N305-Focus Sheet Unit 3—Summer 2019—Complications of Pregnancy, Labor, and Delivery

Ricci, Kyle & Carman Ch 19, 20 & 21; ATI Ch 7-10

Some of the problems which cause complications of Pregnancy as well as Labor and Delivery were discussed during Unit 1 e.g. some of the infections, and during Unit 2 on labor and delivery. So be sure and look at this information from Unit 1 & 2 as you work through this focus sheet. The information will be used to compare and analyze the normal versus the abnormal occurrences in order to make decision for nursing interventions. So, even while you fill out the focus sheet, be thinking about assessments and actions you "as a nurse" can make in the midst of these complications.

Bleeding during ; Medical Conditions; Early Onset of Labor

RKC Ch 19; ATI Ch 7, 9, 10 (Bleeding)

1. List 5 factors that can place a woman at risk during pregnancy.
   a. Smoking
   b. Infection
   c. Cervical insufficiency
   d. Diabetes
   e. Poverty status

2. Define abortion, miscarriage, and stillbirth.
   a. Abortion is the loss of an early pregnancy, usually before week 20 of gestation and can be spontaneous or induced
   b. A miscarriage refers to a loss before the 20th week
   c. A stillbirth is the loss of a fetus after the 20th week

3. Describe the following for spontaneous abortion: p687-689

Pathophysiology	The most common cause for first-trimester abortions is fetal genetic abnormalities, usually unrelated to the mother. Chromosomal abnormalities are more likely causes in the first trimester and maternal disease is more likely in the second trimester. Those occurring during the second the second trimester are more likely related to maternal conditions, such as

	cervical insufficiency, congenital or acquired anomaly of the uterine cavity (fibroids), hypothyroidism, DM, chronic nephritis, use of crack cocaine, inherited and acquired thrombophilia, lupus, POS, severe hypertension, and acute infection such as rubella virus, cytomegalovirus, herpes simplex virus, bacterial vaginosis, and toxoplasmosis.
Nursing Assessment	Vaginal bleeding (Amount, color, and characteristics of the bleeding) Vital signs Abdominal cramping or contractions
Testing	Assist in preparing the woman for procedures and treatments such as surgery to evacuate the uterus or medications such as misoprostol or PGE2. If the woman is Rh negative and not sensitized, expect to administer RhoGAM within 72 hours after the abortion is complete
Management	Providing continued monitoring and psychological support Reassuring the woman that spontaneous abortions usually result from an abnormality and that her actions did not cause the abortion
Patient education needs	Explain some of the causes of spontaneous abortions so that the patient understands hat is happening and may allay her fears and guilt that she did something to cause the pregnancy loss. Providing sensitive listening, counseling, and anticipatory guidance to the woman and her family will allow them to verbalize their feelings and ask questions about future pregnancies.

4. Define threatened abortion, inevitable abortion, incomplete abortion, complete abortion, missed abortion and habitual abortion. P 689

- **Threatened abortion**
  - Vaginal bleeding (often slight) early in pregnancy
  - No cervical dilation or change in cervical consistency
  - Mild abdominal cramping
  - Closed cervical os
  - No passage of fetal tissue
  - Vaginal US to confirm if sac is empty
  - Declining maternal serum hCG and progesterone levels to provide additional information about viability of pregnancy
- **Inevitable abortion**
  - Vaginal bleeding (greater than that associated with threatened abortion)
  - Rupture of membranes
  - Cervical dilation
  - Strong abdominal cramping
  - Possible passage of products of conception
  - US and hCG levels indicate pregnancy loss
- **Incomplete abortion**
  - Intense abdominal cramping
  - Heavy vaginal bleeding

- cervical dilation
- US confirms products of conception still in uterus

- **Complete abortion**
  - History of vaginal bleeding and abdominal pain
  - Passage of tissue with subsequent decrease in pain and significant decrease in vaginal bleeding
  - US demonstrating an empty uterus
- **Missed abortion**
  - Nonviable embryo retained in utero for at least 6 weeks
  - Absent uterine contractions
  - Irregular spotting
  - Possible progression to inevitable abortion
  - US to identify products of conception in uterus
- **Habitual abortion**
  - History of three or more consecutive spontaneous abortions
  - Not carrying the pregnancy to viability or term
  - Validation via client's history

