

# Fetal malposition

By

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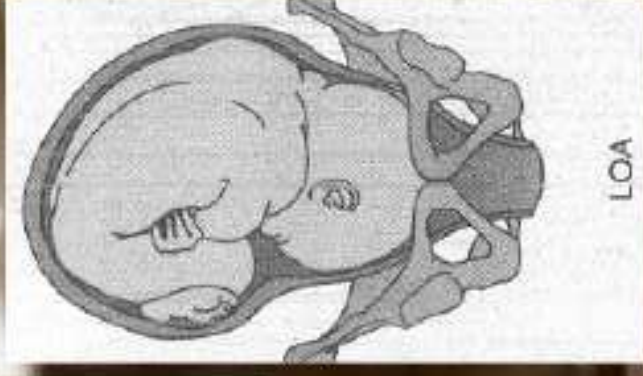
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# Fetal Malposition

Refers to positions other than an **occipitoanterior** position.

Malpositions include **occipitoposterior** and **occipitotransverse** positions of fetal head in relation to maternal pelvis.

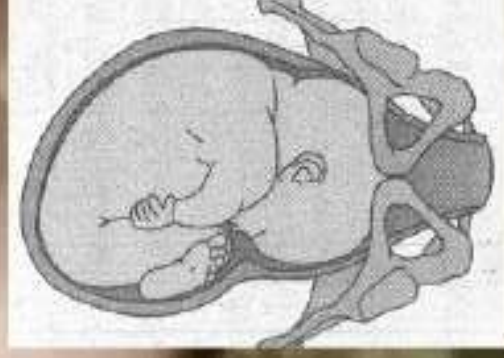
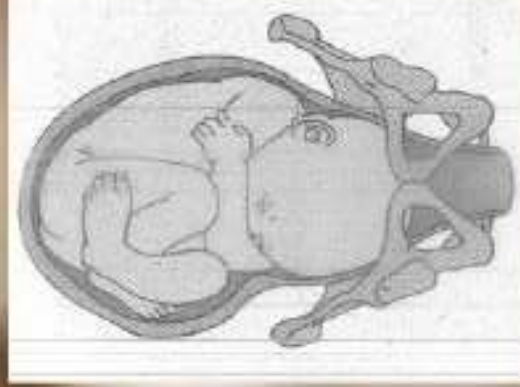
It is usually seen in multipara or those with lax abdominal wall. Fetal malpositions are assessed during labor.



# *Types of Fetal Malposition*

## **Occipitoposterior Position**

Arrested labor may occur when the head does not rotate and/or descend. Delivery may be complicated by perineal tears or extension of an episiotomy.



## **Occipitotransverse Position**

It is the incomplete rotation of OP to OA results in the fetal head being in a horizontal or transverse position (OT).





A



B



C



D



# Causes

- The direct cause is often unknown. But the following are the responsible factors:
  - **Shape of the pelvic inlet:** associated with either an anthropoid or android pelvis.
  - **Fetal factors:** Marked deflexion of fetal head.
  - **Uterine factors:** Abnormal uterine contraction



# Factors that favour malposition

Postulated Causes



- Pendulous abdomen- in multiparae



- Anthropoid pelvic brim- favours direct O.P/O.A



- Android pelvic brim



- A flat sacrum-transverse position



- The placenta on the ant. uterine wall



- R.O.P



# Occipito Posterior Position OP

## Diagnosis

### Antenatal

Diagnosed is important at least to rule out any major causes which may be a contraindication to leave the patient enter into labour

Suspension during antenatal examinations raise when:

- High head
- Large amount of head is palpable
- fetal back is placed posterior
- the sinciput is lower than the occiput



A



B

Comparison of abdominal contour in (A) posterior and (B) anterior positions of the occiput



# Occipito Posterior Position OP

## Diagnosis During Labour

vaginal examination during labour :

- High presenting part
- Anterior fontanel felt near to the symphysis
- Posterior fontanel felt near to the sacral promontory
- Frontal sutures and Frontal bones
- Orbital ridge and Nose




# *Maternal Risks*


- Prolonged labor r/t decreased pressure exerted by the breech on the cervix.
- PROM may expose client to infection.
- Cesarean or forceps delivery.
- Trauma to birth canal during delivery from manipulation and forceps to free the fetal head.
- Intrapartum or postpartum hemorrhage.



