

SPONTANEOUS LATENT PHASE LABOUR: A REVIEW OF ISSUES IN DEFINITION, CLASSIFICATION AND MANAGEMENT OPTIONS

Orhue, Augustine A.E. (Frcog, Fmcog); Aziken, M.E. (Fmcog, Fwacs); Osemwenkha, A.P. (Fwacs)

Human Reproduction Research Program Unit

Department Of Obstetrics And Gynaecology, University Of Benin Teaching Hospital, Benin City, Edo State, Nigeria

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Spontaneous latent phase labour: Current definition, classification and management.

ABSTRACT

Latent phase labour has been a subject of controversy since the time of the original concept over 5 decades ago by Friedman and this controversy is still persisting till date. There is presently so much of new knowledge of labour which when applied to latent phase may clear several of the grey areas particularly in the definition and diagnosis. However, there is still substantial debate and heat in the areas of classification and the management of latent phase where for now there is still no consensus. This review has attempted to throw more light on the grey areas in the definition and diagnosis by reviewing the original studies by Friedman, Hendricks and O'Driscoll who are the lead scholars in the evolutionary history of latent phase labour. The studies of several other workers in the debate on classification and management were critically review with a view to evolve a consensus. It is finally concluded that nowadays latent phase labour is a clinically recognizable entity with clear cut features and parameters for a prospective diagnosis. Also in spite of the current debate, it is suggested that latent phase which is only the earlier aspect of 1st stage labour, be classified as a continuum consisting of normal latent phase, prolonged latent phase and false labour. By this type of classification, false labour is not a differential diagnosis but a continuum of prolonged latent phase. Based on the knowledge that latent phase of whatever classification is merely yet the earlier aspect of first stage labour, the management should be passive observation until transformation into active phase labour in the absence of any associated complication either before or during the observation. This is the best option to avoiding or evoking further problem from what is a normal occurrence.

INTRODUCTION

Latent phase labour of spontaneous onset, is today a clinical entity even though there are still some aspects of it, in which there are debate. This is the reason there are still no consensus on what constitute latent phase and hence also why there is lack of a consensus treatment option. Indeed, the pathophysiology is still not clear. While some workers regard latent phase as a physiological event in the build-up to the actual labour, some others belief, it is pathological, and hence deserve treatment to correct the anomaly. This debate is ranging on because, there was so much of vagueness surrounding when to time the beginning of labour which started several decades ago, and this vagueness has not been removed till today. Although this vagueness is persisting, this review adduce facts to confirm that latent phase is today easily recognizable and diagnosable. The controversies on classification which is based on lack of consensus on the pathophysiology of latent phase, is critically

reviewed and recommendations offered for an easy classification to form the basis for the recommended treatment option of observation until active phase transformation. In the light of this review it is hoped that the grey areas in the definition, classification and treatment options in latent phase can be easily explained so that a consensus on the definition, classification and management can evolve.

Correspondence Address:

Professor A.A.E. Orhue
Programme Director
Human Reproduction Research Program Unit
Department Of Obstetrics And Gynaecology,
University Of Benin Teaching Hospital,
Benin City
EDO STATE, NIGERIA
E-mail: aaeorhue@yahoo.com
Phone no: +2348023396744

Search strategy for the review

For this review, the Medline, Pubmed, some selected journal articles, some selected W.H.O publications and reputable textbooks published from 1954 to 2010 were searched. The search also included the Cochrane database systemic review from 2000 to 2009. The selected publications were those dealing with the evolution of the latent phase labour to assist with the definition and diagnosis. The other publications reviewed were in the debate of the classification and management of latent phase labour in the past and present times and the aim was to use findings recommend a consensus in the current practice for classification and management.

