Vaginal Exams: To check or not to check by Margie Kline

Vaginal checks in pregnancy (also called cervical or pelvic exams)

Many OBs and some midwives begin doing vaginal exams at 36 weeks to learn if the cervix is beginning to change. There are many issues surrounding this practice. 1st of all this is done in the name of collecting information. But let's look at the purpose of collecting the information. The stated purpose is to determine if there are cervical changes. Ok, let's say hypothetically that there are changes at some point in late pregnancy. What does that tell us? Frankly, it tells us nothing that is of any benefit. If we find that a cervix is beginning to change in some way (moving from posterior or anterior to midline, effacing, softening, or actual dilation) this still gives us zero information about when the woman will actually go into labor. Changes in the cervix can occur over the last weeks of pregnancy gradually, or they can happen in a day or even hours. There is only one real benefit of checking a cervix in late pregnancy, and that is to satisfy the mother's or the practitioner's CURIOSITY!
Many, many women find this to be invasive and uncomfortable. Some women find it extremely painful or emotionally disturbing.
There is evidence supporting the fact that it can even lead to premature rupture of the membranes.
Time and time again I have heard first hand and have also read many written reports that tell of doctors, nurses, and midwives doing something called "stripping or sweeping the membranes". Depending on the practitioner this can range from being mildly uncomfortable to excruciating.
Routine cervical checks are not done in my practice. I only do them around the due date to satisfy the mother's curiosity upon request, but always stress the fact that they do not tell us when a mother may actually go into labor.
Stripping or sweeping membranes will only be done at the mother's request and it is my opinion that it should not be done until 41 weeks.
For VBAC hopefuls a vaginal exam can be done to try to assess if there is enough room for the baby to pass. This is done only at the mother's request, and does not guarantee a vaginal birth.

Vaginal checks in labor (also called cervical or pelvic exams)

When I arrive at a birth, if mother appears to be in active labor there is no real need to check cervical dilation, because again, it gives us no real information. If the mother is 6 cm, 7 cm, 9 cm, etc., it could be minutes, or hours before she actually gives birth. The reason for this is that we are not only waiting for cervical dilation. We are waiting for the baby's head to conform (molding), we are waiting for the mother's pelvic bones to slightly shift to allow for the baby to come down, we are waiting for the baby to make the slow rotation as they move down, down, into the pelvic bowl and begin to enter the birth canal. This (sometimes loooonnnng) process is called laboring the baby down. It takes TIME, and PATIENCE, and oh so much HARD WORK on the mother's part by having many, many contractions.
If I arrive at a birth and a mother does not appear to be in active labor, It is my preference to check her cervix. This is only to determine whether she is in active labor. "Active" labor is when the cervix has reached at least 4 – 5 cms. If I find a mother's cervix is still long and closed this tells me that the mother is either in very early labor, or that perhaps this is a "false" labor. This happened to me on my 7th baby. I felt strong contractions that were fairly consistent, growing

closer and closer together. The midwife arrived and checked my cervix only to find no dilation. I had had 6 natural deliveries before but was still fooled by my body. We all had a good laugh, and the midwife packed up and went home. My baby was born several days later.

If a labor seems very long and slow, or stalled in some way, I will offer to check the cervix. This may tell us if the bag of waters is bulging in front of baby's head, preventing good contact with the cervix, and possibly slowing the labor down. I can also assess how the baby's head is positioned, which may give us some ideas of some spinning baby techniques to try to help move things along. Once I have gathered this information we can discuss the situation together and either plan to take some kind of action, or we may decide to do nothing, and just keep waiting patiently.

If a mother has had a strong urge to push, to the point where she can no longer resist, then I generally like to let her body take over and begin to push on it's own. I find this to be much more effective then checking dilation often and telling the mother to start pushing when she reaches 10 cm.
However, if a mother has begun to push and we do not see bulging at the perineum (a sign of decent of baby's head) within the first few minutes, then I offer to check to make sure all cervix is out of the way.
If pushing urges cannot be resisted, and consent is given, I often find a swollen lip of cervix is in front of baby's head causing decent to be hindered. In this case it is necessary for mother to blow through contractions, and/or find various positions where it is easier for her to resist pushing. Sometimes we need to wait an hour or two before resuming pushing. This is difficult but very possible. Much better to labor the baby down than to have mother exhausted from hours of pushing. In rare cases I find a very stretchy cervix, and can offer to try to slip the cervix over the baby's head. However this procedure can be very painful as it requires me to leave my fingers in the vagina during the contractions to try to assist. It is often futile and we then must resort to laboring without pushing once again.
In formal training we are taught to do many vaginal exams during labor to be able to follow the diltation of the cervix, to ensure the mother is "progressing" at an acceptable rate. It has been my experience that this kind of invasive management of labor, actually hinders the mother's dilation by introducing pain and stress. Supporting mother through labor, talking her through the last long, hard contractions, and having her resist pushing for as long as possible is a much more efficient way to manage labor to get to the final pushing stage.

There are studies that show that multiple vaginal exams can lead to the possibility of infection, the mother's labor stalling, dilation reversal, and mother's experiencing trauma.

