

## OPERATIVE VAGINAL BIRTH

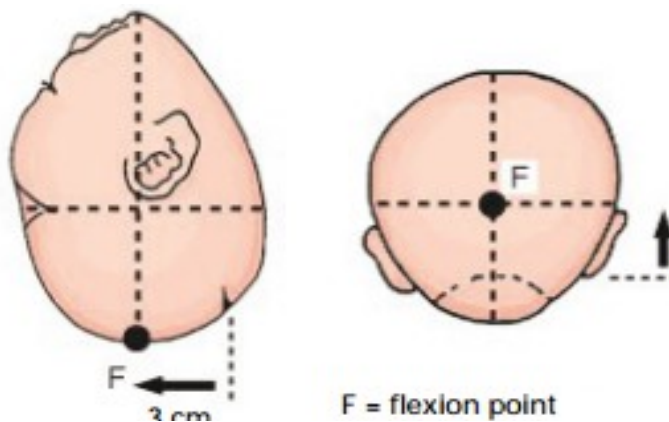
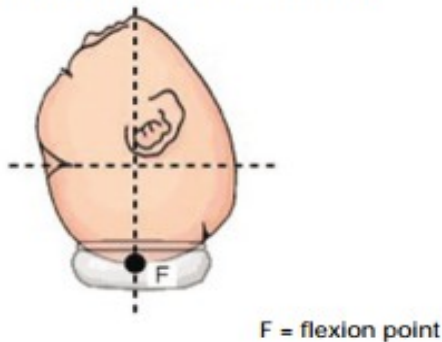
Operative Vaginal birth refers to forceps or vacuum assisted vaginal delivery. When second stage of labour problems affect maternal or fetal well being, non operative interventions need to be maximized and when there is a further need, the options and risks of operative vaginal birth and Caesarean section should be considered.

Whether or not operative vaginal birth is appropriate, is a complex decision with many risks to balance the maternal wellbeing, the fetal wellbeing and availability of facilities and personnel. A nonreassuring fetal status, indications to cut short second stage of labour, failure of maternal powers with adequate uterine activity and no evidence of cephalopelvic disproportion are the points for consideration.

The prerequisites are vertex presentation with fully engaged head, fully dilated cervix, ruptured membranes , adequate pelvis, empty bladder, appropriate analgesia, informed consent, skilled operator, backup personnel and facility, Paediatrician 's presence.

The relative contraindications are premature fetus, midpelvic station, unfavorable attitude of head, rotation of more than 45 degrees from occipitoanterior to occipitoposterior. The absolute contraindications are non vertex presentation, unengaged head, CPD, Incomplete dilatation of Cervix, fetal coagulopathy.

In vacuum assisted deliveries(VAD), the centre of the cup is applied at the flexion point. when the center of the extraction cup has been placed over the flexion point and traction is applied, conditions are optimal for delivery. The flexion point is a critical landmark for VAD. The flexion point is 3cms anterior to the posterior fontanelle with vacuum pressure of not more than 500 to 600mm Hg used. Traction is applied with contractions and axis of traction follows pelvic curve. Maximum of 3 pulls are advocated.Pop offs should be avoided. Cups can be rigid or soft, metallic or plastic.



In forceps delivery it could be outlet or low or midcavity application depending on the level of leading point of skull. Knowing

the instrument and applying the forceps blades appropriately with sagittal suture perpendicular to plane of shanks is important.

Potential complications are fetal intracranial hemorrhage, cephalhematoma, subaponeurotic hemorrhage, skull fracture, scalp laceration, facial nerve palsy, retinal hemorrhage, external ocular trauma, maternal vaginal, cervical and Perineal injuries.

Failure of the chosen method to achieve delivery of fetus in a reasonable time should indicate abandonment of the procedure. So when operative vaginal birth is not successful or not acceptable to patients or is unsafe, switching to Caesarean section is mandatory . The most appropriate intervention needs to be chosen on an individual basis within the context of each woman's unique circumstances. One is not clearly safer or more effective than the other.

**Dr. Vijayalakshmi Seshadri**