Result of the search

The search identified 45 publications made up of 9 textbooks, 2 W.H.O publications, 2 Cochrane database systemic review and 32 selected journal articles. The review relied on studies listed from 1 – 17 for the definition of latent phase through detailed review of the evolutionary history and studies listed from 18 – 26 for the diagnosis. The critical review of the debate on the classification is from studies listed from 27 – 35 and finally the studies cited from 36 to 45 were in the area of treatment option and these expressed diverse opinions. The discussion in the review is divided into subheadings for ease of understanding and end with a set of recommendations as basis for a consensus on definition, classification and management of spontaneous latent phase.

DISCUSSION

Evolutionary history of latent phase labour

Latent phase labour is the aspect of spontaneous labour which is not so familiar to the midwives and non-specialist medical healthcare providers. Even among the obstetricians, knowledge of latent phase is comparatively vague and trailed by debates and controversies (1-5). This vagueness is so because several decades ago, knowledge of spontaneous labour was not distilled into components, for recognition of latent phase as a distinct entity with clinical features as it is known today (6). In those early days, labour was defined as the act of expulsion of the fetus and placenta per vaginam through the 1st, 2nd and 3rd stages of labour. The 1st stage labour as the beginning of labour is clinically characterized by regular and progressive contractions at term but with an onset that lacked precise clinically recognizable parameters. Hence the timing of the beginning of

labour was always put as the retrospective recall by the labouring parturient, as the time when contractions became painful and regular (7). This was always with the hope that such time as recollected by the parturient as the time when contraction became painful, coincided with when the cervical os begin to open to usher first stage labour. There were no clear cut features or parameters to mark when the cervical os begin opening from zero cms. Even till date, this is still how first stage labour is timed in several units in the world (8).

The scientific approach to the study of labour began with the work of Friedman on cervical dilatation pattern in labour during the first stage, displayed in a graphic pattern. This work, developed the concept of three functional division of first stage labour viz preparatory, dilatational and pelvic (9). The preparatory division is the latent phase which is the earliest aspect of first stage labour during which, there is marked changes in the connective tissue component of the cervix leading to softening and effacement. Clinically, there is regular contraction but with only minimal cervical os dilation between zero and 3centimeters (10,11). The dilatational and pelvic division is the active phase of 1st stage labour clinically characterized by regular, painful, palpable and progressive contractions associated with progressive descent and cervical os dilatation from 3 centimeters to 10centimeters (12). Thus, the work of Friedman proposed the idea of latent phase as the earliest aspect of first stage labour characterized by regular contractions and cervical os dilatation from zero to 3 centimeters and active phase labour marked by regular palpable and progressive contractions with cervical os dilatation from 3 cm to 10cm.

Against this view by Friedman of first stage being composed of latent and active phase, is the opposite view that latent phase does not exist at all, because the changes described as occurring in the latent phase with respect to softening, effacement and dilatation of the cervical os take place slowly and usually during the last 4 weeks of pregnancy and not as a manifestation of any aspect of first stage labour (13,14). For Hendricks and others who believed that what Friedman described as latent phase was a mere pre labour event of no clinical significance, they advocated that labour duration should begin from the time of admission in actual or active phase labour (13). It was the belief of workers like Hendricks and others that women with latent phase features, as described by Friedman are not yet in labour and

hence not admitted into labour ward that should be reserved only for women in active phase labour so they can have undiluted attention (15,16). However, the features of active phase as conceived by this group with the above belief led by O'Driscoll, were listed as progressive contractions at term, associated with any or all of the features like rupture of membranes, bloody show and complete cervical effacement. There was no reference at all to initial cervical os dilatation; all that was required was complete cervical effacement. This made the features of active phase still rather vague because complete cervical effacement is not easy generally to elicit especially for non specialist. The debate has therefore continued as to whether or not, latent phase exist to mark the earliest aspect of first stage labour.

