Assisted vaginal birth

Most babies are born without any need for assistance. However, there may be times when an assisted vaginal birth is recommended for the health and wellbeing of either you or your baby. We have written this factsheet to explain what an 'assisted birth' is, how common it is and why it might be recommended.

Reading this factsheet during your pregnancy will enable you to make informed, evidence-based decisions if an 'assisted birth' is recommended for you. Knowing what to expect can help you, and those supporting you, to feel more confident about the process.

Please discuss any questions you may have with your midwife or obstetrician. We have also included a list of additional sources of information at the end of this factsheet.

What is an assisted vaginal birth?

An 'assisted vaginal birth' (also known as an 'instrumental delivery' or an 'operative vaginal birth') is when forceps or a ventouse are used to help with the birth of your baby.

Forceps are smooth metal instruments which look like a pair of large bent spoons with hollow centres and lock together at the handles. They are curved to fit around your baby's head.

There are different types of forceps. The choice of forceps used will depend upon your baby's position. Neville Barnes forceps or Wrigley's forceps will be used if your baby is facing towards your back. Kielland's forceps (also known as rotational forceps) will be used if your baby is facing towards your abdomen (in a back-to-back position) and needs to turn before being born.

A **ventouse** (also known as a vacuum extractor or suction cup) is an instrument that uses suction to carefully position a small round plastic cup on your baby's head.

How common are assisted vaginal births?

In the UK, approximately one in eight births are assisted vaginal births.

However, if you are expecting your first baby, the likelihood of an assisted birth is higher, with one in three women having an 'assisted vaginal birth'.

If you have given birth vaginally before, the likelihood of you having an assisted vaginal birth is much lower.

Why might I need to have an assisted vaginal birth?

An assisted birth may be recommended during the 'pushing' (second) stage of labour, in order to shorten your labour.

This may be because:

- there are concerns about the wellbeing of your baby and your baby needs to be born quickly
- there are concerns about your wellbeing
- your labour is not progressing as would usually be expected
- you are unable to, or have been advised not to, push during birth. Your midwife and obstetrician will discuss this with you before you go into labour
- you become too tired to give birth to your baby without assistance after a long labour. This is particularly likely after a prolonged period of pushing
- your baby may be facing your abdomen (in a back-to-back position)
- you have an epidural. Epidurals can have a relaxing effect on your pelvic floor muscles. This may cause your baby to move into a position which makes giving birth without assistance more difficult. The epidural may also work so well that you have less of an urge to push.

Having an epidural for pain relief in labour may increase the chance of you needing an assisted vaginal birth, but this is less likely with modern epidural anaesthetics. If you have an epidural and this is your first baby, waiting longer from when your cervix (neck of the womb) is fully dilated until you start to push can help your baby's head move lower in the birth canal. Lying on your side (in a lateral position) rather than sitting upright may also help.

Can I reduce the chance of needing an assisted birth?

You are less likely to need an assisted vaginal birth if you:

- have continuous support in labour from your birth partner(s). Please discuss your 'birth choices' with your midwife.
- birth in a midwifery-led birth centre or at home. Birthing in a midwifery-led environment is only recommended if you and your baby have been well during your pregnancy, there have been no complications in this or a previous pregnancy, and midwifery-led labour care is appropriate for you. You are advised to discuss your birthplace options with your midwife. You may also find it helpful to download the 'My Birthplace' app or the 'Choosing where to have your baby' booklet. Please visit **www.uhs.nhs.uk/maternity** for more information.
- remain upright and active during labour. This allows your baby to adopt a good position for passing through your pelvis. It also allows gravity to assist you, encouraging stronger and more efficient contractions. If you feel unable to maintain an upright position or if you have an epidural, lying on your side after your cervix is fully dilated can reduce the likelihood of you needing an assisted vaginal birth.
- wait until you have strong urges to push after your cervix is fully dilated. Sometimes, it is beneficial to delay pushing by one to two hours, especially if you have an epidural. Your midwife and obstetrician will advise you according to your individual situation.

