LESSON ASSIGNMENT

LESSON 5
Special Situations in Labor and Delivery.

TEXT ASSIGNMENT
Paragraphs 5-1 through 5-11.

LESSON OBJECTIVES
After completing this lesson, you should be able to:

5-1. Identify descriptive statements that concerns the nine special situations in labor and delivery.

5-2. Identify the causes for dystocia and oversized babies.

5-3. Identify conditions that predispose a mother to preterm labor.

5-4. Identify the indications for the induction of labor.

5-5. Select descriptive statements that describe the four classifications of dystocia.

5-6. Identify the four complications that occur in the delivery of an oversized baby.

5-7. Select those characteristics that are used to assess a mother for an amniotic fluid embolism.

5-8. Identify the indications for a cesarean section.

5-9. Identify the indications for forceps delivery.

5-10. Identify the types of forceps.

5-11. Select the nursing interventions that are used when caring for patients with a special situation in labor and delivery.

SUGGESTION
After studying the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.
LESSON 5

SPECIAL SITUATIONS IN LABOR AND DELIVERY

5-1. GENERAL

Accurate assessment of the rapid changing status of the mother and her fetus is essential if the nursing and the medical care plan are to meet their needs. Although most labors and deliveries are routine, occasionally there may be a deviation from the norm. This lesson contains information that will help you in caring for a patient who has a special situation in labor and delivery. The special situations in labor and delivery are categorized as preterm labor, postterm labor, induction of labor, dystocia of labor, oversized babies, amniotic fluid embolism, multiple pregnancies, cesarean section, episiotomies, and forceps delivery.

5-2. PRETERM LABOR AND DELIVERY

Preterm birth is traumatic for both the parent and the child. The parents are faced with an unexpected emotional crisis as a result of the natural process of pregnancy and birth being altered, whereas, the infant is faced with adjustment to extrauterine existence before final readiness for the event. Parents and the infant who are experiencing the crisis of premature birth need the concerted support of all members of the health care team.

a. Definition. Preterm labor is labor that occurs prior to 38 weeks gestation. It may be spontaneous or medically induced.

b. Conditions That Predispose to Preterm Labor. There are certain factors or reasons that may increase a woman's chances of having premature labor, but the specific cause or causes of premature labor are not known. Sometimes a woman may have premature labor for no apparent reason. Nevertheless, it is important that you be familiar with the following conditions of a patient who may predispose to preterm labor:

(1) Spontaneous rupture of membranes.
(2) Cervical incompetency - weakness of the cervix.
(3) Uterine anomalies.
(4) Overdistended uterus caused by hydramnios or two or more fetuses.
(5) Anomalies of the products of conception.
(6) Faulty placentation - abruptio placentae, placenta previa.
Retained intrauterine device.

Fetal death.

Serious maternal disease. This refers to a systemic disease in the mother, that when severe, may be due to serious hypoxia accompanying some diseases such as pneumonia and diseases with high fever.

Unknown causes.

c. Responses to Preterm Labor.

Once preterm labor is diagnosed, the patient and her obstetrician must decide if early delivery of the fetus is more advantageous for survival or is the fetus remaining in utero more advantageous for survival.

Preterm labor is not interrupted if any of the following conditions are present:

(a) Labor is active and cervical dilation has progressed beyond 4 cm.

(b) There is severe bleeding.

(c) Gross fetal anomaly or anomalies is/are present.

(d) The fetus is already dead.

(e) There is fetal distress present.

(f) There are complications that contraindicate prolonging the pregnancy (e.g., severe maternal hypertension, ruptured membranes, intrauterine infection, and severe fetal intrauterine growth retardation).

d. Nursing Interventions When Preterm Delivery is Imminent.

Prepare for delivery if interventions to arrest preterm labor fail.

Inform the expectant parents of changes in the status of care. Many times the nature of emergencies in a labor and delivery area often allows time for brief explanations. Whenever possible, expectant parents should be given thorough explanations and emotional support.

Parents should not be left alone if possible.

Notify the nursery personnel and pediatrician when delivery is imminent.
(4) Assemble the resuscitation equipment and make sure it functions properly.

