

Intrapartum pain management

Good practice points

- Discuss labour pain management antenatally, early in labour, intermittently during labour
- Share information to support decision making and enhance sense of autonomy
- Consider values, beliefs, culture, expectations, intentions, previous experiences
- Support the woman's preferences, choices and promote a flexible approach
- Create clinical spaces that feel calm, safe and private
- Provide known carers whenever possible
- Sensitively discuss normal labour sensations as physiological and purposeful—less fear, intervention and greater self-efficacy
- Encourage support person/s to provide continuous presence, praise and advocacy
- If heightened anxiety or fear of childbirth, offer additional support/referral
- Audit feedback about pain management and impact on birth experience
- Consider environmental impact of pain relief strategies

Non-pharmacological strategies

- Align strategies with the body's physiology/psychology to alter or change response to labour sensations/pain
- Offer reduction in pain intensity with few or no adverse effects
- Combine strategies/use alongside pharmacological agents (if chosen) to increase relief

Neurotransmitter release

- Acupuncture
- Acupressure
- Distraction
- Sterile water injections

Gate control theory

- Massage, touch, warmth
- Movement, active positioning
- TENS
- Water immersion

CNS activation

- Aromatherapy
- Breathing
- Hypnosis
- Mindfulness
- Yoga

Pharmacological options

- Consider side effects and impact on labour and birth
- Efficacy and outcomes unclear due to conflicting findings and limited high quality evidence

Nitrous oxide/oxygen

- Mild inhalation analgesia
- Use in any stage of active labour
- Consider contraindications
- Side effects (e.g. nausea, vomiting, dizziness)
- Self administer only
- Coach with breathing: inhale—exhale via mask/mouthpiece
- Combine with other strategies (e.g. TENS)
- Use in well ventilated space
- Use safety equipment (e.g. filters) and demand valve to reduce occupational exposure

Opioids

- Variable analgesic response
- Follow local prescribing protocols
- Side effects (e.g. nausea, vomiting, drowsiness, sedation, dysphoria)
- Consider anti-emetic
- Changes in FHR more likely
- Consider estimated TOB prior to administration and possible post-natal impacts
- If neuraxial analgesia isn't an option, consider remifentanyl or fentanyl via PCA

Neuraxial analgesia

- Most effective pharmacological method
- Use in any stage of labour following anaesthetic assessment
- May be clinically indicated (e.g. for hypertensive or cardiac conditions)
- Gain IV access
- Low concentration LA with opioid reduces motor block
- Additional surveillance (e.g. CEFM, motor weakness, block height)
- Mobility assessment prior to active positioning
- Bladder management required
- May increase length of labour
- Increased likelihood of assisted birth, maternal hyperthermia, antibiotic use

CNS: central nervous system; **>:** greater than; **TENS:** transcutaneous electrical nerve stimulation; **TOB:** time of birth; **FHR:** fetal heart rate, **PCA:** patient controlled analgesic, **IV:** intravenous; **LA:** local anaesthetic; **CEFM:** continuous electronic fetal monitoring; **IDC:** indwelling catheter

Queensland Clinical Guideline. *Intrapartum pain management* Flowchart: F23.75-1-V1-R28