Lie, Presentation, Position & Engagement

تم تفريغ كلام الدكتور **ناثر حاوا** على المحاضرة باللون الأخضر

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The Fetal Lie

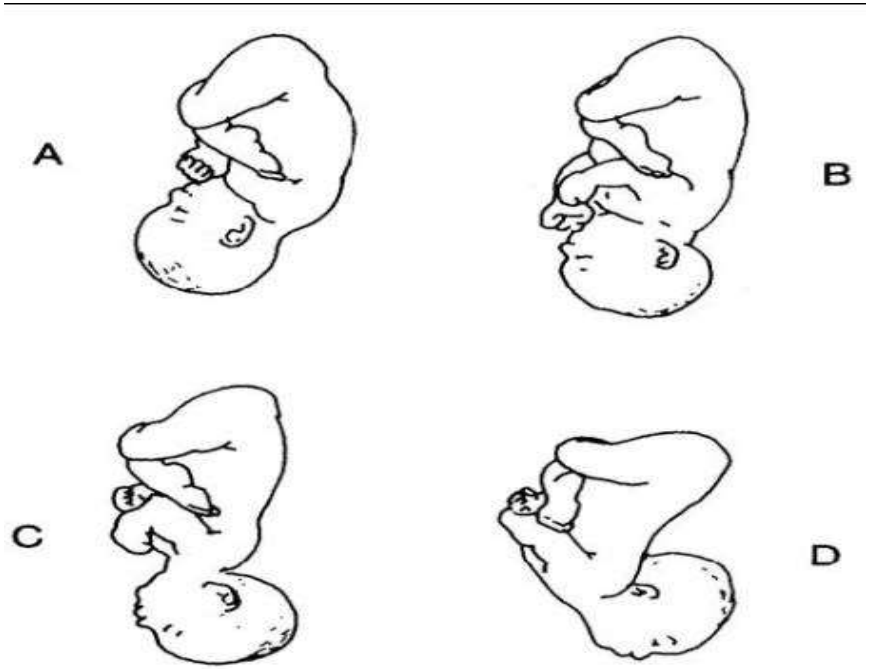
- The relation of the long axis of the fetus(spine) to the long axis of the mother(spine of mother).
  - Longitudinal lie (99.5%).
  - Transverse lie
  - Oblique lie (unstable lie).

Fetal attitude

- The fetal attitude describes the relationship of the fetus' body parts to one another. (ie: body is flexed; hands are flexed, arms are flexed, head is flexed. Some times only one part can be flexed or extended, then we have to specify each part.
- Normally, the fetus is in flexion attitude. Not necessary all parts

