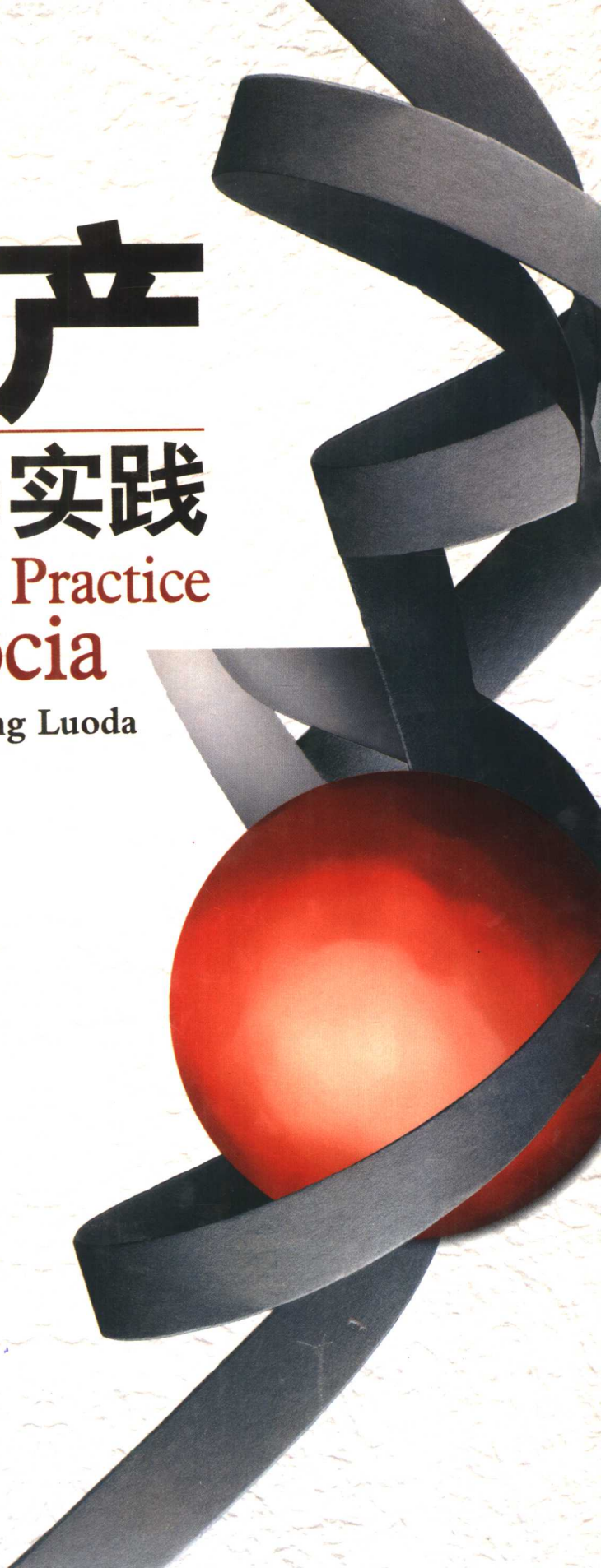
中英文对照
ENGLISH AND CHINESE

难产
理论与实践
Theory and Practice of Dystocia

凌萝达 主编 ◇ Ling Luoda

重庆出版集团 重庆出版社



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Theory and Practice of Dystocia

图书在版编目(CIP)数据

难产理论与实践/凌萝达主编. —重庆:重庆出版社,2006.10
ISBN 7-5366-8026-0

Ⅰ.难… Ⅱ.凌… Ⅲ.难产—诊疗—汉、英 Ⅳ.R714.4

中国版本图书馆 CIP 数据核字(2006)第 093904 号

难产理论与实践
NANCHAN LILUN YU SHIJIAN
凌萝达 主编

出 版 人:罗小卫
责任编辑:王 念 江 萍 宿文忠 王 灿
装帧设计:钟丹珂

重庆出版集团
重庆出版社 出版
重庆长江二路 205 号 邮政编码:400016 http://www.cqph.com
重庆出版集团艺术设计有限公司制版
自贡新华印刷厂印刷
重庆出版集团图书发行有限公司发行
E-MAIL:fxchu@cqph.com 邮购电话:023-68809452
全国新华书店经销

