

Hypoxia	Features	Management
<b>No Hypoxia</b>	<ul style="list-style-type: none"> <li>Baseline appropriate for G.A.</li> <li>Normal variability and cycling</li> <li>No repetitive decelerations</li> </ul>	<ul style="list-style-type: none"> <li>Consider whether the CTG needs to continue.</li> <li>If continuing the CTG perform routine hourly review. (see CTG Assessment Tool below)</li> </ul>
<b>Evidence of Hypoxia</b>		
<b>Chronic Hypoxia</b>	<ul style="list-style-type: none"> <li>Higher baseline than expected for G.A.</li> <li>Reduced variability and/ or absence of cycling</li> <li>Absence of accelerations</li> <li>Shallow decelerations</li> <li>Consider the clinical indicators: reduced fetal movements, thick meconium, bleeding, evidence of chorioamnionitis, postmaturity, IUGR</li> </ul>	<ul style="list-style-type: none"> <li>Avoid further stress</li> <li>Expedite delivery, if delivery is not imminent</li> </ul>
<b>Gradually Evolving Hypoxia</b>	<b>Compensated</b>	<ul style="list-style-type: none"> <li>Likely to respond to conservative interventions (see below)</li> <li>Regular review every 30-60 minutes to assess for signs of further hypoxic change, and that the intervention resulted in improvement.</li> <li>Other causes such as reduced placental reserve MUST be considered and addressed accordingly.</li> <li>Needs urgent intervention to reverse the hypoxic insult (remove prostaglandin pessary, stop oxytocin infusion, tocolysis)</li> <li>Delivery should be expedited, if no signs of improvement are seen</li> </ul>
	Rise in the baseline (with normal variability and stable baseline) preceded by decelerations and loss of accelerations	
	<b>Decompensated</b>	
	<ul style="list-style-type: none"> <li>Reduced or increased variability</li> <li>Unstable/ progressive decline in the baseline (step ladder pattern to death)</li> </ul>	
<b>Subacute Hypoxia</b>	<ul style="list-style-type: none"> <li>More time spent during decelerations than at the baseline</li> <li>May be associated with saltatory pattern (increased variability)</li> </ul>	<b>First Stage</b>
		<ul style="list-style-type: none"> <li>Remove prostaglandins/stop oxytocin infusion</li> <li>If no improvement, needs urgent tocolysis</li> <li>If still no evidence of improvement within 10-15 minutes, review situation and expedite Delivery</li> </ul>
		<b>Second Stage</b>
		<ul style="list-style-type: none"> <li>Stop maternal active pushing during contractions until improvement is noted.</li> <li>If no improvement in noted, consider tocolysis if delivery is not imminent or expedite delivery by operative vaginal delivery</li> </ul>
<b>Acute Hypoxia</b>	Prolonged Deceleration (> 3 minutes)	<b>Preceded by reduced variability and lack of cycling or reduced variability within the first 3 minutes</b>
		Immediate delivery by the safest and quickest route
		<b>Preceded by normal variability and cycling and normal variability during the first 3 minutes of the deceleration (see 3-minute rule above)</b>
		<ul style="list-style-type: none"> <li>Exclude the 3 accidents (i.e. cord prolapse, placental abruption, uterine rupture - if an accident is suspected prepare for immediate delivery)</li> <li>Correct reversible causes</li> <li>If no improvement by 9 minutes or any of the accidents diagnosed, immediate delivery by the safest and quickest route</li> </ul>
<b>Unable to Ascertain fetal wellbeing</b> (Poor signal quality, uncertain baseline, possible recording of the maternal heart rate)		<ul style="list-style-type: none"> <li>Escalate to senior team</li> <li>Consider Adjunctive Techniques, if appropriate</li> <li>Consider the application of FSE to improve signal quality</li> </ul>