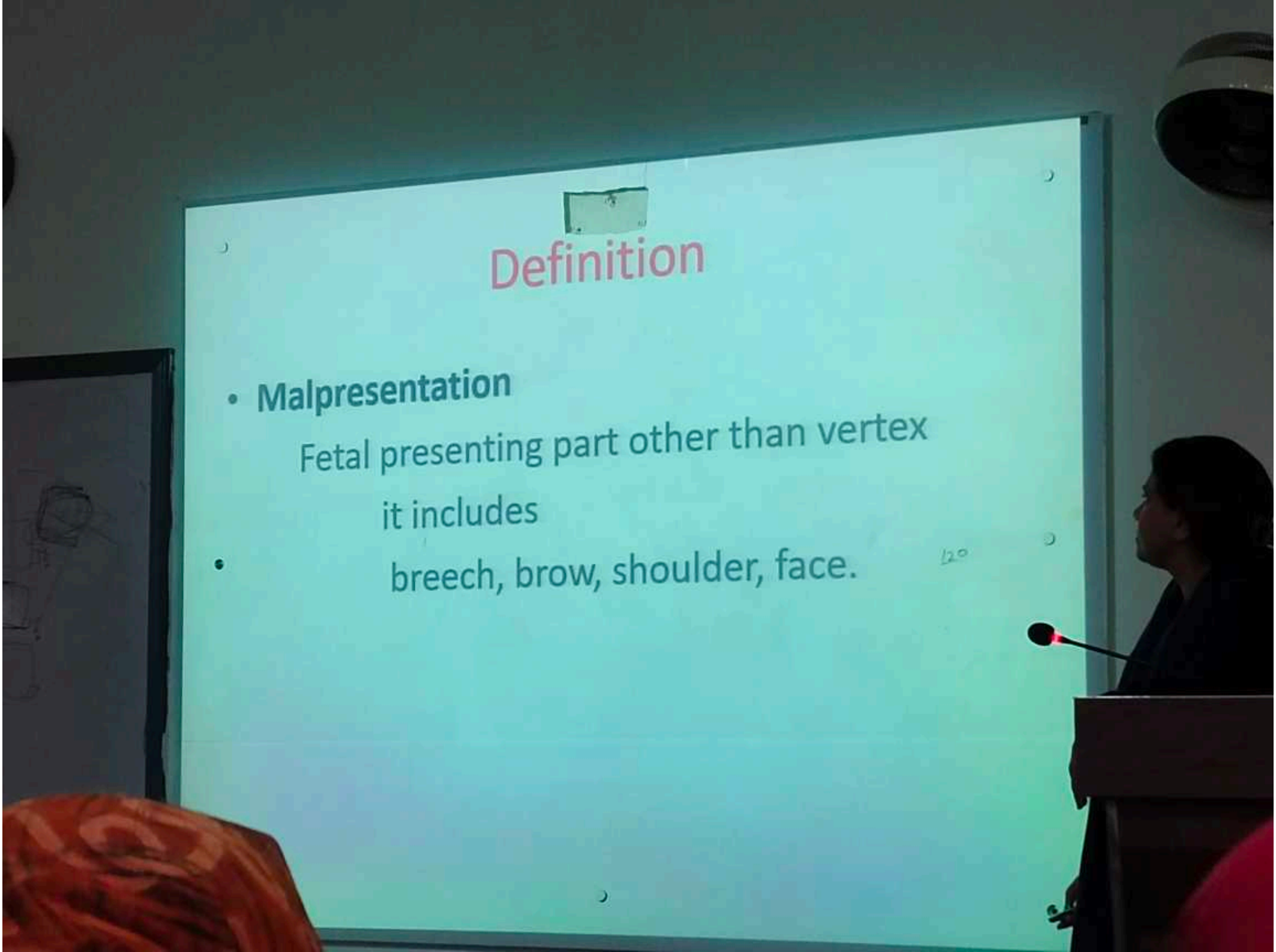
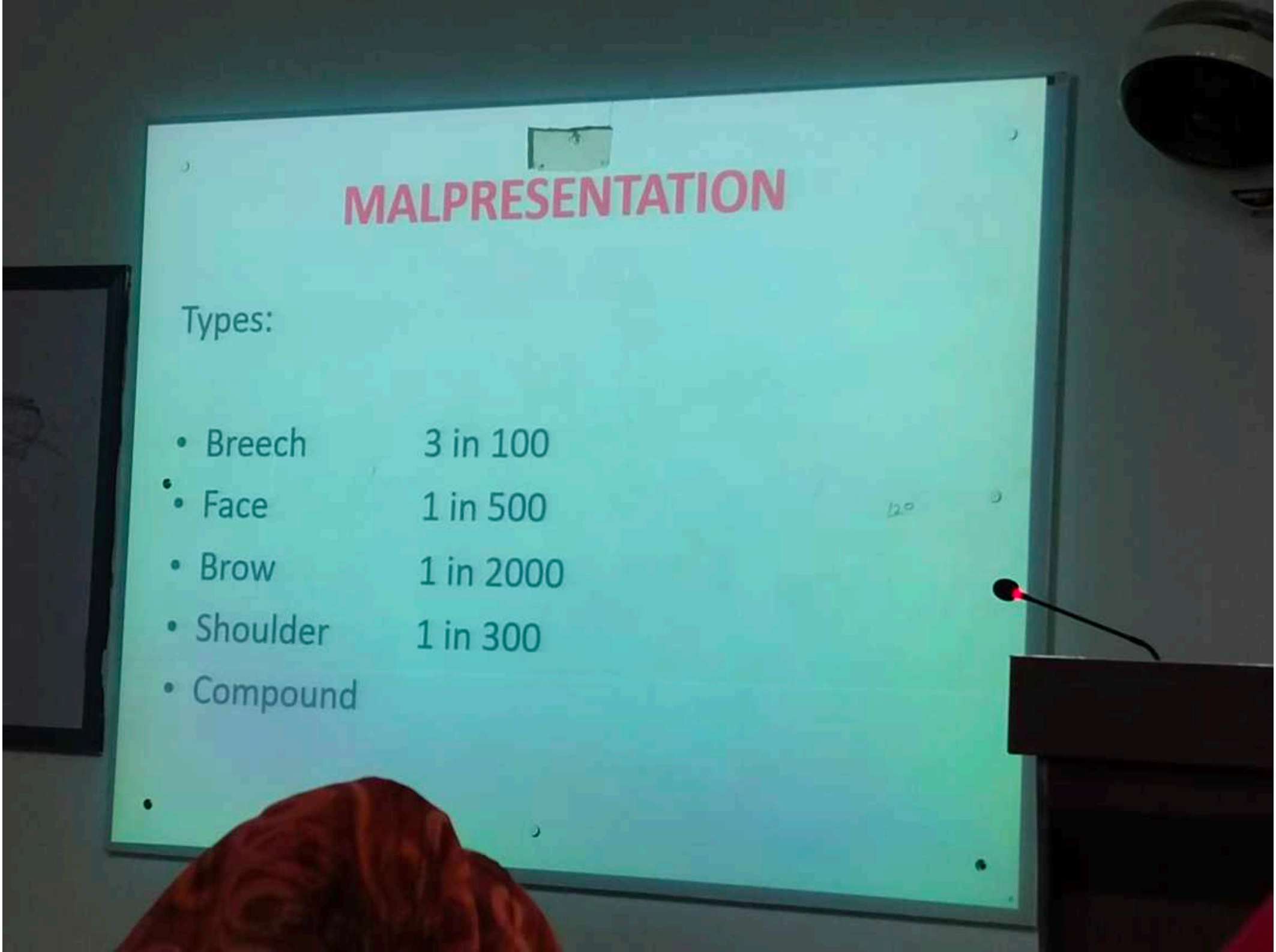
