VII CONGRESSO CATARINENSE DE OBSTETRÍCIA E GINECOLOGIA

II Congresso Catarinense de Perinatologia

25 a 27 de junho de 2015 | Expoville | Joinville | SC

Pablo de Queiroz Santos

Declaração de conflito de interesse

Não recebi qualquer forma de pagamento ou auxílio financeiro de entidade pública ou privada para pesquisa ou desenvolvimento de método diagnóstico ou terapêutico ou ainda, tenho qualquer relação comercial com a indústria farmacêutica

Experiências em Humanização: sala de parto

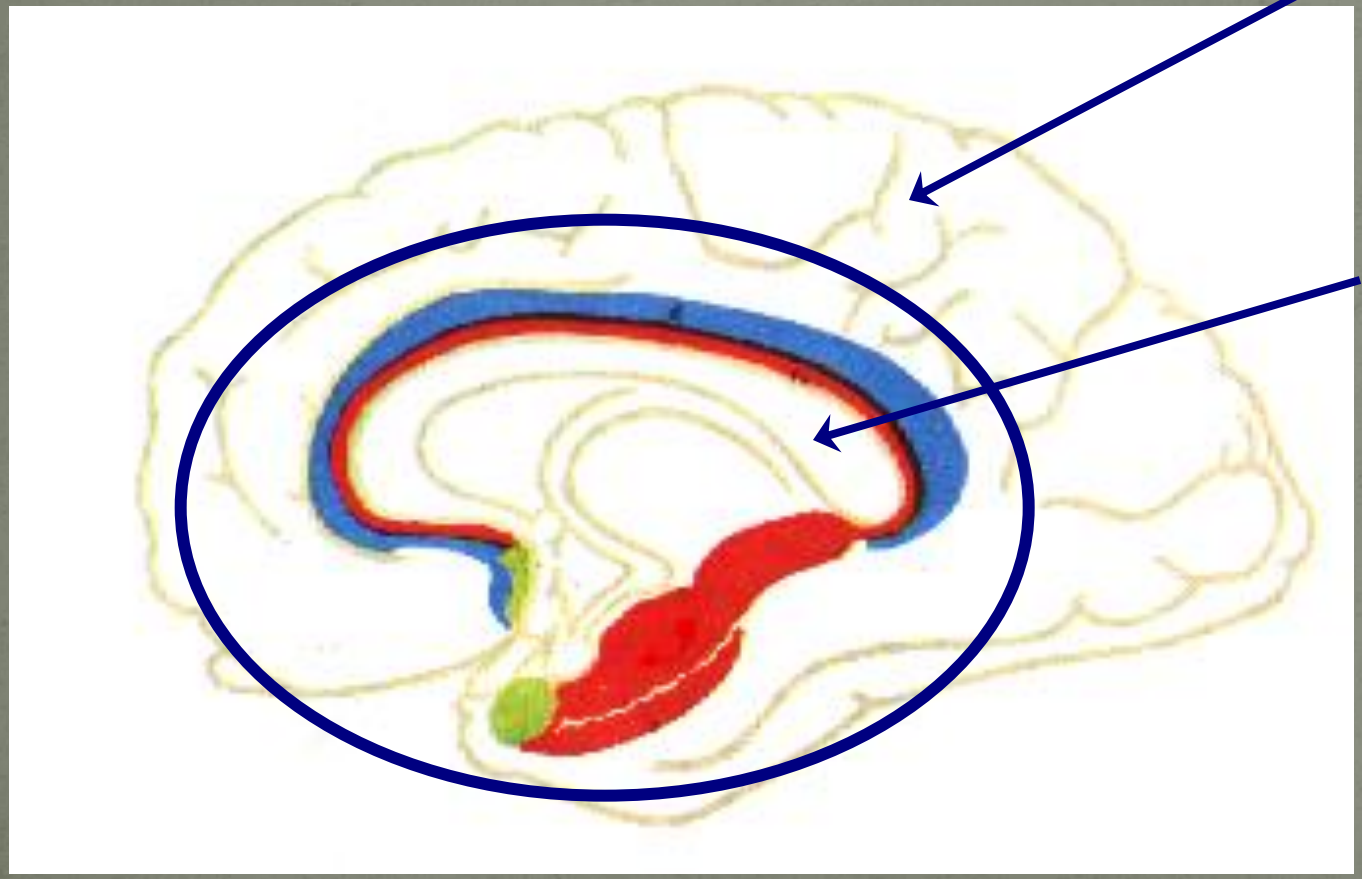
Dr. Pablo de Queiroz Santos

Hospital Universitário – UFSC

ALSO (Advanced Life Support in Obstetrics)

