BELIEVE MIDWIFERY SERVICES, LLC

TITLE: LATENT PHASE OF LABOR: DIAGNOSIS AND MANAGEMENT
EFFECTIVE DATE: December 4th, 2015

POLICY STATEMENT
Negotiating the latent phase of labor can result in fatigue, dehydration, and fear. Successfully managing this stage of labor, particularly in the first time mother, may be the most important factor in achieving a successful home birth.

BLOOD BORNE PATHOGEN EXPOSURE CATEGORY: I (Involves exposure to blood, body fluids, or tissues)

FUNCTION: Care of Clients

EQUIPMENT:
1. Doula support and comfort measures

POINTS OF EMPHASIS:
Clinically, the latent phase of labor is poorly understood and hard to define. Its duration can vary so greatly that a normal range is difficult to measure. Labor frequently does not have a discrete beginning, thus determining the time on onset is a source of frustration for researchers and clinicians. Some question if in fact, a distinct latent phase exists.

The concept of the latent phase has great significance in understanding normal labor because labor is considerably longer when a latent phase is included.

Although most clinicians currently use 4 centimeters cervical dilation as the end of latent phase, individual differences exist in the exact dilation at which women enter active labor. Multiparas can remain in the latent phase until 6 centimeters dilation. In fact, many now argue that 6 centimeters is the “new onset of active labor” for all women.

The descriptors of “false” and “true” labor are antiquated and imprecise. The term “false” tends to minimize what the woman has been experiencing, when in fact what she is experiencing is a gradual physiologic changes that the uterus and cervix undergo in preparation for labor. Clear distinctions between prelabor and labor contractions may not be easily identifiable. One study found that women in prelabor actually experienced greater discomfort on the somatic symptom scale than did women in labor.

Approximately 5% to 6.5% of women are given the diagnosis of prolonged latent phase of labor. Because no current diagnostic guidelines for prolonged latent phase exist, most clinicians continue to use Friedman’s original definition from 50 years ago. Friedman identified prolonged latent phase as greater than or equal to 20 hours in nulliparas and 14 hours in multiparas.

More current studies demonstrate labors to be significantly longer than those defined for the Friedman studies. Albers et al (1996) demonstrated natural, non-interventive labors for nulliparas mothers at 17.5 hours long and 13.8 hours for multiparas. The statistical limits for second stage were more alike, at 1.75 hours for nulliparas and 1 hours for multiparas in Friedman’s data, and 2.5 hours and 1 hours, respectively, in Albers (1996) study. Most importantly, the greater time in labor in the Albers study, all attended by nurse-midwives, was not associated with increased morbidity for mother or infant. Morbidity measures assumed to be a function of prolonged labors, may therefore be linked with the care measures that often accompany long labors (multiple vaginal examinations, oxytocin, epidurals, assisted delivery), and not necessarily caused by the time in labor.
Postpartum hemorrhage and chorioamnionitis were more frequent in women who had longer latent phases, but there was no increase in transfusion, cesarean hysterectomy, or neonatal sepsis. Patience is reasonable if maternal and fetal condition do not necessitate immediate intervention.

Recent studies of current intrapartum populations have found that half of all nulliparous women with spontaneous labor consent receive exogenous oxytocin augmentation. Moreover, cesarean rates following early labor admission are more than twice as high as reference group rates. Interestingly as well, among studies reporting specific surgical indications, the incidence of cesarean for dystocia was higher in earlier admission groups. The evidence is clear that admitting women in more advanced labor to the hospital is associated with decreased oxytocin use and increased rates of vaginal birth (Neal, Lamp, Buck, Lowe, Gillespie, & Ryan, 2014).

