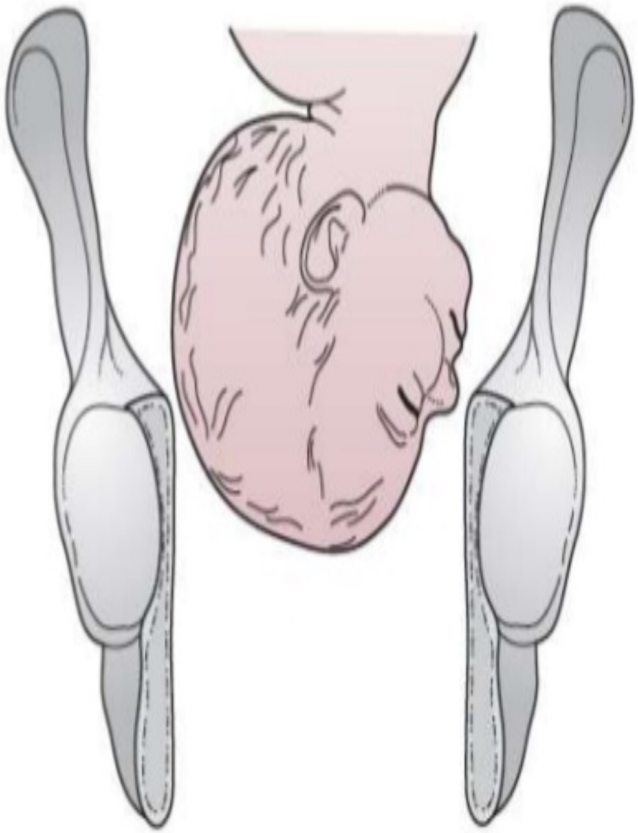
Malpresentation (cont.)

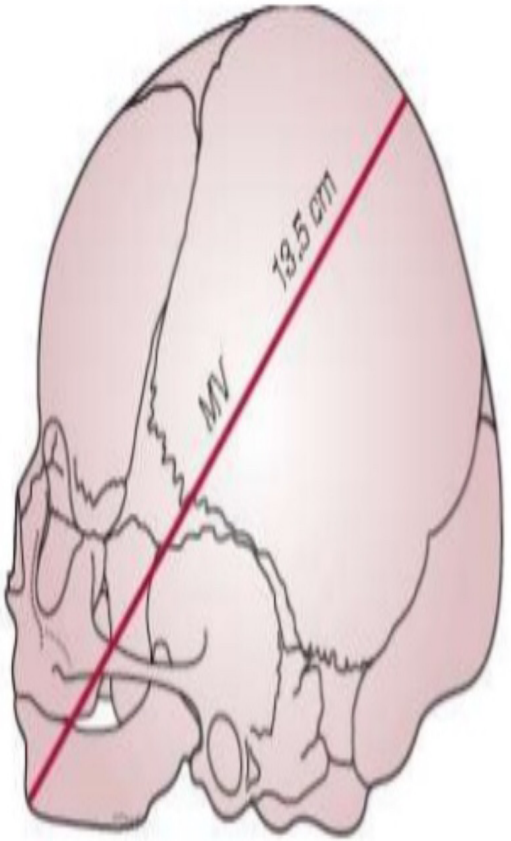
Asmaa kadhim

2020

Brow presentation



Diameter of brow presentation



BROW PRESENTATION

Incidence and aetiology

The incidence of brow presentation is quoted at 1/1000 deliveries. It is due to a deflexed head and is associated with prematurity. Other rare associations are fetal neck tumours (including goitre) which cause obstruction to head flexion.

Clinical findings

In labour, failure to progress in the first or second stage may be noted. Care must be taken in assessment of such women, especially in the presence of multiparity when labour progress is less likely to halt secondary to ineffective uterine action. On vaginal examination, the forehead is the leading part felt through the cervix. The anteroposterior diameter of the head is therefore 'mento-vertical' and is about 13 cm at term. In contrast, the average antero-posterior and lateral diameters of the female mid-pelvis are

