**Analgesia in labour**

Pain is a complex phenomenon and a pain-free labour will not necessarily be more satisfying.

Working with women’s pain rather than alleviating it underpins many midwives’

practice. Indeed many would argue that some degree of pain is an essential

part of labour: ‘as it stimulates the brain to release a cocktail of hormones, which in

turn stimulate the uterus to contract’. Leap (2010) distinguishes

between midwives who ‘work with pain’ and those who provide ‘pain relief’.

Most midwives encourage natural and non-interventionist methods first, with pharmacological

methods only if these methods are deemed insufficient.

**Massage and touch.** These can be powerful analgesics (Figure 1.2), encouraging

pain-relieving endorphin release. Never underestimate the effect of being ‘with

woman’. Be sensitive however. Touch can be irritating or distracting, particularly in

later labour. Labour can induce flashbacks for sexual abuse victims

and some women come from cultures where *any* non-essential touching by strangers

feels invasive.

\_ **Distraction**, e.g. breathing patterns, music, television:

‘In labour I spend a lot of time in a monotone voice quietly talking women through

a contraction. *Breath in through your nose,* (pause) *blow out from your mouth* . . . *let*

*your shoulders drop, arms relax, unclench your hands.* . . . Next out breath I add: *let*

*your legs relax and sink into the chair/bed etc . . . unclench your toes!!* I don’t think this

is hypnobirthing but it’s working with each contraction and it seems to work!’

(Midwife, personal communication).

\_ **Position changes with aids.** Upright postures reduce the intensity of pain**:** e.g. beanbags, wedges, stools and birthing balls (e.g. Figures 1.3 and 1.4).

\_ **Transcutaneous electrical nerve stimulation (TENS).** Despite conflicting opinions

on its effectiveness, including possible placebo effect, many women report that it

provides good analgesia, especially in the first stage of labour : 20%

of women use it and most say they would use it again. There is no adverse effect on the mother or baby. However, lack of substantial non-anecdotal evidence has led to conclusion, controversially, that TENS should not be recommended in established labour.

\_ **Aromatherapy.** The use of essential oils may aid relaxation in labour. Oils should

be diluted, preferably to half the usual dilution, in pregnancy. For a bath, adding

the drops to milk prior to putting them in water helps them disperse. Some trusts

have an agreed policy for use of oils in labour. Without this, a midwife who has not

received any training in aromatherapy should be careful not to give uninformed

advice to a woman in labour about the use of oils. Only oils known to be safe in

pregnancy should be used: some are contraindicated in pregnancy.

Continuous vaporisation may impede concentration and have adverse maternal

effects (Tiran, 2006).

\_ **Other methods, e.g. acupuncture/pressure, reflexology, shiatsu, yoga, hypnosis**

**(including self-hypnosis), sterile water blocks, homeopathic and herbal remedies.**

Normally only midwives trained in these specialist areas or qualified practitioners

offer these therapies. Non-pharmacological methods are notoriously difficult

to evaluate by standard research methods. Acupuncture, acupressure and

hypnosis have been clinically proved to work (Smith *et al.*, 2006; NICE, 2007;

Smith *et al.,* 2011a; Smith *et al.*, 2011b). A Cochrane review is underway to evaluate

the effects of 0.1ml intradermal water injection (Derry *et al.*, 2011). Anecdotal

accounts of interventions e.g. hypnobirthing yield extraordinary stories

(<http://www.hypnobirthing.co.uk>).



**Fig. 1.2** Hands on comfort: massage and touch



**Fig. 1.3** Kneeling forwards onto a pillow.



**Fig. 1.4** Side lying.

**Water.** Deep-water immersion has unique benefits. The opportunity to labour in

water should be part of routine labour care.

**Pharmacological analgesia**

\_ **Entonox (nitrous oxide):** the most commonly used labour analgesic in the UK.

There is little evidence on fetal/maternal effects; it appears fairly safe. Side effects

are minor, e.g. dry mouth or nausea, but it is quickly excreted so effects wear off

rapidly. Long-term exposure risks are well documented, including risk to pregnant

staff with high labour ward workload.

\_ **Opioids, e.g. pethidine, diamorphine:** usually given intramuscularly (IM) but occasionally

by patient-controlled analgesia. Antiemetics should be given prophylactically

with opioids. Opioids can ‘take the edge off’ the pain for some

women, inducing a feeling of well-being and allowing some rest. Many midwives

recount stories of anxious, scared women who, on receiving pethidine, fall into a

doze and wake up fully dilated. Arguably, this ‘emotional dystocia’ can be addressed in other ways, e.g. good caring support. There are considerable doubts about effectiveness of opioids and concern about potential maternal, fetal and neonatal side-effects. Maternal side-effects include nausea, vomiting and hypertension. Some women feel disorientated

and out of control. Neonatal side effects include respiratory depression (which may

require injection of the antagonist naloxone), subdued behaviour patterns, including

a lack of responsiveness to sights and sounds, drowsiness and impaired early

breastfeeding (NICE, 2007). Babies of mothers receiving opiates in labour appear

more likely to become addicted to opiates/amphetamines in later life (Nyberg *et al.*, 2000).

\_ **Regional anaesthesia (epidural, spinal or combination)** aims to remove pain altogether

from the lower half of the body. Patient controlled analgesia using a pump

connected via the epidural catheter gives women control and reduces breakthrough

pain.

