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Second Stage of Labour & Other Pitfalls

MRCOG Part 2 Online Revision Course

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Aims & Objectives

- Cover specific topics that are generally answered poorly by MRCOG Part 2 candidates

Exam Question Topics that get answered wrong..

- VTE risk assessment – both Obstetrics & Gynaecology
- Aspirin in pregnancy
- Colposcopy / Cervical screening
- Adenomyosis
- Fibroids
- Ultrasound image based questions
- 5 year survival rates for gynaecological cancers
- **Second stage of labour**
- **Management of large for gestational age (LGA) babies**
- **Polyhydramnios**

Why is 2nd Stage a difficult topic in MRCOG Part 2?

- Candidates perform poorly at questions about management of second stage of labour
- Often answer based on personal practice rather than national guidance
- Purpose of these questions is to assess safe practice not individual skill set
- UK based examination based on UK clinical practice – avoid answering based on non-UK practice

Key Tips for Answering SBA/EMQs on 2nd stage

- Indication for intervention
  - FTP – NICE guideline
  - Presumed fetal compromise – CTG will be described for you, unlikely in question to be unclear if delivery indicated (e.g. pathological, bradycardia)
- Location for delivery – reasons to do in theatre as per RCOG OVD GTG
- Any contraindications to rotational delivery – e.g. low platelets
- Do not assume that CS is the correct answer if appears ‘difficult’ OVD – double check for contraindications in the question

Operative Vaginal Delivery

- RCOG GTG - Trial in theatre if any of:

  - maternal BMI greater than 30
  - short maternal stature
  - estimated fetal weight of greater than 4 kg or a clinically big baby
  - head circumference above the 95th percentile
  - occipito–posterior position
  - midpelvic birth or when one-fifth of the head is palpable per abdomen.

Key Tips for Answering SBA/EMQs on 2nd stage

- Questions are written with the default presumption of ventouse rather than forceps unless fetal bradycardia
- Station: +2 -> delivery in room regardless of position (!)
- Station: +1 or higher -> delivery in theatre
- Pathological CTG and station +2 -> Ventouse in room
- Bradycardia and station +2 -> Forceps in room
- Pathological CTG and station +1 or higher -> FBS **then** trial
- 1/5th palpable PA – Trial
- 2/5th palpable PA - CS

(Everyone's face when we give this talk)

Specific Second Stage Scenarios

- Maternal medical disease – indications for shortening 2nd stage
  - Tip: TOG articles ->

- Sequential instruments
- Breech at full dilation
- Second twin / internal podalic version
- FGM
- Risks of 2nd stage CS

- ** DO AS THE GUIDELINE SAYS, NOT WHAT YOU DO **


TOG The Obstetrician & Gynaecologist

Review

Pregnancy and spinal cord injury

Rehana Dawood MBBS MRCOG, Efstathios Altanis Ptychion Iatrikes MRCOG, Pura Ribes-Pastor FRCA FFARCSI MSc, Felicity Ashworth MA BM BCh FRCS FRCOG

First published: 23 April 2014 | https://doi.org/10.1111/tog.12083 | Citations: 19


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Review | Free Access

Ocular manifestations of pregnancy and labour: from the innocuous to the sight threatening

Ajay D Patil MA (Cantab) FRCOphth, Abdallah A Ellabban FRCS MSc PhD, Dilip B Patil MRCOG, David Yorston FRCOphth, Thomas H Williamson FRCOphth ... See all authors

First published: 25 May 2020 | https://doi.org/10.1111/tog.12670 | Citations: 2


TOG The Obstetrician & Gynaecologist

Review | Free Access

A review of stroke in pregnancy: incidence, investigations and management

Azriny S Khalid MRCPI MRCOG, Adriana Hadbavna MRCPI, David Williams PhD FRCPI FRCPE, Bridgette Byrne MD FRCOG

First published: 14 November 2019 | https://doi.org/10.1111/tog.12624 | Citations: 7

