

## Baby not descending and stalled pushing



### What stalled pushing means

The second stage of labor begins when the cervix is fully dilated and ends with birth. During this stage, the baby usually descends through the pelvis while also rotating and flexing the head. Descent is not always smooth or linear. Some labors have a long early second stage with passive descent, especially with epidural anesthesia, followed by more visible progress once active pushing begins.

Clinically, stalled pushing is more than feeling like nothing is happening. The team assesses whether the fetal head is moving to a lower station, whether rotation is occurring, whether caput or molding is increasing, how effective contractions are, and how mother and baby are tolerating labor. A baby may be low but not rotating, high despite strong pushing, or descending slowly with each contraction and then moving back between contractions.

The term arrest of descent generally refers to a pattern in which there is no meaningful descent despite adequate time and effort, but exact thresholds depend on parity, epidural use, fetal position, and institutional practice. Guidance from obstetric organizations emphasizes that time alone should not be the only factor; lack of descent or rotation, fetal status, maternal condition,

and the likelihood of safe vaginal birth all matter.

### **How the team assesses descent**

The central exam finding is fetal station in labor, which describes where the presenting part is relative to the maternal ischial spines. A station of 0 means the presenting part is at the spines; negative stations are higher, and positive stations are lower. Station is interpreted alongside fetal head position, such as occiput anterior, occiput posterior, or transverse.

Clinicians may also assess cervical completeness, bladder fullness, pelvic shape, fetal heart rate pattern, contraction frequency, and the quality of pushing. Ultrasound may sometimes help clarify fetal position or head direction when a vaginal exam is uncertain. This can be useful when swelling, molding, or caput makes the exam harder to interpret.

A practical question is whether the baby is truly not moving or whether progress is subtle. Small changes can matter: improved flexion, rotation toward anterior, or descent from a high to a lower station may support continued pushing if everyone remains stable. Conversely, repeated exams showing no descent, no rotation, and increasing maternal or fetal stress suggest that the plan needs to change.

### **Common reasons descent slows or stops**

Several mechanisms can lead to a baby not descending. One is fetal malposition. In an occiput posterior or transverse position, the presenting diameter may be less favorable, and the baby may need more time or positional help to rotate. Deflexion of the head, asynclitism, or a brow or face presentation can also make descent more difficult.

Another possibility is a mismatch between fetal size, head position, and the maternal pelvis, often discussed as cephalopelvic disproportion. This does not always mean the baby is objectively too large; sometimes the issue is the angle or position of the head. Suspected macrosomia, gestational diabetes, hydramnios, and a higher starting station may increase the chance of difficult descent.

Contractions matter as well. If contractions are too infrequent or not strong enough, pushing may not generate enough downward force. In selected situations, clinicians may discuss oxytocin augmentation if membranes, fetal status, uterine activity, and other factors make it appropriate. This decision is individualized because stronger contractions are not always the answer and require monitoring.

Maternal factors can contribute too. Nulliparity, epidural analgesia, dense neuraxial block, obesity, hypertensive disorders, intra-amniotic infection, fever, dehydration, and exhaustion have all been associated with prolonged or arrested second stage. These factors are not blame; they are clinical context for understanding why labor may be harder than expected.

### **Time thresholds and why they are flexible**

Many clinicians use time-based criteria to frame discussions about prolonged second stage. Consensus guidance has described second-stage arrest as no progress after at least 3 hours of pushing in a first birth with epidural anesthesia, 2 hours without epidural anesthesia, 2 hours with epidural anesthesia in someone who has given birth vaginally before, or 1 hour without epidural anesthesia in someone who has given birth before. These are not automatic cutoffs for cesarean birth; they are thresholds for careful reassessment.

The distinction between prolonged second stage and arrest matters. A prolonged stage with ongoing descent, reassuring fetal status, and a mother who wants to continue may be managed differently from a shorter but clearly arrested pattern with no descent or rotation. The pushing stage and delivery plan should be individualized rather than driven only by a clock.

Epidural anesthesia can also change the rhythm of second stage. Some patients benefit from laboring down after full dilation, meaning they wait for passive descent before active pushing, particularly if there is no urgent need to push immediately. Others need active pushing sooner because of fetal status, maternal symptoms, or local practice. The safest approach depends on real-time assessment.

### **Options before operative delivery**

When pushing stalls but there is time to continue safely, the team may try several measures. Position changes can help the fetal head rotate or improve pelvic dimensions. Side-lying pushing position, hands-and-knees positioning, supported squat, upright positions, or semi-recumbent positions may be considered depending on epidural mobility, monitoring needs, and maternal comfort.

Bladder emptying is a simple but important step because a full bladder can obstruct descent. The team may also coach different pushing techniques, adjust timing with contractions, or encourage open-glottis pushing if appropriate. If the epidural is very dense and the patient cannot feel pressure or coordinate pushing, anesthesia may evaluate whether an adjustment is possible while maintaining pain control.

Rest can be therapeutic when exhaustion is the limiting factor and fetal status is reassuring. Hydration, temperature management, treatment of suspected infection, and emotional support are also part of care. A stalled second stage often becomes more stressful as time passes, so clear communication matters: what has changed, what has not, what the next reassessment point is, and what options may come next.

### **When assisted birth or cesarean may be discussed**

If the baby is low enough, the position is known, the cervix is fully dilated, the membranes are ruptured, and the clinician has appropriate expertise, operative vaginal birth with vacuum or forceps may be an option. This is not simply a shortcut; it has strict prerequisites and specific risks, including scalp or facial injury, maternal perineal trauma, and the possibility that the attempt may not succeed.

Cesarean birth may be recommended when the head remains too high for safe assisted vaginal birth, when there is no descent despite adequate pushing and contractions, when fetal position or pelvic factors make vaginal birth unlikely, or when maternal or fetal status becomes concerning. A cesarean in the second stage can be more technically complex than one earlier in labor because the fetal head may be deeply engaged, so the team may take extra steps to reduce complications.

Shared decision-making is still important, even when decisions need to be made quickly. Patients and partners can ask what the current station and position are, whether there has been any descent since the last exam, whether fetal heart rate is reassuring, what the risks are of continuing, and what the risks are of vacuum, forceps, or cesarean in that specific situation.

### **Emotional support after a stalled second stage**

Stalled pushing can be emotionally intense. Many people describe feeling trapped between exhaustion and urgency, especially if plans change after hours of effort. These feelings are valid whether the birth ends vaginally, with assistance, or by cesarean. A difficult second stage can leave physical soreness, pelvic floor symptoms, wound concerns, feeding challenges, and memories that need time and support.

After birth, it can help to request a debrief with the clinician or midwife. Useful questions include: What was the fetal position? Was there arrest of descent or slow progress? Were contractions adequate? Was infection suspected? Why was the final delivery method chosen? Understanding the clinical reasoning can reduce self-blame and help with future pregnancy planning.

Follow-up should include both physical and emotional recovery. Persistent pelvic pain, urinary or fecal leakage, severe perineal pain, wound concerns, fever, heavy bleeding, intrusive memories, panic, or depressive symptoms deserve professional attention. The goal is not to relive the birth in detail before someone is ready, but to make sure recovery is supported and complications are not missed.