Fetal presentation

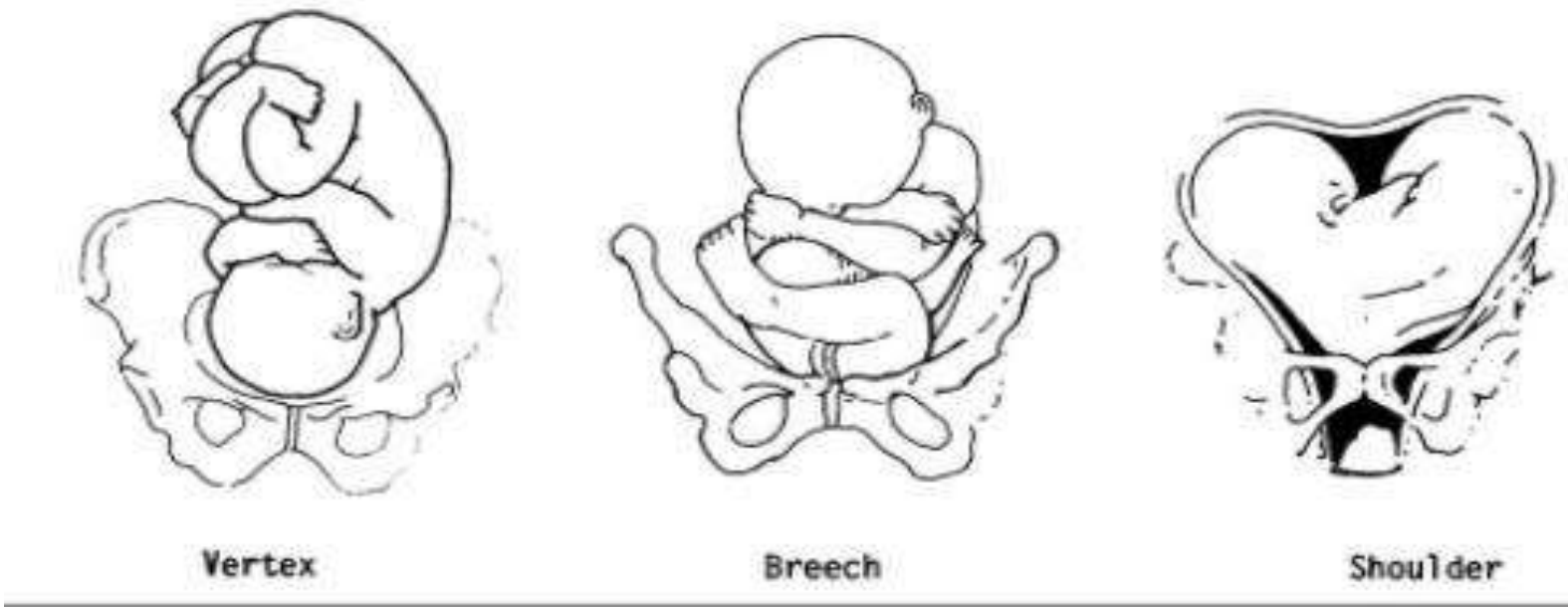
- The lowest part of the fetus that lies closest to or has entered the true pelvis and it can be reached on vaginal examination.
- Cephalic (head) presentation: Found in about 97% of pregnancies at term. we can dx in abdominal = breech but to determine type we have to do a vaginal examination
- There are different types of cephalic presentation, which depend on the fetal head attitude (degree of head flexion).
  - Vertex presentation (A)FLEXED
  - Brow presentation © deflexed
  - Face presentation D extended



Abdominal = determine presentation
Vaginal = presenting part
The part of presentation that we dx in abdominal that can be felt in vaginal

Fetal presentation

- Breech presentation
- Shoulder presentation
- Compound presentation (head/arm) , (head , leg) , (head, umbilical cord)



- **If I do vaginal examination, I can identify the presenting part.**
- **If I do an abdominal examination, I can identify the presentation.**
- **What appears to be cephalic presentation on abd. Examination, can be either vertex, brow or face presentation on vaginal examination.**
- **Compound presentation >???**

Fetal Position

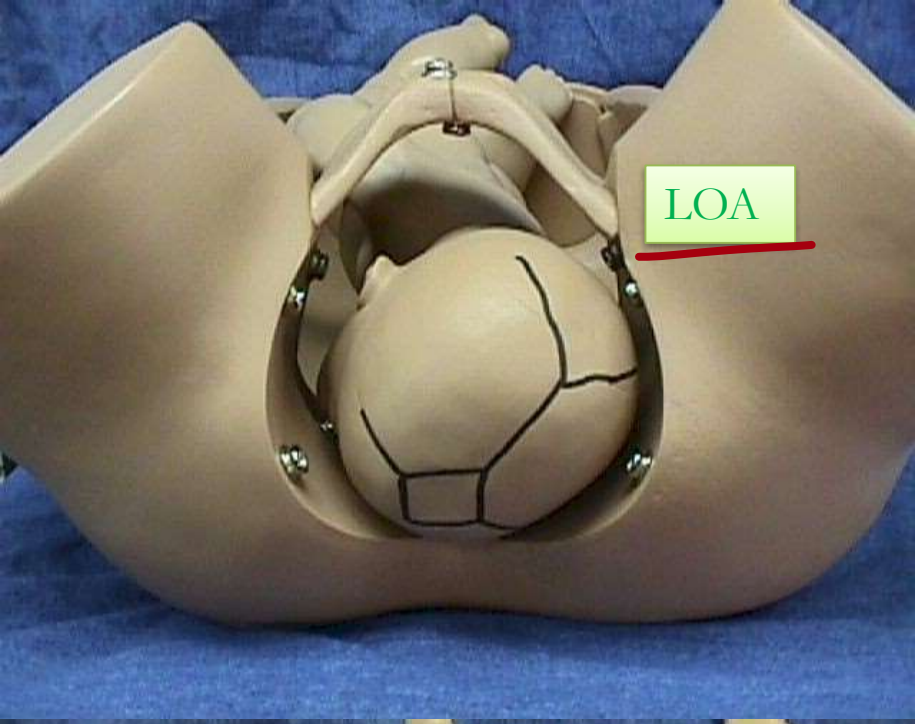
- The relation of an arbitrary chosen portion of the presenting part of the fetus (called denominator or indicator) to four quadrants of the birth canal (right and left anterior quadrants and right and left posterior quadrants)
- The denominator is:
  - Vertex: Occiput.
  - Face: Mentum (the chin).
  - Brow: Sinciput.
  - Breech: Sacrum.