PROCEDURE:

1. The latent phase of labor commences with the onset of regular contractions and ends when the rate of cervical dilation begins to accelerate; this concomitantly signals the beginning of the active phase of labor.
2. The latent phase of labor should be discussed with women prenatally.
3. Caregivers should ask women when their labor started and how they knew, rather than when regular contractions began.
4. Clinically, it is more important to recognize when active phase has not yet started. The mistaken diagnosis of active phase of labor may result in unnecessary consequences, such as mental exhaustion, artificial rupture of membranes in effort to augment labor, transfer of care for administration of oxytocics or operative birth for abnormal labor progress, when in fact, the women is still in latent phase labor.
5. In summary, the latent phase starts with maternal perception of labor onset, not necessarily regular contractions; it is accompanied by progressive, albeit slow, cervical dilation; and it usually ends between 3 cm to 6 cm cervical dilation. This time should be recorded by the midwife on the Labor & Birth Summary as the initiation of labor.
6. The diagnosis of labor can only be made in retrospect after serial vaginal examinations detect progressive cervical dilation. To help determine if the woman is in labor, the clinician may encourage the woman to walk for a couple of hours and then have a repeat cervical examination. This procedure is not fool-proof, because cervical change in latent phase occurs slowly and may not be recognizable during the re-evaluation process.
7. The responsibility of the woman to identify labor onset through the imprecise and unreliable method of detecting a change in contraction pattern can contribute to the woman’s mental and emotional workload in the latent phase of labor.
8. Women in prelabor or latent phase of labor should be offered education, encouragement, support, and advice on an outpatient basis. Monitoring of the midwife in the home is not necessary, and in fact, may stall progression and/or lead to transport to the hospital both because of maternal exhaustion (whether physical or mental) and intervention by the provider.
9. The clinician’s goal should be to delay arriving in the client’s home until active phase of labor has commenced. Rather, if assessment is necessary, the midwife would be encouraged to invite the client into the clinic setting.
10. If the mother is doing well and there is reassuring fetal status, she should be encouraged to continue her normal daily activities, maintain hydration, eat small frequent meals, and notify the midwife if she perceives a change in labor status or the membranes rupture.
11. It may be helpful to specify a specific time for re-evaluation, so the woman does not feel abandoned or ignored. This may help allay some of her anxiety.
12. Suggesting a number of management alternatives provides the woman with choices and some control over the situation. While she implements the suggestions, valuable time is gained, allowing for progression into active phase.
13. Obstetric intervention should be based on maternal and fetal condition rather than the length of the latent phase.

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<tr>
<th>Management Alternatives for Latent Phase of Labor</th>
<th>Possible Labor Effect</th>
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<tr>
<td>Treatment</td>
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<td>Management Alternatives for Latent Phase of Labor</td>
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<tr>
<td>Ambulation/activity</td>
<td>Activities that are relaxing may help decrease the perception of pain. Walking has not been shown to enhance or impair progress in labor but it is not harmful, and mobility may result in greater ability to tolerate labor.</td>
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<td>Bathing</td>
<td>A tub bath may provide relief from prelabor, whereas a hot shower may stimulate contractions because of the upright posture and some degree of nipple stimulation. A tub bath could slow labor progress if the woman enters the bath before active labor or stays in the tub for more than 1 or 2 hours.</td>
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<td>Hydration</td>
<td>Correcting dehydration may help decrease or stop prelabor contractions theoretically by increasing uterine blood flow and by decreasing pituitary secretion of antidiuretic hormone and oxytocin.</td>
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<td>Alimentation</td>
<td>Exactly how eating influences labor duration is still unclear. However, lack of nutrients can deplete the uterus, mother and fetus of energy to sustain active labor.</td>
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<td>Support</td>
<td>Communication; involving the support person in comfort measures; remaining with the woman who may be anxious; keeping the woman informed of the baby’s status; individualizing care; and considering sending friends and family away; taking the phone off the hook to decrease the pressure to perform may increase the woman's coping ability and provide her reassurance.</td>
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<td>Nipple Stimulation</td>
<td>Breast stimulation causes the uterus to contract, though the mechanism remains unclear. It may increase levels of the hormone oxytocin, which stimulates contractions. Breast stimulation is more effective in stimulating labor if the cervix is ripe. Because it may cause uterine hyperstimulation, it should not be used in high-risk women.</td>
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<td>Membrane Sweeping</td>
<td>Sweeping, or stripping, of the membranes has the potential to initiate labor by increasing local production of prostaglandins. The available data suggest that sweeping of the membranes promotes the onset of labor and decreases use of other methods of induction of labor. There is no evidence that it increases the risk of maternal or neonatal infection or of premature rupture of membranes. The procedure does cause discomfort, some bleeding, and irregular contractions, and should be performed only with the woman’s informed consent.</td>
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<td>Sexual Intercourse</td>
<td>Semen contains prostaglandins, which may help to ripen the cervix and induce labor. There is not enough evidence to determine whether sexual intercourse is effective in stimulating labor.</td>
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<td>Castor oil and enemas</td>
<td>Insufficient evidence exists to make any conclusions regarding the effectiveness of these methods as induction agents. As well, this is less than pleasant for the mother. A plethora of other alternative options for induction of labor exist that might be more appropriate options.</td>
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<td>Small glass of wine</td>
<td>Ethanol was used as a tocolytic in the late 1960s. Its mechanism of action may be to inhibit the secretion of oxytocin by the posterior pituitary and thereby inhibit contractions. A small glass of wine may provide the woman with needed rest and stop or decrease prelabor contractions. Ethanol passes readily through the placenta and is less easily eliminated in the newborn. Ethanol causes the same fetal effects that are associated with opioid analgesics like morphine, which are used for therapeutic rest.</td>
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12. Indication to intervene in prolonged latent phase of labor is required when there is a maternal or fetal indication for expediting the birth, when outpatient management options have failed, or at the woman’s request, without regard to arbitrary time parameters.

