Obstetrics and Gynecological Nursing II

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CHAPTER SEVEN
ABNORMAL LABOUR

Learning objective

- At the end of this chapter students will be able to: -

✓ Define malpresentation and malposition - Identify causes of Post partun Heamorrage. (P.P.H).

✓ Define prolonged labour –

✓ Diagnose Cephalo pelvic disproportion (C.P.D). - List the cause of rupture of uterus

Mal presentation and Malpostion

- ✓ Malpresentation and malpositions are essentially abnormalities of fetal position, presentation, attitude or lie.
- ✓ They collectively constitute the most common cause of fetal dystocia occurring in approximately 5% of all labors.
- ✓ Breech presentation is the commonest malpresentation.
- ✓ The other malpresentations are face

Causes

- ✓ polyhydraminous
- ✓ Abnormality of pelvis
- ✓ Abnormal shape of uterus
- ✓ Laxcity of uterine muscles
- ✓ Multiple pregnancy

- All ill fitting part is associated with (results in):
- 1. Early rupture of membrane with risk of cord prolapsed

2. Premature labour
3. Slow, irregular, short-lived contractions
4. Uncoordinated and excessively painful labour after rupture of membranes
5. Prolonged and obstructed labour
6. Post partum hemorrhage
7. Fetal and maternal distress

Breech Presentation

- Definition: When the fetus lies with his buttock in the lower pole of the uterus.

  It occurs in 1: 40 cases of labor after 34 weeks

1. Breech with extended legs or frank breech- in this type of breech the thighs are flexed and the legs are extended along the fetal abdomen. It is the common one.
2. Complete breech the fetus lies in a flexed attitude and the legs are flexed on the abdomen. The presenting part is bulky and consists of buttocks external genitalia and both feet.
3. Footling- one or both feet present because neither hips nor knees are fully flexed.
4. Knee presentation. On this case both the hips are extended with the knees flexed.

Causes

- Poly hydromnios
- Prematurity
- Multiple pregnancy
- Placenta preveia
- Contracted pelvis
- Uterine abnormalities
- Hydrocephalus
- Extended legs

Diagnosis

On palpation

- ✓ Lie is longitudinal
- ✓ The fundus contains a firm, smooth and rounded mass which dependently moves with the back.
- ✓ On pelvic palpation no head is palpated pelvic has a soft and irregular mass

On auscultation

- The fetal heart beat is heard above the umbilicus if the breech is not engaged below the umbilicus if it is engaged.

Vaginal examination

- No sutures and fontanels are felt.
- When the membrane are ruptured the anal sphincter grips the finger when fresh meconeum seen on the examining finger

Antenatal management

- The presentation may be confirmed by ultrasound scan or Xray of abdomen.
- The obstetirician may decide to do an external cephalic version before 36 weeks of gestation

Management in labor in breech presentation

- The method of delivery is chosen depend on

  1. Parity of the mother if she is preimigravida

2. Size o f the baby

3. Other obstetrical complication

Principles of Management

- Intelligent observation
- Avoidance of unnecessary interference
- Prompt action carried out with manual dexterity when assistance is needed
- Avoidance of fetal injury and hypoxia

Management of Labor in Breech Delivery…

- It is managed depending on types of presentations
- Types of delivery –
- Spontaneous breech delivery
- - Assisted breech delivery-assistances for delivery of extended legs arms and the head.
- Breech extraction this is the manipulative delivery to extract the breech when the mother is unable to deliver.

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First Stage

- Careful observation

- Warn mother not to push

- Vaginal examination when membrane ruptures (to rule out cord prolapse)

–Sedation often necessary

- Be prepared for the delivery

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Delivery of Flexed Breech

- ✓ Full dilatation of the cervix should be confirmed by vaginal examination before allowing the woman to push to prevent the breech slipping through incompletely dilated and the head may be trapped by the cervix.
- ✓ Active pushing is not commenced until the buttocks are distending the vulva
- ✓ □ Encourage her to push with the contraction and the buttocks are delivered spontaneously episiotomy may be necessary □
- ✓ The hands off the breech get mother to push when the buttocks are born pull down a loop of cord feel for pulsation put in to the hollow of the sacrum to prevent pressure and traction. □

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- ✓ Fell for the elbows on the chest the shoulder should be born easily with the arms flexed across the chest if not help them out by flexing the arm.
- ✓ Grasp the baby by iliac crest with the thumbs held parallel over his sacrum and tilt the baby towards the maternal sacrum to free the anterior shoulder.
- ✓ Wrap small towel around the baby hip to preserve the warmth and improve the grip on the slippery skin.
- ✓ When the anterior shoulder is born lift the buttocks towards the mother’s abdomen to enable the posterior shoulder to pass over the perineum

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Delivery of the head

- Delivery of flexed head (Burn’s Marshal Method) After the shoulder is born the baby is allowed to hang unsupported.
- With in one minute the nape of the neck (hair line) appears. The baby is now grasped by the ankle and maintains traction while supporting the head on the perineum with the right hand.
- Hold the baby on a stretch and slowly bring the feet up to an angle of 180 degrees.
- When the face appears get some one to clean the air ways then delivery the head very slowly taking 2 to3 minutes to allow the vault of the head to be expelled.
- The mother should breathe out the head

