OBSTETRICS

Lec: 10

Transverse lie- oblique lie **Dr. Haider Al-Shamma'a**

Objectives

- Able to define transverse and oblique lie
- The student should be able to diagnose transverse , oblique lie
- Should be able to list the causes.
- Able to outline the management and justify it
- Able to define unstable lie
- Able to list the causes
- Able to outline the management and can justify it
- Able to identify fetal causes of abnormal labor
- Able to outline the management with justification
- The student should be able to diagnose cord prolapse
- Able to appreciate the risks of cord prolapse
- Able to manage the patient with cord prolapse

- **Transverse lie: -** occurs when the longitudinal axis of the fetus is perpendicular to the longitudinal axis of the mother the

presenting part is the shoulder (also named shoulder presentation).

- Oblique lie :- when the head or the breech is slightly higher than the other side

Fetus in transverse lie presentation

ADAM

- the denominator is the back (dorsum)
- Dorso-anterior is more common than dorso-posterior
- Incidence :- 1/250 – 1/500 deliveries

Causes of transverse lie

1. Multiparity is the most common cause
2. Prematurity
3. Polyhydramnious
4. Multiple pregnancy
5. Contracted pelvis
6. Placenta previa
7. Fibroids of the lower segment
8. Congenital abnormalities of the uterus as septate and arcuate uterus

Diagnosis of transverse lie

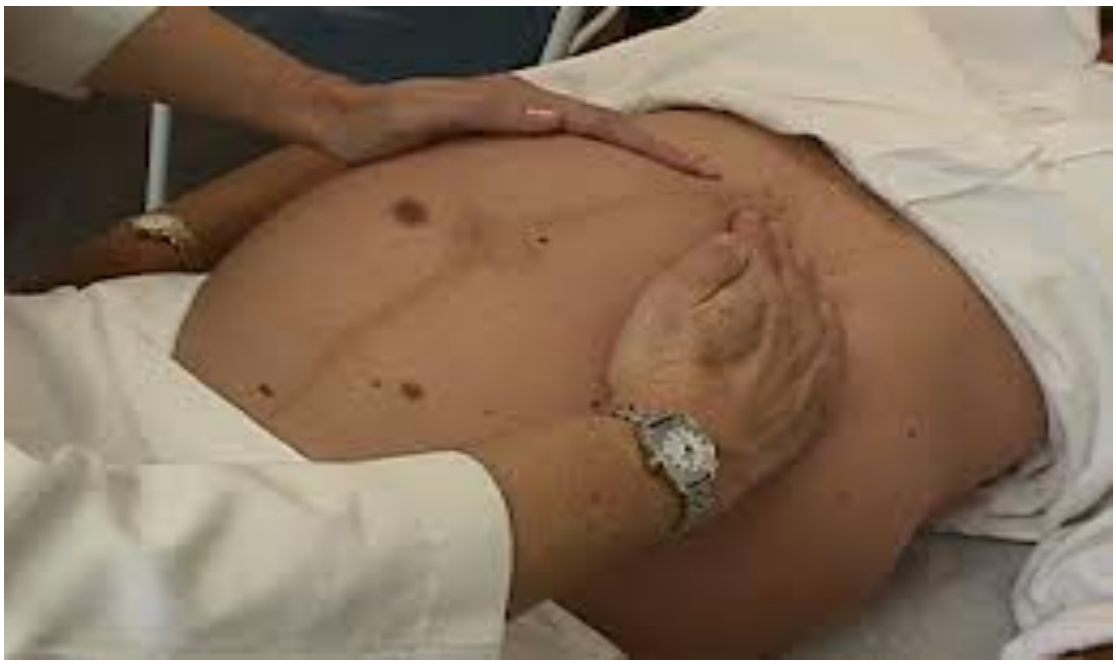
- **<u>On abdominal examination:-</u>**

1) The abdomen is asymmetrically distended
2) Width more than length
3) Fundal height less than expected
4) Round heard mass at one iliac fossa , softer breech at the other fossa
5) Absent presenting part (pelvic grip feel empty lower segment