(5) Discourage the patient from bearing down if the presenting part is a head. Bearing down could cause damage to soft tissues. Preterm labor usually means a small fetus. Less cervical dilations and effacement are required due to the small size of the premature fetus. Administration of medications during labor is kept to a minimum because the infant has an immature system that has difficulty metabolizing medication. Medications have an increased effect on the fetus. Local anesthesia is used for delivery rather than general anesthesia. This again is due to the increased effect that general anesthesia has on the infant and the infant’s decreased ability to metabolize the anesthesia and to get it out of its system after delivery. Parents should be informed about these decisions.

e. Delivery of the Preterm Infant.

(1) Perform only those procedures that are absolutely necessary. Injury can occur easily and infection is of primary concern.

(2) Establish respirations then move the infant to a warm and humid environment that contains adequate oxygen. Position the head slightly down to allow for tracheal drainage and then position the head flat. Place the infant on its back with the shoulders elevated slightly so the abdomen is lower than the thorax. Ensure that the airway is kept clear. Place a folded towel or diaper under the infant's shoulders and back. This allows for expansion of the thoracic cavity.

(3) Introduce the newborn briefly to the parents.

(4) Transfer the newborn to the special care nursery as soon as possible.

5-3. POSTTERM PREGNANCY AND DELIVERY

a. Definition. Postterm pregnancy is any pregnancy that goes beyond 42 weeks gestation.

b. Nursing Interventions in the Delivery of the Postterm Infant

(1) Notify and have a pediatrician present for delivery. The infant requires immediate assessment of his condition. In addition, the infant may need immediate intervention to establish adequate respiratory function.

(2) Perform tracheal suctioning immediately at delivery. In postterm pregnancy, the amniotic fluid is frequently thick since it decreases after 38 weeks. The infant frequently has a bowel movement (meconium) prior to or during labor due to stress. This fluid tends to clog the air passages and irritates the lungs when aspirated. Aspirated meconium-stained amniotic fluid can lead to meconium aspirations syndrome or pneumonia.
(3) Evaluate the newborn for hypoglycemia via dextrostix. The infant has been forced to use up energy stores due to prolonged pregnancy. Blood sugar less than 45 mg/dl is low and requires immediate oral glucose feedings, or IV glucose feeding followed by frequent formula feedings to prevent subsequent drops.

(4) Give special care to the infant to prevent loss of body heat. Place a hat on his head, keep him wrapped; then, and place him in a warm incubator. The postterm infant is subject to cold stress because of low amounts of subcutaneous fat and large body surface.

5-4. FACTS ABOUT THE INDUCTION OF LABOR

a. **Definition.** Induction of labor is the deliberate initiation of uterine contractions prior to their spontaneous onset and after the period of viability.

b. **Indications for Induction.**

   (1) When continuation of the pregnancy would affect maternal or fetal well-being.

   (2) When fetal well-being would be compromised by remaining longer in the uterus. Possible problems could be:

      (a) Intrauterine growth retardation (IUGR).

      (b) Decreased placental circulation (evidenced by late decelerations).

   (3) When done electively (occasionally).

      (a) Induction may be done for the convenience of the physician or patient due to the patient being a long distance from the hospital, history of rapid labor, and term pregnancy with a history of herpes but two negatives cultures at present.

      (b) This procedure is not strongly supported due to risks of the medications, possibility of delivery of a preterm infant, and the possibility of cesarean section due to failure of progress.

   (4) When complications of pregnancy are present that may affect the fetus. The complications are diabetes, hypertensive disease, hemolytic disease, postmaturity, and premature rupture of membranes if term and no labor has started after twelve hours.

   c. **Techniques Used for Induction.**

      (1) **Enema.** An enema may stimulate contractions if the patient is ready.
(2) **Oxytocin induction.** Pitocin® or Syntocinon® may be used and administered by slow intravenous drip.

(3) **Vaginal gel.** Porstaglandin E-2 vaginal gel has been used in some cases.

d. **Nursing Interventions.**

(1) Never leave the patient alone. There may be potential hazards to the patient and fetus during oxytocin administration. Check the IV rate of flow frequently to ensure it is accurate.

(2) Alleviate fears of the mother that induction may harm the fetus. The patient needs reassurance that her contractions will not differ in their effects from those of the full-term patient. Instruct the patient in breathing techniques. This will help in relieving discomfort.

5-5. **DYSTOCIA OF LABOR AND CAUSATIVE REASONS**

a. **Description.**

(1) Dystocia of labor refers to labor that is difficult due to mechanical and functional factors.

