Tips for Practitioners – Practical Obstetrics & Emergency Obstetrics

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Episiotomy ??

Evidence for the protective effect of episiotomy is conflicting.

Episiotomy is the classic example of EBM

(Evidence biased medicine !)

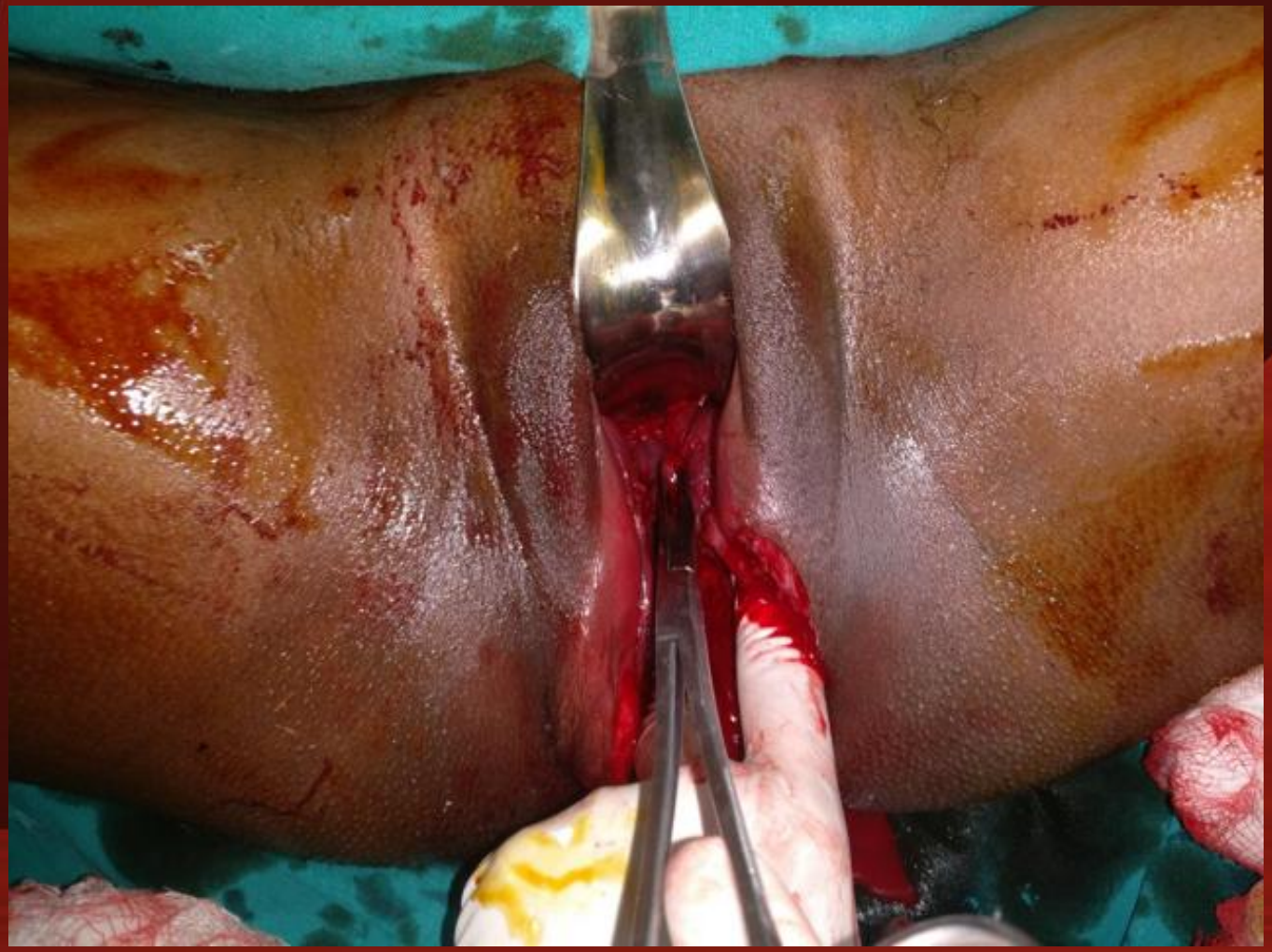
In our patients we do require episiotomies for almost all primis.

Episiotomy - tips

- Shorter the perineum more lateral you cut.
- Thinner the perineum more lateral you go.
- Starting from midline <u>60^0 away</u>

→ 60^0 episiotomy results in 45^0 post delivery angle (RCOG)

For easy suturing of episiotomy catch the apex by long Allis forceps



Episiotomy wound gap

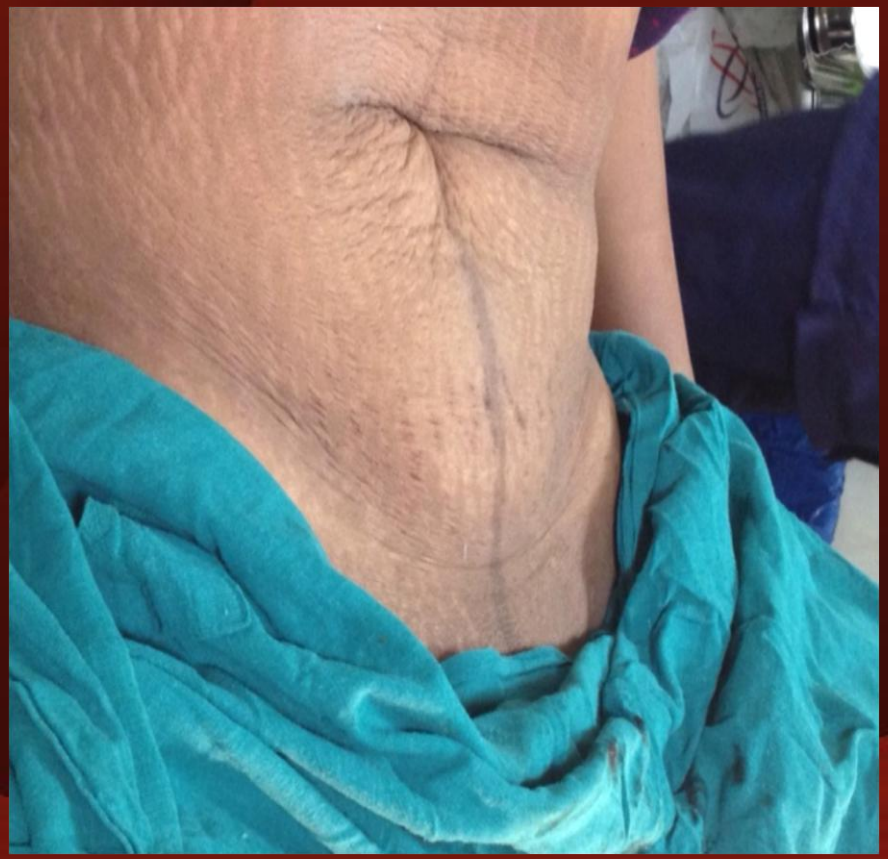
→ **Blood supply of perineum is better than your skill**