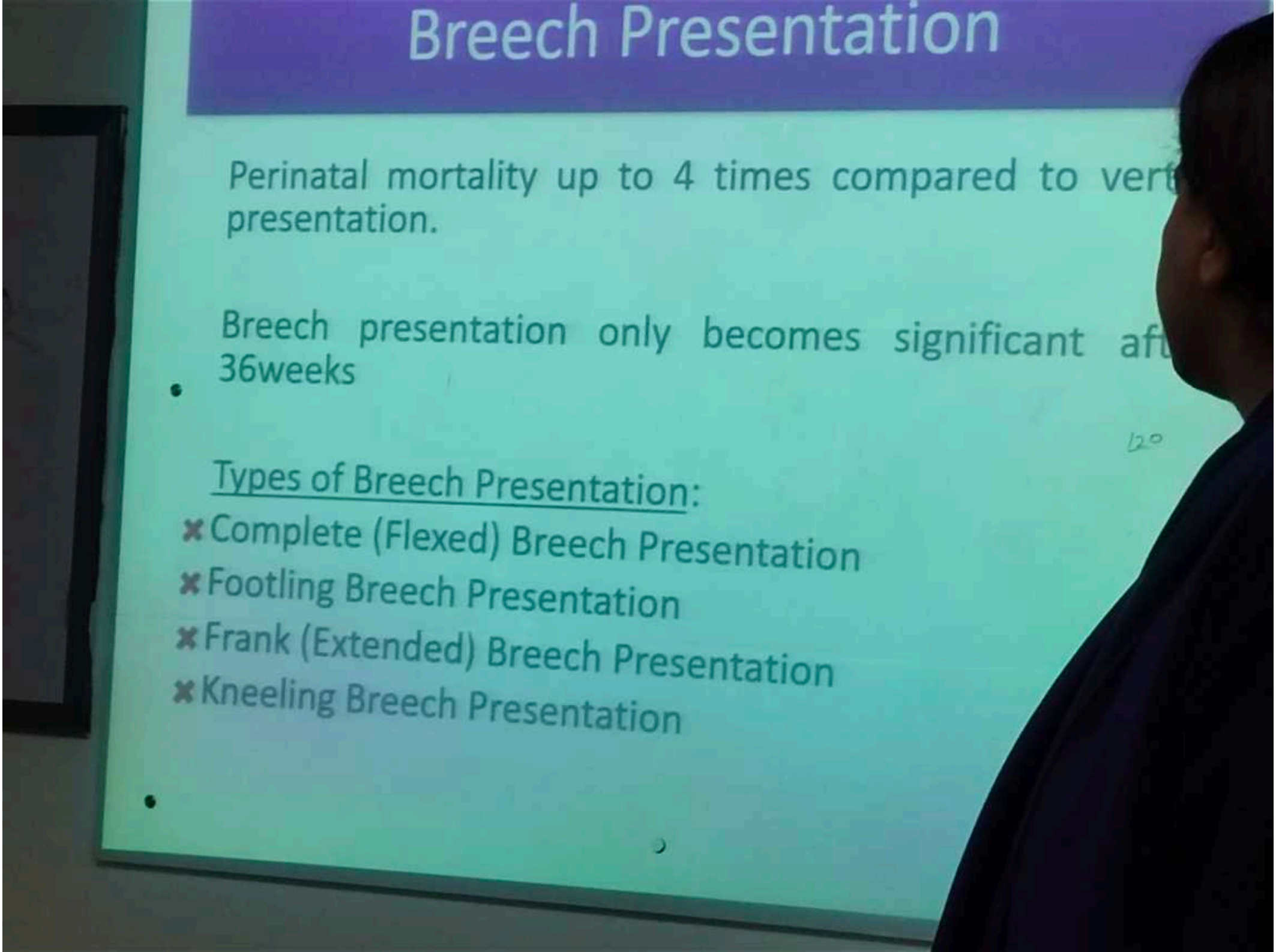