Timing of the beginning of first stage labour and the debate

However, the beginning of first stage in which the cervical os will be imagined as zero centimeters dilatation still remained vague even with the concept of latent phase labour when the cervical os could be anything from zero to 3cm. In which case, a diagnosis of latent phase does not equate to any particular cervical os dilatation but a range from zero to 3cm. Hence even when latent phase labour concept is accepted, the time when first stage labour begin and therefore the time from when to estimate labour duration continue to be the recall by the parturient of the time when contractions became painful as representing when the cervical os would have been zero centimeter dilatation. Similarly, if latent phase was regarded as a pre-labour event and the time of admission in active phase assumed as the beginning of first stage labour, the parameters listed for active phase diagnosis by O'Driscoll and Hendricks did not even include **any initial cervical os dilatation** but only emphasized complete effacement. The timing of the beginning of first stage of labour [by this approach which was led by Hendricks and O'Driscoll] is when active phase labour is diagnosed irrespective of the cervical os dilatation at the time of confirmation of active phase labour using the listed parameters. Even at this, there are still some flaws because for the women who are fully effaced but have zero centimeter dilatation and as by the parameters listed by O'Driscoll as the diagnosis of the active phase, this timing would be right for the duration of first stage. However, for those who may have further cervical os dilatation than zero, the timing of the first stage duration would

not be correct. Thus, whether the concept of latent phase labour is accepted or not, the timing of the duration of labour remains very vague and very imprecise even when timing of first stage is from time of admission in active phase labour till date.

Generally in several units, the assessment of the time that labour actually begin is done by the midwife, who rely on the recall by the parturient as to when contractions became painful which is equated automatically as when 1st stage labour began or cervical os assumed to be zero or when the cervical os started opening up whether the parturient was admitted in latent or active phase. This is always subjective because the parturient who is distressed with pains cannot recall anything correctly. There is now another view by several other workers, that the estimate of duration of first stage labour, should be from when the woman was confirmed to be in active phase labour, since nowadays it is only the active phase aspect of first stage labour that deserve support and close supervision (14,15). These workers emphasized that, the outcome of labour can only be influenced by the management adopted after the woman presented herself for care and not whatever happened before she availed herself of the opportunity for care of the labour (14,16). Several units nowadays rely on first stage of labour duration assessment from the time of admission in active phase labour and not any longer on the recall of time by the parturient (17-20).

DIAGNOSIS OF LATENT PHASE

The past diagnosis

Just like the definition, the diagnosis of latent phase has been the subject of several controversies (21). For those who do not believe that latent phase labour exist, there is only active phase labour to mark the beginning of first stage labour because all changes before active phase are pre labour changes of no clinical significance (13-16). Latent phase labour was conceived by Friedman as the early aspect of first stage labour characterized at term by contractions associated with cervical dilatation of less than 3cm while active phase labour is contraction associated with cervical dilatations from 3cm to 10cm (10). The WHO accepted the concept and published a Partograph for supervising first stage labour in which latent phase features are recorded (22). The problem with this concept, is that, there is no reference to effacement of the cervix and the 3cm dilatation for active phase diagnosis is applicable to both primigravida and multipara.

Primigravida commonly achieve full cervical effacement before dilatation begins, whereas multipara undergo effacement and cervical dilatation together concurrently (15,16). Thus it is possible for the primigravida and multipara who have not achieved the appropriate effacement to become 3cm and hence not yet technically in active phase. Some other worker therefore argue that cervical dilatation of 3cm is not dependable enough yet for a diagnosis of active phase in both primigravida and multipara and therefore suggested the more advanced cervical dilatation of at least 5cm and hence latent phase as a cervical dilatation of 4cms or less (23,24). Some others, suggested different parameters for primigravida and multipara such that active phase in the primigravida should be full 100% effacement and at the same time 3cm dilatation but for the multipara, it should be 50% effacement and 4cm dilatation and anything less than these finding would be latent phase labour (4). This later concepts brought in the need to consider effacement of the cervix and not just cervical dilatation alone. This is so because, some primigravida maybe 3cm dilated but not yet 100% effaced, while some multipara may achieve 3 or 4cm cervical os dilatation without significant effacement. It is important to ensure that the parameters for active and latent phase labour are dependable and objective hence the need to consider not only cervical dilatation but also effacement of the cervix to avoid a mistaken diagnosis of latent for active phase. In modern clinical practice, it is now expected as the strategy for care in labour that, normal cervical dilatation rate is 1cm per hour for women in active phase labour which assertion will be wrong when active phase labour has not been correctly diagnosed. However, the diagnosis of latent phase by W.H.O. as by the publication in 1988 has not been generally accepted by all because the diagnosis of latent phase did not reflect cervical effacement concurrent with dilatation (25).