Sistema Nervoso Central

Fisiologia



Psicofisiologia e parturição

Ocitocina x Adrenalina

Psicofisiologia e parturição

- Sentir-se segura
- Não se sentir observada
- Temperatura adequada

Assistência no 1° período

- Admissão
  - Fase ativa do trabalho de parto
  - Admissão precoce → intervenção

Uso rotineiro de enema glicerinado

.Reveiz L, Gaitán HG, Cuervo LG. Enemas during labour. Cochrane Database Syst Rev 2013; 7:CD000330.

Uso rotineiro de tricotomia

Basevi V, Lavender T. Routine perineal shaving on admission in labour. Cochrane Database Syst Rev 2014; 11:CD001236.

Dieta

Singata M, Tranmer J, Gyte GM. Restricting oral fluid and food intake during labour. Cochrane Database Syst Rev 2013; 8:CD003930.

Deambulação / Posição vertical

- Reduz duração do trabalho de parto (1h 22m)
  - -1.36, IC95% -2.22 a -0.51
- Diminui uso de analgesia
  - RR 0.81, IC95% 0.66 a 0.99
- Reduz taxa de cesárea
  - RR 0.71, IC95% 0.54 a 0.94
- Diminui admissão em UTI neonatal
  - RR 0.20, IC95% 0.04 a 0.89

Lawrence, A, Lewis, L, Hofmeyr, GJ, et al. Maternal positions and mobility during first stage labour. Cochrane Database Syst Rev 2013

Deambulação / Posição vertical

Suporte emocional contínuo (Doula / familiar)

- ↑ Parto espontâneo

RR 1.08, IC95% 1.04 a 1.12

- ↓ Analgesia intraparto

RR 0.90, IC95% 0.84 a 0.97

- ↓ Insatisfação

RR 0.69, IC95% 0.59 a 0.79

- ↓ Duração do T.P.

Mean difference -0.58 hours, IC95% -0.86 a -0.30

- ↓ Parto Cesárea

RR 0.79, IC95% 0.67 a 0.92

- ↓ Parto vaginal assistido

RR 0.90, IC95% 0.84 a 0.96

- ↓ Apgar 5º min <7

RR 0.70, IC95% 0.50 a 0.96

Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database Syst Rev 2013

Immersion in water in labour and birth

Cluett Elizabeth R, Burns Ethel

Cochrane Database of Systematic Reviews, April 2009

Imersão em água

- Reduz uso de analgesia
  - OR 0.82, IC95% 0.70 a 0.98
- Reduz duração 1º estágio TP
  - -32.4 min, IC95% -58.7 a -6.1 min

- Não altera resultado neonatal, infecção, trauma perineal, taxa de cesárea ou parto vaginal assistido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IMMERSION IN WATER DURING LABOUR AND BIRTH

Royal College of Obstetricians and Gynaecologists/Royal College of Midwives Joint statement No.1

Summary

1 Both the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives support labouring in water for healthy women with uncomplicated pregnancies. The evidence to support underwater birth is less clear but complications are seemingly rare. If good practice guidelines are followed in relation to infection control, management of cord rupture and strict adherence to eligibility criteria, these complications should be further reduced.

