OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Operative vaginal birth

(previously known as 'Instrumental Vaginal Delivery')

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH and OPH

This document should be read in conjunction with this Disclaimer

Contents

Operative vaginal birth- quick reference guide

Quick Reference Guide

Preparation:

1. Prepare **equipment, explain** the procedure to the woman, gain **consent**, assess **analgesia** requirements, check contraindications, and **empty** the woman's **bladder**.
2. **Notify** Coordinator and advise Neonatologist (KEMH) to attend birth. At OPH- see local Paediatrician Attendance guideline
3. Perform an **abdominal palpation** and **vaginal examination** and **position** the woman in dorsal lithotomy.
4. Monitor **fetal heart rate** during procedure.
5. Proceed with **either** forceps or vacuum procedure below. Evaluate for **episiotomy**.

Forceps:

a. Consider trial of forceps **in theatre** if high risk of failure.

b. **Insert** the left **blade** into the left side of vagina while guarding the vaginal tissue with other hand; insert the right blade with right hand. **Note the time** of forceps application.

c. **Assess the blades** to ensure correct application and lock the blades together when positioned correctly.

d. **Apply traction** during a contraction while the woman bears down (unless contraindicated), following the pelvic curve. The dominant hand gives outward pull while the other hand gives continuous downward pressure.

e. **Remove forceps** in opposite order to the application. **Note time** forceps removed.

Vacuum:

a. **Apply vacuum** cup with centre at or behind the flexion point over the sagittal suture. The flexion point is 3cm in front of the posterior fontanelle. **Check vacuum position / application and** no cervical or vaginal tissue is in the cup.

b. **Apply traction.** Only obstetric medical staff competent in assisted birth are to undertake or supervise the procedure.

- **Note the time** the cup is applied / traction initiated and **turn on suction** pressure as per medical practitioner (up to max. 80kPa). Chignon is formed after 1-2 minutes.
- **During a contraction and** with maternal expulsive effort (unless contraindicated), apply gentle steady **traction** at right angles to the cup, with the axis of traction following pelvic curve during the contraction. **Note the time** of each traction pull.
- Abandon the procedure if difficult application, no progressive descent, not imminent birth within 3 pulls, cup detachment 3 times, or >15-20 minutes since cup application.

c. **Cease suction and remove** vacuum cup when the jaw is visible, birth the baby.

Post procedure

6. **Document** procedure in the woman's medical record, Operative Vaginal Delivery form and Labour and Birth Summary including when the attempt has been unsuccessful. *If adverse outcome or unsuccessful assisted vaginal birth complete Clinical Incident Form.
7. **Assess and repair vagina** trauma (as required). Provide **bladder care, analgesia** and measures to reduce perineum pain and swelling (if trauma occurred). Recommend intravenous (IV) **antibiotic prophylaxis** within 6 hours of birth where appropriate- see section for criteria and administration.
8. Prior to hospital discharge **medical staff to counsel** the woman about the indication for operative birth, management of complications and prognosis for future births.

Note: This flowchart represents minimum care and should be read in conjunction with the following full guideline and disclaimer. Additional care should be individualised as needed.

Forceps birth and vacuum extraction birth

Key points

The following key points are separated into General, Forceps and Vacuum points.

General

1. Obtain informed consent and document in the medical record, including for episiotomy if required.
2. **Competency**: Obstetric medical practitioners performing operative vaginal births should have the knowledge, experience and skills necessary, or an appropriate supervisor present,[1] to assess the woman, complete the procedure and manage any complications that may occur.[2]
    - An obstetric trainee should be supervised by an accredited operator with expertise in the chosen procedure and should demonstrate competency before conducting unsupervised births.[1, 2]
    - Trainees are to receive appropriate training in vacuum and forceps birth, including theoretical knowledge, simulation and clinical training under direct supervision.[2]
3. The choice of instrument used for an operative vaginal birth is determined by the judgement of the operator (e.g. clinician's skill, available choices) and the clinical circumstance.[1, 3]
4. The **threshold for abandoning** an operative vaginal birth differs between clinicians and clinical situations.[1] Operative vaginal birth should be abandoned if:
    - Difficulty in applying the instrument,[4]
    - No evidence of progressive descent with each pull[1]
    - No evidence of imminent birth following three pulls of a correctly placed instrument by an experienced operator[2]
    - Birth is not imminent within a reasonable period of time (e.g.15-20 minutes)[4]
    - See also points for rotational forceps below
    - For vacuum, in addition, discontinue if the cup detaches three times[1, 4]

