UNIVERSITÄT ZU LÜBECK

Die physiologische Geburt

…im Spannungsfeld zwischen Gesundheitswirtschaft, Menschenwürde und Professionen

Prof. Dr. Christiane Schwarz, Hebamme

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normale Geburt?

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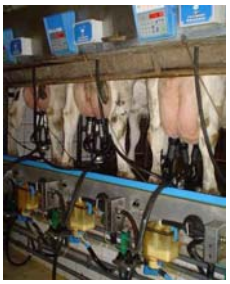
Was ist „normal“?








3

50 Jahre Geburts“hilfe“…

- Durchtrittsnarkose, Forceps
- Dammschnitt (Rasur, Einlauf) für alle
- Ersatznahrung
- Programmierte Geburten
- Frühe geplante Sectiones
- Einleitung (23%), Wehentropf (30%), Sectio (32%)
- …

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Warnende Stimmen…

- Michel Odent (1976): Bien Naître
  - Die Schizophrenie der medikalisierten Geburt
- Ina May Gaskin (1977): Spiritual Midwifery
  - Frauen können Kinder kriegen
- Marjorie Tew (1990): Safer childbirth?
  - Statistik richtig interpretieren
- Marsden Wagner (1994): Pursuing the Birth Machine
  - Vorsicht mit zu viel Geburts-Technologie

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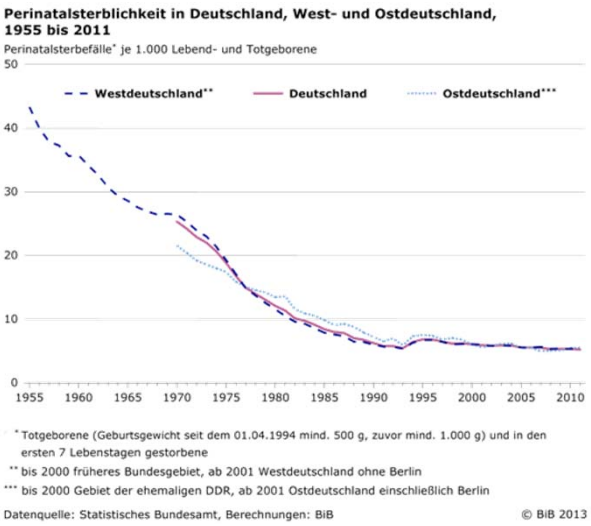
Perinatalsterblichkeit



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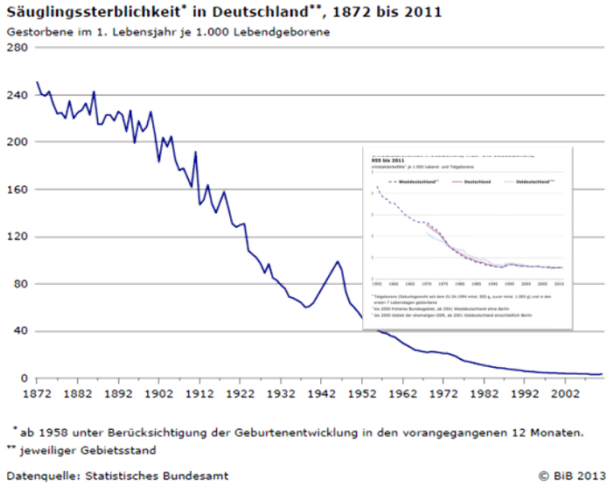
…im Kontext



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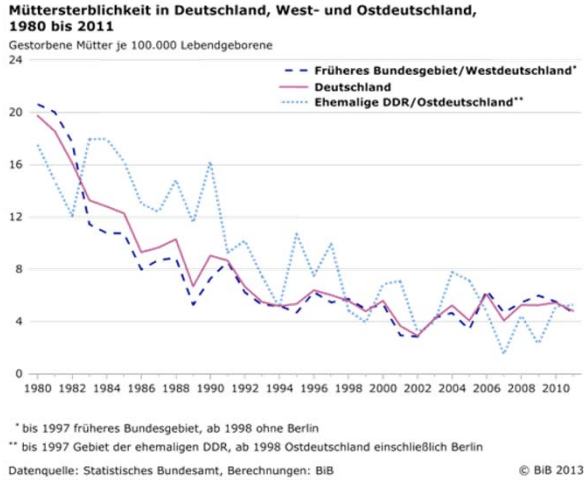
Müttersterblichkeit



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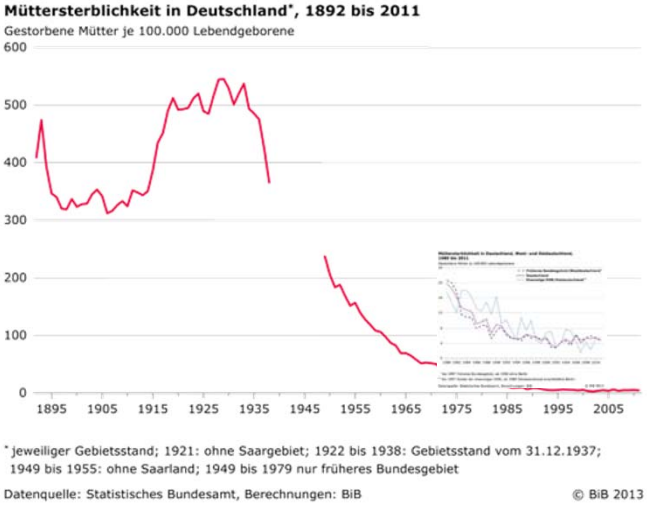
…im Kontext



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Evidenzbasiertes Arbeiten

…zur gemeinsamen Entscheidungsfindung bei klinischen Fragestellungen

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Evidenz?

- RCT: randomisierte kontrollierte Studien
  - Zufällige Zuordnung („randomized“)
  - Kontrollgruppe („control“)
  - Studie („trial“)

- Zusammenfassungen
  - Reviews
  - Metaanalysen

THE COCHRANE COLLABORATION®

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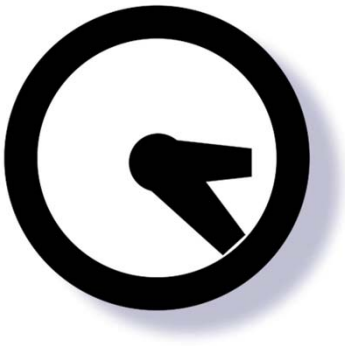
Beispiel RCT

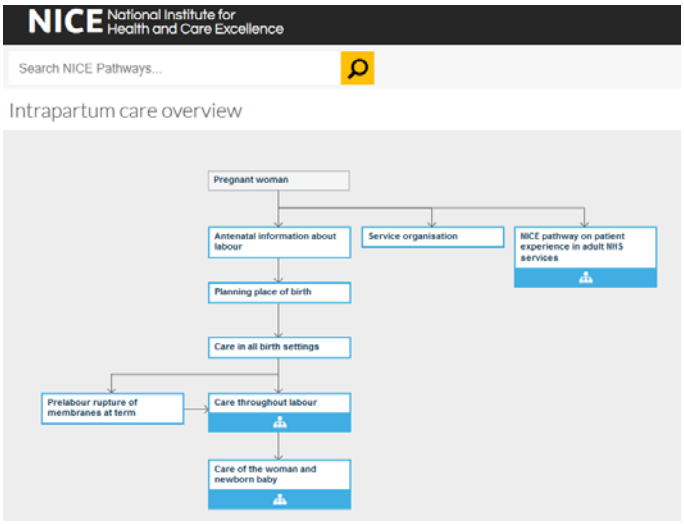
- Was ist bei Zwillingen besser – Sectio oder vaginale Geburt?



Barrett JFR, Hannah ME, Hutton EK, et al. A randomized trial of planned cesarean or vaginal delivery for twin pregnancy. N Engl J Med 2013;369:1295-1305

12

NICE Leitlinie (Dezember 2014)



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NICE Intrapartum Care

General care throughout labour

Clinical intervention

Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well.

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ACOG Leitlinie (März 2014)

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine

OBSTETRIC CARE CONSENSUS

Number 1 • March 2014

Safe Prevention of the Primary Cesarean Delivery

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ACOG Positionspapier 2017

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 687 • February 2017

Committee on Obstetric Practice

The American College of Nurse–Midwives and the Association of Women's Health, Obstetric and Neonatal Nurses endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice, in collaboration with American College of Nurse–Midwives' liaison member Tekoa L. King, CNM, MPH, and College committee members Kurt R. Wharton, MD, Jeffrey L. Ecker, MD, and Joseph R. Wax, MD.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Approaches to Limit Intervention During Labor and Birth

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WHO Betreuung für eine positive Geburtserfahrung 2018

WHO recommendations: intrapartum care for a positive childbirth experience

Authors:
WHO

Publication details

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Downloads

– WHO recommendations: intrapartum care for a positive childbirth experience
pdf, 3 MB
– Web annex: Evidence base
106 pages, 2.69 MB

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ACOG 2014: Warum?

- Höheres Krankheits- und Sterberisiko für die Mutter (x 3)
  - Atonie
  - Narkosezwischenfälle, Schock, Atem-/Herzstillstand
  - Akutes Nierenversagen
  - Thromboembolien
  - Infektionen
  - Wundheilungsstörungen
  - Hämatome
  - …

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Warum?

- Probleme in der Folgeschwangerschaft
  - Plazenta praevia
  - Plazenta accreta
  - Totgeburten
  - …

→ Probleme durch Sectio kumulieren in Folgeschwangerschaften

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Warum?

- Probleme in der Folgeschwangerschaft
  - Plazenta praevia
  - Plazenta accreta
  - Totgeburten
  - …

→ Re-Sectiones führen zu exponenziell steigenden Sectioraten

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Und das sind nur die…

- …messbaren Probleme!

www.cocoon.uk.com/pages/professional-help-for-pnd-mothers.aspx

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Un-necessary

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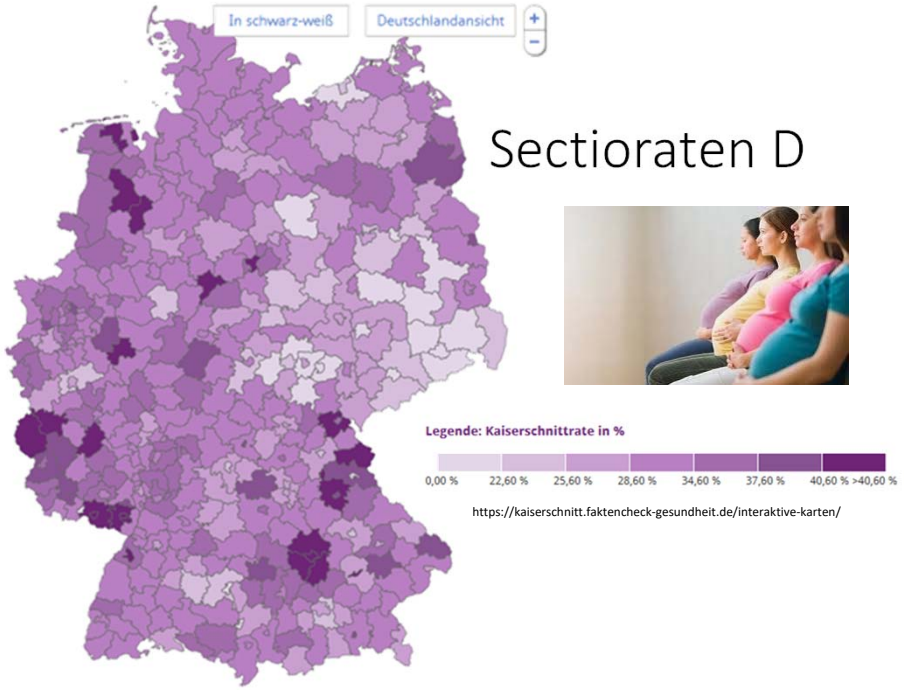
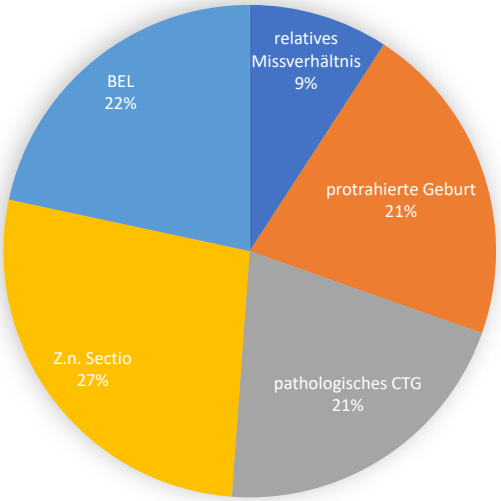


Sectioraten D

23

Sectioindikation Deutschland 2014

bei Einlingen n=211.062 (31,2%) von 677.204



AQUA 2015 www.sqg.de

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Geburtsstillstand EP?

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ACOG 2014: Geb.stillst. In EP

- Aktive EP beginnt erst ab 6 cm Muttermund
- Erst- und Mehrgebärende: 0,5 cm/Stunde ungefährlich
- Frauen mit langer Latenzphase (> 20/> 14 Std) brauchen *fast nie* (!) Wehenmittel
- Definition Geburtsstillstand
  - BS, Mm > 6cm,
  - > 4 Std kräftige/ regelm. (6 Std schwache/ unregelm.) Wehen

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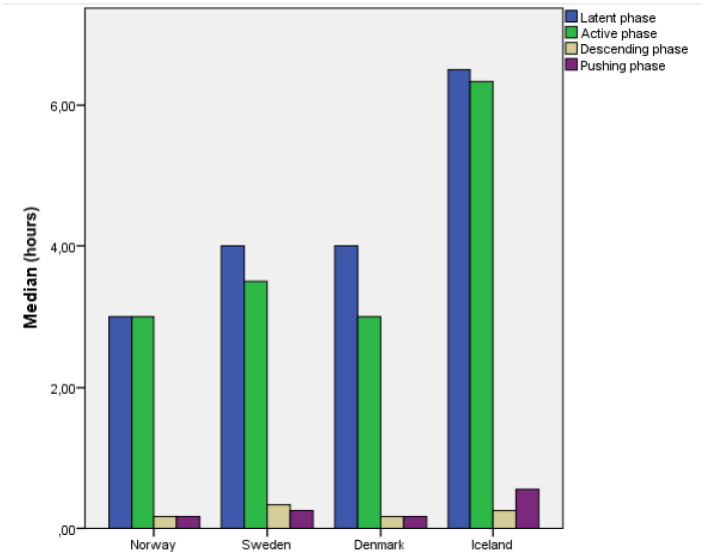

Hildingsson, I., et al.(2015). How Long Is a Normal Labor? Contemporary Patterns of Labor and Birth in a Low-Risk Sample of 1,612 Women from Four Nordic Countries. *Birth. 15.10.2015:* E-pub ahead of print.

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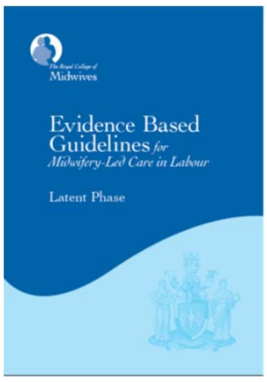
Was tun?

- Latenzphase außerhalb des Kreißsaals
  - Familienzimmer
  - Hausbesuche
  - Bestätigung von Normalität
  - Konkrete Ansagen/ Hilfsmittel
  (TENS, Baden, Ball,
  Massagen, Schlafen, …)
  - Frauen ernst nehmen/
- Partogramm ab 6 cm



The Royal College of Midwives (2012): Evidence Based Guidelines for Midwifery-Led Care in Labour: Latent Phase. www.rcm.org.uk

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ACOG 2017

- 1:1 Betreuung
- Nicht-pharmakologische Analgesie
- Keine Amniotomie
- Intermittierende Auskultation
- Bewegung

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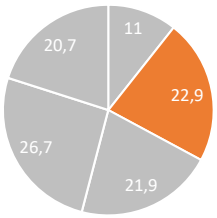
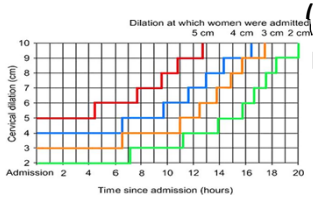
Geburtsstillstand AP?



- Lange AP ist gefährlich?
  - Fetal distress
  - Infektionen
  - Hypoxie
- Normale Geburtsgeschwindigkeit = 1 Std? 2 Std? 3 Std?
- Alle Frauen (mit gleicher Parität) ren gleich schnell?



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ACOG 2014: Geb.stillst. In AP

- Kinder: kein Zusammenhang zw. langer AP (> 3-5 Std.) zu „adverse outcomes“: Apgar, pH, Intubation, KiKl., Sepsis
- Mütter: mehr Atonie, DR, Infektionen
- Aber: insgesamt selten; auch bei „normal langen“ Geburten < 1,5 Std
- Empfehlung:
  - *Aktive* AP > 3 Std abwarten (PDA länger)

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ACOG 2017

- Keine „Powerpressen“ (Valsalva)
- Bei vollst. Mm: Ruheperiode von 1-2 Stunden anbieten (Primip und Frauen mit PDA länger)

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WHO 2018: Grundsätze

Summary list of recommendations on intrapartum care for a positive childbirth experience

Care option	Recommendation	Category of recommendation
Care throughout labour and birth		
Respectful maternity care	1. Respectful maternity care – which refers to care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth – is recommended.	Recommended
Effective communication	2. Effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods, is recommended.	Recommended
Companionship during labour and childbirth	3. A companion of choice is recommended for all women throughout labour and childbirth.	Recommended
Continuity of care	4. Midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with well functioning midwifery programmes.[a]	Context-specific recommendation

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WHO 2018: Latenzphase

First stage of labour		
Definitions of the latent and active first stages of labour	5. The use of the following definitions of the latent and active first stages of labour is recommended for practice. — The latent first stage is a period of time characterized by painful uterine contractions and variable changes of the cervix, including some degree of effacement and slower progression of dilatation up to 5 cm for first and subsequent labours. — The active first stage is a period of time characterized by regular painful uterine contractions, a substantial degree of cervical effacement and more rapid cervical dilatation from 5 cm until full dilatation for first and subsequent labours.	Recommended
Duration of the first stage of labour	6. Women should be informed that a standard duration of the latent first stage has not been established and can vary widely from one woman to another. However, the duration of active first stage (from 5 cm until full cervical dilatation) usually does not extend beyond 12 hours in first labours, and usually does not extend beyond 10 hours in subsequent labours.	Recommended

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WHO 2018: Geburtsfortschritt

Progress of the first stage of labour	7. For pregnant women with spontaneous labour onset, the cervical dilatation rate threshold of 1 cm/hour during active first stage (as depicted by the partograph alert line) is inaccurate to identify women at risk of adverse birth outcomes and is therefore not recommended for this purpose.	Not recommended
	8. A minimum cervical dilatation rate of 1 cm/hour throughout active first stage is unrealistically fast for some women and is therefore not recommended for identification of normal labour progression. A slower than 1-cm/hour cervical dilatation rate alone should not be a routine indication for obstetric intervention.	Not recommended
	9. Labour may not naturally accelerate until a cervical dilatation threshold of 5 cm is reached. Therefore the use of medical interventions to accelerate labour and birth (such as oxytocin augmentation or caesarean section) before this threshold is not recommended, provided fetal and maternal conditions are reassuring.	Not recommended

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WHO 2018: Geburtsphase

Techniques for preventing perineal trauma	38. For women in the second stage of labour, techniques to reduce perineal trauma and facilitate spontaneous birth (including perineal massage, warm compresses and a "hands on" guarding of the perineum) are recommended, based on a woman's preferences and available options.	Recommended
Episiotomy policy	39. Routine or liberal use of episiotomy is not recommended for women undergoing spontaneous vaginal birth.	Not recommended
Fundal pressure	40. Application of manual fundal pressure to facilitate childbirth during the second stage of labour is not recommended.	Not recommended

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WHO 2018: Nachgeburtsphase

Prophylactic uterotonics	41. The use of uterotonics for the prevention of postpartum haemorrhage (PPH) during the third stage of labour is recommended for all births.[a]	Recommended
	42. Oxytocin (10 IU, IM/IV) is the recommended uterotonic drug for the prevention of postpartum haemorrhage (PPH).[a]	Recommended
	43. In settings where oxytocin is unavailable, the use of other injectable uterotonics (if appropriate, ergometrine/methylergometrine, or the fixed drug combination of oxytocin and ergometrine) or oral misoprostol (600 µg) is recommended.[a]	Recommended
Delayed umbilical cord clamping	44. Delayed umbilical cord clamping (not earlier than 1 minute after birth) is recommended for improved maternal and infant health and nutrition outcomes.[b]	Recommended

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