5. What are the actions and implications of the use of Cytotec, Cervidil (dinoprostone)/Prepidil(Gel), Rh Immunolglobulin Rhogam related to abortions (elective or spontaneous)? Chart p 690

Misoprostol (Cytotec): Stimulates uterine contractions to terminate a pregnancy; to evacuate the uterus after abortion to ensure passage of all the products of conception

PGE2, (Prepidil gel, Cervidel): Stimulates uterine contractions, causing expulsion of uterine contents; to expel uterine contents in fetal death or missed abortion during second trimester, or to efface and dilate the cervix in pregnancy at term

Rh(D) immunoglobulin (RhoGAM): Suppresses immune response of non-sensitized Rh-negative clients who are exposed to Rh-positive blood; to prevent isoimmunization in Rh-negative women exposed to Rh-positive blood after abortions, miscarriages, and pregnancies

6. Describe the following for ectopic pregnancy:

Pathophysiology	Ectopic pregnancy is the abnormal implantation of a fertilized ovum outside of the uterine cavity usually in the fallopian tube, which can result in tubal rupture causing a fatal hemorrhage. Ectopic pregnancy is the second most frequent cause of bleeding in early pregnancy and a leading cause of infertility.
Nursing Assessment	• Unilateral stabbing pain and tenderness in the lower-abdominal quadrant • Delayed (1 to 2 weeks), lighter than usual, or irregular menses • Scant, dark red, or brown vaginal spotting occurs 6 to 8 weeks after last normal menses; red, vaginal bleeding if rupture has occurred

	• Referred shoulder pain due to blood in the peritoneal cavity irritating the diaphragm or phrenic nerve after tubal rupture • Report of indications of shock such as faintness • Clinical finding of hemorrhage and shock
Testing	Transvaginal ultrasound, serum beta hCG; additional testing to rule out other conditions
Management	• Medical: drug therapy (methotrexate, prostaglandins, misoprostol, and actinomycin) • Surgery if rupture o Salpingostomy is done to salvage the fallopian tube if not ruptured o Laparoscopic salpingectomy (removal of the tube) is performed when the tube has ruptured • Rh immunoglobulin if woman Rh negative
Patient education needs	• Instruct client who is taking methotrexate to avoid alcohol consumption and vitamins containing folic acid • Advise the client to protect herself from sun exposure • Provide client education and psychological support

7. Describe the following for Gestational Trophoblastic Disease.

Pathophysiology	GTD is the proliferation and degeneration of trophoblastic villi in the placenta that becomes swollen, fluid-filled, and takes on the appearance of grape-like clusters. The embryo fails to develop beyond a primitive state and these structures are associated with choriocarcinoma, which is a rapidly metastasizing malignancy. Two types of molar growths are identified by chromosomal analysis.
Nursing Assessment	• Prior molar pregnancy • Clients in early teens or older than age 40 • Excessive vomiting due to elevated hCG levels • Rapid uterine growth more than expected for the duration of the pregnancy due to the over proliferation of trophoblastic cells • Bleeding is often dark brown resembling prune juice, or bright red that is wither scant or profuse and continues for a few days or intermittently for few weeks and can be accompanied by passage of vesicles. • Anemia from blood loss • Clinical findings of preeclampsia that occur prior to 24 weeks of gestation
Testing	• Immediate evacuation of uterine contents (D&C) • Long-term follow-up and monitoring of serial hCG levels
Management	• Preoperative preparation • Emotional support • Education: treatment, serial hCG monitoring, prophylactic chemotherapy

Patient education needs	• Provide client education and emotional support • Offer referral for clients and partners to pregnancy loss support groups • Instruct the client to use reliable contraception as a component of follow-up care • Reinforce the importance of follow-up due to the increased risk of choriocarcinoma

When would you anticipate that Methotrexate would be prescribed?

Methotrexate is started prophylactically after the evacuation of the fetus.