    The majority of malpractice litigation results from failure to abandon the procedure at an appropriate time.[1, 2] Increased risk of neonatal trauma and admission to special care units are associated with excessive vacuum pulls (>3) and sequential use of instruments.[1]
5. Sequential instrumentation should not be used if any of the indications for abandonment are present from the first unsuccessful attempt at birth. In circumstances where there has been good descent but birth has not been achieved, the use of a second instrument may be appropriate.[4]
6. All women who have undergone operative vaginal birth should have management of bladder according to the WNHS OGD guideline: Bladder Management.

7. Routine episiotomy may not be required for operative vaginal births. Individual clinical judgement should be applied for each birth.
    - Offer an episiotomy if forceps or vacuum are required and this is the woman's first vaginal birth (due to increased risk of third and fourth degree tears)[5]. See WNHS OGD Perineal Care and Repair guideline.
    - Providing episiotomy in first vaginal births leads to fewer anal sphincter injuries (24% less with forceps and 16% less with vacuum)[1]
8. **Consider trial of operative vaginal birth in theatre** for births which are at risk of higher failure rates e.g. maternal BMI >30, short maternal stature, estimated fetal weight >4kg or a clinically big baby, head circumference >95th percentile, occipito-posterior position, mid-cavity or when 1/5 head is palpated abdominally.[1, 2]
    - Written consent should generally be obtained prior to an operative vaginal birth attempt in theatre and women advised of the possibility that attempts may need to be abandoned and caesarean performed.[1]
9. Standardised checking processes outlining the responsibilities for the operator and assistant are contained in the following documents which must be read in conjunction with this guideline **[RCA Recommendation]**:
    - WNHS Policy: Procedural Count: Management and Procedure
    - Perioperative: Surgical Count: Management and Procedure
      (Available to WA Health employees through HealthPoint)
10. Effective analgesia should be obtained prior to commencing an assisted birth.[1] Although there is insufficient evidence to support one particular analgesic method in operative vaginal birth,[6] regional or pudendal block and effective perineal infiltration are adequate forms of analgesia for low and outlet births. A regional block (epidural or spinal) is usually required for a mid-rotational birth.[1]

Forceps

1. Clinicians must receive appropriate training and maintain experience if they perform rotational forceps or a forceps birth should be conducted with appropriate training and under supervision of a trained and experienced obstetrician credentialed in forceps birth.[1]
2. Rotation of the fetal head should only be attempted when the uterus is relaxed between contractions.[1]
3. Rotational forceps birth should be **abandoned** if:
    - the forceps are not easily applied
    - the handles are not easily approximated
    - rotation is not easily effected with gentle traction[1]
4. Forceps should be conducted in theatre if there is an expectation of difficult birth / forceps.
5. High forceps birth should not be attempted.

Vacuum extraction

1. To decrease risk of cephalhaematoma and intracranial bleeding the utilisation of the vacuum extractor is not recommended it situations with face presentations, or if the fetus is less than 34 weeks gestation.[1, 7]
2. The use of the vacuum extraction for operative vaginal birth is recommended as the first line method of birth in situations where there are no clear indications for a specific instrument.[3]
3. The preferred option in situations where women are infected or at high risk of infection (e.g. viral infections such as HIV or hepatitis) is to use forceps or a soft cup rather than a metal cup for assisted vaginal births.[3]
4. The use of the metal vacuum cup is superior at achieving greater traction with a higher rate of successful births than with use of a soft cup e.g. for occipito-lateral or occipito-posterior positions.[3] An OP metal cup or the KIWI Omnicup are superior to anterior cups for mid cavity OT and OP positions.
5. When rapid birth is required, use of a rapid negative pressure application of vacuum suction rather than increasing pressure in a stepwise increment reduces duration of the procedure, with no difference in outcomes to the woman or neonate.[7]
6. The use of the metal cup is associated with more cases of scalp injury and cephalhaematoma, and retinal haemorrhage than the soft cup.
7. Abandon the procedure if difficult application, no progressive descent, not imminent birth within three contractions/pulls (although more pulls may be acceptable if the head has descended to the level of the pelvic floor or perineum[1]), cup detachment three times, or >15-20 minutes since cup application. There should be descent of the presenting part with each pull.

