PIPADOR REVISION

MRCOG Part 1 Revision Notes

Prolonged Labour

CLINICAL MANAGEMENT • LECTURE 478

VISUAL EXAMINATION REVISION NOTES

2026 Edition

478

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Prolonged Labour

Definitions, durations, causes, assessment and management of prolonged and obstructed labour

4 cm	≈ 8 h / 5 h	2 h / 1 h	3 Ps
Established first stage	Average first stage (nullip/parous)	Active 2nd stage delay	Causes

■ KEY FACTS: Learning objectives

- Define the stages of labour, prolonged labour and obstructed labour.
- Describe the causes of prolonged labour and how to assess them.
- Describe management and complications of prolonged and obstructed labour.

478.1 Key definitions

Term	Definition
Latent first stage	Painful contractions with cervical change, including effacement and dilatation up to 4 cm
Established first stage	Regular painful contractions and progressive cervical dilatation from 4 cm
Second stage — passive	Full dilatation before or without involuntary expulsive contractions
Second stage — active	Baby visible, expulsive contractions or active maternal effort with full dilatation
Prolonged labour	Labour progressing more slowly than expected (delay criteria in Lecture 477)
Obstructed labour	No progress despite adequate contractions because of mechanical obstruction (cephalopelvic disproportion, malposition)
Cephalopelvic disproportion (CPD)	Mismatch between fetal head and maternal pelvis

■ IN PLAIN ENGLISH: Prolonged labour

Labour is a race between **power** (contractions) and **resistance** (baby's size/position and the pelvis). Prolonged labour means something is slowing it down; obstructed labour means it cannot continue safely and needs operative birth.

478.2 Durations

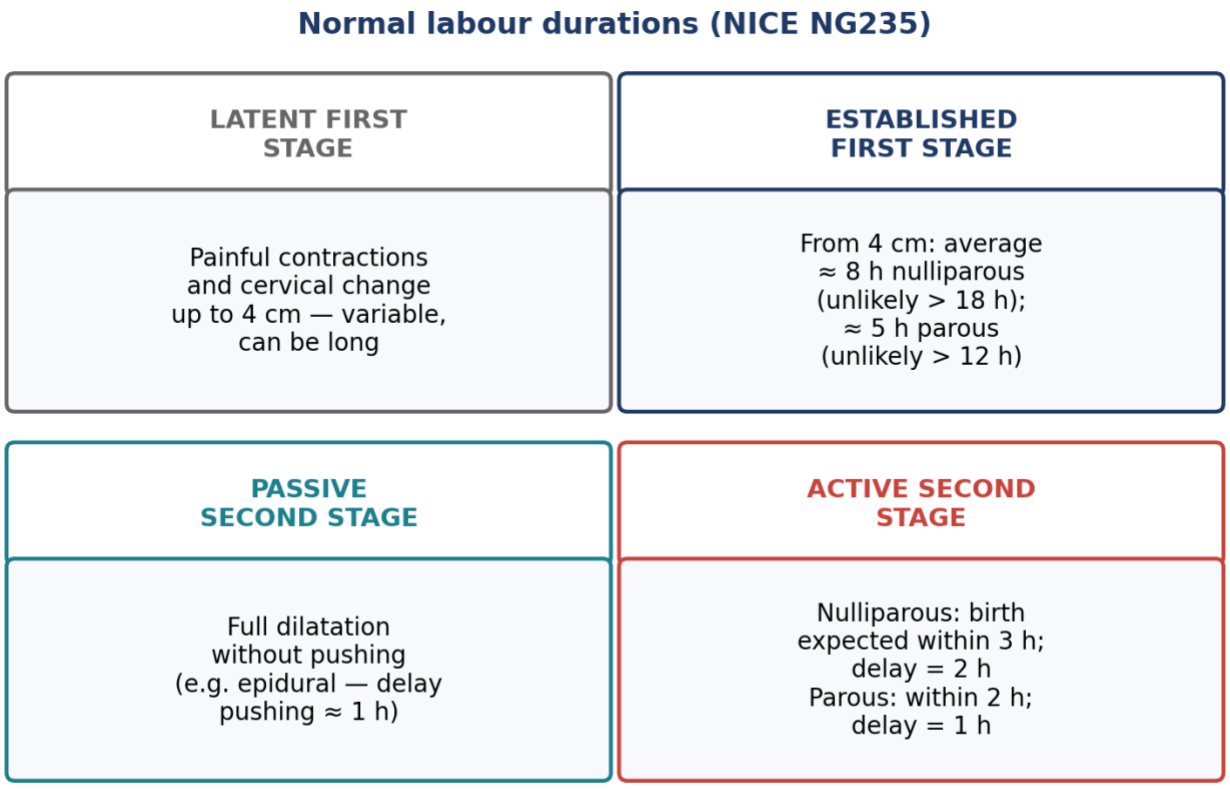


Figure 478.1 — Normal labour durations (NICE NG235)

