## Challenges and assisted pushing with epidural

### Why pushing can feel different with an epidural

The second stage of labor begins when the cervix is fully dilated and ends with the birth of the baby. Without regional analgesia, many people experience an intense spontaneous urge to bear down, often described as overwhelming rectal pressure. With an epidural, pain signals from the uterus, cervix, vagina, and perineum are reduced. This can be a tremendous relief, but it may also make the urge to push less obvious or delayed.

Modern epidurals are not designed to make a person completely numb from the waist down. Low-dose local anesthetic, often combined with an opioid medication, aims to reduce pain while preserving some pressure sensation and leg movement. Many people can still recognize contractions, feel descending pressure, and coordinate pushing. Others have a denser block, especially if they needed higher doses for pain control, had a recent top-up dose, or respond strongly to the medication.

The challenge is not simply whether someone can push, but whether they can interpret altered body cues. A contraction may feel like tightening, heaviness, rectal pressure, or only a change on the monitor. Nurses and midwives often help by placing a hand on the abdomen, watching the contraction tracing, or

giving verbal cues about when a contraction starts and peaks. This support can transform a confusing sensation into effective, coordinated effort.

**Epidural effects on second-stage duration**

Research summarized by Evidence Based Birth indicates that epidurals are associated with higher odds of a prolonged second stage. A prolonged second stage is commonly defined as more than three hours for a first birth and more than two hours for someone who has given birth vaginally before, although local guidelines and clinical circumstances vary. The same review reports higher odds of vacuum or forceps-assisted birth among people with epidurals, while noting that epidurals do not increase cesarean rates.

Several mechanisms may contribute. Reduced pelvic floor tone can sometimes allow descent, but reduced sensation may make spontaneous pushing less instinctive. Motor weakness, if present, can limit upright or squatting positions. The baby's position also matters: an occiput posterior or asynclitic position may require more time and rotational descent regardless of pain relief. Maternal fatigue, fetal station, contraction strength, and parity all influence the pace of progress.

A longer second stage is not automatically dangerous. Clinicians assess the whole picture: fetal heart rate patterns, maternal vital signs, infection concerns, bleeding, descent of the fetal head, rotation, caput or molding, and the birthing person's stamina. If the baby is descending steadily and both mother and baby are stable, continued pushing may be reasonable. If progress stalls or fetal status becomes concerning, the team may discuss assisted vaginal birth or cesarean birth, depending on station, position, urgency, and local expertise.

**Immediate pushing, delayed pushing, and laboring down**

For many years, some clinicians recommended delayed pushing for people with epidurals. This approach, often called laboring down, means waiting after full dilation until the baby descends further or the urge to push becomes stronger. The rationale was that passive descent might reduce active pushing time and fatigue. However, recent evidence challenges a routine delay for everyone.

NIHR Evidence summarized research in which delaying pushing by 60 minutes did not improve outcomes for women with epidural or spinal pain relief. Immediate pushing produced a shorter overall labor duration, with similar spontaneous vaginal delivery rates compared with delayed pushing. The delayed group had longer active pushing by about 9.2 minutes and was associated with higher risks of postpartum hemorrhage and chorioamnionitis in that study summary.

This does not mean delayed pushing is never appropriate. A brief period of rest may help a fatigued person, allow an epidural dose to settle, or permit descent when fetal and maternal conditions are reassuring. But the evidence supports individualized decision-making rather than an automatic one-hour wait. The practical question is: what is safest and most effective right now, given the baby's station, maternal energy, contraction pattern, epidural density, and fetal monitoring?

If you have preferences about timing, it can help to ask: "Is the baby descending?" "Is the fetal heart rate reassuring?" "What are the benefits and risks of waiting versus pushing now?" These questions invite shared decision-making without placing the burden of medical judgment on the laboring person.

**Assisted pushing techniques that preserve participation**

Assisted pushing does not always mean forceps or vacuum. Often it means skilled bedside support that helps the birthing person work with altered sensation. The goal is to preserve agency and physiologic progress while responding to medical realities.

Position changes after epidural analgesia: Side-lying, supported sitting, semi-recumbent, hands-and-knees with adequate assistance, or a supported squat bar may improve comfort and pelvic dimensions. Not every position is safe for every epidural density, so staff support is essential.
Open-glottis pushing: Some people exhale or vocalize while bearing down, which may feel less forceful and more sustainable. Others benefit from short coached pushes during the peak of contractions.
Mirror or touch feedback: Seeing crowning in a mirror or feeling the baby's head, if desired and appropriate, can help a person direct effort when sensation is muted.

