Obstetric Terms

Presentation:

The part of the fetus related to the pelvic brim and first felt during vaginal examination.

The presentation may be:

(a) Cephalic (96%):

i) Vertex: when the head is flexed.

ii) Face: when the head is extended.

iii) Brow: when it is midway between flexion and extension.

(b) Breech (3.5%).

(c) Shoulder (0.5%).

Cephalic presentation is the commonest as this makes the foetus more adapted to the pyriform-shaped uterus with the larger buttock in the wider fundus and the smaller head in the narrower lower part of the uterus.

Position:

The relation of the foetal back to the right or left side of the mother and whether it is directed anteriorly or posteriorly.

The denominator: is a bony landmark on the presenting part used to denote the position.

In ***vertex*** it is the ***occiput***.

In ***face*** it is the ***mentum (chin)***.

In ***breech*** it is the ***sacrum***.

In ***shoulder*** it is the ***scapula***.

Occipito-anterior positions are more common than occipito - posterior positions **because in occipito - anterior positions the concavity of the anterior aspect of the foetus due to its flexion fits with the convexity of the vertebral column of the mother due to its lumbar lordosis.**

* In each presentation, except the shoulder , there are 8 positions. In vertex presentation they are:

- Left occipito -anterior (LOA) 60%.

- Right occipito-anterior (ROA) 20%.

- Right occipito - posterior (ROP) 15%.

- Left occipito-posterior (LOP)5%.

- Left occipito-transverse (LOT).

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- Right occipito - transverse (ROT).

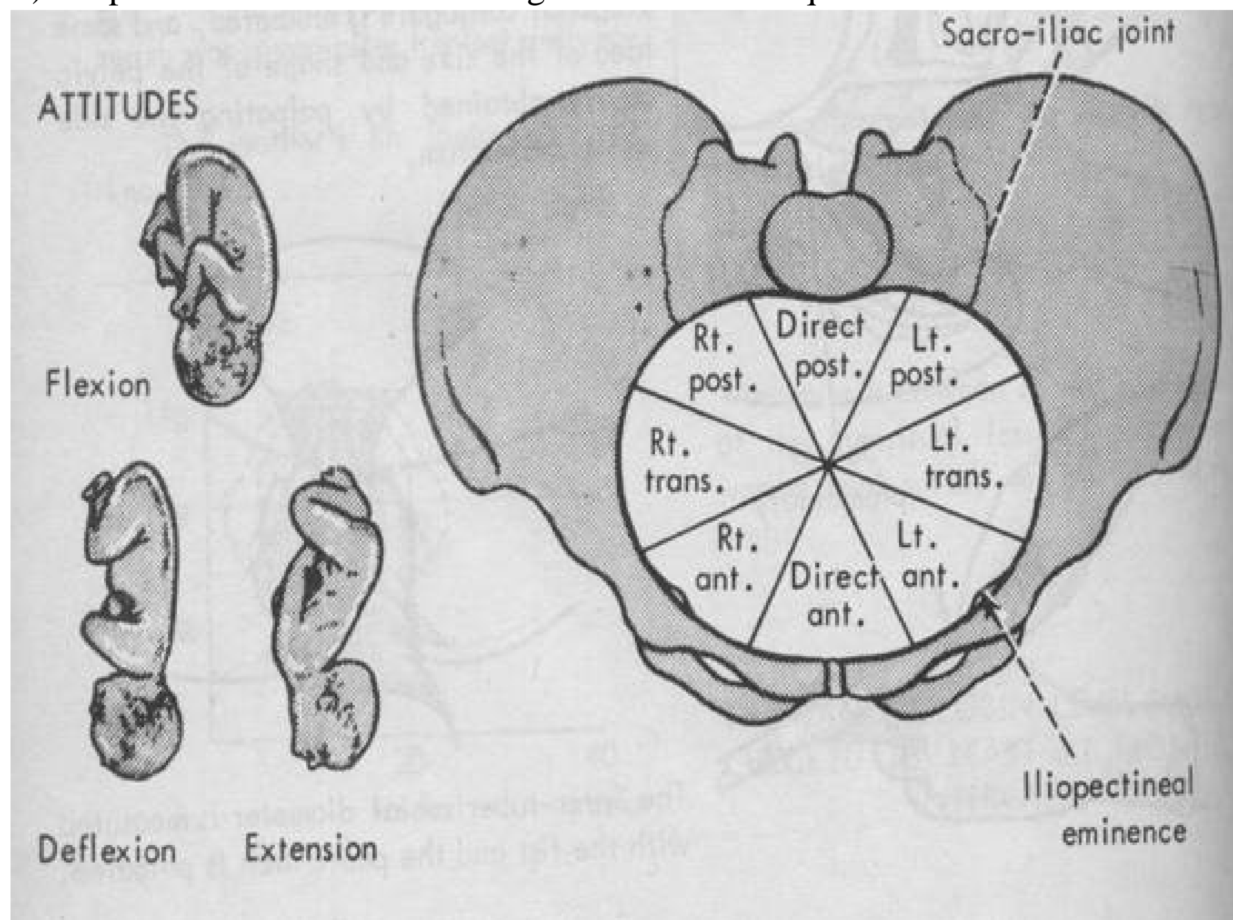
- Direct occipito -anterior (DOA).