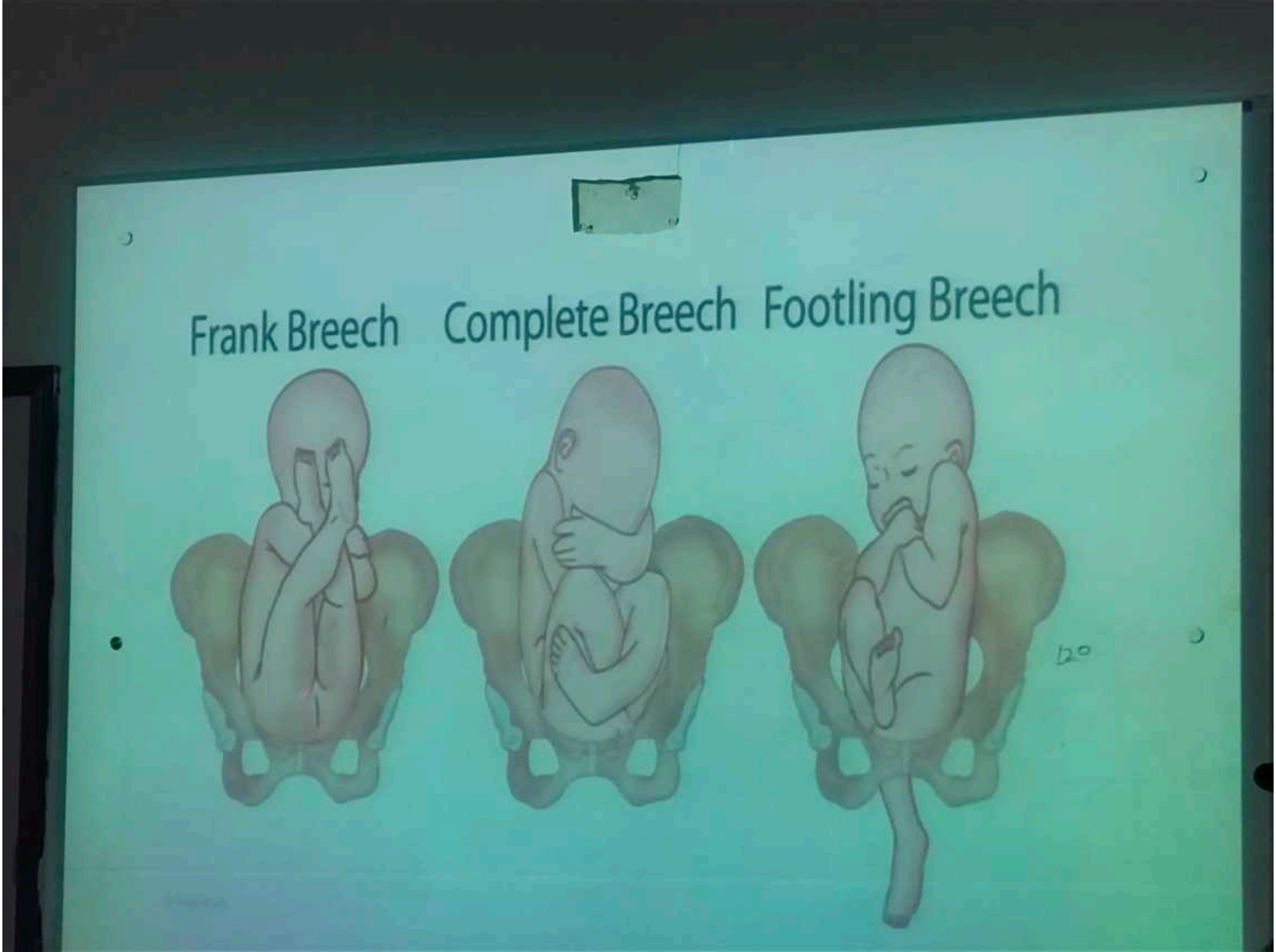
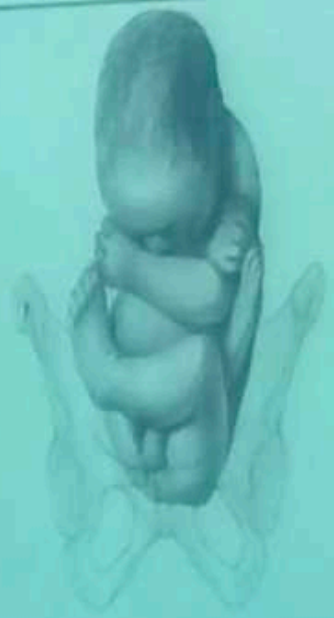

