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Compilation

« Expression abdominale »

Base de données de l'AFAR
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Compilation

« Expression abdominale »

Méthode de travail : Nous avons sélectionné les 15 fiches contenant le mot-clé « Expression abdominale » dans la base de données de l'AFAR, fin juillet 2004.

Convention : Le numéro entre [crochets] est celui de la fiche dans la base de données.

<p>Les dystocies des épaules vraies sont rares, mais hautement morbides. Associé à l'expression abdominale le taux de séquelles neurologiques et orthopédiques atteint 77%.</p>	<p>[857] Shoulder dystocia is an uncommon complication of delivery with a high morbidity rate. Ninety-one cases were coded for shoulder dystocia at the Toronto General Hospital from 1980 through 1985. True shoulder dystocia was found in 24 cases, an incidence of 0.23%. There was no significant difference in average weight and percentage of macrosomia between cases of true shoulder dystocia and those merely coded as such. True shoulder dystocia was associated with a neonatal morbidity rate of 42%, consisting of a respiratory arrest and neurological and orthopedic damage. Fundal pressure, in the absence of other maneuvers, resulted in a 77% complication rate and was strongly associated with orthopedic and neurologic damage. Delivery of the posterior shoulder and the corkscrew maneuver were associated with good fetal outcome.</p> <p>Gross SJ, Shime J, Farine D.. Shoulder dystocia: predictors and outcome. A five-year review. Am J Obstet Gynecol. 1987 Feb;156(2):334-6.</p> <p>http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=3826169</p>
<p>Des pressions excessives sur le crâne du bébé peuvent entraîner des dommages neurologiques: hypertonie utérine, forceps, expression abdominale.</p>	<p>[856] Sometimes the relationship between peripartum events and neonatal CNS injury is obvious: for example, following complete abruptio placentae or umbilical cord prolapse and occlusion with a delay of many minutes before delivery of the baby. These circumstances are, of course, rare in modern obstetrics. Usually, when a neonate develops neurological injury, a host of various potentially adverse peripartum factors are assumed to be the aetiology, but without definitive evidence. Among these latter factors are those we have focused on in this paper: the mechanical forces exerted on the fetal head during labour when the full-term fetus is in cephalic presentation. The mechanical events during the first stage of labour are reviewed, showing how uterine contractions result in cervical dilatation and descent and rotation of the fetal head. The consequences of these forces on the fetal intracranial pressure and blood flow are discussed: FHR remains normal up to a certain pressure</p>

	<p>threshold, above which decelerations occur. In other words, excessive pressures applied to the fetal head, either spontaneously (e.g. uterine tetany) or iatrogenically (e.g. traumatic forceps delivery or excessive fundal pressure) can increase fetal intracranial pressure to such a degree as to result in significant decreases in cerebral blood flow that are associated with fetal heart rate decelerations. Even when decelerations are simultaneous to contractions, decelerations cannot be considered as reflex and innocuous, as they are indeed associated with a decreasing cerebral blood flow. They must therefore be considered and evaluated in the management of labour. Cord compression and functional modifications of intervillous space by mechanical forces may further compromise the biological status of the fetus, leading to severe asphyxia. Neurological evaluation of the neonate within the first few days after delivery is currently the only way to provide the obstetricians with information on the possible consequences of an abnormal labour. The assessment of normality of the CNS in the neonate born at term, and its value in predicting late outcome are discussed. When abnormalities are detected after one or repeated assessments, abnormal neurological signs and symptoms are classified into three grades at the end of the first week. According to our data, a good correlation exists between this neonatal grading of cerebral dysfunction and late outcome. A careful evaluation of fetal head deformation, extensive caput succedaneum, and extensive retinal haemorrhages can help to interpret an abnormal labour retrospectively.</p> <p>Amiel-Tison C, Sureau C, Shnider SM.. Cerebral handicap in full-term neonates related to the mechanical forces of labour. Baillieres Clin Obstet Gynaecol. 1988 Mar;2(1):145-65.</p> <p>http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=3046797</p>
<p>Plus de 80% des sages-femmes de Floride utilisent l'expression abdominale.</p>	<p>[855] The intensity of the legal climate and the focus on standards of practice in the obstetric setting have forced nurses to carefully scrutinize clinical techniques. The use of fundal pressure during the second stage of labor is a cause of great concern for many obstetric nurses. A nationwide pilot study was conducted to determine whether fundal pressure application is an accepted part of nursing practice in contemporary obstetrics. Sixty-two of the respondents (84%) used fundal pressure during the second stage of labor in their institutions.</p> <p>Kline-Kaye V, Miller-Slade D.. The use of fundal pressure during the second stage of labor.</p>

