بسم الله الرحمن الرحيم

نقش پوزیشن در اختلالات لیبر و زایمان

اتیولوژی اختلالات لیبر و زایمان (دیستوشی)

دیستوشی سرویکس	سرویکس خلفی و سفت در شروع لیبر
دیستوشی جنینی	بد قرارگیری، آسنکلیتیسم، سر بزرگ یا عدم فلکشن، عدم آنگاژمان
دیستوشی لگن	بد فرمی
دیستوشی رحمی	انقباضات ناکارآمد یا ناکافی
دیستوشی عاطفی	دیسترس یا ترس مادر، خستگی شدید، درد شدید
دیستوشی تشخیصی	عدم تشخیص صحیح لیبر یا مرحله دوم زایمان، استفاده نابجا از اکسی توسین، دارو، عدم تحرکت مادر، دهیدریشن، مخدوش کردن روند زایمان

عوامل موثر در سیر لیبر

- Passage
- Passenger
- Power

•Psycho-emotional
•Physical
•physiological

Psycho-emotional state of mother(reducing maternal distress)

Maternal effects of anxiety (‘ fight or fight ’ response) in labor Excessive catecholamine levels in first stage labor cause:

- ↓ **blood flow to uterus**
- ↓ **uterine contractions**
- ↑ **duration of first stage labor**
- ↓ **blood flow to placenta**
- ↓ **oxygen available to fetus**
- ↑ **fetal production of catecholamines**
  - **fetal conservation of oxygen**
  - **fetal heart rate decelerations**
- ↑ **negative or pessimistic perception of words or events by woman**
- ↑ **need for reassurance & support, protectiveness towards fetus**

Excessive catecholamine levels in second stage labor causes:

- same fetal effects as listed above
- ‘ fetal ejection reflex ‘ (rapid expulsion fetus)

Physical and Psycho – emotional measures

Before Labor:

- ✓Birth plan

During Labor:

- ✓Introduce yourself & her to unit
- ✓Ask about her plans & preferences
- ✓Encourage an atmosphere of privacy, comfort, intimacy
- ✓Explain any clinical procedures or tests
- ✓Inform mother of signs of progress
- ✓Suggest comfort measures
- ✓Reassure the mother

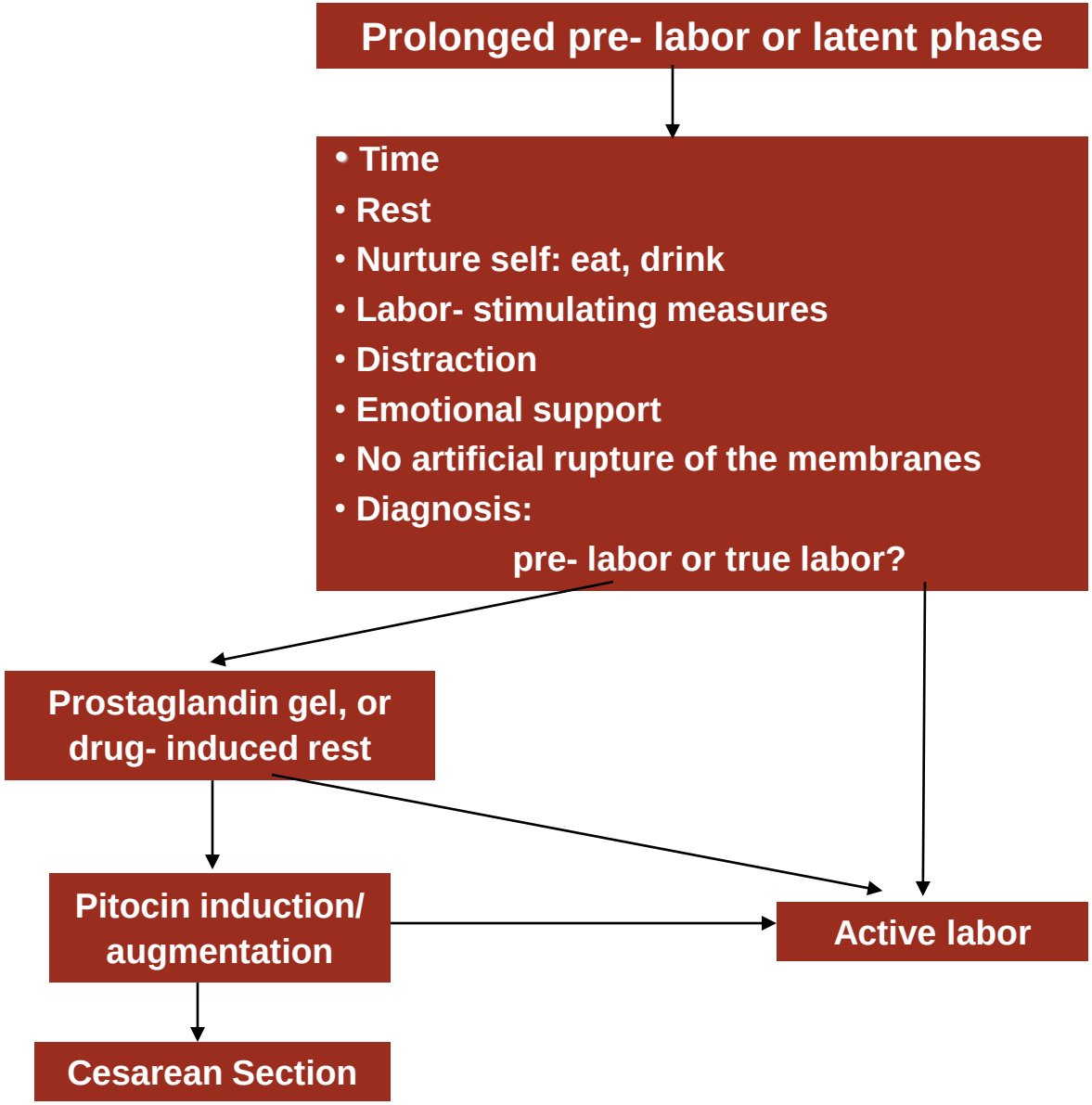
Physiological measures

- Encourage to empty her bladder
- Well hydrated but not over hydrated
- Encourage to seek comfort
- Encourage to relax her voluntary muscles

Techniques to Elicit Stronger Contraction

- Hydratation
- Movement and Position
- Comforting touch
- Nipple Stimulation
- Warm compress

Prolonged Pre-Labor or Latent first Stage



اصلاح وضعیت در L F

✪ اگر مشکوک به OP :

Fig. 4.10 Standing, leaning on a tray table.

Fig. 4.11 Standing, leaning forward on partner.

Fig. 4.12 Standing, leaning on ball.

Fig. 4.13 Kneeling with a ball.

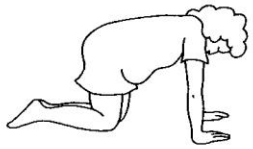


Fig. 4.14 Hands and knees.

Fig. 4.15 Kneeling over bed back.

✪ اگر تون عضلانی ابدومن ضعیف باشد :

Fig. 3.7 Semi-sitting.

Fig. 3.8 Abdominal lifting.