(2) When dystocia is present, the following factors tend to interfere with the ultimate goal of labor (dilation of the cervix and pushing the fetus through the birth canal into the outside world) which is caused by deviations of the normal interrelationships between any of the five Ps of labor.

(a) Passage-bones and soft tissue of the birth canal.

(b) Power-uterine contractions.

(c) Passenger-the fetus, its size, presentation and position, and anomalies.

(d) Placenta-position, time, and mode of expulsion.

(e) Psyche-emotional response of the woman to labor.

(3) The interrelationships of these five factors determine the pattern and progress of labor.
b. **Classification of Dystocia.**

   (1) **Pelvic dystocia.** This occurs when there is a significant shortening of the internal diameters of the bony pelvis.

   (2) **Soft tissue dystocia.** This is caused by an obstruction of the birth passage by an anatomic abnormality other than that of the bony pelvis. Those abnormalities may be tumors, injuries that prevent dilatation, and congenital anomalies (e.g., bicornate uterus).

   (3) **Fetal dystocia.** This refers to conditions that involve the passenger (fetus) that can delay and complicate the process of labor. The conditions may be excessive size of the fetus, fetal anomaly (e.g., hydrocephalus, conjoined twins, or gross ascites), or fetal malpresentation such as a breech presentation.

   (4) **Uterine dystocia.** This is an abnormality of the contractile pattern of the uterine muscles that prevents normal progress in labor. The contractions may be too weak, too short, too irregular, or too infrequent. Labor may also be extremely forceful, rapid, or traumatic.

c. **Nursing Intervention.**

   (1) Continue monitoring uterine contractions and the FHTs.

   (2) Keep the patient informed of the progress.

   (3) Instruct the patient in proper breathing techniques to decrease discomfort.

   (4) Allow the patient to ventilate feelings and frustrations.

   (5) Monitor the patient’s bladder status. The bladder should be kept empty to provide as much space as possible for descent of the fetal head.

5-6. **OVERSIZED BABIES AND THEIR DELIVERY**

   a. **Description.** An oversized baby is an infant that weighs more than 10 pounds (4500 grams). The infant may be classified as large for gestational age (LGA). Most oversized babies are boys. Usually, causes of oversized babies are maternal diabetes, postterm pregnancy, and inheritance from one or both parents who are large.

   b. **Complications.**

      (1) **Shoulder dystocia.** Wide shoulders of the fetus are likely to be a problem at the time of delivery. The fetus head may deliver, but the shoulders are too large for the pelvic inlet.
(2) Trauma to the birth canal may result during delivery due to the size of the infant. The trauma may be lacerations of the vagina or of the perineum.

(3) Trauma to the fetus as a result of pressure placed on it by the delivery process (especially the head and neck), may cause:

(a) Damage to the brachial plexus (nerve injury). This includes a network of lower cervical and upper dorsal spinal nerves, supply arm, forearm, and hand, may have flaccid arm, hand, forearm, and hand rotates inward. Damage to the brachial plexus may be referred to as Erb’s Palsy or Erb-Duchenne diseases. Damage is not usually permanent.

(b) Dislocation of the cervical vertebrae as a result of traction to get the infant out.

(c) Fracture of the clavicle. This is the most common problem and is done during delivery of the shoulders.

(d) Cerebral hemorrhage (intracranial). This is due to repeated pounding on the pelvis.

c. **Medical Interventions for Delivery of the Oversized Infant.**

(1) Assessment of feto-pelvic size to determine if vaginal delivery is possible.

(2) Monitor the patient's progress closely.

(3) Perform cesarean section if the infant fails to descend.

(4) Fracture, intentionally, the humerus or clavicle to decrease the size of the fetus shoulder girdle and facilitate delivery. This is done if shoulder dystocia results during vaginal delivery. The mother may flex her thighs on her abdomen to enlarge her maternal pelvis inlet. Suprapubic pressure may be applied by someone to collapse the diameter of the shoulders.

d. **Nursing Interventions.**

(1) Monitor progress of the labor and the FHT’s closely for any signs of fetal distress.

(2) Keep the mother and father informed of the progress.