	<p>J Obstet Gynecol Neonatal Nurs. 1990 Nov-Dec;19(6):511-7.</p> <p>http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=2269906</p>
<p>L'expression abdominale en cas de dystocie des épaules laisse trop souvent un bébé gisant flasque et sans voix.</p>	<p>[854] "The delivery of the head with or without forceps may have been quite easy, but more commonly there has been a little difficulty in completing the extension of the head. The hairy scalp slides out with reluctance. When the forehead has appeared it is necessary to press back the perineum to deliver the face ... time passes. The child's head becomes suffused. It endeavors unsuccessfully to breathe. Abdominal efforts by the mother or by her attendants produce no advance; gentle head traction is equally unavailing. Usually equanimity forsakes the attendants. They push, they pull. Alarm increases. Eventually by greater strength of muscle or by some infernal juggle, the difficulty appears to be overcome, and the shoulders and trunk of a goodly child are delivered. The pallor of its body contrasts with the plum-colored cyanosis of the face, and the small quantity of freshly expelled meconium about the buttocks. It dawns upon the attendants that their anxiety was not ill-founded, the baby lies limp and voiceless, and too often remains so despite all efforts at resuscitation".</p> <p>Penney DS, Perlis DW.. Shoulder dystocia: when to use suprapubic or fundal pressure. MCN Am J Matern Child Nurs. 1992 Jan-Feb;17(1):34-6.</p> <p>http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=1738307</p>
<p>L'expression abdominale est associée à une deuxième phase plus longue et plus de déchirures sévères du périnée.</p>	<p>[840] Fundal pressure is a controversial obstetric technique used by some practitioners in second-stage labor. In this preliminary study, 34 deliveries in which fundal pressure was used to expedite birth were matched with 34 deliveries that occurred spontaneously. Several parameters were compared between the two groups. In the group of women who were delivered with use of fundal pressure, second-stage labor was longer and a higher incidence of third- and fourth-degree perineal lacerations was observed compared with those women who delivered spontaneously. This article discusses the possible reasons for these findings, the reasons fundal pressure was used, and the controversial issues that surround this technique.</p> <p>Cosner KR.. Use of fundal pressure during second-stage labor. A pilot Study. J Nurse Midwifery. 1996 Jul-Aug;41(4):334-7.</p> <p>http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T8N-3W31500-8&_coverDate=08%2F31%2F1996&_alid=186013980&_rdoc=1&_fmt=&_orig=search&_qd=1&_cdi=5091&_sort=d&view=c&a</p>

	cct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=795852d29b62e2ee2b411c3b3800325e
L'expression abdominale en cas de dystocie des épaules est associée à un taux de morbidité fœtale de 77%, laissant surtout des séquelles neurologiques et orthopédiques.	<p>[853]</p> <p>Hankins GD.. Lower thoracic spinal cord injury – a severe complication of shoulder dystocia. Am J Perinatol. 1998 Jul;15(7):443-4.</p> <p>http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9759912</p>
L'expression abdominale multiplie par plus de quatre le risque de rupture de sphincter anal.	<p>[568] OBJECTIVE: To determine risk factors for obstetric anal sphincter tears and to evaluate symptomatic outcome of primary repair.</p> <p>METHODS: Obstetric-procedure, maternal, and fetal data were registered in 845 consecutive vaginally delivered women. Risk factors for anal sphincter tears were calculated by multiple logistic regression. All 808 Swedish-speaking women who delivered vaginally were included in a questionnaire study regarding anal incontinence in relation to the delivery. Questionnaires were distributed within the first few days postpartum, and at 5 and 9 months postpartum.</p> <p>RESULTS: Six percent of the women had a clinically detected sphincter tear at delivery. Sphincter tears were associated with nulliparity (odds ratio [OR] 9.8, 95% confidence interval [CI] 3.6, 26.2), postmaturity (OR 2.5, 95% CI 1.0, 6.2), fundal pressure (OR 4.6 95% CI 2.3, 7.9), midline episiotomy (OR 5.5 95% CI 1.4,18.7), and fetal weight in intervals of 250 g (OR 1.3 95% CI 1.1, 1.6). Fifty-four percent of women with repaired sphincter tears suffered from fecal or gas incontinence or both at 5 months and 41% at 9 months. Most of the symptoms were infrequent and mild.</p> <p>CONCLUSION: Several risk factors for sphincter tear were identified. Sphincter tear at vaginal delivery is a serious complication, and it is frequently associated with anal incontinence. Special attention should be directed toward risk factors for this complication. Symptoms of anal incontinence should explicitly be sought at follow-up after delivery.</p> <p>Zetterstrom J, Lopez A, Anzen B, Norman M, Holmstrom B, Mellgren A.. Anal sphincter tears at vaginal delivery: risk factors and clinical outcome of primary repair. Obstet Gynecol. 1999 Jul;94(1):21-8.</p> <p>http://www.greenjournal.org/cgi/content/abstract/94/1/21</p>
Les tractions du	[852] Although birth-related brachial plexus injury