- **Semi setting Position move the fetus ‘s center of gravity toward her back** → **Synclitisme Position**
- **Abdominal lifting: realigned the angle between the baby ‘s torso and the pelvic in let**

Prolonged active Phase

→ Definition: insufficient rate of dilatation after active labor

- ◆

Possible Causes:

- **Malpositions: occiput posterior, presistent occiput transverse position, or presistent asynclitism.**
- **Macrosomia, CPD**
- **Inadequate and the intensity of contractions.**
- **Presistent cervical lip.**
- **Emotional dystocia ‘ : fear, anxiety, tension, or hostility.**
- **Maternal exhaustion, dehydration.**
- **Maternal physical factors: severe lumbar lordosis (especially if combined with a lack of mobility in the lumbar spine), or a pendulous abdomen, due to lack of abdominal muscle tone.**
- **Combination of etiologies or unknown etiology.**

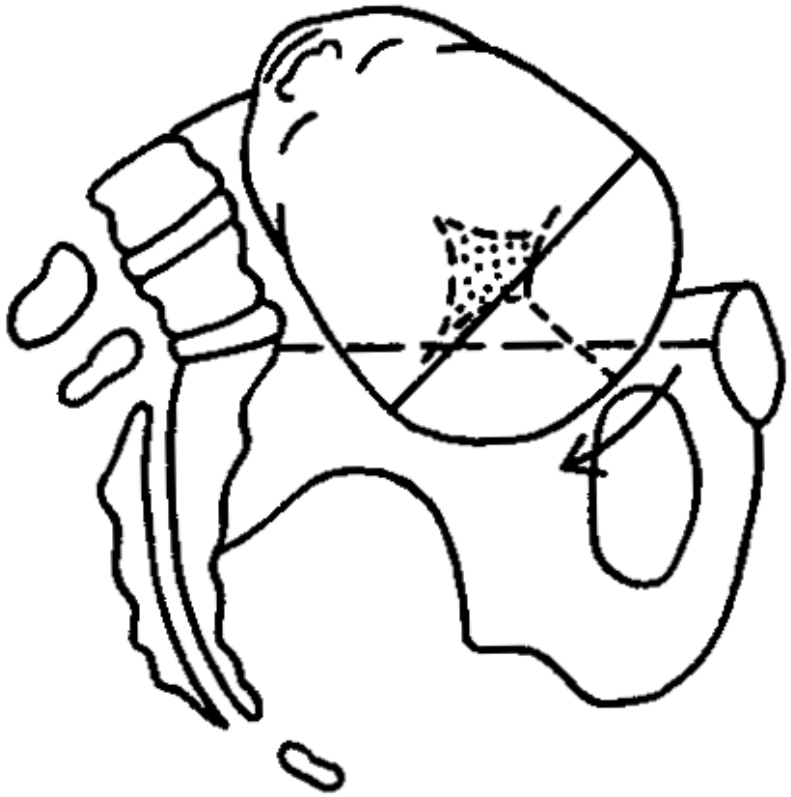


Fig. 4.1 Posterior asynclitism.

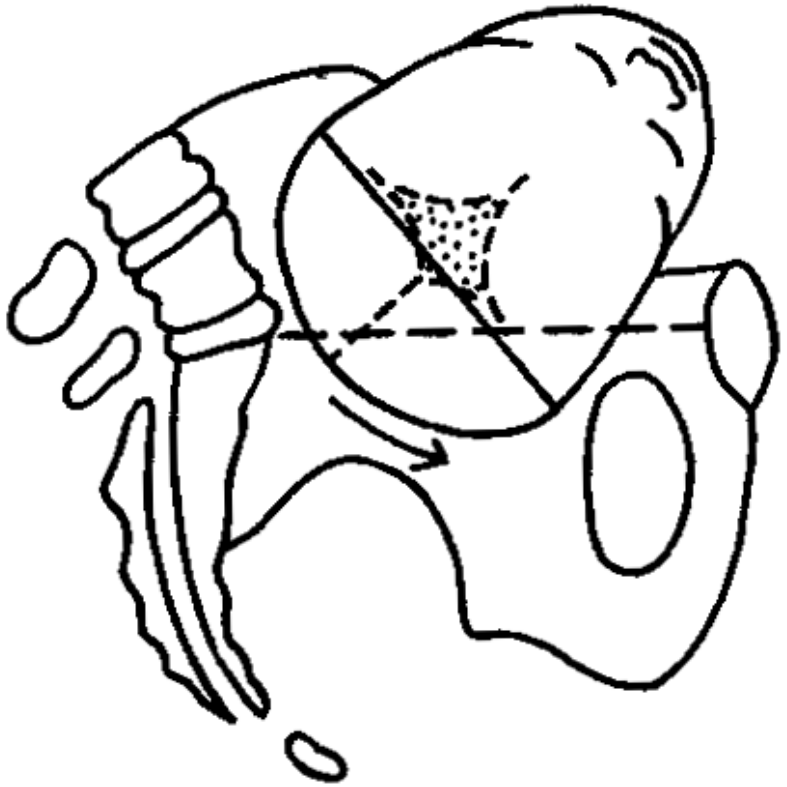


Fig. 4.2 Anterior asynclitism.

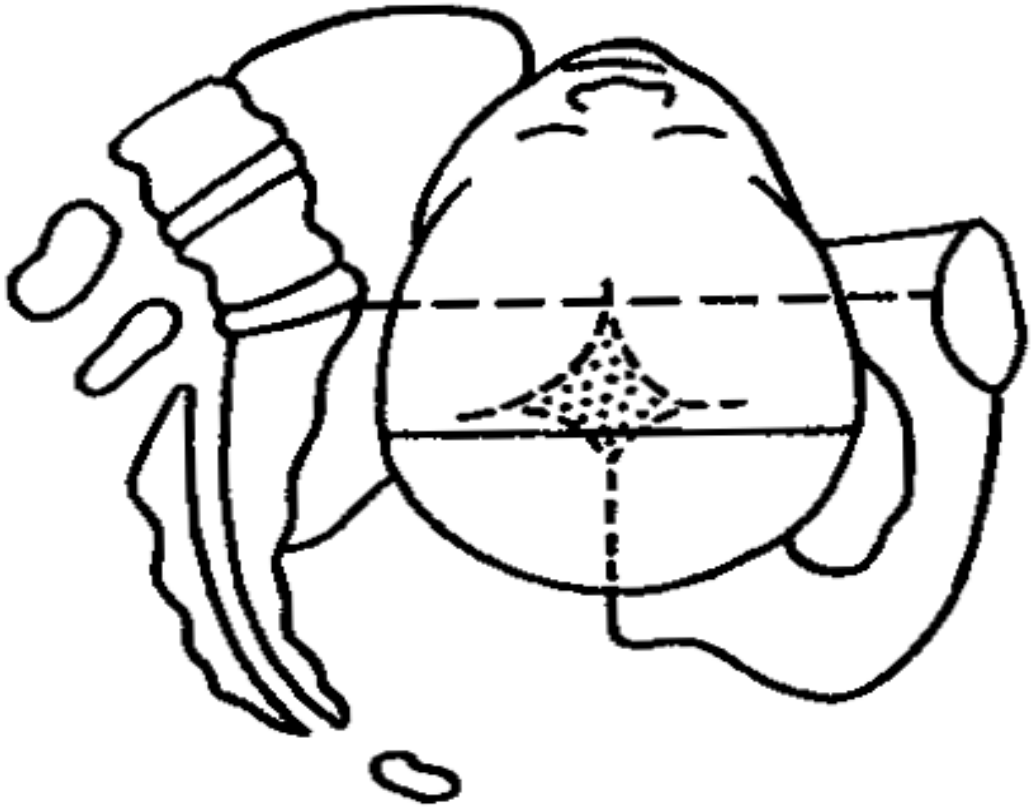


Fig. 4.3 Synclitism.

Matrenal Position and Movement

Occiput posterior / asynclitism in first stage

↓

Try to determine position (LOP, ROP, or asynclitic)

↓

- **Time / maintenance**
- **Rotate baby:**
  - **Knee–chest position**
  - **Hands and Knee**
  - **Pelvic rock**
  - **Lunge**
  - **Cold / heat**
  - **Abdominal lifting**
  - **Walk / movement**
  - **Avoid pushing**
- **Deal with back pain**
  - **Positions**
  - **Pressure**
  - **Hydrotherapy**
  - **Tens**
- **Monitoring fetal heart rate contraction**

I-V narcotics or epidural block
Pitocin
Time

Rotation and progress

No progress or fetal distress Cesarean section

- ForwardLeaning Position (May aid Fetal repositioning)

Fig. 4.16 Kneeling, partner support.

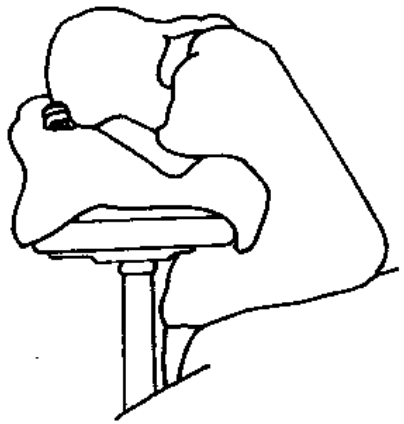


Fig. 4.6 Sitting leaning on a tray table.

Fig. 4.7 Straddling a chair.

Fig. 4.8 Straddling toilet, facing backwards.

Fig. 4.9 Standing, leaning on bed.

