

Information for you

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An assisted vaginal birth (ventouse or forceps)

About this information

This information is for you if you wish to know more about assisted vaginal birth (operative vaginal delivery). An assisted vaginal birth is where a doctor or midwife uses specially designed instruments to help deliver the baby during the last part of labour.

Why might I need help with the birth of my baby?

There are several reasons. The main ones are:

- your baby is not moving out of the birth canal as would normally be expected
- there are concerns about your baby's wellbeing during birth
- you are unable to, or have been advised not to, push during birth.

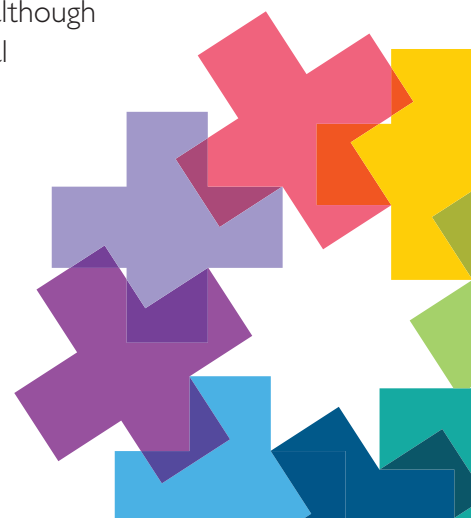
The purpose of an assisted vaginal birth is to mimic a normal (spontaneous) birth with minimum risk to you and your baby. To do this, an obstetrician or midwife uses instruments (ventouse or forceps) to help your baby to be born.

How common is an assisted vaginal birth?

Overall about 1 in 8 (12%) of births in the UK will be an assisted vaginal birth, although an assisted vaginal birth is much less common in women who have had a vaginal birth before.

Can I avoid an assisted vaginal birth?

Women who have continuous support during labour are less likely to need an assisted vaginal birth, particularly if the support comes from someone you know as well as a midwife. You should have someone you know and trust with you during labour if you can.



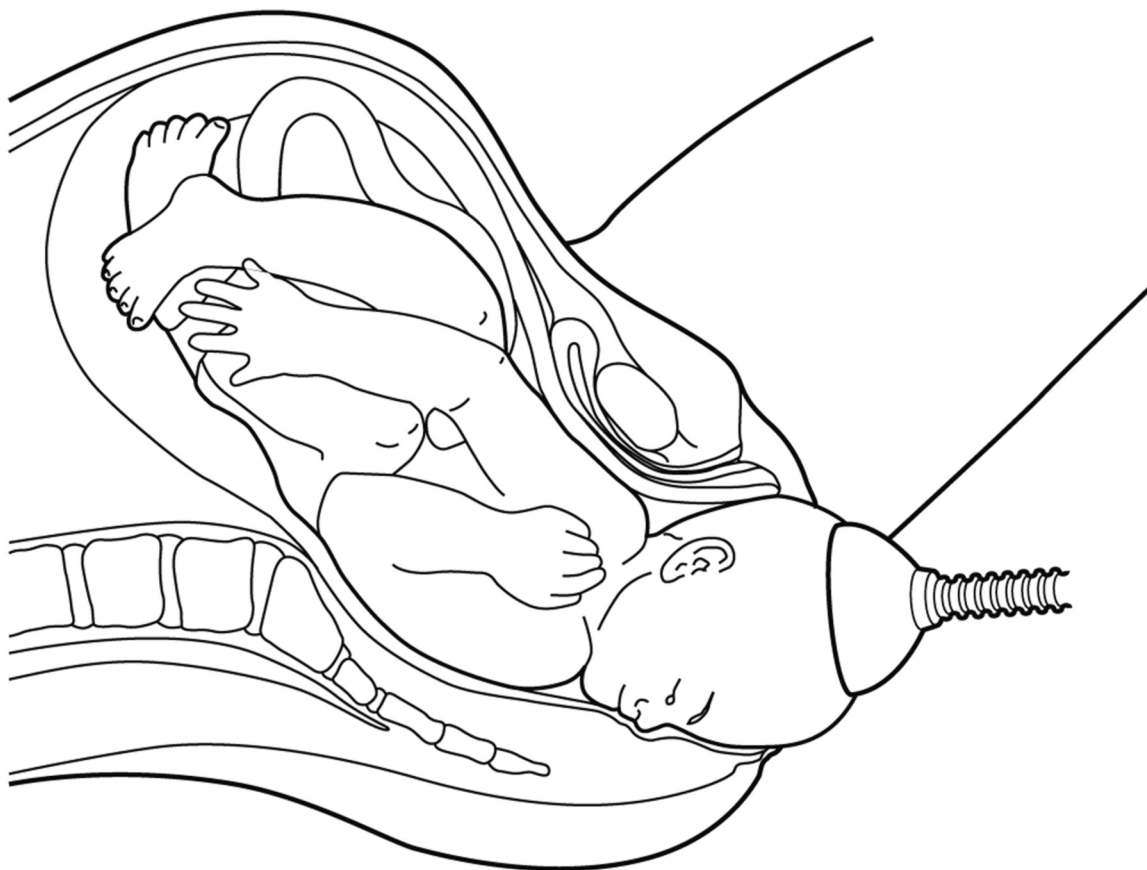
Using upright positions or lying on your side as well as avoiding epidural pain relief can also reduce the need for an assisted birth.