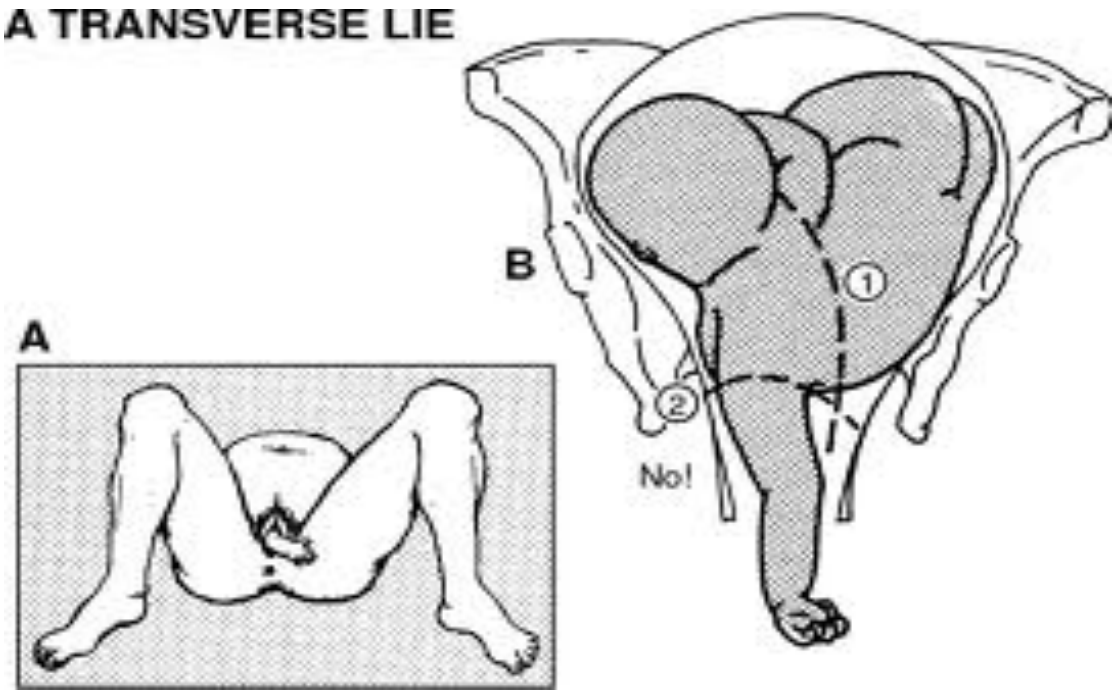
<u>On p/v examination:-</u>

1) Cannot feel the presenting part (high)
2) Bulging membranes or rupture membranes
3) Fetal arm or umbilical cord may prolaps to the vagina

Abdominal Finding T. Lie



Hand prolapse



Mechanism of labor

- No mechanism of labor due to very large dimensions of the fetus , in a neglected case lead to fetal death and rupture of the uterus and maternal death
- Rarely in a small premature dead macerated fetus in a stout mother , the baby may fold on itself and deliver vaginally

Management of transverse lie

1. **Before labour :-**

Manage as breech do ECV *

2. **During early labor:-**

Before rupture membrane can try ECV

3. Advanced labor , failure of ECV or contraindicated ECV :-

Cesarean section is the safest method even incase of a dead fetus (TLSCS or easier LVCS)

- Rarely in advanced neglected case with no facilities of CS

Decapitation by hook or saw , then pull the hand to deliver the trunk then deliver the head by forceps