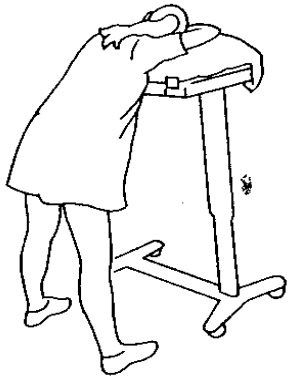


Fig. 4.10 Standing, leaning on a tray table.

Fig. 4.11 Standing, leaning forward on partner.

Fig. 4.12 Standing, leaning on ball.

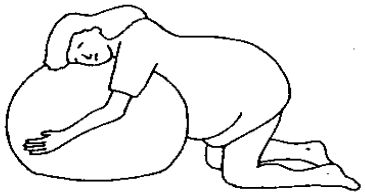


Fig. 4.13 Kneeling with a ball.

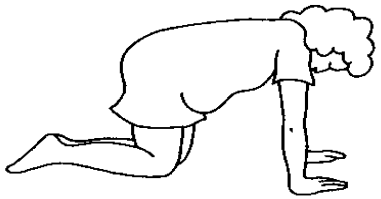


Fig. 4.14 Hands and knees.

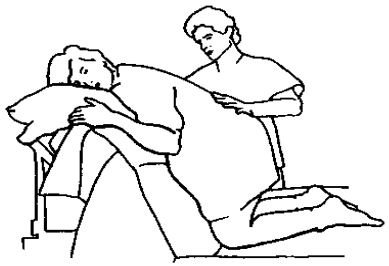


Fig. 4.15 Kneeling over bed back.

What this Position does .....

- **Side lying Positions**

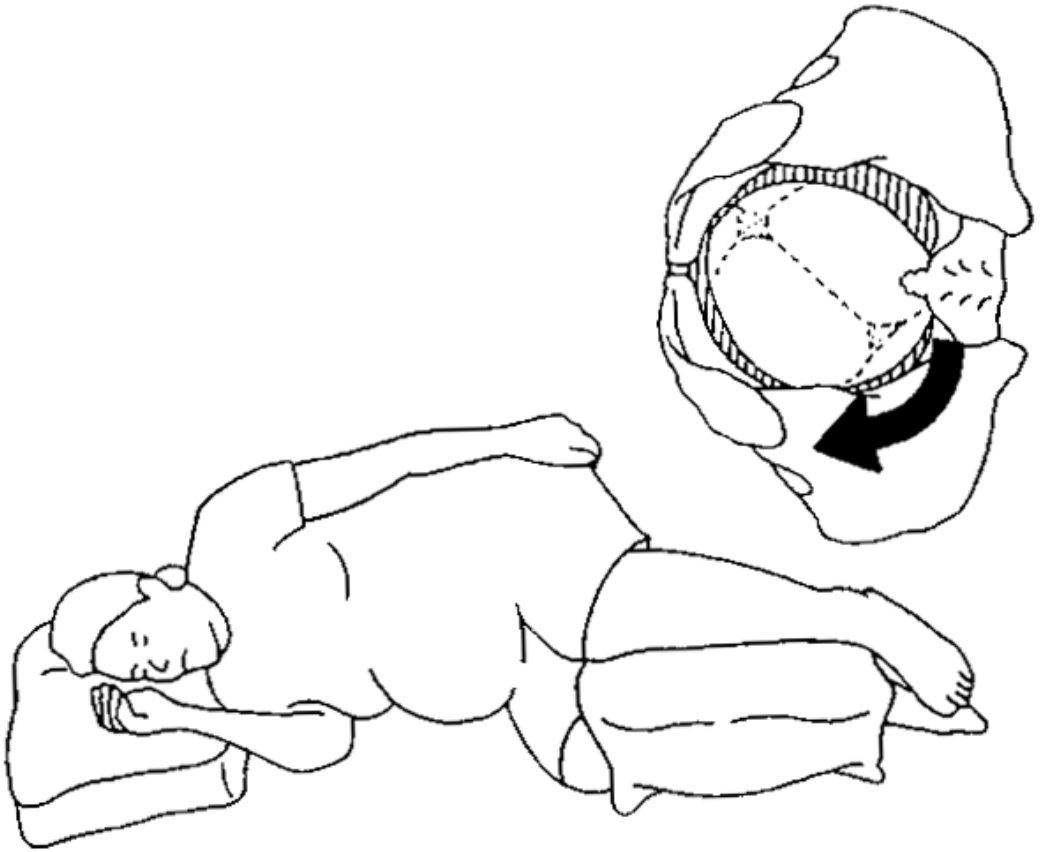


Fig. 4.17 Woman in pure sidelying on the 'correct' side, with fetal back 'toward the bed'. If fetus is ROP, woman lies on her right side. Gravity pulls fetal head and trunk towards ROT.

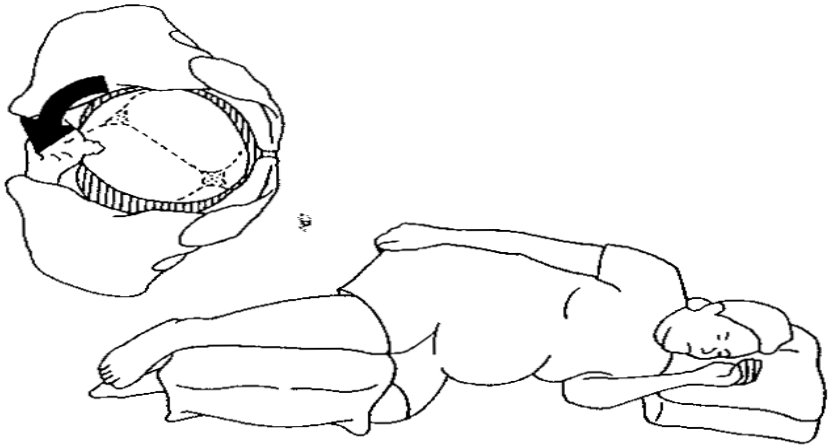


Fig. 4.18 Woman in pure sidelying on the 'wrong' (left) side for an ROP fetus. Fetal back is toward the ceiling. Gravity pulls fetal occiput and trunk toward direct OP.

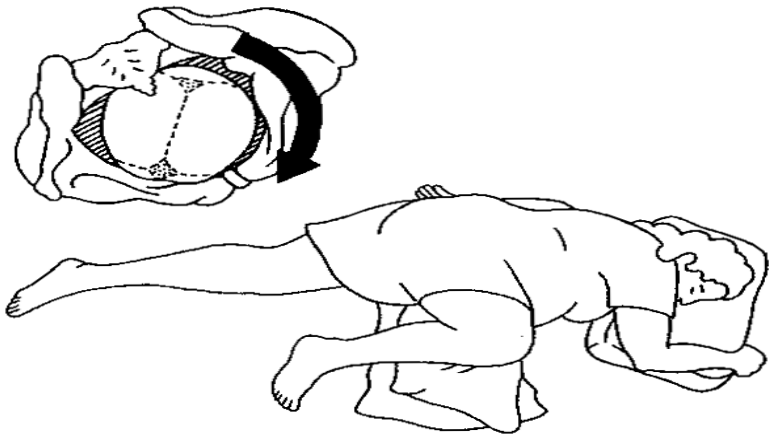


Fig. 4.19 Woman semi-prone on the 'correct side' – with fetal back 'toward the ceiling'. If fetus is ROP, the semi-prone woman lies on her left side. Gravity pulls fetal occiput and trunk toward ROT, then ROA.

Asymmetrical Position and Movements

- This may allow more space where it is needed for rotation
- If the baby is OP, the woman should lunge in the direction of the occiput

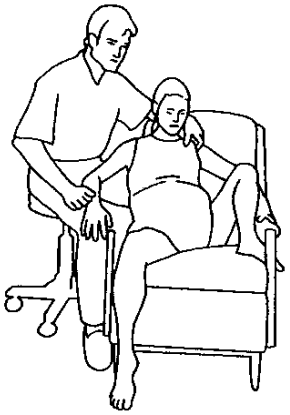


Fig. 4.20 Sitting with one leg elevated.

Fig. 4.21 Standing with one leg elevated.