Management of Large-For-Gestational Age Babies

Inducing labour

NICE guideline

Published: 4 November 2021

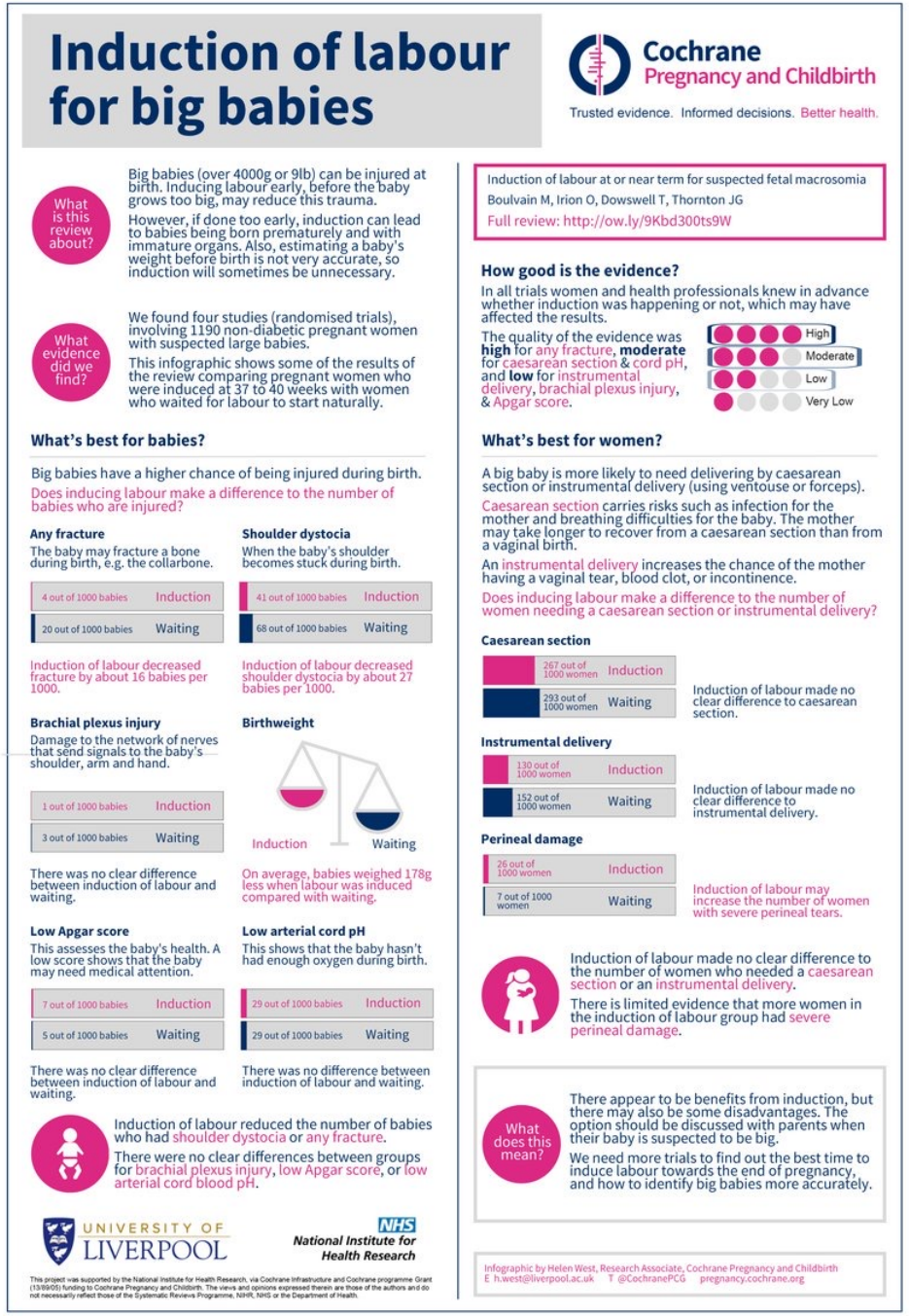
www.nice.org.uk/guidance/ng207

Shoulder Dystocia

Green–top Guideline No. 42

2nd Edition I March 2012

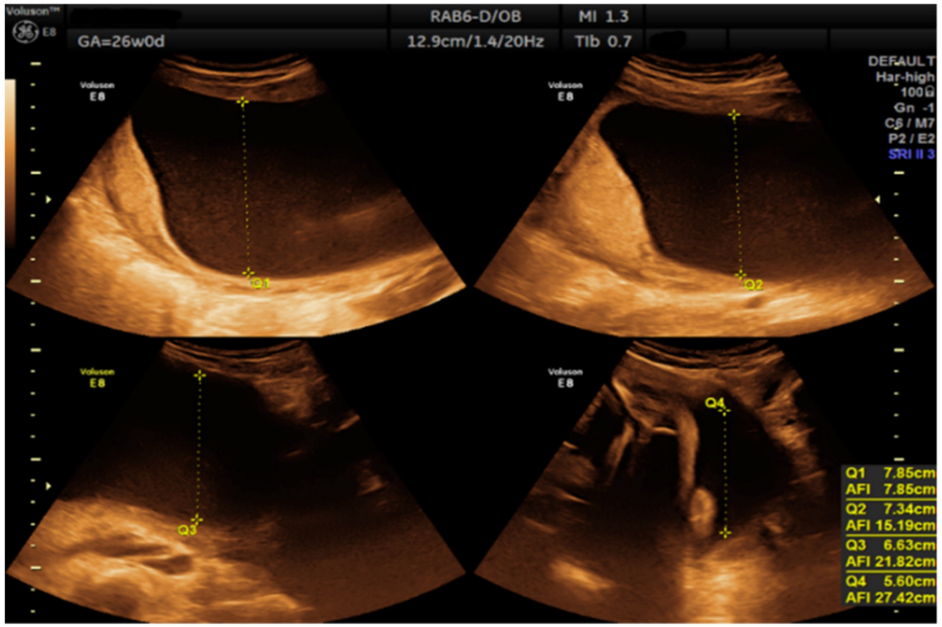
Investigation report: Severe brain injury, early neonatal death and intrapartum stillbirth associated with larger babies and shoulder dystocia