While it is not always possible to avoid an assisted vaginal birth, it is important to discuss ways of reducing the likelihood with your midwife or obstetrician. They will be happy to answer any questions you may have.

Occasionally a hormone drip is needed to give your contractions more power and increase the likelihood of a spontaneous vaginal birth.

Sometimes all of these steps are followed, and an assisted vaginal birth is still necessary. This is nobody's 'fault' and, like the rest of pregnancy and labour, can be unpredictable.

Choosing between ventouse and forceps

Your obstetrician will recommend the instrument most appropriate for you and your baby, based on your individual circumstances. Many factors will need to be considered, including the pain relief you are using, how quickly your baby needs to be born, what position your baby is in and how many weeks pregnant you are. Assisted vaginal birth will only be recommended if it is considered to be the safest option for you and your baby.

If you are in premature labour and less than 36 weeks pregnant when an assisted birth is recommended, your obstetrician will usually recommend forceps. This is because your baby's head is softer than it would be if you had reached 'full-term'.

If you have any concerns about ventouse or forceps, please discuss this with your midwife and obstetrician during your pregnancy. Decision making in labour can be difficult, especially if there are significant concerns about the wellbeing of you or your baby and there is less opportunity for discussion at the time of your baby's birth. This is why it is important to explore any concerns you may have with your midwife or obstetrician before you go into labour.

It is also important to discuss your concerns with your birth partner. Having a supportive and knowledgeable birth partner can help you with your decision making.

Caesarean section during the second stage of labour

It is important to consider the alternatives available to you if an assisted birth is not appropriate or is not successful, or if you choose not to have an assisted birth. The alternative is a caesarean section. Various factors determine the likelihood of you having a successful assisted vaginal birth. Your obstetrician will discuss these with you so you can make an informed decision.

An assisted vaginal birth is less likely to be successful if:

- your body mass index (BMI height/weight ratio) is over 30 at your booking appointment
- you are less than 161cm tall
- your baby is estimated to be more than 4kg in weight
- your baby is lying with their back to your back at the end of your labour
- your baby's head is not low down in the birth canal at the end of your labour.

A caesarean section during the second stage of labour (when your cervix is fully dilated, and you are pushing) is a more complex operation, with greater risks to you and your baby than a planned caesarean or a caesarean in the first stage of labour (when your cervix is dilating). An assisted vaginal birth may also lead to quicker birth of your baby than a second stage caesarean section. This is an important consideration if there are concerns about your baby's wellbeing.

If you are in labour and choose not to have an assisted vaginal birth, the alternatives are: to wait for your baby to be born without assistance, or to have an emergency caesarean section.

If you are sure you would not want an assisted vaginal birth under any circumstance, please discuss your birth plans with a consultant midwife or obstetrician during your pregnancy.They will discuss your individual situation and the advantages and disadvantages of a planned caesarean section with you, and answer any questions you may have.

Preparing for an assisted birth

Before they recommend the most appropriate mode of birth for you and your baby, your midwife or obstetrician will ask for your consent to perform an abdominal and vaginal examination. This will enable them to determine your baby's position and make a recommendation for the safest method of birth.

Based on this examination and the wellbeing of you and your baby, your obstetrician may suggest that you change your position or give you directions of where and when to push, to see if, with more time, your baby will be born without assistance. These techniques may also be helpful while preparations for an 'assisted birth' are being made.

Your obstetrician will discuss their findings with you and agree a plan for the birth of your baby with you. Please use this opportunity to ask your obstetrician any questions you may have.

Your obstetrician will ask you for your verbal consent to an assisted vaginal birth if plans are made for your baby to born in your room on Labour Ward. If arrangements are made to transfer you to the operating theatre for the birth of your baby, you will be asked to sign a written consent form.

Your midwife and obstetrician will not undertake any procedure that you do not agree (consent) to. We will only recommend an assisted vaginal birth if it is the safest option for you and your baby.

Place of birth

If your midwife or obstetrician expects your assisted vaginal birth to be straightforward, they will recommend that you give birth on Labour Ward. The alternative is giving birth in the operating theatre.