(a)

(b)

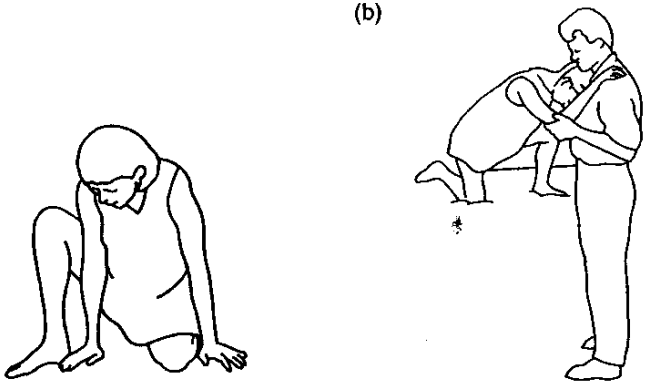


Fig. 4.22 (a) Asymmetrical kneeling, (b) asymmetrical kneeling, leaning on partner.

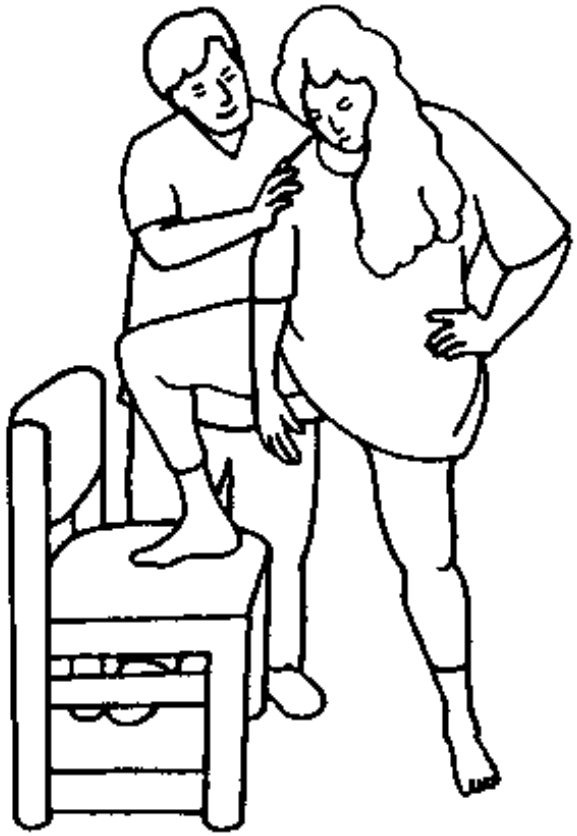


Fig. 4.23 Standing lunge.

Fig. 4.24 Kneeling lunge.

Note regarding supine and semi-sitting positions for occiput posterior

When a woman is fully supine or semi-sitting, gravity encourages the trunk of the Op fetus to lie next to the woman ‘s spine, increasing the changes of supine hypotension, but also minimizing the likelihood or rotation to OA.

These positions also increase the pressure of the fetal occiput against the woman ‘s sacrum, thus worsening her back pain (Fig. 4.25a). There is a much greater likelihood of rotation, and less back pain when the woman sits upright or leans forward. (Fig. 4.25b).

When a woman is supine, the head of an occiput posterior fetus is directed more toward the pubic bone during contraction (Fig. 4.26a). When the woman is upright, the uterus, tilting forward, direct the fetal head into the pelvic basin (Fig. 4.26b).

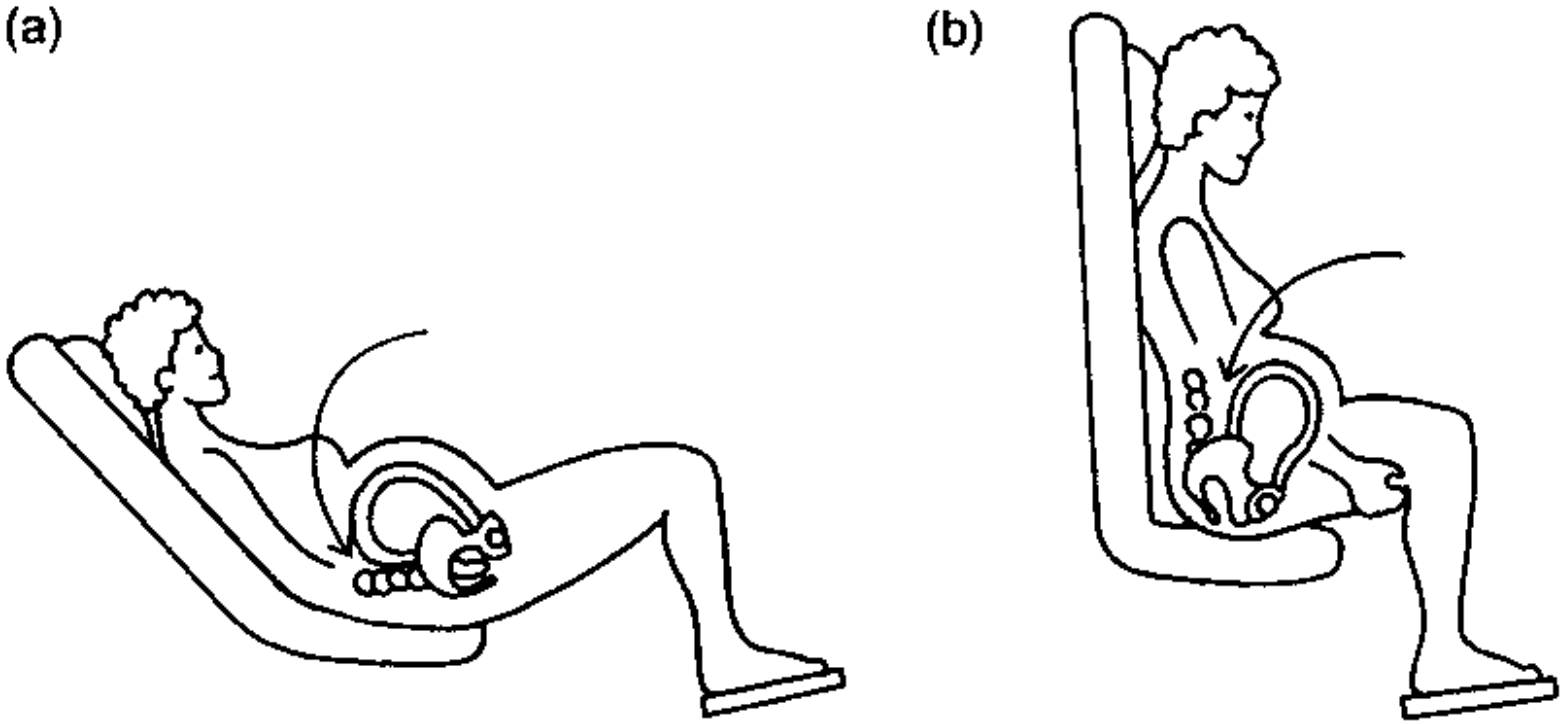


Fig. 4.25 (a) Woman reclining. Weight of uterus rests on her spine. Adapted from reference 10. (b) Woman upright. Fundus tilts forward. Adapted from reference 10.

