PIPADOR REVISION

MRCOG Part 1 Revision Notes

Augmentation

CLINICAL MANAGEMENT • LECTURE 477

VISUAL EXAMINATION REVISION NOTES

2026 Edition

477

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Augmentation

Definitions and stepwise management of slow labour progress, including oxytocin use (NICE NG235)

< 2 cm in 4 h	Amniotomy	Oxytocin	4–5 per 10 min
Delay suspected	First step	Continuous CTG	Target contractions

■ KEY FACTS: Learning objectives

- Define augmentation of labour and delay in the first and second stages.
- Describe the stepwise approach to suspected delay (NICE NG235, 2023).
- Describe safe oxytocin use and its complications.

477.1 Key definitions

Term	Definition
Augmentation of labour	Interventions to speed up labour that has started spontaneously but is progressing slowly (amniotomy, oxytocin)
Established first stage	Regular painful contractions with progressive cervical dilatation from 4 cm
Suspected delay (first stage)	Cervical dilatation < 2 cm in 4 hours (nulliparous and parous women), or slowing progress in parous women
Confirmed delay	Progress < 1 cm in 2 hours after amniotomy (or on reassessment)
Delay in second stage	Active second stage > 2 h (nulliparous) or > 1 h (parous) without imminent birth
Oxytocin	Synthetic hormone that increases frequency and strength of contractions

■ IN PLAIN ENGLISH: Augmentation

When labour slows, first check the **3 Ps** and the woman's wellbeing. Augmentation strengthens weak contractions — but oxytocin is powerful: it must be titrated carefully with **continuous fetal monitoring**.

477.2 Delay in the first stage

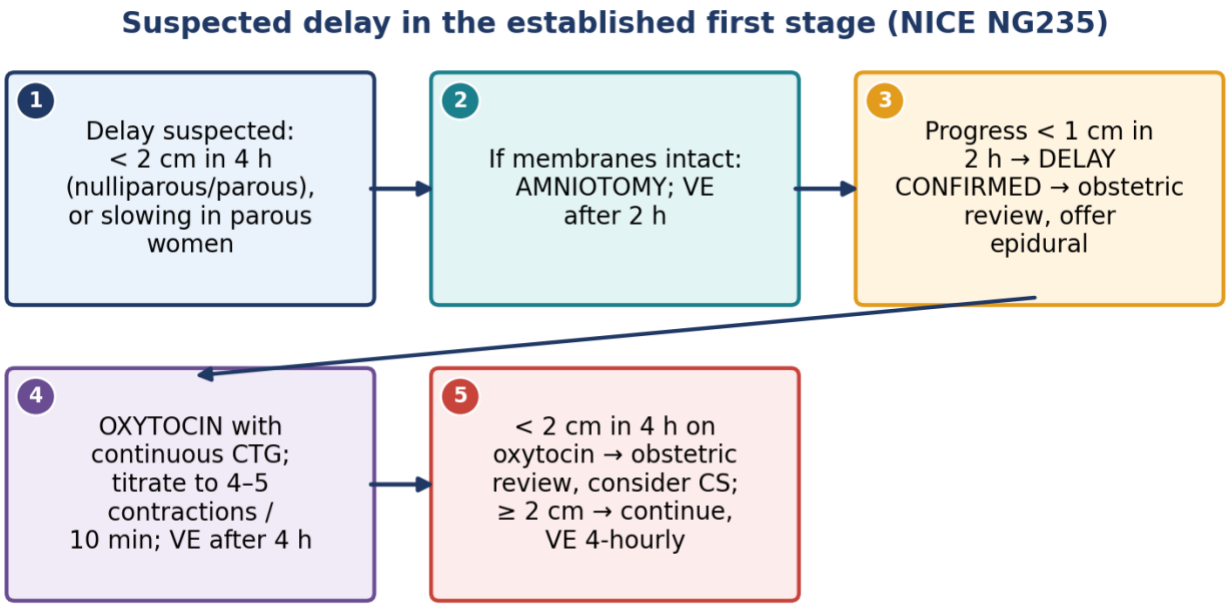


Figure 477.1 — Suspected delay in the established first stage (NICE NG235)

- Before augmentation: consider hydration, mobilisation, emptying bladder, analgesia, emotional support
  - Assess contractions, fetal position and descent, signs of obstruction.
- Amniotomy shortens labour by ≈ 1 hour but is not offered routinely in normally progressing labour.
- Explain that oxytocin increases the frequency/strength of contractions and the need for continuous monitoring
  - Offer an epidural before oxytocin is started.