You may be advised to give birth in the operating theatre if:

- your midwife or obstetrician thinks that the assisted vaginal birth may be more complicated
- you may need additional pain relief (spinal analgesia)
- your baby's head is 'high' or your baby is in a back-to-back position.
- there is a chance that an assisted vaginal birth might not be successful (this is known as a 'trial of operative birth')

Pain relief

Before your baby's birth, your obstetrician will make sure you have adequate pain relief. If you are birthing your baby on Labour Ward, you will be given an injection of local anaesthetic to numb your vagina and perineum (the area of muscle and skin between your vagina and back passage).

For an assisted vaginal birth in the operating theatre, preparations will be made so that your obstetrician can perform a caesarean section if the assisted vaginal birth is unsuccessful.

You will have a cannula (a thin plastic tube) inserted, usually into your hand or forearm so your anaesthetist can give you medicine and fluids as needed. The anaesthetist will then give you a spinal anaesthetic or 'top up' your epidural (if you already have one). This allows you to be awake and experience your baby's birth without any pain in your lower body. For more information about anaesthetic, please visit: **www.labourpains.com**

Once you are comfortable, a catheter (thin plastic tube) will be used to empty your bladder. This protects your bladder and increases the space available for your baby to be born.

Monitoring your baby's wellbeing

Your baby's heart rate will be monitored continuously during the preparation for birth. This may involve using a sensor on your abdomen (CTG) or placing a 'clip' (FSE) temporarily on your baby's head to ensure their heart rate is monitored effectively. Your contractions will also be monitored.

Birthing your baby

Once you are comfortable, your obstetrician will apply either a ventouse or pair of forceps carefully to your baby's head. Sometimes your obstetrician will need to gently turn your baby's head with their hand to apply the instrument.

As you push, your obstetrician or midwife will gently guide your baby's head through the birth canal with the aid of the ventouse or forceps to help you give birth to your baby. During this process an episiotomy (a small cut to enlarge your vaginal opening) may be needed to reduce the risk of tears to your perineum and make space for your baby. Your baby is usually born after a few contractions rather than straight away.

Sometimes the ventouse cup can detach, making a 'popping' sound. If this happens your midwife or obstetrician may need to re-apply the cup to your baby's head before continuing.

If one instrument has been chosen and is not effective, your obstetrician may then either recommend using the other instrument to help you have a vaginal birth or offer a caesarean section, depending on your individual circumstances. If neither instrument is effective in helping you give birth, your obstetrician will recommend an emergency caesarean birth as your safest option.

Your baby's care immediately after birth

Cutting the cord

Depending on the wellbeing of you and your baby, your birth partner may wish to cut your baby's umbilical cord. You may also wish to consider 'deferred cord clamping' if appropriate.

Please discuss your options with your midwife, who will be happy to answer any questions you may have, or download the 'Deferred cord clamping' factsheet from: **www.uhs.nhs.uk/maternity**.

Skin to skin

After an assisted vaginal birth, your baby will initially be placed on your abdomen. If there have been concerns about your baby's wellbeing, a paediatrician (doctor who specialises in the care of babies) will be present at your baby's birth to assess and observe your baby's wellbeing.

If your baby is well, you will be able to hold and cuddle them against your skin. This type of skin-to-skin contact has been shown to offer many benefits, including helping to regulate your baby's temperature, heart rate and breathing, and supporting breastfeeding.

Birthing your placenta

When you give birth vaginally there are usually two options for birthing your placenta:

- **Physiological management:** This means that you will birth your placenta naturally, which can take up to an hour and is associated with greater blood loss
- **Active management:** You will be given an injection of a drug called oxytocin into your thigh as you give birth. This will help your womb contract allowing you to give birth to your placenta within a few minutes, although it can sometimes take up to half an hour. This reduces your risk of heavy bleeding, but it can make you feel sick.

Active management of your placenta is recommended after an assisted vaginal birth to reduce your risk of heavy bleeding. It is important to discuss this with your midwife or obstetrician, who will be able to answer any questions you may have.