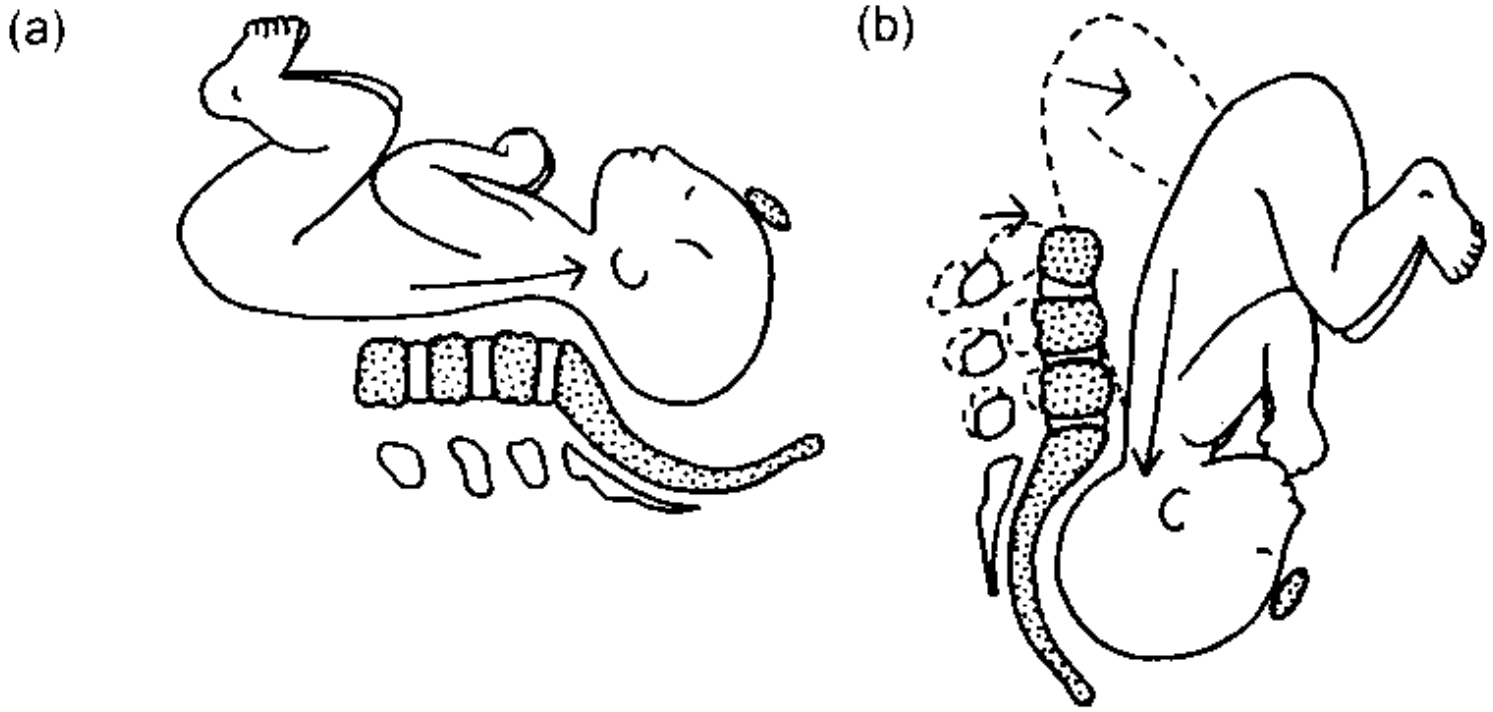


Fig. 4.26 (a) Woman reclining. Head of OP fetus directed toward pubic bone. Adapted from reference 10. (b) Woman upright. Head directed into pelvic basin. Adapted from reference 10.

Positions for tired women

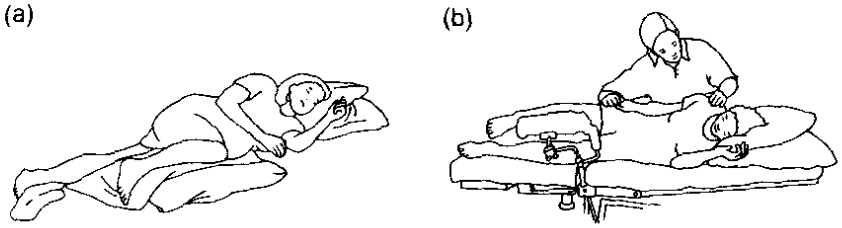


Fig. 4.33 (a) Semi-prone, lower arm forward, (b) lateral with leg support.

Fig. 4.34 Semi-sitting.

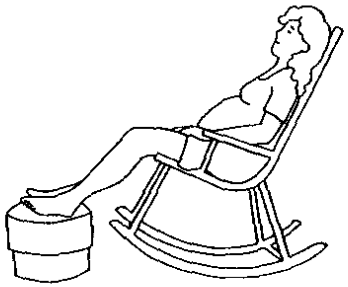


Fig. 4.35 Sitting in a rocking chair.

Fig. 4.36 Sitting backward on toilet.

Presistent Cervical lip or a Swollen Cervix

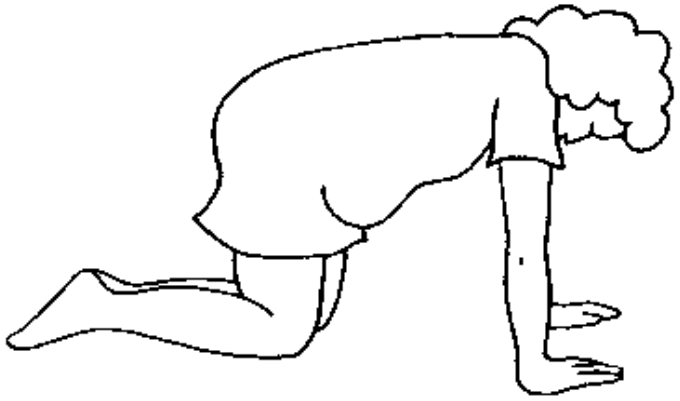


Fig. 4.37 Hands and knees.

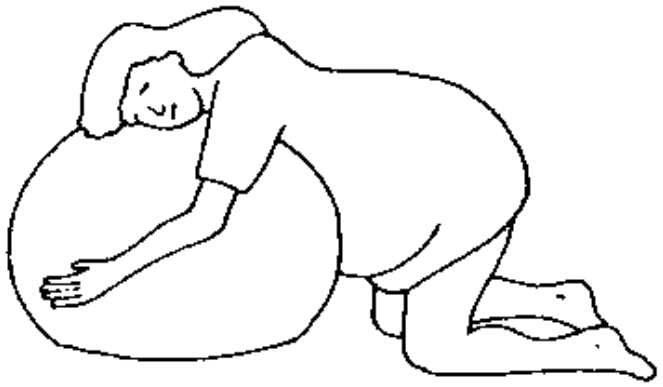


Fig. 4.38 Kneeling with a ball.

Fig. 4.39 Open knee–chest position.

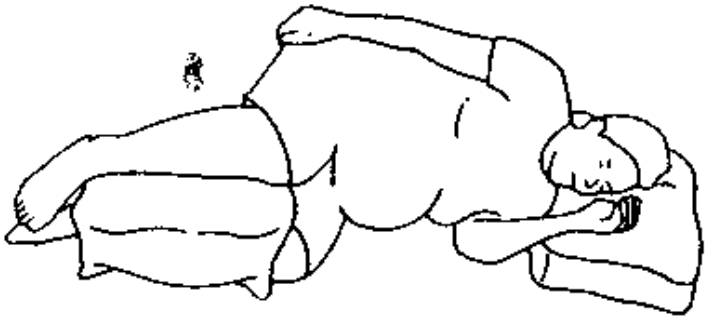
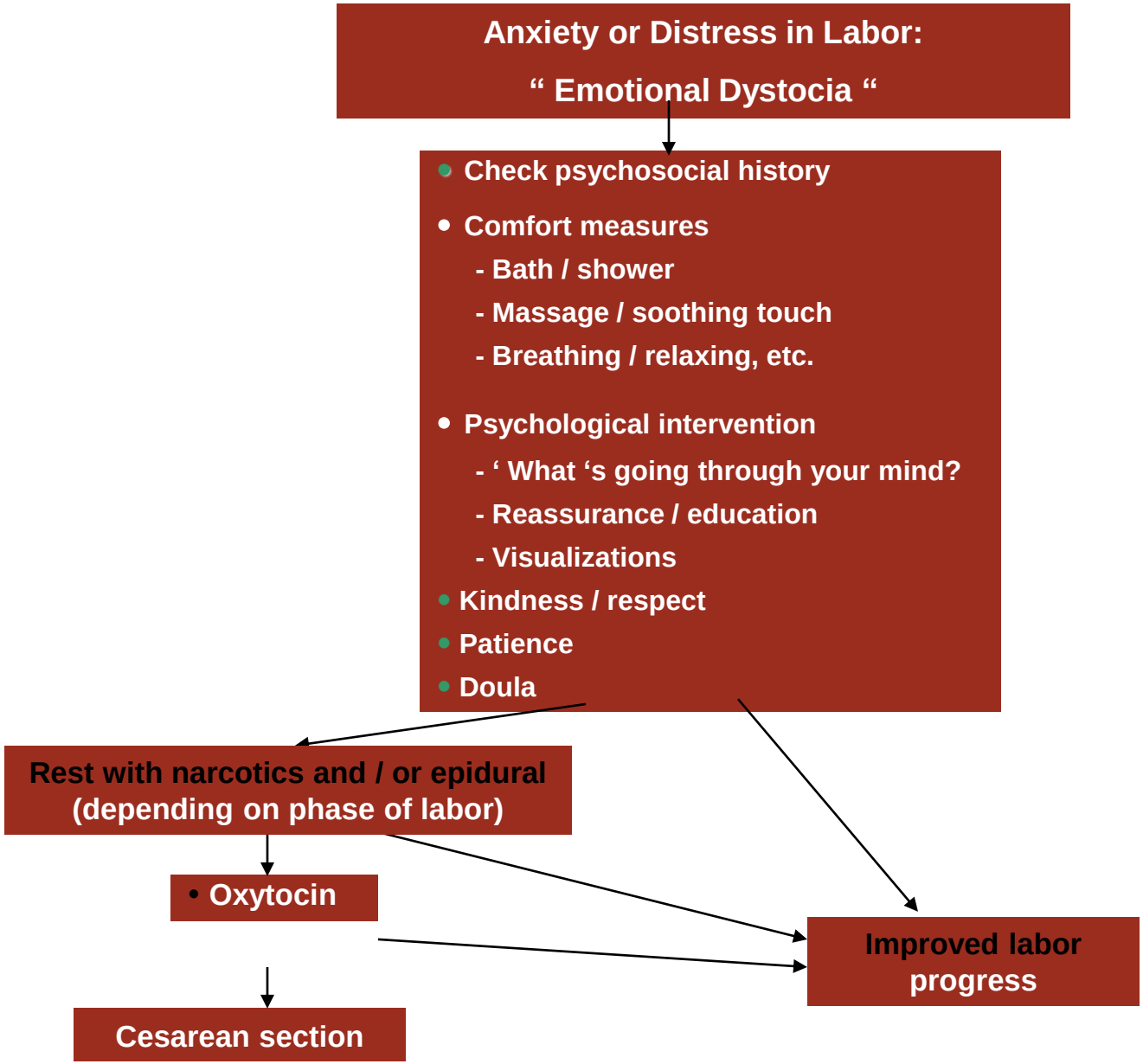