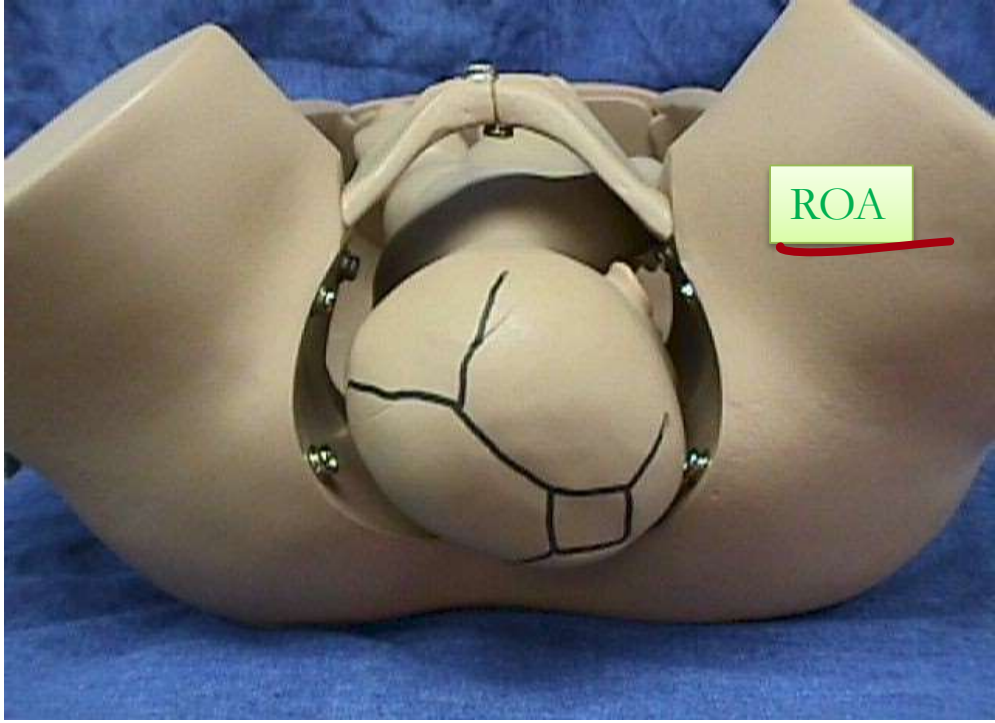
Face to pubis =DOP
How ?
1.PV
2.US –intrapartum
?? > caput succedum

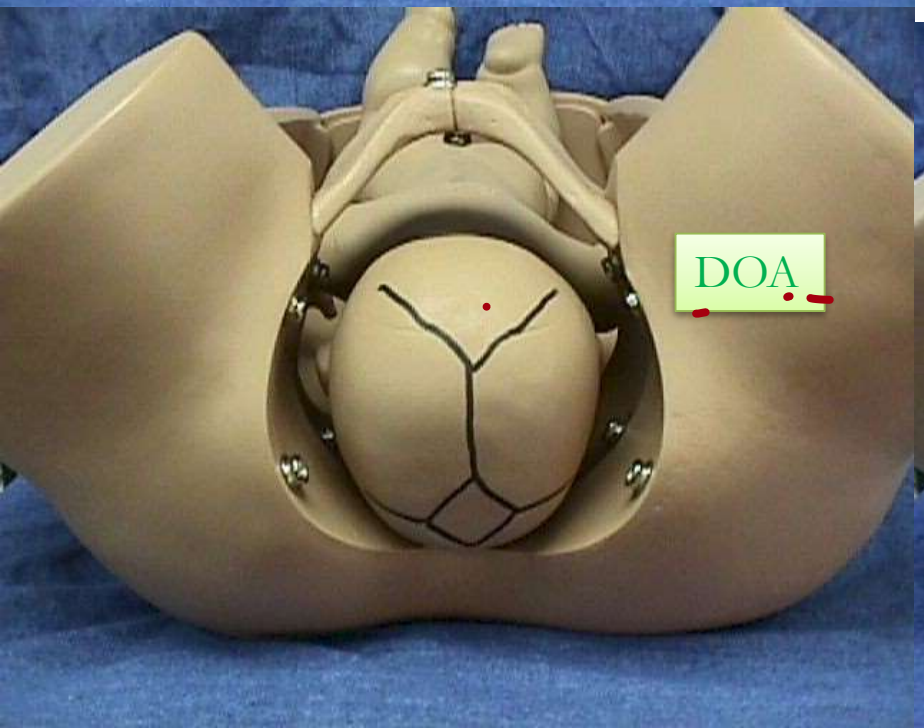
- The denominator is selected according to the presentation
- If the presenting part is the occiput, we choose the vertex as its denominator.
- If the presenting part is the face, we choose the chin
- And so on