8. Describe the following for Cervical Insufficiency:

Pathophysiology	• Premature dilation of cervix • Cause unknown; possibly due to cervical damage
Nursing Assessment	• Risk factors • Pink-tinged vaginal discharge or pelvic pressure • Cervical shortening via transvaginal ultrasound
Testing	• Bed rest, pelvic rest, avoidance of heavy lifting • Cervical cerclage
Management	• Continuing surveillance; close monitoring for preterm labor • Emotional support • Education
Patient education needs	• Emotional support • Education

9. Describe the following for Placenta Previa:

Pathophysiology	• Cause unknown; placenta implants over cervical os
Nursing Assessment	• Risk factors • Vaginal bleeding (painless, bright red in second or third trimester,

	spontaneous cessation then recurrence)/dangerous and an emergency
Testing	• Transabdominal or transvaginal US • Fetal monitoring for fetal well-being assessment
Management	• Monitoring of maternal–fetal status (placenta grows up) • Vaginal bleeding; pad count (painless bright red bleeding/emergency) • Avoidance of vaginal exams • FHR/positioning needs to be done/ IV needs to be started
Patient education needs	• Support and education: fetal movement counts, effects of prolonged bed rest (if necessary); signs and symptoms to report • Preparation for possible cesarean birth

10. Why is it important to know if a woman who is presenting to labor and delivery has a placental previa?

Doctors and nurses need to be on standby and have necessary equipment and surgical room ready prior to admitting the patient. Also, due to blood loss that can occur during this type of birth, type and cross of mom's blood is necessary to replace any blood lost during the delivery

How would her care be altered?

Constant assessment to the degree of vaginal bleeding; inspect the perineal area for blood that may be pooled underneath the woman. Estimate and document the amount of bleeding. Perform a peripad count on an ongoing basis, making sure to report any changes in amount or frequency to the health care provider. If the woman is experiencing active bleeding, prepare blood typing and cross-matching in the event a blood transfusion is needed

11. Describe the following for Abruptio Placentae (Abruption):

Pathophysiology	• Separation of placenta leading to compromised fetal blood supply • Etiology unknown
Nursing Assessment	• Risk factors • Bleeding (dark red) • Pain (knife like), uterine tenderness, contractions (usually C section has to be done) • Fetal movement and activity (decreased) • FHR
Testing	CBC, fibrinogen levels, PT/aPTT, type and cross-match, nonstress

	test, biophysical profile
Management	Tissue perfusion: left lateral position, strict bed rest, oxygen therapy, vital signs, fundal height, continuous fetal monitoring
Patient education needs	Empathy, understanding, explanations, possible loss of fetus, reduction of recurrence

12. Describe shoulder dystocia **RKC Ch 13 p 464 Ch 21 p 797 & 806**

An injury during birth when one or both of the fetus shoulders get stuck in the mothers pelvis.

13. In your own words describe Disseminated intravascular coagulation (DIC).

A bleeding disorder characterized by an abnormal reduction in the elements involved in blood clotting resulting from their widespread intravascular clotting. This disorder can occur secondary to abruptio placentae, amniotic fluid embolism, endotoxin sepsis, retained dead fetus, post-hemorrhagic shock, hydatidiform mole, and gynecologic malignancies. DIC is usually associated with high mortality and morbidity rates.

14. Describe the following for Hyperemesis Gravidarum

Pathophysiology	• Severe form of nausea and vomiting • Symptoms usually resolve by week 20 • Weight loss >5% of pre-pregnancy body weight • Dehydration, metabolic acidosis, alkalosis, and hypokalemia
Nursing Assessment	• Onset, duration, course of N/V; diet history; risk factors, weight, associated symptoms, perception of situation • Liver enzymes, CBC, BUN, electrolytes, urine specific gravity, ultrasound
Testing	• Conservative (diet and lifestyle changes) • Hospitalization with parenteral therapy
Management	• Comfort and nutrition (NPO, IV fluids, hygiene, oral care, I&O)
Patient education needs	• Reassurance • Home care follow-up

15. What three medications are commonly used for hyperemesis gravidarum? What nursing considerations should be addressed for each of these?