<p>bébé ou pressions sur l'utérus excessives peuvent être à l'origine de traumatismes du plexus brachial de l'enfant (centre nerveux des membres supérieurs).</p>	<p>(BPI) was first described more than two centuries ago, it still represents therapeutic dilemma. Incidence is 0.37-2.0 per 1000 live births. The most frequent etiologic cause is extreme lateral traction and excessive fundal pressure in a case of shoulder dystocia. However, in last decade there are reports that cite of BPIs occurring prior to delivery in up to 46% cases--intrauterine maladaptation. In 1998. and 1999. at the Rehabilitation Department of Pediatric Hospital, Clinical University Center in Sarajevo 32 children with BPI were treated. The incidence is 2.67 per 1000 live births. There were 21 cases of Erb's palsy (65.63%), 2 cases of Klumpke's palsy (6.25%). Total plexus palsy was present in 9 children (28.63%), and Horner's Syndrome in 1 case. In 25.77% of cases (8 children) there was no evidence of shoulder dystocia at delivery. Treatment of the brachial plexus injuries in newborn is still controversial. Proper immobilization in first 7-15 days is of great importance. In this study 25 children (78.13%), in average age of 4.6 days, were brought for examination with improper immobilization. The role of widely applied electrotherapy is controversial. Complete recovery is expected in about one half, and in this study it was achieved in 75% of cases (24 children). Consensus about timing of surgical approach does not exist still. However, there is strong agreement that decision about eventual surgical treatment should be based on clinical motor testing and that MRI should precede the surgery. Although the electrodiagnostic studies have proven to be of limited prognostic value in the evaluation of children with acute obstetrical brachial plexus injuries, electromyography should be performed prior the surgery in the aim of later comparison of the results. According to our data, at this particular moment in BiH surgical treatment in this age is not available, as well as use of MRI in diagnostics of BPIs.</p> <p>Buljina A, Zubcevic S, Catibusic F.. [Obstetrical injuries of the brachial plexus] [Article in Croatian] Buljina A, Zubcevic S, Catibusic F.</p> <p>http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=11219905</p>
<p>Facteurs de risques des déchirures graves du périnée: nulliparité, taille du bébé, forceps, ventouse, expression abdominale, syntocinon.</p>	<p>[755] Objective To determine risk factors for the occurrence of third degree perineal tears during vaginal delivery.</p> <p>Design A population-based observational study.</p> <p>Population All 284,783 vaginal deliveries in 1994 and 1995 recorded in the Dutch National Obstetric Database</p>

	<p>were included in the study.</p> <p>Methods Third degree perineal rupture was defined as any rupture involving the anal sphincter muscles. Logistic regression analysis was used to assess risk factors.</p> <p>Main outcome measures An overall rate of third degree perineal ruptures of 1.94% was found. High fetal birthweight, long duration of the second stage of delivery and primiparity were associated with an elevated risk of anal sphincter damage. Mediolateral episiotomy appeared to protect strongly against damage to the anal sphincter complex during delivery (OR: 0.21, 95% CI: 0.20-0.23). All types of assisted vaginal delivery were associated with third degree perineal ruptures, with forceps delivery (OR: 3.33, 95%-CI: 2.97-3.74) carrying the largest risk of all assisted vaginal deliveries. Use of forceps combined with other types of assisted vaginal delivery appeared to increase the risk even further.</p> <p>Conclusions Mediolateral episiotomy protects strongly against the occurrence of third degree perineal ruptures and may thus serve as a primary method of prevention of faecal incontinence. Forceps delivery is a stronger risk factor for third degree perineal tears than vacuum extraction. If the obstetric situation permits use of either instrument, the vacuum extractor should be the instrument of choice with respect to the prevention of faecal incontinence.</p> <p>J.W. de Leeuw, P.C. Struijk, M.E. Vierhout, H.C.S. Wallenburg. Risk factors for third degree perineal ruptures during delivery. BJOG: An International Journal of Obstetrics and Gynaecology. Vol. 108 Issue 4 Page 383 April 2001</p> <p>http://www.blackwell-synergy.com/links/doi/10.1111/j.1471-0528.2001.00090.x/enhancedabs/</p>
<p>L'expression abdominale est une pratique très ancienne, qui perdure. Très peu documentée scientifiquement, pouvant être très dangereuse pour la mère et l'enfant, bien connue dans les</p>	<p>[839] The role of fundal pressure during the second stage of labor is controversial and can result in clinical disagreements between nurses and physicians. Clearly the time for resolution of this issue is not when there is a physician request at the bedside in front of the patient. A prospectively agreed upon plan specifying how this request will be addressed is ideal. In order to develop this plan, risks, benefits, and alternative approaches to the use of fundal pressure should be reviewed by an interdisciplinary perinatal team. Much of the data</p>

