Uterine Electrical Activity During First Stage of Labor

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Abstract

Palpation technique still used today, studies have shown that this technique is uneffective for measuring uterine contractions during labor. Electromyogram (EMG) with surface electrodes is a non-invasive tool that can be used to monitor uterine activity in labor with more objective and accurate result. The aim of this study was to explain the uterus electrical activity during first stage of labor. This is a prospective observational of 10 singleton deliveries. Maternal contractions monitored using 3-channel surface electrodes of the EMG. Recording was done from begining until complete servix dilatation every 30 minutes for 10 minutes. Recordings are then calculated the average frequency, duration, interval, and the action potentials. Ten random data sequence was piked by data normalization and presented in a trend. The results showed the frequency, duration and action potential experiencing a rising trend approaching second stage of labor, with average respectively (3.65 ± 0.89) time/10 minutes, (67.40 ± 27.03) second and (62.82 ± 29.12) mV. But in the frequency and action potential decreased at the end of first stage of labor. The duration of the contraction was significantly decreased approached second stage of labor with average (3.79 ± 1.18) minutes. Changes in uterus activity was a natural mechanism during labor in the mother's body to adjust physiological conditions of the mother and fetus in the womb to be through normal birth process.

Keywords: Uterine Contraction, Uterine electricity, First stage of labor, Electromyography.

Introduction

In Indonesia there are still obstacles in efforts to reduce maternal mortality. Among them are poor quality of health care antenatal, delivery and postpartum. One woman dies every hour during childbirth or due to pregnancy-related causes.[¹] Monitoring during labor and after delivery, including the use of partographs is still not optimal. Partograf is used as a tool for making clinical decisions, relating to early recognition of possible complications and choosing the most appropriate action.[²] Uterine contractions as one
of the main factors affecting childbirth are of the utmost importance to be monitored during labor to identify complications in labor.

Dystocia in labor may be caused by contraction abnormalities. By closely monitoring the contractions, medical personnel can be used to perform early detection of contraction disorders such as uterine inertia, hypertonic contractions, hypotonic, and incoordinate uterine action that may result in latent and active phases in the first stage of labor. The resulting consequences of this in the mother is the occurrence of intrapartum infection, uterine rupture, fistula formation, pelvic floor muscle injury. Whereas in the fetus may lead to caput succedaneum and fetal head molasses may even result in skull fracture if labor management is not performed well.\[2\]

Palpation techniques in Indonesia are still used by birth attendants as a method of measuring uterine contractions in labor. Clinically the measurements with palpation are less useful and to date the measurement of uterine contractions is done by placing the palms on the fundus area then calculated and recorded the frequency, interval, and duration. Previous research has found that measurements by palpation are ineffective and inaccurate, requiring more accurate measurement methods.\[3\]

Previous studies have measured electrical voltages due to uterine contractions by Uterine Electromyography using an ECG-like surface electrode which is a more simple, accurate, and risk-free measure of his or her own.\[4\] EMG is a method for evaluating muscles based on the detection of muscle electrical activity.\[5\]

The EMG signal burst responsible for uterine contractions is seen in clear temporal correspondence with the toxin output (TOCO) simultaneously. However, TOCO can only measure the degree of contraction and (coarse and inaccurate) contraction amplitude. The uterine EMG signal, can be analyzed by a number of advanced mathematical methods to determine prolong electrochemical readiness of the myometrium for labor.\[6\] Several previous studies also examined the electrical activity, but about uterine electrical activity during the period of pregnancy.\[7\] In addition, previous studies examined uterine electrical activity as a predictor of preterm labor.\[8\] By using EMG, it is expected that the measurement and monitoring of uterine contractions in labor can be performed optimally with more objective and valid results. Based on the description, then in this research will be measured uterine electrical activity in the first stage of labor.