## *Fetal Risks:*

 Compression or prolapse of umbilical cord.

 Entrapment of fetal head in incompletely dilated cervix.

 Aspiration and asphyxia at birth.

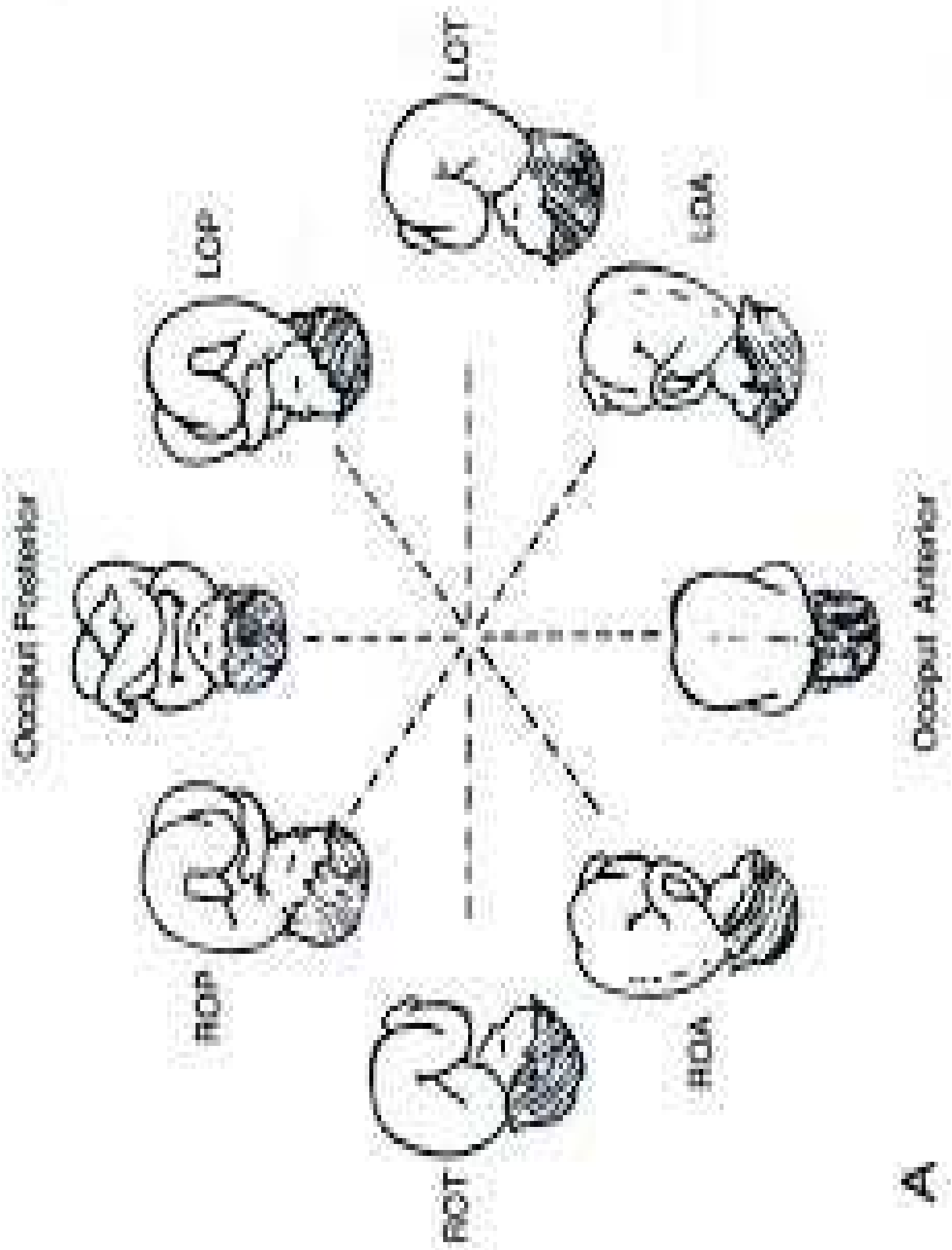
 Birth trauma from manipulation and forceps to free the fetal head.

