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Preface

Operative vaginal delivery



Operative vaginal delivery (OVD) accounts for 10–15% of all births in the United Kingdom and Ireland and up to a third of births among first-time mothers. There is variation among individuals, centres, regions and countries, but in the UK, approximately half of all OVDs are completed by forceps and half by vacuum extraction. In the Netherlands, Denmark and Scandinavia, the vast majority of OVDs are by vacuum. Access to skilled OVD care in low-resource settings is limited, and in the United States of America, OVD rates are falling rapidly because of medico-legal concerns and loss of skills. From a clinical perspective, the important questions are when to intervene, which instrument to use, when to abandon an attempt at OVD and how best to counsel women in a dynamic and time-sensitive manner.

Surprisingly, the research on when to intervene is limited, with guideline recommendations relying largely on expert opinion and interpretation of cardiotocography. A nulliparous woman in the UK is likely to be offered an OVD after 1–2 hours of active pushing, while her counterpart in the US is likely to push for up to 3 hours. How long is too long for the second stage of labour? Such a fundamental question is worthy of a high-quality randomised controlled trial (RCT).

The choice between vacuum and forceps has been well served by regularly updated Cochrane systematic reviews although one could argue that the core data have been unchanged for more than a decade and the updates may not reflect the demographics of our current patient populations. The most challenging question for the obstetrician, and therefore for the woman, is whether to attempt a mid-pelvic rotational OVD or to proceed directly to second-stage caesarean section. The latter is increasingly preferred, but this may be short-sighted for the woman who is aiming to have more than one birth. To date, there is not a single randomised trial addressing this question.

Most appropriately counselled women cope well with the minor traumatic injuries associated with low-pelvic or lift out OVDs, and with good communication skills, the birth can closely mimic a spontaneous vaginal birth. The difficulty arises when significant pelvic floor morbidity, infection, haemorrhage and incontinence or poor neonatal condition at birth and disability ensue. A core outcome set (COS) for comparative research would be very helpful in defining these important outcomes from a clinical, obstetric and patient perspective (mother and baby), and this is currently in development.

Given the marked changes in the epidemiology of childbirth, it is timely to review the place of OVD in modern obstetric practice. An approach that encompasses historical perspectives, global health care needs, maternal and infant morbidity and mortality, training needs in the technical and non-technical aspects of delivery, technological advances including high-fidelity mannequins and portable ultrasound assessment gives a broad understanding of OVD based on research evidence and expert opinion. Sadly, the uncommon tragic adverse birth-related outcomes, particularly those that are deemed preventable, have a powerful influence on how clinical services are configured, and with that in mind, the final review is on medico-legal aspects of OVD.

Conflict of interest statement

None declared.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.bpobgyn.2019.02.003>.

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