Indications for operative vaginal birth

Note that indications are not absolute, with assessment and clinical judgement required in every case.[1, 2]

- Fetal compromise – suspected or anticipated[1, 2]
- Delay in second stage[1, 2]
- Maternal medical conditions where maternal effort is contraindicated[1] e.g. cerebral aneurysm, risk of aortic dissection, proliferative retinopathy, severe hypertension or cardiac failure[1], myasthenia gravis, spinal cord injury, cerebral vascular disease[2]
- Maternal exhaustion/fatigue[1, 2]

Contra-indications for operative vaginal birth

- Less than full dilatation.[2] Exception: a prolapsed cord in a multiparous woman, or a second twin.
- Additional vacuum contraindications- gestation <34 weeks (risk of intracranial haemorrhage); face presentation[1]

Relative contraindications:

- Fetal bleeding disorders (e.g. alloimmune thrombocytopenia)[1, 2]
- Fetal pre-disposition to fracture (e.g. osteogenesis imperfecta)[1, 2]
- Unknown fetal position[8]
- Inexperienced operator[8]
- Additional vacuum relative contraindications- between 34 and 36 weeks gestation (where limited evidence at these gestations); prior fetal scalp blood sampling[1] or application of fetal scalp electrode[2]

N.B. Maternal blood-borne viral infections are not a contraindication, however care should be taken to avoid situations where increased trauma to the fetal scalp is more likely.[2]

Prerequisites for operative vaginal birth

1. Full abdominal and vaginal examination
    - Fetal head is ≤ 1/5 palpable abdominally
    - Vertex presentation
    - Cervix is fully dilated and the membranes are ruptured
    - The exact position of the head is able to be determined to allow correct placement of the instrument. Ultrasound may be helpful in determining position of the vertex.
    - Assessment of caput and moulding
    - Pelvis is deemed adequate
2. Preparation of the woman
    - Informed maternal consent
        - Clear explanation given including possible episiotomy, and consent obtained appropriate to clinical situation. The time spent in obtaining consent may be determined by the urgency of the situation[1]. Verbal consent should be obtained and documented in the medical record.[1]
    - Adequate analgesia appropriate for the birth is in place and effective
        - For mid-cavity rotational births this is commonly a regional block
        - Pudendal block may be appropriate, particularly if urgent birth
    - Bladder emptied recently- Deflate or remove an indwelling catheter (IDC)
    - Aseptic technique
3. Preparation of the staff
    - Skilled trained operator to perform the procedure
        - See general key points
        - A senior obstetrician competent in performing mid-cavity births should be present if a clinician inexperienced as a solo operator is performing the birth
    - Adequate facilities available (appropriate equipment, bed, lighting)

- A backup plan is made should the procedure be unsuccessful
  - For mid-cavity births- theatre staff should be immediately available to allow a caesarean section to be performed without delay (less than 30 minutes)
- Anticipation of complications that may arise (e.g. shoulder dystocia postpartum haemorrhage
- Personnel trained in neonatal resuscitation are available/paged. See WNHS OGD Labour and Birth guideline: Neonatal Team Attendance at Birth

Types of forceps available at WNHS

Outlet and/or low forceps:

- Wrigley – suitable for use when the head is on the perineum[8], for the after-coming head of a breech birth, and at caesarean section.
- Neville-Barnes – used for low or mid-cavity birth.[4]

Mid cavity forceps

- Neville-Barnes – used for low or mid-cavity birth
- Kielland – generally used for rotational birth when the head is in the transverse or the occipital-posterior position. The lock allows sliding to correct asynclitism.