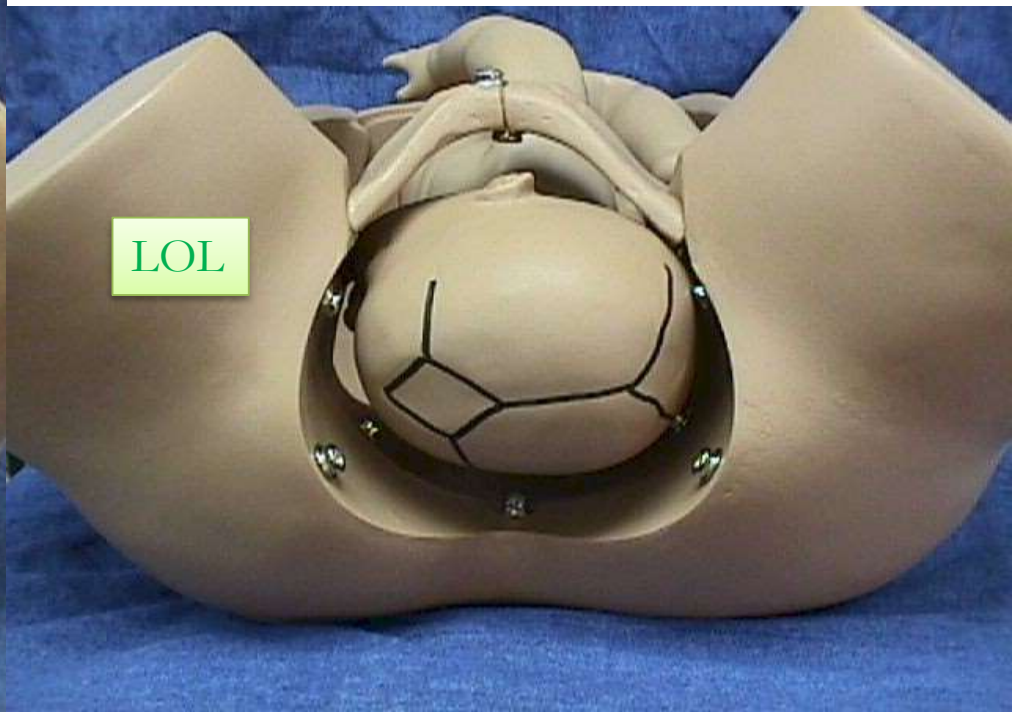
- Then this denominator is assessed according to the position.
- Ex: Left occiput anterior/right occiput anterior