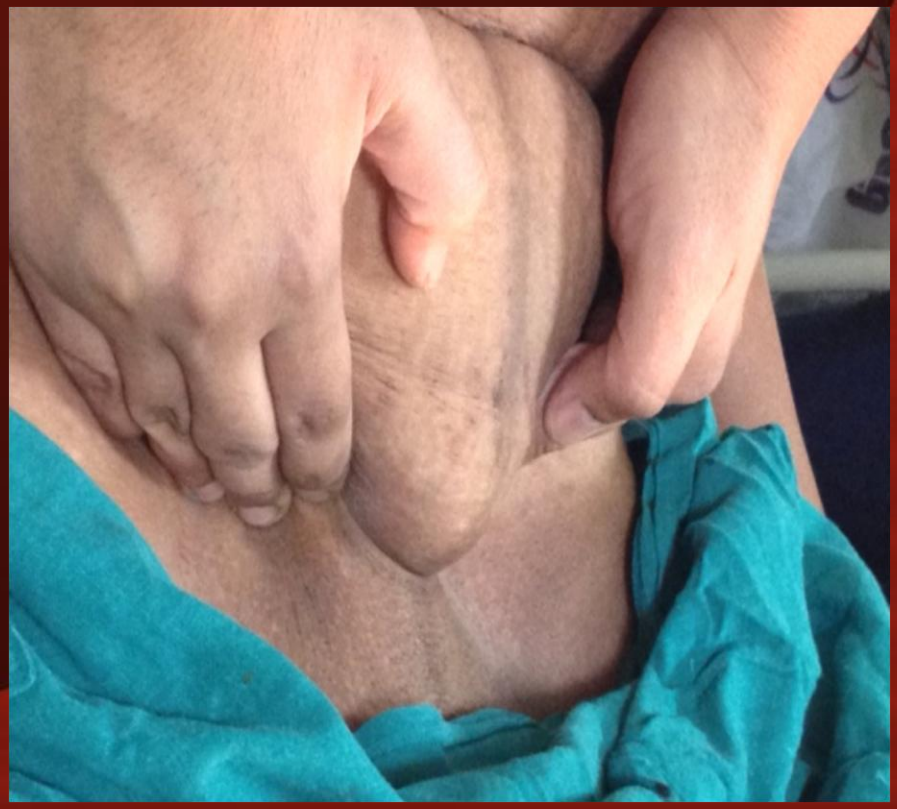
→ **Blood supply of perineum is better than your suture material.**

