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Use of oxytocin after spontaneous onset of labor in France

New guidelines by the French National College of Midwives (CNSF), in collaboration with the French National College of Gynecologists and Obstetricians (CNGOF)

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Introduction
- France had no clinical guideline for oxytocin usage during spontaneous labor
- 58% of French women in spontaneous labor received oxytocin (2010).
- Oxytocin is probably overused due to obsolete definition of normal labor and misuseage
- Oxytocin usage might have serious consequence for mothers and newborns

Objectives
- To define normal and abnormal labor
- To specify the indications, dosage, procedures and effects of oxytocin administration
- To describe the adverse maternal and perinatal effects associated with it

1. Normal and abnormal labor

1st stage of labor (one latent and one active phases)
- No labor dystocia during the latent phase
- Active phase start at 5-6cm of dilation
- Dilation speed should be considered abnormal if:
  - slower than 1 cm/ 4 h before 7cm
  - slower than 1 cm / 2h after 7cm

2nd stage of labor (one descent and one expulsion phases)
- The maximum duration of the descent phase of the second stage of labor cannot be determined from the literature
- But the risk-benefit balance becomes less favorable after 3 hours

2. Oxytocin administration
- Oxytocin should be administered at ruptured membrane in case of labor dystocia or in case of 2nd stage prolonged beyond 2 hours
- Oxytocin should be administered at the minimum effective dose
- Uterine response and fetal heart rate must be taken into account
- Amniotomy should be performed 1h before oxytocin administration
- No routine amniotomy or oxytocin before 5cm of dilation
- Epidural is not a reason for routine oxytocin administration
- Oxytocin administration should be considered as indicator for monitoring quality of care in delivery room

3. Procedure for administration
- Intravenous, using dose flow-rate control equipment
- Oxytocin should be administered at an initial dose of 2mU/min
- The oxytocin dose should be increase by 2mU/min, waiting at least 30min between each increase, until cervical modification or 5 effective uterine contractions / 10min
- Dose should not exceed 20mU/min

4. Maternal and fetal adverse effects
- Oxytocin administration is associated with increased risk of uterine hyperactivity, post-partum hemorrhage, rupture of unscarred uterus, and neonatal acidosis
- We observed no evidence of causal relation with pain, women dissatisfaction with their birth experience, neonatal morbi-mortality (industrialized countries), hypotremia, neonatal jaundice, or autism spectrum disorder.
- Oxytocin perfusion and the condition of its use should be analyzed during morbidity and mortality conferences
