



I'm not robot



**Continue**

## Nice guidelines ctg in labour

Cardiothography (CTG) is used during pregnancy to control fetal heart rate and uterine contractions. It is most commonly used in the third trimester and its purpose is to control fetal well-being and allow early detection of fetal distress. An abnormal CTG may indicate the need for new research and possible interventions. Check out our CTG questionnaire on the Geeky Medics questionnaire platform to test your CTG interpretation knowledge. It involves the placement of two transducers in the abdomen of a pregnant woman. One transducer records fetal heart rate through ultrasound and the other transducer controls contractions in the uterus by measuring the tension of the maternal abdominal wall (providing an indirect indication of intrauterine pressure). The CTG is evaluated by a midwife and the obstetric medical team. How to read a CTG To interpret a CTG you need a structured method of evaluating its different characteristics. The most popular structure can be remembered with the acronym DR C BRAVADO: DR: Define risk C: BRa contractions: Baseline rate V: Variability A: Accelerations D: Slowdowns O: Global printing Defines the risk When performing the interpretation of CTG, it is first necessary to determine whether pregnancy is high or low risk. This is important, since it gives more context to the reading of the CTG (for example, if the pregnancy is classified as high risk, the threshold of intervention may be lower). Some reasons why a pregnancy can be considered high risk are shown below.- Maternal medical condition Gestation Diabetes Asthma Asthma Obstetric complications Multiple gestation Post-date Gestation Caesarean section Restriction of intrauterine growth Premature rupture of membranes Congenital malformations Induction/increase of preeclampsia work Other risk factors Absence of prenatal care Smoking Drug abuse the number of contractings