<p>Annales judiciaires.</p>	<p>about maternal-fetal injuries related to fundal pressure are not published for medical-legal reasons; however, anecdotal reports suggest that these risks exist. Unfortunately, it is therefore difficult to quantify with any degree of accuracy the exact number of maternal-fetal injuries that are directly related to use of fundal pressure to shorten an otherwise normal second stage of labor. However, there is enough evidence to suggest that if injury does occur when fundal pressure is used, there are significant medical-legal implications for the health care providers involved. This article will review what is currently known about fundal pressure including risks, benefits, and alternative approaches. In that context, suggestions will be offered for a safe approach to managing the second stage of labor.</p> <p>Simpson KR, Knox GE.. Fundal pressure during the second stage of labor. Review. MCN Am J Matern Child Nurs. 2001;26(2):64-70.</p> <p>http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=11265438</p>
<p>Ruptures utérines associées à: syntocinon, forceps, et expression abdominale.</p>	<p>[849] Uterine rupture contributes significantly to high maternal mortality rates in developing countries. We conducted a prospective study of 63 cases of uterine rupture during pregnancy in the Gazobi Hospital in Niamey, Niger between November 1977 to December 1998. The incidence in the maternity department was 2.3%. Most of the patients were transported from inland areas. Mean age was 29 years, and mean parity was 5.7. More than half of patients (53%) presented uterine scar defects. Two thirds of patients had undergone no prenatal care. Analysis of iatrogenic etiologic factors demonstrated strong correlation with use of oxytocin, forceps delivery and fundal pressure. In 75% of cases, diagnosis of uterine rupture was made before delivery. The main symptom was hemorrhage. Surgical treatment consisted of hysterorrhaphy in 79% of the cases. Maternal mortality was 4.7% and perinatal mortality was 76%. Discussion focuses on the frequency of uterine rupture in developing countries, etiologic factors, diagnostic modalities, and therapeutic guidelines. Several simple preventive measures are proposed to reduce the incidence of uterine rupture in developing countries.</p> <p>Vangeenderhuysen C, Souidi A.. [Uterine rupture of pregnant uterus: study of a continuous series of 63 cases at the referral maternity of Niamey (Niger)] Med Trop (Mars). 2002;62(6):615-8.</p> <p>http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=12731309</p>
<p>Cas de rupture</p>	<p>[850] BACKGROUND: Rupture of an unscarred uterus is</p>

