CFU. DEPARTMENT OF OBS. & GYN. 1

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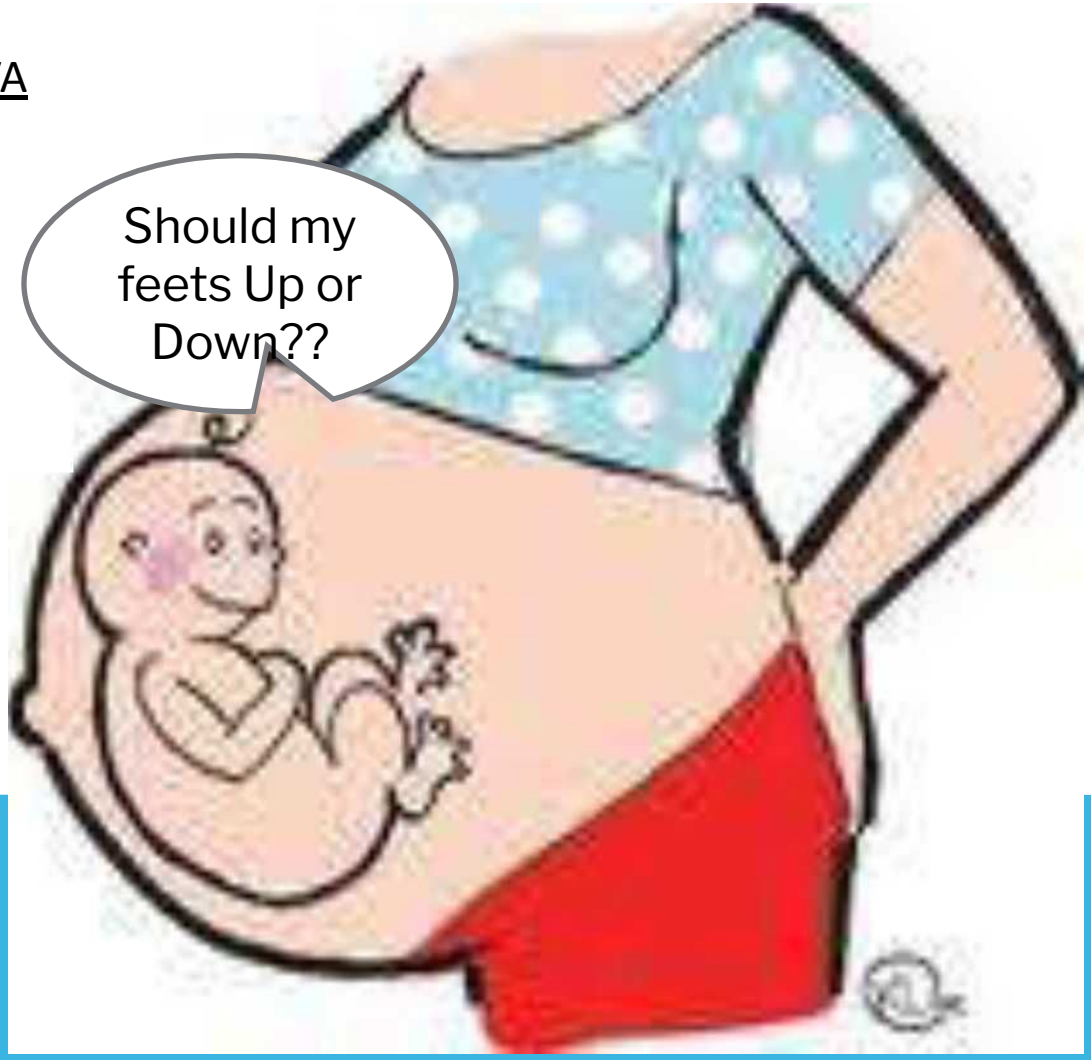

PRESENTED BY:-

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LA1-CO-163B(2)

ON :- FETAL MALPRESENTATION

Fetal malpresentation refers to fetal presenting part other than vertex and includes breech, transverse, face, brow, and sinciput.

Malpresentations may be identified late in pregnancy or may not be discovered until the initial assessment during labor.

- The woman has had more than one pregnancy
- There is more than one fetus in the uterus
- The uterus has too much or too little amniotic fluid .

- The uterus is not normal in shape or has abnormal growths, such as fibroids
- placenta previa
- The baby is preterm

Types of Malpresentation

BREECH

x *Complete (Flexed) Breech Presentation*
x *Footling Breech Presentation* **x** *Frank (Extended) Breech Presentation* **x** *Kneeling Breech Presentation*

VERTEX

K *Brow Presentation* **K** *Face Presentation*
K *Sincipital Presentation*

TRANSVERSE

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Face Presentation

Face Presentation

Definition

It is a cephalic presentation in which the head is completely extended.

- Incidence
- About 1:300 labours.

Aetiology

- l.Primary face:

a. It is less common.

b. It occurs during pregnancy.

c. It is usually due to foetal causes which may be:>

Anencephaly: due to absence of the bony vault of the skull and the scalp while the facial portion is Normal

>Loops of the cord around the neck.

>Tumours of the foetal neck e.g. congenital goitre.

>Hypertonicity of the extensor muscles of the neck.

>Dolicocephaly: long antero-posterior diameter of the head, so as the breadth is less than 4/5 of the length.

>Dead or premature foetus

Aetiology

- Secondary face:

a. It is more common.

b. It occurs during labour.

c. It may be due to:

>ontracted pelvis particularly flat pelvis which allows descent of the bitemporal but not the biparietal diameter leads to extension of the head.

> Pendulous abdomen or marked lateral obliquity of the uterus.