ACOG

- 1º estágio:
  - Reduz duração do trabalho
  - Reduz uso de analgesia
  - Seguro
- 2º estágio:
  - Ainda carece de maiores estudos
  - Relatos de casos adversos
  - Dever ser considerado experimental

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

COMMITTEE OPINION

Number 594 • April 2014

Committee on Obstetric Practice
American Academy of Pediatrics

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Immersion in Water During Labor and Delivery

ABSTRACT: Immersion in water has been suggested as a beneficial alternative for labor, or delivery, or both and over the past decades has gained popularity in many parts of world. Immersion in water during the first stage of labor may be associated with decreased pain or use of anesthesia and decreased duration of labor. However, there is no evidence that immersion in water during the first stage of labor otherwise improves perinatal outcomes, and it should not prevent or inhibit other elements of care. The safety and efficacy of immersion in water during the second stage of labor have not been established, and immersion in water during the second stage of labor has not been associated with maternal or fetal benefit. Given these facts and case reports of rare but serious adverse effects in the newborn, the practice of immersion in the second stage of labor (underwater delivery) should be considered an experimental procedure that only should be performed within the context of an appropriately designed clinical trial with informed consent. Facilities that plan to offer immersion in the first stage of labor need to establish rigorous protocols for candidate selection, maintenance and cleaning of tubs and immersion pools, infection control procedures, monitoring of mothers and fetuses at appropriate intervals while immersed, and immediately and safely moving women out of the tubs if maternal or fetal concerns develop.

Immersion in water has been suggested as a beneficial alternative for labor, or delivery, or both and over the past decades has gained popularity in many parts of world (1–4). Approximately 1% of births in the United Kingdom include at least a period of immersion (5), and a 2006 joint statement from the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives supported immersion in water during labor for healthy women with uncomplicated pregnancies and stated that to achieve best practice with water birth, it is necessary for organizations to provide systems and structure to support this service (6). The prevalence of this practice in the United States is unknown because such data are not collected as part of vital statistics. A 2001 survey found that at least 143 U.S. birthing centers offered immersion in water during labor, or delivery, or both (7). A 2005 commentary by the Committee on Fetus and Newborn of the American Academy of Pediatrics did not endorse underwater birth (8). This Committee Opinion reviews the literature concerning the reported risks and benefits of immersion in water during labor and delivery.

Evidence Regarding Immersion in Water During Labor and Delivery

Before examining available evidence concerning immersion during childbirth, it is important to recognize limitations of studies and evidence in this area. Most published literature that recommend underwater births are retrospective reviews of a single center experience, observational studies using historical controls, or personal opinions and testimonials, often in publications that are not peer reviewed (1–3, 9–11). Also of importance, there are no basic science studies in animals or humans to confirm the physiologic mechanisms proposed to underlie the reported benefits of underwater births.

Other issues, in addition to the nature and design of studies, complicate the interpretation of the published findings, including the absence of a uniform definition of the exposure itself. Often, immersion is referred to as "underwater birth," but effects and outcomes may be different for immersion during the first stage and second stage of labor. This document, accordingly, avoids the

MFE Contínua – baixo risco

- Intervensões por traçados anormais quando comparados à ausculta intermitente
  - 63% taxa de cesarea
  - 15% parto vaginal assistido

- Não melhora resultado neonatal

National Institute for Health and Care Excellence (NICE) 2014

FIGO 2015

Assistência no 1° período

- Amniotomia de rotina
  - Não reduz duração TP
    - -20min IC95% -96 a +55 min
  - Sem diferença na taxa de cesárea
    - RR 1.27, IC95% 0.99 a 1.63
  - Sem diferença no Apgar 5º min <7
    - RR 0.53, IC95% 0.28 a 1.00

Smyth RM, Markham C, Dowswell T. Amniotomy for shortening spontaneous labour. Cochrane Database Syst Rev 2013

Assistência ao 2° período

- Posição materna
  - Semi-sentada
  - Sims
  - Cócoras
  - Genupeitoral
  - Litotomia
  - Ortostática

