HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (L&D)		
Document:	Departmental Policy and Procedure		
Title:	Abnormal Fetal Presentation		
Applies To:	All Obstetrics and Gynecology Staff		
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1. PURPOSE:

1.1 To standardize and streamline the health care provided in L&D and to elaborate the lines of communications.

2. DEFINITIONS:

2.1 **Malpositions**- are abnormal positions of the vertex of the fetal head (with the occiput as the reference point) relative to the maternal pelvis.

2.2 **Chin – Anterior Position**- in this position, the chin is facing the front of the mother.

2.3 **Chin – Posterior Position**- the chin is facing the mother's back, pointing down towards her buttocks in mentum posterior position. In this position, the newborn's head, neck, and shoulders enter the pelvis at the same time, and the pelvis is usually not large enough to accommodate this. Also, an open fetal mouth can push against the bone (sacrum) at the upper and back part of the pelvis, which also can prevent descent of the fetal through the birth canal.

2.4 **Compound Presentation**- is a fetal presentation in which an extremity presents alongside the part of the fetus closest to the birth canal. The majority of compound presentations consist of a fetal hand or arm presenting with the vertex. This topic will review the pathogenesis, clinical manifestations, diagnosis, and management of this uncommon intrapartum problem.

2.5 **Transverse Lie and Shoulder Presentation**- is when the arm, shoulder or trunk of the baby enters the birth canal first.

3. POLICY:

3.1 Malpresentation are all presentations of the fetus other than vertex. That may result to prolonged or obstructed labour.

4. PROCEDURE:

4.1 If abnormal presentations are suspected, the physician should assess the patient immediately. Discuss management with physician:

- 4.1.1 Breech presentation refers to P&P breech delivery.
- 4.1.2 Brow Presentation:
  - 4.1.2.1 Brow presentation is transient fetal presentation with deflexion of fetal head.
  - 4.1.2.2 During normal course of labour, conversion to face or vertex presentation generally occurs.
  - 4.1.2.3 If no conversion takes place, caesarean section is indicated as engagement is impossible with average size.
- 4.1.3 4.1.2.4 If the pelvis is large and fetus is very small, labour is generally easy.
- 4.1.4 Face presentation the chin serves as the reference point in describing the position of the face.
  - 4.1.4.1 **Chin- Anterior Position**
    - 4.1.4.1.1 If the cervix is fully dilated:

4.1.4.1.1.1 Allow to proceed with normal childbirth;
4.1.4.1.1.2 If there is slow progress and no sign of obstruction augment labour with Oxytocin.
4.1.4.1.1.3 If the cervix is not fully dilated and there are no signs of obstruction, augment labour with Oxytocin. Review progress as with vertex presentation.

4.1.4.2 **Chin- Posterior Position**

4.1.4.2.1 If the cervix is fully dilated, deliver by caesarean section.
4.1.4.2.2 If the cervix is not fully dilated, monitor descent, rotation and progress. If there are signs of obstruction, deliver by caesarean section.

4.1.5 **Compound Presentation** spontaneous delivery can occur only when the fetus is very small or dead and macerated. Arrested labour occurs in the expulsive stage.

4.1.5.1 Replacement of the prolapsed arm is sometimes possible (after discussion with physician):

4.1.5.1.1 Push the arm above the pelvic brim and hold it there until a contraction pushes the head into the pelvis.
4.1.5.1.2 Proceed with management for normal childbirth.

4.1.6 **Transverse Lie and Shoulder Presentation**

4.1.6.1 If the women is in early labour and the membranes are intact, attempt external version (after discussion with senor registrar or consultant and after counselling the patient)
4.1.6.2 If external version is successful, proceed with normal childbirth; Monitor for signs of cord prolapsed and delivery is not imminent, deliver by caesarean section.
4.1.6.3 If external version fails or is not advisable delivers by caesarean section.
Note: Ruptured uterus may occur if the woman is left unattended. In modern practice, persistent transverse lie in labour is delivered by caesarean section whether the fetus is alive or dead.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurses
6.3 Midwives

7. APPENDICES:

N/A

8. REFERENCES:

8.1 Guidelines for Obstetrics and Gynecology/ Ministry of Health, General Directorate of Health Centers-Riyadh, 2013
8.2 http://hetv.org/resources/reproductivehealth/impac/Symptoms/Malpositions__malpresetations_S69_S81.html
8.3 https://www.abclawcenters.com/practice-areas/prenatal-birth-injuries/abnormal-position-or-presentation/
8.4 https://www.uptodate.com/contents/compound-fetal-presentation

9. APPROVALS:

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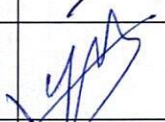
Reviewed by:	Dr. Mohannad Yaghmour	Head of the Department		January 12, 2025
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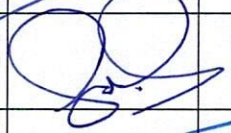
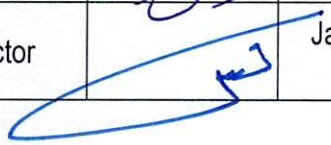
Reviewed by:	Mr. Abdulelah Ayed Al Mutairi	QM&PS Director		January 15, 2025
Approved by:	Mr. Fahad Hezam AlShammari	Hospital Director		January 22, 2025