- Promethazine (Phenergan)-Becareful what you put it with

- Symptomatic relief of nausea and vomiting, and motion sickness
  - Be alert for urinary retention, dizziness, hypotension, and involuntary movements
  - Institute safety measures to prevent injury secondary to sedative effects
  - Offer hard candy and frequent rinsing of mouth for dryness
- Prochlorperazine (Compazine)
  - Controls nausea and vomiting
  - Be alert for abnormal movements and neuroleptic malignant syndrome such as seizures, hyper/hypotension, tachycardia, and dyspnea
  - Assess mental status, intake and output
  - Caution client not to drive as a result of drowsiness or dizziness
  - Advise to change position slowly to minimize effects of orthostatic hypotension
- Ondanestron (Zofran)
  - Blocks serotonin release, which stimulates the vagal afferent nerves, thus stimulating the vomiting reflex
  - Monitor for possible side effects such as diarrhea, constipation, abdominal pain, headache, dizziness, drowsiness, and fatigue
  - Monitor liver function studies as ordered

16. What is the difference between chronic and gestational hypertension?

Chronic: before pregnancy or before 20 weeks gestation. When hypertension is first identified during a woman's pregnancy and she is less than 20 weeks' gestation, blood pressure elevations usually represent chronic hypertension.

Gestational: fter 20 weeks gestation resolving by 12 weeks postpartum. Gestational hypertension is defined as systolic pressure >140 mmHg and/or diastolic >90 mmHg on at least two occasions at least 4 to 6 hours apart after the 20th week of gestation.

17. Please fill in the table below:

	Mild Preeclampsia	Severe Preeclampsia	Eclampsia
Blood pressure	140/90	160/110	160/110
proteinuria	300 mg/24 hour or greater than 1+ protein on a random dipstick urine sample	>500 mg/24 hour; greater than 3+ on random dipstick urine sample	Marked proteinuria
Seizures/coma	No	No	Yes
hyperreflexia	No	Yes	Yes
Other signs or symptoms	Mild facial or hand edema, Weight gain	Headache, Oliguria, Blurred vision, scotomata (blind spots), Pulmonary edema, Thrombocytopenia	Severe headache, Generalized edema, RUQ or epigastric pain, Visual disturbances, Cerebral

		(platelet count <100,000 platelets/mm^3, Cerebral disturbances, Epigastric or RUQ pain	hemorrhage, Renal failure
Treatment/ management	Home management for mild preeclampsia	Hospitalization for severe preeclampsia; quiet environment, sedatives, seizure precautions, antihypertensives DTR testing, assessing for magnesium toxicity and labor	Seizure management for eclampsia; fetal monitoring; uterine contraction monitoring; preparation for birth

18. We will discuss in class the protein/creatinine (P/C) ratio. This is not in your text. Here is a

Urine protein tests detect and/or measure protein being released into the urine. Normal urine protein elimination is less than 150 mg/day and less than 30 mg of albumin/day. Elevated levels may be seen temporarily with conditions such as infections, stress, pregnancy, diet, cold exposure, or heavy exercise. Persistent protein in the urine suggests possible kidney damage or some other condition that requires additional testing to determine the cause.

19. Medications used with preeclampsia and eclampsia

Medication	Indications (why is this needed for THIS patient?)	Nursing Implications (what are you watching for?)	Dose
Magnesium Sulfate	Blockage of neuromuscular transmission, vasodilation, Prevention and treatment of eclamptic seizures	Monitor serum mag levels closely, Assess DTRs and check for ankle clonus, Have calcium gluconate readily available in case of toxicity, Monitor for signs and symptoms of toxicity such as flushing, sweating, hypotension,	Loading dose of 4-6 grams by IV in 100 mL of fluid administered over 15-20 minutes, followed by a maintenance dose of 2 grams as a continuous intravenous infusion

		and cardiac and central nervous system depression	
Hydralazine hydrochloride (Apresoline)	Vascular smooth muscle relaxant, thus improving perfusion to renal, uterine, and cerebral areas, Reduction in blood pressure	Use parenteral form immediately after opening ampule Withdraw drug slowly to prevent possible rebound hypertension Monitor for adverse effects such as palpitations, headache, tachycardia, anorexia, nausea, vomiting, and diarrhea	Administer 5-10 mg by slow intravenous bolus every 20 minutes as needed
Labetalol hydrochloride (Normodyne)	Alpha-1 and beta blocker, Reduction in blood pressure	Be aware that drug lowers blood pressure without decreasing maternal heart rate or cardiac output Monitor for possible adverse effects such as gastric pain, flatulence, constipation, dizziness, vertigo, and fatigue	Administer IV dose of 20-40 mg every 15 minutes as needed and then administer intravenous infusion of 2 mg/min until desired blood pressure value achieved
Nifedipine (Procardia)	Calcium channel blocker/dilation of coronary arteries, arterioles, and	Monitor for possible adverse effects such as	Administer 10-20 mg orally for three doses and then every 4-8 hours

	peripheral arterioles, Reduction in blood pressure, stoppage of preterm labor	dizziness, peripheral edema, angina, diarrhea, nasal congestions, cough	

20. What are the signs of Magnesium toxicity? What is the therapeutic level for magnesium sulfate? What drug should always be at the bedside of a patient who has Magnesium sulfate infusing?