478.3 Causes and assessment

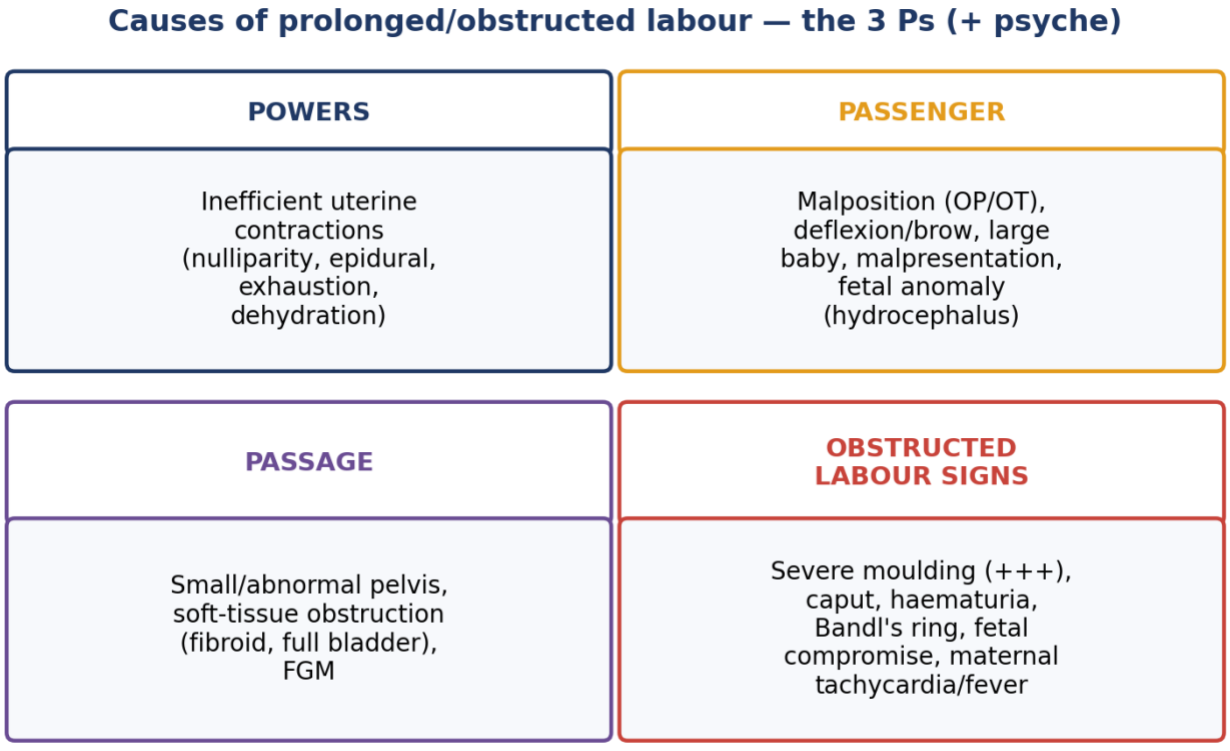


Figure 478.2 — Causes of prolonged/obstructed labour

Assessment	Look for
Maternal	Pulse, BP, temperature (infection), hydration, ketones, bladder (retention), pain, fatigue, emotional state
Abdominal	Contractions (frequency, strength), fifths of head palpable, lie/presentation, Bandl's ring
Vaginal examination	Dilatation, position (OP/OT), flexion, station, moulding, caput, membranes, liquor
Fetal	CTG features; meconium
Partogram	Plot progress (WHO Labour Care Guide/partogram) — action lines

478.4 Management

- **Supportive**: one-to-one care, mobilisation/upright positions, hydration, analgesia (epidural), emptying the bladder.
- **Augmentation** (amniotomy, oxytocin) for inefficient uterine action once obstruction excluded (Lecture 477).
- **Malposition**: OP position — maternal positioning, manual/instrumental rotation in second stage, or CS.
- **Second stage delay**: assisted vaginal birth if criteria met (Lecture 480), otherwise CS — consider trial in theatre.
- **Obstructed labour**: stop oxytocin, CS (beware impacted head — disimpaction techniques, Fetal Pillow, push-up/pull methods; RCOG guidance on impacted fetal head).

478.5 Complications

Maternal	Fetal/neonatal
• Exhaustion, dehydration, ketosis • Infection (chorioamnionitis), PPH (atony), operative birth, OASI, uterine rupture • Obstetric fistula (low-resource settings) • Psychological trauma	Hypoxic injury, acidosis, infection, birth trauma, impacted head injuries at CS, NICU admission

■ COMMON PITFALLS

Augmenting with oxytocin in an obstructed labour.

Missing signs of obstruction (moulding +++, caput, haematuria).

Not anticipating PPH after prolonged labour.

478.6 Must-know summary

■ EXAM TIP

- Established labour from 4 cm; average ≈ 8 h (nullip), 5 h (parous); unlikely > 18/12 h.
- Second-stage delay: active 2 h nulliparous, 1 h parous.
- Causes: powers, passenger (malposition, deflexion, size), passage (pelvis, soft tissue) — and psyche.
- Obstruction (moulding, caput, haematuria, Bandl's ring) → CS; anticipate PPH and impacted head.

■ MNEMONIC / MEMORY AID

'Powers, Passenger, Passage — and Psyche'.