Fig. 4.40 Lateral.

Emotional dystocia

How to help a woman for whom emotional distress is a likely cause of labor dystocia



Prolonged Second Stage

Definition: **Complete dilatation of Cervix and ends with the birth of baby**

Latent phase: **Lull in uterine activity around the time of Complete dilatation = resting phase = rest and be thankful**

It is probably a physiological phenomenon relating to the retraction of the Cervix around the head and the descent in to Vaginal Canal

What is the latent phase of the Second Stage Persists

In the lull in uterine activity persists for more than 20 or 30 min:

- **Monitoring**
- **Sitting up right (in bed or on the toilet)**
- **Squatting**
- **Walking**
- **(Acupressure, nipple Stimulation)**

Solution for Second Stage dystocia

- **Position and other Strategies for Suspected OP , OT**
  - **Leaning forward while Kneeling, Standing or Sitting**

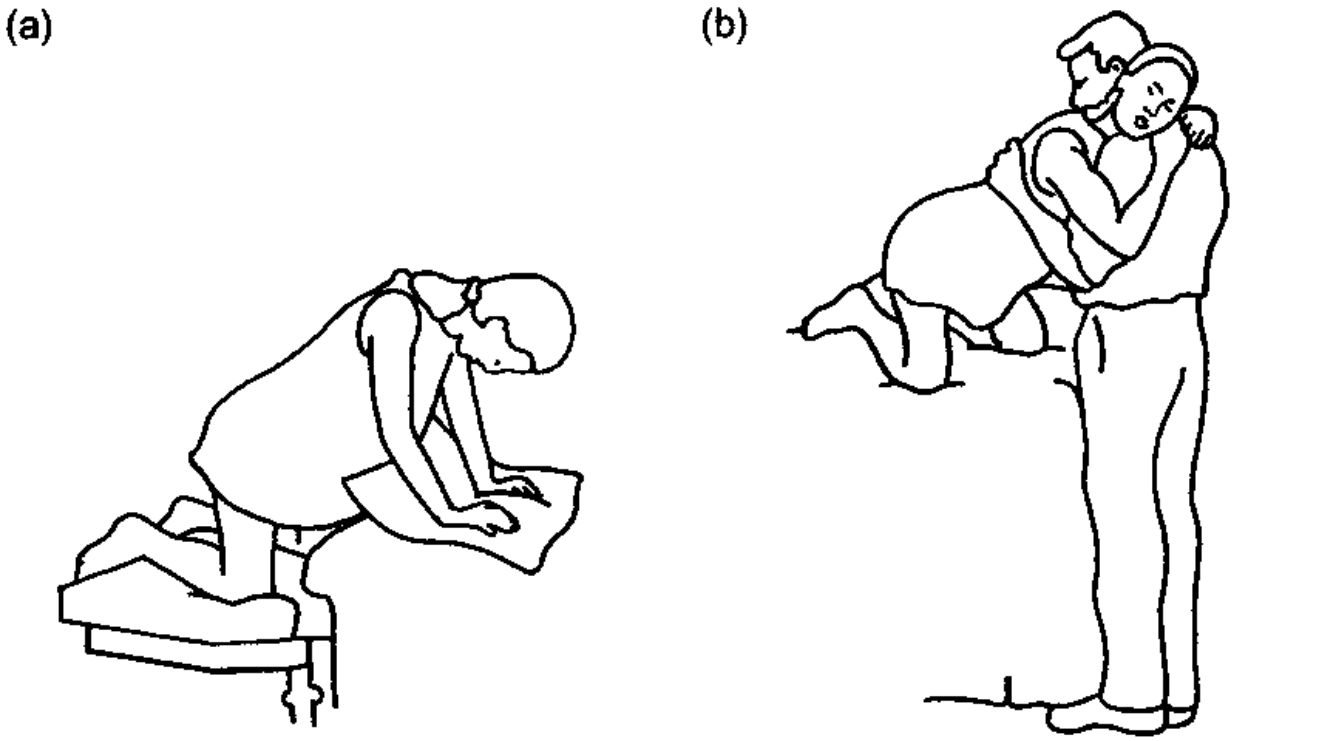


Fig. 5.3 (a) Kneeling on foot of bed. (b) Kneeling, leaning on partner to push.

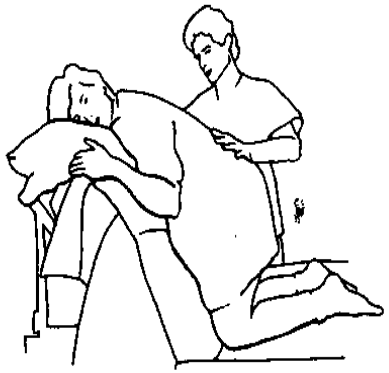


Fig. 5.4 Kneeling, leaning on the raised head of the bed.

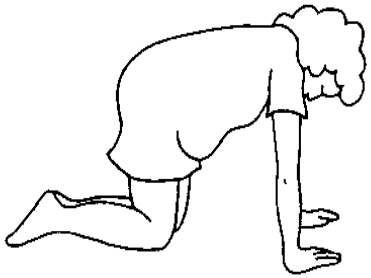


Fig. 5.5 Hands and knees.

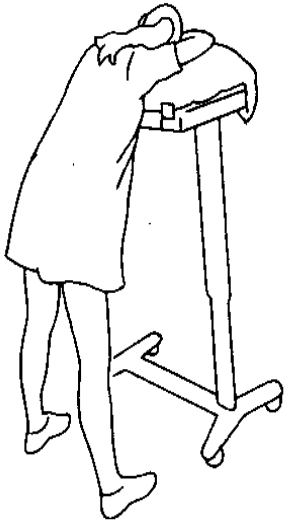


Fig. 5.6 Standing, leaning on a tray table.

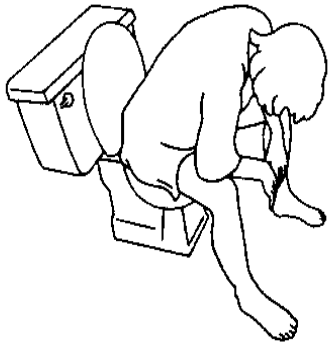


Fig. 5.7 Sitting forward on toilet.