(3) Give emotional support to the parents.
5-7. AMNIOTIC FLUID EMBOLISM DURING PREGNANCY OR DELIVERY

a. Description. Amniotic fluid embolism refers to the accidental infusion of amniotic fluid into the mother's bloodstream under pressure from the contracting uterus. The amniotic fluid enters the maternal blood sinuses through defects in the membranes, after membranes have ruptured or after partial premature separation of the placenta has occurred. Solid particles suspended in the amniotic fluid enter the maternal circulation (this may be fetal skin cells carried to the lungs as emboli) and produces dramatic clinical symptoms of pulmonary embolism. This is a common cause of death among mothers who die suddenly during labor.

b. Assessment for Amniotic Fluid Embolism. Amniotic fluid embolism is characterized by sudden dyspnea, chest pain, tachycardia, hypotension, and typical bluish, gray seen in patients with a pulmonary embolism. Death may occur within minutes without immediate intervention. Death may be maternal or fetal.

c. Medical and Nursing Interventions for Amniotic Fluid Embolism.

   (1) Give immediate and vigorous treatment.

   (2) Give oxygen by face mask.

   (3) Maintain normal blood volume through administration of plasma and intravenous fluids.

   (4) Prevent development of disseminated intravascular coagulation (DIC). Serious complications can occur.

   (5) Administer whole blood and fibrinogen.

   (6) Monitor the patient's vital signs.

   (7) Deliver the fetus as soon as possible.

NOTE: Disseminated intravascular coagulation is an acute abnormal stimulation of the normal coagulation process. The normal clotting process is a balance between clot formation and dissolution. In DIC, the balance is disrupted. The abnormal stimulation of coagulation results in widespread thrombi formation that eventually exhausts clotting factors and platelets and activates the process that dissolves fibrogen. Major bleeding results.

5-8. FACTS ABOUT MULTIPLE PREGNANCY AND DELIVERY

a. Description.

   (1) Multiple pregnancy is the presence of two or more fetuses in the uterus at the same time.
High-risk conditions may be associated with and include premature delivery, hemorrhage, hypertensive disorders, abnormal presentation and position, hydramnios (an excess of amniotic fluid), and uterine dysfunction.

Uncomfortable symptoms experienced by the mother during the last trimester are the same as for the mother with a single fetus. However, the symptoms occur earlier and are more intense. The symptoms are:

(a) Heaviness of the lower abdomen.
(b) Back pains.
(c) Swelling of the feet and ankles.
(d) Difficulty in sleeping that is due to abdominal distention.
(e) Woman tires easily.

b. Labor and Delivery Process.

(1) The first stage of labor for the mother is essentially the same as for the woman with a single fetus. Effacement and dilatation occur the same if there is an adequate labor pattern.

(2) Possible complications during labor and delivery include the following.

(a) Possible prolapsed cord. Babies of multiple births tend to be smaller than single fetus and may not fill the pelvis completely. The cord may drop when the membranes rupture.

(b) Possible fetal respiratory distress that is due to analgesia. Analgesia is administered very conservatively. The infant's size normally prevents them from metabolizing analgesia from their systems prior to birth. Withholding it avoids respiratory difficulties following delivery.

(c) Entanglement of fetuses during delivery. Presentation of all fetuses should be known prior to delivery. If the first fetus is not vertex, cesarean section is normally done. This prevents the first fetus from becoming entangled with other fetuses. More than two fetuses indicate cesarean section for control and quick access to the infants.

c. Nursing Interventions.

(1) Monitor the patient and fetuses continuously. Internal monitoring is applied to the presenting fetus. External monitoring is applied to the second fetus. Additional fetuses should be monitored at least every 15 minutes during the first stage with a Doppler and recorded. The mother's vital signs should be checked and recorded frequently.
(2) Start intravenous infusion with at least an 18-gauge as soon as the patient presents to labor and delivery.

(3) Type and cross-match the patient for blood (at least 2 units) on admission for possible administration or as stated in the unit SOP.

(4) Notify appropriate personnel to be present for actual delivery.
   
   (a) An anesthesiologist or anesthetist should be notified in case an emergency cesarean becomes necessary. Anesthesia may be required for the delivery of the subsequent fetuses.

   (b) A physician and a nurse team should be notified for each fetus. The nurse should be skilled in resuscitative measures. The physician should be a pediatrician.

(5) Have enough equipment available to accommodate the number of fetuses to be delivered.

(6) Identify and care for each fetus immediately at delivery.
   
   (a) The first fetus born is A or twin I.

   (b) The second fetus is B or twin II. and so on.

   (c) Tag the infant prior to leaving the delivery room. Do not depend on memory.

