Summary of Key Changes: 2020 SOGC FHS Intrapartum Consensus Guideline

Terminology

The guideline writing committee recognized the need for clarification around many of the terms defined in the 2007 guideline. Further clarification of the following terms has been included:

- **Tachysystole:** any excessive uterine activity (UA)
- **Repetitive decelerations:** 3 or more decelerations in a row
- **Recurrent decelerations:** decelerations that occur with ≥50% of contractions in a 20-minute period
- **Intermittent decelerations:** decelerations occurring with <50% of contractions in a 20-minute period
- **Episodic gradual deceleration:*** gradual deceleration (≥30 seconds from onset to nadir) not associated with a contraction
- **Interpretable electronic fetal monitoring:** electronic fetal monitoring tracing that has a continuous display of the fetal heart rate and uterine activity with minimal gaps

* denotes new terminology

Uterine activity (UA)	• Document frequency of uterine activity as number of contractions present in a 10-minute window, averaged over 30 minutes (e.g., 3 contractions in 10 minutes). • If fetal heart rate is atypical or abnormal in the first 10 minutes of tachysystole, initiate a response without averaging over 30 minutes.
Intermittent auscultation (IA)	• Monitor pregnancies ≥37 weeks gestation in healthy women in spontaneous labour without perinatal risk factors via intermittent auscultation (IA). • While the presence of spontaneous accelerations is a normal finding, it is not required in order for the fetal health surveillance (FHS) assessment to be classified as normal. • If a person begins labour following cervical ripening, base the determine method of intrapartum FHS monitoring based on ongoing risk factors. • Use a handheld device for IA and not an electronic fetal monitoring (EFM) transducer connected to a hard drive, even if the paper is turned off, because the tracing is saved on the hard drive and retained in the medical record but is not seen by the caregiver. • If a deceleration is heard by IA immediately following a contraction, assess further by having the woman change position and listening after the next contraction *or* by immediately initiating EFM. If decelerations persist after the next contraction, initiate EFM if not already initiated to confirm the fetal heart rate pattern. Intrauterine resuscitation should be initiated as required. • If EFM was initiated for abnormal IA, you can discontinue monitoring if the tracing is normal and if you have reviewed the overall clinical picture and have determined there are no maternal risk factors present; the recommended minimum period for EFM tracing is 20 minutes.

This table was adapted from: The Society of Obstetricians and Gynecologists of Canada (SOGC) Clinical Practice Guideline No. 396 - Fetal health surveillance: Intrapartum consensus guideline. *J Obstet Gynaecol Can* 2020, 42(3):316–348.

Electronic fetal monitoring (EFM)	• Additional conditions when EFM may be beneficial:
	  ◦ Presence of single umbilical artery
	  ◦ Presence of velamentous cord insertion
	  ◦ Presence of 3 or more nuchal loops of cord
	  ◦ With use of combined spinal−epidural analgesia
	  ◦ Presence of labour dystocia
	  ◦ Presence of FHR arrhythmia
	  ◦ Patient with pre-pregnancy body mass index >35 kg/m^2
	• If a variable deceleration occurs with a contraction and the fetal heart rate does not return to baseline by the end of contraction, consider it a complicated variable deceleration with the same physiological significance as late decelerations.
	• Consider decelerations with large amplitude and long duration to be significant: variable decelerations that last ≥60 seconds AND decrease to ≤60 bpm *or* drop ≥60 bpm below baseline are classified as complicated variable decelerations.
	• Consider using fetal spiral electrode and/or intrauterine pressure catheter, if available, when external EFM monitoring does not provide interpretable tracings.
	• If internal monitoring is unavailable, carry out external FHS with greater frequency in order to obtain the information needed for an accurate interpretation.
	• Allow interruptions in EFM for up to 30 minutes if necessary to facilitate periods of ambulation, hydrotherapy, or position change, providing: (i) the maternal−fetal condition is stable and (ii) if oxytocin is being administered, the infusion rate is stable.

Second stage of labour assessment	• In the active second stage of labour, assess and document fetal health and classification; if not normal, document the interpretation and response:
	  ◦ Intermittent auscultation: at least every 5 minutes
	  ◦ Electronic fetal monitoring (EFM): with continuous EFM tracing of uterine activity and fetal heart rate and a caregiver present at all times: at least every 15 minutes; otherwise, every 5 minutes
	• NOTE: Consider using a fetal spiral electrode and/or an intrauterine pressure catheter to help maintain continuous tracing.
	• Ensure documentation is contemporaneous.

Maternal heart rate (MHR)	• Place greater emphasis on differentiating maternal heart rate (MHR) from fetal heart rate (FHR).
	• Assess and document MHR:
	  ◦ At initial assessment when determining baseline FHR
	  ◦ At any time when it is unclear whether detecting MHR or FHR
	• Assess and document the MHR based on recommended frequency, which varies by stage of labour:
	  ◦ In the active first stage and passive second stage of labour with intact membranes: every 4 hours
	  ◦ In the active first stage and passive second stage of labour with ruptured membranes: every 2 hours
	  ◦ In the active second stage of labour: every 15−30 minutes

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Epidural	• Use electronic fetal monitoring (EFM) with use of combined spinal−epidural analgesia (CSE) because CSE is associated with a higher risk of an atypical or abnormal fetal heart pattern than with the use of epidural alone.
Interpretation and classification	• Place greater emphasis on the overall clinical picture when determining fetal health surveillance classification and clinical response. • Use continuous tracing of fetal heart rate and uterine activity to be able to more accurately interpret electronic fetal monitoring (EFM) results. • Classify intermittent auscultation as abnormal when tachysystole is present. • Tachysystole can be present with a normal, atypical, or abnormal EFM tracing. • While the presence of spontaneous accelerations is a normal finding, it is not required in order for the EFM tracing to be classified as normal. • Consider accelerations in the presence of abnormal FHR tracings as part of the overall clinical picture; however, the accelerations do not change the tracing classification.
Paper speed	• Facilities should adopt a tracing paper speed of 3 cm/min for electronic fetal monitoring to facilitate national consistency.

Intrauterine resuscitation	• Reserve intravenous fluid bolus for cases where indicated (e.g., maternal hypovolemia, hypotension).
	• Reserve maternal oxygen for confirmed maternal hypotension or hypovolemia; do not use routinely for atypical or abnormal fetal heart tracings.
	• Include the following in intrauterine resuscitation:
	  • In the second stage, ask mother to modify or pause her pushing efforts.
	  • Obtain, assess, and document maternal vital signs.

Further testing	• Consider fetal scalp lactate sampling to reliably identify intrapartum fetal acidosis.
Documentation	• Always include the FHR classification when documenting fetal health surveillance (III-A).
Education	• Implement formal education requirements in fetal health surveillance for all providers of intrapartum obstetrical care (physicians, nurses, midwives) with a review every 2 years.

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