MALPRESENTATION – Instructions for faculty
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Presentation – The portion of the fetus that is foremost or "presenting" in the birth canal

Diagnosis: abdominal palpation, vaginal examination and ultrasound

Positions: Vertex , Face, Brow, Breech or Shoulder

Spend majority of time on breech. Face and brow - ensure candidates can make the diagnosis and know management. OP needs a little more time to do hands on teaching of manual rotation.

FACE - occurs in 0.1 to 0.2 percent of singleton deliveries
Discuss

- Head is hyperextended – Identified primarily by vaginal exam, position of mentum
- Causes: Fetal: anencephalic fetus, enlargement of the neck or numerous coils of cord around the neck
  Maternal: pendulous abdomen of a grand multipara
- Need for a large episiotomy
- Warning parents about facial appearance – show the slide of the face if available.

Demonstrate

- Findings on vaginal exam: the mouth and malar prominences on a face forms a triangle and the baby may suck your finger. The anus and ischial tuberosities of a breech form a straight line.
- Why mentum posterior cannot deliver vaginally.
- Allow candidates to practice vaginal exam on mentum anterior and mentum posterior
- Forceps being applied to a mentum anterior.

Brow - occurs in 0.02 percent of singleton deliveries
The portion of the fetal head between the orbital ridge and the anterior fontanelle presents at the pelvic inlet.
Discuss

- Vaginal delivery can not occur unless fetus is very small or pelvis is very large
- Causes similar to face

Demonstrate

- Findings on vaginal exam: frontal sutures, anterior fontanelle, orbital ridges, eyes and root of nose may be felt. Often confusing because of edema

OP – occurs in 5 to 10 percent of deliveries
Discuss

- Diagnosis can be difficult and based on observation of the patient and examination: abdominal palpation, back pain or "back labor" is a clinical hallmark of OP, asymmetric dilatation with persistent anterior lip, palpation of anterior fontanelle on vaginal exam.
- Can deliver spontaneously as OP, manual rotation, vacuum, forceps as OP, rotational forceps
- Manual rotation: need cooperative mother who understands that the whole hand needs to be inserted into vagina
- Position of mother: in lithotomy, left lateral Sims or on hands and knees.
- For midwives- Supervision issue- discuss with your supervisor before undertaking this maneuver

Demonstrate

- Position of rotating hand
- Rotate the shortest distance
- ROP use left hand and rotate clockwise:
- LOP use right hand and rotate counter clockwise
- Encourage flexion with contractions/pushing and the head will rotate itself

ALSO **Breech – occurs in 3 to 4 percent of deliveries**

FACTORS **PREDISPOSING**

Frank : hips flexed and knees extended
Complete: tailor sitting, hips and legs flexed
Footling: One or both hips and knees extended with one or both feet presenting

Prematurity	↑ parity
Polyhydramnios	Oligohydramnios
Fetal anomalies	Uterine anomalies
Previous breech	Pelvic tumors
Macrosomia	Anencephaly

Mechanism of delivering breech is the same whether delivery is abdominal or vaginal; some women choose to delivery vaginally and some come in fully dilated! Hence need to learn procedure.

Demonstrate

- Types of breeches
- Mechanism of labor and rotation of back anteriorly
- Correct hold of the baby
- Delivery of legs- finger behind knee to flex knee and abduct the hip
- Modified Lovsett's maneuver to deliver arms after tip of scapula visible
- Modified Mauriceau-Smellie-Veit to deliver head, avoid fingers in mouth
- Resolution of nuchal arm - right arm is nuchally displaced rotate baby counter clockwise. If left arm turn baby clockwise. These maneuvers bring the nuchal arm to the front of the fetus (this is easy to demonstrate this on yourself).

Discuss

- Diagnosis: abdominal palpation, vaginal examination, ischial tuberosities and anus form a straight line
- Management: offer ECV if prior to 37 weeks.
- Episiotomy is often recommended to allow operator to perform various manipulations more easily.
- **Do not pull on the fetus until the umbilicus is delivered**
- Fetal back to remain anterior**: Stress importance of keeping fetal back anterior-** head will not deliver
- When the umbilicus delivers, a loop of several inches of cord should be gently pulled down

Remember if head will not deliver – try McRoberts/ suprapubic pressure/ forceps to aftercoming head /check for cervix if preterm (Duhrssen's incisions)

Conduct of a twin delivery-second twin

Demonstrate:

- Confirmation of lie of twin 2
- ECV if non vertex

Discuss

- Length of interval between 1st and 2nd twin
- Fetal monitoring (relates to acceptable interval)
- ECV if twin B is non vertex
- Once twin B has turned the membranes can be ruptured and oxytocin augmentation given
- Cesarean section for delivery of a second twin has not identified improvement in neonatal outcome
- Breech extraction
- Complications of multiple gestation include: prematurity, congenital anomalies, PIH, placenta previa and fetal death (0.5%-6.8%)

DOCUMENTATION - ***If it's not written it didn't happen*** ***DOCUMENT, DOCUMENT, DOCUMENT***

DEBRIEF: patient, partner and L&D staff