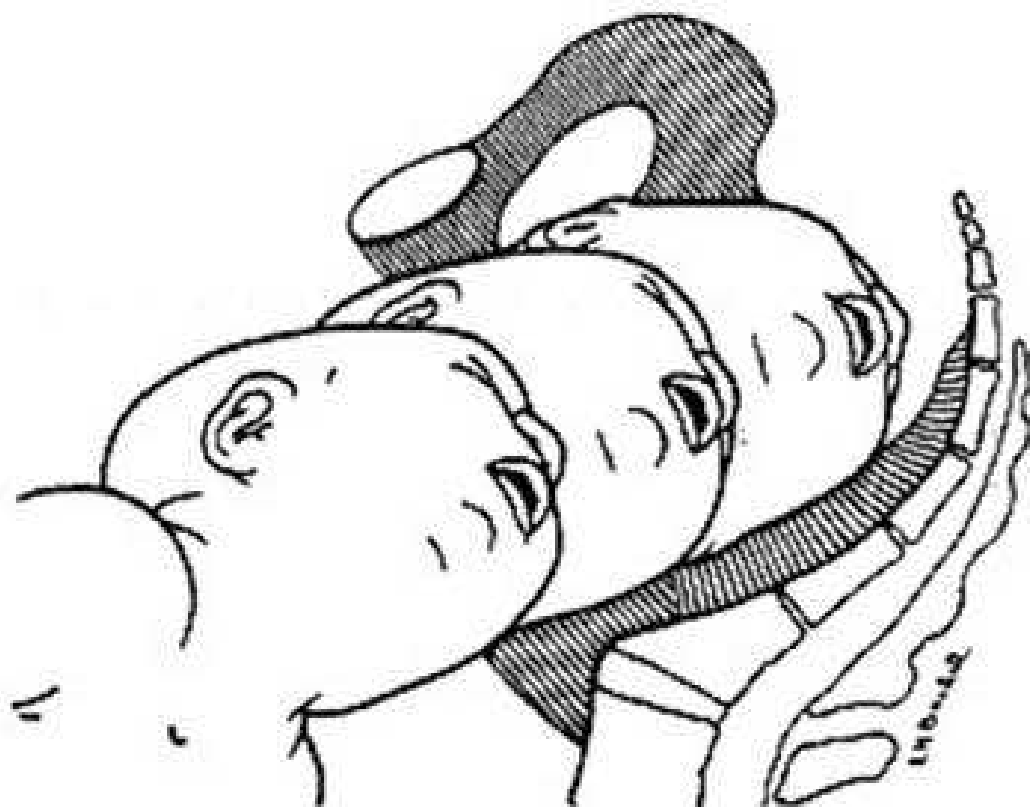
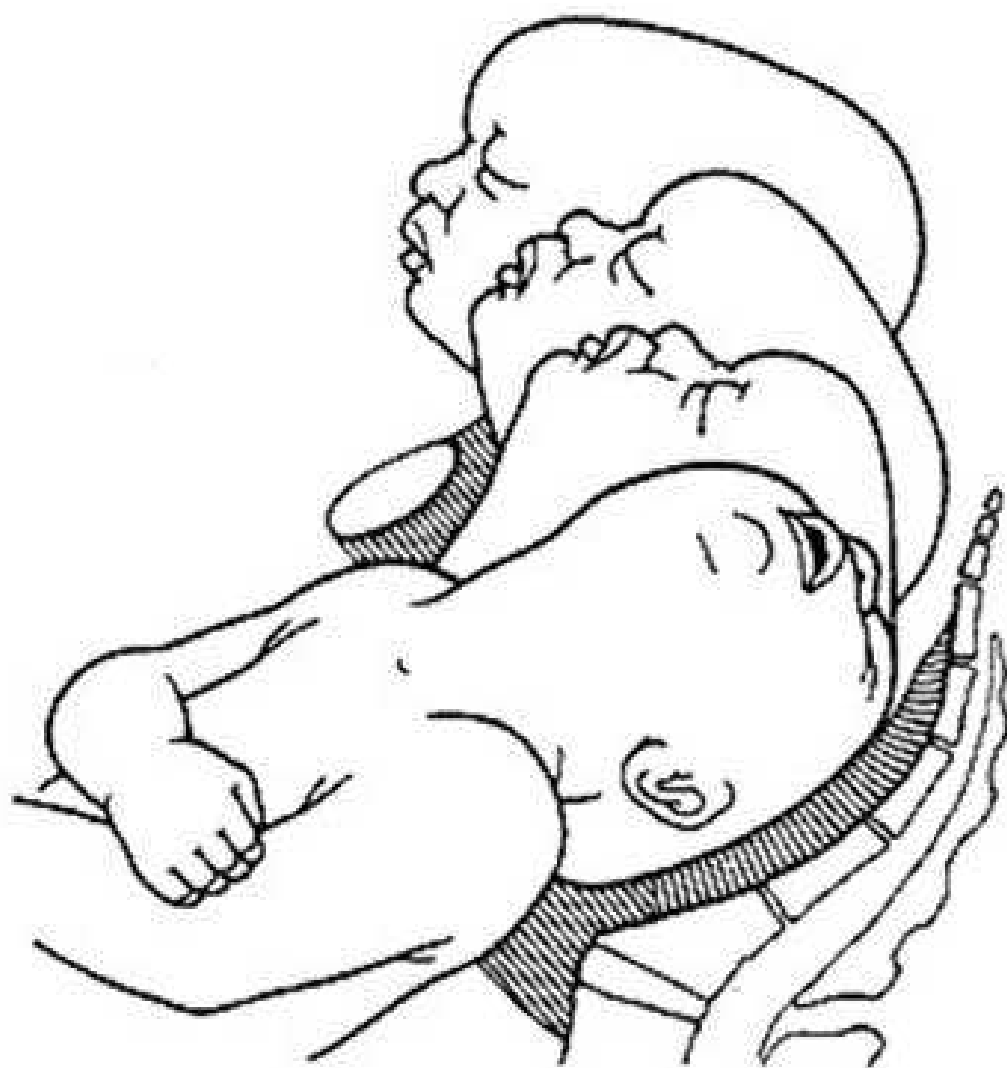
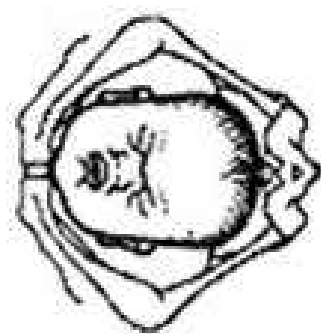