Contraction cueing: When the urge is subtle, the nurse or midwife may use the monitor or abdominal palpation to guide timing.
Epidural adjustment: If the block is very dense, the anesthesia team may be able to adjust dosing. This must be individualized because reducing analgesia can also allow severe pain to return.

Effective support also includes emotional language. A person with an epidural may feel frustrated if they cannot sense what their body is doing. Clear, calm feedback such as "That push moved the baby lower" or "Let’s rest through this contraction and reset" can reduce panic and improve coordination.

**When vacuum or forceps may enter the conversation**

Assisted vaginal birth, also called operative vaginal birth, may be considered when the cervix is fully dilated, the fetal head is low enough, the position is known, membranes are ruptured, and vaginal birth is judged feasible. Common reasons include prolonged second stage with inadequate progress, maternal exhaustion, or a need to shorten birth because of non-reassuring fetal heart rate patterns. The decision depends on the clinician’s skill, the baby’s station and position, estimated size, pelvic assessment, and whether cesarean birth would be safer.

Vacuum and forceps are different instruments. A vacuum uses suction on the baby’s scalp to assist traction during contractions. Forceps are curved instruments placed around the baby’s head to guide descent and, in some cases, rotation. Both require informed consent whenever circumstances allow. The team should explain why assistance is being recommended, what alternatives exist, what risks are relevant, and what might happen if the attempt is unsuccessful.

Potential maternal risks include perineal trauma, bleeding, pain, and pelvic floor injury. Potential newborn risks include scalp bruising or swelling with vacuum, facial marks with forceps, and, rarely, more serious injury. These risks must be weighed against the risks of continuing a prolonged or deteriorating second stage, as well as the risks of cesarean birth at full dilation. A thoughtful discussion may include whether an episiotomy is recommended, who will perform the procedure, what neonatal support is available, and how many attempts or pulls will be considered before changing course.

## Communication, consent, and emotional safety

The pushing phase can become intense quickly, especially if fetal monitoring changes or the room suddenly fills with staff. Even in urgent circumstances, respectful communication matters. A concise explanation such as "The baby’s heart rate is not recovering well, and we recommend vacuum assistance because the head is low" can help the birthing person understand the reason for action.

People with epidurals may also need reassurance that needing coaching or assistance is not a personal failure. Epidural analgesia changes sensory information; it does not remove the person’s effort, courage, or role in birth. Many people push effectively with an epidural, and some need additional help because of fetal position, fatigue, or urgency. Both experiences are valid.

Before labor, consider discussing preferences with your clinician: how you feel about coached versus spontaneous pushing, which positions may be possible with an epidural, what thresholds are used for prolonged second stage, and how assisted delivery decisions are handled. During labor, a support person or doula can help repeat information, ask for clarification, and remind the team of preferences while clinicians focus on safety.

After birth, especially after an unexpected assisted delivery, a debrief can be valuable. Asking what happened, why decisions were made, and what to watch for in recovery may reduce lingering confusion or distress. Emotional recovery after assisted delivery is part of postpartum care, not an afterthought.

## Recovery considerations after assisted or prolonged pushing

Recovery after a long second stage or assisted delivery varies widely. Some people have mild soreness; others experience significant perineal pain, swelling, hemorrhoids, urinary difficulty, pelvic floor symptoms, or emotional distress. Early postpartum assessment should include bleeding, pain control, bladder function, wound checks when there are tears or episiotomy, and newborn evaluation when instruments were used.

Seek professional guidance if pain is worsening rather than improving, bleeding is heavy, fever develops, urination is difficult, or there is new fecal

incontinence, severe pelvic pressure, or concern about wound healing. These symptoms do not prove a complication, but they deserve prompt assessment. Pelvic floor physical therapy may be helpful for some people after prolonged pushing, operative vaginal birth, or obstetric anal sphincter injury, but it should be coordinated with postpartum medical care.

For future births, a prior epidural or assisted vaginal birth does not determine what will happen next time. A clinician can review the operative note, fetal position, duration of pushing, type of tear if any, and neonatal outcomes. That information can guide individualized planning, including pain relief preferences, second-stage support, and when to consider obstetric consultation in labor.