- Direct occipito - posterior (DOP).

LOA is more common than ROA, and ROP is more common than LOP as in LOA and ROP the head enters the pelvis in the right oblique diameter which is more favourable than the left oblique because:

i) anatomically, the right oblique is slightly longer than the left,

ii) the pelvic colon reduces the length of the left oblique.



Lie:

It is the relation between the long axis of the foetus and that of the mother.

- Longitudinal in cephalic and breech presentations.

- Transverse or oblique in shoulder presentation.

Attitude:

The relation of foetal parts to each other.

- Flexion in the majority of cases.

- Extension in face presentation.

Synclitism:

The posture in which the 2 parietal bones are at the same level.

Asynclitism:

- The posture in which one parietal bone is at a lower level than the other due to lateral inclination of the head.

- Asynclitism is beneficial in bringing the shorter subparietal supraparietal diameter (9 cm) to enter the pelvis instead of the longer biparietal (9.5 cm).

- Slight degree of asynclitism may occur in normal labour.

(1) Anterior parietal bone presentation:

- The anterior parietal bone is lower and the sagittal suture is near to the promontory.

- It occurs more in multigravida due to laxity of the abdominal wall.

- It occurs also in contracted flat pelvis.

(2) Posterior parietal bone presentation:

- The posterior parietal bone is lower and the sagittal suture is near to the symphysis.

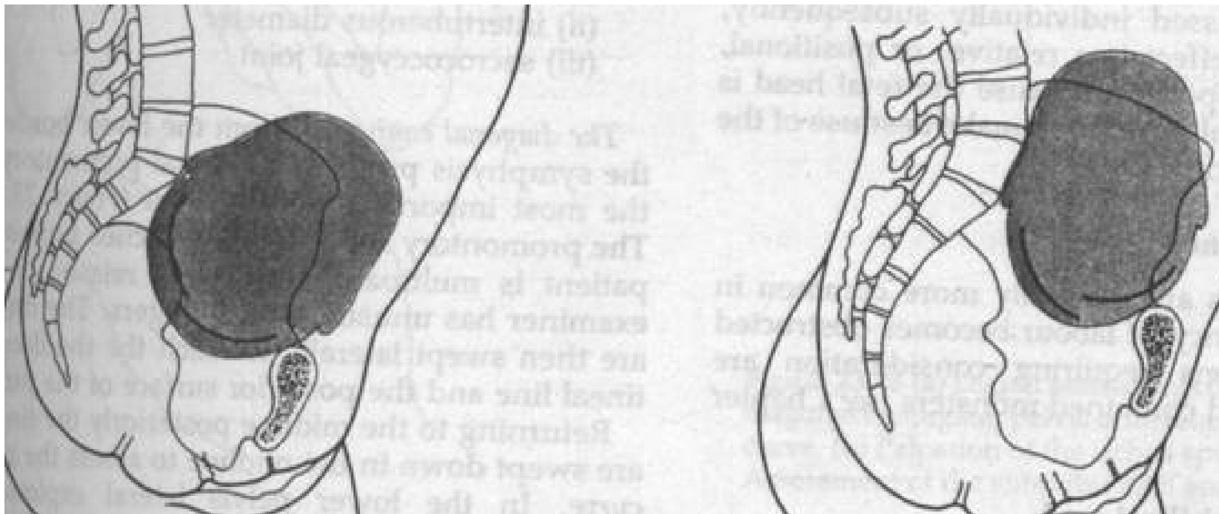
- It occurs more in the primigravida due to tense abdominal wall.

Anterior parietal bone presentation is more favarouble because;

The head lies more in the direction of the axis of the pelvic inlet.

