



C-Obs 13

Rotational forceps

Introductory Comments

Reviews of Kielland's forceps have consistently found a place for their use. In comparison to Caesarean section, there is an increased, but small risk of traumatic intracranial haemorrhage and cervical spine injury. It is hard to accurately quantify the true risk but it is likely to compare favourably with the added maternal risks of emergency Caesarean section in the index and subsequent pregnancies. Whilst the ventouse has been popularised over the last decade in many hospitals to effect rotational delivery, it is associated with higher failure rates and an incidence of intracranial and subaponeurotic/subgaleal haemorrhage. Nevertheless, it remains a valid option in experienced hands.

Usually, instrumental rotational delivery is reserved for those fetuses where asphyxia is not a dominant feature. In considering rotational delivery, it is also appropriate to have unsuccessfully first attempted manual rotation prior to proceeding with use of the Kielland's forceps.

Suggested Guidelines in performing rotational forceps delivery

1. Adequate Station

The head should be engaged as determined clinically by BOTH abdominal and vaginal examination under adequate analgesia. Allowance should be made for extensive caput and/or moulding of the fetal head.

2. Adequate analgesia

In most circumstances, rotational forceps delivery will be performed under regional anaesthesia - either epidural/spinal or good pudendal block.

3. Adequate experience or supervision

As with all obstetric interventions, clinicians must receive appropriate training if they are to perform rotational forceps deliveries. Until such training has taken place, rotational forceps should only be performed under the supervision of a trained and experienced obstetrician.

4. Rotation must only be attempted with the uterus relaxed

Rotation of the fetal head should only be attempted between contractions. Consideration may be given to using a short acting tocolytic, such as glyceryl trinitrate, to ensure adequate uterine relaxation.

5. Low threshold for abandoning the procedure and resorting to Caesarean section

The procedure should be abandoned if the forceps cannot be applied easily, the handles do not easily approximate, or rotation is not easily effected with gentle pressure. Under conditions where difficulty is more likely to be encountered (e.g. moulding of the fetal head or the presenting part is only just engaged), the trial of forceps should be performed in an operating theatre equipped for Caesarean section. Rotational forceps deliveries should not be attempted in hospitals not equipped to perform an immediate Caesarean section unless exceptional circumstances exist.

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