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TRIAL LABOUR

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(1) INTRODUCTION:

Labour is a physiological process in the vast majority of cases, as it ends naturally without any material and foetal complications. In few only it may have some untoward complications, hence the importance of proper antenatal and intranatal care, just to reduce the maternal and foetal morbidity and mortality. The importance of antenatal care is all the more important in cases of contracted pelvis or disproportion, as previous knowledge of such a case goes a long way in shaping the prognosis.

The scope of antenatal and intranatal attention is very limited in our country even today. However, we as students of this branch of medicine should try our best to do as much as is possible.

As the subject is very big and can be discussed from various aspects, let us take up the subject "Trial Labour" which is often a "Trial of an obstetrician"—in reality.

(2) DEFINITION:

Trial labour means, when in certain selected cases of borderline cephalo-pelvic disproportion, a trial of labour,

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a chance to uterine power mainly, is given to effect delivery. That is, we allow such cases to go on to labour in the usual way and wait and watch the progress which might end ultimately to a natural one, when we call "success of Trial"; or in certain cases it may require operative interference when nature fails to terminate such a labour.

(3) CASES FOR TRIAL:

The question of Cephalo-pelvic disproportion can be discussed from two headings. This means that either there is contraction of the pelvis or the foetal head is big, or both. On the other hand, if there is contraction of the pelvis, this does not mean that there is disproportion, as the foetal head may be smaller in size, and *vice versa*. Therefore it is a relative term between the bony pelvis, mainly inlet, and the foetal head. We also know that usually the head engages roughly about three weeks before term in primigravida, and from few weeks to few days to few hours before actual delivery in cases of multigravida. As the question of disproportion in multigravida is rare indeed, we can for the sake of simplicity limit ourselves to the primigravidae only.

First, suspicion arises when in a primigravida there is a "Floating head" or a non-engaged head any time from 38th week of pregnancy. Of all the causes of non-engagement of the foetal head in the primigravida, one of the commonest and the most important is disproportion, and it can not be too often or too strongly impressed upon the beginner that when the head is found to be movable over the pelvic brim three weeks before the estimated date of delivery it is necessary to find out the reasons and to exclude contracted pelvis. Incidentally the common causes in order of importance of non-engagement of head, are—

(1) Wrong menstrual dates.
(2) Loaded Colon and Rectum.
(3) Contracted Pelvis.
(4) Occipito-posterior position.
(5) Immature lower segment and Cervix.

(6) Lava on toneless abdominal wall.
(7) Multiple pregnancy.
(8) Hydramnios.
(9) Placenta Praevia (Rare in Primigravida).
(10) Pelvic Tumors.

Therefore, keeping those above mentioned probable causes in mind, one has got to come to a conclusion before labour pain starts. Then and then only a plan for proper management can be thought out beforehand. Otherwise a case first seen intranatally complicating with disproportion may often end sadly, mostly on the part of the foetus.

(4) ASSESSMENT FOR THE PRESENCE OF DISPROPORTION:

After excluding the possibilities of wrong dates and loaded colon and rectum by suitable purgative the groups of "floating head" cases found at or near about term in primigravidae, are further examined in detail in the following ways, just to have an idea of the room in the pelvic brim and the size of the foetal skull, i.e., the relation between the bony passage and the bony head.

It may be pointed out that in such cases the presentation must be vertex always. If doubt exists as to the presence of pelvic contraction in presentation other than the vertex, previous skiagraphy, followed by Cephalic version should be performed and then assessed few days after the version is performed.

The important points are:—

(a) General informations regarding height, built, stature, weight, features.
(b) Any deformity of spine, pelvis and inferior extremities.
(c) Gait.
(d) External pelvic measurements for interspinous, Intercristal, Ext. conjugate, Transverse diameter of the outlet.
(e) Muller-Kerr's method of assessment and the degree of over-lapping.
(f) Examination under anaesthesia if required, just to

have an idea of the pelvis, diagonal conjugate, sacral curvature, Ischial spine, Sacro-Sciatic notch, descending rami, Subpubic angle, and lastly the head fitting. This is more reliable, as foetal head is the best pelvi-meter.

(g) Skiagraphy for X'Ray pelvi-metry and Cephalometry, any bony deformities, tumors, foetal abnormalities, hydrocephalus etc.

It is noteworthy to remember in this connection that, clinical examination and assessment bimanually under anaesthesia, are much more practical and reliable, than mere X'Ray. Assessment for passage and passenger have been done so far. As no exact idea as to the state of power is possible to have, we are to wait for its behavior until labour pain starts.