开本:787mm×1 092mm 1/16 印张:19.25 字数:433 千
2006 年 10 月第 1 版 2006 年 10 月第 1 次印刷
印数:1~3 000 册
定价:39.60 元

如有印装质量问题,请向本集团图书发行有限公司调换:023-68809955 转 8005

作者简介

凌萝达教授(博士导师),浙江人,1920年生,1945年于上海医学院本科毕业后,一直在上海医学院的几个附属医院从事妇产科工作。1958年调入重庆医学院,先后在附属第一、第二医院工作至1990年退休,退休至今仍坚持对难产理论与实践进行经验总结。50余年来,她把全部精力奉献给了妇产科工作,尤其精通难产业务。1978年,她率先发表了头位难产的论文,1986年又以英文刊登在香港出版的《中国医学》上向国外介绍。她与她所领导的围产研究室的同仁们对这一课题继续潜心研究。1980年及1986年进行了两次全国性难产流行病学调查,并受卫生部委托于1982～1987年举办了5期全国难产防治学习班。先后发表有关论文20多篇。出版了《难产与围产》(科技文献出版社重庆分社,1983年),《头位难产》(重庆出版社,1990年)及《难产》(重庆出版社,2000年)。参加编写《实用妇产科学》(人民卫生出版社,1987年)、《中华妇产科学》(人民卫生出版社,1999年)。

Introduction of the Editor

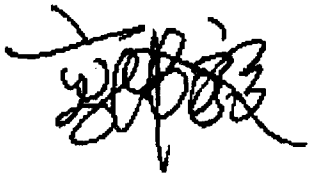
Professor Ling Luoda (doctoral adviser), born in 1920, graduated from Shanghai Medical College in 1945, and worked in its affiliated hospital's Obstetric and Gynecological Department from then up to 1958. In that year she moved to Chongqing and worked in the First and then the Second Affiliated Hospital of Chongqing University of Medical Sciences, till her retirement in 1990. After retirement, she still works hard in summarizing her rich clinic experiences in dystocia into a new theoretical structure. It was in 1978 when she published *Cephalic Dystocia*, the first paper on this topic, and then in the year of 1986 this paper was published in English in the book of *Chinese Medicine* Published in Hong Kong, which was the first time this new theory was brought out worldwide. The research on dystocia was carried on and two nationwide epidemiological studies of dystocia were carried out in the years of 1980 and 1986. She was charged by the National Health Minisrty with the task that classes on prevention and control held for 5 times under her direction, during the period from 1982 to 1987. She has published more than 20 articles on dystocia and three books: *Dystocia and Perinetologe* (1983), *Cephalic Dystocia* (1990) and *Dystocia* (2000). And she also wrote the chapters of dystocia in the books of *Practical Obstetric and Gynecology* (1987) and of *Obstetric and Gynecology of China* (1999).

序

凌萝达教授主编的《难产理论与实践》中英文对照本问世了。这是产科界的一个喜讯，在国内也是一个新的尝试。

凌萝达教授从事妇产科教学、科研、医疗工作50余年，有丰富的临床经验，尤其对难产问题有很深的造诣。1978年率先发表《头位难产》论文。她特别强调理论联系实践，建议新的难产分类法，按临床表现将难产分为头位难产、臀位、横位及复合先露，认为此种分类法更为合理与实用。