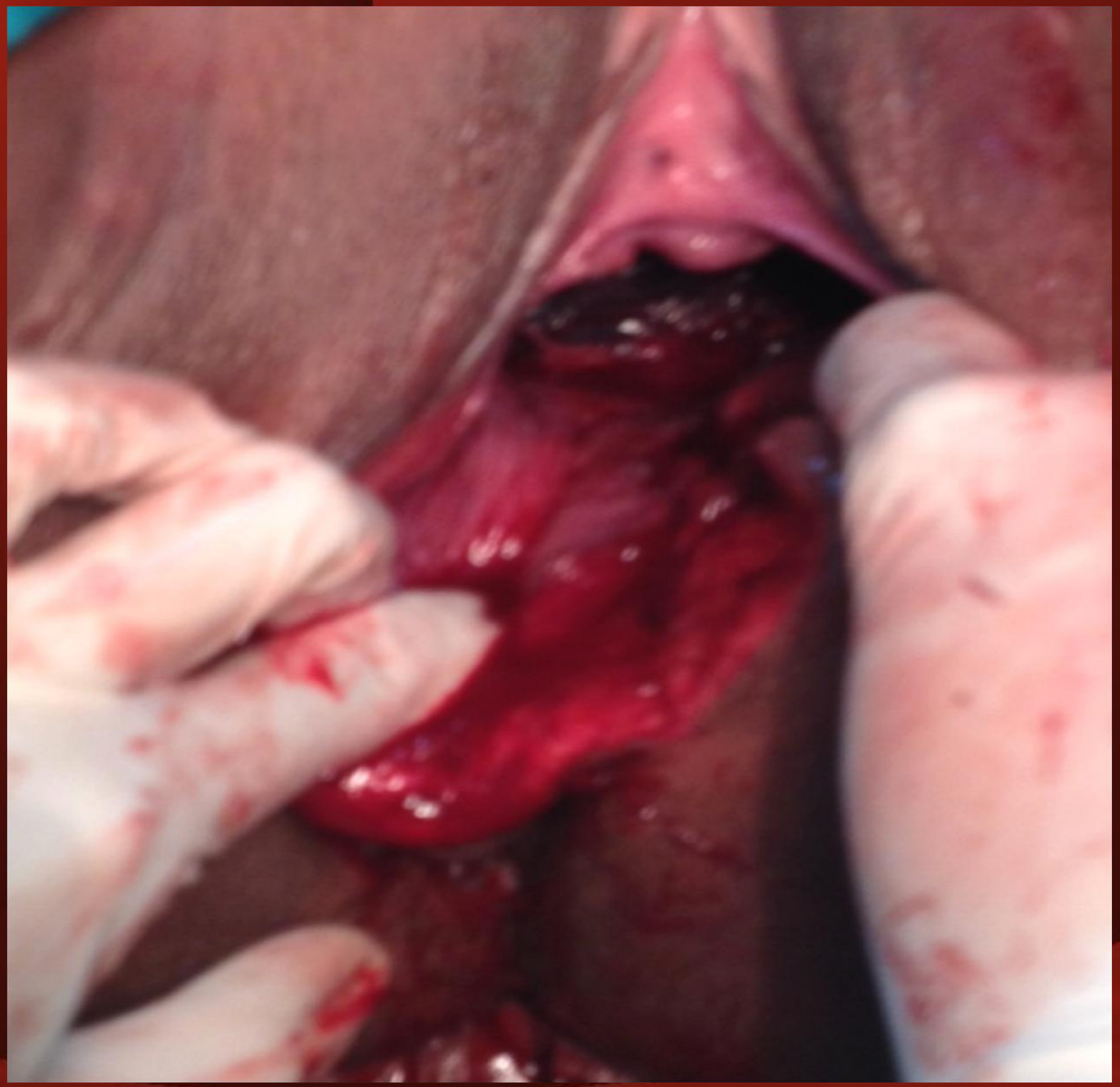
DON'T RESUTURE ALWAYS

Exploration for vaginal tears

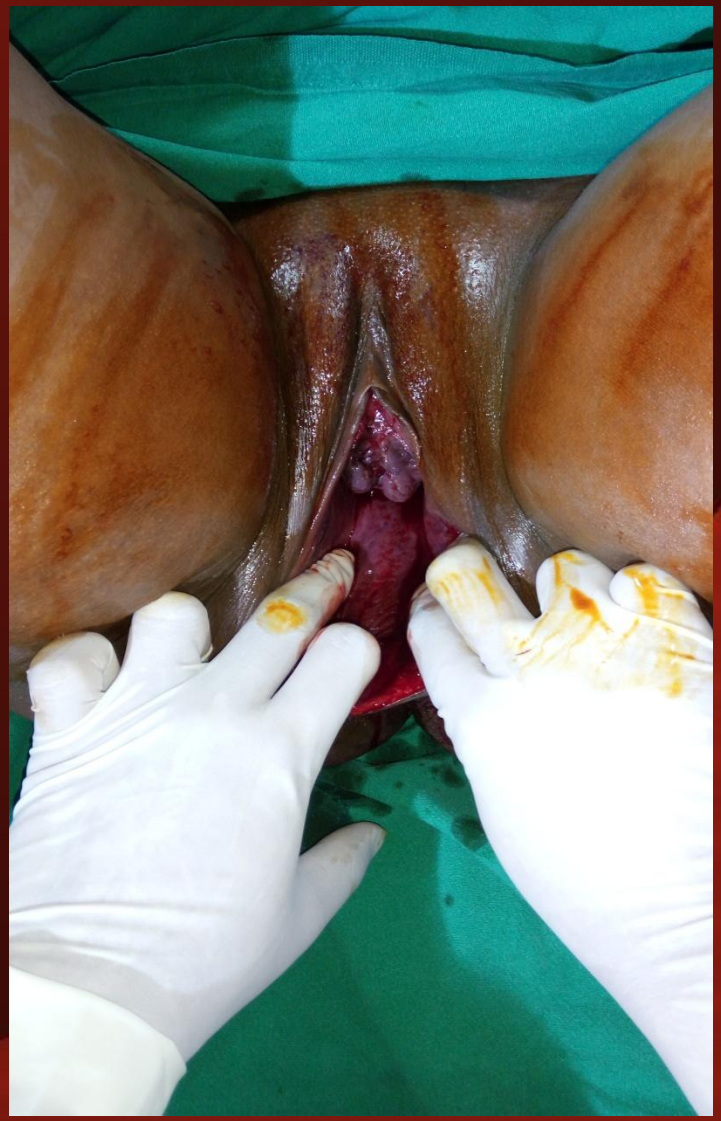
- **Ask the assistant to pull the whole uterus above from abdominal route (Hands on suprapubic region)**







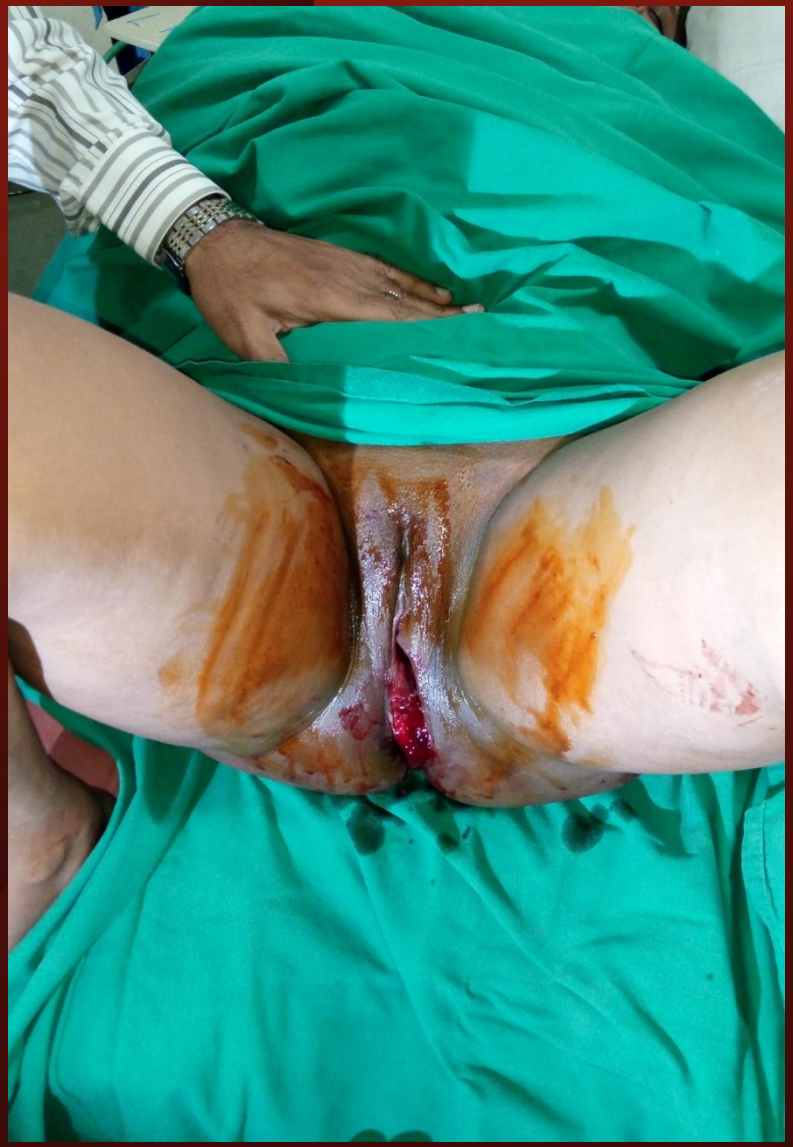
Vagina will be converted in big canal and you can easily detect site & size of the any bleeder, tear or laceration