Malpresentation
&
Malposition
PROF. DR. SH
MBBS,FC
GYNAE/


Definition
Malpresentation
Fetal presenting part other than vertex
it includes
breech, brow, shoulder, face.


MALPRESENTATION
Types:
• Breech 3 in 100
• Face 1 in 500
• Brow 1 in 2000
• Shoulder 1 in 300
• Compound


Breech Presentation
Perinatal mortality up to 4 times compared to vert
presentation.
Breech presentation only becomes significant aft
36weeks
Types of Breech Presentation:
Complete (Flexed) Breech Presentation
Footling Breech Presentation
Frank (Extended) Breech Presentation
Kneeling Breech Presentation

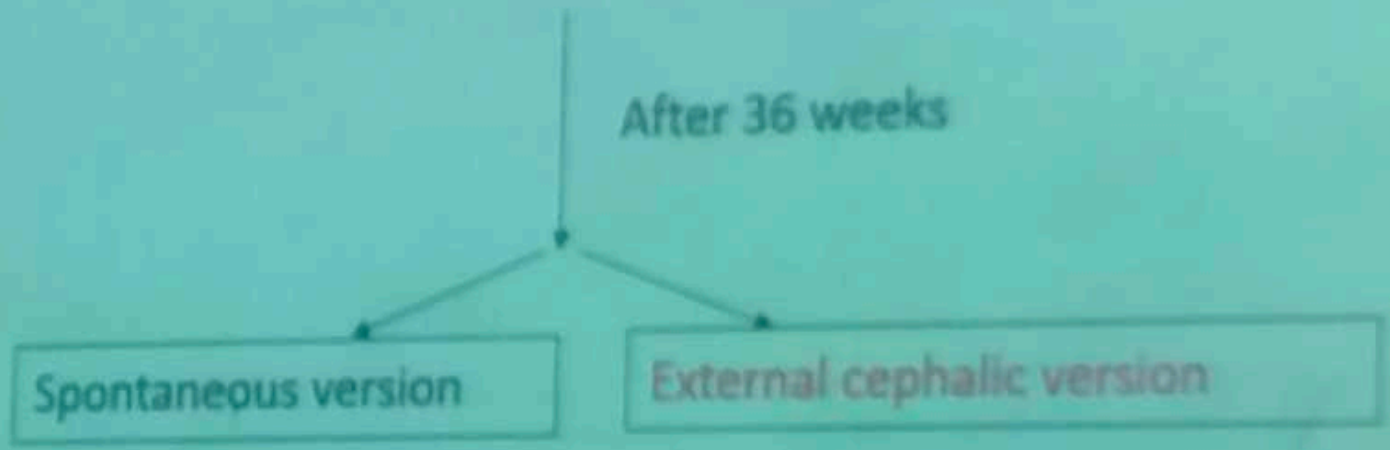

Frank Breech
Complete Breech
Footling Breech

| Frank Breech (65%) | Complete Breech (10%) | Incomplete Breech (25%) | |
|---|---|---|---|
| | | Footling Breech | Kneeling Breech |
|  |  |  |  |
| The baby's hip joints are flexed and knee joints are extended. | The baby's hip and knee joints are flexed. | The baby's hip and knee joints are extended on one or both sides. | The baby's hip joints are extended and knee joints are flexed on one or both sides. |

- Predisposing factors:
  - Fetal
    - Prematurity
    - Fetal abnormality
    - Intrauterine death
  - Placental
    - Placenta praevia
    - Placental cornual
  - Amniotic fluid
    - Polyhydramnios
  - Uterine/ pelvic
    - Bicornuate/ septate
    - Pelvic masses

# BREECH PRESENTATION

## -- Management



# BREECH PRESENTATION

## -- External Cephalic Version

- Attempt external cephalic version if:
  - Breech presentation is present at or after 36 weeks
  - Vaginal delivery is possible;
  - Membranes are intact and amniotic fluid is adequate;
  - There are no complications (e.g. fetal growth restriction, uterine bleeding, previous caesarean delivery, fetal abnormalities, twin pregnancy, hypertension, fetal death).

# BREECH PRESENTATION
## -- External Cephalic Version

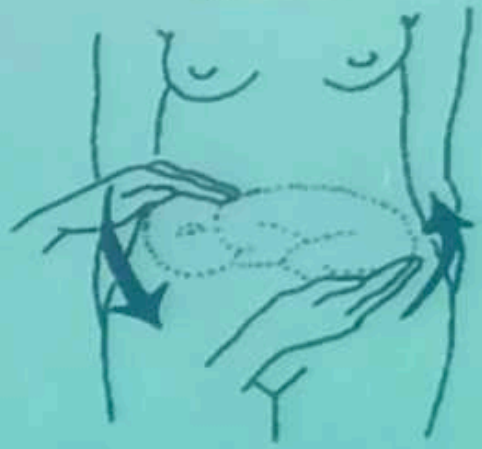
- Risks:
  - Placental abruption
  - Premature rupture of the membranes
- 
  - Cord accident
  - Transplacental haemorrhage
  - Fetal bradycardia

# BREECH PRESENTATION
## -- External Cephalic Version

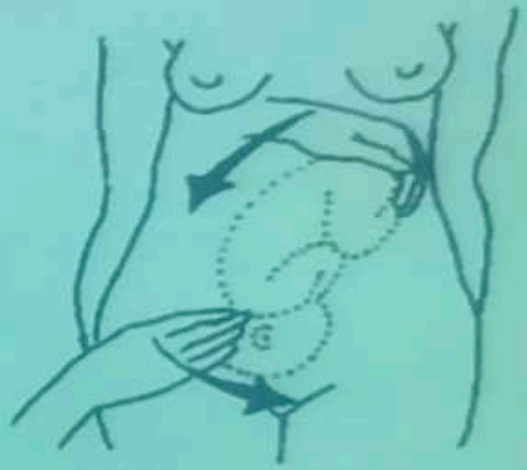
- Absolute contraindication:
  - Previous scar on the uterus
  - Placenta praevia
  - Unexplained APH
  - Pre-eclampsia
  - Multiple pregnancy

- Relative contraindications:
  - Rhesus isoimmunisation
  - Elderly primigravida
  - IUGR
  - Oligo/ polyhydramnios