Assistência ao 2° período

- Ação da gravidade

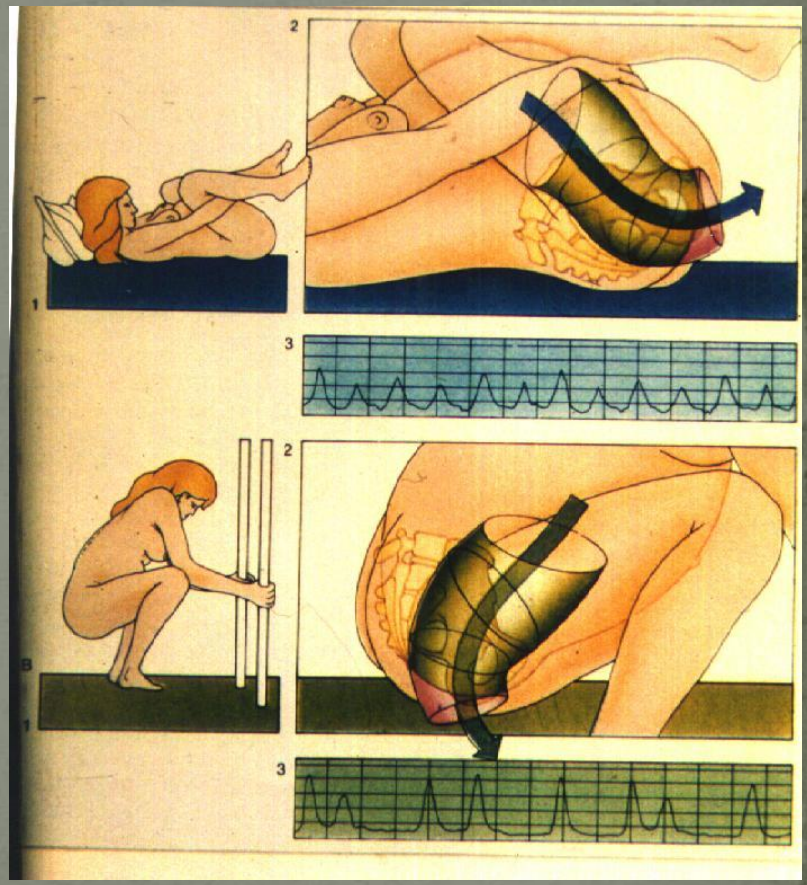
  Howard 1958, Mendez-Bauer 1975, Russel 1982, Sabatino 1997

- Menor risco de compressão dos grandes vasos maternos

  Scott 1974, Sabatino 1984, Sabatino 1997,

- Melhora do equilíbrio ácido básico materno

  Ang 1969



Assistência ao 2° período

- Ação da gravidade

  Howard 1958, Mendez-Bauer 1975, Russel 1982, Sabatino 1997

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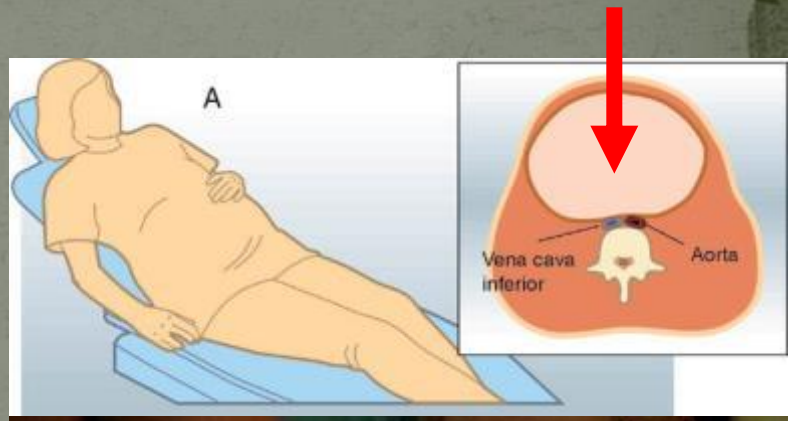

Assistência ao 2° período

- Melhora da função pulmonar materna
  Ang 1969, Gallo 1992
- Contrações uterinas mais fortes e eficientes
  Caldeyro-Barcia 1960, Mendez-Bauer 1975, Sabatino 1984
- Menores pressões intravaginais
  Sabatino 1995

Tabela IV - Período de expulsão

	Deitada	Sentada	P
M C V (1)	2,71 + 0,35	3,14 + 0,34	p = 0,006
V E F1 (1)	2,22 + 0,23	2,66 + 0,30	p = 0,0001
I T	82,17 + 6,29	84,79 + 4,78	N S
M V V (1/M)	66,17 + 6,99	79,42 + 9,01	p = 0,001
M F E (1/S)	4,36 + 0,46	5,32 + 0,94	p = 0,004
F E F (1/M)	3,57 + 0,47	4,23 + 0,58	p = 0,005
F M F 25-75 (1/S)	2,60 + 0,45	3,27 + 0,38	p = 0,001
F M F T (S)	0,55 + 0,13	0,49 + 0,08	N S