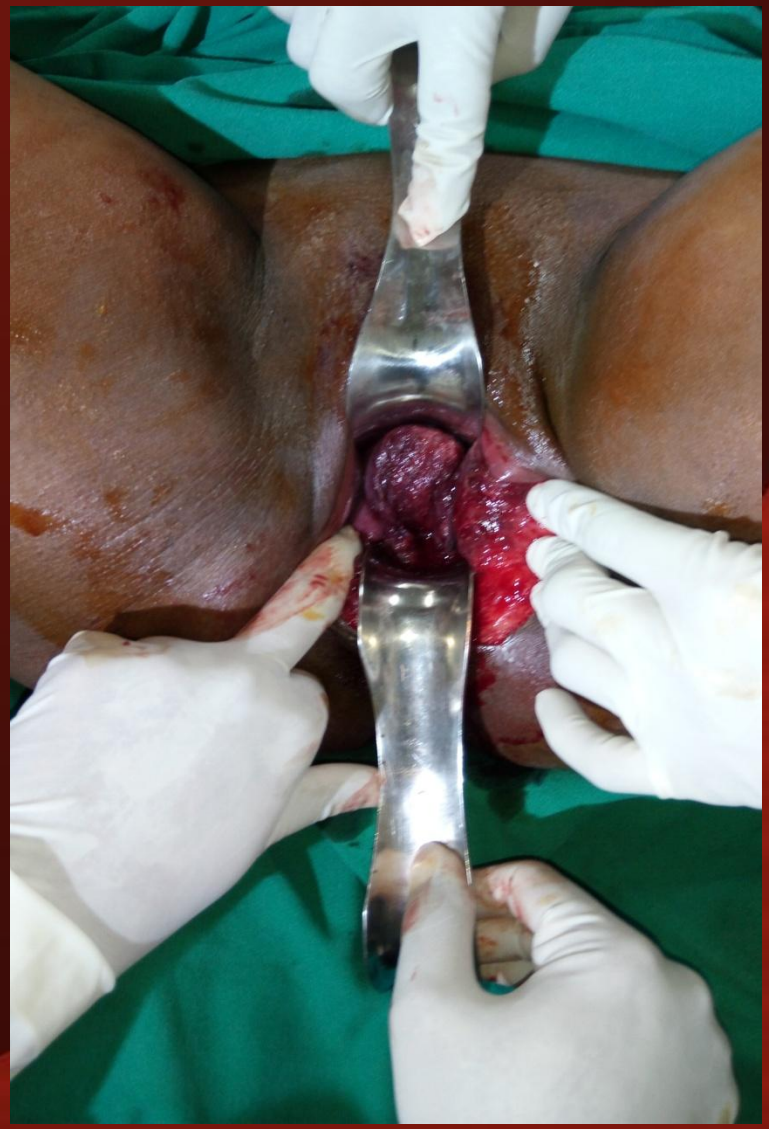


Exploration of cervix

When you want to explore the cervix ask the assistant to push the postpartum uterus – fundus from above.

Cervix will be almost at introitus & very easy to explore





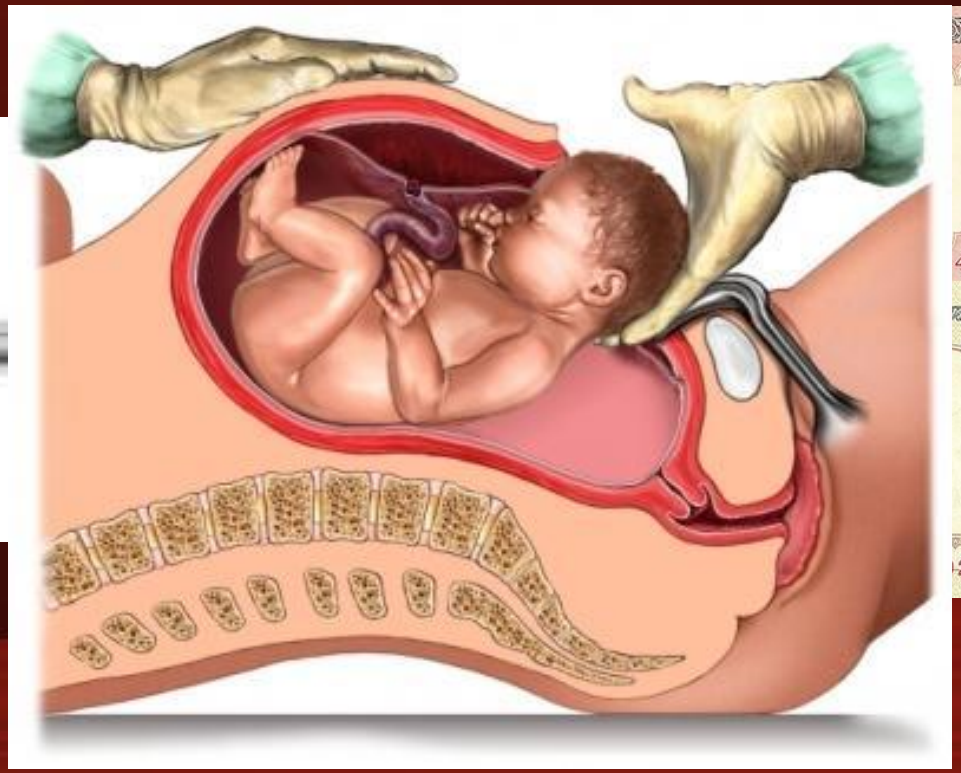
Episiotomy hematoma

Rx - Medium & large one requires exploration

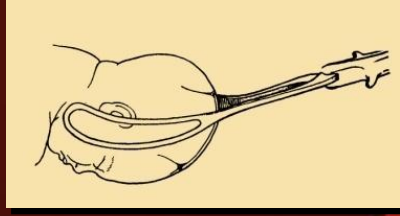
- **Copious saline irrigation with force (jet)**
- **All clots are drained**
- **Clots look like tissues (False)**
- **Blood stains the tissues (Real)**
- **Bleeders may not be always found**
- **Suturing from depth of hematoma cavity**

Hematoma is always bigger than you think

Instrumental delivery
A Vanished art ?
Like vanihed notes !



Forceps Technique - Tips

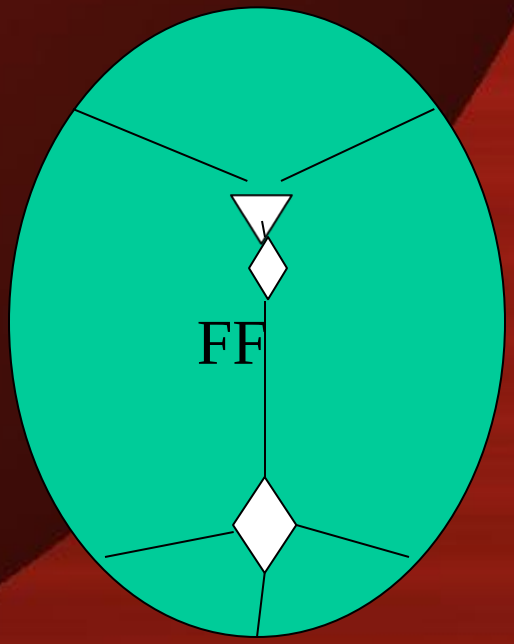


- Abdominal examination of the fetal head is an important step to judge the depth of engagement.

- Even that may be misleading in occipito - posterior ! !

