since 1996, without evidence of concomitant decreases in maternal or neonatal morbidity or mortality, raises significant concerns about contemporary cesarean delivery rates (4). Childbirth by its very nature carries potential risks for the pregnant individual and the newborn, regardless of the route of delivery. For certain clinical conditions —such as placenta previa or uterine rupture—cesarean delivery is firmly established as the safest route of delivery. However, for most low-risk pregnancies, cesarean delivery appears to pose greater risk of maternal morbidity and mortality than vaginal delivery, and labor dystocia is the predominant driver for this intervention (5). This guideline provides definitions for labor arrest, along with recommendations for management of dystocia in the first and second stages of labor that may help optimize labor management and assist with assessment of indication for cesarean delivery for labor dystocia.

SUMMARY OF RECOMMENDATIONS

Labor and Labor Arrest

ACOG recommends that cervical dilation of 6 cm be considered the start of the active phase of labor. **(STRONG RECOMMENDATION, MODERATE-QUALITY EVIDENCE)**

ACOG suggests that *active phase arrest of labor* be defined as no progression in cervical dilation in patients who are at least 6-cm dilated with rupture of membranes despite 4 hours of adequate uterine activity or 6 hours of inadequate uterine activity with oxytocin augmentation. **(CONDITIONAL RECOMMENDATION, LOW-QUALITY EVIDENCE)**

ACOG recommends that *prolonged second stage of labor* be defined as more than 3 hours of pushing in nulliparous individuals and 2 hours of pushing in multiparous individuals. An individualized approach should be used to diagnose second-stage arrest; incorporating information regarding progress, clinical factors that may affect the likelihood of vaginal delivery, discussion of risks and benefits of available interventions, and individual patient preference is recommended when time in the second stage is extended beyond these parameters. **(STRONG RECOMMENDATION, HIGH-QUALITY EVIDENCE)**

Arrest in the second stage can be identified earlier if there is lack of fetal rotation or descent despite adequate contractions, pushing efforts, and time. **(GOOD PRACTICE POINT)**

ACOG recommends that neuraxial anesthesia be offered for pain relief during any stage of labor. **(STRONG RECOMMENDATION, MODERATE-QUALITY EVIDENCE)**

STRENGTH OF RECOMMENDATION

STRONG

ACOG recommends

Benefits clearly outweigh harms and burdens. Most patients should receive the intervention.

ACOG recommends against

Harms and burdens clearly outweigh the benefits. Most patients should not receive the intervention.

CONDITIONAL

ACOG suggests

The balance of benefits and risks will vary depending on patient characteristics and their values and preferences. Individualized, shared decision making is recommended to help patients decide on the best course of action for them.

QUALITY OF EVIDENCE

HIGH

Randomized controlled trials, systematic reviews, and meta-analyses without serious methodologic flaws or limitations (eg, inconsistency, imprecision, confounding variables)
Very strong evidence from observational studies without serious methodologic flaws or limitations
There is high confidence in the accuracy of the findings and further research is unlikely to change this.

MODERATE

Randomized controlled trials with some limitations
Strong evidence from observational studies without serious methodologic flaws or limitation

LOW

Randomized controlled trials with serious flaws Some evidence from observational studies

VERY LOW

Unsystematic clinical observations
Very indirect evidence from observational studies

GOOD PRACTICE POINTS

Ungraded Good Practice Points are incorporated when clinical guidance is deemed necessary in the case of extremely limited or nonexistent evidence. They are based on expert opinion as well as review of the available evidence.