(7) Keep the mother informed of each infant’s status.
   
   (a) Identify the sex of the infant.

   (b) Allow the mother to see the infant prior to being transferred from the delivery room if at all possible.

(8) Administer Pitocin® as soon as all placentas are delivered and upon physician's order. Massage the fundus to stimulate contractility. Excessive blood loss is common with multiple pregnancy during the third stage of labor.

5-9. FACTS RELATED TO CESAREAN SECTION DELIVERY

   a. Definition. Cesarean section refers to a surgical incision made into the abdomen and uterus to deliver the fetus (see figure 5-1).
b. Indications for a Cesarean Section.

(1) A patient who is unable to deliver vaginally without jeopardizing her life or health or jeopardizing the health of the fetus.

(2) If there is a disproportion between the size of the infant and the mother's bony birth canal.

(3) If there is previous classical cesarean section or some other extensive uterine or vaginal surgery.

(4) In some women with severe preeclampsia or eclampsia.

(5) In some women with placenta previa or placenta abruption.

(6) When there is fetal distress or impending fetal distress.

(7) In some malpresentation (for example, transverse lie, primipara breech).

c. Nursing Interventions.

(1) Perform preoperative care. Cesarean section is classified as "Major Surgery." Care is the same as for any abdominal surgery unless an emergency exists or labor has started. Insert a retention catheter prior to surgery. This keeps the bladder empty, prevents trauma to the bladder, and prevents obstruction of the surgical field from a full bladder. Have oxytocin available for administration after delivery.
(2) Perform postoperative care. Care is the same as for any abdominal surgery. Allow the mother to breast feed as soon as she wishes.

(3) Care for the newborn. Have a pediatrician present. A warm crib and resuscitation equipment should be available. Respiratory distress tends to be higher in infants delivered this way. Infants born early do not have a chance to adjust to atmospheric pressure changes. Mucous is not expressed from the lungs since the infant did not descent through the birth canal.

5-10. FACTS ABOUT EPISIOTOMIES

a. **Definition.** Episiotomy is an incision into the perineum made to facilitate delivery.

b. **Types of Episiotomies**

See figure 5-2 for illustrations of the types of episiotomies.

(1) **Median or midline episiotomy.** An incision is made in the midline of the perineum. The advantages of a median or midline episiotomy are that they are easy to repair, faulty healing is rare, there is less pain during the postpartal period, there is less blood loss, and the anatomic end results almost always excellent.

(2) **Mediolateral episiotomy.** An incision is made in the midline but directed to the right or left. The advantages of a mediolateral episiotomy are that there is less tearing beyond the incision and the incision can be directed away from the rectum. The
disadvantages are that there is greater blood loss, faulty healing is more common, there is more perineal discomfort, and they are more difficult to repair.

c. Reasons for Episiotomy. An episiotomy results in a clean surgical cut instead of a ragged tear, it minimizes pressure on the fetal head, and shortens the second stage of labor.

d. Repair. The obstetrician sutures the cut after delivery of the fetus and the placenta. There is usually slight blood loss because pressure of the presenting part constricts the cut edges and keeps bleeding to a minimum.

e. Nursing Intervention.

(1) Observe incision for signs of infection (for example, redness, swelling, unusual discharge).

(2) Instruct the patient to change her perineal pad each time she uses the toilet.

(3) Teach the mother to do perineal cleansing each time she uses the bathroom.

(4) Assist the mother to use the Sitz bath as ordered.

(5) Use a perineal lamp (usually a gooseneck lamp) to improve circulation, promote healing, and ease discomfort. The lamp should not be used too early, otherwise bleeding may occur. Wait about 12 hours after delivery. The lamp should be placed no less than 18 inches from the perineum. Use a 25 to 40 watt bulb. The lamp can be used several times a day for 20-minute intervals. Drape the patient legs to provide maximum privacy.

(6) Offer local anesthetics (nupercainal ointment, tucks, witch hazel compresses) as ordered.

5-11. FACTS ABOUT FORCEPS DELIVERY

Forceps are used to assist in labor and delivery. Forceps delivery is considered an operative obstetric procedure. The commonly used forceps have a cephalic curve shaped similarly to that of the fetal head. A pelvic curve of the blades conforms to the pelvic axis (see figure 5-3). The blades are joined by a pin, screw, or groove arrangement. These locks prevent the forceps from compressing the fetal skull.

a. Indications for Use.

