

Posterior Labors

Longer, Harder and Almost Always Mishandled

- The infamous “back labor” occurs statistically in 25% of women’s labors but accounts for the “lion’s share” of complications .And until the 1990’s accounted for the majority of births by cesarean section. In 1984 when I started my first birth center after doing home births exclusively for twelve years, posterior labors were already one of the reasons I was so driven to establish a birth center. In fact posterior labors counted for the highest cesarean rates, the most common reason for “operative delivery” which means vacuum extraction or outlet forceps. Women whose babies stayed in a posterior position were four times more likely to go over due. The majority of these women had babies that were high in the pelvis. So that meant most posterior babies were not putting pressure on the internal os of the cervix and thus quality of the cervix would be longer, harder, thicker, less compliant (poor Bishops score). So inducing a posterior baby that was overdue was inducing a bigger baby with an old placenta and with a maternal cervix that would take hours to soften, thin out, and dilate.
- This cook book of complications is how and why so many women who were dedicated to natural childbirth were instead given long inductions usually with an increased amount of anesthesia, cesarean sections or both. Of the women who did deliver vaginally, many were so fatigued from long labors they were transferred from homes or birth centers (a little less common with birth centers that use monitors). These problem labors started a long research program on posterior babies at the Natural Birth and Women’s Center.
- But all posterior labors were much longer (statistically 50%). “Normal” for posterior labor was different. Many more complications and transports to the hospital occurred with posterior babies even when women were young, healthy and their babies were biologically normal xx or xy chromosomes and structurally normal. In fact posterior labors account for the largest number of transfers to the hospital for fatigue and long labors and or “failure to progress”.
- Because all of this I began an in house retrospective study which took almost fifteen years to complete. What we found was astonishing, the way we manage posterior labors was so incorrect we were making labors much longer. So to begin with we ask;” Why are approximately 25% of

babies posterior prior to or at the onset of labor?” To answer this we reviewed our own patients records and found about 10% Of pregnant women in our care had a one or more bones in the pelvis that were less than ideal shape or measurement. Maternal pelvic bones would be slanted slightly inward or the pelvic inlet would be narrower in some direction. There were many variations.

□ But that counted for only a small number of our back labors. The vast majority occurred when the placenta was implanted on the anterior (front) of the uterus. Thus babies simply rotated away from the placenta. The position of the placenta occurs with implantation and it is completely arbitrary where the fertilized egg attaches to the uterine wall. The third reason for posterior labors we studied was an increased amount of amniotic fluid (polyhydramnios) which occurs more frequently with gestational diabetes.

□ Moreover, posterior babies were typically more difficult if a baby when trying to descend into the maternal pelvis cocked his/her head (an asynclitism) to the side. This makes descent difficult and labor can aggravate the problem by pushing the baby into the pelvis in a posterior position with the fetal cocked to the side where neither descent nor rotation is possible,

□ In addition to asynclitism, babies with a deflexed head (chin up, also called military attitude) may not descend well either. Finally an arm or hand up beside the head called a compound presentation can stop rotation and descent and this is more likely to occur if the baby’s head is in a posterior position.

□ Most of these complications are handled by walking the mother, putting her in a hands and knees position or laboring her on a birthing ball. With a posterior fetus all of these actions are completely the wrong things to do. In hundreds of posterior labors we walked the mother until she was fatigued-the theory being that with a vertical position, and walking gravity would bring the baby down. The baby’s head would put more pressure on the cervix and dilation would occur. That is not what actually happens. Gravity brought the babies down but in the wrong position and “deep transverse arrest occurred in about 25% of women. We would then have an exhausted mother who could not push her baby out. In many of the women who were transported to the hospital for failure to progress and fatigue the usual management at the hospital was to simply

lay them on their side. In the women where this was done correctly the baby rotated , descended and delivered vaginally.

- In women who labored on their hands and knees to move the baby up and then descend in a better diameter it was useful in only one in five women but more of a problem for four out of five.
- In these women hands and knees neither helped nor improved a dysfunctional labor. The position was helpful for a few women for back pain relief but that group was less than half.
- The birthing ball posed another problem, as women leaned forward the cord was compressed by the fetal body giving “variable fetal heart rate decelerations”. Variable decelerations of the fetal heart rate are a common cause of (usually) mild fetal distress. This problem was rectified by having the laboring woman move into side lying position.
- So what we found was that posterior labors were commonly associated with prolonged latent phase (long starts) poor fetal rotation and descent, long labors, but almost all of this could be mitigated and improved by the following:
 1. Soften cervix early with Evening Primrose Oil capsules and sometimes adding specific homeopathics.
 2. Establish labor on time with positioning, nipple simulation etc.
 3. DO NOT WALK the women, labor them on their sides UNTIL the baby rotates and begins descent.
 4. Use hands and knees sparingly and only for pain relief.
 5. Never use a birthing ball. The air in the ball pushes the fetal head up and will prolong labor.
 6. As women labors use the *Brooks Maneuver* (inlet hip press)only during active contractions. This maneuver must be taught and must be done correctly.
 7. Walk the laboring women or put her in the vertical position ONLY after rotation and descent is occurring.

8. DO NOT PUSH UNTIL ROTATION OF FETAL HEAD IS COMPLETE.

This is a diagnostic that would be done by the midwife or doctor.

9. We also delayed putting women in water until the baby had rotated or was significantly down in the pelvis because water does not usually help rotation which must occur.

□ The (# 8) action made the descent of the baby easy on the fetus and effective pushing for the mother.

□ When we followed the nine actions listed above all women's length of labor whose babies were posterior were reduced by at least 50%- case number 1500 births. 200 were transfers, the mean time of the 800 births we managed with the 9 point plan: 17 hours, with an average pushing time of 1 hour 50 minutes for first babies. In the 700 posterior labors managed by walking the average length of labor for first babies was 33 hours. Vertical labors took more than twice the time than for those women labored in a lateral position. Of the 200 transports 50% of the women were delivered by cesarean upon transfer.

□ Parameters of the study were all first deliveries following low risk pregnancies. In short we solved the problem of long hard posteriors labors most of the time by simply laboring women on their side and by ignoring our true midwifery beliefs of walking posteriors, birthing balls and gravity. Simple? It would seem so but what we had to find out.

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