Your care immediately after your baby's birth

After your baby's birth, your blood pressure, pulse, temperature and blood loss will be monitored. Your vagina and perineum will be examined to check for any tears. This involves checking your back passage. This examination is recommended after any vaginal birth.

Your midwife or obstetrician will discuss the 'type' of tear with you, and any perineal tears or episiotomy will be repaired with dissolvable stitches which do not need to be removed. Stitches stop any bleeding from a tear or episiotomy and join the skin and muscle together. The number of stitches varies according to the location and extent of the tear.

Assisted vaginal birth is associated with a higher chance of a vaginal tear that involves the muscle or wall of the anus or rectum.

This is known as a third or fourth degree tear and affects:

- 3% (3 in every 100) of women having a spontaneous vaginal birth
- 4% (4 in every 100) of women whose baby is born with the help of a ventouse
- 8 to 12% (8 to 12 in every 100) of women whose baby is born with the help of forceps

A third or fourth degree tear requires precise surgery to repair it. The repair is done in an operating theatre and is usually performed under an epidural or spinal anaesthetic or, very occasionally, a general anaesthetic. If you sustain a third or fourth degree tear, the care you receive and the advice you will be given is very specific. If this applies to you, you are advised to read the factsheet 'Information and advice if you have had a third or fourth degree perineal tear'. This is available to download from: **www.uhs.nhs.uk/maternity**.

After an assisted vaginal birth you will also be offered a single dose of antibiotics through a drip to reduce your risk of developing an infection.

You will be offered support as you feed and care for your baby. You and/or your partner will also be encouraged to continue skin-to-skin contact with your baby.

Pain relief for you

Most women feel bruised and sore after an assisted birth, so you will be offered regular pain relief. Initially this is in the form of a suppository, (which is inserted into your rectum (back passage) after any perineal tears or episiotomy have been repaired) and then as oral tablets.

It is important to take pain relief regularly, as this will allow you to remain mobile and take care of your baby. Paracetamol and ibuprofen are usually enough, but if you feel that your pain has not been adequately treated, please tell your midwife. Stronger painkillers can be provided if necessary.

While you are in hospital, you can ask your midwife for pain relief at any time or choose to be responsible for storing and taking your own pain relief at the times it is prescribed. This is known as self-medication. You will be provided with a locker for safe storage and additional medication if required. This is not appropriate for everyone. Please discuss this with your midwife if you think this may be appropriate for you.

You are advised to make sure you have paracetamol and ibuprofen at home to use for pain relief once you leave hospital. Your midwife will discuss the frequency and dose with you before you go home.

Care of your perineum after an assisted birth

It is very common to need stitches after any vaginal birth but especially after an assisted vaginal birth. The stitches stop any bleeding from a tear or episiotomy and join the skin and muscle together. They will start to dissolve after about ten days and have usually completely disappeared after six weeks. It is normal to find small pieces of the stitch material when you are bathing or when you go to the toilet.

Tears and episiotomies can cause pain and discomfort after birth. Sometimes passing urine or emptying your bowels can be painful, but this should improve over time. It can take up to six weeks for your perineum to heal and may take up to six months to for you to feel completely comfortable again. Your midwife will give you advice on hygiene, pain-relieving drugs and self-help measures, all of which will help to reduce your discomfort. You may also find it helpful to read the ‘How to care for your perineum following the birth of your baby’ factsheet. This is available to download from: **www.uhs.nhs.uk/maternity**.

Please speak to your midwife or GP if:

- you have any questions or concerns about the healing process
- you are experiencing pain or difficulty going to the toilet, or incontinence
- your mental health is affected

Your stitches will be examined to make sure they are healing well.

Please tell your midwife, GP or the maternity day assessment unit (telephone: **023 8120 4463**) if:

- your perineal area becomes hot, swollen, weepy, smelly or very painful
- a tear or episiotomy which has been repaired starts to open
- you develop a temperature and flu-like symptoms

If you experience any of these symptoms, you may be developing an infection and may need treatment with antibiotics.