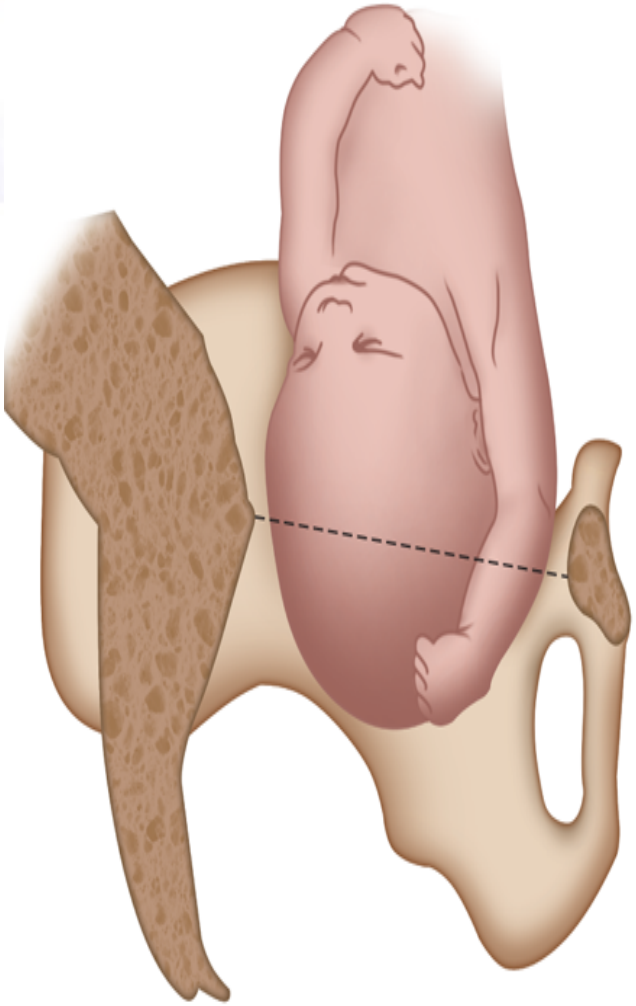
12*12 cm and should therefore the 13 cm brow will not usually be able to pass the midpelvis

Management

- Diagnosis in the early first stage may warrant expectant management for a short time (2–3 hours) as the brow may flex into a vertex or deflex to a face presentation and thus become amenable to vaginal delivery [E].
- Diagnosis is often made in the late first or second stage of labour when caesarean delivery is advised.
- If associated with failure to progress, caesarean delivery is advised [E].
- Augmentation with syntocinon has been described but is not advised as this could result in uterine rupture [E].
- The mento-vertical dimensions may be smaller in a preterm fetus, thus allowing vaginal delivery. However, caesarean should still be considered, especially in the context of failure to progress because of the risk of cervical cord or intracranial damage.

Compound presentation

- When a hand, or occasionally a foot, lies alongside the head, the presentation is said to be compound.
- This tends to occur with a small fetus or roomy pelvis and seldom is difficulty encountered except in cases where it is associated with a flat pelvis.
- On rare occasions the head, hand and foot are felt in the vagina – a serious situation that may occur with a dead fetus.