# Mode of delivery

- *Long anterior rotation of the occiput:* Spontaneous or aided vaginal delivery usually occurs (90%)
- *Short posterior rotation:* Spontaneous or aided vaginal delivery may occur as face to pubis.
- *Non-rotation or short anterior rotation:* Spontaneous vaginal delivery is unlikely except in favourable circumstances.
- *Moulding:* The characteristic moulding of head occurs in face to pubis delivery. There is compression of the occipito-frontal diameter with elongation of the vault at right angle to it. The frontal bones are displaced beneath the parietal bones.





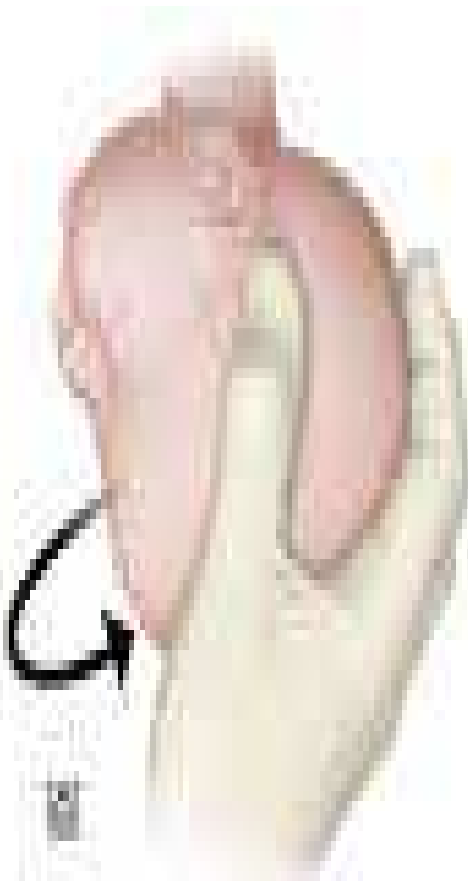


# Persistent Occiput Posterior

- Labor and delivery need not differ remarkably from OA
- Progress may be determined by assessing cervical dilatation and descent of the head
- Possibilities for vaginal delivery
  1. Spontaneous delivery
  2. Forceps delivery with occiput directly posterior
  3. Manual rotation to the anterior position followed by spontaneous forceps delivery
  4. Forceps rotation of the occiput to the anterior position and delivery



(a)



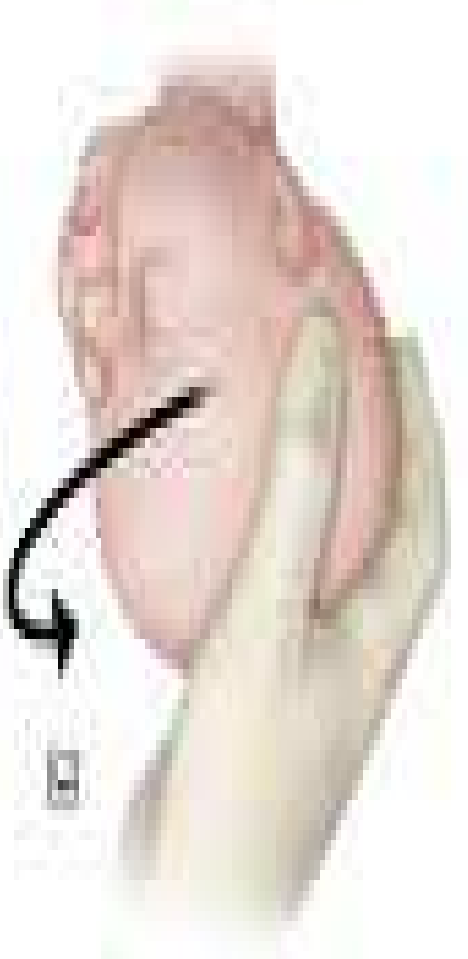
(b)



(c)



(d)



(e)