Sexual intercourse
Sexual intercourse can be resumed when you feel comfortable. You may wish to use a lubricating jelly and try out different positions to find one that is comfortable to you. If having sex is painful or if you have any questions or concerns, please speak to your midwife or GP.

You are also advised to use contraception from three weeks after your baby's birth, because fertility can return quickly even if you are breastfeeding. Please discuss the most appropriate contraception for you, with your midwife or GP. It is advisable to leave a 12 month gap between pregnancies.

Lochia
Recovery from pregnancy and birth is different for all women. However, all women will experience some vaginal bleeding in the days and weeks after birth. The medical name for this loss of blood is 'lochia'. It is a combination of mucous, tissue and blood that is shed after birth as your womb (uterus) replaces its lining. Immediately after an assisted birth, heavier bleeding is more common. The bleeding in the days afterwards should be similar to a spontaneous vaginal birth.

It is important that you know what is normal and when you should ask for advice from your midwife or doctor. You are advised to read the 'Blood loss – what to expect after the birth of your baby' factsheet. This is available to download from: **www.uhs.nhs.uk/maternity**. Please ask your midwife if you have any questions or concerns.

Passing urine and caring for your bladder
Avoiding damage to your bladder during the birth of your baby is essential. Your bladder will be emptied by your midwife or obstetrician, through use of a urinary catheter (a thin plastic tube), before the birth of your baby. This catheter will be removed again immediately after your baby's birth unless you have an epidural or spinal anaesthetic.

If you have an epidural or spinal anaesthetic, the catheter will need to remain in your bladder until the anaesthetic has worn off and the feeling in your legs has returned. This enables you to empty your bladder until you can go to the toilet independently.

To make sure your bladder is working well, your midwife will ask you to measure your urine, using a measuring jug when you go to the toilet for the first few times.

It is important to let your midwife know if you are having any problems when you pass urine, such as leaking urine, only being able to pass small amounts of urine or not being able to pass urine at all.

Exercising your pelvic floor muscles will help to prevent urine leaking from your bladder when you cough or sneeze. It can also reduce initial bruising and swelling after birth. For more information about pelvic floor exercises, please read the 'Shape up after pregnancy' factsheet. This is available from: **www.uhs.nhs.uk/maternity**.

Risk of blood clots
During pregnancy and in the first six weeks after birth, your blood is stickier. This reduces your risk of bleeding heavily when your baby is born but increases your risk of developing a blood clot in your legs (DVT) or in your lungs (PE).

It is important to remain hydrated, active and mobile after you have given birth to reduce the risk of these conditions.

You will be encouraged and helped to get out of bed as soon as possible after your baby is born. If you have had an epidural or spinal anaesthetic, the numbness in your legs will take a few hours to wear off completely, so you should only get out of bed for the first time when your midwife or a maternity care assistant is with you, in case your legs are still weak.

You will be encouraged to walk around the ward, and once your catheter is removed, walk out to the toilet.

Depending on your individual risk of developing a blood clot, you may be offered anti-embolic stockings or a daily injection of an anti-coagulant (a medicine that reduces your blood's ability to clot). Your midwife or obstetrician will discuss this with you if appropriate.

It is important that you are aware of the symptoms of DVT and PE so that you know when to seek medical advice if you are concerned.

Symptoms of a blood clot (DVT)

- pain in the calf or thigh associated with swelling of the limb - this may be worse when the foot is bending upwards towards the knee
- heat or redness, particularly in the back of the leg, below the knee
- you may find it difficult to put weight on the affected leg

DVT usually affects one leg.

Symptoms of pulmonary embolus (PE)

- difficulty in breathing or shortness of breath
- coughing up blood-stained sputum (a thick fluid produced in the lungs)
- chest pain that is often worse when breathing in
- collapse

If you have any of these symptoms while you are in hospital, please tell your midwife. If you are at home and you have any of these symptoms, please call the maternity day assessment unit on **023 8120 4463** for advice. If your symptoms are severe, please call **999** or go to your nearest emergency department immediately

What does an assisted birth mean for my baby?