(1) Maternal. To shorten the second stage in dystocia, when the patient's expulsive efforts (inability to push) are deficient (for example, she is tired or has been given spinal anesthesia), and when the patient is endangered (for example, cardiac decompensation).
(2) Fetal. To rescue a jeopardized fetus (for example, premature labor or fetal distress close to delivery).

b. Complications of Forceps Delivery.

(1) Maternal.

(a) Lacerations of the vagina and cervix, predisposing to hemorrhage and infection.

(b) Rupture of the uterus.

(c) Injury to the bladder or rectum.

Figure 5-3. Types of forceps.
(2) Fetal.

(a) Cephalohemohematoma.

(b) Brain damage and intracranial hemorrhage.

(c) Skull fractures.

(d) Facial paralysis.

(e) Cord compression.

c. **Conditions for Forceps Delivery.** The following conditions must occur for successful forceps delivery.

(1) **Fully dilated cervix.** Severe lacerations and hemorrhage may ensue if a rim of cervical tissue remains.

(2) **Head engaged.** The extraction of a mature fetus with a "high" (unengaged) head usually is disastrous.

(3) **Vertex presentation or face presentation.** Other presentations require wider-than-average pelvic diameters.

(4) **Membranes ruptured.** This will ensure a firm grasp of the forceps on the fetal head.

(5) **No cephalopelvic disproportion.** If there is engagement, there must be no outlet contracture or gross sacral deformity.

(6) **Empty bladder and bowel.** This will avoid laceration and fistula formation.

d. **Levels of Forceps Application.** The station of the fetal head determines the level of forceps application and, generally, the relative difficulty to be expected in forceps operations.

(1) **High forceps.** The biparietal diameter of the vertex is above the ischial spines (the head has not yet engaged) when the forceps are applied. High forceps delivery is an exceedingly difficult and dangerous operation for both patient and fetus and is rarely done.

(2) **Midforceps.** The vertex is at the ischial spines, almost to the ischial tuberosities on application of the forceps. The delivery often is difficult, depending on the size of the vertex, its position, and the pelvic architecture and diameters. A cesarean birth is preferred to a potentially difficult midforceps delivery.
(3) **Outlet (low) forceps.** Outlet or low forceps is used when the fetal head is on the perineal floor (visible or almost so) and internal rotation may have already occurred, so that the fetal head lies in a direct anteroposterior position.

e. **Nursing Interventions.**

(1) Obtains forceps designated by the physician.

(2) Checks, reports, and records the fetal heart rate before forceps are applied.

(3) Informs the patient that the forceps blades fit like two tablespoons around an egg. The blades come over the fetus ears.

(4) Rechecks, reports, and records the fetal heart rate again before traction is applied after application of the forceps. Compression of the cord between the fetal head and the forceps would cause a drop in fetal heart rate. The physician would then remove and reapply the forceps.

(5) Give support to the patient.

(6) Observe for signs and symptoms of complications.

(7) Assess the newborn for indications of injury.

**Continue with Exercises**

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EXERCISES, LESSON 5

INSTRUCTIONS: Answer the following exercises by marking the lettered response that best answers the exercise, by completing the incomplete statement, or by writing the answer in the space(s) provided.

After you have completed all of these exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers. For each exercise answered incorrectly, reread the material referenced with the solution.

1. List six conditions that could increase a pregnant woman chances of having premature labor.

   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

2. Assemble resuscitation equipment and make sure it functions properly is one of the nursing interventions when:

   a. Amniotic fluid enters into an opened maternal blood sinus.
   b. Preterm delivery is imminent.
   c. Multiple fetuses are known.
   d. C-sections are performed.

3. List the four classifications of dystocia.

   ______________________________________________________________________
   ______________________________________________________________________
4. What type of episiotomy is made on the midline but directed to the right or left?

_____________________________________________________________________

FOR EXERCISES 5 THROUGH 13. Match the terms in Column A with the correct definition or statement as listed in Column B. Place the letter of the correct answer in the space provided to the left of Column A.

