Early Pushing Urge in labour, midwifery practice & midwives and women's experiences

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Introduction

- Some women experience the urge to push before the full cervical dilatation: this phenomenon is clinically called **early pushing urge (EPU)**.
- The **diagnosis of EPU** is made with the perception of irresistible urge to push by the woman before full cervical dilatation, confirmed by vaginal examination (Downe, 2008).
- How frequently does the EPU occur? Which is the nature of the phenomenon? How do midwives manage EPU? How women experience EPU?

Background

- In the past, the dominant idea about EPU was mainly related to the **pathology** of the event and to the potential harm in bearing down before full cervical dilatation (Berkley, 1931; Benyon, 1957; Gaskin, 1990).
- The concept of EPU as **physiological** event if occurring within good maternal and foetal conditions is relatively recent (Downe, 2003).
- There are **controversies** about:

Prevalence of EPU
Nature of the phenomenon
Optimal response to EPU

- **Women's experiences** of EPU have not been explored.

Aims and methods

Project 1

AIM: to investigate EPU incidence, to explore how it is managed by midwives and its relation to some obstetric outcomes. Prospective observational study, data collection sheet, 60 EPU cases.

Project 2

AIM: **to explore midwives' experiences of EPU in caring for women during labour.** Qualitative phenomenology, interviews + vignettes, 20 midwives.

Project 3

AIM: **to explore women's experiences of EPU during labour.** Qualitative phenomenology, interviews, 8 women.

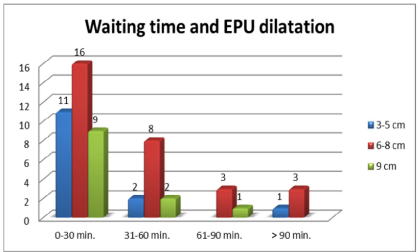
Findings – Project 1

A. EPU INCIDENCE AND MAIN CHARACTERISTICS.

- **Total EPU incidence**: 7.6% (n=60/789)
- Average of incidence per midwife: 7.8%
- Single midwives' incidences **range**: 2.3% (n=1/44) - 20% (n=4/20)

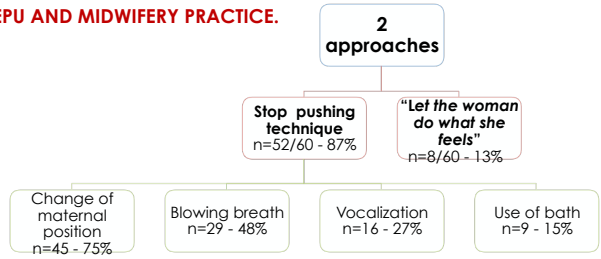
The number of diagnoses of EPU proportionally decreases the longer midwives wait to investigate it.

Dilatation at EPU diagnosis	N women	%
9	13	22
8	13	22
7	9	15
6	10	16
5	9	15
4	5	8
3	1	2
TOTAL	60	100



- **Parity:** 44 nulliparous women (73%) and 16 multiparous women (27%).
- **Foetal posterior position** (n=25/60, 41%), **deflected head** (n=18/60, 30%) or both (n=16/60, 27%) conditions predisposed to EPU.

B. EPU AND MIDWIFERY PRACTICE.



+ combination of techniques
e.g. change of position + blowing breath (n=18/60, 30%)

- Maternal positions: **hands and knees** (n=35/60, 78%), **lateral** (n=4/60, 9%) or both (n=9/60, 13%).
- **Medical interventions**: epidural analgesia (n=9/60, 15%), reduction of anterior cervical lip (n=6/60, 10%), amniorexi (n=2/60, 3%) and oxytocin infusion (n=1/60, 2%).

C. MATERNAL AND NEONATAL OUTCOMES.

- Maternal and neonatal outcomes were **very good** with 93% (n=56/60) **spontaneous delivery** rate.
- 39% (n=23/60) of women had an intact perineum and there were no third degree tears, cervical laceration or postpartum haemorrhages.
- **Association between dilatation at EPU diagnosis and** medical interventions, operative deliveries, first degree tears, episiotomies.

Findings – Project 2 - Midwives

'I would help her trying to find a position that alleviate the urge to push, for example hands and knees or lateral positions'

'I would try to give her time to reach the complete dilatation but if she can't hold I would say her to do what she feels'

'When I have an EPU in a completely physiological situation, it means that there is a reason so I usually don't stop it. If there are physiological elements, the pushing urge is physiological as well'

'I know it's difficult not to push if she has the urge to do so. I would try to explain to her the reasons for why it's better not to push, without making her feeling guilty'.

'The woman should avoid pushing ineffectively. Ineffective pushes are detrimental and a waste of energies'

'If you need to manage an early pushing urge at 5 cm, the success lies in the relationship you established with the woman which influences how much she trusts you and how much she allows you to guide her'

'The environment in which you work is really important. If physiology is your responsibility, this gives you more freedom in choosing a management rather than another one. And I feel that having the opportunity of asking for colleagues' advices is essential as well'

'Yes, my approach has surely changed due to my experience. Now I feel more confident in my everyday practice and I know that EPU might occur sometimes'

Findings – Project 3 - Women

'When I was pushing I put all of my efforts into that. And in the end, after I was exhausted I felt like a bottle cap, as the baby's head was like a bottle cap. After the pushing there was the contraction and this feeling was still there, like I still had a bottle cap there'

'With my first baby I felt really like an emptiness feeling. Instead, with my second baby I really felt that after the push I still had that need of pushing, I felt like there was a bottle cap that didn't unblock'

'When I was in the lateral position I naturally felt like I needed to push. When I changed position and I was on my hands and knees I was more able to control pushes by breathing'

'The midwife told me to blow out but I was not able to do it, I was really exhausted and I didn't have any air left to breathe'

'It was such a strange thing because no one believed me. It was strange because my body was telling me to do something and I had to do the opposite'

Conclusions

- EPU = **physiologic** variation in labour (good maternal-foetal conditions).
- Relation between **waiting time** and EPU diagnosis.
- **Management**: stop-pushing techniques - letting the woman do
- Importance of **midwife and partner's support**
- Further investigation: association dilatation at EPU diagnosis and obstetric outcomes, comparison maternal positions, case studies.

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