477.3 Oxytocin

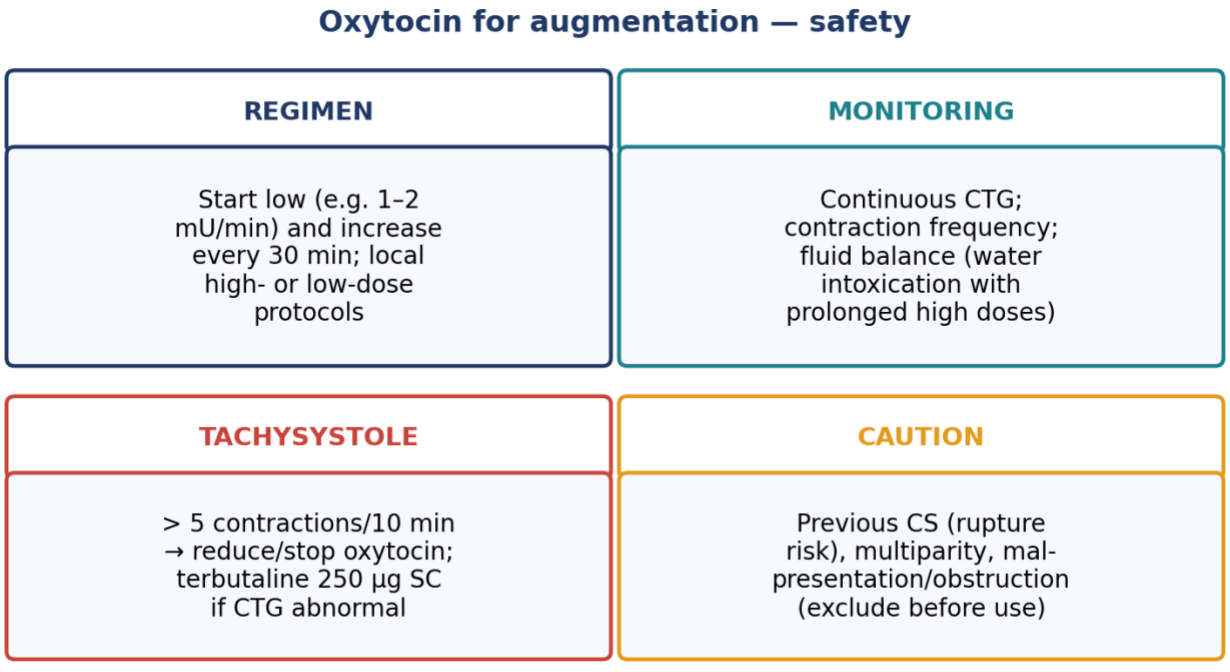


Figure 477.2 — Safe use of oxytocin

Topic	Details
Starting	• Exclude obstruction and malpresentation • Confirm membranes ruptured • Continuous CTG
Titration	Increase at intervals of at least 30 minutes until 4–5 contractions per 10 minutes
Review	• Vaginal examination 4 hours after starting • If < 2 cm progress → obstetric review and consider CS • If ≥ 2 cm → continue with 4-hourly VE
Second stage (nulliparous)	• If contractions inadequate at onset of second stage, consider oxytocin (with regional analgesia) • Senior review before oxytocin in parous women
Previous CS	Discuss with senior obstetrician — ↑ uterine rupture
Adverse effects	• Tachysystole/hyperstimulation, fetal hypoxia, uterine rupture • Water intoxication/hyponatraemia (high doses, hypotonic fluids) • PPH (atony after prolonged infusion)

477.4 Delay in the second stage

- Nulliparous: suspect delay if progress inadequate after 1 h of active second stage — offer amniotomy if membranes intact, consider oxytocin
  - Diagnose delay at 2 h → obstetric review for assisted birth.
- Parous: suspect delay after 30 min of active second stage; delay diagnosed at 1 h.
- Women with an epidural: delay pushing for at least 1 hour (unless urge to push/head visible).

■ COMMON PITFALLS

Starting oxytocin in obstructed labour or with malpresentation.

Increasing oxytocin more often than every 30 minutes.

Failing to recognise tachysystole and fetal compromise.

477.5 Must-know summary

■ EXAM TIP

- Suspected first-stage delay: < 2 cm in 4 h → amniotomy → reassess 2 h → < 1 cm = confirmed delay.
- Confirmed delay → obstetric review, offer epidural, oxytocin with continuous CTG.
- Titrate every ≥ 30 min to 4–5 contractions/10 min; reassess after 4 h (< 2 cm → consider CS).
- Second-stage delay: nulliparous 2 h, parous 1 h of active pushing.

■ MNEMONIC / MEMORY AID

First-stage delay — '2 in 4, then 1 in 2'.