MALPOSITIONS AND MALPRESENTATIONS

LIE: Relationship of the long axis of the fetus to that of the mother, longitudinal, transverse, or oblique (unstable).

PRESENTATION: Presenting part. (Face, brow, vertex, breech, or compound)

POSITION: Relationship of the fetal presenting part to the maternal pelvis (e.g. left occiput anterior).

Occiput Posterior: Possible managements include:
- Allow spontaneous rotation to OA
- Walking, all-fours position
- Spontaneous delivery in the OP position
- Forceps delivery in the OP position
- Manual rotation to OA
- Forceps rotation to OA by skilled user

*** Do not attempt to rotate fetal head with vacuum extractor!

Face Presentation: (on exam - the mouth and eyes form a triangle)
- Cesarean section frequently necessary
- Spontaneous vaginal delivery may occur, but only in mentum anterior. Must stay in mentum anterior position. Watch labor curve and fetal position CAREFULLY
- Do not attempt to convert a face to vertex
- Use FSE only if absolutely necessary and ONLY on fetal chin
- Vacuum extractions contraindicated

Brow Presentation: (can feel fetal cephalic prominence on same side as fetal back)
- Will usually spontaneously convert to vertex or face
- Otherwise cesarean is usually necessary

Compound Presentation:
- The prolapsed extremity will usually retract as the presenting part descends, or it may deliver with the presenting part
- It should not be forcefully replaced

Transverse Lie:
- External version may be attempted if adequate fluid and membranes intact. Success is better at 37 weeks GA. CAUTION if placenta is anterior.
- Consider malformation of fetus or high or low implantation of placenta if fetus has transverse lie.
- Persistent transverse lie requires delivery by cesarean.

Breech Presentation: (on exam, the ischial tuberosities and anus are in a straight line)

- External version can be attempted at HCMC OBTU at 36-37 weeks, not in VBAC's!
- Footling breeches (feet presenting part) require cesarean section
- Frank breeches (butt is presenting part) are usually delivered by c-section; May be delivered vaginally, as can some complete breeches. **Consult OB/GYN ASAP**.

Management:

1. Capabilities of emergency C-section with double set-up ready (vag. and c/s)
2. Physician experience
3. Anesthesia personnel present
4. Fetal size between 1500 and 4000 grams. Caution in low EFW as head is disproportionately large.
5. Must exclude hyperextension and macrocephaly. Many advocate getting an abdominal flat plate prior to attempting the delivery.
6. CT pelvimetry. This may provide information about the type of breech, presentation, flexion of the fetal head. All measurements must be normal or above.
7. Allow labor to continue. Do not pull on the breech until the umbilicus is out. Pulling increases the risk of nuchal arms and hyperextension of the head.
8. Deliver the anterior and posterior hips
9. Generous episiotomy
10. When the umbilicus is at the introitus, gently pull down several inches
11. Deliver legs by rotating the breech and inserting a finger behind the thigh to flex the knee
12. Gentle downward traction, and then deliver the arms by rotating the body and hooking the inside of the elbow and dragging it across the chest. A nuchal arm is freed by pulling the feet and ventral surface up and over the mother's groin.
13. Gentle suprapubic pressure will maintain flexion of the fetal head. The physician may pull on the malar eminences or jaw to maintain flexion.
14. Piper forceps should be available.