Source: G. D. Posner, Jessica DY, A. Black, G. D. Jones: Human Labor & Birth, 6th Editi
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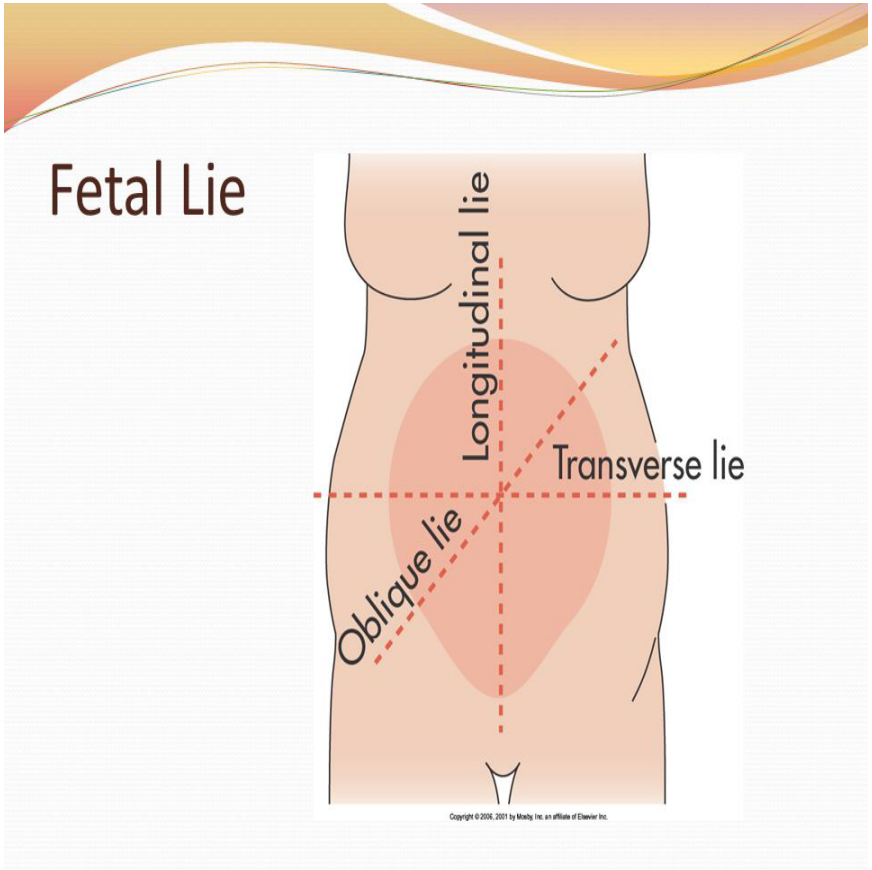
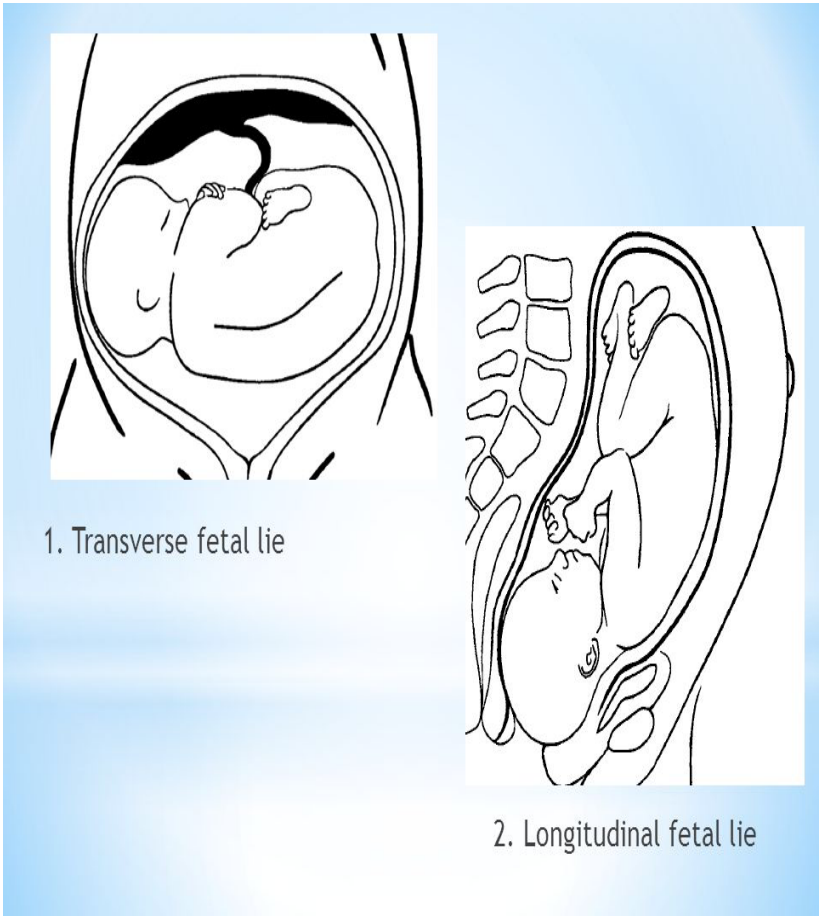
Abnormal lie





- Transverse , oblique. And. Unstable lie
- Causes
- As mentioned above for malpresentation

- Diagnosis
- Abdominal exam small for date uterus , head mobile and felt on one side , no presenting part on pelvic grip

  Vaginal exam Scapula , ribs may be felt ,or no presenting part

- Management
- Antepartum Conservative if preterm for spontaneous version
- ECV at term
- For unstable lie ECV and stabilized induction at term
- Intrapartum. Early labour and intact membrane . ECV
- Ruptured membrane or advanced labour ---- CS (CLASSICAL)
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Shoulder presentation

- When the fetus lies with its long axis across the long axis of the uterus (transverse lie) the shoulder is most likely to present. Occasionally the lie is oblique but this does not persist as the uterine contractions during labour make it longitudinal or transverse.

- Shoulder presentation occurs in approximately 1:300 pregnancies near term.

- Only 17% of these cases remain as a transverse lie at the onset of labour; the majority are multigravidae.

Shoulder presentation

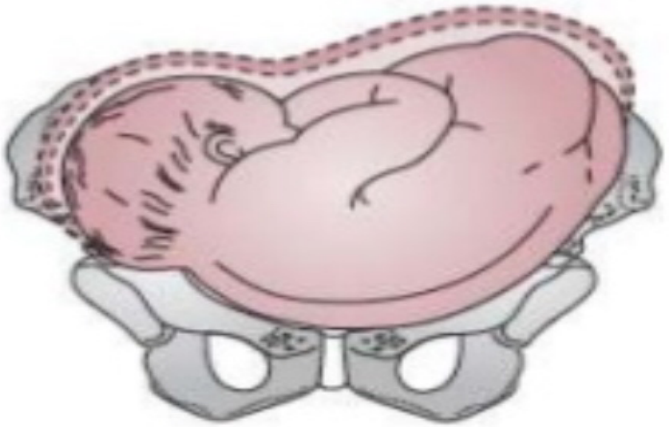

Figure 31.55 Shoulder presentation, dorsoanterior.

Figure 31.56 Shoulder presentation, dorsoposterior.


Thank you