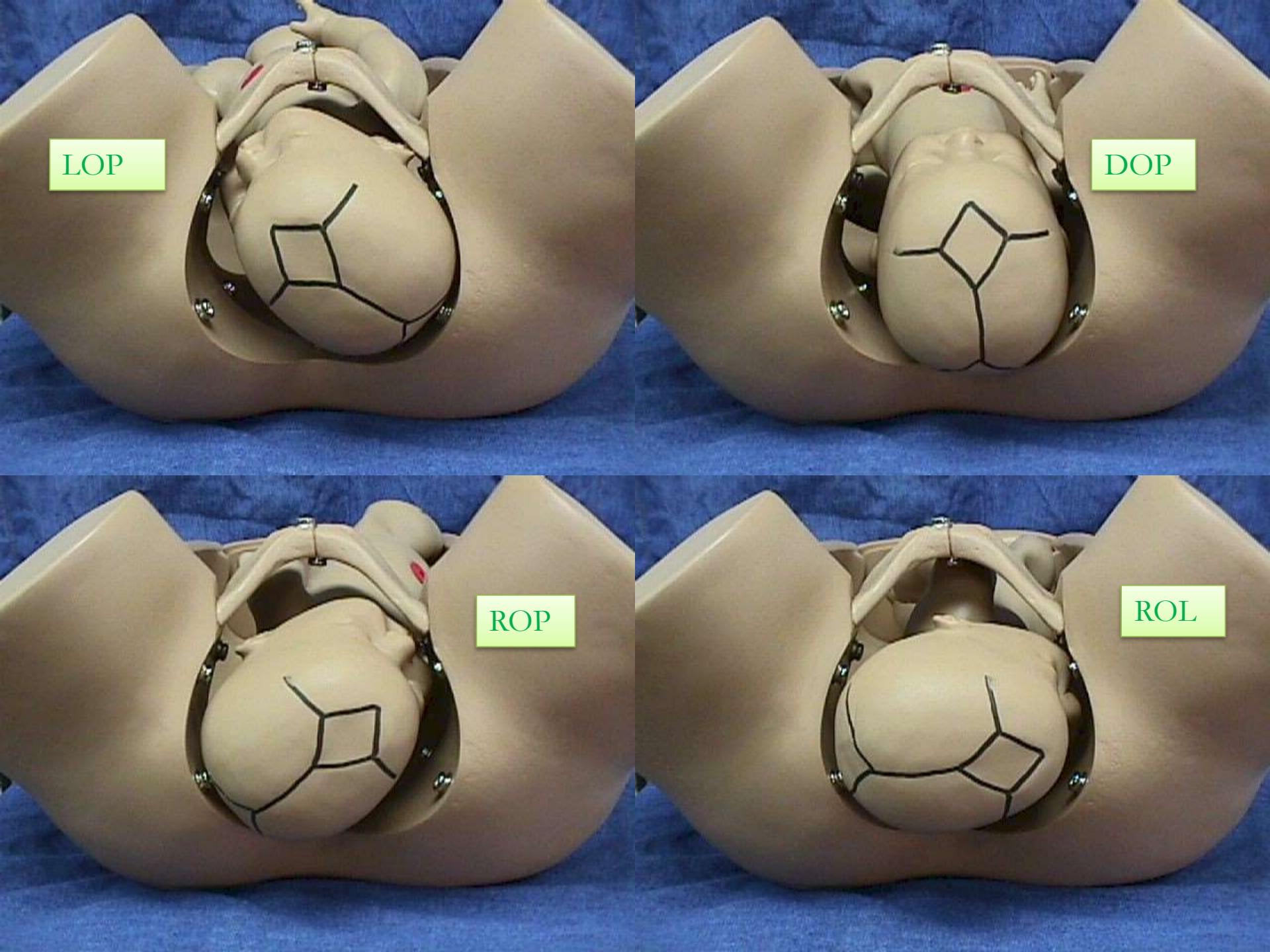
- Some times the position varies and so the naming is …..
- This is important for vertex and face presentation because it will change the way of delivery


LOA


ROA


DOA


LOL


LOP
DOP
ROP
ROL

Fetal engagement

Biparietal+interischial

- When the largest transverse diameter of the presenting part has passed the pelvic inlet. In cephalic presentation it is the Biparietal diameter.

Abdominal diagnosis: (Role of five)

If > 2/5 of the head is palpable above the pelvic brim it is not engaged.

1) If ≤ 2/5of the head is palpable above the pelvic brim it is engaged.