A. Mobilization of the breech

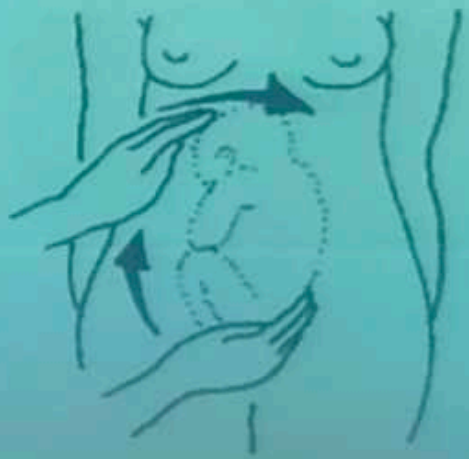


B. Manual forward rotation using both hands, one to push the breech and the other to guide the vertex

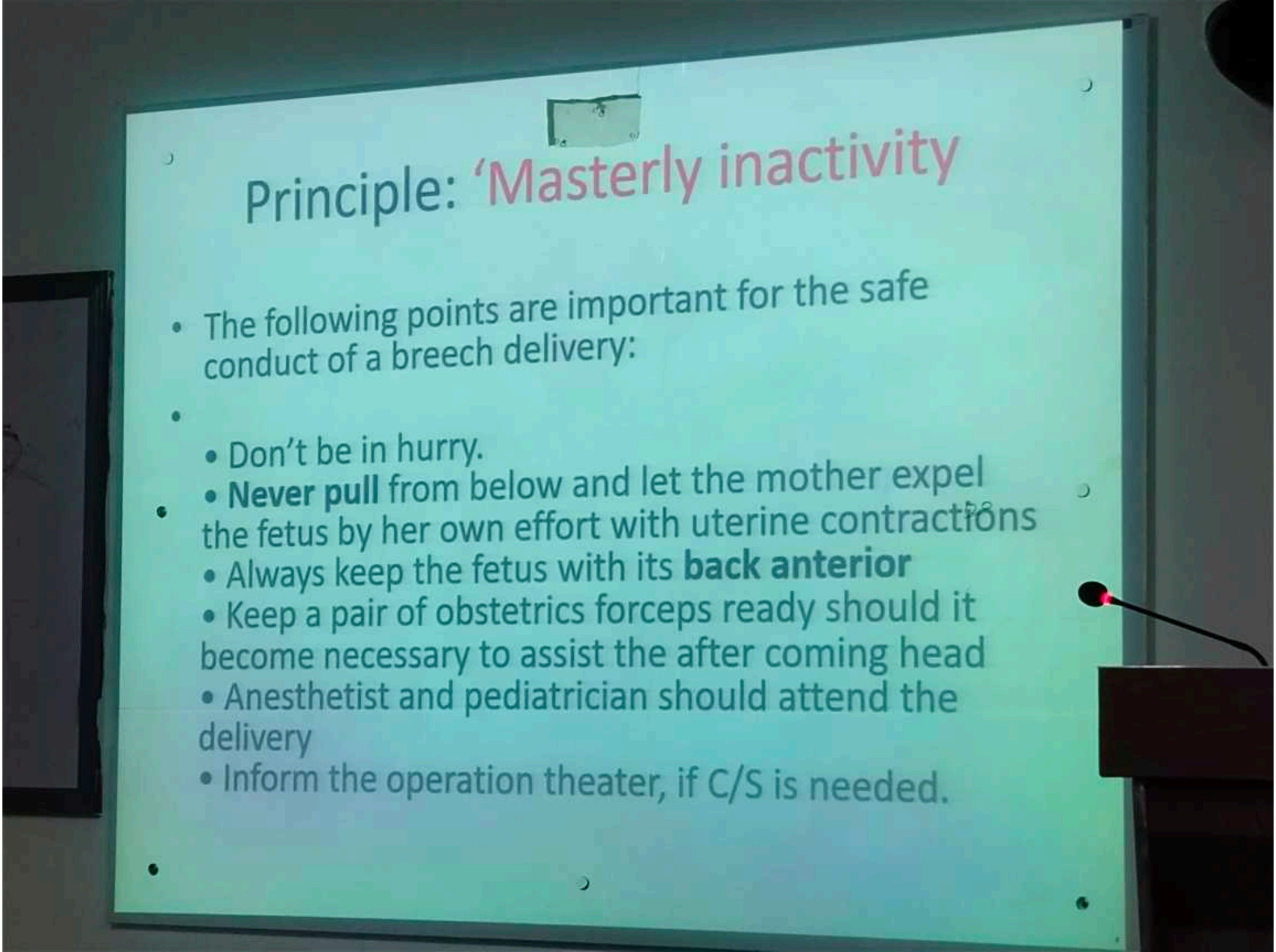


C. Completion of forward roll

120



D. Backward roll


Principle: 'Masterly inactivity
• The following points are important for the safe conduct of a breech delivery:
• Don't be in hurry.
• **Never pull** from below and let the mother expel the fetus by her own effort with uterine contractions
• Always keep the fetus with its **back anterior**
• Keep a pair of obstetrics forceps ready should it become necessary to assist the after coming head
• Anesthetist and pediatrician should attend the delivery
• Inform the operation theater, if C/S is needed.

# BREECH PRESENTATION

## -- Vaginal Breech Delivery

- Await for spontaneous labour
- A vaginal examination is done not only to assess the progress of labour
- If the **membranes rupture**, do a vaginal examination immediately to exclude uterine cord prolapse.
- If the **membranes not rupture**, examine for cord presentation.
- Do not rupture the membranes
- Examine and monitor the woman regularly and adhere strictly to the partogram.
- Poor progress may occur if sacrum is posterior/ bigger baby than expected
- If there is any delay, the fetus is best delivered by an emergency caesarean section.

# BREECH PRESENTATION

## -- Vaginal Breech Delivery

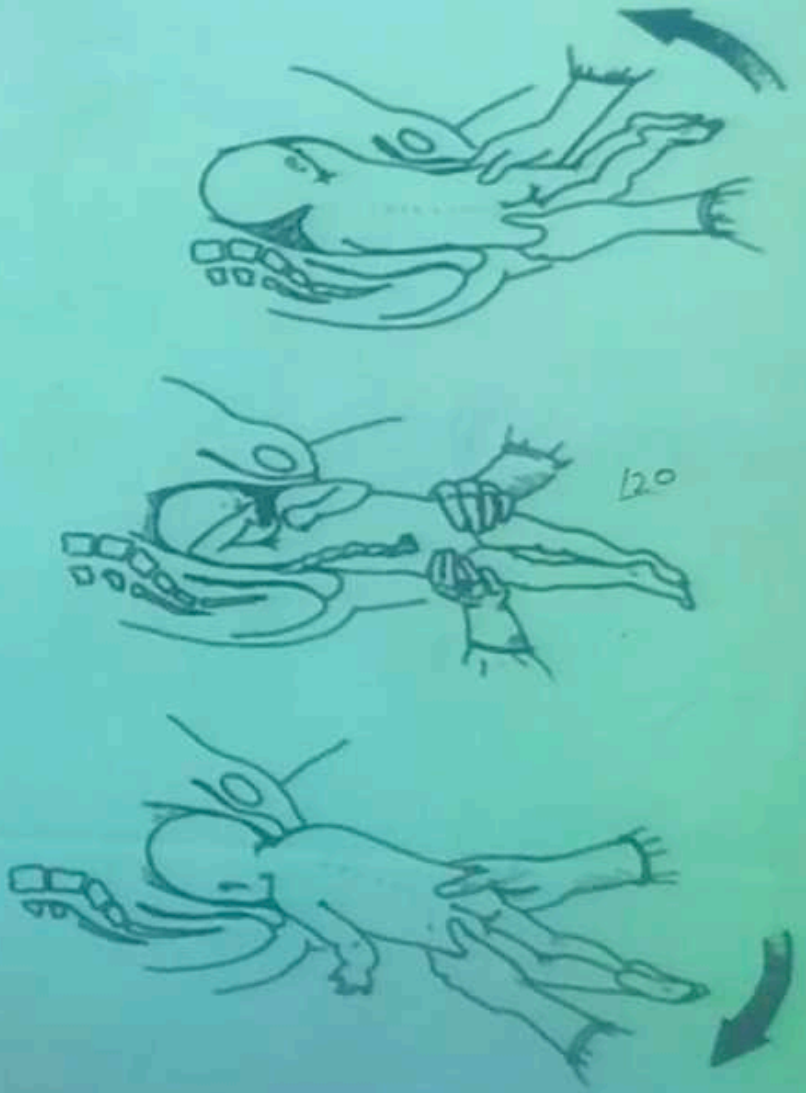
- Delivery of the buttocks
  - Occur naturally
- Delivery of the legs and lower body
  - Legs flexed : spontaneous delivery
  - Legs extended : 'Pinard's manoeuvre'
- Delivery of the shoulders
  - Loveset's manoeuvre
- Delivery of the head
  - Burns Marshall method
  - Mariceau-Smellie-Veit manoeuvre
  - Forceps delicery of the aftercoming head

