



اسم السياسة /الخطة: سياسة إدارة الولادة المتعسرة Management of Obstructed Labor
رقم السياسة/ الخطة: OSD-PP- 08

المعنيين بالسياسية: كوادر قسم النسائية والتوليد		المجموعة: رعاية المرضى
توقيع مسؤول صالات الولادة:	تاريخ الاعداد: 2025/8/12	إعداد: قسم النسائية والتوليد
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1. Purpose:

- 1.1 To establish a treatment plan to prevent potential complications during delivery.
- 1.2 To provide a safe delivery of the mother and the baby.
- 1.3 To prevent complications of obstructed labor
- 1.4 To ensure timely identification and management of obstructed labor.
- 1.5 To prevent maternal and neonatal morbidity and mortality

2. Policy:

- 2.1 Initial Assessment & Conservative Measures by resident doctor and midwife to determine the possibility of obstructed labor in
- 2.2 Monitor labor progress with a partograph.(Strict initial and continuous assessment to detect any deviation from normal)
- 2.3 Ensure adequate hydration and pain relief.
- 2.4 Consent is a must for any surgical intervention
- 2.5 Mode of delivery depends on the presentation of the fetus
- 2.6 Strict initial and continuous assessment to detect any deviation from normal

3. Scope:

- 3.1 labor ward.....This policy is applicable to all patients admitted for labor in

4. Responsibility:

- 4.1 It is responsibility of head department unit to assure applied this policy
- 4.2 It is responsibility of all Midwives who interact with patient.
- 4.3 It is responsibility of gyne and obstetrics GYNE AND OBSTETRICS resident doctors who interact with patient.

5. Definitions:

- 5.1 **Obstructed labor, also known as labor dystocia:** is a serious childbirth complication where the fetus cannot progress through the birth canal due to mechanical issues.
- 5.2 **Bandl's ring:** The difference between upper and lower segment may be seen as a ridge obliquely crossing the abdomen during labor
- 5.3 **Bandl's Sign :** is a clinical sign observed in obstructed labor, indicating impending uterine rupture. It is characterized by a pathological retraction ring that forms between the upper segment and lower segment of the uterus.
- 5.4 Obstructed labor is a major cause of maternal and neonatal mortality. Proper management and timely intervention are crucial for preventing complications.

6. Equipments/Forms/Attachments:

- 6.1 Sphygmomanometer , Stethoscope
- 6.2 Cross matching to prepare blood
- 6.3 consent form for urgent surgery
- 6.4 Hypo tray for IV fluid
- 6.5 Blood tubes sets and IV sets
- 6.6 Cannula 18to 20 gauge
- 6.7 Ultrasound for fetal position and estimated fetal weight.

- 6.8 Cardiotocography
- 6.9 Partograph form.

7. Procedure:

- 7.1 Complete general and specific assessment by resident doctor and midwife to detect possible causes of obstructed labor which includes:
 - 7.1.2 Absolute CPD deep transverse arrest malpresentation
 - 7.1.3 Lower segment fibroids
 - 7.1.4 Fetal hydrocephaly
 - 7.1.5 Multiple pregnancy with conjoined or locked twins
 - 7.1.6 Risk Factors for Obstructed Labor:
 - 7.1.6.1 Cephalopelvic disproportion (CPD)
 - 7.1.6.2 Fetal malpresentation (e.g., breech, transverse lie)
 - 7.1.6.3 Multiple pregnancies
 - 7.1.6.4 Congenital fetal anomalies
 - 7.1.6.5 Pelvic abnormalities
 - 7.1.6.6 Inadequate uterine contractions
 - 7.1.7 History :
 - 7.1.7.1 Prolonged labor despite good uterine contractions
 - 7.1.7.2 Severe lower abdominal pain
 - 7.1.7.3 Exhaustion and dehydration
 - 7.1.7.4 Failure of fetal descent
- 7.3 Ultrasound : Assist in ultrasound procedure: to check gestational age fetal position and estimated fetal weight, placental site, amount of liquor uterine malformation as fibroid ,fetal malformation., malpresentation.....etc
- 7.4 Physical examination :skilled observation and assessment of progress, particularly abdominal examination, will alert the midwife or the obstetric and gyne resident to any malpresentation or to the lack of advancement of the presenting part despite optimal uterine contractions.
- 7.5 Signs:
 - 7.5.1 Maternal tachycardia, dehydration, fever (if infected)
 - 7.5.2 Bandl's ring (pathological retraction ring)
 - 7.5.3 Fetal distress (abnormal fetal heart rate)
 - 7.5.4 Caput succedaneum and excessive molding of fetal head
 - 7.5.5 Vaginal examination: Cervical edema, unmoving presenting part
- 7.6 Clinical Signs:
 - 7.6.1 Prolonged labor (failure to progress beyond active phase)
 - 7.6.2 Maternal distress (tachycardia, dehydration, fever)
 - 7.6.3 Bandl's ring formation
 - 7.6.4 Fetal distress (abnormal heart rate patterns)
 - 7.6.5 Failure of fetal descent despite strong contractions
- 7.7 Vaginal examination will confirm suspected malpresentation, and where the presentation is vertex, reveal increasing caput succedaneum or moulding. With a high presenting part, The obstetrician is informed as soon as possible so that the birth can be expedited.

- 7.8** If obstructed labor is not recognized, the mother's uterus will continue to contract to overcome the obstruction.
- 7.9** mother will become progressively more dehydrated, ketotic, pyrexial and tachycardic. The fetus will develop a bradycardia because of the relentless contraction. As the uterus continues to contract and retract the upper segment becomes progressively thicker, closely enveloping the fetus, and the lower segment becomes increasingly thinner.
- 7.10** Indications for Emergency Intervention:
 - 7.10.1** No progress despite 4 hours of strong contractions.
 - 7.10.2** Fetal distress or maternal complications.
 - 7.10.3** Evidence of CPD, severe malpresentation, or uterine rupture risk.
- 7.11** The difference between upper and lower segment may be seen as a ridge obliquely crossing the abdomen (Bandl's ring). The mother will be in severe and unrelenting pain. If vaginal examination is possible, the presenting part will be high with excessive molding. The uterus is in imminent danger of rupture and emergency measures must be taken to avoid uterine rupture.
- 7.12** Uterine rupture can lead to maternal mortality and the tonic contractions and uterine rupture cause the hypoxia, asphyxia and subsequent perinatal mortality.
- 7.13** Management:
 - 7.13.1** Immediate Resuscitation:
 - 7.13.1.1** IV fluids to correct dehydration
 - 7.13.1.2** Pain relief (opioids if needed)
 - 7.13.1.3** Oxygen therapy (if fetal distress)
 - 7.13.1.4** Antibiotics (if infection suspected)
 - 7.13.2** Cesarean Section (C-Section):
 - 7.13.2.1** The safest option if vaginal delivery is impossible.
 - 7.13.2.2** Indicated in cephalopelvic disproportion (CPD), transverse lie, or fetal distress.
 - 7.13.3** Assisted Vaginal Delivery (if no CPD and cervix fully dilated)
- 7.14** Post-Delivery Care:
 - 7.14.1** Monitor for postpartum hemorrhage (PPH)
 - 7.14.2** Antibiotics if there was prolonged rupture of membranes
 - 7.14.3** Emotional and psychological support
 - 7.14.4** Counseling on future pregnancies (elective C-section in cases of CPD)

8. References:

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