《难产理论与实践》全书集中反映了著者们数十年来有关难产的临床实践经验和科研成果，并吸纳了国内外新资料的精华所在，整合出一套有关难产的理论体系及处理原则。该书重点突出，理论联系实际，这对学习难产理论与提高对难产处理的能力以及提高专业英语水平都会有很大帮助。该书由于是中英文对照，更便于进行国际学术交流。读者如能按书中的建议加以实践，定能解决不少产科中的困难问题，造福于母儿。



中华医学会副会长　中华妇产科学会会长　曹泽毅

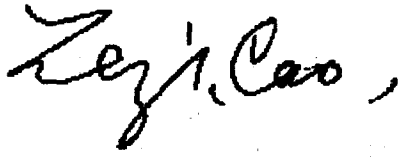
2006年9月10日

Preface

Theory and Practice of Dystocia, edited in both Chinese and English by Professor Ling Luoda, is a valuable asset for people who work in the field of obstetrics. It also presents some new approaches to obstetrics in China.

Professor Ling Luoda had done scientific research and has practised in gynecology and obstetrics for more than 50 years. She has rich clinical experience, and especially has full knowledge in dealing with dystocia. In 1978, she played a leading role in publishing of a paper on *Cephalic Dystocia*. She emphasizes that theory should be related to and applied to practice. She suggests new classifications for dystocia, i.e. that dystocia should be divided into cephalic dystocia, breech, transverse lie and compound presentation according to clinical reality. She holds that this classification is more reasonable and more practical than earlier classifications.

Theory and Practice of Dystocia reflects those authors' clinical experience and scientific research of dystocia for dozens of years. In addition to gathering the essence of new material from Chinese and foreign sources, it summarizes a series of theories and procedural principles related to dystocia. Her book highlights key points where theory is applied to reality. The book should prove very helpful for studying theory and for improving the treatment of dystocia, and, for those whose English is the second language, to improve professional English. Since the book is written in both Chinese and English, it becomes valuable for international academic exchange. If readers can practise the suggestions made in the book, they should definitely be able to deal better with many of the difficulties faced in obstetrics for the benefit of mothers and their children.



Chinese Medical Association Vice-chairman
President of the Chinese Obstetrics and Gynecology Association Cao Zeyi
September 10, 2006

前　言

我们的专业知识均来自国内外许多专业先驱者辛勤的积累，但在继承这些专业基础后，仍应不断总结经验，并有所前进、有所创新。本人在50年的妇产科专业实践中认识到产科是一个广阔、复杂的学科，它关系到母子两人的安危。产时处理不当可影响母子健康，甚至危及生命。因此，产时处理应列为围产医学承上（孕期保健）启下（产褥期保健）的重要一环。

20世纪50年代初，本人晋升为主治医师，不久即被分配至上海第一医科大学附属妇产科医院工作。该院每周有一次疑难病例讨论，而十之八九为产科病例，每每由讨论诊断处理难产不当的病例而吸取教训，对我而言印象特别深刻，因此立志研究难产，在王淑贞院长的领导下成立了难产研究小组。20世纪50年代尚允许做骨盆摄影测量，故陆续收集了500套有难产倾向病例的X光骨盆测量、临床骨盆测量及一切关于分娩的记录，奠定了难产研究的基础。

1958年调往重庆医科大学工作时，仍继续努力坚持难产科研方面的工作。1978年发表了《头位难产及头位分娩评分法》论文。我首先提出头位难产的概念及其高发病率应受到重视。由于正常分娩是以头为先露，因此发生于头位的难产往往会被忽略。此后，我对骶骨、骨盆狭窄、入口面倾斜度及它们的分类进行了探讨。为更进一步研究头位难产，对头位中的胎头高直位、持续性枕后位及持续性枕横位等提出了诊断与处理方法及见解，并第一个提出过去在中外书籍中均未曾明确提出的枕横位中的前不均倾位。