Prerequisites

- Position precisely known
  - 3 fingers examination
  - Beware of false fontanelle
  - Lambdoid suture is on more curved surface
- Generous mediolateral episiotomy



* Willingness to abandon the attempt

Forceps Technique - Tips

- **If difficulty in locking**

  → **Depress the handles**

  → **Manipulate the right blade or**

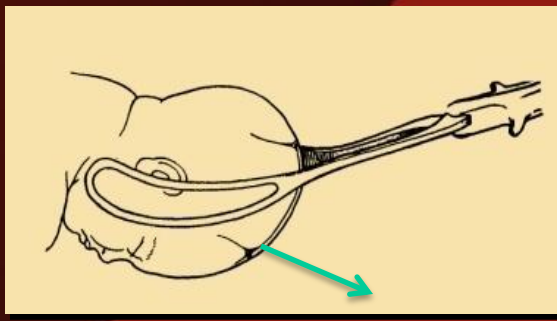
  → **Push the blades in – then you can rotate**

Difficulty in locking indicate malposition or deflexion

Forceps - Tips

- Traction in axis of pelvis & mimicking spontaneous delivery

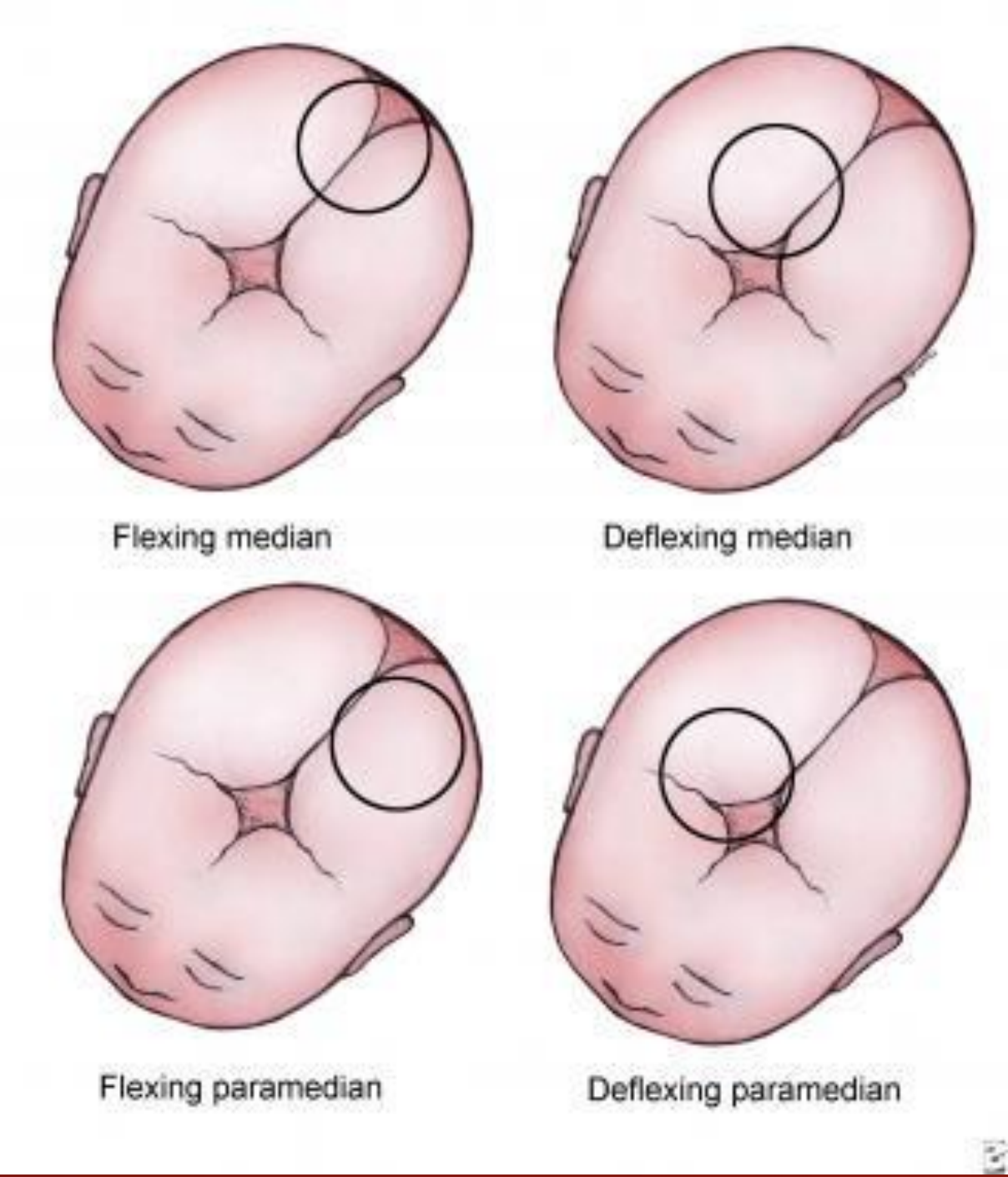
Give traction posterior to handles



Traction should be only using force afforded by flexed elbows (!)

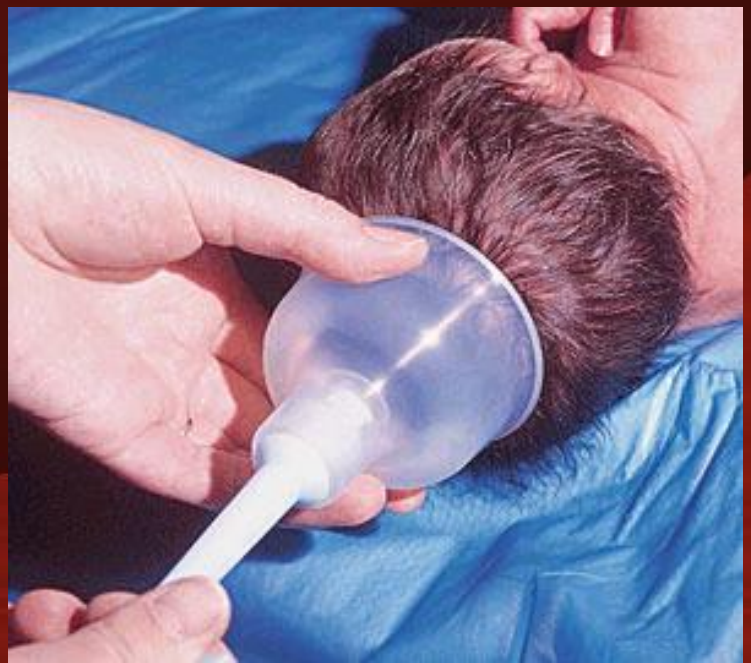
Outlet & Low Forceps are absolutely safe

Vacuum Technique - Tips



Vacuum Technique - Tips

- **Pull in axis of pelvis, when uterus is contracting and mother is pushing.**
- **Support the cup in off-perpendicular pull**



Vacuum Technique - Tips

It is prudent to wait until the vacuum cup is beyond the vulval outlet prior to applying forward traction

* Tension on the extractor handle is allowed to build gradually paralleling uterine contraction

Forceps or Vacuum ?

