Will I need an instrumental vaginal delivery? (vacuum or forceps)

A vacuum extractor is a plastic device that is applied to the baby's head, and suction is then used to allow traction for expediting the delivery process. Forceps are metal instruments that are applied around the baby's head with the same purpose. These instruments are only used when there are important health reasons for expediting birth. The most common indications for instrumental vaginal delivery are signs of inadequate fetal oxygenation (usually assessed by evaluating the fetal heart rate) and a prolonged second stage of labour (the final phase of labour, during which the cervix is fully dilated and the mother experiences the urge to push). Some women have medical conditions that contraindicate active pushing during labour; and in such cases instrumental vaginal delivery may represent the safest alternative.

Instrumental vaginal delivery is generally considered a safe procedure. However, as with any medical intervention, it is associated with certain risks. For the mother, there is a slightly increased risk of having tears around the vagina, and a greater likelihood of requiring an episiotomy (an incision made in the tissues around the vagina to facilitate delivery of the baby's head). For the newborn, there is a slightly increased risk of causing a haematoma (a collection of blood) of the scalp, leaving temporary forceps marks on the head, or showing a yellow discoloration of the skin (jaundice). All of these findings usually resolve within the first 48 hours of life.

Can I have a vaginal birth after a previous caesarean?

Most women who have had one previous caesarean section in the past can have a vaginal birth in a subsequent pregnancy, and this is usually the safest option (please see the leaflet "I had a caesarean section in the past - what is important to know?"). For women with two or more previous caesarean sections, the benefits and risks of attempting a vaginal birth are less clear, and in these circumstances, a planned repeat caesarean is generally recommended.

Vaginal delivery remains the safest mode of childbirth

Is vaginal birth painful?

For most women, the uterine contractions of labour are painful. However, the perception of pain is influenced by many factors and can vary considerably between individuals. As a result, many pregnant women feel some degree of anxiety about labour, particularly those who are about to experience it for the first time. However, several very effective methods of pain relief are currently available and can be provided throughout labour (please see leaflets "Non-pharmacological methods for pain relief in labour" and "Pharmacological methods for pain relief in labour"). A calm and supportive environment, together with the continuous presence of an accompanying person, can also contribute to a reassuring and emotionally fulfilling childbirth experience.

References

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UNIDADE LOCAL DE SAÚDE
SANTA MARIA

WHEN AND HOW WILL MY BABY BE BORN?

UNIDADE LOCAL DE SAÚDE SANTA MARIA

Av. Prof. Egas Moniz—1649-035 Lisboa

SNS SERVIÇO NACIONAL DE SAÚDE

When should labour and delivery occur?

Pregnancy lasts on average of 40 weeks. This means that some women will give birth before 40 weeks and others will give birth afterwards. Ideally, birth should occur between **37 and 42 weeks** of pregnancy. This period is referred to as "**term pregnancy**", and babies born within this interval have the lowest risk of health complications. In uncomplicated pregnancies, one usually waits for the spontaneous onset of labour during this period.

What is a preterm birth?

Preterm birth is defined as a birth occurring before 37 weeks of gestation. When this happens, the newborn has an increased risk of health complications in the first weeks of life (respiratory difficulties, infections, haemorrhage, etc.). This risk increases proportionally, with earlier gestational ages. In some cases, preterm birth cannot be avoided, particularly when continuing the pregnancy poses significant risks to the mother or the baby.

How long will my pregnancy last?

When pregnancy extends beyond 42 weeks of gestation, the risk of health complications for the baby progressively increases. For this reason, induction of labour (artificial initiation of labour) is usually recommended a few days before this threshold. Your healthcare provider will inform you if this becomes necessary.

Can my labour be induced?

If pregnancy continues beyond 41 weeks without the spontaneous onset of labour, your healthcare provider will recommend induction of labour for the reasons described above. In specific situations, earlier induction of labour may be necessary, sometimes even before 37 weeks of gestation. Your doctor will inform you if this is the case. Induction of labour without any health indication (i.e., solely for scheduling convenience) is not considered good clinical practice, as it is associated with longer and more intense labour pain and an increased risk of fetal compromise.

Induced labour carries higher risks for both the mother and the baby and should not be undertaken in the absence of a health indication.

Will I need a caesarean section?

A caesarean section is a surgical operation that involves an incision in the lower abdomen and uterus, in order to deliver the baby. The vast majority of pregnant women do not need a caesarean section. A low caesarean section rate is internationally regarded as an indicator of high-quality maternity care. Caesarean section is most commonly performed when labour is not progressing normally or when there are signs that the baby is not receiving an adequate amount of oxygen. If this occurs, the attending clinician in the labour ward will explain the situation and recommend a caesarean section. In some cases of pre-existing maternal diseases or complications of pregnancy, a caesarean section before the onset of labour may need to be scheduled. Your healthcare provider will inform you if this is the case. Sometimes, complications may also arise during labour that require a caesarean section to be quickly performed.

Is caesarean section a safe procedure?

Caesarean section is currently considered a safe surgical procedure. However, like any surgery, it has its risks, and is considered a less safe option than vaginal birth, particularly in low-risk uncomplicated pregnancies. Caesarean section is associated with an increased risk of neonatal respiratory difficulties (4% versus 2%), particularly when performed before 38 weeks of pregnancy or before the onset of labour. These respiratory difficulties are usually transient, but may occasionally require some days of treatment in a neonatal intensive care unit. It is also known that infants born by caesarean section have a 20–25% higher risk of developing allergies, obesity, and diabetes in childhood.

From a maternal perspective, caesarean section is associated with a slower recovery period (after surgery, additional help at home may be required, and you may not be able to drive for a few weeks), a longer hospital stay (on average three days compared with two days after vaginal birth), and increased abdominal pain. Serious maternal complications are extremely rare, regardless of the mode of delivery; however, they are estimated to be 4–5 times more frequent after caesarean section. Although absolute numbers remain low, caesarean section is associated with approximately twice the risk of anaesthetic complications, a 31-fold increase in surgical complications (such as bladder or bowel injury), an 11-fold increase in postpartum infection, a fourfold increase in venous thromboembolism (appearance of blood clots, usually in the legs) and pulmonary embolism (migration of these clots to the lungs). Caesarean section performed during labour carries slightly higher risks than a scheduled procedure.

The existence of a uterine scar due to caesarean section increases risks in future pregnancies. It increases by approximately 50% the likelihood of requiring a repeat caesarean, in women attempting a vaginal birth the risk of uterine rupture is approximately 0.47%. Each prior caesarean increases threefold the risk of placenta previa (abnormally low implantation of the placenta, often associated with bleeding). The risk of placenta accreta (a placenta that is abnormally adherent to the uterus, and may require extraction of the uterus to control haemorrhage) also increases, approximately sevenfold after a previous caesarean, affecting more than half of women after four or more caesareans. Both conditions are associated with important health risks for the mother.

When a caesarean section is planned, it is usually scheduled at around 39 weeks of pregnancy, in order to minimise the risk of neonatal respiratory complications. However, there is approximately a 10% chance of spontaneous onset of labour before this date.

Caesarean section is associated with higher risks for both the mother and the baby and should not be considered in the absence of a medical

Does caesarean section prevent urinary incontinence in the future?

Pregnancy itself increases the risk of urinary incontinence and pelvic organ descent (prolapse) in later years. Women who deliver by caesarean section have a 40% lower risk of developing these conditions compared with those who give birth vaginally. However it does not completely eliminate the risk.