The present diagnosis

As a way to provide an answer for all the issues about the diagnosis of latent phase labour the WHO in 2000, came up with the new concept in which active phase labour was now a cervical dilatation of 4cm in all women at term in which there were progressive contractions at least one in every 10minutes interval (26). The choice of 4cm cervical dilatation for all parturients, obviate the need for consideration of effacement which would be irrelevant for both

primigravida and multipara who have attained 4cm cervical os dilatation. Hence, for present day clinical practice, latent phase labour is when there are progressive contractions at term and cervical os dilatation is yet, less than 4cm in which case the cervical os dilatation is 3cm or less. This is now the universally acclaimed consensus basis for the diagnosis of both latent and active phase.

Classification of latent phase: past and present

A. Friedman's concept and the controversies

The studies by Friedman described the latent phase as the earliest aspect of first stage labour and is preparatory to active phase labour with a normal duration of 20 hours in primigravida and 14hours in multipara (7,9).

The classification of latent phase by Friedman was based on the outcome of therapeutic intervention with strong sedation as follows:

- i. Normal latent phase describe the 85% of cases who following the sedation, established active phase features within 20hours for primigravida and 14hours for multipara relying on the recall by the women as when contractions became painful to time the beginning of the labour process.
- ii. Prolonged latent phase described the 5% of the cases who did not establish in active phase within 20hours and 14hours respectively for primigravida and multipara (10)
- iii. False labour describe the 10% of cases who following the sedation stopped contractions completely for both primigravida and multipara.

This classification by Friedman particularly of the prolonged latent phase has not been accepted by some workers who argue that this classification is unreliable because it relied on the recall by the women of the time the contraction began painful to time when the labour process began and reported that prolonged latent phase in all parities is the same and only about 3 – 4% and not as much as 5% (27).

B. W.H.O classification and controversies

WHO in 1988 presented a classification of latent phase as follows:

- i. Normal latent phase is a duration of 8 hours in all parities in which active phase occurred
- ii. Prolonged latent phase is a duration of over 8 hours in all parities in which active phase has not occurred
- iii. False labour are the cases who after 8 hours of latent phase had no contractions following sedation in all parities but still active phase features has not occurred. This means that false labour by this classification is a differential diagnosis of prolonged latent phase because in both situations active phase has not occurred after 8 hours, but in prolonged latent phase there are still contractions while in false labour there are no contractions.

This WHO classification has several controversial areas. Firstly, prolonged latent phase is when active phase has not occurred after 8 hours as the lower limit but the maximum duration of prolonged latent phase was not defined and this is important for cases that may still remain in latent phase for longer periods like 24 hours or beyond. Secondly, the absence of contractions after 8 hours of latent phase does not appear a dependable enough differential, between prolonged latent phase and false labour because of the very common clinical observation that often some cases who turn out to establish active phase within 8 hours do have weak and infrequent contractions at the time of admission whereas some women with strong and frequent contractions at the time of admission fail to establish in active phase within 8 hours. This may suggest that consideration of false labour as a differential diagnosis of prolonged latent phase labour based on the presence or absence of contractions following sedation after 8 hours in those not transformed yet into active phase, is rather simplistic. Hence some workers have suggested a classification in which prolonged latent phase is a situation in which latent phase features persist after 8 hours in spite of sedation but up to a maximum duration of 24 hours irrespective of whether or not there are contractions. False labour is the state when the latent phase feature is persisting after 24 hours irrespective of the contraction status (6). Thus by this classification, latent phase is a continuum classified as normal latent phase when duration is within 8 hours but prolonged latent phase when duration is over 8 hours but within 24 hours and false labour when the latent phase features are persisting beyond 24 hours without transformation into active phase. This, essentially means that, false