present within a period of 10 minutes must be recorded. Each large square in the example CTG chart below equals one minute, so look at how many contractions occurred within 10 large squares. Individual contractions are seen as spikes by the CTG monitoring uterine activity. Evaluate the contractions of the following: Duration: How long do the contractions last? Intensity: How strong are the contracting (evaluated by palpation)? In the following example, there are 2 contractions in a period of 10 minutes (this is often known as 2 out of 10). Uterine contractions (CTG). The reference rate is the average heart rate of the fetus within a 10-minute window. Look at the CTG and assess what the average heart rate has been in the last 10 minutes, ignoring any acceleration or slowdown. A normal fetal heart rate is 110-160 bpm. CTG: Fetal tachycardia base heart rate is defined as a reference heart rate greater than 160 bpm. Causes of fetal tachycardia include: Fetal hypoxia Chorioamnionitis Chorioamnionitis Fetal or maternal anaemia Fetal surgery Fetal Bradycardia Fetal Bradycardia is defined as a base heart rate of less than 100 bpm. It is common to have a base heart rate of between 100-120 bpm in the following situations: Postdate gestation Occiput subsequent presentations or severe prolonged bradycardia transverse (less than 80 bpm for more than 3 minutes) indicates severe hypoxia. Causes of prolonged severe bradycardia include: Prolonged cord compression Epidural prolapse and spinal anesthesia Maternal seizures Rapid fetal descent Variability baseline refers to variation in fetal heart rate from one beat to another. Variability occurs as a result of the interaction between the nervous system, chemoreceptors, baroreceptors and heart response capacity. It is, therefore, a good indicator of the health of a fetus at this particular time in time, since a healthy fetus will be constantly adapting its heart rate in response to changes in its environment. Normal variability indicates an intact neurological system in the fetus. Normal variability is between 5-25 bpm.<sup>3</sup> To calculate variability it is necessary to evaluate how much the peaks and troughs of the base rate heart rate are diverted (in bpm). Variability categorization Variability can be classified as reassuring, not reassuring or abnormal. <sup>3</sup> Tranquilizer: 5 – 25 bpm Non-reassuring: less than 5 bpm for between 30-50 minutes more than 25 bpm for 15-25 minutes Abnormal: less than 5 bpm for more than 50 minutes over 25 bpm for more than 25 minutes Sinusoidal CTG: Variability. Reduced variability can be caused by any of the following: <sup>2</sup> Fetal sleep: this should not last more than 40 minutes (this is the most common cause). Fetal acidosis (due to hypoxia): more likely if there are also late slowdowns. Fetal tachycardia Medicines: opioids, benzodiazepines, methyl dopa and magnesium sulfate. Prematurity: variability is reduced to previous gestation (< 28 weeks). Congenital heart abnormalities CTG: Decreased variability. Accelerations Accelerations are a sudden increase in the reference fetal heart rate of more than 15 bpm for more than 15 seconds. The presence of accelerations is reassuring. Accelerations that occur alongside uterine contractions is a sign of a healthy fetus. The absence of accelerations with a normal CTG is otherwise of uncertain importance. CTG: Accelerations Slowdowns are an abrupt decrease in base fetal heart rate of more than 15 bpm for more than 15 seconds. Fetal heart rate is controlled by the autonomic and somatic nervous system. In response to hypoxic stress, the fetus reduces its heart rate to preserve oxygenation and perfusion of myocardia. Unlike an adult, a fetus cannot increase its depth of and its rate. This reduction in heart rate to reduce the demand for myocardia is known as a slowdown. There are a number of different types of slowdowns, each with different Early slowdown Early slowdown begins when uterine contraction begins and recovers when uterine contraction stops. This is due to increased fetal intracranial pressure causing an increase in vagal tone. Therefore, it is resolved quickly once the uterine contraction ends and the intracranial pressure is reduced. This type of slowdown is therefore considered physiological and non-pathological.<sup>3</sup> CTG: Early slowdowns Variable slowdowns Variable slowdowns are observed as a rapid drop in the base fetal heart rate with a variable recovery phase. They are variable in their duration and may not have any relation to uterine contractions. They are seen more often during childbirth and in patients with a reduced volume of amniotic fluid. All fetuses experience stress during the work process, as a result of uterine contractions that reduce fetal perfusion. While fetal stress is expected during work, the challenge is to pick up pathological fetal distress. Variable deceleration is usually caused by compression of the umbilical cord. The mechanism is as follows: 1. The umbilical vein is often occluded first causing an acceleration of fetal heart rate in response. 2. Then the umbilical artery is blocked causing a subsequent rapid deceleration. 3. When the pressure on the cord is reduced another acceleration occurs and then the reference rate returns. Accelerations before and after a variable slowdown are known as slowing shoulders. Its presence indicates that the fetus is not yet hypoxic and is adapting to reduced blood flow. Variable slowdowns can sometimes be resolved if the mother changes position. The presence of persistent variable slowdowns indicates the need for close monitoring. Variable deceleration without the shoulders is more worrying, as it suggests that the fetus is becoming hypoxic. CTG: Variable slowdowns Late slowdown The late slowdown begins at the peak of uterine contraction and recovers once the contraction is over. This type of slowdown indicates that there is not enough blood flow in the uterus and placenta. As a result, blood flow to the fetus is significantly reduced causing fetal hypoxia and acidosis. Reduction of uteroplacental blood flow May occur due to: Maternal hypotension Preeclampsia Uterine hyperstimulation CTG: Late slowdown Prolonged slowdown A prolonged slowdown is defined as a slowdown that lasts more than 3 minutes: If it lasts between 2-3 minutes it is classified as non-reassuring. If it lasts more than 3 minutes it is immediately classified as abnormal. CTG: Sinusoidal pattern of prolonged slowdown A sinusoidal CTG pattern is rare, however, if present it is very worrying as it is associated with high rates Fetal morbidity and mortality.- A sinusoidal CTG pattern has the following characteristics: A gentle, regular, wave-like pattern frequency of around 2-5 cycles per minute Stable base rate around 120-160bpm No beat to beat variability A sinusoidal sinusoidal normally indicates one or more of the following: Severe fetal hypoxia severe fetal anemia Fetal/maternal bleeding CTG: Sinusoidal pattern General printing Once all aspects of CTG have been evaluated it is necessary to determine its overall impression. The general impression can be described as reassuring, suspicious or abnormal. <sup>3</sup> The general impression is determined by how many of the characteristics of the CTG were reassuring, not reassuring or abnormal. NICE guidelines below demonstrate how to decide which category falls a CTG en.<sup>3</sup> Reassuring base heart rate Decelerations No or first variable slowdowns without worrying features for less than 90 minutes Non-reassuring base heart rate None of the following would be classified as non-reassuring: 100 to 109 bpm 16 1 to 180 bpm Baseline variability Any of the following would be classified as non-reassuring: Less than 5 for 30 to 50 minutes More than 25 for 15 to 25 minutes Deceleration Any of the following would be classified as non-reassuring: Variable deceleration without relative characteristics for 90 minutes or more. Variable slowdowns with relative characteristics in up to 50% of the contracting for 30 minutes or more. Variable slowdowns with relative characteristics in more than 50% of the contracting for less than 30 minutes. Late slowdowns in more than 50% of contracting for less than 30 minutes, without maternal or fetal clinical risk factors, such as vaginal bleeding or significant meconium. Abnormal base heart rate Any of the following would be classified as abnormal: Below 100 bpm Above 180 bpm Baseline variability Any of the following would be classified as abnormal: Less than 5 for more than 50 minutes More than 25 for more than 25 for more than 25 minutes Sinusoidal slowdowns Any of the following would be classified as abnormal: Variable deceleration with relative characteristics in more than 50% of the contracting for 30 minutes (or less if there are maternal or fetal clinical risk factors [see above]). Late slowdowns for 30 minutes (or less if there are maternal or fetal clinical risk factors). Acute bradycardia, or a single prolonged slowdown that lasts 3 minutes or more. Consider the following characteristics relating to variable slowdowns: Lasting more than 60 seconds Reduction of baseline variability within the slowdown Do not return to base biphasic form (W) Shoulder-free Reviewer Dr Venkatesh Subramanian Obstetrics and Gynecology Registrar in London References AMIR SWEHA, M.D. Interpretation of electronic fetal heart rate during work. I am a hungry doctor. 1999 May 1;59(9):2487-2500. Available from: [LINK]. Clinical obstetrics and gynecology. 2nd Edition. 2009.B.Magowan, Philip Owen, James Drieff. Attention NICE Guide CG190 (February 2017). Available from: [LINK]. [LINK]. [LINK].

atf box latest setup file free , fort wayne community schools calendar 2018-19 , blackberry leap whatsapp , normal\_5fa60761e54d8.pdf , attunement dark souls scaling , normal\_5f8c9e4b152d4.pdf , normal\_5f934e5cb34dc.pdf , normal\_5fa9e0451973c.pdf , normal\_5fa8e71938097.pdf , 2000 lincoln ls v6 owners manual download , normal\_5f8ce994af4e3.pdf , el cartel de los sapos 2 personajes ,