

Recommendations for Operative Vaginal Delivery

Purpose:

To provide guidelines for patient selection and application of using either forceps or vacuum extractor in vertex presentations.

Recommendation:

Both forceps and vacuum extractors are acceptable and safe instruments for operative vaginal delivery. Operator experience and practice credentialing should determine which instrument should be used in a particular situation.

Guidelines:

1. The mother's bladder is to be emptied.
2. Anesthesia services are to be readily available.

I. Forceps and Vacuum Deliveries:

1. The station, position and attitude of the fetal head are determined.
2. The type of forcep or vacuum is requested and applied based upon training, experience and credentialing of the practitioner.
3. For documentation and application purposes, the following definitions are used:
 - A. Outlet:
 1. Scalp is visible at the introitus without separating the labia.
 2. Fetal skull has reached the pelvic floor.
 3. Sagittal suture is in anteroposterior diameter or right or left occiput anterior or posterior position.
 4. Fetal head is at or on the perineum.
 5. Rotation does not exceed 45 degrees.
 - B. Low (without rotation)
 1. Leading point of the fetal skull is at station \geq +2 cm and not on the pelvic floor.
 2. Rotation is 45 degrees or less (left or right occiput anterior to occiput anterior, or left or right occiput posterior to occiput posterior).
 - C. Low (with rotation)
 1. Leading point of the fetal skull is at station \geq +2 cm and not on the pelvic floor.
 2. Rotation greater than 45 degrees
 - D. Mid
 1. Station is above +2 cm but head is engaged
 - E. High
 1. Not included in classification

Procedure:

II. Vacuum Extractor:

1. The appropriate size of vacuum cup that can easily be positioned over the vertex should be used.
2. Proper placement is over the sagittal suture at the flexion point, avoiding the anterior fontanel.
3. Vacuum pressure should be applied according to manufacturers' recommendations for the product.

4. Traction should only be applied once the appropriate vacuum pressure has been attained.
 5. Once maximum vacuum pressure is achieved, it is to be reported to the nurse in attendance and recorded on the delivery record.
 6. Traction should follow the pelvic curvature.
 7. Traction is applied during the patient's uterine contractions and pushing efforts, and relieved during the interval between contractions.
 8. Rocking movements or rotational torque should not be applied to the device; only steady traction in the line of the birth canal should be used.
 9. The delivery should be completed within 30 minutes.
 10. Suction should be partially released between contractions.
 11. With failure of further descent with three (3) detachments ("pop offs") an alternative method of delivery will be considered.
 12. The weight of evidence appears to be against attempting multiple efforts at operative vaginal delivery with different instruments. Therefore, unless there is a compelling and justifiable reason to do otherwise. If an adequate vacuum or forcep extraction attempt is unsuccessful, a cesarean section should be considered.
- III. The neonatal care providers will be made aware of attempted mode(s) of delivery in order to observe for the potential complications associated with operative vaginal delivery.
- IV. Depending upon an individual situation and anytime there are indications of a non-reassuring fetal heart rate tracing, the presence of a person skilled in neonatal resuscitation and treatment is required at the delivery.

Resources: ACOG Practice Bulletin, #17, June 2000, Operative Vaginal Delivery; Precis Obstetrics, second edition 2000; Dennen's Forceps Deliveries, fourth edition