(5) CONTRA-INDICATIONS FOR TRIAL LABOUR:

The points are:—

(1) Conjugate vera or true conjugate less than 8·9 cm (3½ Inches).
(2) Presentation other than Vertex.
(3) Muller-Kerr's method fails to show a hope for vaginal delivery.
(4) Elderly Primigravida.
(5) Previous child and low fecundity.
(6) Maternal complications like anaemia, Toxaemia, Hypertension and Diabetes.
(7) Previous Caesarean section for disproportions with probable history of postoperative pyrexia (more chance of weak uterine scar and rupture of uterus).

(6) CONDITIONS TO BE FULFILLED BEFORE TRIAL:

(1) Patient must be in a Hospital or in an institution where all possible emergencies can well be tackled.
(2) Obstetrician-in-charge should have some experience

of such cases or consult for a second valued opinion when needed.

(7) CONDUCTION OF TRIAL:

The general principles like maintenance of strength and nutrition of the patient with adequate fluids, glucose, vitamins, calcium, suitable sedative, are to be observed more rigidly. But overenthusiasm in the use of sedative is also deplorable. Evacuation of bowel and bladder should also receive due attention from the very beginning of labour pain.

More often than not, the psychological aspect, the morale of the patient are overlooked. This brings about a phenomenon of "Stress". An anxious young primigravida with no experience of labour is always nervous and suffers from varied apprehension and fear. Fear, therefore produces tension, pain, and pain increases fear. And so the vicious circle of a prolonged and difficult labour is complete. With such a tension in mind, the trial of prolonged labour may be impossible as Primary uterine inertia will set in soon. Mental and Physical relaxation are essential. Peace is the only atmosphere which is conducive to relaxation. Therefore along with suitable and adequate nutritional therapy, sedatives, assurance and suggestions are also of great help in successful conduction of a trial labour.

From the onset of labour pain observe maternal general state including her pulse rate, respiration, temperature, fluid balance, from time to time progress of head by abdominal palpation only. Note the foetal heart sound in between.

(8) MANAGEMENT PROPER:

With intelligent and watchful expectancy the following can be done in those cases where disproportion are of first degree, that is by Muller Kerr's method, there is flushing of the foetal skull with anterior surface of the pubis. The cases which show complete head entry into the cavity, should go for natural labour as there is no disproportion

and on the otherhand, which shows second degree of disproportion that is head overlaps the symphysis pubis or overhangs, should go for Caesarean section early in labour, preferably of lower segment type as there is no chance of vaginal delivery in such cases with a living child.

(9) PROHIBITION DURING TRIAL:

(1) Minimum internal examination, as it directs to potential sepsis.

(2) Too conservatively dragged—too long a trial, which often produces, foetal distress or intrauterine death.

(3) Uterine stimulants—Oxytocic drugs like pituitrin should not be used in such cases, as there is a great chance of rupture of uterus from an often undiagnosed and underestimated obstruction.

(4) Anything which causes early rupture of membrane, the bag of water, before adequate dilatation and taking up of the cervix and engagement of the head.

(10) WHEN FULL TRIAL IS OVER:

When during a trial labour, cervix is fully dilated and taken up, membranes have ruptured, and there is no further progress of the head for about an hour or two in the absence of any foetal and or maternal distress. Different authors of outstanding experience define in their own ways which are quoted as follows:—

(a) "A full trial of labour can only be said to have been given when good pains have been recurring every four or five minutes for at least two hours, during which the cervix has been fully dilated and the membranes ruptured"—F. J. Brown.

(b) "The test of labour should be permitted only long enough to convince the Physician that labour is not progressing"—J. P. Greenhill.

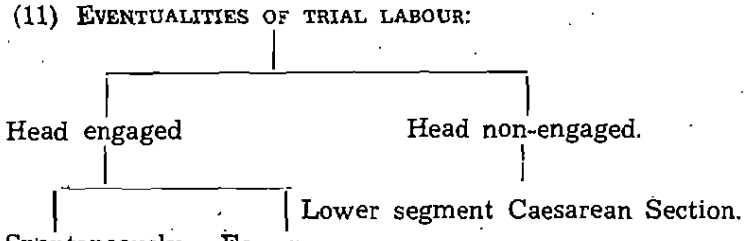
(c) "Any fixed period, even with good contractions may be insufficient test for one woman and too long a test for another"—Moir.

Hence according to Moir, the points to decide the trial are:—

(i) Mother's mental and physical condition.
(ii) Foetal heart rate, rhythm, character etc.
(iii) Force of uterine contractions.
(iv) The ability of uterus to relax between pains.
(v) Above all the evidence of 'Progress'—the descent of head as furnished by both abdominal and vaginal examinations.

(d) "Time lapse between the rupture of membrane and the delivery is directly proportionate to intrauterine sepsis and placental insufficiency". —Keneath Bowss.

(11) EVENTUALITIES OF TRIAL LABOUR:



When foetus is dead during the trial, craniotomy is indicated.

