MANAGEMENT OF EXCESSIVE UTERINE ACTIVITY

Excessive uterine activity is either: tachysystole or uterine hypertonus without fetal heart rate abnormalities

Uterine hyperstimulation is either tachysystole or uterine hypertonus in the presence of fetal heart rate abnormalities

Tachysystole: more than five active labour contractions in ten minutes

Uterine hypertonus: contractions lasting more than two minutes in duration or contractions occurring within 60 seconds of each

Excessive Uterine Activity in the absence of fetal heart rate abnormalities

Appropriate management includes:

- Notify medical staff and midwife in charge
- continuous cardiotocography (CTG)
- consider reducing or ceasing oxytocin infusion
- maternity staff remain with the woman until normal uterine activity is observed
- tocolysis may be considered

Where associated with Prostaglandins

- tocolysis may be considered
- Change maternal position Commence or continue CTG
- Notify midwife in charge and ask for medical review
- IV access

Where associated with Oxytocin Infusion

- Change maternal position
- Increase IV fluids
- Continuous CTG Decrease oxytocin infusion to previous rate
- Monitor uterine activity and fetal heart rate
- Notify midwife in charge and ask for medical review
- If no change in hyperstimulation after 20 minutes halve infusion rate

Where the uterine activity and CTG becomes normal after a period of 30 minutes cautiously maintain/continue oxytocin infusion

Uterine Hyperstimulation in the presence of fetal heart abnormalities

Appropriate management of uterine hyperstimulation includes:

- Notify medical staff and midwife in charge
- continuous cardiotocography (CTG)
- reducing or ceasing oxytocin infusion
- maternity staff remaining with the woman until normal uterine activity is observed
- consideration of tocolysis
- consideration of urgent delivery

Where associated with Prostaglandins

- Change maternal position
- Continuous CTG monitoring
- Notify midwife in charge and ask for medical review
- Vaginal assessment – ARM if able
- If Cervidil® in situ: remove pessary by pulling the withdrawal tape
- If dinoprostone (PGE2) gel is used, consider manually removing the gel
- Prepare and administer emergency tocolysis
- Consider fetal scalp blood sampling if possible

Where associated with Oxytocin Infusion

- CEASE OXYTOCIN INFUSION
- Change maternal position
- Increase IV fluids
- Notify midwife in charge and ask for medical review
- Vaginal assessment
- Consider fetal scalp blood sampling if possible
- Exclude placental abruption

Where hyperstimulation persists consider:

Emergency tocolysis

- Terbutaline 250 mcg IV or SC (0.5ml) or
- Sublingual GTN spray (Nitrolingunal) 1 metered spray (400ug) administered under the tongue. Repeat after 5 minutes if hyperstimulation continues
- Fetal scalp blood sampling

Consider the need for Emergency caesarean section if:

- fetal compromise persists despite emergency treatment
- fetal Scalp Lactate >4.7mmol/l