Procedure

Equipment

1. Check all equipment is available for use:
   - Sterile bowl pack
   - Sterile trolley cover
   - Sterile gloves
   - Lithotomy equipment
   - Sterile cotton wool balls
   - Sterile large combine pad
   - Urinary catheter
   - Lubricant
   - Plastic apron, protective glasses/face shield and mask
   - Instrument pack – including x4 Howard Kelly forceps, x1 episiotomy scissors, x1 cord cutting scissors
2. Ensure equipment is available as required to perform an episiotomy
   - 1x 20 mL syringe
   - 1x 19 gauge needle
   - 1x 22 gauge needle
   - 10 mL 1% Lignocaine
3. Ensure equipment is available for pudendal analgesia:
   - Pudendal needle, syringe
   - Lignocaine 1%
4. Vacuum extraction machine – ensure it is tested and working prior to commencement.
5. Provide a selection of vacuum cup types and sizes and a selection of forceps.
6. Check the neonatal resuscitation cot is pre-warmed, checked, and equipment is operational.

Preparation

1. **Informed consent**: Ensure the woman has given informed consent and document in the medical record.[1] Check for contraindications
2. **Analgesia**: Assess and provide appropriate analgesia.[1]
3. **Notify appropriate personnel:**
    - Inform the Labour/Birth Suite Midwifery Coordinator
    - Advise the Neonatologist (KEMH) to attend the birth. At OPH follow OPH specific guideline for Paediatrician Attendance.
4. **Abdominal palpation**

    Perform an abdominal palpation, followed by a bimanual vaginal examination. Ascertain the side of the fetal back and limbs and the side of the fetal heart (this is best done by placing the doptone in the midline and angulating to either side to detect where it is louder). When the fetal back is on the left, the position is twice as likely to be OA than OP. When the fetal back is on the right, the position is twice as likely to be OP than OA.
5. **Maternal positioning:** Place the woman in dorsal lithotomy[9]
6. **Bladder care**: Ensure the bladder is empty
7. **Fetal heart rate (FHR) monitoring** Monitor the FHR during the procedure.
8. **Vaginal examinations**: Perform a vaginal examination to determine:
    - dilatation
    - position
    - station
    - moulding
    - presence of caput
    - overall size of the pelvis
    - If the position on vaginal examination is not in agreement with the expected findings on abdominal examination, an ultrasound scan should be performed.

    Allowance should be made for extensive caput and/or moulding of the fetal head.[1] If substantial caput is present soft parts of the fetal head may be felt below the ischial spines, but the leading bony part of the head may be above the ischial spines

Then follow step 9 for either forceps or vacuum procedure below

FORCEPS

Location for forceps: Consider a 'trial of forceps' birth in theatre if higher failure risk.

Application of the forceps

9.1 Insert the left blade into the left side of the vagina while simultaneously guarding the vaginal tissue with the right hand.[9]

9.2 Insert the right blade into the right side of the vagina while guarding the vaginal tissue.[9]

9.3 Note the time of forceps application.

Adjustment and articulation of the blades

9.4 Assess the blades to ensure correct application.[9] Adjust if required.

The plane of the shank lies over the cranial flexion or pivot point, the sagittal suture should lie in the midline of blades, and blades should be symmetrically applied to the skull.

9.5 Lock blades together when positioned correctly[9]

Applying traction

9.6 Instruct the woman to bear down with contractions unless contra-indicated.[10]

9.7 Apply traction to follow the pelvic curve during contraction. The dominant hand gives outward pull which is deflected by continuous downward pressure by the accoucheur's other hand.

Removing the forceps

9.8 The forceps are removed in the opposite order to the application.[9] Note the time forceps are removed. Then go to Post-procedure care.

VACUUM:

Application of the vacuum cup

9.1 Apply the centre of the cup at or behind the flexion point located over the sagittal suture 3cm in front of the posterior fontanelle.[4] For a 6cm outer diameter cup (Bird OP or KIWI), the edge of the cup will be on the edge of the posterior fontanelle. The distance from the other edge of the cup to the edge of the anterior fontanelle should be 3 cm for an average fetus.

9.2 Check cup position and application and no vaginal or cervical tissue is caught by cup.

Applying traction

9.3 Note the time the cup is applied and traction is initiated.

Adequate chignon forms within 1-2 minutes of suction.[7]

9.4 Turn on the suction pressure as requested by the medical practitioner up to the limit of 80 kilopascals (kPa).

Note: Some practitioners may request the pressure be initially turned up to 20 kPa; the position of the cup is checked, then the assistant may be requested to turn up the pressure to 80 kPa.

