CASE STUDY

Chiropractic Care of a Patient with Dystocia & Pelvic Subluxation

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Abstract

Objective: To report on the successful collaboration of chiropractors and midwives, we describe the care of a woman in labor with problems associated with dystocia.

Clinical Features: The patient is a 26-yr-old nulliparous female attended to during a home birth delivery with 3 midwives and her chiropractor. With lack of cervical dilation, descent and diminished uterine contractions along with decreased fetal heart tones at 23 hours of labor, all involved decided to initiate chiropractic care with the Webster Technique.

Interventions and Outcomes: The result of using Webster Technique was stronger and more frequent contractions with stabilized fetal heart tones. At 28 hours, the fetus was determined to be asynclitic. Synclitism describes the condition of parallelism between the plane of the pelvis and that of the fetal head. The midwives attempted various patient positioning and more homeopathic remedies, performing a surgical rupture of the patient’s membranes with recommendation of further chiropractic care. At 34 hours of labor, the attending chiropractor performed the psoas release and ½ hour later, the patient was at complete cervical dilation. The labor progressed rapidly thereafter and a healthy baby girl was born.

Conclusion: The successful birthing outcome of a patient with dystocia through the cooperative efforts of the patient’s midwives and chiropractor is described. We advocate continued co-operation in similar patients and for further investigation in this field.

Key Words: Chiropractic, pregnancy, dystocia, Webster Technique, subluxation

Introduction

In 1998, Eisenberg et.al.1 estimated that the total number of visits to complementary and alternative medicine (CAM) practitioners would exceed the total number of visits to primary care physicians for the next two years thereafter. Furthermore, they estimated that Americans would spend some $27 billion dollars out-of-pocket for such services.

In 2002, a much larger nationwide survey by Barnes et.al.2 estimated that American utilization of CAM therapies may be as high as 62% when the use of prayer healing and megavitamins were included in the types of CAM therapies used.
Today, the term *integrative medicine* is used to emphasize and reflect the vitalistic and holistic nature of the various CAM therapies in combination with conventional medicine. The term emphasizes the innate ability of the individual to heal, a Freirean approach to patient care and the relationship among its practitioners, and that the approach to patient care incorporates evidence-based practice.

Under the auspices of integrative medicine, the collaboration of chiropractors and midwives would seem a natural development considering their common theoretical and clinical framework for patient care. To report on such collaboration and its successful outcome, we describe the care of a woman in labor with problems associated with dystocia.

**Case Report**

The patient is a 26-yr-old nulliparous female attended to during a home birth delivery with 3 midwives and her chiropractor. The patient’s labor began with strong contractions at 4-5 minute intervals. Twelve hours into labor, cervical dilation was at 4-5 cm with her contraction frequency and duration characterized as “inconsistent.” With the patient exhausted and twenty two hours into labor, her cervix had dilated to 7 cm but her contraction frequency and duration had diminished “significantly.” The patient’s lack of cervical dilation, descent and diminished uterine contractions are indicative of dystocia.

The midwives responded to the patient’s lack of progress by using various homeopathic remedies and patient positioning which resulted in decrease fetal heart tones. At 23 hours of labor, the midwives determined that the fetus was asynclitic again. The midwives suggested an inversion technique with the patient prone with her chest flat on the floor and her pelvis raised in a caudal inclination to improve fetal positioning. The fetal heart tone improved but the patient’s uterine contractions were still “weak” and the fetal positioning unchanged. At this point, the midwives discussed for the possibility of a transfer to the hospital.

**Decision to Utilize Webster Technique**

Following a discussion that included the patient, her chiropractor and the attending midwives, it was decided that the Webster Technique was to be applied.

With the patient already in the prone position, the Webster Sign was not difficult to perform wherein the patient’s knees are flexed in a heel-to-buttock maneuver. The side with the greater resistance in the heel-to-buttock maneuver was the side of sacral posterior rotation (+θY or -θY). The patient was determined to have a left sacral posterior rotation (+θY).

The patient was adjusted accordingly for a left posterior rotation of the sacrum. Furthermore, the chiropractor alleviated the “tension” in the patient’s right psoas with pregnancy psoas release technique. During this procedure, a sustained ligament contact in accordance with the Webster protocol resulted in the fetus being “felt” to move, as reported by the mother. Thereafter, the midwives reported a significant improvement in labor progression since time of chiropractic adjustment. The patient’s contractions became stronger and more frequent; and following cessation of the “all fours position,” the fetal heart tones stabilized. Twenty eight hours into labor, the fetus was determined to be asynclitic again.

The midwives again attempted various patient positioning, more homeopathic remedies and performed a surgical rupture of the patient’s membranes. Furthermore, they recommended further chiropractic care.