◦ *Epidural anaesthesia*: administration of local anaesthetic and/or opiates into the

epidural space around the spinal column

◦ *Spinal anaesthesia*: an opiate, and sometimes anaesthetic drug injected through

the covering of the spinal cord; faster and usually short-acting

◦ *Combined epidural–spinal anaesthesia*: quicker but gives no better

pain relief than epidural alone.

For many women regional anaesthesia provides welcome relief from pain; if labour

is complicated and/or slow, the risks may be of little consequence at the time.Women

should be aware of those risks however: e.g. pyrexia, leg weakness, hypotension, poor mobility, longer labour, increased malposition, increased oxytocin augmentation and significant perineal trauma due to increased instrumental delivery

. Cochrane review found no increase in CS, long term backache or immediate neonatal effects from epidural, although any use of opiates will result in some placental transfer, and decreased mother–baby interaction and poorer breastfeeding

rates following epidural anaesthesia have been reported (Buckley, 2004b). However if a woman really wants an epidural she should be able to have one if humanly possible.

Ongoing publicity about midwives denying women epidurals in the belief that all

women should give birth naturally, reflects a breakdown in communication between

mother and midwife.

Increasingly in the UK low-dose epidurals, often rather optimistically known as

‘walking epidurals’, are being offered. These are intended to increase mobility, allowing

a woman to adopt upright positions, and occasionally to stand or walk. It is hoped

that she may be able to push more actively, and an increase in vaginal deliveries has

been recorded. More research is needed into other possible effects; a

Cochrane review is underway to assess the effect of upright positions with an epidural

in situ

.

**Care for a woman with regional anaesthesia includes**

\_ intravenous (IV) access, hourly sensory block check and continual pain assessment

\_ BP monitoring every 5 min for 15 min, particularly following establishment of block

and following any bolus administration (top-up)

\_ continuous CTG for 30 min following establishment of block and following bolus

(top up)

\_ regular position changes and non-supine, side lying or all fours position

(if possible) with attention to pressure areas

\_ bladder care: in/out or continuous catheter; and

\_ avoidance of aortocaval compression.

Some epidurals provide only partial pain relief or none at all.

A woman in this situation needs particular support. She may feel panicky and out

of control. A midwife may have to be a very strong advocate for her; recalling the

anaesthetist, possibly a more senior one. Sometimes little can be done, and the midwife

will need to give great emotional support to a disappointed, distressed women.

**Mobility and positions**

‘Get her off the bed’ (RCM, 2010).

Midwives are the major influence on whether a woman is free to mobilise. Actively

encouraging mobilisation during labour is a fundamental component of good midwifery

practice and is a safe, cost-effective way of reducing complications caused by

restricted mobility and semi-recumbent postures, as well as enriching the woman’s

birth experience. Cochrane review found that upright positions shorten the first stage

by around an hour, and reduce epidural use.

Women’s expectations of how to behave in labour, unfamiliar surroundings, the

labour room bed, lack of privacy and medicalised care models, all inhibit mobility in

labour. Most women labouring upright say they would do the same again; those labouring

supine would prefer to be upright for a subsequent labour/birth (MIDIRS, 2007).

However, 20% women report they were not enabled to choose the most comfortable

position in labour .

*‘Think about how you can help the woman to adopt other positions in labour – observe what*

*works and what doesn’t, and review when and why these positions were most successful.*

*Your knowledge of anatomy can also help you to understand how different positions aid the*

*physiological processes (e.g., the curve of Carus)*’.

Try to witness other midwives or ask a colleague for support when the mother is

giving birth in an unfamiliar non-supine position.

\_ Women often get stuck on the bed following an examination or during electronic

fetal monitoring (EFM). Suggest that she changes position or walks out to the toilet.

\_ Mind your back. Avoid twisting: try to be square to the woman, perhaps temporarily

kneeling or squatting, depending on your preference and the mother’s

position.

**Transition**

Towards the end of the first stage contractions may become almost continuous or,

conversely, space out a little. Many women may have a bearing down sensation at the

peak of the contraction as the cervix approaches full dilatation. This stage may be the

most painful and distressing. It can last a few contractions, but for some women it lasts

much longer. Labour stress hormones peak; this has a positive effect in producing the

surge of energy shortly needed to push.

*‘The diagnosis of the transitional stage is a far more women-centred and subjective*

*skill. essentially a midwifery observation and as such is dependent on knowing the*

*woman and recognising any changes in her behaviour. Progress can thus be diagnosed*

*without the need to resort to a VE’*

.

The woman experiencing the ‘extreme pain’ of transition has a decreased ability to

listen or concentrate on anything but giving birth. She becomes honest in vocalising

her needs and dislikes, ‘unfettered by politeness’ This should not be

misinterpreted by the midwife or birth partner as rejection or rudeness.

Typical behaviour may include:

\_ distressed/panicky statements: ‘I want to go home!’, ‘Get me a caesarean/

epidural!’, ‘I’ve changed my mind!’;

\_ non-verbal sounds: groaning/shouting, involuntary pushing sounds;

\_ body language: agitated, restless, toes curling, closed eyes due to intense concentration

and pain;

\_ withdrawing from activities/conversation of people around.