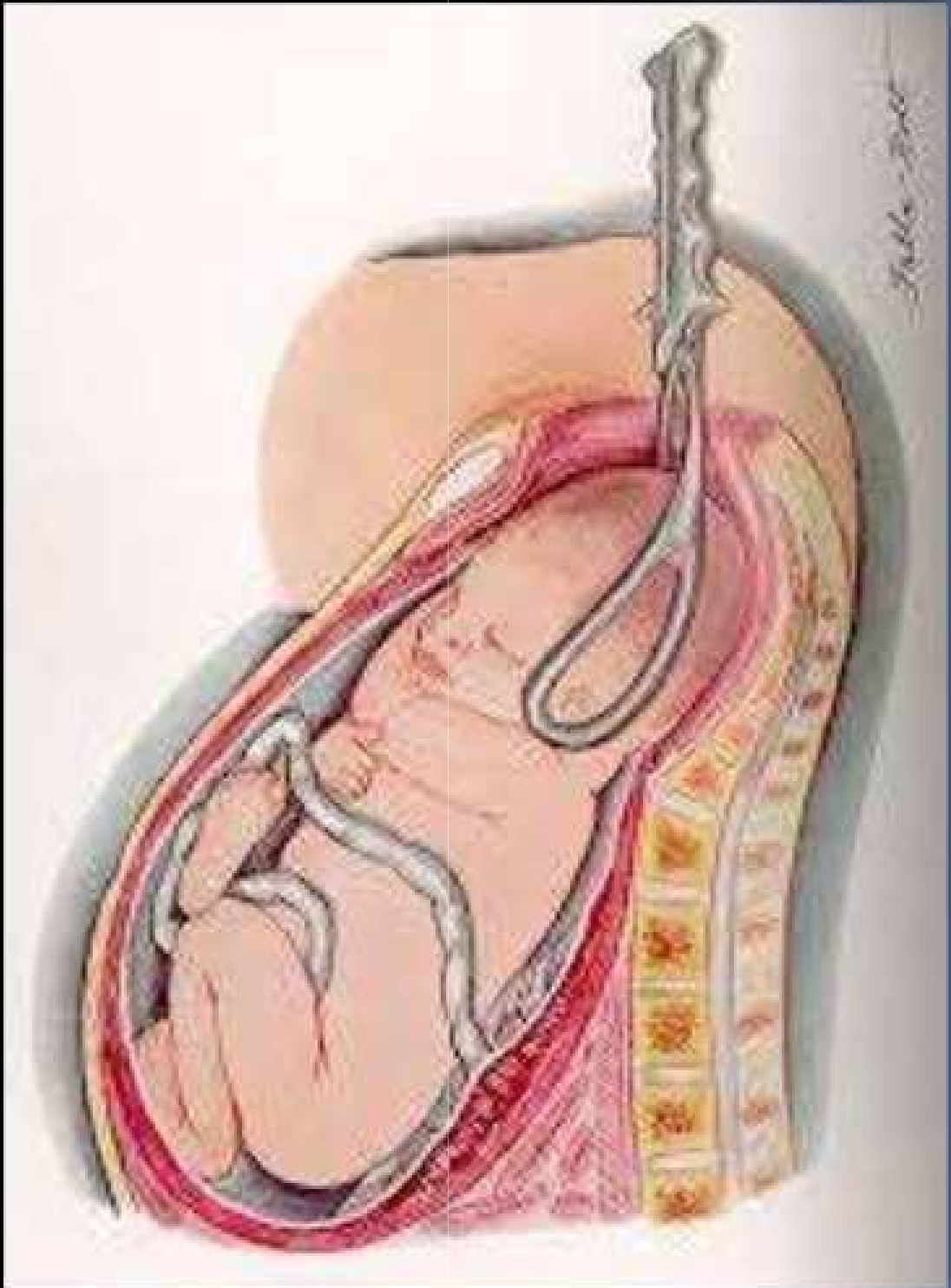
(f)

## Delivery of head in a persistent occipitoposterior position



Grasping the head to bring the face down from under the symphysis pubis and Extension of the head