There are many ways to know if a mother is "progressing" in labor without doing vaginal exams. With my first home birth I was left so traumatized by my four hospital births that I requested zero vaginal exams. My 8 lb 7 oz daughter came out just fine, despite no one knowing at any point how dilated I was. We all knew I was "10 cm" when we saw the tips of her beautiful curls peaking out.

In case of hospital transfer for lack of progress, malpositioning, maternal exhaustion, or stalled labor you can decline cervical exams. It is your body, and ultimately your decision. If allowed

they may find some evidence that I never learned (especially if I do no cervical exams). I have seen mother's go in, and AFTER their epidural, allow cervical exams. This is much more comfortable as you feel the exam very little.

After the birth, while delivering the placenta, I will often follow the cord up a little ways to see if the placental is coming away or not, or to assess whether it is sitting at the cervical opening, or caught right above your pubic bone. This can be very uncomfortable because your vagina is very tender. These procedures are done, to try to ensure your safety and so you do not bleed too much. However, you are still in charge and you may tell me to stop at any point.

I will also take some soft gauze squares and examine the opening of your vagina after birth to see if you sustained any tears during the birth, again, this can be uncomfortable. If you need suturing I will use lidocaine. These injections sting but you will be numb very quickly. Again, this will be done with your consent. You may decline the exam, and if you have a tear, you may decline the sutures. Many, many 1st degree tears will heal on their own, but you may need to avoid stairs and sit with your legs together for several days (No sitting with criss-crossed legs, and you must swing legs up together when getting in and out of bed).

This quote was excerpted from an article in The PhillyVoice called Dear OB, It's Not Your Vagina by Amy Wright Glenn Rachel Leavitt, RN, founder of New Beginnings Doula Training, describes what it is like to work at the Babymoon Inn Birth Center in Phoenix, Ariz.:

"We look at a lot of different signs to determine progression. We do very few cervical checks. We use signs such as change in contraction pattern, how the woman is coping, physical signs such as shaking, nausea, bloody show and moaning. You can see how a woman begins to turn inward and the ability to concentrate decreases. These are the typical things we will look for and chart. We only check when women first come in, and if they refuse, we don't worry about it. We will also check if it has been a long time without any external signs of progression or if there is a clinical need. Again, a woman's right to refuse is acknowledged."

Here is a picture of a laboring mom by

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of Hearth and Home Midwifery in Oregon

Imagine at 8:00pm a laboring person is talking in complete sentences between contractions. They might be finding humor in things, feel excited, and stay aware of what's going on in the room. It's not uncommon at this stage to hear a birthing person say something like, "Take the lasagna out of the freezer that I made for the after the birth!" They are focused when the contraction comes, and take a moment to quietly ride the wave, but in between they are more or less themselves. Each time they go to the bathroom, they have a small amount of "bloody show" on their toilet paper, which looks like red mucous when they wipe. They are able to eat and drink a small amount.

At 4:00am this same person is laying on their side on the bed with one leg hiked up supported by pillows. They are not interested in talking, and when they want a sip of water, they simply say, "Water." They might be irritated by certain kinds of touch but really want counter-pressure on their sacrum or another part of their pelvis. When a contraction comes, they moan powerfully and completely inwardly focused, unable to do anything else but ride the wave. They are so challenged by the physical task that they are no longer interested in engaging with the room. When they go to the bathroom, there is more bloody show on the toilet paper and in the toilet bowl. They may have begun to have a purple, red, or brown line on their bum that is visible to those behind them. They might have small bites of food and sips of water, but nothing more.

At 11:00 am, this person is shaking and saying, "I can't do this. I really can't do this." They are starry-eyed and wild, behave somewhat like someone who is using hallucinogenic drugs. Contractions continue to come every 3 minutes or so, and they last a long time. During the contraction, they moan powerfully, focusing hard to keep from crying out. Often, they need to squint their face or bare their teeth to powerfully force out sound that matches the intensity of the contraction they are feeling. The purple line, if they have one, is now visible to the end of their butt crack. They may vomit and have trouble drinking more than small sips of water. Soon, they will start to introduce a grunt to the noise they make during the contraction involuntarily. They share that they have a feeling of immense pressure in their bottom- like they need to have a bowel movement immediately. This is the urge to push, and it means that their baby's head is very low and likely the cervix is completely dilated or almost dilated. Soon, they will be ready to start pushing and their baby will be born.

Every body is different, and every baby is different. Therefore, every labor is different. We can't always rely on these signs to assess progress, and sometimes cervical checks are necessary because they help the client make informed decisions about what they want to do and help the midwife suggest interventions might be helpful or necessary. That said, they are NOT required in many labors. We hope this has been educational and, if you are planning a pregnancy or are having a baby soon, we hope this helps you advocate for what the kind of birth you want.

I hope this handout helps you understand the limitations of vaginal exams, and why it is completely ok to have them done, or to decline them. It is NOT MANDATORY, nor is it necessary for me to care for you during pregnancy, labor and birth. I have caught many babies without ever putting a finger inside of their mother's vaginas. This is your body, your birth and always, always YOUR CHOICE.