Assistência ao 2° período

- Melhora da função pulmonar materna
  Ang 1969, Gallo 1992
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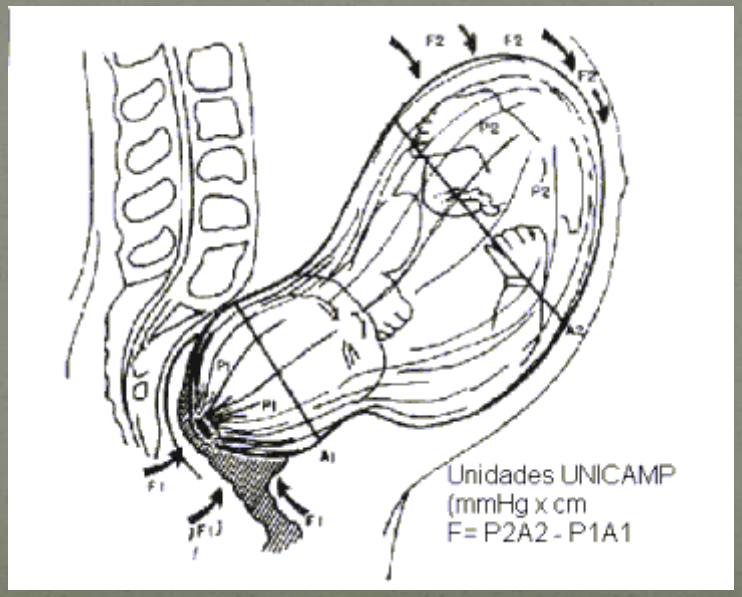
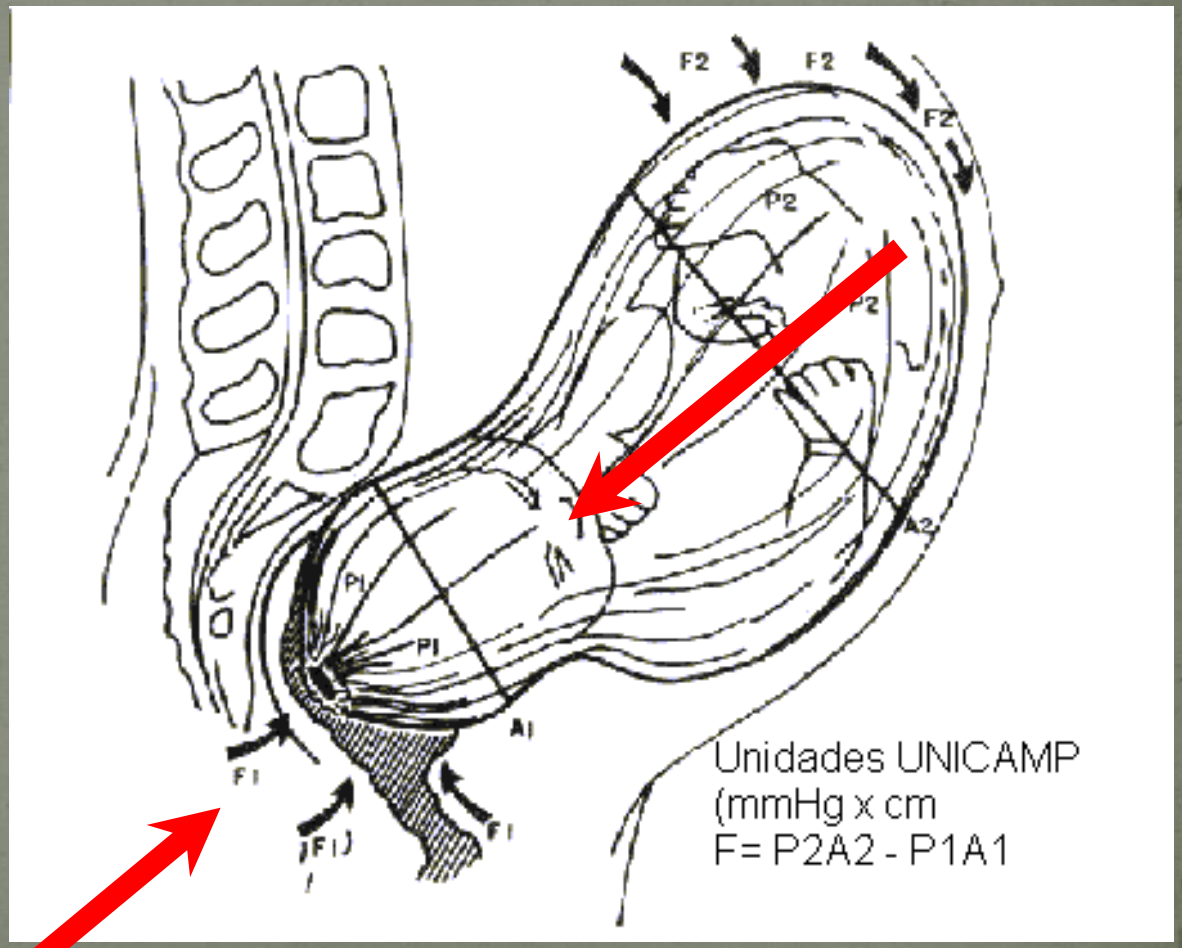