Management of Large-For-Gestational Age Babies

- There is no national definitive guidance
- RCOG has commissioned a scientific impact paper but this is postponed pending the results of the NIHR Big Baby study
- The exam is not likely to ask questions that where the evidence is unclear
- Look carefully in the question for leading statements e.g. *"The woman wishes to avoid perineal trauma and is concerned about the risk of shoulder dystocia"*
- NICE is clear: offer a choice of expectant management, early term IOL or planned CS for EFW >95th
- If question is for EFW >90th but <95th then answer as if not LGA

Polyhydramnios



- **Prevalence**: 1 in 100 pregnancies.
- **Ultrasound diagnosis**:
  - The vertical measurement of the deepest pocket of amniotic fluid free of fetal parts is used to classify polyhydramnios into mild (8–11 cm), moderate (12–15 cm) and severe (≥16 cm).
  - In about 80% of cases the polyhydramnios is mild, in 15% moderate and in 5% severe.
  - Most cases of mild polyhydramnios are idiopathic, but most cases with moderate or severe polyhydramnios are due to maternal or fetal disorders.
  - In most cases, polyhydramnios develops late in the second or in the third trimester of pregnancy

Polyhydramnios

- There are essentially two major causes of polyhydramnios:
  - **Reduced fetal swallowing**: due to brain abnormalities (e.g anencephaly, Dandy-Walker malformation), facial tumors, gastrointestinal obstruction (e.g. esophageal or duodenal atresia, small bowel obstruction), compressive pulmonary disorders (e.g. pleural effusions, diaphragmatic hernia, CPAM, CHAOS), narrow thoracic cage due to skeletal dysplasias), and fetal akinesia deformation sequence (due to neuromuscular impairment of fetal swallowing).
  - **Increased fetal urination**: maternal diabetes mellitus and maternal uremia (increased glucose and urea cause osmotic diuresis), hyperdynamic fetal circulation due to fetal anemia (e.g. red blood cell isoimmunization or congenital infection), fetal and placental tumors (e.g. sacrococcygeal teratoma, placental chorioangioma), or twin-to-twin transfusion syndrome.

Polyhydramnios

- **Investigations**:
  - Detailed ultrasound examination – specifically check fetal swallowing, stomach bubble, bladder and kidneys, MCA Dopplers to check for anaemia, cardiac function (high output failure)
  - Glucose tolerance test
  - Invasive testing for karyotyping and array if there are fetal abnormalities or growth restriction. DNA testing for the myotonic dystrophy mutation if there is abnormal posturing of the extremities.
  - TORCH test if there are fetal features suggestive of infection.

Polyhydramnios

- **Delivery**:
  - Standard obstetric care and delivery in most cases.
  - Fetal abnormalities: induction of labor at 38 weeks' gestation in a hospital with neonatal intensive care and facilities for pediatric surgery.
  - Severe polyhydramnios: controlled induction and membrane rupture at 38 weeks' gestation to avoid risk of umbilical cord prolapse.
- **Prognosis**:
  - This depends on the cause of polyhydramnios and the gestational age at delivery.
- **Recurrence**:
  - Idiopathic: no increased risk.
  - Associated maternal or fetal conditions: depends on the cause.

Polyhydramnios

- Some tips:
  - If question on polyhydramnios – define the severity and try and work out the cause
  - Management is based on the CAUSE
  - Don’t assume that IOL is indicated for mild/moderate idiopathic polyhydramnios – it’s not in any guideline
  - TORCH screening is generally obsolete in clinical practice
  - If asked what the next investigation is for mild/moderate polyhydramnios, glucose tolerance testing if not already done
  - If asked what the next investigation is for severe polyhydramnios with normal GTT, amniocentesis

Polyhydramnios

- Some tips:
  - The combination of SGA fetus and significant polyhydramnios is concerning
  - Severe polyhydramnios carries a 1 in 10 chance of an underlying chromosomal/genetic condition – for AFI >40 / DVP >16cm, offer amniocentesis
  - Amniodrainage is rarely indicated unless severe polyhydramnios with maternal compromise – it carries a 1 in 4 risk of preterm labour and should be done with steroid cover and preferably after 32 weeks gestation
  - Exam questions are highly unlikely to ask the average MRCOG candidate to make a ‘decision’ for amniodrainage – definitely subspecialist level and outside the remit of the exam

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