If this is your first baby and you have an epidural, the need for an assisted birth can be reduced by waiting until you have a strong urge to push or by delaying when you start pushing. The length of time that you delay pushing will depend on your individual situation and your wishes, but is usually 1–2 hours after the cervix (neck of your womb) is fully open. Your midwife will guide you at the time. Starting a hormone drip may also reduce the need for an assisted vaginal birth.

An assisted vaginal birth and the ways to reduce the need for such a birth should be discussed with you during your pregnancy.

What is a ventouse birth?

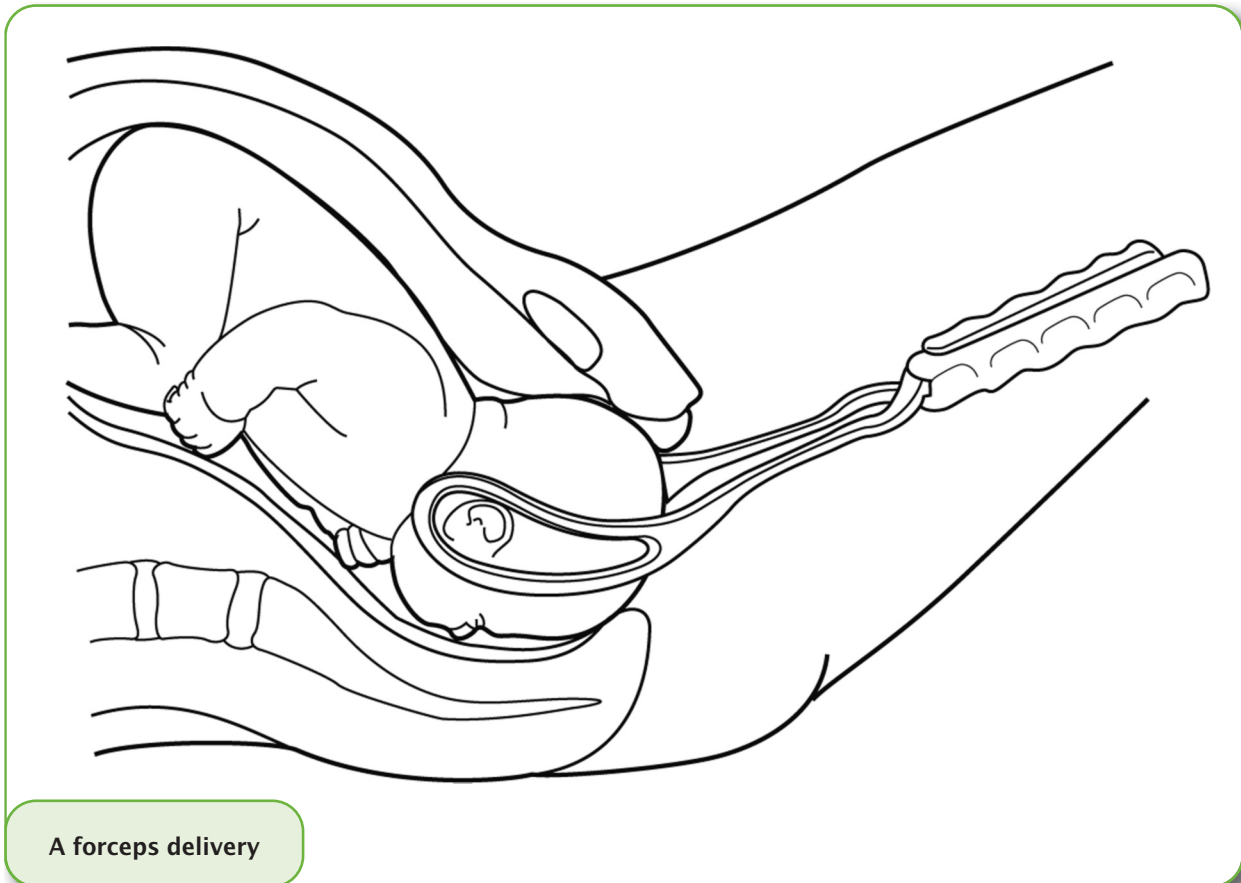
A ventouse (vacuum extractor) is an instrument that uses suction to attach a soft or hard plastic or metal cup on to your baby's head. The obstetrician or midwife will wait until you are having a contraction and then ask you to push while he/she gently pulls to help deliver your baby. More than one pull is often required.