>Further deflexion of brow or occipito - posterior positions.

>Other causes of malpresentations as polyhydramnios and placenta praevia.

Positions

a. Right mento-posterior (RMP).

b. Left mento-posterior (LMP).

c. Left mento-anterior (LMA).

d. Right mento-anterior (RMA), are the more common positions.

e. Right mento-transverse (lateral), left mento-transverse, direct mento-posterior and direct mento-anterior are rare and usually transient positions.

Positions

- The first position (RMP) corresponds to the first normal position (LOA) as the back should be to the left and anterior in the first position.Mento-anterior are more common than mento-posterior as most cases arise from more deflexion of the head in occipito-posterior position usually in flat contracted pelvis.

Diagnosis

During pregnancy (difficult) * The back is difficult to feel.

* The limbs are felt more prominent in mento-anterior position.
* The chin may be felt on the same side of the limbs as a horseshoe-shaped rim in mento-anterior position.
* In mento-posterior, a groove may be felt between the occiput and the back particularly after rupture of the membranes.
* Second pelvic grip: the occiput is at a higher levelthan the sinciput.
* The FHS are heard below the umbilicus through the foetal chest wall in mento-anterior position.
* Ultrasound or X-ray: confirms the diagnosis and may identify associated foetal anomalies as anencephaly.

Diagnosis

* During labour

Vaginal examination shows the following identifying features for face:

* supra-orbital ridges,
* the malar processes,
* the nose (rubbery and saddle shaped),
* the mouth with hard areolar ridges.
* the chin.

- Late in labour, the face becomes oedematous (tumefaction) so it can be misdiagnosed as a buttock (breech presentation) where the two cheeks are mistaken with buttocks and the mouth with anus and the malar processes with the ischial tuberosities.

The following points can differentiate in-between:

Face Presentation	Frank Breech
The foetal mouth and malar processes form the apexes of a triangle.	The anus is on the same line with the ischial tuberosities.
The gum is felt hard through the mouth.	No hard object through the anus.
The examining finger may be sucked by the foetal mouth during vaginal examination.	The anus does not suck the finger.

Mechanism of Labour

- Mento-anterior position
- Descent.
- Engagement by submento-bregmatic diameter 9.5 cm.
- Increased extension.
- Internal rotation of chin 1/8 circle anteriorly.
- Flexion: is the movement by which the head is delivered in mento-anterior position when the submental region hinges below the symphysis. The vulva is much distended by the submento-vertical diameter 11.5 cm.
- Restitution.
- External rotation.

Engagement is delayed because:

- The biparietal diameter does not pass the plane of pelvic inlet until the chin is below the level of the ischial spines and the face begins to distend the perineum.
- Moulding does not occur as in vertex presentation.

Mento-posterior position

a. Long anterior rotation 3/8 circle (2/3 of cases): so the head is delivered as mento-anterior.

b. In about 1/3 of cases one of the following may occur:

> Deep transverse arrest of the face: when the chinrotates 1/8 circle anteriorly.

>Persistent mento-posterior: when no rotation occurs.

- >Direct mento-posterior: When the chin rotates 1/8 circle posteriorly.

*In the last 3 conditions no further progress occurs and labour is obstructed.

* Direct mento-posterior, unlike direct occipito-posterior, cannot be delivered because:
* Delivery should occur by extension while the head isalready maximally extended.
* As the length of the sacrum is 10 cm and that of neck is only 5 cm, the shoulders enter the pelvis and becomeimpacted while the head still in the pelvis, thus the labour is obstructed.

Management of Labour

* Mento-anterior

* First stage: as in occipito-posterior.

* Second stage:

> Spontaneous delivery usually occurs.

> Forceps delivery may be indicated in prolonged 2nd stage.

>Episiotomy is necessary because of over distension of the vulva.

Management of Labour

- Mento-posterior
- First stage: as mento-anterior.
- Second stage:Wait for long anterior rotation of the mentum 3/8 circle and the head will be delivered as mento-anterior.During this period oxytocin is used to compete inertia which is common in such conditions as long as there is no contraindication. Failure of this long rotation is more common than in occipito-posterior position so earlier interference is usually indicated.

Management of Labour

- Failure of long anterior rotation 3/8 circle or development of foetal or maternal distress at any time, is managed by:
- Caesarean section: which is the safest and and the current alternative in modern obstetrics.
- Manual rotation and forceps extraction as mento-anterior, orthe current alternative in modern obstetrics.

Brow Presentation

Brow Presentation

- Definition
- It is a cephalic presentation in which the head is midway between flexion and extension.

- Incidence
- About 1:1000 labour.

Diagnosis

During pregnancy:

- It is difficult.
- The occiput and sinciput may be felt at the same level.
- Ultrasonography and X-ray may be helpful.

Diagnosis

During labour:

- In addition to the previous findings, vaginal examination reveals the following features:

> frontal bones,

> supra-orbital ridges, and

>root of the nose but not the chin.

Mechanism of Labour

* Persistent brow:

The engagement diameter is the mento-vertical 13.5 cm which is longer than any diameter of the inlet so there is no mechanism of labour and labour is obstructed.

* Transient brow:

may occur during conversion of vertex into face presentation. So if brow is flexed to become vertex or extended to become face it may be delivered.

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* Early in the first stage:

> Exclude contracted pelvis, if present do caesarean section.

> The case is considered as transient brow, observed carefully and given a chance for spontaneous conversion into either face or vertex.

>The rest of management as other malpresentation.

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In the second stage: The case is considered as persistent brow so:

> Caesarean section is done if the foetus is living.

> Craniotomy if the foetus is dead.

THANK YOU