# BREECH PRESENTATION

## -- Vaginal Breech Delivery

**Loveset's manoeuvre**

- baby's trunk is made to rotate with downward traction holding the baby at the iliac crest so that posterior shoulder comes below symphysis pubis and the arm is delivered by flexing the shoulder followed by hooking at the elbow and flexing it followed by bringing down the forearm 'like a hand shake'.
- The same procedure is repeated by reverse rotation of 180 degree so that anterior shoulder comes below the symphysis pubis.



# THE BURNS–MARSHALL MANOEUVRE

A

let him hang until you can see the hair at the back of his neck

D

swing his head clear

C

free his mouth and suck him out

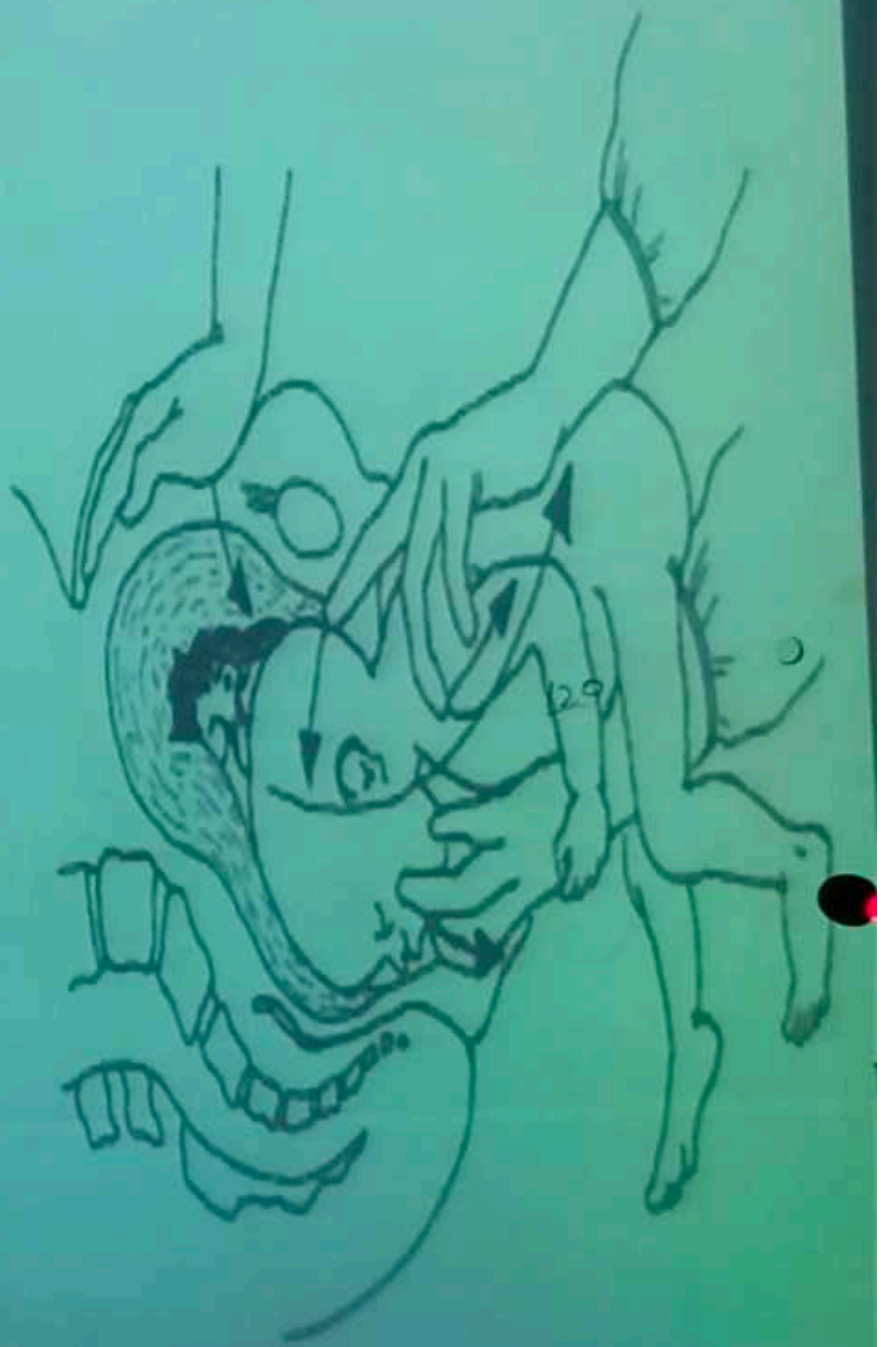
B

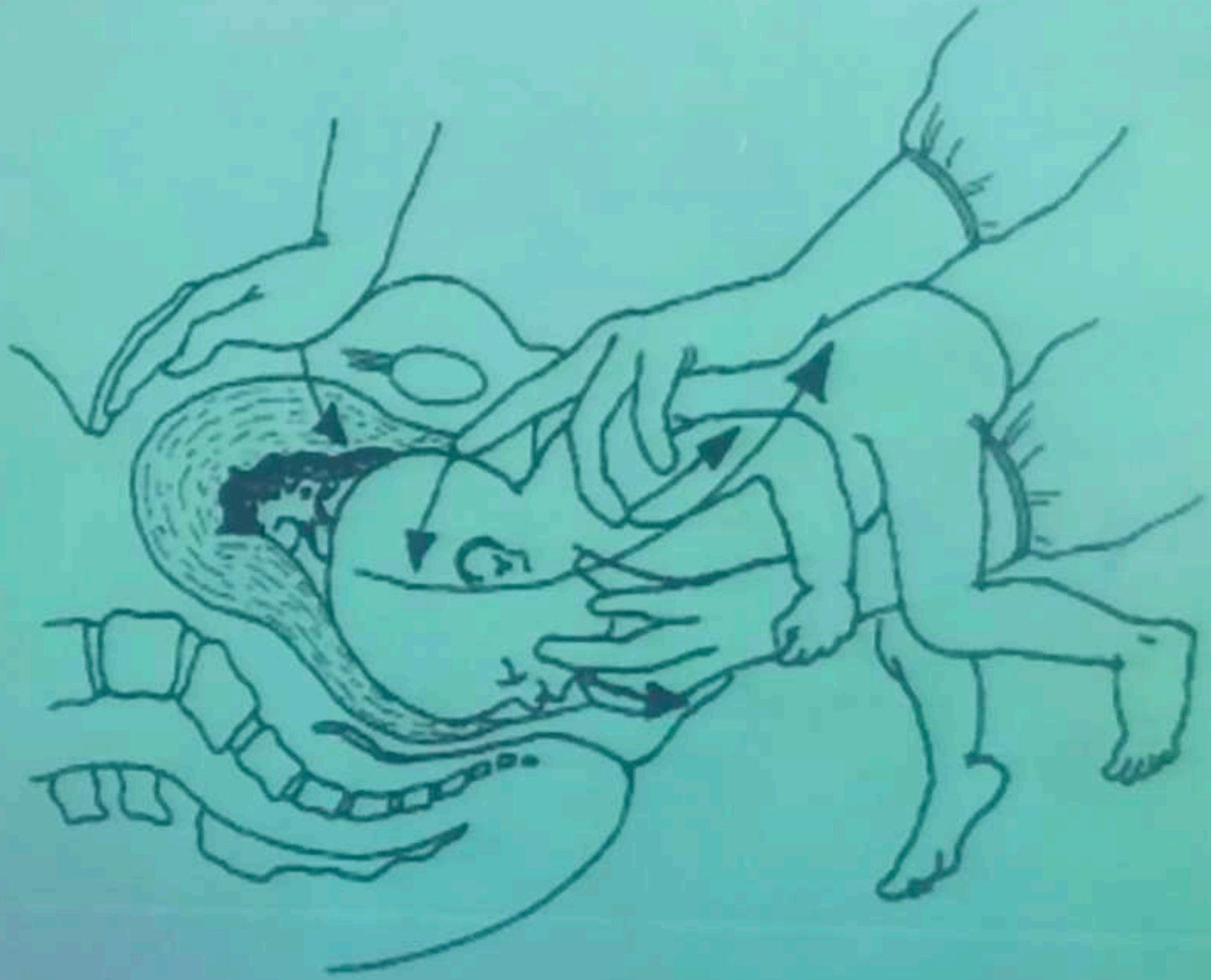
hold his feet

# Mariceau-Smellie-Veit Manoeuvre

*Jaw* flexion *and shoulder traction—JFST(*Mariceau-Smellie-Veit Manoeuvre*)*

- Here the baby is allowed to rest on the left supinated forearm of the obstetrition, with the limbs hanging on either side.