(12) SCOPE OF HOMOEOPATHIC MEDICINE IN TRIAL LABOUR:

We find that the prospective mother during pregnancy and labour reacts extremely well to Homœopathic remedies as it has been said that the organism is then in a specially receptive state.

Prophylactic treatment:

Those border line cases of disproportion which may undergo trial labour at term should have constitutional treatment during pregnancy by antipsorics, antisycotics and anti-syphilitic drugs as the case may be. This will certainly help to bring success in trial labour.

Drugs during trial labour:

Aconite Nap 200—fear, anxiety and tension often affects the women at the beginning of trial labour. The terror and distress are ordinarily dissipated by the calm and assured manner of the obstetrician and others around her, but should they continue one or two doses of Aconite at half hourly interval would definitely prevent that.

Belladonna 30—This drug is indicated when labour pains come and go suddenly and they are violent. Cervix is not dilating and edges are hard. The face gets red with every pain.

Pulsatilla 30—When the pains are slow, weak and ineffectual. The patient is of mild temperament and likes open air. Tongue is dry with absolute thirstlessness. Sometimes in certain patients pain affects the back only, without progress in labour. Pulsatilla almost always improves the pain.

Kali Carb 30, 200—is also indicated where pain affects the back only but Kali Carb patient is irritable.

Opium 6—In certain cases pains proceed regularly for some time, then suddenly stops without a known cause, with heaviness of head, drowsiness, numbness and trembling of limbs but the cervix is dilated or dilatable. In such a case opium will cause cessation of symptom and return of pain.

Gelsemium 30—Is also indicated when pain suddenly stops and there is drowsiness and trembling of limbs. But in Gelsimium pain is weak and infrequent from the beginning of labour, then it suddenly stops and dilatation of os as unsatisfactory and more or less rigid.

Kali Phos 6x—Is very useful to improve pain in nervous neurotic type of patients.

Coffea 6—Sometimes especially in primipara when the head of the child touches the Vulva, the patient complains of intense pain caused by its distension which arrests the expulsive efforts and threatens to produce convulsion, a

dose of Coffea will often calm these pains and give time to the tissues to prepare themselves for the distension, necessary to the passage of the child.

Secale Cor 30—This drug is used in feeble anaemic and cachectic type of patients, where labour pain is prolonged and ineffectual. There is tendency of formation of contraction-ring. Pulse is weak and quick. Patient does not like covering the body.

Nux vom 30—Is used when labour pain is spasmodic and severe in type and there is constant inclination to pass stool or to urinate with each pain. Patient is very irritable, cannot bear noise, odour, light and is always fault-finding.

There are many other drugs to tackle with a case of difficult labour. But the Drugs which we have mentioned have been found quite effective when these are given according to the mentioned indications.

(13) PROGNOSIS OF TRIAL LABOUR:

Prognosis of these groups of cases certainly depend upon many factors. And if we are allowed to view the whole "show" from another outlook, it will be as follows—

The arrangements are:

	Patient's co-operation.
Producers:	Patience of obstetrician-in-charge.
	Personal experience and watchfulness.
Director:	Power of Uterus (Uterine Force).
Deputy	Plasticity of foetal head.
Directors:	Pelvic yield.
General Manager:	Persistence of membrane and the bag of water.
Personal Assistant to Producers:	Prolapse cord—When occurs during a trial labour immediate termination of labour is indicated, for the safety of the baby by a suitable method.

(14) SUMMARY:

A brief but comprehensive outline of Trial Labour and its management has been discussed.

The details of management from hour to hour during an actual trial labour has been omitted purposely, in order to avoid monotony. Moreover, as already pointed out, personal clinical experience with intuition brings about the virtue of Obstetrical judgment, which no amount of theoretical knowledge can help. There are also cases of "surprise dystocia", by which it is meant that there is disproportion but not detected previously by clinical examination and X-Rays. There is no shame in recognising these groups of cases while a trial is going on and doing the needful in right time for the safety of mother and child.

Needless to add, from our personal experience and from the experience of others, that sympathetic visitors and relatives often stimulate and interfere with the surgeon's decision with an end, result of a premature termination, mostly by an abdominal delivery. This has to be guarded from the beginning and the best way to avoid this, is to avoid relatives as far as practicable.

(15) CONCLUSION:

"Wards are the greatest of all research laboratories". Hence it should be the bounden duty of every medical student to go round the Wards, to see the patients, to learn the ethics of both case-taking and treatment. Curepathy does not mean medicinal treatment. A patient is to be treated as a whole, naturally the considerations of etiological treatment, symptomatic relief, Psychosomatic aspects, diet etc. are of utmost importance. Lastly it is a great art in the midst of a most progressing and living Science i.e., Medicine.

—*The Calcutta Homœo. Medical College Magazine, May '55.*