9.5 During a contraction apply gentle steady traction, at right angles to the cup, with the axis of traction following the pelvic curve during a contraction.[4] Note the time of each traction pull.

9.6 **Abandon the procedure if required** – see general key points for 'threshold for abandoning'.

9.7 Evaluate the need for episiotomy.

Removing the vacuum cup

9.8 Cease the suction pressure and remove cup when the jaw is visible.[4]

Note the time the cup was removed.

Note the time of birth.

Post procedure

10 Documentation

Document the operative vaginal birth or unsuccessful attempt on the:

- Operative Vaginal Birth (MR275 KEMH)
- Labour and Birth Summary (MR230.01 KEMH)

Communication

Inform the neonatal doctor if there has been difficulty with the operative vaginal birth (including recourse to caesarean or where sequential use of instruments involved), so the neonate may receive appropriate surveillance.[1] See also OGD guideline: Neonatal Care: 'Additional observations for subgaleal haemorrhage'

11 Post procedure management

11.1 Assess the vagina for trauma and repair as required.

11.2 Recommend administration of maternal prophylactic IV antibiotics after the cord has been clamped, within 6 hours of birth.[11] See antibiotic section below for criteria and administration.

11.3 Discuss bladder management with the woman and monitor voids.[1, 2]

See Clinical Guideline: Bladder Management

11.4 Initiate measures to reduce swelling and pain to the perineum if trauma has occurred.

11.5 Unless contraindicated, offer regular analgesia (paracetamol and anti-inflammatories).[1, 2]

11.6 Prior to discharge the medical team should counsel the woman about:

- the indication for operative vaginal birth
- management of any complications
- prognosis for future births.[1, 2]

Where possible, the obstetrician who performed the birth should review and debrief the woman.[1, 2]

Notes: After operative vaginal birth in a first labour there is a high probability (78-91%) of achieving spontaneous vaginal birth in the next pregnancy.[1]

For women who experience a third or fourth degree tear, the obstetric team should discuss risk of recurrence and implications with future births.[1, 2]

Antibiotic prophylaxis following operative vaginal birth

Antibiotic prophylaxis should be recommended to women following operative vaginal birth.

Background

The ANODE trial found that the administration of **IV** Amoxicillin + clavulanic acid (1g + 200mg) **within 6 hours of birth** was associated with a reduction of confirmed or suspected maternal postnatal infection within 6 weeks of birth. Significantly fewer

women allocated to the treatment arm of the study had an infection (11%) compared with women allocated to placebo (19%; Risk ratio 0.58, 95% CI 0.49 – 0.69; p<0.0001; absolute risk reduction 8%; NNT = 13).[11]

Administration

Recommend to women who have undergone vacuum or forceps birth:

- Amoxicillin + clavulanic acid 1.2g **IV** (as a single dose) within 6 hours of birth
- To minimise neonatal exposure, only administer **AFTER cord clamping**

For women **allergic to penicillins** alternative regimens to consider include:

- Cefazolin (Cephazolin) 2g IV + metronidazole 500 mg IV if non severe hypersensitivity (immediate or delayed) to penicillin
- OR Clindamycin 600mg IV [1] if severe hypersensitivity (immediate or delayed) to penicillin
- OR Discuss with Microbiology Registrar or on-call Microbiology Consultant if concerns. In the presence of multiple antibiotic allergies the risk benefit of prophylactic antibiotics should be carefully considered
- For further information regarding penicillin hypersensitivity, refer to "Management of patients reporting hypersensitivity to penicillin" in the Therapeutic Guidelines 2020

For women **without IV access**[1], or who **decline IV** antibiotics, with no concern regarding penicillin hypersensitivity, the following regime may be considered:

- Amoxicillin + clavulanic acid 875/125mg oral (as a single dose) within 6 hours of birth

Exclusion criteria:

- Gestation <36 weeks
- Attempted/unsuccessful forceps / vacuum that progresses to caesarean birth (will instead receive caesarean section antibiotic prophylaxis)
- Other indications for **ongoing postpartum** antibiotics (refer instead to relevant guidelines for antibiotics for these indications):
  - On triple IV antibiotics intrapartum for suspected sepsis
  - Third or fourth degree perineal tears
- Contraindications to prophylactic amoxicillin and clavulanic acid. Note- see alternatives above if allergic to penicillins

Pudendal nerve block

Pudendal nerve blocks are used to provide analgesia for second stage labour pain; low forceps birth,[12] or vacuum extraction birth; women who have contra-indications to lumbar analgesia; episiotomy; or for the repair of vaginal or perineal lacerations.