2) On 0 station in ischial spine

Fetal engagement

Pelvic diagnosis: bony parts

Level of the fetal vault to the ischial spines. This is measured in cm. (-3 level means 3 cm above the ischial spine)

- 3 level = 5/5 palpable head abdominally (not engaged head)
- 2 level = 4/5 palpable head (not engaged head)
- 1 level = 3/5 palpable head (not engaged head)

0 level = 2/5 palpable head (engaged head)

+1 level = 1/5 palpable head (engaged head)

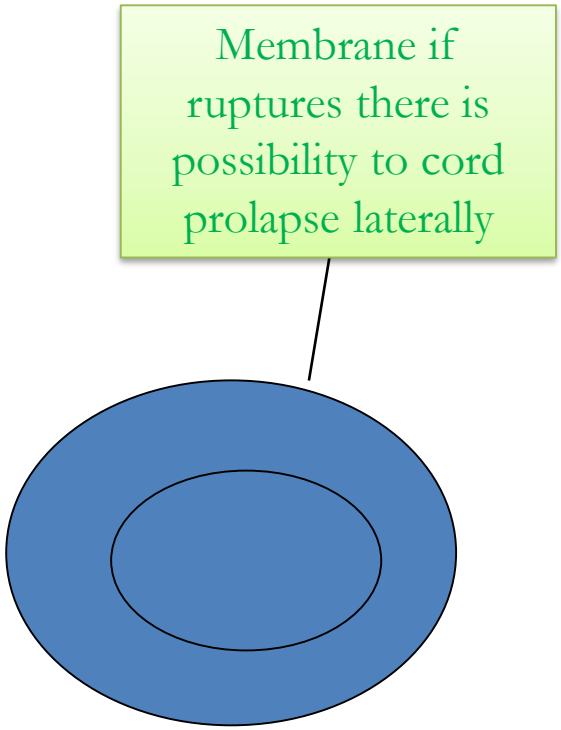
+2 level = 0/5 palpable head (engaged head)

+3 level = head crowning at the perineum. (doesn't need to be examined)

Once the head is engaged it will go out

Fetal fixity

- Fixity is diagnosed when you can't move the fetal head from side to side in the birth canal.
- Fixity of the head is not essentially mean that the head is engaged. (ex: big fetal head)
- Fixity is good because it prevents cord prolapse after rupture of membranes



Head Asynclitism

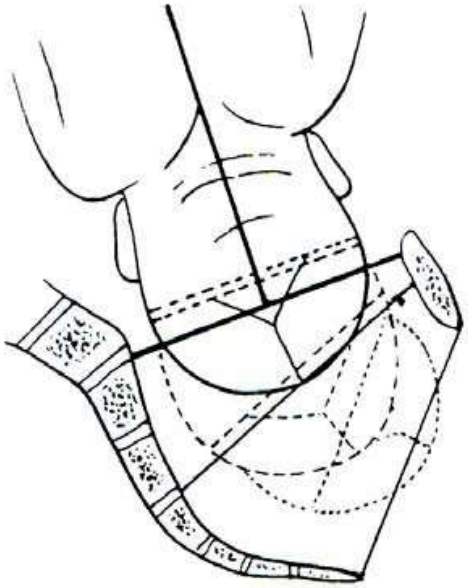
- Although the fetal head tends to accommodate to the transverse axis of the pelvic inlet, the sagittal suture may not exactly midway between the symphysis and sacral promontory. The sagittal suture is deflected either posteriorly toward the promontory or anteriorly toward the symphysis. Two types:

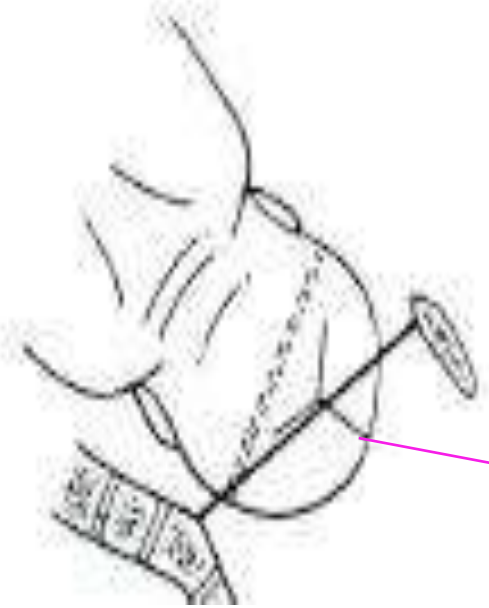
1- Anterior asynclitism. Saggital suture posteriorly

2- Posterior asynclitism. Saggital suture anteriorly

Head Asynclitism (cont.) NOT CS

- Mostly asynclitism correct it self spontaneously during labour especially in early labor, but if persist it may cause obstructed labour and need CS.





Posterior because saggital is anterior