CMQCC
California Maternal
Quality Care Collaborative

CMQCC Guidance in Response to ACOG's "Clinical Practice Guideline #8, First and Second Stage Labor Management"

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Introduction

In January 2024, the ACOG Committee on Clinical Practice–Obstetrics released the revised "Clinical Practice Guideline #8, First and Second Stage Labor Management", replacing "Obstetric Care Consensus 1" guideline from March 2014.

The labor management guidelines in CMQCC's *Toolkit to Support Vaginal Birth and Reduce Primary Cesareans* are in large part based upon ACOG's previous "Obstetric Care Consensus 1" guideline. CMQCC has received many inquiries since the publication of ACOG's new guideline. The guidance herein is CMQCC's response to those inquiries.

ACOG Clinical Practice Guidelines with CMQCC Response

ACOG Clinical Practice Guideline #8 categorizes recommendations as ***ACOG Recommends, ACOG Recommends Against***, and ***ACOG Suggests***. Readers should consider these categories when counseling patients and consider whether the recommendation is based upon low- or high-quality evidence.

Additionally shared decision making leads to improved patient experience and improved outcomes. Shared decision making is "a patient-centered, individualized approach to the informed consent process that involves discussing the benefits and risks of available treatment options in the context of a patient's values and priorities."[1]

LABOR AND LABOR ARREST DEFINITIONS

I. ACOG ***recommends*** the start of active labor is defined as 6 cm. (strong recommendation, moderate quality evidence)

CMQCC Key Points:

- Most people with prolonged latent phase will enter active labor spontaneously.
- Latent phase of labor is significantly longer in induced labor.

II. ACOG ***suggests*** that active phase arrest of labor be defined as no progression in cervical dilation in individuals who are at least 6 cm dilated with rupture of membranes despite 4 hours of adequate uterine activity or 6 hours of inadequate

[1] Informed Consent and Shared Decision Making in Obstetrics and Gynecology: ACOG Committee Opinion, Number 819. *Obstet Gynecol*. Feb 1 2021;137(2):e34-e41. doi:10.1097/aog.0000000000004247

uterine activity with oxytocin augmentation. (conditional recommendation, low quality evidence)

CMQCC Key Points:

- ACOG's suggested definition of active phase arrest is a conditional recommendation based on low-quality evidence, as they acknowledge. Nonetheless, this is important insofar as patient counseling and shared decision making when deciding the course of care after labor arrest has been diagnosed. The risks of adverse neonatal and maternal outcomes with arrest of labor must be discussed with the patient and balanced against the knowledge that in those patients with potential arrest disorder (no change after 4 hours while on oxytocin), over 80% of multiparas will go on to deliver vaginally if oxytocin is continued, and over 50% of nulliparas will do so.
- Balancing the risks of prolonged labor with avoidance of cesarean, there is room for individualization and shared decision making.

III. ACOG ***recommends*** that prolonged second stage of labor be defined as more than 3 hours of pushing in nulliparous individuals and 2 hours of pushing in multiparous individuals. (strong recommendation, high-quality evidence)

CMQCC Key Points:

- ACOG's definition of prolonged second stage no longer specifies that patients with epidurals have a lengthened time frame for diagnosis of prolonged second stage. However, the guideline notes that "parity, epidural analgesia, maternal body mass index, birth weight, occiput posterior position, and fetal station at complete dilation all have been shown to affect the length of the second stage of labor." Shared decision making based on the patient's individual labor course is key.
- Balancing the risks of prolonged labor with avoidance of cesarean, there is room for individualization and shared decision making.

TIMING OF EPIDURAL USE DURING LABOR

I. ACOG ***recommends*** that neuraxial anesthesia be offered for pain relief during any stage of labor. (strong recommendation, moderate-quality evidence)

CMQCC Key Point:

- Patients should be offered *all* pain relief modalities and provided with the benefits and risks of each. A shared decision making approach should be utilized in order to ensure the patient's values, needs, and wants are considered.