Your baby may have bruising and grazes (small cuts) on their head and face after birth. These affect 10% (1 in 10) of babies born with the assistance of ventouse or forceps and usually heal quickly.

- Babies born with the help of a ventouse often have an area of swelling on their head, called a chignon (pronounced sheen-yon), which is caused by fluid trapped inside the tissue of the scalp when the cup is applied. This swelling is normal and usually subsides within 24 hours. Occasionally, the ventouse may leave grazes on your baby's scalp due to the friction of the suction cup. These grazes may take several days to heal.

- The ventouse cup may also cause a bruise called a cephalohaemtoma. This occurs in up to 12% (1 to 12 in 100) of babies and resolves in time. It rarely causes any long-term problems for babies.

- Marks from the forceps on your baby's face are very common but these usually disappear within 48 hours

Pain relief for your baby
Some babies have sore heads after an assisted birth and may need some pain relief for one or two days. Paracetamol can be prescribed by a paediatrician if your baby is unsettled and in pain. This is a good painkiller and is safe for your baby.

Jaundice
Jaundice is a yellowing of your baby's skin and eyes, and is common in newborn babies affecting up to 60% of babies. It can be more common after an assisted vaginal birth if your baby has any bruising. Babies with jaundice may be sleepy and less interested in feeding.

If you have any concerns about your baby's wellbeing or questions about jaundice, please speak to your midwife. You can read more information about jaundice on the NHS website: **www.nhs.uk**.

Other risks
One of the less common risks of an assisted birth is bleeding in a baby's brain. This happens in 5 to 15 of every 10,000 babies. Serious traumas, such as fractures or nerve damage, are rare.

With any vaginal birth, either spontaneous or assisted, there is a risk of shoulder dystocia. Shoulder dystocia is when one of your baby's shoulders becomes stuck behind your pubic bone, after their head is born, delaying the birth of their body. If this happens, extra help is usually needed to release the baby's shoulder. Your midwives and obstetricians are all trained to deal with this emergency situation and the actions needed to release the shoulders and deliver your baby. In the majority of cases, your baby will be born promptly and safely.

You can read more information about shoulder dystocia on the NHS website: **www.nhs.uk** or on the Royal College of Obstetricians and Gynaecologists website: **www.rcog.org**. If you have any questions or concerns about shoulder dystocia, please speak to your midwife or obstetrician.

Going home
Having an assisted vaginal birth may mean that you stay in hospital slightly longer than expected. However, your stay is likely to be shorter than if you have an urgent caesarean section.

Before you go home from hospital, you will be given the chance to talk to your obstetrician about the birth of your baby and ask any questions that you may have.

It is important that you have a six week postnatal appointment. This follow-up enables your doctor to check that everything is healing well and that there are no problems. This is usually with your GP, but you may be asked to come back to the hospital if there were complications that need to be discussed with your obstetrician.

Future births
It is advisable to leave at least a 12 month gap between pregnancies. This enables your body to recover from pregnancy, labour and birth. Having an assisted vaginal birth does not mean

that you will need one again in the future. There is a 90% that chance your baby would be born spontaneously in a future birth.

Birth afterthoughts

If you would like to discuss the birth of your baby in more detail, please contact our birth afterthoughts team on **023 8120 6834**. Alternatively, please discuss your questions and concerns with your midwife or obstetrician.

Useful links

Royal College of Obstetricians and Gynaecologists
'Assisted vaginal birth' leaflet: This is available to download from: **www.rcog.org**

Royal College of Obstetricians and Gynaecologists
Greentop Guideline 26: **www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg26**

Royal College of Obstetricians and Gynaecologists
Consent advice for assisted birth: **www.rcog.org.uk/globalassets/documents/guidelines/ca11-15072010.pdf**

NHS
Information on assisted birth: **www.nhs.uk/conditions/pregnancy-and-baby/ventouse-forceps-delivery/**

For a translation of this document, or a version in another format such as easy read, large print, Braille or audio, please telephone **023 8120 4688.**

For help preparing for your visit, arranging an interpreter or accessing the hospital, please visit **www.uhs.nhs.uk/additionalneeds**

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