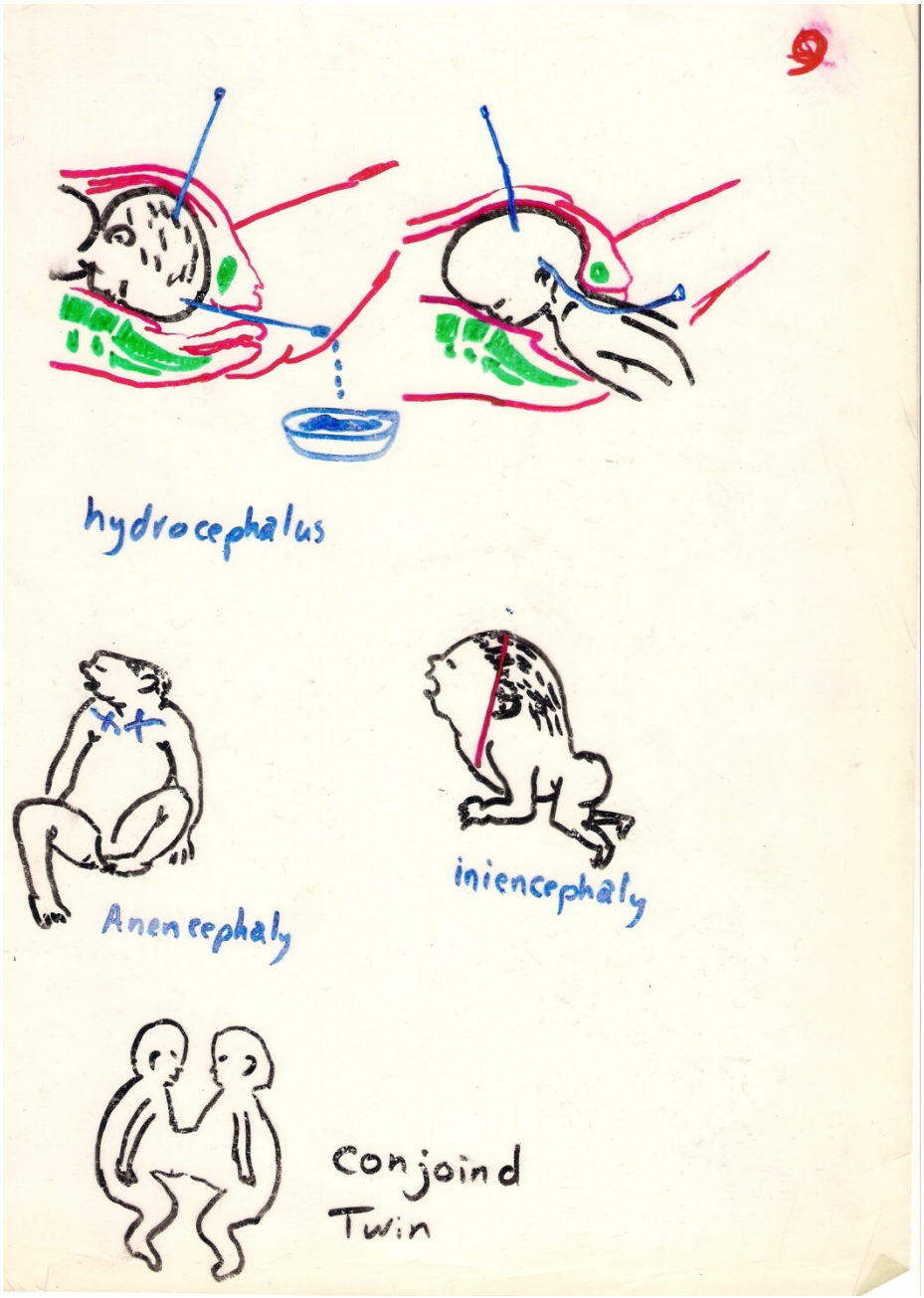
Cesarean section is safer

Unstable lie

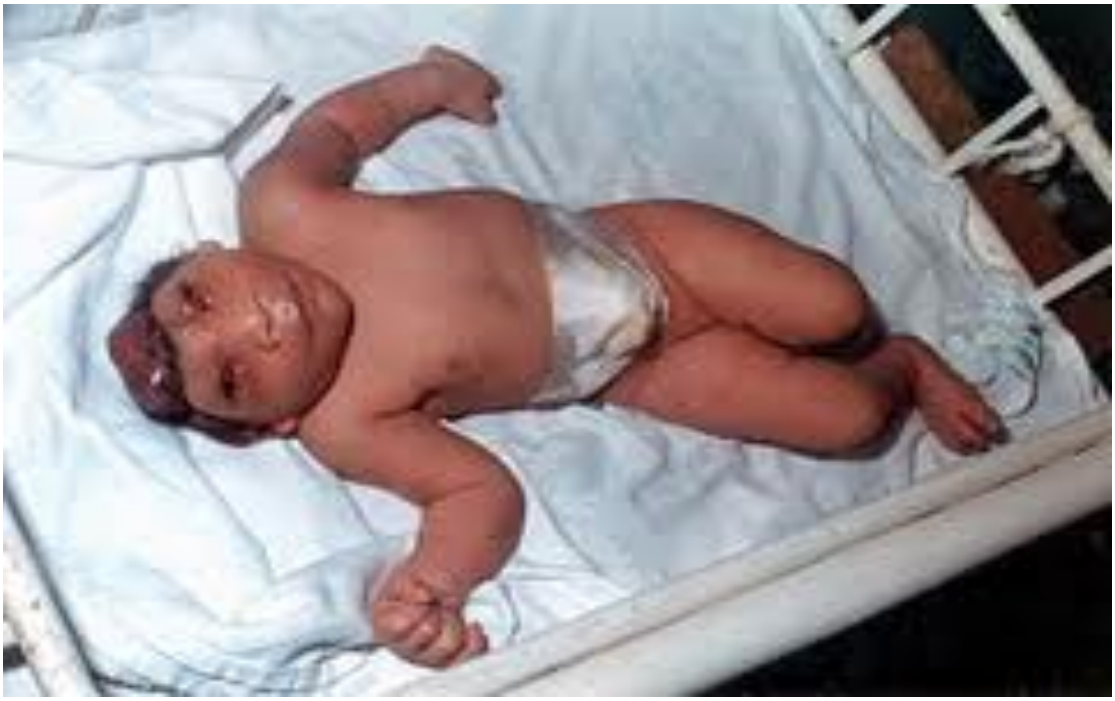
- When the fetus changes its axis every visit
- Causes as t lie
- Management :-ECV each visit after 36 weeks
- ((same contraindication as ECV of breech)
- Admission to hospital at 36 weeks
- ECV and induction of labor at 38 wks
- Elective cs may be performed in selected cases