- Left index and middle finger is placed on the malar bones, while the right index and ring fingers are placed on the respective shoulders and the middle finger on the sub-occipital region.
- To achieve flexion, traction is now given in downward and backward direction and simultaneous suprapubic pressure is maintained by the assitant until the nape of the neck is visible.
- Thereafter, the baby is pulled in upward and forward direction so that the face is born and by depressing the trunk the **head** is born.

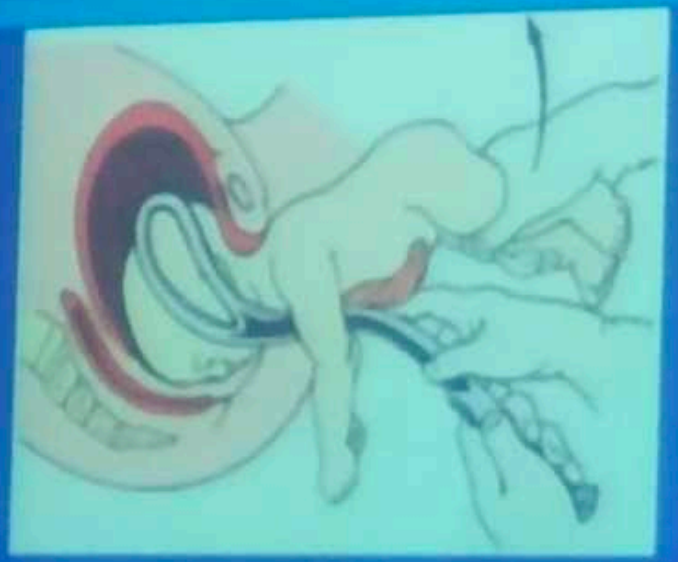


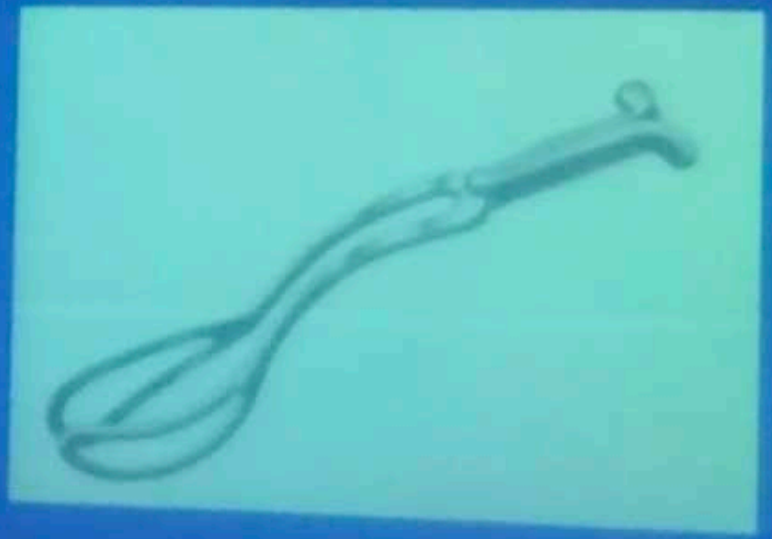


# Forceps delicery of the aftercoming head

- Piper's forceps.
- The important prerequisite is that head must be in the pelvic cavity and the occiput is directly anterior, i.e. the face is facing the posterior pelvic wall.
- Baby is lifted up by the assistant without deviating the trunk to any side and forceps applied from ventral side.