<table>
<thead>
<tr>
<th>COLUMN A</th>
<th>COLUMN B</th>
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<tbody>
<tr>
<td>5. Induction of labor.</td>
<td>a. Surgical incision made into the abdomen and uterus to deliver the fetus.</td>
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<td>6. Oversized baby.</td>
<td>b. Labor that is difficult which is due to mechanical and functional factors.</td>
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<td>7. Episiotomy.</td>
<td>c. Labor that occurs prior to 38 weeks gestation.</td>
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<td>9. Post term labor.</td>
<td>e. Deliberate initiation of uterine contractions prior to their spontaneous onset and after the period of viability.</td>
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<tr>
<td>10. Dystocia</td>
<td>f. An incision into the perineum made to facilitate delivery.</td>
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<td>11. Preterm labor.</td>
<td>g. Pregnancy that goes beyond 42 weeks gestation.</td>
</tr>
<tr>
<td>12. Pelvic dystocia.</td>
<td>h. An infant that weighs more than 4500 grams.</td>
</tr>
<tr>
<td>13. Cesarean section.</td>
<td>i. Two or more fetuses in the uterus at the same time.</td>
</tr>
</tbody>
</table>
14. Complication associated with oversized babies and their delivery are given below. Write the type of complication described in the blank before the description.

a. ___________________________ -- the fetus head may deliver, but the shoulders are too large for the pelvic inlet.

b. ___________________________ -- possible lacerations of the vagina or of the perineum.

c. ___________________________ -- dislocation of the fetus cervical vertebrae or fracture of the clavicle.

15. List the special situations in labor and delivery.

_________________________________
_________________________________
_________________________________
_________________________________
_________________________________
_________________________________
_________________________________
FOR ITEMS 16 THROUGH 27. The following statements/phrases may be true or false. Indicate the correct answer by circling the "T" for true and "F" for false.

16. Preterm labor is not interrupted if there is severe bleeding or if the fetus is already dead.  
   T   F

17. The amniotic fluid is frequently thin in post term pregnancy, therefore, tracheal suctioning immediately at delivery is not performed.  
   T   F

18. An enema may be used to stimulate contractions if the patient is ready to deliver.  
   T   F

19. Most oversized babies are girls.  
   T   F

20. A Cesarean section is performed if an oversized fetus fails to descend.  
   T   F

21. A possible prolapsed cord is considered a possible complication during labor and delivery of multiple births.  
   T   F

22. Only on physician and on nurse should be notified to assist in multiple births.  
   T   F

23. The physician sutures the episiotomy (incision) after delivery of the fetus.  
   T   F

24. A Cesarean section is classified as major surgery.  
   T   F

25. Forceps delivery aids in shortening the second stage in dystocia.  
   T   F

26. The fetal head must be engaged for forceps delivery.  
   T   F

27. Midforceps delivery is an easy forceps delivery.  
   T   F

Check Your Answers on Next Page
SOLUTIONS, LESSON 5

1. Any six of the following conditions:
   - Spontaneous rupture of membranes.
   - Cervical incompetency.
   - Uterine anomalies.
   - Overdistended uterus caused by hydramnios or two or more fetuses.
   - Anomalies of the products of conception.
   - Faulty placentation.
   - Retained intrauterine device.
   - Fetal death.
   - Serious maternal disease.
   - Unknown causes. (para 5-2b)

2. b (para 5-2d(4))

3. Pelvic.
   - Soft tissue.
   - Fetal.
   - Uterine. (para 5-5b)

4. Mediolateral. (para 5-10b(2))

5. e. (para 5-4a)

6. h. (para 5-6a)

7. f. (para 5-10a)

8. l. (para 5-8a)

9. g. (para 5-3a)

10. b. (para 5-5a)

11. c. (para 5-2a)

12. d. (para 5-5b(1))

13. a. (para 5-9a)

   - Trauma to the birth canal.
   - Trauma to the fetus. (para 5-6b(1),(2),(3))
15. Preterm labor.
   Post term labor.
   Induction of labor.
   Dystocia of labor.
   Oversized babies.
   Amniotic fluid embolism.
   Multiple pregnancies.
   Cesarean section.
   Episiotomies. (para 5-1)

16. T (para 5-2c(2))
17. F (para 5-3b(2)(a))
18. T (para 5-4c(1))
19. F (para 5-6a)
20. T (para 5-6c(3))
21. T (para 5-8c(4)(b))
22. F (para 5-8c(4)(b))
23. F (para 5-10d)
24. T (para 5-9c(1))
25. T (para 5-11a(1)(a))
26. T (para 5-11b(2))
27. F (para 5-11c(2))