Signs of magnesium toxicity: Absence of patellar deep tendon reflexes, Urine output less than 30 mL/h, Respirations less than 12/min, Decreased level of consciousness, Cardiac dysrhythmias.

Therapeutic level for magnesium sulfate: 4 to 7 mEq/L serum levels

Antidote to magnesium sulfate: Calcium gluconate

21. When grading a deep tendon reflex, does the grading scale of 0-4 state no movement is graded as a 0 or a 4?

0 is no movement.

22. What does clonus evaluate and what does a positive clonus look like?

Clonus evaluates for nervous system irritability related to preeclampsia. Positive clonus is movement that is jerky and rapid after quickly releasing the foot from a dorsiflexed position.

23. What does HELLP stand for?

Hemolysis, **E**levated **L**iver enzymes, **L**ow **P**latelets

24. Describe the following for HELLP syndrome

Pathophysiology	Is a variant of GH in which hematologic conditions coexist with severe preeclampsia involving hepatic dysfunction. HELLP syndrome is diagnosed by laboratory tests, not clinically
Nursing Assessment	Hypertension, proteinuria, periorbital, facial, hand and abdominal edema; pitting edema of lower extremities, vomiting, oliguria, hyperreflexia, scotoma, epigastric pain, RUQ pain, dyspnea, diminished breath sounds, seizures, jaundice, signs of progression of HTN disease with indications of worsening liver involvement, kidney failure, worsening hypertension, cerebral involvement, and developing coagulopathies
Testing	Liver enzymes, serum creatinine, BUN, uric acid, and magnesium; CBC; clotting studies; chemistry profile
Management	Assess LOC, obtain pulse oximetry, monitor urine output, and obtain a clean-catch urine sample to assess for proteinuria;

	obtain daily weights; monitor vital signs; encourage lateral positioning; perform NST and daily kick counts; I and O
Patient education needs	Maintain the client on bed rest and encourage side-lying position; Promote diversional activities; Have the client avoid foods that are high in sodium; Instruct the client to drink six to eight 8-ounce glasses of water a day

25. What is Rh factor incompatibility? When is RhoGAM administered? Who is at risk if it is not given?

Rh incompatibility: exposure of Rh-negative mother to Rh-positive fetal blood; sensitization; antibody production; risk increases with each subsequent pregnancy; and fetus with Rh-positive blood.

RhoGAM is given at 28 weeks. The baby and mom is at risk if not given,

26. What fetal risks are associated with polyhydramnios and oligohydramnios?

Polyhydramnios: fundal height, abdominal discomfort, difficulty palpating fetal parts, or obtaining FHR

Oligohydramnios: fluid leaking from vagina

27. Define multiple gestation and explain why it may be concerning for the mother/fetus.

A pregnancy with two or more fetuses. The increasing number of multiple gestations is a concern because women who are expecting more than one infant are at high risk for preterm labor, polyhydramnios, hyperemesis gravidarum, anemia, preeclampsia, and antepartum hemorrhage.

28. What do monozygotic and dizygotic mean?

Monozygotic: Identical twins; single fertilized ovum splits during the first 2 weeks after conception

Dizygotic: Two sperm fertilizing two ova produce fraternal twins

29. Describe the following for Premature rupture of membranes:

Pathophysiology	women beyond 37 weeks' gestation
Nursing Assessment	Risk factors, signs and symptoms of labor, electronic FHR monitoring, amniotic fluid characteristics
Testing	Nitrazine test, fern test, ultrasound
Management	Infection prevention Identification of uterine contractions
Patient education	Discharge home (PPROM) if no labor within 48 hours Monitor baby's activity by counting fetal kicks

needs	Check temperature daily and report any temperature increases Take showers daily for hygiene needs

