these are slightly increased if the caesarean section is carried out as an emergency. These include haemorrhage (blood loss), infection, risk of thrombosis (blood clots), and injury to the bladder or bowel. Also, small grazes or cuts of the baby's skin sometimes occur.

In the following situations a doctor would recommend an emergency caesarean section:

- Fetal distress: certain variations to the baby's heartbeat during pregnancy and in labour can suggest the baby is having problems and needs to be delivered without delay.

- Obstructed labour: this is where the baby is either too big or in a position where they cannot pass through the pelvis and therefore making a vaginal delivery impossible.

- Other medical conditions: which may present in you and/or your baby that require immediate delivery.

Whether the caesarean section is planned (elective) or as an emergency, all risks to you and/or your baby will be discussed with you in detail if it is recommended that your baby is delivered in this way.

Further information is available in "Having a Caesarean Section" and "Vaginal Birth after Caesarean Section" leaflets. Please ask your midwife for a copy of this leaflet if you would like one, or find it on the hospital website.

Coping with pain in labour

Pain in labour is an individual experience and each woman will make her own choices about how she copes with it. Some women find that their ideas about

labour and pain changes during labour, therefore it is important to keep an open mind and to keep talking to your midwife about how you are feeling.

Throughout your pregnancy it is important to eat healthily and take regular exercise, such as walking, swimming and yoga, as this will help keep you fit and prepare you for labour. Preparation for birth classes (antenatal classes) can help to inform you about what to expect during labour and birth, and the choices that are available. Feeling prepared for labour can help to make you more comfortable, reduce anxiety and feel in control of your choices during labour and birth.

Finding ways to relax and be comfortable in labour is very important. For example, the use of dim lighting, music, cushions and warm/cold compresses can help with this. If you wish to listen to music in labour, you are welcome to bring in your own battery powered audio equipment.

Transcutaneous Electric Nerve Stimulation (TENS): TENS is a self-administered form of pain relief, which works by encouraging the body to release its own natural painkillers called endorphins and helps to reduce pain by reducing pain signals from the uterus to the spinal cord and brain. The device consists of 4 rubber pads placed on the lower half of your back. Small electrical impulses are sent through these all the time, causing a tingling sensation, which is enhanced using a self-controlled remote during a contraction. TENS is most effective when it is started in early labour.

Hydrotherapy (use of water): In the early stages of labour, spending time in a relaxing bath or shower can be soothing. Once labour is established getting into a deeper pool of water can be beneficial as it relaxes you, supports your weight and can alleviate the pain of contractions.

Massage and aromatherapy: Massage of the back, legs, shoulders or hands can be very relaxing and helpful in reducing pain during labour and any soothing touch can encourage the body to release endorphins and help reduce discomfort. Some women may choose to use aromatherapy to help them relax and remain calm.

Entonox: Also known as ‘gas and air’, this is a mixture of nitrous oxide and oxygen, which is inhaled through a mouthpiece during contractions. It can be useful particularly towards the end of labour on its own or in addition to other pain-relieving methods.

Pethidine: Pethidine is a synthetic opioid drug that can be given during labour by injection, into your thigh or buttock. Once given it takes approximately 20 minutes

to become effective. It works by making you feel more relaxed during and in between contractions and makes the contractions feel shorter.

Epidural: This is a medical procedure, carried out by an anaesthetist (doctor). An epidural is the most effective form of pain relief that can be offered as it allows you to continue to feel your uterus tightening but it should no longer feel painful. There is a 24-hour service for having an epidural but it does take time to set up for this procedure. Very occasionally it may not be possible for your epidural procedure to start immediately if the anaesthetist is dealing with an emergency case. Every effort will be made to facilitate your choice as soon as it is safe to do so. For a few women an epidural is not an appropriate method of pain relief.

The anaesthetist will discuss the procedure and associated risks prior to siting the epidural and will place a fine plastic tube into the space between the bones of your back (known as the epidural space), where local anaesthetic will be continuously administered.

Women that choose to have an epidural can still move about on the bed, however mobility will be limited and you will no longer be able to walk around the room in labour.

After you have given birth, the anaesthetist will visit you on the postnatal ward to ensure you have recovered from the epidural.