labour is not a differential diagnosis but a continuum, of prolonged latent phase of labour. Clinically false labour by this concept can be defined as a diagnosis in retrospect of a parturient at term in whom latent phase labour features has not transformed into active phase after 24 hours of presentation or observation in any labour ward. This view of latent phase classification has wide implication for the treatment of latent phase (6).

THE MANAGEMENT OF LATENT PHASE LABOUR

Past management and the controversies

Friedman conceived latent phase as an innocuous aspect of first stage labour in which there is as yet, softening and preparation of the cervix before the actual entering into active phase labour and hence recommended treatment with strong sedation to relieve the pain and thereafter observation until active phase transformation (12). Even for prolonged latent phase and false labour, Friedman still recommended observation until active phase labour. The false labour cases are discharged home. Prolonged and false labour were not viewed as any sinister sign of subsequent active phase problem that require any intervention. Against this, was the view that prolonged latent phase, herald the sinister sign of grave fetomaternal complication in the subsequent course of active phase labour and therefore a recommendation of intervention with artificial rupture of membrane (ARM) and oxytocin infusion treatment to expedite labour and delivery as the way to prevent subsequent active phase labour complications (28-32).

The WHO (1988) recommended sedation and observation only for normal latent phase which are the cases who transform into active phase within 8 hours after this sedation but advised intervention with ARM and oxytocin stimulation for prolonged latent phase which are cases persisting with latent phase after 8 hours in spite of the sedation. Prolonged latent phase was regarded by WHO as an abnormality suggestive of complication later in the active phase (22). However, cases of false labour in whom contractions stopped are recommended for discharged home and follow-up at the antenatal clinic until admission in active phase. The WHO felt that latent phase should be managed as a part of 1st stage labour and eventually produce a Partograph for labour management in which there was provision for recording latent phase labour features. The effectiveness of this Partograph was tested in a

multicenter study in 3 Asian countries which involved over 35000 deliveries and the protocol for latent phase labour management in that study was as follows. Sedation and observation for 8hours as soon as latent phase was diagnosed. After 8hours, those in false labour (cases with latent phase feature but without contractions) were discharged home for subsequent follow-up at the antenatal clinic but if any one re-established contractions within 24hours they were now reclassified and managed as prolonged latent phase. For those in prolonged latent phase (persisting latent phase features but still with contractions after 8hours) the recommended treatment, was to expedite labour with ARM and oxytocin infusion. When there was no progress after 8hours of this stimulation, treatment by cesarean section delivery was effected (33). The findings from this study were a latent phase incidence of 27% out of which 95% was normal latent phase and 4.6% was prolonged latent phase which were treated with ARM and oxytocin infusion. The c/s rate in those with normal latent phase was 0.39% but for those with prolonged latent phase, who were treated with ARM and oxytocin infusion the c/s rate was 20.4% and there were high rate of babies with apgar score of less than 7 at 5minutes of birth. The outcome of cases diagnosed as false labour in the study was not reported.

This study confirmed like several other studies, the higher c/s rate and poor perinatal outcome in women admitted into latent phase labour (23,24,34,35). As reported in the WHO study, the higher c/s rate affected mainly the prolonged latent phase, since the c/s rate in women with normal latent phase was 0.39% which is comparable to women admitted in straight active labour phase. This has led to the suggestion that latent phase particularly prolonged latent phase, is an anomalous feature suggesting intrinsic dysfunctional labour in subsequent active phase and the need for oxytocin to expedite delivery. This mode of treatment still resulted in the higher c/s rate and poor perinatal outcome from the published report.