<p>utérine sans antécédent de césarienne après expression abdominale.</p>	<p>rare, with a reported incidence of 1 in 8,000-15,000 pregnancies. We report a case occurring during labor.</p> <p>CASE: A 33-year-old woman, gravida 3, para 0, abortion 2, was admitted at 40 weeks' gestation with ruptured membranes. Fundal pressure was applied during delivery due to maternal exhaustion. Uterine rupture was diagnosed from palpation of the fetal extremities coupled with a decreased fetal heartbeat. A 6-cm transverse laceration was discovered over the lower uterine segment during emergency cesarean section. The uterus was sutured. There were no further complications, and the postoperative course was uneventful.</p> <p>CONCLUSION: Spontaneous rupture of the unscarred uterus during labor is rare, with only one case recorded at our institution over a 10-year period. Risk factors include weakness of the uterine muscle and the application of fundal pressure. Early detection and immediate surgical intervention are the mainstays of management.</p> <p>Pan HS, Huang LW, Hwang JL, Lee CY, Tsai YL, Cheng WC.. Uterine rupture in an unscarred uterus after application of fundal pressure. A case report. J Reprod Med. 2002 Dec;47(12):1044-6.</p> <p>http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=12516327</p>
<p>De l'expression abdominale « câlibrée » pour un contrôle parfait des praticiens...</p>	<p>[851] OBJECTIVE: To investigate the relationship between intrauterine pressure and the application of a standardised fundal pressure manoeuvre, and to determine the maternal, fetal and labour characteristics that modulate the relationship.</p> <p>DESIGN: Prospective measurement of intrauterine pressure during the second stage of labour.</p> <p>SETTING: North American university hospital.</p> <p>POPULATION: Forty full-term women in spontaneous labour were studied during the second stage. Each woman acted as her own control. All women laboured with requested epidural analgesia.</p> <p>METHODS: A fundal pressure manoeuvre was performed so as to standardise the level of force and the surface area of application. Intrauterine pressure was measured using a sensor-tip catheter. Five interventions were analysed: 1. valsalva during a uterine contraction; 2. fundal pressure and valsalva during a contraction; 3. fundal pressure during a contraction without valsalva; 4. fundal pressure in the absence of uterine contractions; and 5. valsalva in the absence of uterine contractions.</p>

	<p>RESULTS: Women in the second stage of labour transiently increased their expulsive force (as reflected by intrauterine pressure) by 86% of their baseline contraction using valsalva and fundal pressure simultaneously. The efficiency by which both contraction-enhancing manoeuvres increased intrauterine pressure was directly related to gestational age and inversely related to myometrial thickness.</p> <p>CONCLUSION: Fundal pressure applied under controlled conditions significantly increases intrauterine pressure in some, but not all women. Simultaneous measurement of intrauterine pressure, to maintain feedback during application will create a 'controlled environment' for the obstetrician and reassurance that this manoeuvre can be applied in a controlled fashion. Future delineation of the group of women that could benefit from fundal pressure, as well as the group that is refractory is essential to avoid unnecessary or delayed operative interventions.</p> <p>Buhimschi CS, Buhimschi IA, Malinow AM, Kopelman JN, Weiner CP.. The effect of fundal pressure manoeuvre on intrauterine pressure in the second stage of labour. BJOG. 2002 May;109(5):520-6.</p> <p>http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=12066941</p>
<p>L'expression abdominale est utilisée en France pour 50% des accouchements, d'après une enquête de l'institut des mamans.</p>	<p>[842]</p> <p>Institut des mamans. Pratique obstétricales et frustrations des mamans: quelle réalité. Enquête. Publication électronique http://www.institutdesmamans.com/Online/</p> <p>http://www.institutdesmamans.com/Online/resumPratiquesObst.pdf</p>
<p>Eviter l'expression abdominale traumatisante et dangereuse.</p>	<p>[841] Le Conseil national de l'Ordre des sages-femmes a demandé l'inscription dans l'article 18 du Code de déontologie la possibilité, pour les sages-femmes, de pratiquer le vacuum extractor à la partie basse de l'excavation pelvienne en cas d'efforts expulsifs insuffisants, en accord avec le médecin de garde ou d'astreinte.</p> <p>Cette technique raccourcit l'effort de la durée d'expulsion parfois prolongé par la fatigue maternelle associée de surcroît, dans certains cas, à l'inhibition de la contractilité utérine consécutive à la péridurale.</p> <p>Par ailleurs, cette technique évitera l'expression abdominale traumatisante et dangereuse qui est à nouveau trop souvent pratiquée faute de pouvoir utiliser le vacuum extractor.</p>

	<p>Lors de la dernière parution de la revue du Conseil national de l'Ordre des sages-femmes, "Contact sages-femmes" n°7, a été joint un questionnaire sur cette pratique et il a été demandé à l'ensemble des sages-femmes en activité de bien vouloir y répondre.</p> <p>Voici les résultats de cette enquête:</p> <p>69,05 % des sages-femmes qui ont répondu ont dit NON</p> <p>30,95 % des sages-femmes qui ont répondu ont dit OUI</p> <p>Bicheron F.. Communiqué du conseil national de l'ordre des Sages-Femmes. PRATIQUE DE LA VENTOUSE. Publication électronique. (http://www.ordre-sages-femmes.fr/)</p> <p>http://www.ordre-sages-femmes.fr/actualites/communiques/commui37.htm</p>
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