Introduction and definitions:

Presentation:
The lowest pole of the fetus that presents to the lower uterine segment and the cervix.

**95% of fetuses at term present by the vertex** in labour and hence is called **normal presentation**

Introduction and definitions:

*Malpresentations*: When the presentation is other than the vertex, that is, breech, brow, face or shoulder.
The definitive aetiology for malpresentations is not known in the majority of cases

**Aetiology of malpresentation:**
1. contracted pelvis,
2. large baby,
3. polyhydramnios,
4. multiple pregnancy,
5. low-lying placenta,
6. preterm labour,
7. anomalies of the fetus (neck tumours),
8. uterus (congenital or acquired, e.g. lower segment fibroids).

**Transverse Lie:**

*Aetiology of transverse & unstable Lie:*
1. Polyhydramnios causing an increased ratio of fluid to fetus.
2. Something preventing the engagement of the head in the pelvis.
3. Placenta praevia.
4. Fibroids.
5. Contracted pelvis.
6. Abnormal shape of uterus (subseptate or arcuate uterus).
7. Second twin.
8. Grand multiparity (5+).
**Diagnosis**

1 - Abdominal examination— the head is in one flank and the buttocks in the other. Commonly, the fetus can be rotated to a cephalic presentation quite readily but reverts back to a transverse position.

2 - Vaginal examination— the pelvis is empty of presenting parts.

3 - Investigation: ultrasound scan confirms diagnosis.

**Management of transverse lie in pregnancy and labour:**

1 - Before 36 weeks, the position is usually self-curing.

2 - Past 37 weeks in a multiparous patient, admission to hospital should be advised, where ECV is attempted each day.

3 - Should the woman go to term with the fetus still in a transverse position, management may be by either of the following:

**Management:**

• **A stabilizing induction:**
  ECV (external cephalic version) is done in the labour ward.
  The fetal head is held over the brim of the mother’s pelvis and high membrane rupture is performed.
  Amniotic fluid escapes and the head often sinks into the pelvis.
  Labour follows in the normal fashion.

• **An elective Caesarean section:**
  this may be the safer line of treatment for the fetus since it cuts down the risks of prolapsed cord during labour,
  but it does leave the mother with a scarred uterus for future pregnancies and an increased risk of postpartum problems.

4 Occasionally a woman is admitted in mid or late labour with a transverse lie.

This would lead to an impacted shoulder presentation, the folded fetus having been driven a varying amount down the pelvis, depending on how far labour has gone.

Treatment must be by immediate caesarean section even if the fetus is dead because of the risk of uterine rupture.

**Shoulder presentation**

Transverse lie. Right acromiodorsoposterior (RADP)

The shoulder of the fetus is to the mother's right, and the back is posterior.
Complication of Transverse and Unstable lie:
- Cord or hand prolapse.
- Obstructed labour.
- Uterine rupture.
- Difficult intra operative delivery of the fetus.
- Birth trauma (erbs pulsy).
- Postpartum haemorrhage.

Unstable Lie:
- Unstable Lie is defined as a condition in which at any time after the beginning of 38 weeks of pregnancy, the fetal lie is oblique or transverse and the presentation is varies.
- This condition exclude lie that is fixed in a constant abnormal presentation but includes a high central presenting fetal pole which is mobile and easily moved.

Another definition:
Unstable lie refers to the frequent changing of fetal lie and presentation in late pregnancy (usually refers to pregnancies > 37 weeks).
Lie refers to the relationship between the longitudinal axis of the fetus and that of its mother, which may be longitudinal, transverse or oblique.

Contributing factors:
- High parity
- Placenta praevia
- Polyhydramnios
- Pelvic contracture Or fetal macrosomia
- Pendulous abdomen
- Uterine abnormalities (e.g. bicornuate uterus or uterine fibroids).
- Fetal anomaly (e.g. tumours of the neck or sacrum, hydrocephaly, abdominal distension)

Associated risk factors
Cord presentation or prolapse if membranes rupture or at the onset of labour
Fetal hypoxia if left unattended in labour
Shoulder presentation and transverse lie in labour
Uterine rupture

Diagnosis:
Usually made when a varying fetal lie is found on repeated clinical examination in the last month of pregnancy.

Management:
85% of fetal lies will become longitudinal before rupture of the membranes or labour.
Abdominal palpation to assess for polyhydramnios
Pelvic examination as indicated (assess pelvic size and shape)
Inform woman of need for prompt admission to hospital if membranes rupture or when labour starts
Hospital admission from 37 weeks onwards is recommended
May attempt external version to cephalic presentation in early labour with access to facilities for immediate delivery if indicated

**Intrapartum management**

**Vaginal and pelvic assessment:**
- Establish presentation
- Exclude cord presentation
- Assess if polyhydramnios
- Assess cervical dilatation
- **If the lie is longitudinal**
- Normal labour management

**Intrapartum management**
- If the lie is not longitudinal
- Consider external version to correct lie
- ARM (artificial rupture of membrane) should be done with caution
- If the lie is not longitudinal and cannot be corrected
- Caesarean section is considered.

**MCQ:**

1. Aetiology of malpresentation:
   a. contracted pelvis.
   b. Small baby.
   c. polyhydramnios.
   d. Abruptio placenta.

2. Transverse lie (shoulder presentation):
   a. The incidence is 1:100 cases at term.
   b. less common in preterm labour.
   c. less common in primigravida.
   d. give large for date during abdominal examination.

3. Complication of Transverse and Unstable lie are all except:
   a. Cord or hand prolapse.
   b. Obstructed labour.
   c. Shoulder dystocia.
   d. Uterine rupture.

4. Unstable lie is:
   a. the same as a transverse lie.
   b. a type of abnormal position.
   c. Corrected by external cephalic version only.
   d. reverse to longitudinal lie in 85% of cases spontaneously.

**Answer:**
1. a, c.
2. c.
3. c.
4. d.