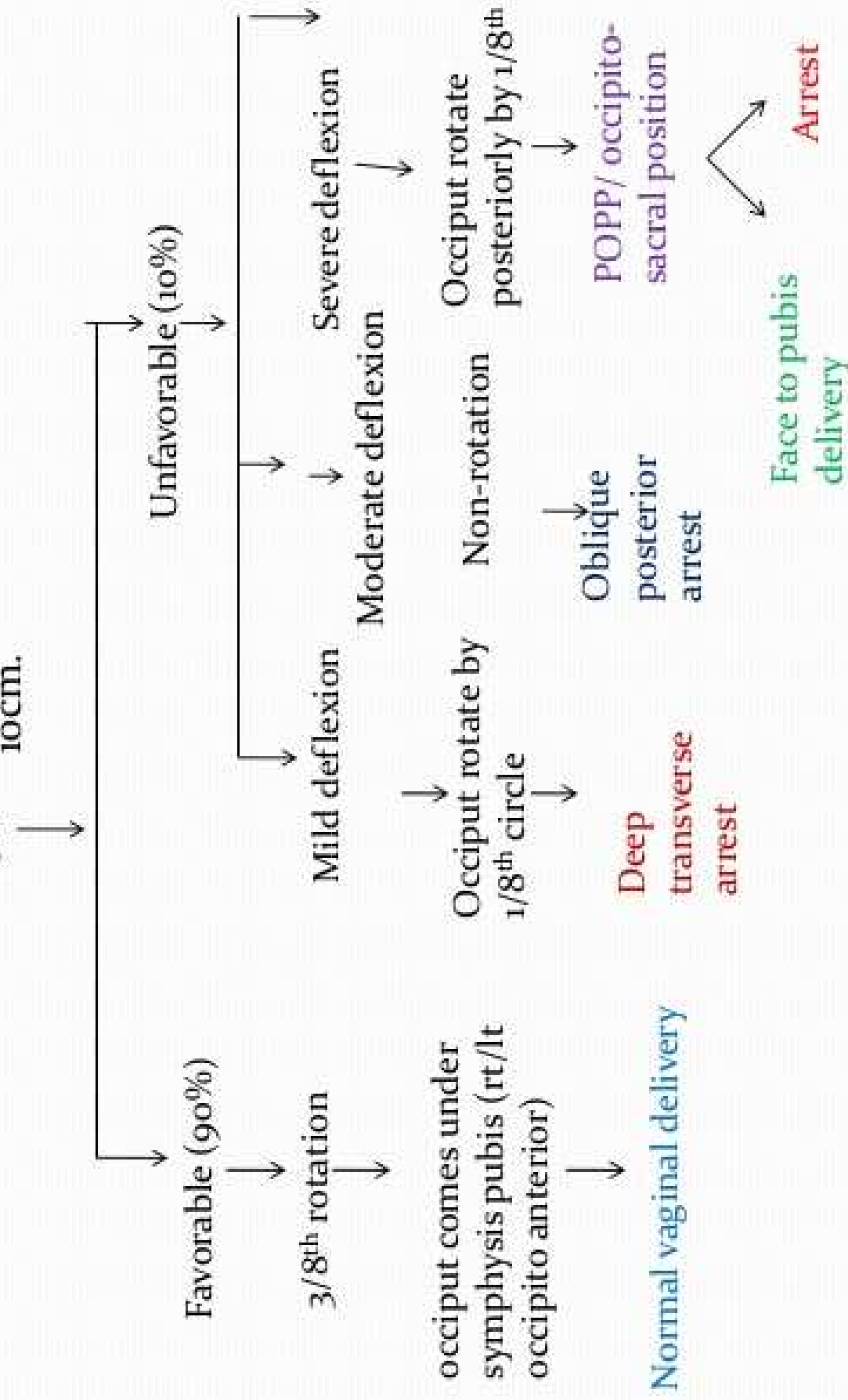




# Fate of OPP

Engaging diameter :- occipito-frontal 11.5cm or sub-occipitofrontal 10cm.

OPP





# Deep transverse arrest

- The head is deep into the cavity, the sagittal suture is placed in the transverse bipsinous diameter and there is no prognosis in descent of the head even after  $\frac{1}{2}$  -1 hour following full dilatation of cervix.
- May be end result of incomplete anterior rotation of the oblique OPP, or it may be due to non rotation of the commonly primary occipito transverse position of normal mechanism of labour.



# Deep transverse arrest cont...

## Causes:

- Faulty pelvic architecture
- Prominent ischial spine,
- Flat sacrum and convergent side walls,
- Deflexion of head,
- Weak uterine contraction,
- Laxity of the pelvic floor muscles.

## Diagnosis

- Head is engaged
- Sagittal suture lies in transverse bispinous diameter,
- Anterior fontanelle is palpable,
- Faulty pelvic architecture may be detected.

# Deep transverse arrest cont...

## *Management:*

- Vaginal delivery is found safe.
- Ventouse
- Manual rotation and application of forceps
- Forceps rotation and delivery with Keilland in hands of an expert.
- Vaginal delivery is not safe: caesarean section.



Thank  
you