RKC Ch 20; ATI Ch 9

1. Discuss each of the following for Gestational Diabetes:

Pathophysiology	Changes in insulin resistance Effects on mother
Nursing Assessment	Health history; physical examination; risk factor
Testing	Maternal surveillance: urine for protein, ketones, nitrates, and leukocyte esterase; evaluation of renal function/trimester; eye exam in first trimester
Management	Optimal glucose control Blood glucose levels; medication therapy Nutritional therapy Measures during labor and birth; postpartum Prevention of complications
Patient education needs	Instruct the client to perform daily kick counts Educate the client about die, including standard diabetic diet and restricted carbohydrate intake. Dietary counseling by a registered dietitian should occur Educate client about exercising Instruct the client about self-administration of insulin

2. What effects can uncontrolled gestational diabetes have on the fetus/newborn?

    - Cord prolapse secondary to polyhydramnios and abnormal fetal presentation
    - Congenital anomaly due to hyperglycemia in the first trimester
    - Macrosomia resulting from hyperinsulinemia stimulated by fetal hyperglycemia
    - Fetal asphyxia secondary to fetal hyperglycemia and hyperinsulinemia
    - Perinatal death due to poor placental perfusion and hypoxia
    - Subsequent childhood obesity and carbohydrate intolerance

3. What cardiovascular changes are noted during pregnancy?
   The prevalence of cardiac disease is increasing as a result of lifestyle patterns, including cigarette smoking, diabetes, and stress. As women are delaying childbearing, the incidence of cardiac disease in pregnancy will continue to increase. The cardiovascular adaptations during pregnancy are well tolerated by the normal heart, but may unveil undiagnosed underlying heart disease, or tip the hemodynamic balance and lead to decompensation in those with existing heart disease.

   Why might these put a woman at risk for cardiovascular disease?

Women are delaying childbearing, the incidence of cardiac disease in pregnancy will continue to increase

4. Discuss each of the following for iron deficiency anemia.

Pathophysiology	Usually due to inadequate dietary intake
Nursing Assessment	Fatigue, weakness, malaise, anorexia, susceptibility to infection (frequent colds), pale mucous membranes, tachycardia, pallor
Testing	Low hemoglobin, low hematocrit, low serum iron, microcytic and hypochromic cells, and low serum ferritin
Management	Compliance with drug therapy: prenatal vitamin and iron supplement Dietary instruction and counseling
Patient education needs	Education for drug therapy

5. After reading about adolescence and pregnancy, discuss how you as the nurse would care for this patient. What would you do differently?

   Vision of self in future, Realistic role models; emotional support, Level of child development education, Financial and resource management; work and educational experience, Anger and conflict resolution skills, Knowledge of health and nutrition for self and child

   How would you approach topics?

   Tackling the many issues surrounding adolescent pregnancy is difficult. Making connections with clients is crucial regardless of how complex their situation is. Nurses must take proactive positions in knowing how and when to advise a teen and when to listen and refrain from giving advice.

   Would you focus more on the support people?

Future planning (return to school; career or job counseling); options for pregnancy, Frequent evaluation of physical and emotional well-being

6. What changes would you incorporate in the nursing care of the advanced maternal age (AMA) woman?
   a. Preconception counseling; lifestyle changes; beginning pregnancy in optimal state of health
   b. Laboratory and diagnostic testing for baseline; amniocentesis; quadruple blood test screen

7. Define teratogen.
    a. A substance known to be toxic to human development

8. Fill in the following table.

Substance	Effects on pregnancy and fetus/newborn
Alcohol	Spontaneous abortion, inadequate weight gain, IUGR, fetal alcohol spectrum disorder, the leading cause of intellectual disability
caffeine	Vasoconstriction and mild diuresis in mother; fetal stimulation, but teratogenic effects not documented via research
nicotine	Vasoconstriction, reduced uteroplacental blood flow, decreased birth weight, abortion, prematurity, abruptio placentae, fetal demise
cocaine	Vasoconstriction, gestational HTN, abruptio placentae, abortion, “snow” baby syndrome, CNS defects, IUGR
marijuana	Anemia, inadequate weight gain, “amotivational syndrome,” hyperactive startle reflex, newborn tremors, prematurity, IUGR
Opiates/ narcotics	Maternal and fetal withdrawal, abruptio placentae, preterm labor, premature rupture of membranes, perinatal asphyxia, newborn sepsis and death, intellectual impairment, malnutrition
methamphetamines	CNS stimulant, risk for preterm birth, low birth weight, placental abruption, fetal growth restriction, and congenital anomalies