At 34 hours of labor, the attending chiropractor performed the psoas release once again. One-half hour later, the patient was at complete cervical dilation. The labor progressed rapidly thereafter, and the patient began pushing. A healthy baby girl was born vaginally at home one hour (i.e., 35 hours of labor) after receiving her last spinal adjustment.

**Discussion**

According to Williams Obstetrics, the causes of dystocia may be due to the following variables: (1) abnormalities of the expulsive forces due to inadequate (weak) uterine forces or inappropriately coordination to efface and dilate the cervix (i.e., uterine dysfunction), or inadequate voluntary muscle effort during the second stage of labor; (2) the presence of abnormalities in the maternal bony pelvis resulting in dysfunctional pelvic contractions; (3) malposition or malpresentation of the developing fetus; and (4) abnormalities of the soft tissue structures of the reproductive tract that interfere or form an obstacle for fetal descent.

As reflected in the use of birthing augmentation to dystocia, the number of operative vaginal delivery or Cesarean section performed, dystocia in the nulliparous is very common. In 2003, some 17% of women received oxytocin augmentation for dystocia while in 2004, the primary cesarean delivery rate (i.e., cesarean delivery in women without previous cesarean) increased to 20.6% with over 50% of these procedure as a result of dystocia.

**Medical Approach to Dystocia**

Based on the data from hundreds of women in labor, Friedman defined the normal progress of labor as shown in Table 1 at end of report. However, according to Shields et. al., a more recent study examining 1,329 women in labor by Zhang et.al would seem to indicate that the range/definition of normal labor is much broader when compared to Friedman’s original definition from a mean rate of cervix dilation from 1.1 cm per hour to 1.2 cm per hour. For completeness, we provided a brief overview of the medical approach to dystocia. We iterate that this is by no means a comprehensive description but rather is intended to provide a general overview. In this effort, we credit the article by Shields et. al. upon which this writing was based.

According to Shields et.al., four issues must be considered when attending to the woman with dystocia. These considerations affect the course of care of the patient and they are: (1) the adequacy of the woman’s contractions; (2) the presence of fetal malposition; (3) the presence of...
Dystocia

second stage of labor does not automatically indicate operative
strength and frequency. According to Shields et.al., prolonged
mother with the inversion technique as described above. At
In the case report presented, the midwives positioned the
side-lying, or asymmetrical sitting or kneeling.

include knee-chest, hands and knees, pelvic rocking, lunging,
patient is to assume various positions or movements to resolve
true cephalopelvic disproportion.

Manual rotation of the fetus is one option for the birthing
clinician. A hand is positioned palm upward into the vagina,
and during a contraction the hand serves as a wedge to flex the
fetal head while the fingers exert a rotating force to bring the
occiput to the anterior. Like all manual therapies, this requires
training and clinical skill/experience. Another option is for the
clinician. A hand is positioned palm upward into the vagina,
positioning unchanged.

In the case report presented, the midwives positioned the
mother with the inversion technique as described above. At
this second stage of labor, intravenous oxytocin can be
initiated or increased to address contractions with decreased
strength and frequency. According to Shields et.al., prolonged
second stage of labor does not automatically indicate operative
vaginal or cesarean delivery. Only a non-reassuring fetal heart
tracing indicates a need for consideration of operative vaginal
or cesarean delivery.

The Webster Technique

In the case presented, the Webster Technique4,5,13 was
provided as a means of addressing the patient’s lumbosacral
subluxation concomitant with dystocia. The Webster
Technique was founded on the clinical and theoretical
framework of the application of a specific chiropractic
adjustment, which reduces interference to the nervous system
and facilitates balance in the pelvic structures thereby
improving the physiological functioning of the pelvic muscles
and ligaments. This is turn removes in-utero constraint and
allows for the fetus to get into the best possible position for
birth.

In light of the manual rotation procedure described above as
an option for the attending clinician during the second stage of
labor; perhaps the Webster Technique may provide an
alternative and less invasive option for facilitating the fetus
to assume the correct position for birthing. The Webster
Technique is not nor does it impose upon the practice of
obstetrics.

The Webster Technique is a specific chiropractic adjustment
intended to correct sacral subluxation and is well within the
chiropractor’s scope of practice. As such, we advocate for
continued co-operation between midwives and medical
doctors under the auspices of integrative medicine. At no time
does the chiropractor attempt with a direct hands-on approach
to change the position of the fetus as is done with the external
cephalic version or direct manual rotation as described above.