2000年，我出版了《难产》(《头位难产》修订版)，整理出一套崭新的难产理论，将难产以临床表现分为头位难产、臀位、横位及复合先露，理论上有异于传统的根据3种分娩因素(产道、产力、胎儿)异常而进行的分类。这些分娩因素异常，单独或同时存在均可导致难产，它们不能作为分类的标准，只能作为难产发病因素。因此，我认为难产应按临床表现分类。

本书以中英文对照，采用了2000版《难产》的精髓部分，按照新的难产理论体系将其分为难产总论及难产各论两部分，下设7篇，22章。是否妥当，望读者提出宝贵意见。

著者希望这本书可供产科医生参考，并对毕业后的学生及妇产科专业继续深造者有益。

本书由美国新闻编辑 Akei Konoshima 及上海第一医科大学陈忠年教授等审阅，并得到王志彪教授及同仁们的协助，特此表示衷心的感谢！

凌萝达

2006年9月1日

Foreword

Our specialized knowledge has been all got from the accumulations of the diligent works of our forerunners in obstetrics and gynecology from our motherland and foreign countries. Based on this previous basic knowledge, we should incessantly draw conclusions from our work and experience, so that we may have some progress and something new. In my 50 years' practice in obstetrics and gynecology I found obstetrics is a science of broad and complicate field. It is closely related to maternal and fetal safty, any improper management will affect health of the mother and the new born, even their lives. Therefore the management during labor should be listed under perinatal medicine, which acts as a bridge between pregnancy and puerperium.

Early in 1950s, not long after I was promoted to physician-in-charge, I was appointed to work in Affiliated Gynecology and Obstetrics Hospital of Shanghai First Medical College. There we had weekly seminar to discuss the management and its result of those unusual cases we had come across, about 80%~90% of the obstetric cases . We learned a lot of lessons from the case we discussed. I was deeply impressed by them, hence I made up my mind to devote to the investigation of dystocia. Then under guidance of Prof. Wang Shuzhen, the headmistress of the Hospital, the project of dystocia investigation group was set up. At that time, the measurement of pelvis by means of X-ray film was allowed. We collected 500 sets of data including films and clinical pelvic measurements, and records taken during labor thus laid the foundation for dystocia investigation.

When I was appointed to work in the Chongqing University of Medical Sciences in 1958, I still continued and insisted on my favorite project of dystocia. In 1978, the paper "Cephalic Dystocia and Score Evaluation on Cephalic Presentation Labor" was published. In this paper the term Cephalic Dystocia was defined, and the high incidence of this kind of dystocia was shown so as to call attention on this problem. In the past cephalic presentation was usually taken as sign of normal delivery, therefore cephalic dystocia was often neglected. Afterwards the investigations on sacrum, contracted pelvis, inclination of pelvic inlet, as well as classification of contracted pelvis were carried out. For further investigation on cephalic dystocia, the diagnostic criteria and management in high longitudinal position, persist occiput posterior and, persist occiput traverse were established, and for the first time suggested the term anterior asynclitism in occiput transverse position, and its mechanism and significance

are explained.

Till the publication of *Dystocia* (revised *Cephalic Dystocia*) in 2000, new theory about dystocia was developed in which the dystocia based on the clinical manifestations was classified into cephalic dystocia, breech presentation, transverse lie and compound presentation. Theoretically it is different from the traditional classification according to the abnormality of three factors of labor (the passage, the power and the passenger). Abnormality of any of these factors singly or in combination, may result in dystocia, consider them as etiology of dystocia, but not as criteria of classification of dystocia. That is why I prefer to classify dystocia according to clinical manifestation.

This book is written by two kinds of language English and Chinese, and takes the main parts from the book *Dystocia* published in 2000. It is arranged into two parts (the General and the Individual), under which there are seven sections and twenty-two chapters. Your opinions about this book will be sincerely appreciated.

Author hopes that this book may serve as a reference for obstetricians, and be of great benefit to the students of postgraduate, and students who take course for further study in obstetrics through continual education.