→ **Encourage rotation of the trunk from Posterior**

→ **Back pain is relieved**

- **Squatting Position enlarge the Space in the Pelvic**

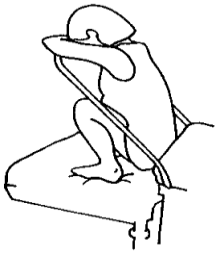


Fig. 5.8 Squatting with bar.

Fig. 5.9 Lap squatting.

Asymmetrical positions

In these each of the woman's legs is in a different position (for example, one knee up and one knee down). This changes the shape of the pelvis in ways that are different from 'symmetrical' positions such as squatting, and hands and knees. The pelvic joints on one side of the pelvis widen more than the joints on the other side. Sometimes the fetus is more likely to rotate with such positions. See Figs 5.10–5.12, and pages 58 and 141–3 for more information on asymmetrical positions.

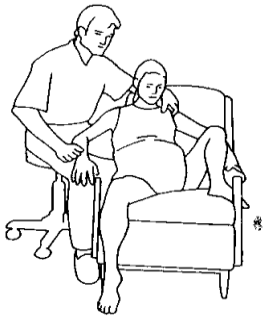


Fig. 5.10 Asymmetrical sitting.

What does Position does?

- Provides gravity advantage
- Enlarges Pelvic outlet by increasing the inter tuberous diameter
- May require less bearing - down effort than horizontal Positions
- May enhance urge to push
- May enhance fetal descent
- May relieve backache

If continued for a prolonged Period, Compresses the blood vessels and nerves located behind the Knee Joint

What not to use Squatting?

- Joint injury, arthritis, Weakness in legs
- When fetal head has not reached the level of the ischial Spines

Asymmetrical Positions

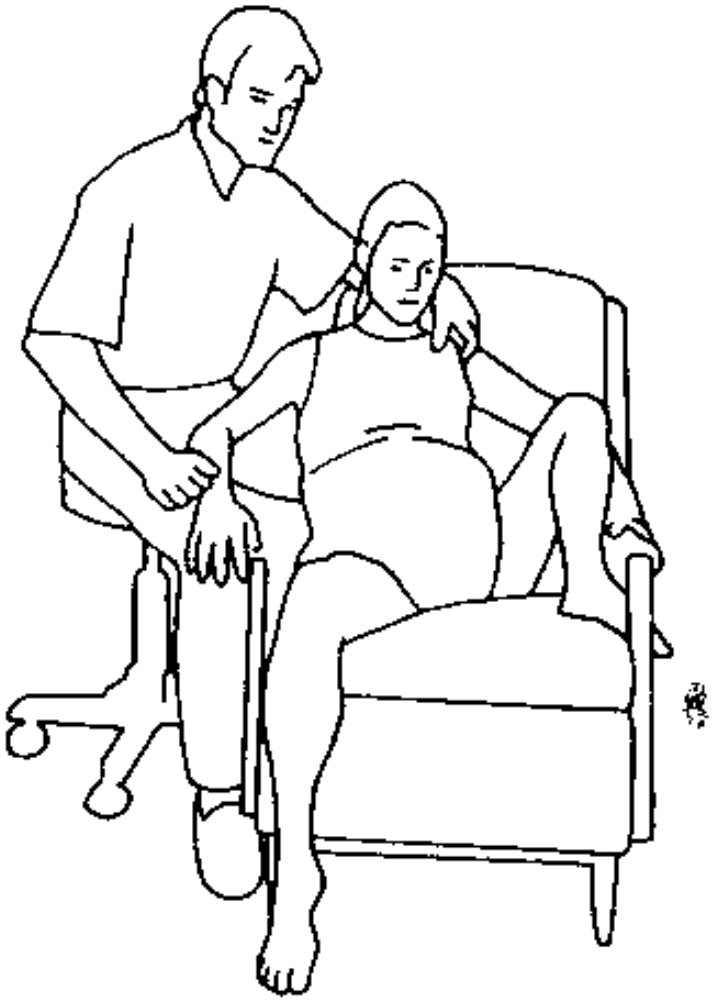


Fig. 5.10 Asymmetrical sitting.

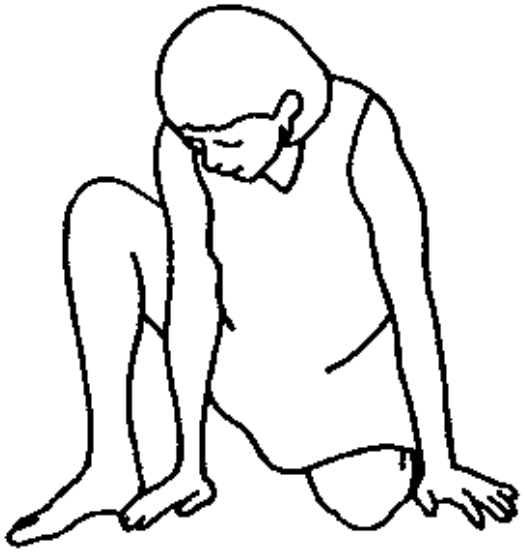


Fig. 5.11 Asymmetrical kneeling to push.

Fig. 5.12 Asymmetrical standing.

- **Supported Squat or "dangle" Position**
- **Provide more V**

(a) (b)

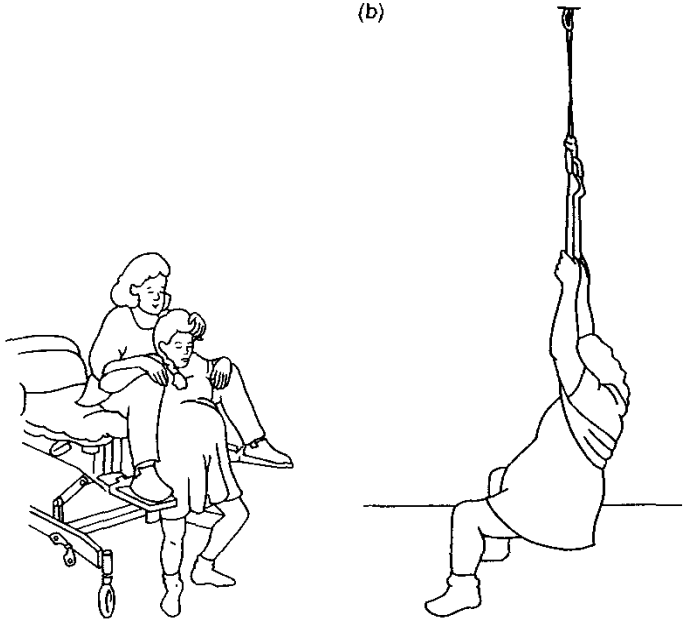


Fig. 5.17 (a) Dangle. (b) Dangle with birth sling.

Other strategies

The *pelvic press* is sometimes helpful in cases of deep transverse arrest, occiput posterior, or a 'tight fit' in the second stage, as a method to increase midpelvic and outlet dimensions to make room for fetal rotation and descent[25]. (See Fig. 5.18a, b and also the Toolkit, Chapter 6, page 161, for a description of the pelvic press.)

Please note that the pelvic press is not the same as the 'double hip squeeze.' The main difference between the two is the placement of the hands. The pelvic press is used to enlarge the pelvic outlet in the second stage; the double hip squeeze is used to relieve back pain at any time in labor.

A variety of movements may help rotate the fetus. See Chapter 6 for pelvic rocking (Fig. 5.19 and page 152), lunging (Fig. 5.20 and page 154), slow dancing (Fig. 5.21a and page 157), and swaying on a ball (Fig. 5.21b and page 162).