During correction of asynclitism, the head meets only the resistance of the sacral promontory while in posterior parietal bone presentation the head meets the resistance of the whole length of the symphysis pubis.

In posterior parietal bone presentation the head stretches the anterior wall of the lower uterine segment with liability to rupture.



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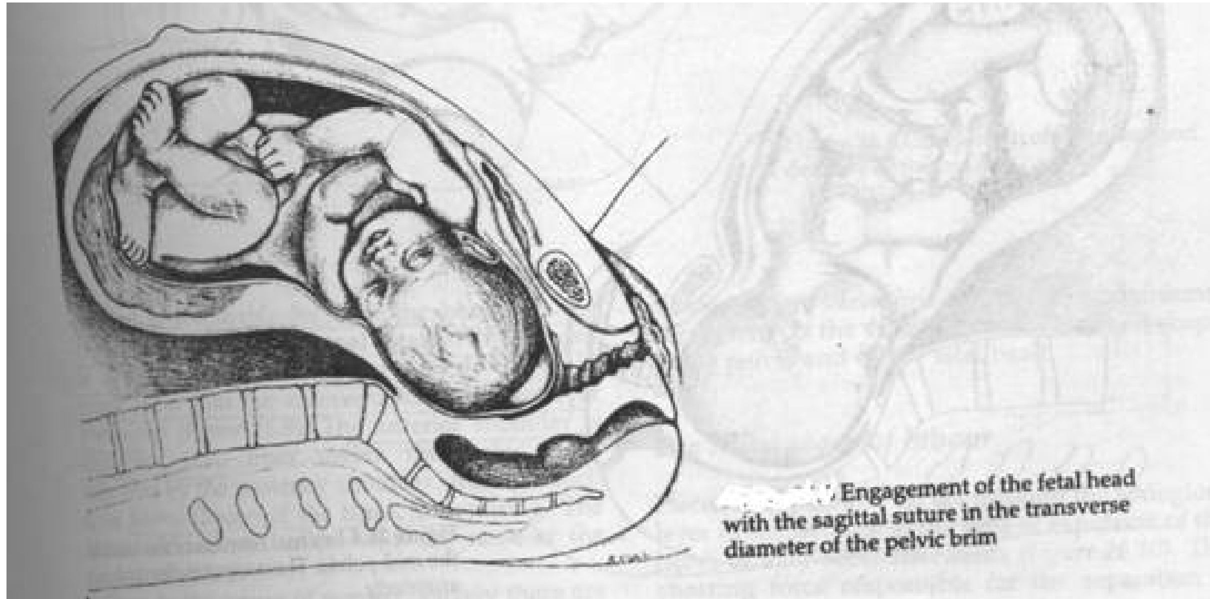
1-anterior 2-posterior



Engagement of the fetal head with the sagittal suture in the transverse diameter of the pelvic brim

Engagement:

- It is the passage of the widest transverse diameter of the presenting part, which is the biparietal in vertex presentation, through

the pelvic inlet.

- The engaged head cannot be easily grasped by the first pelvic grip, but it can be palpated by the second pelvic grip.

- Rule of fifths: 2/5 or less of the foetal head is felt abdominally above the symphysis pubis.

- Vaginally : the vertex is felt vaginally at or below the level of ischial spines.

- Stations:

Station 0 the vertex at the level of ischial spines.

Stations -1,-2 and -3 represents 1,2 and 3 cm respectively above the level of ischial spines.

Stations +1, +2 and +3 represents 1,2 and 3 cm respectively below the level of ischial spines.

- In the primigravidas, engagement of the head occurs in the last 3-4 weeks of pregnancy due to the tonicity of the abdominal and uterine muscles.

- In the multipara, the head is usually engaged at the onset of labour or even at the beginning of the second stage due to less tonicity.

Causes of non-engagement:

(I) Faults in the passenger:

1- Large head.

2- Hydrocephalus.

3- Occipito-posterior positions.

4- Malpresentations.

5- Multiple pregnancy.

6- Placenta praevia.

7- Short cord.

8- Polyhydramnios.

(II) Faults in the passages:

1- Contracted pelvis.

2- Pelvic tumours.

3- Full bladder or rectum.

(III) Faults in the power:

Inefficient uterine contraction

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Prof.Dr. Samir fouad Khalaf

Cairo 0123158046
ÇáÞÇåÑÉ 0123158046
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mohamedsamir@arabicobgyn.net

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