My gratitude to Dr. Akei Konoshima, editor of American newspaper, Prof. Chen Zhongnian of Shanghai Medical College for their reviews on this book, and Prof. Wang Zhibiao, and colleagues for their help in publishing this book.

Ling Luoda
September 1st, 2006

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第一部分

难产总论

PART Ⅰ GENERAL TITLE FOR DYSTOCIA

概　述

近30多年来，我们为了保护母儿健康而发展了围生医学，重视母儿保健，在妊娠期做产前监护紧密随访，使她们能以最佳状态通过孕期及分娩。在产后为降低母儿患病率及死亡率，我们也做了大量的工作。这些工作大大改善了母儿预后。但我们也不能忽略产时工作。我们应该重视产时工作，因为它是围生期最重要的一个阶段。母儿是否能顺利通过分娩是影响母儿预后的重要部分。因此，早期诊断及正确的处理难产是产科学的一个重要课题。

难产系发生任何情况干扰产程进展及阴道分娩并给母儿带来危害者。难产包括所有以手术结束的分娩，如剖宫产、产钳助产、胎头吸引器助产、产钳旋转，甚至包括徒手旋转胎头，并且包括那些有剖宫产指征但被忽略而让她们由阴道分娩导致母儿严重并发症者。

我们不能单纯以产程时间长短来诊断难产。首先，因为有假临产的存在而无法准确地判定临产开始时间；其次，第一产程中的潜伏期产力不强，即使潜伏期延长对母儿影响也不大；一般第二产程超过2 h是异常。但Saunder1992年报告在圣玛利亚医院有7.5%的患者第二产程超过2 h。在没有使用硬膜外镇痛者第二产程平均时间为58 min，而使用硬膜外镇痛者为97 min。这些资料证明硬膜外镇痛几乎使第二产程的时间增加了一倍。但须说明的是，由于硬膜外镇痛第二产程平均时间增加并不一定伴随母子并发症成比例的增加，因此并不存在使用硬膜外镇痛的反指征。因此，我们不能简单地根据第二产程时间来诊断难产。

General Overview of Dystocia

In the past 30 years or so, developments in perinatology have focused on protection of the mother and child, paying close attention during pregnancy to antenatal care of the mother and the fetus and making preparation so that they can go through the pregnancy and labor under the best conditions. We also have spent a lot of efforts during the postpartum period on both mother and child to decrease the morbidity and mortality rate. All of these efforts have improved the prognosis for mother and child but we should not neglect the work during labor. We should pay the closest attention during labor because it is the most crucial time in the process and may determine whether the mother and fetus can go through the period smoothly or not and is an important part of the prognosis. Thus, an early diagnosis and proper treatment of dystocia is an important subject in obstetrics.

Dystocia for most is defined as any circumstance that interferes with the progress of labor and vaginal delivery in a way that endangers either the mother or the child. Dystocia includes all labor ended by operative deliveries such as cesarean section, forceps, vacuum section and forceps rotation as well as manual rotation of the fetal head. The term also applies to cases where a cesarean section is indicated but ended in a vaginal delivery and such case will result in severe complications for mother and child.

We can not simply diagnose dystocia according to the length of time during labor, first because there is false labor and the time of the onset of labor can not be determined accurately. Secondly, during the first stage of labor, uterine contractions are not strong in the latent phase, and if the latent phase is prolonged, it may not affect the mother or child very much. Usually we consider it abnormal if the second stage of labor lasts more than 2 hours, but Saunder stated in 1992 that the St. Mary's Hospital found that the second stage of labor last more than 2 hours in 7.5% of its patients. The average time of the second stage in those without epidural analgesia was 58 minutes and for those with epidural analgesia it was 97 minutes. These studies show that epidural analgesia approximately doubles the mean duration of the second stage of labor but epidural analgesia is not necessarily seen as being associated with a proportionate increase in complications. There is no contraindication for epidural analgesia, so we cannot simply diagnose dystocia according to the length of time of the second stage.