**Method**

This is an observational prospective study. The samples in this study were 10 normal maternity women at Nggesrep Public Health Center who fulfilled the inclusion criteria, namely: normal maternal women both primipara and multipara, have entered labor stage marked by dilatation and cervical leveling and adequate contraction at least 2 times in 10 min with duration>20 second, pregnancy at delivery>37 weeks and <42 weeks, age range 20-35 years, healthy mother, and willing to be respondent. Mothers consume / obtain uterotonica, have sensitive or allergic skin, there is injury in mother's abdomen, delivery time> 24 hours or old labor, premature rupture of membranes will be excluded from the research.

**Table 1 Characteristics of respondent**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Min</th>
<th>Max</th>
<th>Mean±SD</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal age (year)</td>
<td>18</td>
<td>32</td>
<td>25.60±3.75</td>
<td></td>
</tr>
<tr>
<td>Parity</td>
<td>1</td>
<td>3</td>
<td>1.80±0.63</td>
<td></td>
</tr>
<tr>
<td>Gestational age (week)</td>
<td>37.71</td>
<td>40.71</td>
<td>38.98±1.04</td>
<td></td>
</tr>
<tr>
<td>FH (cm)</td>
<td>30</td>
<td>34</td>
<td>32.10±1.37</td>
<td></td>
</tr>
<tr>
<td>BMI (Kg/m²)</td>
<td>22.48</td>
<td>35.79</td>
<td>28.05±3.72</td>
<td></td>
</tr>
<tr>
<td>Second stage duration (minute)</td>
<td>10</td>
<td>55</td>
<td>30.70±17.48</td>
<td></td>
</tr>
<tr>
<td>Birthweight (gram)</td>
<td>2750</td>
<td>3600</td>
<td>3135±279</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 (50)</td>
<td>5 (50)</td>
</tr>
</tbody>
</table>

*FH: Fundus Height; BMI: Body Mass Index;

This research has got certificate of research worthiness from Health Research Ethics Commission of Poltekkes Semarang with number: 001KEPK / Poltekkes-Smg / EC / 2017. Respondents meeting the inclusion criteria were fitted with 1 electrode at the fundus parallel to the umbilicus and 1 electrode above parallel to the umbilicus. 1 electrode is placed on the right side
of the mother's abdomen as a ground, each at a
distance of 3-5 cm from the umbilicus.\cite{9}
Recording of uterine electrical activity is
performed on every 10 minute contraction made
every 30 minutes until complete cervical opening
used EMG by miliVolt (mV) unit. If in the
implementation there are mothers who experience
complications or childbirth to be pathologic as the
mother should be in the operation Sectio cesarea
(SC) it will be issued as a sample (Drop out). The
results that appear newly created trends in the
results of each measurement results.

Result and Discussion

Table 2 Distribution of average data on uterine
electrical activity during first stage of labor

<table>
<thead>
<tr>
<th>Variable</th>
<th>Min</th>
<th>Max</th>
<th>Mean±SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency (x/10 minute)</td>
<td>1.80</td>
<td>4.80</td>
<td>3.65±0.89</td>
</tr>
<tr>
<td>Duration (second)</td>
<td>37.92</td>
<td>127.00</td>
<td>67.40±27.03</td>
</tr>
<tr>
<td>Interval (minute)</td>
<td>2.45</td>
<td>5.83</td>
<td>3.79±1.18</td>
</tr>
<tr>
<td>Potential action (mV)</td>
<td>36.48</td>
<td>137.28</td>
<td>62.82±29.12</td>
</tr>
</tbody>
</table>

Frequency of Uterine Contraction

The frequency of uterine contractions in labor in
the first stage of labor has a tendency to increase
but decrease before the second stage of labor. The
average maximum frequency occurring in the first
stage of labor is 4.57 times/10 minutes, and the
minimum average frequency is 2.80 times / 10
minutes.