- Neither the instrument is perfect & neither is to be condemned
- One should continue with his/her own expertise, original training & experience
- The need of the hour is to preserve the science & art of instrumental delivery
- Sequential delivery ??? NO

Instrumental deliveries- Evidence

- **ACOG Practice Bulletin No. 154: Operative Vaginal Delivery. November 2015**

  The risk for complications with forceps and vacuum extractors is low and they are acceptable for use in operative vaginal delivery. (Level A recommendation)

- **RCOG 2010 – Recognised place for instrumental deliveries in clinical practice**

Medico legal aspects

- **The threat of litigation should not dictate the method of Delivery**

- **Law cannot practice medicine Law is to control malpractices & negligence if at all**

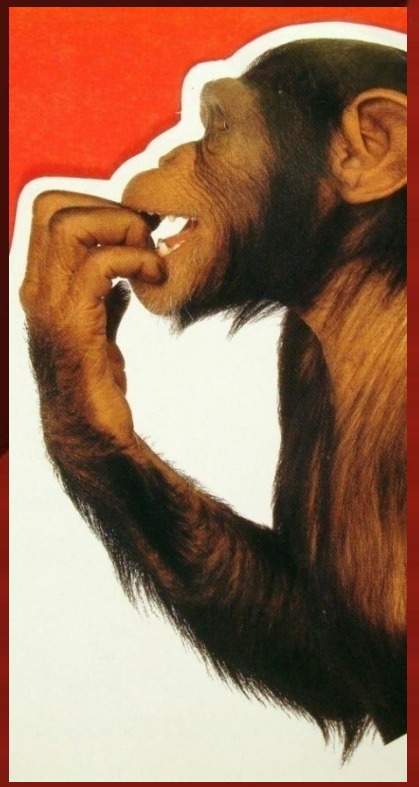
  (Supreme court verdict)

My Surprice !

- It is paradoxical that you readily cut an abdomen of young patient (LSCS)

  BUT

  you would like to do V H (N D V H) when she is old.



Oligohydramnios

- No vertical pocket of 2 cm is diagnostic
- Incidence is 5 %. However with sonography routinely used the incidence is increasing.
- Causes are idiopathic, IUGR, fetal anomalies postdate pregnancy, placental insufficiency
- Daily about 1000 ml fluid flow in the amniotic cavity & same amount flows out in 3rd trime.

Transient oligohydramnios should be disregarded.

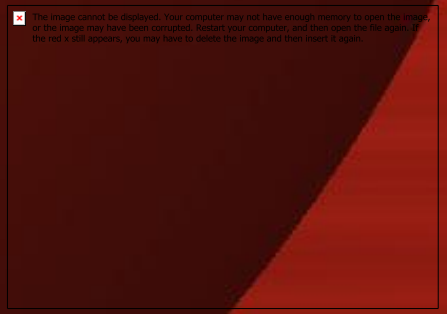
Oligohydramnios

Management :

- **Rest, hydration & fetal wellbeing assess.**
- **Oral or IV hydration improves AFI by 30 %. However it is only temporary.**
- **Treatment of the cause if possible**
- **In idiopathic oligohydramnios aminoacid infusion or oral L arginine might help.**
- ***Oligo → close monitoring in labour***
- ***Oligo + any obst. factor → elective LSCS.***

Severe Preeclampsia

It is extremely difficult to predict which organ will be affected with what severity & what rapidity.



We know the treatment – Termination

- ***Atypical preeclampsia*** **:** ***PE < 20 weeks of gestation and > 48 hours after delivery OR casess that have some of the signs and symptoms of preeclampsia without the usual hypertension or proteinuria.***

Severe Preeclampsia

Management :

< 24 wks → Give antiHT, Mag. Sulph & terminate

> 34 wks → Give antiHT, Mag. Sulph & terminate

<u>24 – 34 wks</u>

→ Antihypertensives

→ Steroids

→ Monitoring- Symptoms, BP, Lab reoorts

Fetal surveillance

→ If worsens →Give Mag. Sulph & terminate

Breech - E C V

- After 36 wks
- Under tocolysis
- Success rate 60 %
- USG before & after procedure is must.
- Rotate on the flexion side
- Risk of fetal complications is extremely rare

Experience can be gained by attempting version at 30-34 wks in parous patients.

Vaginal Breech delivery

- Parous patient – Properly selected cases, proper counselling & written consent
- Give generous episiotomy as late as possible.
- Fundal pressure all throughout delivery but suprapubic pressure for head delivery.
- Aftercoming Head – Breech allowed to hang until the head is fully engaged & nuchal line is visible.

Trapping of aftercoming Head

- Inj.n Epidosin if cervical rim OR Inj.n Nitroglycerin 50 to 100 ug I/V
- Make the head to oblique position & then give traction in exaggerated lithotomy position & proper suprapubic pressure
- Duhrssen's incisions at 4 & 8 o'clock – Not as dangerous as thought

Vaginal Twin delivery

- Vaginal delivery only when first vertex. Even in that, presence of any complicated factor demands LSCS

- Induction not done routinely in twin Only in postdatism induction is indicated, which is rare.

Vaginal Twin delivery

- Oxytocin from the first baby. Deliver 2nd baby in 30-60 min, Do ECV, if unsuccessful IPV under G/A and breech extraction gives better perinatal outcome (EBM)
- C S for second baby:-
  if cervix closes, if second baby is larger, if version fails, if there is excessive bleeding or fetal distress

T O L A C (VBAC)

- **Possible in institutional setup**
- **In private set up problem of consent & One to one continuous monitoring .**
- **Time factor for immediate CS ?**

Tips : Favorable factors during labour most important :- Good uterine action, Early engagement of head, Progressive dilatation of cervix & descent of head.

Low threshold for resorting to LSCS

Intrapartum fetal monitoring

- **Intermittent auscultation with stethoscope or Doppler device is sufficient in low risk patients.**

  Transient irregularity should be disregarded.
- **In preterm labour fetal tachycardia & irregularity can be physiological**
- **Cord round the neck ?→ close monitoring**

  Detect during 9th month USG ”
- **Meconium stained liquor → Thin ”**

Slow progress of labour

- Do not mistake false labour as active labour
- Do not admit patient in latent phase unless you are worried about fetal monitoring
- Once admitted prolonged waiting make patient, relatives and the doctor anxious & restless resulting into unnecessary CS for failure of progress of labour !

Slow progress of labour

- **Do minimum P/V examination. Frequent examination makes you bias & also leads to increased chances of infection.**
- **Assess & manage each case individually. Each fetus & maternal pelvis presents a unique pair of sets.**
- **Slow progress in vertex presentation is usually due to 3 causes: inefficient uterine contractility, OP position (10 %) or CPD (5%)**

Have friendship with cervix !