Assistência ao 2° período

Unidades
UNICAMP

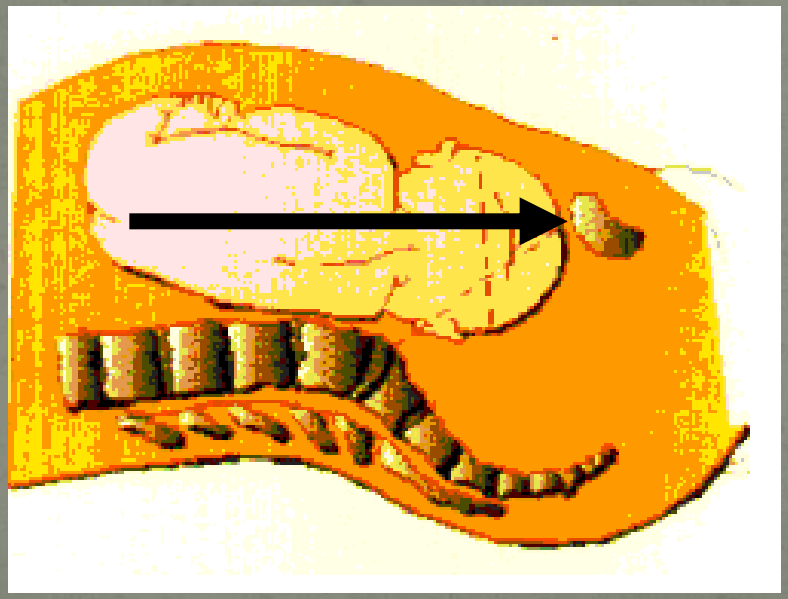
Sabatino 1996



Assistência ao 2° período

- Melhora do ângulo de encaixe (*drive angle*)

  Sabatino 1997, Gold 1950

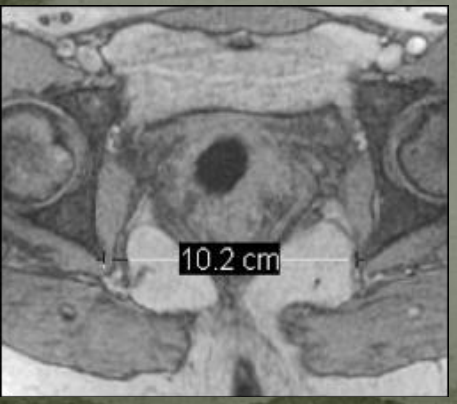


Assistência ao 2° período

- Aumento do diâmetro antero-posterior e transverso da pelve, resultando em um diâmetro total maior.

  Borell 1957, Russell 1969, Russel 1982, Lilford 1989, Gupta 1991, Michel 2002.