9. List five possible characteristics of Fetal Alcohol Spectrum Disorder.

Craniofacial dysmorphia (thin upper lip, small head circumference, and small eyes), IUGR, Microcephaly, Congenital anomalies, and Cardiac defects

RKC Chapter 21

1. Why is the term “failure to progress” often used?
   The term is often used because dystocia cannot be predicted or diagnosed with certainty

2. What factors are associated with an increased risk for dystocia?

a. Epidural analgesia/excessive analgesia
b. Multiple gestation
c. Hydramnios
d. Maternal exhaustion
e. Ineffective maternal pushing technique
f. Occiput posterior position
g. Longer first stage of labor
h. Nulliparity, short maternal stature
i. Fetal birth weight over 8.8 lb
j. Shoulder dystocia
k. Abnormal fetal presentation or position
l. Fetal anomalies
m. Maternal age over 35 years
n. High caffeine intake
o. Overweight
p. Gestational age over 41 weeks
q. Chorioamnionitis
r. Ineffective uterine contractions
s. High fetal station at complete cervical dilation

3. Familiarize yourself with the common Diagnosis and management of common problems associated with dystocia, their therapeutic management and nursing management i.e.what does this mean for the care delivered by the nurse (p799-804)

- Problems with powers
  - Hypertonic uterine dysfunction
  - Hypotonic uterine dysfunction
  - Protracted disorders
  - Arrest disorders
  - Precipitate labor
  - Problems with the passageway
  - Pelvic contraction
  - Obstructions in maternal birth canal
- Problems with passenger
  - Occiput posterior position
  - Breech presentation
  - Multifetal pregnancy
  - Macrosomia and CPD
  - Structural abnormalities
  - Problems with psyche
  - Psychological distress
- Nursing assessment
  - History of risk factors
  - Maternal frame of mind
  - Vital signs
  - Uterine contractions

    - Fetal heart rate, fetal position
- Nursing management
    - Promoting labor progress
    - Providing physical and emotional comfort
    - Promoting empowerment

4. Define the following:

- Hypertonic uterine dysfunction: Occurring in the latent phase of the first stage of labor; uncoordinated
- Force of contraction typically in the midsection of the uterus at the junction of the active upper and passive lower segments of the uterus rather than in the fundus
- Loss of downward pressure to push the presenting part against the cervix
- Woman commonly becomes discouraged due to lack of progress; also has increased pain secondary to anoxia

Hypotonic uterine dysfunction: Often termed secondary uterine inertia because the labor begins normally and then frequency and intensity of contractions decrease. Possible contributing factors: overdistended uterus with multifetal pregnancy or large single fetus, too much pain medicine given too early in labor, fetal malposition, and regional anesthesia

Precipitate labor- Abrupt onset of higher intensity contractions occurring in a shorter period instead of the more gradual increase in frequency, duration, and intensity that typifies most spontaneous labors

5. Why is occiput posterior positioning of the fetus an issue during labor and delivery?

Fetus is born facing upward instead of the normal downward position

Labor usually much longer and more uncomfortable (causing increased back pain during labor) if fetus remains in this position

6. What risks increase with a persistent breech presentation?

Placenta previa, hydramnios, fetal anomalies, and multifetal pregnancy

7. What is a shoulder dystocia? What maneuvers are used to attempt a vaginal delivery when a shoulder dystocia is noted? Describe each.

- Delivery of the fetal head with neck not appearing; retraction of chin against the perineum; shoulders remaining wedged behind the mother's pubic bone, causing a difficult birth with potential for injury to both mother and baby
    - McRoberts maneuver
        - The mother's thighs are flexed and abducted as much as possible to straighten the pelvic curve

- Suprapubic pressure
  - Light pressure is applied just above the pubic bone, pushing the fetal anterior shoulder downward to displace it from above the mother's symphysis pubis. The newborn's head is depressed toward the mother's anus while light suprapubic pressure is applied

8. Macrosomia is defined as a newborn who weighs __4000__ to _4500__ grams.

9. Why is it important to monitor the bowel and bladder status during labor?

Monitor the client's bladder for distention at least every 2 hours and encourage her to empty her bladder often. In addition, monitor her bowel status. A full bladder or rectum can impede descent.