Other Strategies

- **Pelvic Press :**
  - **Increase mid pelvis and Outlet dimension**

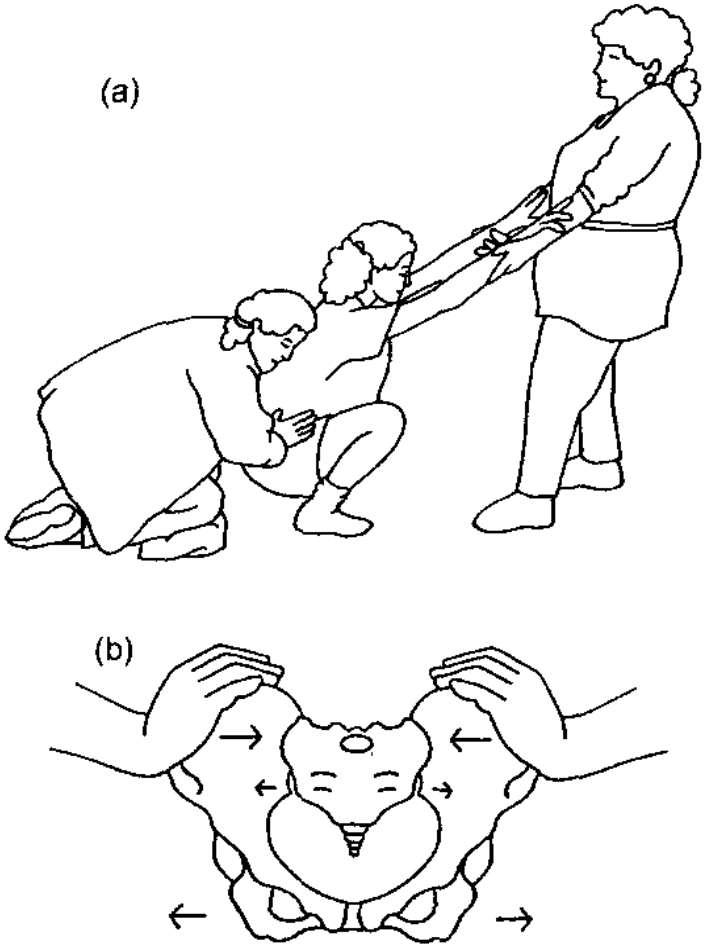


Fig. 5.18 (a) Pelvic press. (b) Detail of pelvic press.

- **Pelvic Rocking :**

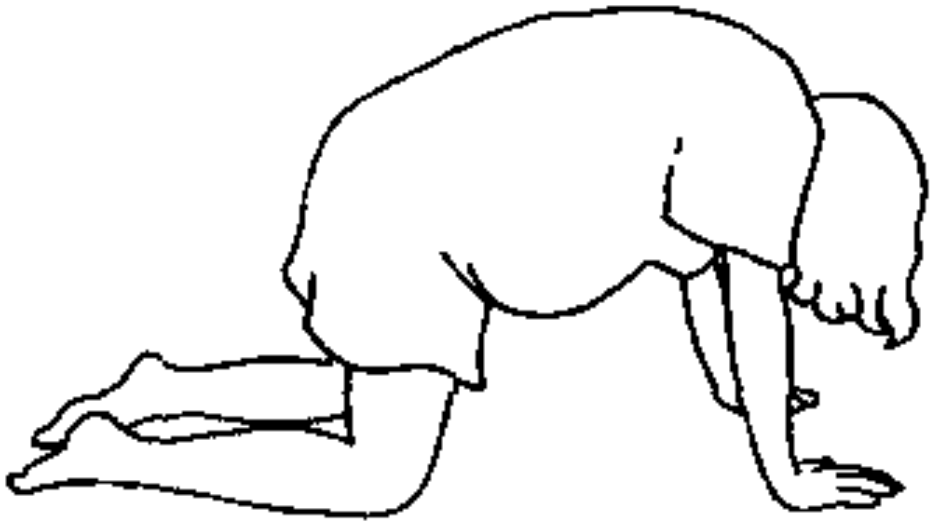


Fig. 5.19 Pelvic rocking.

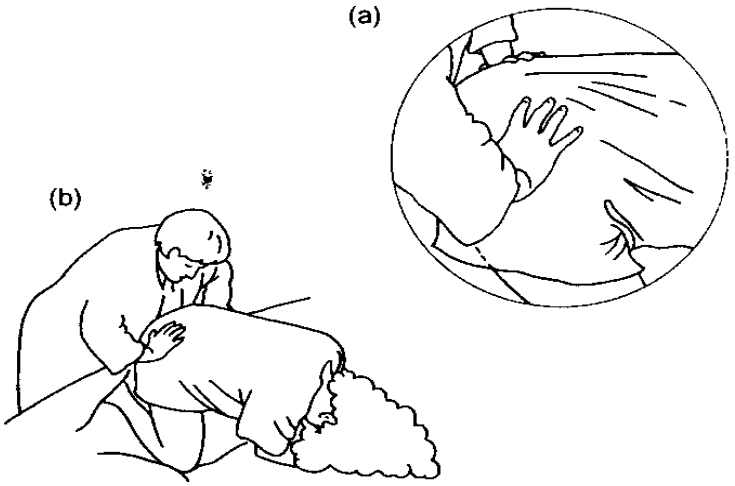


Fig. 5.24 (a) Detail of double hip squeeze. (b) Double hip squeeze.

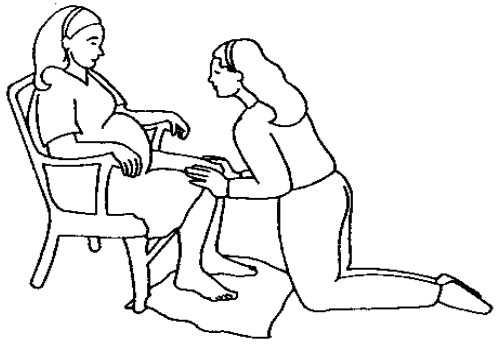


Fig. 5.25 Knee press – woman seated.

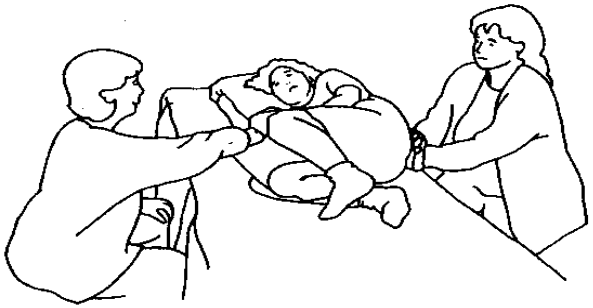


Fig. 5.26 Lateral knee press – woman on her side.

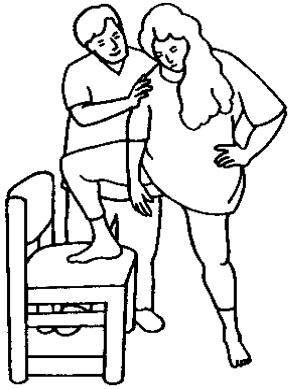


Fig. 5.20 Standing lunge.

(a) (b)

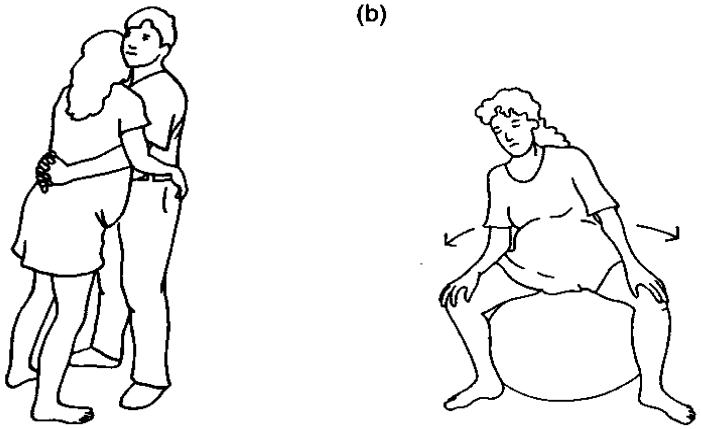


Fig. 5.21 (a) Slow dancing. (b) Swaying on a ball.

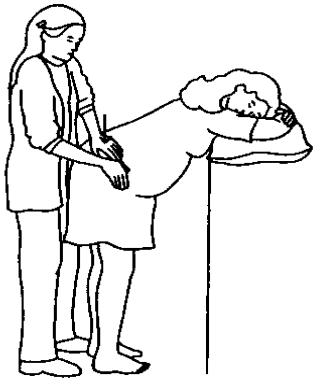


Fig. 5.22 Counterpressure.

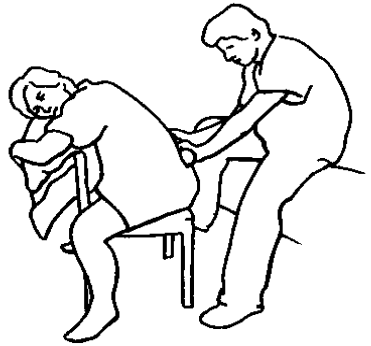


Fig. 5.23 Counterpressure with tennis balls.