PREVALENCE OF SPONTANEOUS VAGINAL DELIVERIES AMONG PREGNANT FEMALES

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ABSTRACT:
Labor is a physiologic process during which the products of conception (ie, the fetus, membranes, umbilical cord, and placenta) are expelled outside of the uterus. Labor is achieved with changes in the biochemical connective tissue and with gradual effacement and dilatation of the uterine cervix as a result of rhythmic uterine contractions of sufficient frequency, intensity, and duration. This retrospective cross-sectional study was conducted among the patients presenting in labor rooms. A total of 230 patients were included in this study. Brief demographic data i.e. name, maternal age, gestational age, any co-morbidity, and any other finding was noted on a predefined proforma. All the data was entered and analyzed in SPSS Ver. 23.0. The quantitative variables were presented as mean and standard deviation. The qualitative variables were presented as frequency and percentages. The mean age of the patients was 30.32±2.34 years. The minimum age was 24 years and maximum age was 33 years. Out of 230 patients, 23 had pre-eclampsia and 38 had gestational diabetes. All the patients were given the trial of labour. Out of 230 patients, spontaneous vaginal delivery was successful in 178 patients (77.40%). Fifty-two patients (22.60%) were shifted for Caesarean section due to certain complications.

Keywords: SPONTANEOUS VAGINAL DELIVERIES
INTRODUCTION:
A vaginal delivery is the birth of offspring in through the vagina (also called the "birth canal"). For humans, the average length of a hospital stay for a normal vaginal delivery is 36–48 hours. Surgery extends that stay. With an episiotomy (a surgical cut to widen the vaginal canal) to enable vaginal birth, the stay is 48–60 hours. The length of stay for a Caesarean section (C-section), a common form of nonvaginal birth, is 72–108 hours. Vaginal delivery is a natural process that usually does not require significant medical intervention. Management guided by current knowledge of the relevant screening tests and normal labor process can greatly increase the probability of an uncomplicated delivery and postpartum course. All women should be screened for group B streptococcus; women who test positive should be treated with antibiotics during labor. Routine human immunodeficiency virus screening of all pregnant women, and treatment with antiretroviral medication for those who test positive, can reduce perinatal transmission of the infection. Once a woman is in labor, management should focus on the goal of delivering a healthy newborn while minimizing discomfort and complications for the mother. In a patient who tests negative for group B streptococcus, delaying admission to the labor ward until she is in active labor decreases the number of possible medical interventions during labor and delivery. Once a patient has been admitted to the hospital, providing her with continuous emotional support can improve delivery outcomes and the birthing experience. Epidural analgesia is effective for pain control and should not be discontinued late in labor to reduce the need for operative vaginal delivery. Epidurals prolong labor but do not increase the risk of cesarean delivery. Research has shown that labor may not progress as rapidly as historically reported; this should be
considered before intervening for dystocia. Routine episiotomy increases morbidity and should be abandoned. Once the infant has been delivered, active management of the third stage of labor decreases the risk of postpartum hemorrhage.

Spontaneous vaginal delivery at term has long been considered the preferred outcome for pregnancy. Because of the perceived health, economic, and societal benefits derived from vaginal deliveries, lowering the cesarean delivery rate has been a goal in the United States for more than 25 years. Although some experts now support elective primary cesarean delivery, and although the percentage of operative deliveries has increased from 21 percent in 1996 to 30 percent in 2005, most women still deliver vaginally. There are relatively few absolute contraindications to vaginal delivery. In 2003, nearly 3 million vaginal deliveries occurred in the United States. Despite a decreasing trend in the number of family physicians providing maternity services, about 25 percent continue to perform vaginal deliveries, whereas less than 5 percent perform cesarean deliveries. Management guided by current knowledge of the relevant screening tests and normal labor process can greatly increase the probability of an uncomplicated delivery and postpartum course (1-3). The objective of this study was to note the prevalence of spontaneous vaginal delivery among the patients presenting in labor rooms.

**Material of Methods:**
This retrospective cross-sectional study was conducted among the patients presenting in labor rooms. A total of 230 patients were included in this study. Brief demographic data i.e. name, maternal age, gestational age, any co-morbidity, and any other finding was noted on a predefined proforma. All the data was entered and analyzed in SPSS Ver. 23.0. The quantitative variables were presented as mean and standard deviation. The
RESULTS:
The mean age of the patients was 30.32±2.34 years. The minimum age was 24 years and maximum age was 33 years. Out of 230 patients, 23 had pre-eclampsia and 38 had gestational diabetes. All the patients were given the trial of labour. Out of 230 patients, spontaneous vaginal delivery was successful in 178 patients (77.40%). Fifty-two patients (22.60%) were shifted for Caesarean section due to certain complications.

DISCUSSION:
Labor is a physiologic process during which the products of conception (ie, the fetus, membranes, umbilical cord, and placenta) are expelled outside of the uterus. Labor is achieved with changes in the biochemical connective tissue and with gradual effacement and dilatation of the uterine cervix as a result of rhythmic uterine contractions of sufficient frequency, intensity, and duration.

Labor is a clinical diagnosis. The onset of labor is defined as regular, painful uterine contractions resulting in progressive cervical effacement and dilatation. Cervical dilatation in the absence of uterine contraction suggests cervical insufficiency, whereas uterine contraction without cervical change does not meet the definition of labor.

As the childbearing population in the United States has changed, the clinical obstetric management of labor also has evolved since Friedman’s studies. Data from number a studies have suggested that normal labor can progress at a rate much slower than that Friedman and Sachtleben had described. Zhang et al examined the labor progression of 1,162 nulliparas who presented in spontaneous labor and constructed a labor curve that was markedly different from Friedman’s: The average interval to progress from 4-
10 cm of cervical dilatation was 5.5 hours compared with 2.5 hours of Friedman’s labor curve. Kilpatrick et al and Albers et al also reported that the median lengths of first and second stages of labor were longer than those Friedman suggested.

A number of investigators have identified several maternal characteristics obstetric factors that are associated with the length of labor. One group reported that increasing maternal age was associated with a prolonged second stage but not first stage of labor.

While nulliparity is associated with a longer labor compared to multiparas, increasing parity does not further shorten the duration of labor. Some authors have observed that the length of labor differs among racial/ethnic groups. One group reported that Asian women have the longest first and second stages of labor compared with Caucasian or African American women, and American Indian women had second stages shorter than those of non-Hispanic Caucasian women. However, others report conflicting findings. Differences in the results may have been due to variations in study designs, study populations, labor management, or statistical power.

In one large retrospective study of the length of labor, specifically with respect to race and/or ethnicity, the authors observed no significant differences in the length of the first stage of labor among different racial/ethnic groups. However, the second stage was shorter in African American women than in Caucasian women for both nulliparas (-22 min) and multiparas (-7.5 min). Hispanic nulliparas, compared with their Caucasian counterparts, also had a shortened second stage, whereas no differences were seen for multiparas. In contrast, Asian nulliparas had a significantly prolonged second stage compared with their Caucasian counterparts, and no differences were seen for multiparas (4-6).
REFERENCES: