Descent of fetal head during active pushing: secondary analysis of prospective cohort study investigating ultrasound examination before operative vaginal delivery

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KEYWORDS: Cesarean section; duration of vacuum extraction; head–perineum distance; second stage of labor; transperineal ultrasound

CONTRIBUTION

What are the novel findings of this work?
Previous studies have shown that ultrasound examination during labor to determine fetal head station and position is more accurate than is digital vaginal examination. This study shows that measuring change in head–perineum distance using transperineal ultrasound during active pushing in women with prolonged second stage of labor provides an objective assessment of fetal head descent.

What are the clinical implications of this work?
Change in head–perineum distance measured using transperineal ultrasound during active pushing can be used to provide objective information to guide decision-making in the labor ward when prolonged second stage of labor is diagnosed.

ABSTRACT

Objectives To investigate if descent of the fetal head during active pushing is associated with duration of operative vaginal delivery, mode of delivery and neonatal outcome in nulliparous women with prolonged second stage of labor.

Methods This was a prospective cohort study of nulliparous women with prolonged second stage of labor, conducted between November 2013 and July 2016 in five European countries. Fetal head descent was measured using transperineal ultrasound. Head–perineum distance (HPD) was measured between contractions and on maximum contraction during active pushing, and the difference between these values (ΔHPD) was calculated. The main outcome was duration of operative vaginal delivery, estimated using survival analysis to calculate hazard ratios (HRs) for vaginal delivery, with values >1 indicating a shorter duration. HR was adjusted for prepregnancy body mass index, maternal age, induction of labor, augmentation with oxytocin and use of epidural analgesia. Pregnancies were grouped according to ΔHPD quartile, and delivery mode and neonatal outcome were compared between groups.

Results The study population comprised 204 women. Duration of vacuum extraction was shorter with increasing ΔHPD. Estimated mean duration was 10.0, 9.0, 8.8 and 7.5 min in pregnancies with ΔHPD in the first to fourth quartiles, respectively, and the adjusted HR for vaginal delivery, using increasing ΔHPD as a continuous variable, was 1.04 (95% CI, 1.01–1.08). Mean ΔHPD was 7 mm (range, −10 to 37 mm). ΔHPD was either negative or ≤2 mm in the lowest quartile. In this group, 7/50 (14%) pregnancies were delivered by Cesarean section, compared with 8/154 (5%) of those with ΔHPD >2 mm (P < 0.05). There was no significant association between umbilical artery pH <7.10 or 5-min Apgar score <7 and ΔHPD quartile.
Conclusion Minimal or no fetal head descent during active pushing was associated with longer duration of operative vaginal delivery and higher frequency of Cesarean section in nulliparous women with prolonged second stage of labor. © 2019 The Authors. Ultrasound in Obstetrics & Gynecology published by John Wiley & Sons Ltd on behalf of the International Society of Ultrasound in Obstetrics and Gynecology.

INTRODUCTION

Movement of the fetal head during active pushing is sometimes used as a clinical variable to inform decision-making regarding mode of delivery. Descent of the fetal head during contraction and return of the presenting part between contractions is what clinicians call the ‘yo-yo-sign’ and is considered to be predictive of successful vaginal delivery. However, evidence of this is not documented in obstetric scientific literature or textbooks. A study has shown that fetal head descent before vacuum extraction, determined subjectively as ‘yes’ or ‘no’, could predict outcome of vacuum extraction1. Others have investigated the progress of labor using transperineal ultrasound and found a change in fetal head direction during contractions2.

Examination of fetal head station is traditionally performed by palpation, although digital vaginal examination has been shown to be largely subjective and has poor reproducibility3. Ultrasound can be used during the active phase of labor, and the International Society of Ultrasound in Obstetrics and Gynecology (ISUOG) has recently published practical guidelines on intrapartum ultrasound. ISUOG recommends determining head position and descent using ultrasound when labor progress is slow and when operative delivery is considered4. Studies have shown that transabdominal ultrasound examination can give a more accurate diagnosis of fetal head position and is more reproducible than is digital vaginal examination5,6. Head station can also be determined with ultrasound using different methods, such as transperineal ultrasound7,7–10. It has been shown that women find transperineal ultrasound examination during labor less uncomfortable than they do digital vaginal examination11,12. The predictive value of fetal head descent is not mentioned in guidelines with regards to assisted or operative vaginal delivery13,14.

The aim of this study was to investigate if descent of the fetal head during active pushing, assessed using transperineal ultrasound, is associated with duration of operative vaginal delivery, mode of delivery and neonatal outcome in nulliparous women with prolonged second stage of labor.

METHODS

This is a secondary analysis of a multicenter cohort study of nulliparous women with slow progress in the second stage of labor at term. Duration of vacuum extraction, according to fetal head station and rotation of the fetal head during vacuum extraction, has been reported previously15,16. According to a power calculation, which was performed before the multicenter cohort study was undertaken, a study population of 220 women was needed. The main outcome of the primary study was duration of vacuum extraction, which was assessed using survival analyses. Head–perineum distance (HPD) of 25 mm corresponds to station +2 and was used to discriminate between groups. To identify a hazard ratio (HR) as low as 1.5 with 80% power, using a two-tailed test with an α-level of 5%, assuming that one-third of the women would have HPD > 25 mm and two-thirds would have HPD ≤ 25 mm, and anticipating 10% censoring, 220 women needed to be included.

All included women had reassuring cardiotocography at the time of the ultrasound examination. The inclusion period was November 2013 to July 2016. Women were included at six delivery departments in five countries. The participating centers were Stavanger University Hospital, Norway; University Hospital of Bologna, Italy; Trondheim University Hospital, Norway; Queen Charlotte’s and Chelsea Hospital, Imperial College Healthcare NHS Trust, UK; Lund University Hospital, Sweden; and Hvidovre University Hospital, Denmark.

Women were included when slow progress in the second stage of labor was diagnosed in accordance with local guidelines. The second stage was divided into a passive phase (< 2 h) and an active phase with pushing. The birth attendant responsible for the delivery made the diagnosis of slow progress, according to the local protocol. An ultrasound examination was performed when the woman had pushed for at least 45 min and vacuum extraction was considered. The cut-off of 45 min was chosen because Norwegian guidelines recommend that vacuum extraction should be considered after 1 h of active pushing. Fetuses were included regardless of position.

HPD was first measured between contractions and thereafter during maximum contraction with active pushing (Figure S1). Descent of the fetal head (AHPD) was calculated as the difference between HPD measured between contractions and HPD measured during active pushing. The main outcome was duration of operative vaginal delivery, which was estimated using survival analyses with HRs for vaginal delivery. Additionally, pregnancies were grouped according to ΔHPD quartile, and mode of delivery (vaginal delivery or Cesarean section) and neonatal outcome (pH < 7.10 in the umbilical artery and 5-min Apgar score < 7) were compared between groups.

HPD was measured as described previously8,13. When measuring HPD, the woman was placed in a semirecumbent position with the legs flexed at the hips and knees at angles of 45° and 90°, respectively, ensuring that the bladder was empty. HPD was measured as the shortest distance between the outer bony limit of the fetal skull and the perineum in a transverse plane on transperineal ultrasound examination. The transcuder was placed in the posterior fourchette between the labia majora, and the soft tissue was compressed with firm pressure against the pubic bone. The transcuder was angled until the skull contour was as
RESULTS

The original study population comprised 222 women. HPD at rest between contractions could be measured in all cases, and HPD during pushing was measured successfully in 204 cases. Figure 1 shows a flowchart of the study population. Forty-six women had spontaneous vaginal delivery, 143 had operative vaginal delivery (all started with vacuum extraction, but seven were converted to forceps) and 15 were delivered by Cesarean section. Table 1 shows the characteristics of the study population.

Duration of vacuum extraction was shorter with increasing ΔHPD, and the estimated mean duration of vacuum extraction was 10.0, 9.0, 8.8 and 7.5 min in pregnancies with HPD in the first to fourth quartiles, respectively. Results of the multivariable Cox regression analyses are presented in Table 2. The adjusted HR for vaginal delivery, using ΔHPD as continuous variable, was 1.04 (95% CI, 1.01–1.08). None of maternal age, BMI, use of epidural analgesia, induction of labor or augmentation with oxytocin had a confounding effect. While BMI influenced the HR for vaginal delivery (dependent variable) in the Cox regression analysis, it did not change the HR for ΔHPD (independent variable), indicating that BMI had no confounding effect on ΔHPD.

Mean HPD between contractions was 27 mm (range, 1–49 mm) and mean HPD during pushing was 20 mm (range, 0–42 mm); this difference was statistically significant (P < 0.01). Mean ΔHPD was 7 mm (range, −10 to 37 mm); 185 cases had a positive value, showing positive advancement of the fetal head during pushing, 13 cases had a negative value and six cases had a ΔHPD

Statistical analysis

Cox regression analysis was used to calculate HRs as an estimate for relative risk of vaginal delivery over time in women undergoing vacuum extraction, and ΔHPD as a continuous variable was used as the test variable. HR > 1 indicates shorter survival i.e. duration of operative vaginal delivery with increasing ΔHPD. Pregnancies that underwent Cesarean section were censored at the time of the decision to perform the Cesarean section. We adjusted for prepregnancy BMI, maternal age, induction of labor, augmentation with oxytocin and use of epidural analgesia. Confounding effect was set at > 10% change in HR of the main test variable. Cox regression assumes proportional hazards, which was evaluated by log-minus-log plots.

The study population was divided according to ΔHPD quartile. Mean duration of vacuum extraction in the four quartile groups was estimated using Kaplan–Meier analysis. The associations between ΔHPD and delivery mode, 5-min Apgar score < 7 and umbilical artery pH < 7.10 were presented descriptively and compared using the chi-square test and Fisher’s exact test. Data were analyzed using the statistical software package SPSS Statistics version 25.0 (IBM Corp., Armonk, NY, USA).
Table 1 Characteristics of study population of 204 nulliparous women with prolonged second stage of labor

| Characteristic               | Value              |
|-----------------------------|--------------------|
| Age (years)                 | 30 (17–43)         |
| Prepregnancy BMI            | 24 (18–39)         |
| Gestational age (weeks)     | 40 (38–41)         |
| Induction of labor          | 134 (66)           |
| Epidural analgesia          | 162 (79)           |
| Oxytocin augmentation       | 158 (78)           |
| Birth weight (g)            | 3658 (2152–4930)   |
| 5-min Apgar score           | 10 (5–10)          |
| Umbilical artery pH         | 7.24 (6.9–7.43)    |
| Postpartum blood loss (mL)  | 400 (100–3400)     |
| Third- or fourth-degree anal sphincter tear | 14 (7) |

Data are given as median (range) or n (%). BMI, body mass index.

Table 2 Cox regression analysis, showing hazard ratios (HR) for vaginal delivery in nulliparous women with slow progress in second stage of labor

| Variable                  | Unadjusted HR (95% CI) | Adjusted HR (95% CI) |
|---------------------------|------------------------|----------------------|
| ΔHPD*                     | 1.04 (1.00–1.08)       | 1.04 (1.01–1.08)     |
| Maternal age              | 0.99 (0.96–1.03)       | 0.99 (0.96–1.02)     |
| Prepregnancy BMI          | 1.05 (1.00–1.09)       | 1.05 (1.01–1.10)     |
| Epidural analgesia        | 0.69 (0.47–1.03)       | 0.76 (0.50–1.17)     |
| Induction of labor        | 0.97 (0.70–1.36)       | 0.95 (0.65–1.14)     |
| Oxytocin augmentation     | 0.75 (0.52–1.09)       | 0.71 (0.46–1.08)     |

*Change in head–perineum distance (ΔHPD) calculated as difference between HPD at rest between contractions and HPD on maximum contraction during active pushing. BMI, body mass index.

DISCUSSION

We found that a greater degree of head descent during active pushing was associated with shorter duration of operative delivery, and that increased frequency of Cesarean section was significantly associated with minimal or no fetal head descent. ΔHPD was not associated with umbilical cord pH or low 5-min Apgar score.

In 19 cases, ΔHPD had a negative value or was 0 mm. This may indicate that fetal head descent was obstructed or that the woman had an ineffective pushing technique. We believe that fetal head movement upwards in the birth canal during pushing can be explained by levator ani muscle coactivation instead of relaxation19,20. The effect of coactivation on labor has been assessed recently21,22. Youssef et al. and Kamel et al. examined nulliparous women at term before onset of labor and before induction of labor, respectively, and showed that women with coactivation had a significantly longer second stage of labor21,22.

Fetal head descent is visible on the ultrasound screen during examination and visual biofeedback may be a future option to guide women to push more effectively. In a randomized controlled pilot study, 40 women randomized to either sonographic coaching or traditional coaching underwent a transperineal ultrasound at the beginning of the active phase of pushing23. The sonographic coaching group observed the progress of the fetal head on the screen, while the other group did not. The sonographic coaching group had a significantly shorter second stage of labor23. Gilboa et al. have shown that women who received visual biofeedback during labor had a more effective pushing technique and felt a stronger connection to the newborn after birth24. The evidence level regarding pushing method is, however, low23. There was no difference in maternal or neonatal outcome when comparing spontaneous and coached pushing or when...
comparing delayed and immediate pushing. All of these studies investigated pushing at the beginning of the second stage. As we investigated pushing during prolonged second stage of labor, it is possible that women with minimal or no fetal head descent may benefit from coaching and receiving visual biofeedback by transperineal ultrasound.

Most failed operative vaginal deliveries which were converted to Cesarean section occurred in the group with no or minimal descent of the fetal head, but failed operative vaginal delivery also occurred in the other groups. In the fourth quartile, comprising pregnancies with the greatest ΔHPD values, there were three Cesarean sections, two of which had fetal occiput posterior position on ultrasound examination. Occiput posterior position is associated with a higher risk of emergency Cesarean section.

Fetal section can be measured with ultrasound using HPD, angle of progression (AoP), progression distance, head–symphysis distance, head direction or intrapartum transverse ultrasound (ITU) head station, and good correlation between methods has been found. Ghi et al. assessed progression of the fetal head using AoP from 3D volumes at the beginning of the second stage of labor and every 20 min thereafter. The results showed that women with a wide AoP had a higher incidence of spontaneous vaginal delivery. Henrich et al. performed translabial ultrasound (another word for transperineal ultrasound) in women immediately before vacuum extraction. They assessed direction and descent of the fetal head during pushing. The head-up sign was a predictor for successful vacuum extraction in cases with protracted labor. In cases with no descent, vacuum extraction was either difficult or failed. This is in line with the results of the current study. Tutschek et al. recorded transperineal digital videos of the fetal head at rest, during contractions and during voluntary pushing. They found that, between ITU head station of −2 and +2, the average change in head direction was 10° during contraction, and between ITU head station of +2 and +3, there was an increased change of 18°. Time to delivery was shorter when the fetal head was below ITU head station of +2.

We found a significant association between ΔHPD and duration of operative delivery and failed vaginal delivery leading to Cesarean section. This is in accordance with a study in which AoP was measured in 20 women before vacuum extraction, in which it was found that a change in AoP of more than 15° predicted 73% of successful vacuum extractions.

Digital vaginal examination is subjective with poor reproducibility. Position of the fetal head is determined more accurately with transabdominal ultrasound than by digital vaginal examination. Fetal head station can also be determined objectively using transperineal ultrasound. A significant advantage of ultrasound is the possibility to document the findings by adding an ultrasound image to the patient’s chart. While ultrasound should not replace clinical examination, it may add important information and may be helpful in decision-making in the labor room.

The strengths of the present study were the multicenter design, blinding of the ultrasound operators and the midwives and doctors in charge of the delivery, and inclusion of only nulliparous women with prolonged second stage of labor and no signs of fetal distress. A limitation is that only HPD was included as an ultrasound measurement in this study. AoP was measured at rest, but in only a few cases during pushing. It was difficult to measure both HPD and AoP during the same contraction and, therefore, it was not possible to calculate ΔAoP. Another limitation is that we do not have clinical evaluation of fetal head descent during pushing. Repeatability of HPD measurement was not assessed in the present study, but this has been examined previously. Additionally, umbilical cord pH was analyzed in 83% of cases as it was not measured routinely in all centers. Furthermore, we did not record if the ultrasound examination was performed by a doctor or a midwife.

In conclusion, this study shows that minimal or no fetal head descent measured using transperineal ultrasound during pushing was associated with longer duration of operative delivery and higher frequency of Cesarean section in nulliparous women with prolonged second stage of labor.

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