![Fig. 1 Frequency trend of Uterine contraction during first stage of labor](image)

This corresponds to the sub phase of the active
phase of the first stage of labor, namely
acceleration (acceleration), maximal dilatation,
and deceleration (deceleration).\cite{10} Previous
studies have found that in the latent phase normal
labo
and causes the cervix to become flat (effacement) and open (dilatation).\textsuperscript{[15]}

There is a difference in the observed duration of contraction based on the increase in pressure measured by TOCO, palpation of the abdomen, and the pain felt by the mother. Measurements of contraction using TOCO showed contraction at the end of labor for 2.5 minutes, whereas from the measurement using abdominal palpation method, the duration of contraction occurred for 1.5 minutes.\textsuperscript{[16]} Compared with the pain felt by the mother during contractions lasts only 45 seconds. A common mistake is to intervene for uterine inertia in the laboring mother when labor has not yet begun (false labor).\textsuperscript{[12]} Especially in multigravida that often occurs despite the insufficient contraction. This makes healthcare workers make early diagnosis in partu which resulted in the waiting period of labor progress will also progress. The result is the occurrence of a diagnostic error with a prolonged labor. As a consequence, maternity will get a prolonged labor handling that is not actually needed.

\textbf{Interval of Uterine Contraction}

The interval of uterine contractions in the first stage of labor has a tendency to shorten near second stage of labor with the longest interval average being 5.21 minutes and the shortest interval average is 2.52 minutes.

![Fig. 3 Interval trend of uterine contraction during first stage of labor](image)

The contraction interval shows the depolarization phase or the resting phase in uterine contractions.

The period of relaxation between contractions is essential for the well-being of the fetus. Hypoxemia in the fetus may occur if contractions occur continuously as they may interfere with uteroplacental blood flow.\textsuperscript{[10]} Intramiometrial pressure is usually the same as maternal artery pressure when the amnionic pressure in the uterus reaches 40 mmHg, but it should be remembered that intramiometrial pressure is 2-3 times the pressure amnion in the uterus. As the contractions ease the flow of blood through the spiral artery continues and at the end of the contraction the blood flow returns to normal. Based on this it can be imagined the danger of oxygen supply being disconnected at each peak of contraction. If the inter-contraction interval shows a very short time, indicating a lack of fetal time to supply oxygen again, then contraction may be a threat to the fetus.\textsuperscript{[17]}

\textbf{Potential Action of Uterine Contraction}

The average potential action on the first stage of labor labor fluctuates but has a tendency to increase, there is a decrease of action potential in the middle of the first stage of labor and before the complete opening. The highest average potential action on the first stage of labor contractions in this study was 86.90 mV and the lowest average action potential was 29.48 mV.

![Fig. 4 Potential action trend of uterine contraction during first stage of labor](image)

The result of trend of action potential in this research is in line with previous research using electrical uterine myography monitoring (EUM).
in active phase labor by using micro watt second unit, uterine electrical activity during labor has tendency to increase but decrease at the end of first stage of labor.[18] Intraterine pressure increases in the active phase of labor that affects the lower segment of the uterus to stretch so that cervical dilatation occurs and the fetus may descend to the pelvic door. This power decreases when the complete cervical clearance goal has been reached and the fetus has entered the pelvic door. The next phase is the phase of fetal discharge which in this phase is the most important is the pressure of the abdomen. Abdominal muscle is an important factor for increasing intraabdominal pressure during the second stage of labor. Pregnant women are encouraged to use abdominal muscles to help release the fetus. Increased pressure on the abdomen is a physiological function (such as defecation). The action of these muscles is related to the reflexes that occur due to stretching of certain muscle receptors. When the lower part of the fetus reaches the pelvic floor it triggers the receptor to transmit afferent impulses through the cervical nerves to the medulla, thus stimulating the motor neurons responsible for abdominal contractions. Although triggered by reflexes, the impetus of maternal forces is important to predict the success of labor.[19]

**Conclusion**
The frequency trends of uterine contractions in labor in the first stage of labor have a tendency to increase but decrease before the second stage of labor. Trend duration of uterine contractions in The first stage of labor labor fluctuated but has a tendency to increase before the second stage of labor. The trending interval of uterine contractions in The first stage of labor labor experiences a shortening tendency near The fsecond stage of labor. The average potential action trends in The first stage of labor labor fluctuate but tend to increase, there is a decrease in action potential in mid-first stage of labor and ahead of complete opening.

**References**