Shoulder dystocia

- Shoulder dystocia is very rare but dangerous complication - as it is rare, it is unexpected - a nightmare for obstetrician.
- Anticipate the problem if there is maternal obesity, diabetes, macrosomia, past history, prolonged 1^{st} or 2^{nd} stage.
- Many cases it may not be anticipated
- Turtle sign' After head is delivered it retracts back tightly against the maternal perineum

Shoulder dystocia

- Fetal head does not restitute & there is no obvious external rotation
- Shout for help. Experienced help better but even paramedical staff or patient's relatives can help because you require 2-3 persons. If help is not immediately available get on with it.
- Give or extend the episiotomy.

Shoulder Dystocia

- Mc Robert's manouever - Maternal thighs are sharply flexed on to the abdomen. Firm steady traction on fetal head is given downwards & backwards.
- Assistant should give firm suprapubic pressure (not fundal pressure) to push anterior shoulder in & anteriorly
- Ask the mother also to push strongly.
- These measures will resolve 90 % cases

Retained placenta - M R P

- **Ketamin / Propofol may be sufficient, but Halothane/Isoflurane may be necessary.**
- **Take care to minimize the profile of hand, introduce FULL hand high inside. Go between the membranes & uterine wall**
- **Abdominal hand maintaining the position of (steady) uterus is important**

Wait → it clicks

Tips for cesareans

- Adequate Skin incision

<u>Repeat CS</u>

- Excise the abdominal scar of previous CS
- Clues for intraabdominal adhesions
  - First trimester P/V → Mobility
  - Constant suprapubic pain during preg.
  - After anesthesia if the scar is indrawn

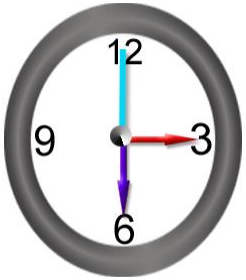
Tips for all cesarean

Uterine incision must be adequate

- **Adequacy of the uterine incision should be checked**

  Adequacy of the uterine incision should be checked

- **Undue haste is to be avoided.**
- **Uterine incision delivery interval upto 180 seconds quite safe - JPOG**

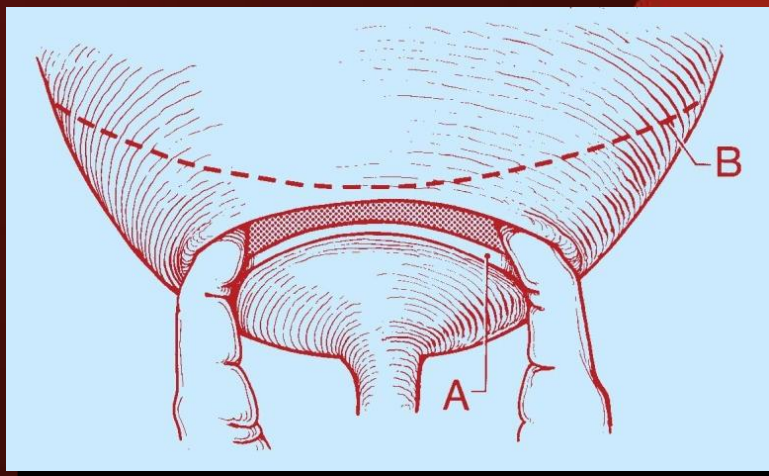


Uterine Incision

Finger Splitting - **Rapid & easy but less space**

Less bleeding !

More extension !



Cutting - Adequate space

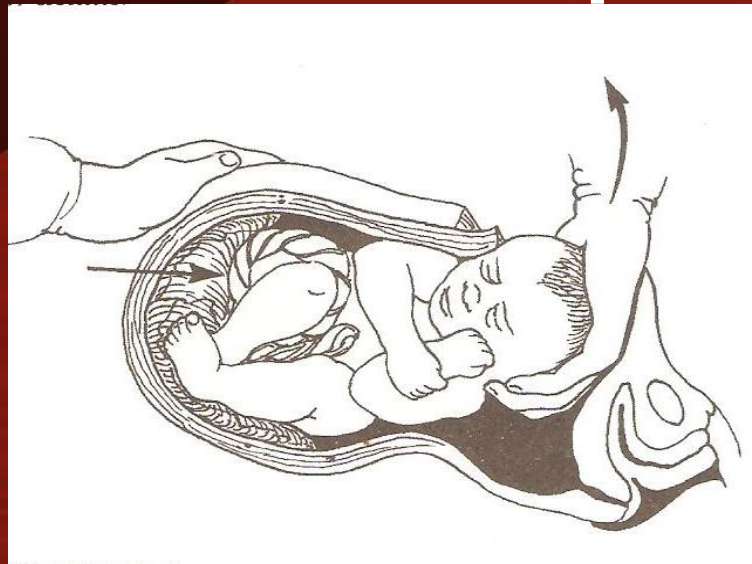
Good for suturing

Strong scar !

Always cut when space is a problem

Tips for all cesarean

- Insert the full hand well below the head
- Have the proper grip (Parieto-Occipital)
- Flex the head, elevate it towards the incision and deliver it - shoe horn technique
- Anterior rotation not must
- Lateral flexion is sufficient



Deeply engaged head

1. Push from below
2. Patwardhan method - EASY delivery
3. Lift the fetal shoulder/s(with uterus) up

High Floating Head

1. Wait, wait & wait - let the liquor drain out
2. Pass hand inside, Catch the leg & deliver as Breech
3. Instrumental delivery : Forceps/Vacuum

P P H

- **Medical Rx make the uterus to contract :-**
  up to 70 % effective

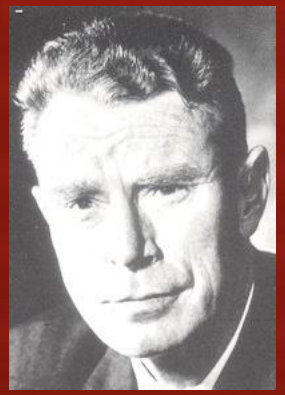
- **Manipulative methods works by pressure hemostasis - outer or inner compression :-**
  up to 80 % effective

- **Surgical methods(cut the blood supply directly) - > 90 % effective**

P P H

- **Bilateral uterine artery ligation is fairly easy, rapid, effective & with low complication rates → <u>Low ligation,</u> <u>Adequate ligation,</u> <u>Bilateral ligation</u>**
- **Hysterectomy :- Definite treatment**

  <u>Early decision most important</u>



"Beware of the inertia not only in the uterus, but also in the attendant " - Ian Donald

P P H at L S C S

- **Prompt & adequate suturing of incision**
- **Exteriorize & massage**
- **Bimanual compression, Hot mops**
- **Uterine artery ligation, stepwi……**

- ***Aortic compression after elevating the uterus - very effective , below the origin of renal vessels***

Compression upto 10 min without any harm.