13. Management involves either stimulation of uterine contractions or rest, and is based on the physical and emotional condition of the mother (degree of fatigue, coping ability, support system, and cervical status) and the well-being of the fetus.

14. The management of prolonged latent phase is controversial with some authorities believing that prolonged latent phase of labor is related to an underlying labor abnormality and should be managed with oxytocin, whereas others recommend a more conservative approach with therapeutic rest. These two management options lack randomized controlled trials supporting their use. Studies have not shown either option to be clearly superior, so either treatment is acceptable, providing that the woman understands the risks and is involved in developing the management plan.

15. The risk associated with therapeutic rest is that it may prolong dysfunctional labor; however, augmentation may unwittingly induce labor if the woman is in prelabor, and is associated with a higher risk of cesarean birth.

**Outpatient Medications for Therapeutic Rest**

1. Therapeutic rest involves administration of medication to relieve discomfort and allow for progression of labor while the woman rests or sleeps. The medications listed below have been used in outpatient settings during latent phase, but their effectiveness has never been studied.
   a. Hydroxyzine (Vistaril) 50-100 mg (PO or IM); has anti-anxiety and sedative properties. Maternal sedation is achieved without significant maternal or newborn side effects.
   b. Diphenhydramine (Benedryl) 50 mg PO or IM; hypnotic and may help with rest.
   c. Zolpidem (Ambien) 5-10 mg PO; hypnotic that may help with rest.

2. The medications are taken once and is not combined with other drugs. If the woman returns with contractions and remains exhausted, other treatment options should be considered.

3. Nembutal and Seconal, while once popular, are contraindicated because of their anti-analgesic effects in the mother and prolonged depressant effects in the neonate. They freely cross the placenta, and because the half-life of barbiturates is quite long, the newborn’s attention span may be depressed for upward of 4 days. They have no known antagonist (Gabbe, Niebyl, Simpson, 2002).

4. Therapeutic rest with morphine is reserved for in-patient management.

**Amniotomy**

1. There is some debate about the use of amniotomy in early labor. A Cochrane review found that amniotomy is effective in shortening the duration of labor by an average of 60 to 120 minutes, and appears to reduce the frequency of oxytocin augmentation.

2. However, there is a trend toward an increase in cesarean sections for fetal heart rate abnormalities, which suggests that this intervention should be reserved for women with abnormal labor progress.

**REFERENCES:**


**Originated:** July, 2011

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**updated**

**12/4/2015**
Holly Hopkins MSN, CNM  
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