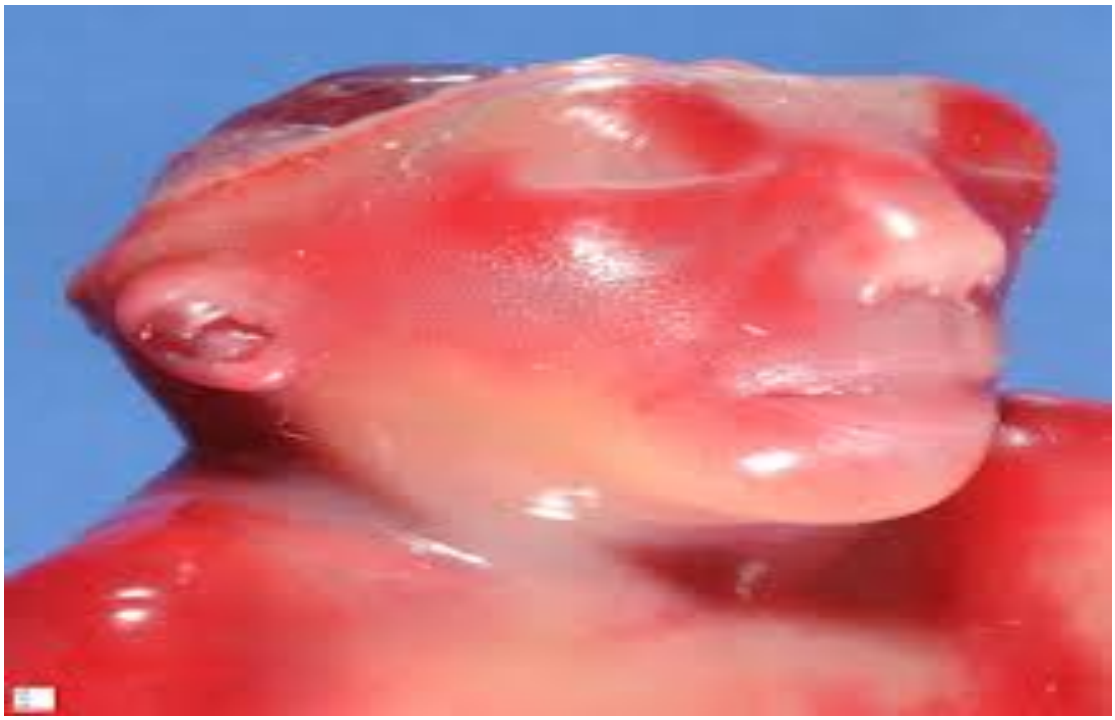
Fetal malformation causes difficult labor

- **Hydrocehalus**
- Diagnosed by U/S
- During labor feel widely separated sutures
- Big head cause obstructed labor rare in modern practice
- Management : terminate pregnancy when the head reaching 9.5 cm by induction of labor or by CS (up to 12cm)
- Advanced obstructed labor perforate the head and drain the CSF and deliver vaginally (rare)


hydrocephalus
Anencephaly
iniencephaly
Conjoind
Twin

- **<u>Anencephalus</u>**
- Absent vault and brain , incompatible with life
- May cause prolonged pregnancy(>42 wks)
- due to irregular shape dilatation is difficult , may need cleidotomy





Conjoined twins

- Suspected if the twins maintain the same relation to each other
- U/S can diagnose the connection
- Cause obstructed labor and need CS even that may be difficult!!

Thoracopagus

- **<u>Compound presentation</u>**
- Head +hand
- Head + foot
- Give large and irregular presenting part with risk of cord prolaps
- Management:-
- Usually corrected spontaneously with progress of head descent
- If persistent try to push limb up
- CS may be needed

Cord prolapse

- Descent of loop of cord through the cervix to the vagina or even outside the

vagina when the membranes ruptures

- **Causes**

1) Malposition mal presentation
2) Rupture of the membranes when the head is high

- **Diagnosis of cord prolaps**
- Feel soft cord felt below the fetus
- Pulsation can be felt and this mean the fetus is alive
- If No pulsation either dead or spasm

Consequences of cord prolapse

- Thermal and tactile stimulation cause spasm that interfere with fetal oxygenation fetal hypoxia and death may occur in less than 30 min
- Also cord compression between the presenting part and boney pelvis

Treatment of cord prolapse

- Steep Trendlingburg position or knee chest position to dis-impact the fetus and reduce cord compression
- Vaginal pack
- Terminate pregnancy by the most rapid method before fetal death

(1^{st} stage C/S) & (2^{nd} stage : forceps , vacuum extractor or C/S which ever can deliver first)

Diagram of cord prolaps Mx