Horizontal



Vertical

Horizontal

Vertical

Assistência ao 2° período

- Diminuição parto vaginal assistido

  RR 0.78; IC95% 0.68 a 0.90
- Redução episiotomia

  RR 0.79, IC95% 0.70 a 0.90
- Diminuição padrões alterados de BCF

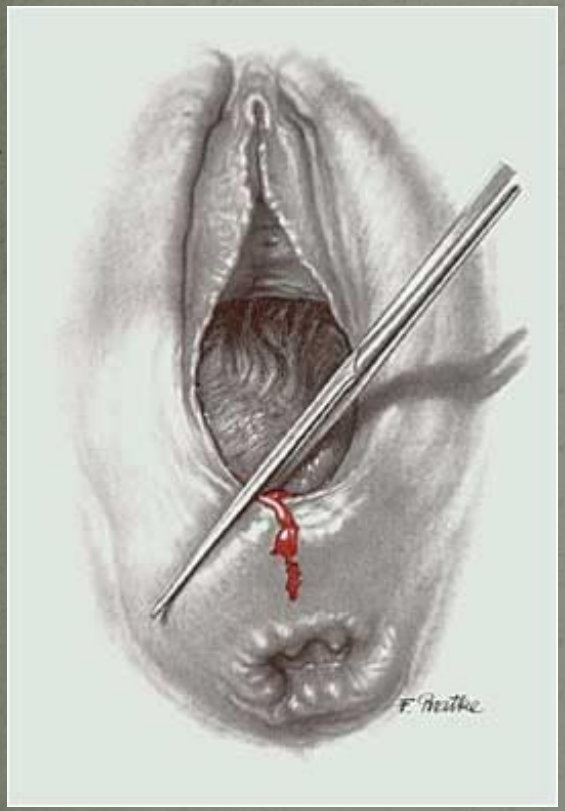
  RR 0.46; IC95% 0.22 a 0.93
- Aumento perda sanguínea >500ml

  RR 1.65; IC95% 1.32 a 2.60

Gupta JK, Hofmeyr GJ, Shehmar M. Position in the second stage of labour for women without epidural anaesthesia. Cochrane Database Syst Rev 2012;

Assistência ao 2° período

Episiotomia



Rotina

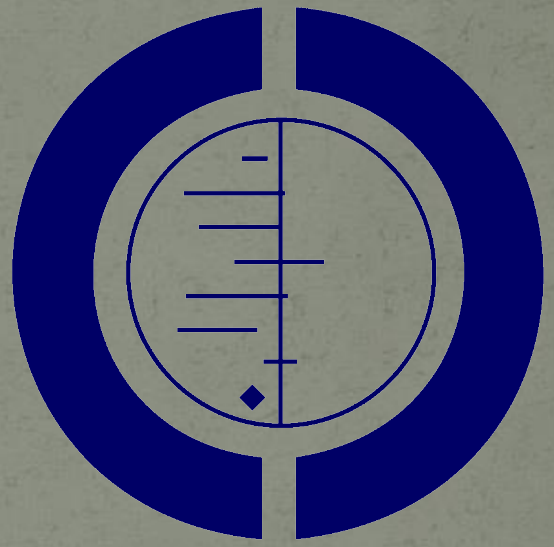
X

Seletiva

Foto:
www.pinterest.com/pin/462181980479518041

Revisão sistemática

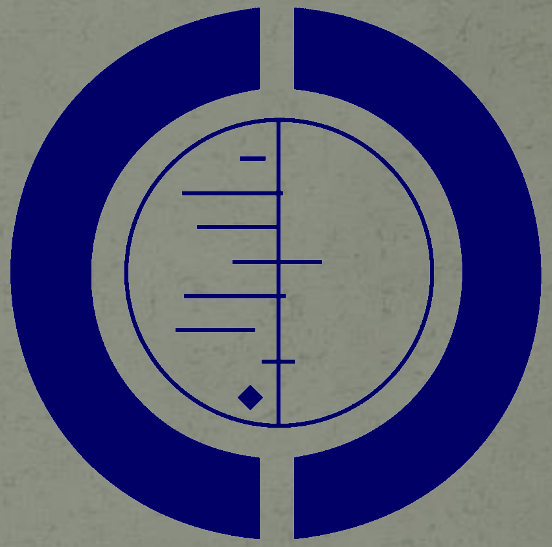
- Episiotomia seletiva:
  - Laceração perineal grave
    0.67 [0.49, 0.91]
  - Qualquer laceração posterior
    0.88 [0.84, 0.92]
  - Laceração com sutura
    0.71 [0.61, 0.81]
  - **Laceração anterior**
    1.84 [1.61, 2.10]



