OLIVE VIEW-UCLA MEDICAL CENTER
LABOR & DELIVERY
POLICY & PROCEDURE

NUMBER: 3654
VERSION: 2

SUBJECT/TITLE: **ABNORMAL FETAL PRESENTATION-LIE**

MD ORDER: **YES [ ] NO [ ]**

POLICY: **POLICY STATEMENTS REGARDING ABNORMAL FETAL PRESENTATION-LIE**

A. Antepartum and intrapartum care should take place at a facility capable of providing risk-appropriate care for the mother and newborn.

B. Persistent transverse and oblique lies in active labor should undergo Cesarean delivery.

C. Face presentation (mentum posterior) should undergo Cesarean delivery.

D. The decision to attempt elective vaginal delivery of a fetus in a breech presentation should be done by a physician who is competent to perform a vaginal breech delivery in consultation with the patient after the risks, benefits and alternatives have been reviewed. Occasionally a fetus in breech position turns to a cephalic presentation spontaneously. Alternatives include: (1) external cephalic version at 37 weeks, and (2) elective cesarean delivery.

PURPOSE: To define abnormal fetal presentation and to define the nursing and medical management during a trial of vaginal delivery.

DEPARTMENTS: **Nursing, Obstetrics, Nursing**

DEFINITIONS: **OVERVIEW - ABNORMAL FETAL PRESENTATION-LIE**

A. Any fetal presenting part other than vertex, such as breech, transverse or oblique lie.

B. Epidemiology

1. Incidence of malpresentation is approximately 5%
2. Incidence of breech is 3% - 4% at term
   a. More common in preterm fetuses (approximately 7% at 32 weeks,

greater than 20% at 28 weeks)
3. Incidence of transverse lie is 0.3% at term
4. Incidence increases in multiple gestation
5. Incidence increases with history of previous breech delivery
6. More common with certain genetic syndromes

PROCEDURE:

I. PATHOPHYSIOLOGY

Abnormal fetal presentation may be associated with the following predisposing factors.

A. Preterm labor with or without rupture of the membranes (ROM)
B. Placenta previa
C. Uterine pathology (uterine malformation, leiomyomata)
D. Fetal congenital anomalies (hydrocephaly, anencephaly)
E. Multiple gestation
F. Hydramnios, oligohydramnios

II. DIAGNOSIS

A. Clinical/Imaging

1. Leopold's maneuver
2. Pelvic examination
3. Ultrasound

III. MEDICAL MANAGEMENT

A. Antepartum: For optimum outcome, the diagnosis should be made prior to the onset of labor.
   1. Expectant management: In most cases, the fetal presentation will spontaneously convert to cephalic.
   2. External cephalic version (ECV) at 36 to 41 weeks with the optimal time being at approximately 37 weeks gestation. ECV may be performed at a facility with capabilities of:
      a. Continuous electronic fetal monitoring
      b. 24-hour ultrasound availability
      c. 24-hour obstetrical anesthesia coverage
      d. Immediate Cesarean delivery
   3. Elective Cesarean delivery: Fetal maturity should be documented or 39 weeks by accurate dates.
   4. Vaginal delivery in selected cases of breech presentation is acceptable

in patients with prior NSVD of > 2500 gms.

a. Informed consent must be obtained
b. Frank or complete breech presentation
c. Head flexed, absence of nuchal arm
d. Estimated fetal weight between 2000 and 3800 grams
e. During a trial of vaginal breech delivery, a neonatal resuscitation team must be present.
f. Adequate gynecoid pelvis
g. Normal labor progression

B. Intrapartum Management

1. Capabilities for immediate Cesarean delivery with appropriate staffing
2. Piper forceps available in the operative field

IV. NURSING MANAGEMENT DURING A TRIAL OF LABOR AND VAGINAL DELIVERY IN BREECH PRESENTATION

A. Careful assessment of fetal presentation and accurate documentation and reporting must be done upon admission of patient.
B. Patient should be considered high-risk and should be placed on continuous electronic fetal monitoring.
C. Anticipation and planning for the following:
   1. Intrapartum
      a. Signs and symptoms of labor
      b. Fetal distress
      c. Prolapsed cord
      d. Emergency Cesarean delivery
      e. Uterine rupture
      f. Appropriate equipment and supplies available (Piper forceps, wet towel)
      g. Appropriate staff

   2. Delivery
      a. Dystocia
      b. Nuchal arm
      c. Hyperextended head (breech)
      d. Head entrapment
      e. Hemorrhage
      f. Ruptured uterus
      g. Need for emergency Cesarean delivery
      h. Need for general anesthesia in an emergency

References: Grover, J.G. and Mendelson, S.G. (2015). PAC/LAC Prenatal and Intrapartum Guidelines of Care.	
Approved by: Jan Love (Clinical Nurse Director II), Paul Buzad Jr (Director, Labor and Delivery)	Date: 10/16/2019
Review Date: **10/16**/2022	Revision Date:
Distribution: Nursing	
Original Date: 10/16/2019	