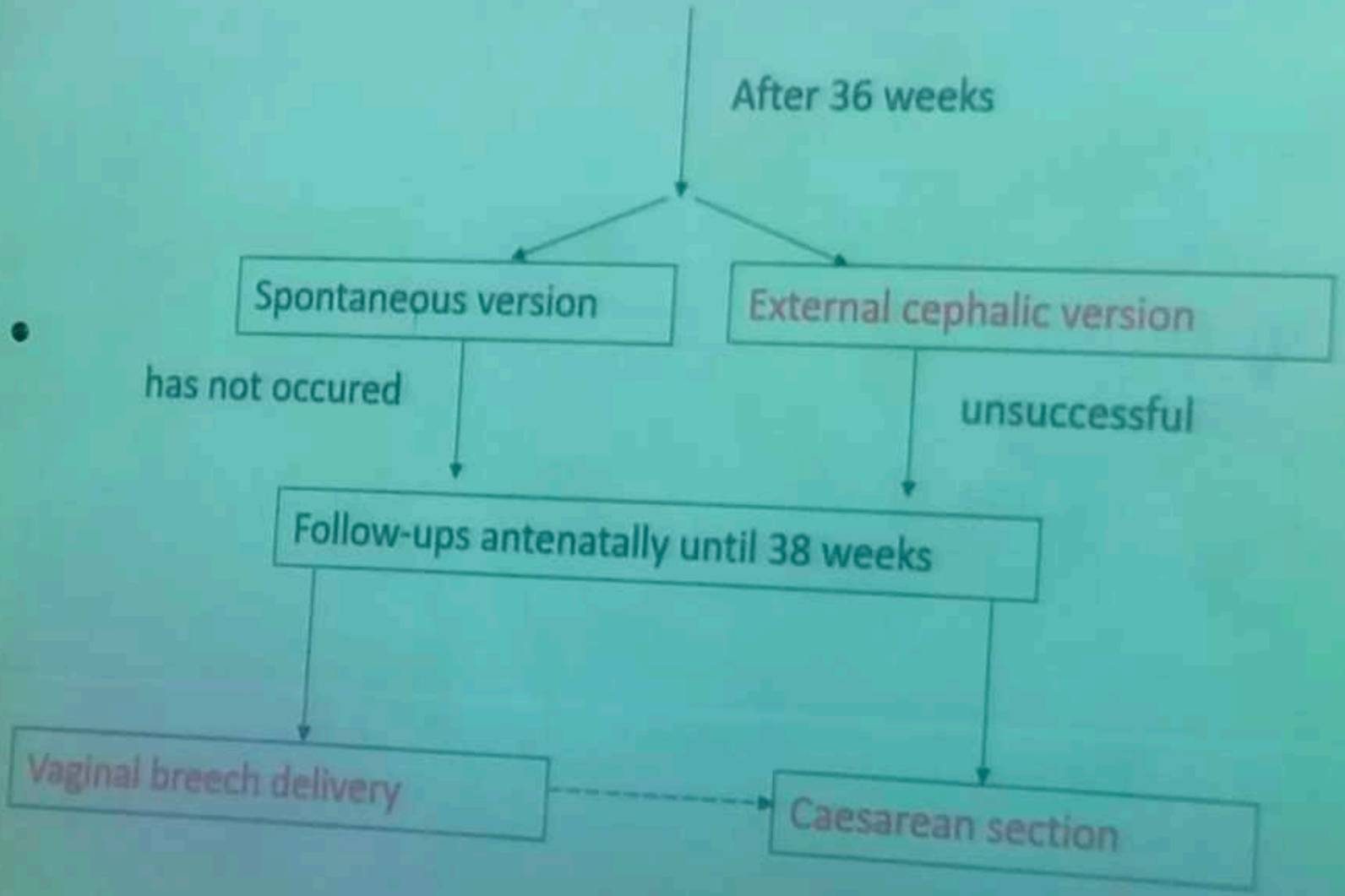
# After coming head in breech ▯ Piper





# BREECH PRESENTATION

## -- Management



# BREECH PRESENTATION

## -- Caesarean Section

- Factors that favour:
  - EBW > 3.5 Kg
  - Small pelvis (anterior posterior inlet or outlet diameter of less than 11cm )
  - Preterm fetus
  - Footling/ flexed breech
  - Hyperextended head
  - Patient with poor obstetric history
  - complications in the present pregnancy such as pre-eclampsia, intrauterine growth restriction, diabetes, cardiac disease, previous caesarean section

# BREECH PRESENTATION

## -- Caesarean Section

- However in 2000 the result of **the Canadian Term Breech Trial** were published. It came out overwhelmingly with the conclusion that singleton breech presentations at term should preferably be delivered by caesarean section.
- Not to do so would invite unacceptable fetal morbidity or mortality.
- There is therefore now a trend to deliver all breeches at term by caesarean section.

# cont

## Management

- Monitor for signs of cord prolapse. If the cord prolapses and delivery is not imminent, deliver by caesarean section.
- In modern practice, persistent transverse lie in labour is delivered by caesarean section whether the fetus is alive or dead.

# Risks of Vaginal Breech Delivery

- **Maternal Risks**

1. Perineal trauma
2. PPH

- **Fetal risks**

1. Birth trauma
   - Intracranial Haemorrhage
   - Spinal cord injuries
   - Injury to abdominal organs
   - # & injuries to limbs
   - Brachial plexus injuries
   - others
2. Birth Asphyxia
3. Perinatal loss