A ventouse delivery

What is a forceps birth?

Forceps are smooth metal instruments that look like large spoons or tongs. They are curved to fit around your baby's head. The forceps are carefully positioned around your baby's head. The obstetrician will wait until you are having a contraction and then ask you to push while he/she gently pulls to help deliver your baby. More than one pull is often required.



Will I be asked for consent?

Forceps and ventouse will only be used to deliver your baby if they are the safest method of delivery for you and your baby. The reasons for having an assisted birth, the choice of instrument and the procedure of assisted birth should be explained to you by your obstetrician or midwife.

The risks to you and your baby of an assisted birth will be discussed with you. Your verbal consent will be obtained before delivering your baby. If your delivery is carried out in the operating theatre, your written consent will be obtained.

What happens during a forceps or ventouse assisted birth?

Before your baby is delivered with forceps or ventouse, your obstetrician or midwife will examine your tummy and perform an internal examination to confirm that an assisted delivery is appropriate for you. Your bladder will be emptied by passing a small tube (catheter) into it.

Pain relief for the delivery may be either a local anaesthetic injection inside the vagina (pudendal block) or a regional anaesthetic injection given into the space around the nerves in your back (an epidural or a spinal). If your baby's head is lying in a way that will need turning, you are likely to be advised to have an epidural or spinal for pain relief during the birth.

You may need to have a cut (episiotomy) to enlarge the vaginal opening and allow the baby to be born, although this is not always the case, particularly if you've had a baby before. If you do not have an epidural, the entrance to the vagina will be numbed with local anaesthetic.

Ventouse or forceps delivery – which one?

Ventouse and forceps are both safe and effective. There are many different types of ventouse and forceps, some of which are specifically designed to turn the baby round, for example if your baby has its back to your back in the late stage of labour. Forceps are more successful in delivering the baby, but a ventouse is less likely to cause vaginal tearing. Your obstetrician will choose the type of instrument most suitable for you, your baby and your situation.

The ventouse is not suitable if you are at less than 34 weeks of pregnancy because the baby's head is softer, which can increase the risk of bruising, brain haemorrhage and jaundice.

What makes a ventouse/forceps less likely to be successful?

Assisted vaginal birth is less likely to be successful if:

- you are overweight with a body mass index (BMI) over 30
- your baby is large
- your baby is lying with its back to your back
- your baby's head is not low down in the birth canal.

If your obstetrician is not sure whether your baby can be safely born vaginally, you may be moved to the operating theatre so that you can have a caesarean section if necessary.

If your baby is not born with the help of a ventouse, occasionally your obstetrician may then decide to change to the use of forceps. Depending on your individual circumstances, it may still be necessary for you to have a caesarean section at this stage. An obstetrician will recommend the method that is most appropriate for your situation.

What happens after my baby is born?