It is believed that the problem in latent phase is the lack of synchrony in the myometrial activity (which is responsible for generating uterine contractions) with the changes in the cervix leading on to effacement and dilatation, typical of active phase. This lack of co-ordination of the uterine contraction with cervical changes, is the reason why the women present with uterine contraction but with cervical changes that is not yet active phase. Hence, the aim is

to correct this asynchrony with oxytocin infusion to facilitate the transformation to normal active phase labour and delivery (1,22). The high c/s rate for failure to progress and poor perinatal outcome by the present treatment of prolonged latent phase, has raised some controversies. It has been suggested that oxytocin infusion treatment in latent phase induce contractions rather than dilatation of the cervix as the reason for the frequent finding of failure to progress as the indication for the high c/s rate in the current treatment of prolonged latent phase with oxytocin stimulation (36,37). Similarly, it has been suggested that the poor perinatal outcome is due to the placenta malformation induced by the oxytocin infusion treatment for prolonged latent phase (38-40). Thus, it seems the high c/s rate and poor perinatal outcome with the present treatment of prolonged latent phase may have been induced by the intervention with oxytocin treatment rather being the result of the intrinsic problems of prolonged latent phase.

The current management of latent phase and the controversies

The question at the moment, is whether or not, latent phase labour which is an integral part of first stage labour should be regarded as a pathology that will be associated with high c/s rate and poor perinatal outcome for those who present with it. Latent phase after all, is a prodromal and preparatory phase that herald active phase labour at term and theoretically all women should pass through this phase though only about one third of women present in latent phase labour for management in any labour ward. If theoretically, all women do experience latent phase, why do some present in latent phase labour and others do not? Or what is it that make those admitted in latent phase labour present? Could it be that, it is the inherent problem in latent phase that make the women present in prolonged latent phase, also manifest as the higher c/s rate when it is treated? Or is it the prolonged exposure to the hospital system from the admission of prolonged latent phase and consequential intervention that causes the higher c/s rate? There is a study which has confirmed that despite the fact that women admitted in latent phase and those in active phase have similar characteristics at admission, those who had prolonged latent phase, had more adverse outcome with higher c/s rate and poor perinatal outcome following the current recommended treatment of prolonged latent phase (41). Such findings allow the speculation that the longer exposure of the

prolonged latent phase women to the hospital system and increased intervention maybe the reason for the difference in the two groups (42-43). A previous study had shown that active management of labour for women as yet in latent phase compared with those in direct active phase labour resulted in higher c/s rate for those in latent phase (44) and hence a higher c/s rate is a risk inherent in oxytocin infusion treatment for women who are yet in latent phase labour.

The issue now is, whether or not intervention treatment for the prolonged latent phase is the risk for the high c/s rate and not any risk inherent in latent phase itself. What then, is the best treatment option for prolonged latent phase? A study by McNiven et al. randomized latent phase treatment into active treatment with oxytocin after amniotomy as the standard treatment or being sent home to come back later only when in active phase labour. The women assigned for readmission when in active phase labour later, had a much lower c/s rate, thus emphasizing the factor of exposure to hospital system and intervention as the risk for the higher c/s rate (35). Beyond this, the study also shows the value of allowing latent phase to transform to active phase without interference whether or not it is classified as prolonged latent phase or false labour. The WHO since 2000 produced a modified Partograph in which active phase in all parities is defined as a cervical os dilatation of 4cm and above and no space for recording latent phase findings, thus suggesting the need to avoid management of women who are yet in latent phase as a way to prevent premature intervention (26). There has been no report of outcome for women who present in latent phase and were allowed transformation into active phase without interference in recent time as is implied in the WHO not providing space for latent phase recording except for a study at the UBTH Benin City which is being reported elsewhere, utilizing the above (that is observation of latent phase till transformation into active phase) as the routine for managing cases of latent phase labour.