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Delivery of extended head (mauriceau smelle’s veit method)

- When the baby is allowed to hang the neck and hair line is not visible, it indicates that the head is extended.
- - Pick up the baby by the feet and lie him astride on the right forearm put the middle finger of the right hand in the babies mouth far back to the roof of the tongue.
- With the other hand on the head and flex it down wards to wards the floor applying traction. When the head is down bring it

Dangers of breech presentation

1. Delay of the after coming head
2. Cerebral damage due to hypoxia
3. Asphyxia (fetal or neonatal), prolapsed of cord or pressure on cord.
4. Prematurity
5. Intracranial hemorrhage due to trauma

Dangers of breech presentation ,,,,

6. Injuries to liver spleen adrenal glands or kidney
7. Erb’s palsy due to damage of the brachial plexus
8. Facial nerve paralysis due to the twisting of the neck.
9. Fracture to femur, tibia, humorous or clavicle
10. Damage to spinal cord due to wrong handling
11. Pneumonia due to premature inspiration

Brow Presentation

- Definition:- When the sinciput or the area between the face and vertex is in the lower pole of the uterus. Attitude – Between flexion and extension (mid way) engaging diameter mentovertical 13:5cm.
- It occurs 1 in 1000 deliveries

Causes

1. Lax uterus, multiple pregnancy, hydraminous
2. Deflexed fetal head - Hypotonus of the neck muscle - Thyroid tumor
3. Anencephaly
4. Abnormal shape of pelvis

Diagnosis

- On palpation – the head is big and high & does not enter the pelvis

On vaginal examination

- It is difficult to touch the presenting part
- A smooth hair less area is felt, with part of the bergman at one side
- The orbital ridges may be felt.

Management

- If brow presentation is diagnosed early in labour, it may be converted to a face presentation by fully extension or it may be flexed to a vertex presentation, however, brow presentation will lead to obsetructed labour.
- Cesearian section is the management for alive baby
- Craniotomy if baby is dead.

Shoulder Presentation

- Definition- When the shoulder of the fetus lies in the lower pole of the uterus in labour.
- A transverse lie becomes a shoulder presentation in labour.
- Incidence-Occurse once in 250-300 deliveries

Causes

- Laxity of uterus
- Placenta previea, hydraminous,
- Multiple pregnancy
- Uterine abnormality
- Preterm pregnancy

Diagnosis

- The uterus appear broad and the funds height is less than expected for the period of gestation
- Easily seen on abdominal examination. When labour progresses, the hand can be felt or the ribs on V.E.
- Arm may prolapsed when membrane rupture ultrasound

Management

- When diagnosed at antenatal clinic after 36 weeks external version will be attempted
- In labour caesarian section is method of choice when attempt of external version have failed.
- When membrane have ruptured before; if there is cord prolepses if arm prolepses even with dead fetus ceaserian section is mandatory.

Complications

Maternal

- Obstructed labour
- Uterine rupture
- Death
- Puerperal sepsis
- PPH

Complication...

Fetal

- Fetal death (cord prolapsed)
- Prematurity
- Malformation
- Arm prolapse

Face Presentation

Definition: When the attitude of the head is extension and the face lies in the lower pole of the uterus

Cause

Lax uterus, multiple pregnancy

- Hydraminous
- Deflexed fetal head
- Ancephaly
- - Abnormal shape of pelvis

Diagnosis

- Abdominal examination Inspection
- irregular abdomen and the shape of the fetal spine is that of an” S.”

Palpation

- prominent occiput is felt on one the same side as the sinceput which is lower than the occiput.
- A deep groove is felt between fetal back and head Auscultation- the fetal heart is heard clearly at midline

Vaginal examination

- The presenting part is high
- A soft irregular mass is felt, the gums are felt and the fetus may examining finger - diagnostic
- Noting the position of mentum is important i.e Anterior, transverse or posterior

Mechanism of face delivery

- Instead of an increase in flexion there is an increase in extension
- The chin rotate instead of occput
- The engaging diameter is sub mentobregmatic 9.5 cm face presentation can be born normally except when the chin is posterior and gets caught in the hollow of the sacrum, when it develops into obstructed labour.

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- Encourage and perhaps sedate because she will have extra discomfort. - When membranes ruptures do vaginal examination to 189
- make sure no cord prolapsed and to note the position - Rotation occurs below the level of spines

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- If the chin is anterior let labour continue, if transverse, watch that it rotates anteriorly. When the face distends the perineum, perform an episiotomy, then hold back the sinciput and allow the chin to be born, when the chin is born flex the head and allow the occupt to be born.
- Always be careful not to damage the baby’s eyes with fingers or antiseptic

Complications

- ✓ Obstructed labour
- ✓ Cord prolapse
- ✓ Facial bruising
- ✓ Cerebral haemorrhage & Maternal trauma