A doctor or nurse who specialises in the care of newborn babies may be there when you have your baby, particularly if there have been concerns about his or her wellbeing or if your delivery is carried out in an operating theatre.

What will an assisted vaginal birth mean for me?

Bleeding

It is normal to have bleeding after the birth of a baby. Immediately after an assisted vaginal birth, heavier bleeding is more common. The bleeding in the days afterwards should be similar to a normal birth.

Vaginal tears/episiotomy

If you have a vaginal tear or episiotomy, this will be repaired with dissolvable stitches.

A third- or fourth-degree tear (a vaginal tear which involves the muscle and/or the wall of the anus or rectum) affects 1 in 100 women who have a normal vaginal birth. It is more common following a ventouse delivery, affecting up to 4 in 100 women (4%). It is also more common following a forceps delivery, affecting between 8 and 12 women in every 100 (8–12%). Further information can be found in the RCOG Patient Information: *A third- or fourth-degree tear during childbirth: Information for you* (www.rcog.org.uk/womens-health/clinical-guidance/third-or-fourth-degree-tear-during-childbirth).

Pain relief

Most women experience some discomfort after they have given birth. If you suffer from discomfort after the birth, you should be offered regular pain relief such as paracetamol and diclofenac.

Bowel and bladder care

Problems with moving your bowels or passing urine are common immediately after birth, but the majority of women have no symptoms later on.

Reducing the risk of blood clots

Being pregnant increases the risk of blood clots forming in the veins in your legs and pelvis (deep vein thrombosis). The risk goes up after an assisted birth. You can help matters by being as mobile as you can after delivery. You may be advised to wear special stockings and to have daily injections of heparin, which makes the blood less likely to clot.

What will an assisted birth mean for my baby?

The suction cup used for a ventouse delivery often causes a mark on a baby's head. This is called a chignon (pronounced sheen-yon) and usually disappears within 24–48 hours. The suction cup may also commonly cause a bruise on a baby's head called a cephalohaematoma. This occurs in between 1 and 12 in 100 babies who are born by the ventouse and disappears with time; it rarely causes any problems with babies except for a slight increase in jaundice in the first few days. Forceps marks on the baby's face are very common and usually small, and usually disappear within 24–48 hours. Small cuts on the baby's face or scalp are also common (occurring in 1 in 10 assisted births) and heal quickly.

Will I be able to discuss the birth before I leave hospital?

Yes. Before your discharge from hospital, you should be able to discuss, ideally with the obstetrician or midwife present at your baby's birth, why you needed an assisted birth.

How will I feel after I leave hospital?

After any birth, including an assisted vaginal birth, you may feel a little bruised and sore. The stitches and swelling may make it painful when you go to the toilet. Any stitches will heal within a few weeks. Pain relief will help. You can begin to have sex again when you and your partner both feel that it's the right time for you.

Some women may wish to talk about the emotional impact of their experience of birth after they have gone home. If you would like to talk to someone, your obstetrician or midwife should be able to help. You can also talk to your GP, who can refer you back to your obstetrician.

Will I need an assisted vaginal birth next time?

Having an assisted vaginal birth does not mean you will necessarily have one in your next pregnancy. Most women who have an assisted vaginal birth deliver spontaneously next time round. Even if your assisted vaginal birth was performed in theatre, you have an 80 out of 100 (80%) chance of having a spontaneous birth next time.

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG guideline *Operative Vaginal Delivery* (February 2011). The guideline contains a full list of the sources of evidence we have used. You can find it online at: www.rcog.org.uk/womens-health/clinical-guidance/operative-vaginal-delivery-green-top-26. It is also based on the RCOG Consent Advice II on *Operative Vaginal Delivery* which can also be found online at: www.rcog.org.uk/operative-vaginal-delivery-consent-advice-II.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

The previous version of this information was reviewed before publication by women attending clinics in Frimley and Norfolk.

A glossary of all medical terms is available on the RCOG website at <http://www.rcog.org.uk/womens-health/patient-information/medical-terms-explained>.

A final note

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

All RCOG guidelines are subject to review and both minor and major amendments on an ongoing basis. Please always visit www.rcog.org.uk for the most up-to-date version of this guideline.