Traumatic P P H

Angle Tear :

- A – Assistant
- N – Needle holder
- G – Good Suction
- L – Light
- E – Exposure

Angle in Ob-Gyn should be respected like Angles

Placenta Accreta

Conservative treatment of placenta accreta when the woman is already bleeding is unlikely to be successful & risks of wasting valuable time.

HYSTERECTOMY

'Planned Preterm Cesarean Hysterectomy with placenta left in situ in suspected placenta accreta'

Obstetric Hysterectomy

- **Subtotal is simpler, safer, quicker & associated with less blood loss**
- **Vertical incision → All pedicles doubly ligated**
  - **→ Keep the clamps as close to uterus as possible**
  - **→ Keep sufficient stump**
  - **→ cut uterus after minimum one pedicle below uterine vessels (Descending cervical secured)**
- **Always keep large bore drain**

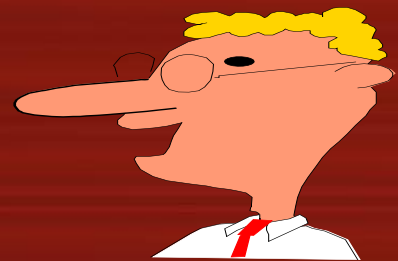
Blood products

- Use them freely without fear
- Use them adequately
- PCV minimal reactions
- FFP - no Rh compat. or X match necessary
- Cryo - no ABORh & X match necessary
- Platelets - group compatibility preferred
- Life saving in DIC & PPH

Tips for Puzzling situations

Difficult cervical dilatation :-

- **Catch the posterior lip**
- **Push 40-50 cc saline through external os & then try**
- **Give I/V Cervical relaxants**
- **USG guidance**
- **Hysteroscopic guidance**



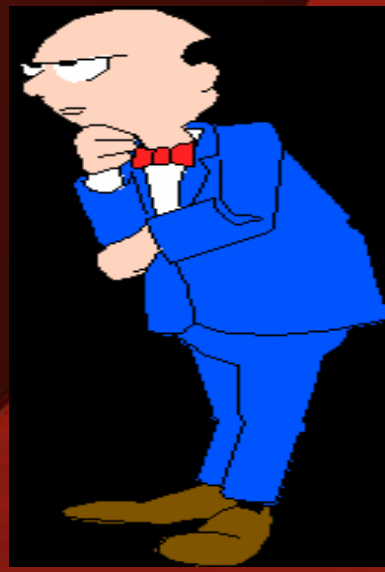
Puzzling situations – Failed Induction

- Wait for 48 hours if there is no pressing indication, Give antibiotics & then try a fresh
- Change of drug PGE1 / PGE2
  Check that Gel was properly preserved & correctly inserted
- Tablet Mifepristone 200 mg 2 days prior ?
- Foley's catheter for 24 hours

Propess dinoprostone 10 mg vaginal insert-pessary

Rescue Cerclage

→ Aim is to prolong the pregnancy till term or at least beyond survival age i. e. > 28 wks



→ Success rate reported is upto 60 %

* Steep trendelenberg position
* Fill the bladder with 600 ml saline
* Vagina washed with dilute betadine solution before & after taking stitch

Rescue Cerclage – Steps

- Mc Donald purse string suture with Prolene or Nylon is taken
- Insert small caliber Foley's catheter in the cervix, inflate the balloon 30ml to push the membranes back. (Membranes can be pushed back by moistened sponge on sponge holder).
- Deflate the balloon of the catheter removing it gradually while tying the suture.

Ectopic pregnancy Medical Rx Selection Criteria expanding

- **Mass upto 5 cm**
- **Beta HCG < 10,000 miu /ml**
- **Upto 8 weeks gestational age**
- **Cardiac activity absent / present**
- **Hemoperitoneum limited to pelvis**

Hemodynamically stable patient
Compliant & well counselled patient

Methotrexate regimen

Single Dose

- 50 mg/m^2 I /M
- B HCG on day 4 & day 7
- It should decrease by 15 % of the initial level

- Easy to use
- Effective (Success rate 80 – 96 %)
- Safe – side effects minimum
- Cost effective (Costly for Obstetrician !)

Scar Ectopic – New entity

Management :

< 6 wks – Suction curettage

≥ 6 to 10 wks –

A. Medical management

Methotrexate : Locally in the sac 25/50mg

→ Under TVS guidance(also KCl)

Systemic - 50 mg given I/M

B. Surgical : Laprotomy - Hysterotomy,

evacuation, excision & suturing the defect

Laproscopy by experts

Cesarean Myomectomy - Technic

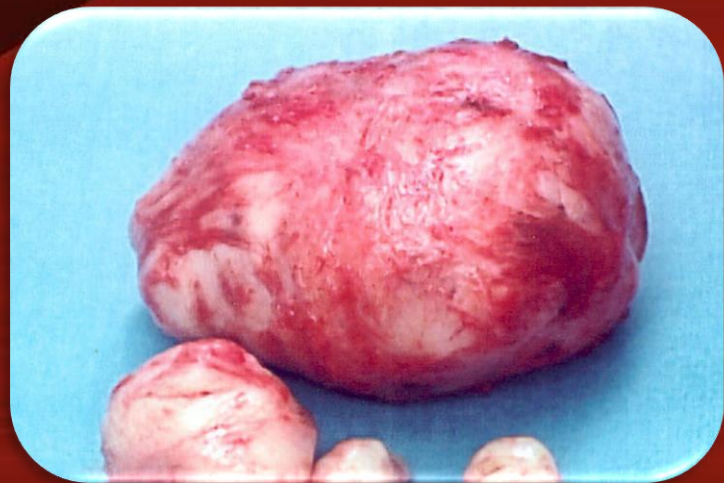
No different from conventional myomectomy

→ Infiltrate vasopressin under the capsule all around & also at the base

→ Enucleate the fibroid by sharp dissection, blunt dissection & use of electrocuatery

→ 2 or 3 layers closure by ‘0’ vicryl

→ no longer a dreaded job & can be carried out by an <u>average surgeon</u>



When you lose
Don’t lose the lesson

- **Every morning in Africa a deer wakes up. It knows it must run faster than the fastest lion or it will be killed.**

- **Every morning in Africa a lion wakes up. It knows it must run faster than the slowest deer or it will starve to death.**

It does not matter if you are a lion or a deer.

When the sun comes up, you would better be running.

<u>A doctor who runs whole life is called an obstetrician</u>

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Wish You all a Successful
Professional life