

***Assisted Vaginal Delivery via Vacuum Extraction***

Practical Session B: Case Study

DIRECTIONS

Read and analyze this case study individually. When you and the others in your group have finished reading it, answer the case study questions. Consider the steps in clinical decision-making as you answer the questions. The other groups in the room are working on the same or a similar case study. When all groups have finished, we will discuss the case studies and each group’s answers.

CASE STUDY

Mrs. Z is an 18-year-old primigravida. She was brought to the health center at 10:00 am having felt labor pains since the early hours of the morning. When she arrived at 10:00 am, the fetal head was palpable at 4/5 above the symphysis pubis; the cervix was 2 cm dilated and not fully effaced; and contractions were two in 10 minutes, each lasting 25 seconds. Membranes ruptured spontaneously at 2:00 pm, and amniotic fluid was clear. It is now 6:00 pm, and the fetal head is 3/5 palpable above the symphysis pubis; the cervix is 4 cm dilated; there is minimum caput and molding (+ only); and contractions continue at a rate of two in 10 minutes, lasting now for 40 seconds.

ASSESSMENT (HISTORY, PHYSICAL EXAMINATION, SCREENING PROCEDURES/LABORATORY TESTS)

1. What will you include in your initial assessment of Mrs. Z, and why?
2. Based upon the initial presentation at 10:00 am, where is Mrs. Z in the process of labor at 10:00 am. What is the plan of management?
3. At 2:00 pm, Mrs. Z is checked again because her membranes have ruptured; what is the reason that she requires another vaginal assessment at this point? What is the plan of management?
4. What is your assessment of the clinical situation now at 6:00 pm? (She has crossed the action line on the partogram.)
5. What particular aspects of Mrs. Z’s physical examination will help you make a diagnosis or identify her problems/needs, and why?
6. When is the next vaginal assessment due?

**DIAGNOSIS (IDENTIFICATION OF PROBLEMS/NEEDS)**

You have completed your assessment of Mrs. A. and your main findings include the following:

* Mrs. Z has no symptoms or signs of cephalopelvic disproportion or obstruction.
* Her vital signs are within normal range, as is the fetal heart rate.
* She is not dehydrated.
* She has a high level of anxiety, however, and is finding it difficult to relax between contractions.
* On assessment, the cervix is found to be still 4 cms dilated (at 6:00 pm).
1. Based on these findings, what is Mrs. Z’s diagnosis, and why?

CARE PROVISION (PLANNING AND INTERVENTION)

1. Based on your diagnosis, what is your plan of care for Mrs. Z, and why?

**EVALUATION**

* At 10:00 pm, Mrs. Z is having three contractions in 10 minutes, each lasting for 50 seconds.
* Her partogram recordings show that her vital signs are normal, the fetal heart rate is within normal range, the cervix is 9 cm dilated, and the fetal head is 1/5 above the symphysis pubis.
1. Based on these findings, what is your continuing plan of care for Mrs. Z, and why?

REFERENCES

*Managing Complications in Pregnancy and Childbirth*: pages S-57; S-64 to S-67