Summary of issues and debate

Latent phase labour is the aspect of first stage labour not generally known and several years ago it was doubted if it existed at all because the features and diagnosis were very vague. Now it is recognized as a definite clinical entity which mark the earlier aspect of first stage in which the dilatation is 3cm or less. In spite of some earlier controversies, WHO classified

latent phase in the past, into normal latent phase when duration is within 8hours and prolonged latent phase when duration is over 8 hours. False labour is the diagnosis if after 8hours there were still latent phase features but no contractions following the sedation and hence false labour by this classification is the differential diagnosis of prolonged latent phase. The recommended treatment then was observation till active phase transformation for normal latent phase and false labour. However prolonged latent phase was viewed as an anomaly in which there was asynchrony between myometrial activity manifesting as contraction and the changes in the cervix leading on the effacement and dilatation typical of active phase. Hence the recommended treatment of prolonged latent phase was oxytocin infusion to correct this anomaly. There have been several reports of high c/s rate and poor perinatal outcome from this management which several studies attributed to the use of oxytocin infusion in latent phase labour. WHO, recently provided a modified Partograph for labour management in which there is no space any longer for recording latent phase labour details which is suggesting observation alone for latent phase labour management until active phase transformation. There is a study which reported a low c/s rate for latent phase labour managed with observation alone till active phase began in comparison to those actively treated in the latent phase with oxytocin infusion to corroborate this attitude of only observation until active phase conversion (35).

Recommendation

(A) Latent phase labour in contemporary obstetric practice is a clinical entity which represent the earlier aspect of first stage labour marked by progressive contractions at term and a vagina examination confirmation of a cervical os dilatation of 3cm or less. The clinical evidence so far has suggested that latent phase labour should be regarded as a continuum of normal latent phase (when duration is within 8hours); prolonged latent phase (when duration is over 8 hours to a maximum of 24hours) and false labour when latent phase persist beyond 24 hours without transformation to active phase labour. The old idea of latent phase being classified as prolonged latent phase or false labour depending on whether or not, there are contraction following the initial sedation treatment is not a dependable enough basis for such classification

because studies have shown a high rate of re-establishment of contraction within 24 hours and thus a reclassification as prolonged latent phase.

(B) Women in latent phase are in labour and hence should be managed in labour ward and not sent out because they are as yet in latent phase unless at the time there is severe bed space problem in the labour ward. The transition from normal latent phase to active phase can be very dramatic for which they require close observation which may not be easy in the lying ward with fewer nurses. Those in false labour may be transferred to the lying ward or even sent home in some selected cases but prolonged latent phase may still be managed in the labour ward unless there is severe pressure on the bed spaces in labour ward at the time.

(C) There is no basis to view presentation in latent phase as any pathology because it is only the earlier aspect of first stage labour in which the dilatation is less than 4cm and theoretically all women do experience latent phase whether or not they present for management. From the clinical evidence of higher c/s rate from intervention treatment of prolonged latent phase labour, because it is suspected to be pathological, the best treatment option therefore is for observation until active phase labour transformation. It is expected that more studies will be mounted to document the outcome of such observation of latent phase labour until transformation into active phase apart from the few already cited in this review. The observation of latent phase / false labour until active phase transformation should only be in the absence of any complications either at the time of presentation or during the observation period. Such complication, if any (such as prolonged pregnancy or other indication for induction) or when they occur, (like rupture of membranes, intrapartum bleeding or fetal distress) will be the reason for the intervention.

(D) The timing of the duration of first stage labour should no longer be from the time the parturient recall contractions as painful which though is accepted by all as highly subjective, is still the practice by most midwives worldwide in assessing the duration of labour. For the twenty-first century obstetric practice worldwide, close labour supervision is reserved for women in active phase labour; anticipating normal progress at 1cm per hour for a maximum

duration of 12hours. Therefore the timing of labour duration should be from when the woman was admitted in active phase labour aiming for delivery within 12hours of that active phase confirmation (45). Such labour duration may have the problem of being only an apparent first stage labour duration but it is the best and more objective basis for estimating the duration of active phase labour which in contemporary obstetrics practice should be a duration of not more than 12hours.

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