Managing the third stage of labour

The third stage of labour is after the baby has been born and involves delivering the placenta (afterbirth). The midwife will check how you are immediately after the delivery of the baby and then the placenta will be delivered or pushed out, depending which option you choose to manage the third stage. You can usually hold your baby during this stage if you want to.

There are 2 options for the third stage; they are called **active** management and **physiological** management. Your midwife will discuss with you these options if you are undecided, when you are in labour or immediately following birth.

Active management: The midwife will give you an injection into your thigh, after the birth of the baby. The drug used is called Syntometrine and contains two active ingredients: ergometrine and oxytocin, which together make the uterus contract and help separate the placenta from the uterine wall. The midwife will gently feel your abdomen (tummy), following signs that the placenta is ready to be delivered, and gently apply traction to the cord to deliver the placenta.

The West Suffolk Hospital follows guidance from NICE 2014 in advising women to have active management of the third stage as it speeds up the delivery of the placenta and is associated with lower risk of heavy blood loss (haemorrhage).

Physiological management: Instead of using a drug to make your uterus contract, your body's natural oxytocin hormone will act in the same way. When there are signs that the placenta is ready to be delivered, the midwife will encourage you to bear down and push the placenta out, unaided. If you choose physiological management of the third stage, guidance advises that if the placenta is not delivered within one hour or you have a heavy blood loss, you will be advised to change to active management.

Information (NICE 2014)	**Active management**	**Physiological management**
Length of third stage	Up to 30 minutes	Up to 1 hour
Risk of heavy bleeding	13 in 1000 women **(1.3%)**	29 in 1000 women **(2.9%)**
Risk of needing a blood transfusion	14 in 1000 women **(1.4%)**	40 in 1000 women **(4%)**
Risk of nausea and vomiting	100 in 1000 women **(10%)**	50 in 1000 women **(5%)**

Sometimes some or the entire placenta stays inside the uterus, regardless of the management option used. If this happens it is recommended that an IV drip is started and doctor will explain why this is needed. You may be advised to have a vaginal examination to check whether the placenta will have to be removed manually (a type of operation). This examination can be painful so you will be advised to have pain relief.

Method of pain relief	Advantages	Disadvantages
TENS	• You are in control of the level at which the TENS machine operates • You can still move around/be mobile during labour • TENS can be used throughout labour, combined with other forms of pain relief • TENS can be used both at home and at hospital • TENS does not cross the placenta therefore has no effect on your baby	• Some women feel it is not enough to help cope with strong labour pains • TENS cannot be used in the bath or shower • TENS cannot be used if you choose to have an epidural • TENS equipment can be expensive to buy or hire. The cost is approximately £20-30 for a six-week period
Entonox	• You control how much you breathe in and how often it is taken • Entonox can be used at any time during labour, including if you choose to use the pool • Entonox does not cross the placenta therefore has no effect on your baby	• Some women feel dizzy and/or queasy using Entonox, however the effects wear off quickly when you stop breathing in the gas • Some women feel it is not enough to help cope with strong labour pains.
Pethidine	• Pethidine helps women to feel more relaxed, calm and the contractions appear shorter	• Occasionally some women feel disorientated and sick. • Pethidine can pass through the placenta and cause your baby to be sleepy for the first 24hours of life

Epidural	• Epidural gives you complete pain relief, allowing you to rest • Women who have high blood pressure may benefit from the use of an epidural as its affect can reduce the blood pressure	• Your blood pressure (BP) may fall as a result of the epidural, but an intravenous (IV) drip will be started and your BP will be closely monitored • Occasionally epidurals do not completely work. This can be corrected by the anaesthetist in most instances • Usually you will have a catheter inserted into your bladder to drain your urine due to lack of sensation in that area and limited mobility to use the toilet • The is a slight increased chance of needing an instrumental delivery due to loss of sensation and lack of urges to push • Epidurals can cause tenderness around the needle site, this will only last a few days • **Very rarely** more serious complications can occur such as nerve damage or infection

If you would like any information regarding access to the West Suffolk Hospital and its facilities please visit the website for AccessAble (the new name for DisabledGo) https://www.accessable.co.uk/organisations/west-suffolk-nhs-foundation-trust

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