Equipment

- 1 X disposable pudendal block needle
- 10mL Local anaesthetic e.g. 1% Lignocaine
- 1 X 20mL syringe

Procedure

1 Prior to commencing

Obtain maternal consent and prepare equipment

2 Position

Place the woman in lithotomy position

3 Technique

3.1 Clean the area with antiseptic solution and aseptic technique.

3.2 Hold the guarded needle between the middle and index finger of the right hand to block the right pudendal nerve (The left hand holds the needle for the left side).

The needle guards the vaginal mucosa and protects the fetal head.

3.3 Palpate the ischial spine

The sacrospinous ligament lies 1 cm medial and posterior to the ischial spine.

3.4 Advance the needle posterior to the ischial spine to a depth of 1-1.5 cm using a loss of resistance method. This places the needle through the sacrospinous ligament.

The tip of the needle will now lie in the area of the pudendal nerve.

3.5 Aspirate for blood.

Aspiration is essential due to the close proximity of the pudendal artery. If blood present, withdraw and reposition.

3.6 Inject up to 10mL of local anaesthetic e.g. 1%Xylocaine / Lignocaine.

Xylocaine 1% appears in maternal and fetal blood within 5 minutes of the block, and peaks between 10 to 20 minutes.

3.7 Repeat the procedure on the opposite side.

Allow a minimum 4-5 minutes after pudendal block administration for effect to start prior to commencing painful procedures

See also: Clinical Guideline, OGD, Perineal Care and Repair: Episiotomy and Infiltration of the Perineum

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Related legislation and policies

Department of Health, Western Australia. MP0175/22 Consent to Treatment Policy (2022)

Related NMHS and WNHS policies, procedures, guidelines and forms

WNHS Policy: Procedural Count: Management and Procedure

Obstetrics and Gynaecology clinical guidelines:

- Birth After Previous Caesarean
- Bladder Management
- Fetal Surveillance: Fetal Heart Monitoring (Intrapartum)

- Labour and Birth: Neonatal Team Attendance at Birth
- Neonatal Care (observations for subgaleal haemorrhage)
- Perineal Care and Repair

Perioperative clinical guidelines: Surgical Count: Management and Procedure

Pharmacy Medication Monographs (Adult): Amoxicillin with clavulanic acid; Cefazolin (Cephazolin), Clindamycin, Metronidazole

Forms:

- Labour and Birth Summary (MR230.01 KEMH)
- Operative Vaginal Birth (MR275 KEMH)

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Version history

Version number	Date	Summary
1	Jul 2003	First version. Original known as 'B5.11 Techniques of Assisted Vaginal Cephalic Birth'
2-6	Prior to July 2018	Archived- contact OGD Guideline Coordinator for previous versions. Initially separate guidelines B5.11 (Instrumental Vaginal Delivery), B5.11.1 (Forceps Delivery), B5.11.2 (Vacuum Extraction), B5.11.3 (Pudendal Nerve Block) dating from 2003. In 2014, guidelines on this same topic were amalgamated into title "Instrumental Vaginal Delivery".

7	July 2018	Routine review- Evidence on this topic was reviewed and overall guidance remains unchanged. Minor changes and formatting have been made. Retitled 'Operative Birth'.
8	Sept 2020	Retitled 'Operative Vaginal Birth'. Antibiotic prophylaxis after operative vaginal birth added; links added to new Procedural Count WNHS policy for standardised checking processes [**RCA Recommendation**]; updated wording, aligning with latest RANZCOG guidance; contraindications, prerequisites, informed consent, episiotomy guidance updated. See Guideline Updates (OGD) for full list of changes
9	Dec 2023	• Routine review. Reformatted with additional information column removed. • The time spent in obtaining consent may be determined by the urgency of the situation. Verbal consent should be obtained and documented in the medical record.