The theoretical and clinical framework of the technique is the
facilitation of proper functioning to the pelvic area and
reduction of intruterine constraint, allowing the fetus to get
into the best possible position for birth. Correlating the cause
dystocia with the corrective accomplishment of the
chiropractic adjustment vis-à-vis the Webster Technique are the
following: (1) Specific chiropractic adjustments to the
lumbosacral spine may have neurological effects facilitating
adequate contractions of the uterus and dilation of the cervix;
(2) Adjustments to the lumbopelvic may structurally correct
pelvic misalignments contributing to dystocia; and (3) The
correction of fetal malposition/malpresentation are corrected.

Chiropractors and Midwives

A recent survey of Certified Nurse Midwives indicates that
CAM usage by pregnant women in common. More than 90%
of midwives reported recommending CAM for their pregnant
patients for stimulation of labor and maternal relaxation in
labor. Specifically related to chiropractic, midwives refer to
chiropractors to address pregnancy-related musculoskeletal
complaint of low back pain, sciatica and malposition.14

Although others have advocated for co-operation and
and collaboration between chiropractors and midwives15-17 and has
been our experience in clinical practice; to the best of our
knowledge this is the first description of the successful
collaboration between chiropractic and midwifery in the care
of a patient with dystocia. As described in the body of the case
report, the addition of chiropractic during the birthing process
helped immensely--as attested to by the midwives and the
patient herself.

The use of various homeopathic remedies and patient
positioning (i.e., inversion technique with the patient prone
with her chest flat on the floor and her pelvis raised in a caudal
inclination) resulted in improved fetal heart tone but the
patient’s uterine contractions were still “weak” and the fetal
positioning unchanged.

The participation of the attending chiropractor helped to
address the patient’s failure to progress, resulting in correction
of the fetal malposition and the eventual progression of labor.
A systematic review by Hofmeyr and Kulier 18 concluded that
having a woman assume the hands and knees position for a
specified period near the end of pregnancy had no effect on
fetal position at delivery. However, their review did not
include studies of women in labor.16 This study highlights the
specifics of what happens when caregivers co-operate to work
together to address possible complications of labor.

A number of significant implications arise from this case
report when one examines the factors preventing the incidence
of dysfunctional labor in nulliparous women. These are: (1)
the use of labor support such as doulas, midwives and from
our perspective – chiropractors are substantial; (2) there is
avoidance of hospital admission in the latent stage of labor;
(3) there is avoidance of elective induction with an unripe

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cervix; and (4) cautious use of epidural analgesia is facilitated.19

Although no healthcare intervention is 100% safe, the choice of this patient to be attended to by her midwives and her chiropractor highlighted her wishes to have as natural a childbirth as possible. This case report described how dystocia and its possible complications were successfully addressed by the midwives and chiropractor. No complications or adverse outcomes could be documented as a result of the presence of the chiropractor during the birthing process. Case reports serve an important function in research. The information they provide are noteworthy for the practicing clinician and for education, but also serve to inform higher level research designs such as in randomized controlled clinical trials.

A selective review of the literature using MANTIS and Pubmed databases supports our notion that, to the best of our knowledge, this is the first reporting of its kind in the scientific literature on the chiropractic and midwifery care of a patient with dystocia with positive outcomes. Pubmed (1966-2007) was searched using the terms “dystocia AND chiropractic” resulting in no available abstracts. MANTIS (1965-2007) was searched using the terms “dystocia,” “birth trauma” and “pregnancy” resulted in similar findings. We acknowledge that the chiropractic care of the pregnant patient has been described in the scientific literature20-21 but to the best of our knowledge, this is the first describing the care of a pregnant patient with dystocia.

In closing, we caution the reader on the lack of generalizability of the findings of the case report presented. Although we advocate for the co-operative effort of chiropractors and midwives in the care of the pregnant patient during gestation and birthing, the success of the efforts described herein are not generalizable. Inherent in its research design, the positive findings in this and in all case reports/case series may be attributed to the following: (a) regression to the mean and (b) the result of placebo. Furthermore, both the chiropractor and her patient may have made incorrect inferences from the chiropractic treatment applied due to (c) the demand characteristics of the therapeutic encounter and (d) subjective validation.

The use of controls, randomization and manipulation of the independent variable (i.e., the care employed) must be examined in higher level designed studies to fully determine the role and salutatory effects of chiropractic care in similar patients. We also advocate for continued clinical documentation of similar cases in the scientific literature.

Conclusion

We described in this case report the successful outcome of a patient with dystocia through the cooperative efforts of the patient’s midwives and chiropractor. We advocate for continued co-operation in similar patients and further investigation in this field.

References


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**Table 1.** Traditional definitions of abnormal labor (Modified from Shields et.al.)\(^{11}\)