

Labour CTG guidelines — HUNTLEIGH

Assess risk

Maternal problems

- Hypertension
- Diabetes
- Collagen disease
- Renal disease

Fetal problems

- Pre / post-maturity
- IUGR / placental insufficiency
- Twins / triplets
- Breech presentation
- Rhesus disease

Labour abnormalities

- Induced/augmented/ prolonged labour
- Prolonged membrane rupture
- Previous Caesarean section
- Epidural

Suspected fetal distress in labour

- Meconium staining
- Suspicious FHR on auscultation or admission CTG
- Vaginal bleeding
- Intrauterine infection

Low risk

Intermittent auscultation or external ultrasound monitoring only

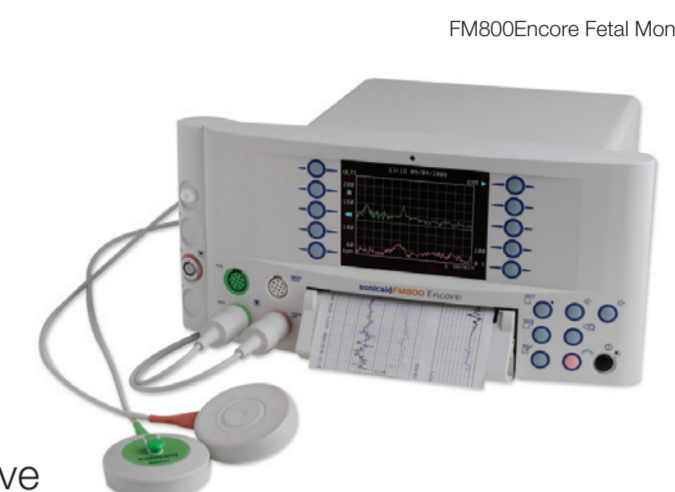
High risk

Continuous monitoring - use fetal scalp electrode only if good trace not possible with ultrasound

- Re-assess regularly - risk level may change at any time.
- Abnormal CTGs may reflect maternal problems, not fetal (eg. maternal pyrexia)
- FETAL MONITORING HAS HIGH -VE PREDICTIVE VALUE BUT LOW +VE PREDICTIVE VALUE - If trace normal reactive, chance of acidosis very low¹. If trace abnormal, fetus not necessarily compromised.

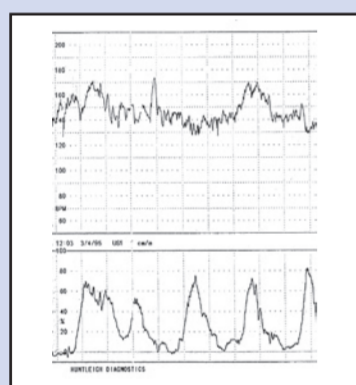
Using the CTG

- Check monitor : undamaged, sufficient paper, date/time correct?
- Correct and sufficient gel used with ultrasound transducer
- Palpate - position U/S transducer over fetal left scapula
- Adjust position for clear fetal heart sounds - slapping valve sounds not swishing cord / placental sounds



Check maternal rate is different from rate displayed by monitor - can be confirmed with intermittent auscultation - check & document regularly

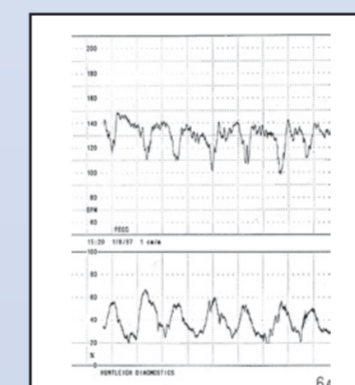
ACCELERATIONS ARE AN INDICATOR OF FETAL WELLBEING



Normal

- FIGO guidelines for normal labour CTG²
 - Baseline rate at term: 110-150bpm (120-160 in early 3rd trimester)
 - Variability : ±5 to ±25bpm
- Presence of accelerations: ↑15+bpm lasting 15s+
- Absence of decelerations: See below (↓20bpm lasting 30s+)

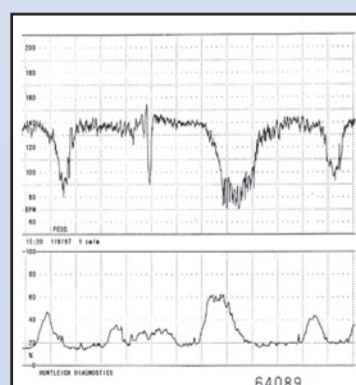
Continue routine management - < 2% risk of acidaemia with normal trace¹



Early deceleration

- Deceleration coincident with contraction
- Normal autonomic response to head compression in most cases
- If baseline and variability normal with rapid return to baseline - fetus probably coping well with stress

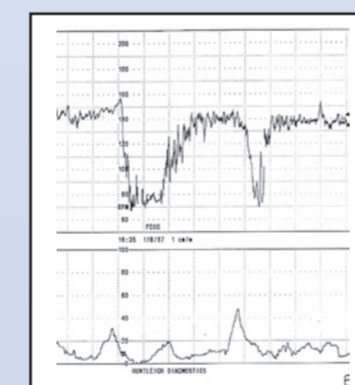
5% incidence of acidaemia¹



Variable deceleration

- Cord compression
- Shallow variable decelerations with reduced variability pathological - may be associated with hyperstimulation (oxytocin)
- If baseline and variability normal with rapid return to baseline - less ominous

25% incidence of acidaemia¹



Late deceleration

- Deceleration delayed relative to contraction
- Non-autonomic biochemical response to transient hypoxia
- Fetus may have limited reserves (?Placental insufficiency)
- If baseline and variability normal with rapid return to baseline - less ominous

50% incidence of acidaemia¹

DECELERATIONS INDICATE STRESS - NOT NECESSARILY PATHOLOGICAL - FETAL ABILITY TO COPE WITH STRESS INDICATED BY OTHER SIGNS (eg. time to return to baseline, baseline rate, variability & accelerations)

Our thanks to Prof. D. K. James, Queen's Medical Centre, Nottingham, UK for his assistance in preparing this

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References:
¹ Steer P.J. and Daniellian P.J. 'Fetal distress in Labor' In: High Risk Pregnancy - Management Options (Eds: James D, Steer P, Weiner C and Gonik B) Publ: London, WB Saunders Ltd pp1077-1100
² FIGO : Guidelines for the use of fetal monitoring. Int.J.Gynaecol.Obstet, 1987, 25 : 159-167.

Disclaimer:
 The information contained in this poster is believed to be correct at the time of going to print based on current European guidelines. It is intended to be used as a guide only and does not cover all risk factors. It remains the responsibility of the clinician to manage each case in accordance with local guidelines and recommended clinical practice.

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