Carroli Guillermo, Mignini Luciano. Episiotomy for vaginal birth. Cochrane Database of Systematic Reviews. In: *The Cochrane Library,* Issue 3, 2014

Revisão sistemática

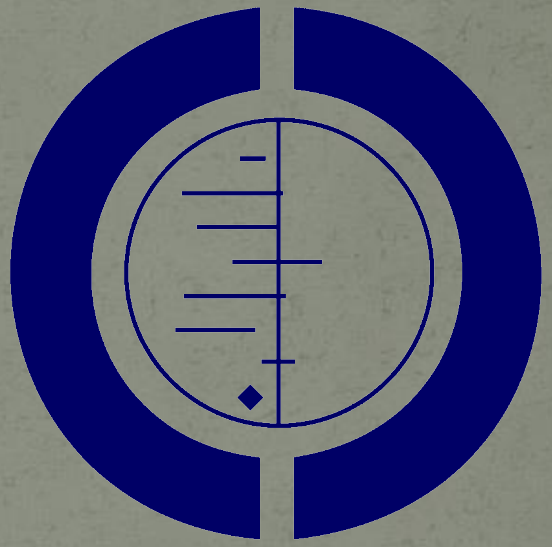
- Episiotomia seletiva:
  - Perda sanguínea
    -58.0 [-107.57, -8.43]
  - Dor perineal na alta
    0.72 [0.65, 0.81]
  - Complicações da cicatriação
    0.69 [0.56, 0.85]
  - Deiscência – 7dias
    0.48 [0.30, 0.75]



Carroli Guillermo, Mignini Luciano. Episiotomy for vaginal birth. Cochrane Database of Systematic Reviews. In: *The Cochrane Library,* Issue 3, 2014.

Revisão sistemática

- Parto vaginal assistido
- Dor perineal – 10 dias
- Dor perineal moderada/severa - 10 dias
- Uso de analgésicos orais – 10 dias
- Dor perineal – 3 meses
- Dor perineal moderada/severa – 3 meses
- Nenhuma tentativa de ter relação sexual em 3 meses
- Dispareunia nos 3 primeiros meses
- Dispareunia – 3 meses
- Algum episódio de dispareunia nos 3 primeiros anos
- Hematoma perineal na alta
- Infecção perineal
- Abaulamento do períneo no 3º mês
- Incontinência urinária - 3 a 7 meses
- Incontinência urinária - 3 anos
- Uso de absorventes para incontinência urinária
- Índice de Apgar <7 no 1º minuto
- Admissão em UTI neonatal



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Carroli Guillermo, Mignini Luciano. Episiotomy for vaginal birth. Cochrane Database of Systematic Reviews. In: *The Cochrane Library,* Issue 3, 2014.

Assistência ao 2° período

- Clampeamento do cordão umbilical (tardio x precoce)
  - Termo
    - ↑ Ht e ferritina (2-6 meses)
    - ↓ Anemia (2-6 meses)
    - Sem diferença no risco de hiperbilirrubinemia grave
    - Aumento necessidade de fototerapia
    - RN saúdavel: Clampeamento antes da respiração espontânea – UTI e óbito
  - Pré-termo
    - ↑ Ht (4h pós-parto)
    - ↓ hemorragia intraventricular
    - ↓ necessidade de transfusão
    - ↓ risco de enterocolite necrotizante
    - Sem diferença na necessidade de tratamento para icterícia

Ersdal HL, Linde J, Mduma E, et al. Neonatal outcome following cord clamping after onset of spontaneous respiration. Pediatrics 2014; 134:265.

McDonald, SJ, Middleton, P. Effect of timing of umbilical cord clamping of term infants on maternal and neonatal outcomes. Cochrane Database Syst Rev 2013; :CD004074.

Rabe, H, Reynolds, G, Diaz-Rossello, J. Early versus delayed umbilical cord clamping in preterm infants. Cochrane Database Syst Rev 2012; :CD003248.

Obrigado

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