LABOR MANAGEMENT

Management of Dystocia (First Stage)

I. ACOG ***recommends*** amniotomy for patients undergoing augmentation or induction of labor to reduce the duration of labor. (strong recommendation, high-quality evidence)

CMQCC Key Points:

- ACOG is not recommending routine amniotomy for all patients. ACOG recommends routine amniotomy for patients *undergoing augmentation or induction of labor* if the goal is to reduce the duration of labor.
- ACOG recommends early amniotomy (rather than late) for those undergoing induction or augmentation of labor. In the setting of induction or augmentation, there are no differences between early and late amniotomy in terms of neonatal and maternal outcomes. Time to delivery is the only measurable difference. It is therefore reasonable to individualize care according to a shared making approach.

II. ACOG ***recommends*** either low-dose or high-dose oxytocin strategies as reasonable approaches to the active management of labor to reduce operative deliveries. (strong recommendation, high-quality evidence)

CMQCC Key Points:

- ACOG does not recommend routine active management of labor for every patient; active management is preferred over expectant management for patients with protracted labor.
- There are no significant differences in neonatal and maternal outcomes with regard to oxytocin dosing, and therefore either approach can be personalized based upon labor course, individual circumstances, and the patient's desires for their labor and birth.

III. ACOG ***recommends*** using intrauterine pressure catheters among individuals with ruptured membranes to determine the adequacy of uterine contractions in those with protracted active labor, or when contractions cannot be accurately externally monitored. (strong recommendation, low-quality evidence)

CMQCC Key Point:

- The 2020 AHRQ systematic review noted no significant differences between external monitors and IUPCs in terms of mode of delivery, time to delivery and neonatal outcomes. Use of internal monitoring is recommended in the setting

of ruptured membranes and protracted labor when one must determine the adequacy of contractions, or for patients with ruptured membranes for whom external monitoring is unreliable.

Additional CMQCC Key Point Regarding Continuous Labor Support

There are various "special adjunctive considerations" listed for treatment or prevention of dystocia, including ***continuous labor support.*** Labor in most essentially healthy people will be a normal physiologic event, and continuous support in labor should be a *primary consideration* for the successful completion of vaginal birth. Those with continuous labor support are more likely to have a spontaneous vaginal birth and shorter labor. Continuous emotional support is key to preventing the hormonal cascade resulting from fear and pain in labor that leads to protracted labor and arrest of labor. Continuous labor support also allows the caregiver to better assess the patient's needs and desires for the other special adjunctive considerations, such as intravenous hydration, mobility, position changes, water immersion, timing of cervical exams, and use of a peanut ball.

Management of Dystocia (Second Stage)

I. ACOG ***recommends*** that pushing commence when complete cervical dilation is achieved. (strong recommendation, high-quality evidence)

CMQCC Key Points:

- The evidence for this recommendation is limited to people with epidurals. People without anesthesia may experience a "lull" in uterine activity at the time of complete dilation. "Laboring down" in this instance, for a person without anesthesia, is typically short-lived and is a normal, physiologic process.[2]
- Lack of fetal rotation and descent during pushing may help diagnose second stage arrest earlier and is useful information to discuss during shared decision making conversations about prolonged second stage.

Management of labor arrest in the first stage of labor

I. ACOG ***recommends*** that cesarean delivery be performed in patients with active phase arrest of labor. (strong recommendation, low quality evidence)

[2] Simkin P, Ancheta R. *The Labor Progress Handbook: Early Interventions to Prevent and Treat Dystocia* 3rd ed. West Sussex, UK: Wiley-Blackwell; 2011.

CMQCC Key Points:

- As noted previously, ACOG acknowledges that this recommendation is a suggestion, based on low-quality evidence. This is important insofar as patient counseling and shared decision making when deciding the course of care after labor arrest has been diagnosed per this definition. The known risks of adverse neonatal and maternal outcomes with arrest of labor must be discussed with the patient and balanced against the knowledge that in those patients with potential arrest disorder (no change after 4 hours while on oxytocin), over 80% of multiparas will go on to deliver vaginally if oxytocin is continued, and over 50% of nulliparas will do so.
- Slow but progressive cervical change in the first stage of labor does not define labor arrest, and thus is not necessarily an indication for cesarean. Balancing the risks of prolonged labor with avoidance of cesarean, there is room for individualization and shared decision making.

Management of labor arrest in the second stage of labor

ACOG ***suggests*** assessment for operative vaginal delivery before performing cesarean delivery for second-stage arrest. (conditional recommendation, low quality evidence)

CMQCC Key Point

- This option should only be offered by a skilled physician who is confident and competent in operative vaginal delivery.