10. What are 3 ways you can empower, inform and advocate for your patient?

1. Educate the client and family about dysfunctional labor and its causes and therapies
2. Explain therapeutic interventions that may be needed to assist with labor process
3. Encourage the client and her partner to participate in decision making about interventions

11. Define preterm labor and list 3 risks that are associated with the infant due to preterm labor/birth.

Preterm labor is defined as the occurrence of regular uterine contractions accompanied by cervical effacement and dilation before the end of the 37th week of gestation. If not halted, it leads to preterm birth

1. Respiratory distress syndrome
2. Congenital heart defects
3. Thermoregulation problems

12. What factors influence the decision to intervene when a woman present with preterm labor?

Many factors influence the decision to intervene when women present with symptoms of preterm labor, including the probability of progressive labor, gestational age, and the risks of treatment.

- Risk prediction
  - Tocolytic drugs: there are no clear first-line drugs to manage preterm labor; may prolong pregnancy for 2 to 7 days while steroids can be given for fetal lung maturity
  - Antibiotic prophylaxis for women with group B streptococcus

Corticosteroids decrease respiratory distress between 24 and 34 weeks

13. When are tocolytics used?

Tocolytic therapy is most likely ordered if preterm labor occurs before the 34th week of gestation to delay birth and thereby to reduce the severity of respiratory distress syndrome and other complications associated with prematurity

14. Name 5 subtle symptoms of preterm labor.

1. Change or increase in vaginal discharge with mucus, water, or blood in it
2. Pelvic pressure
3. Low, dull backache
4. UTI symptoms
5. GI upset: n/v/d

15. What does a fetal fibronectin test determine?

A glycoprotein produced by the chorion is found at the junction of the chorion and decidua. It acts as biologic glue, attaching the fetal sac to the uterine lining. It normally present in cervicovaginal secretions up to 22 weeks of pregnancy and again at the end of the last trimester. It usually cannot be detected between 24 and 34 weeks of pregnancy unless there has been a disruption between the chorion and decidua
The test is a useful marker for impending membrane rupture within 7 to 14 days if the level increases to greater than 0.05 mcg/mL. The accuracy of fetal fibronectins decreased in the presence of lubricants, blood, recent intercourse, or cervical manipulation within previous 24 hours. Conversely, a negative fetal fibronectin test is a strong predictor that preterm labor in the next 2 weeks is likely

16. Define prolonged pregnancy.

A pregnancy that continues past the end of the 42nd week of gestation

17. What is the difference between labor induction and labor augmentation?

Induction: stimulating contractions via medical or surgical means
Augmentation: enhancing ineffective contractions after labor has begun
Indications: prolonged gestation, prolonged premature rupture of the membranes, gestational hypertension, cardiac disease, renal disease, chorioamnionitis, dystocia, intrauterine fetal demise, isoimmunization, and diabetes

18. What is the most common adverse effect of oxytocin?

The most common adverse effect of oxytocin is uterine hyperstimulation, leading to fetal compromise and impaired oxygenation

19. When administering oxytocin what are the primary assessments that need to be made?

water intoxication

20. What does VBAC stand for?

Vaginal **B**irth **A**fter **C**esarean

21. What would you do if you encounter an umbilical cord prolapse?

Change the woman’s position to a modified Sims, Trendelenburg, or Knee-chest

22. What is a typical sign of uterine rupture?

Sudden fetal bradycardia

23. Why might an amnioinfusion be done?

Severe variable decelerations due to cord compression

24. What are the indications for use of forceps or vacuum extractor?

prolonged second stage of labor, non-reassuring FHR pattern, failure of presenting part to fully rotate and descend, limited sensation or inability to push effectively, presumed fetal jeopardy or fetal distress, maternal heart disease, acute pulmonary edema, intrapartum infection, maternal fatigue, infection

25. What are the leading indications for cesarean birth?

breech presentation, dystocia, fetal distress