FACE PRESENTATION

INTRODUCTION

- FETAL LIE
- PRESENTATION
- POSITION
- ATTITUDE

PRESENTATION

Part of the fetus that lies over the pelvic inlet and occupies the lower pole of the uterus.

PRESENTING PART

Most dependent part of the fetus,which felt on vaginal examination.

3 presentations are:

- Cephalic presentation
  - Vertex presentation
  - Brow presentation
  - *Face presentation*
- Podalic/breech presentation
- Shoulder presentation

- In cephalic presentation,the presenting part may be vertex,brow or face,depending upon the degree of flexion.
- In breech presentation
- Flexed breech
- Extended breech

Face presentation

Brow presentation

Vertex presentation

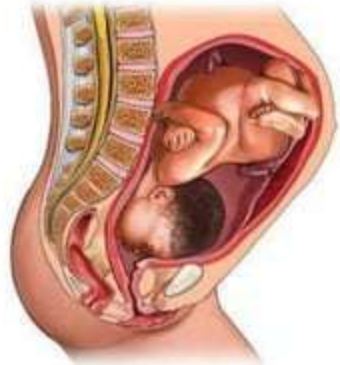
Breech presentation

Shoulder presentation

- Common presentation: Vertex it is considered normal.
- Malpresentations: other than vertex

FACE PRESENTATION

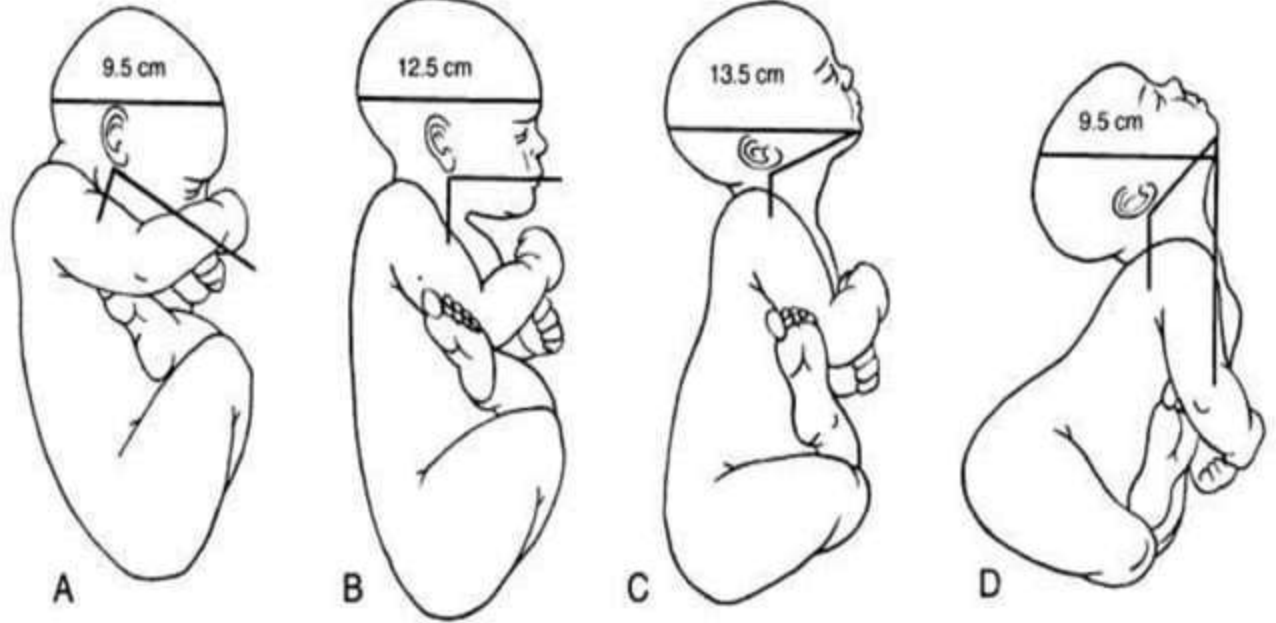
- DEFENITION
- POSITIONS
- INCIDENCE&AETIOLOGY
- DIAGNOSIS



Face Presentation

DEFENITION

- Cephalic presentation
- Attitude:complete extension
- Presenting part:face
- Denominator:mentum/chin
- Engaging diameter:submentobregmatic{9.4}


9.5 cm
12.5 cm
13.5 cm
9.5 cm
A
B
C
D

Presentation 2 types

Primary

present before onset of labour

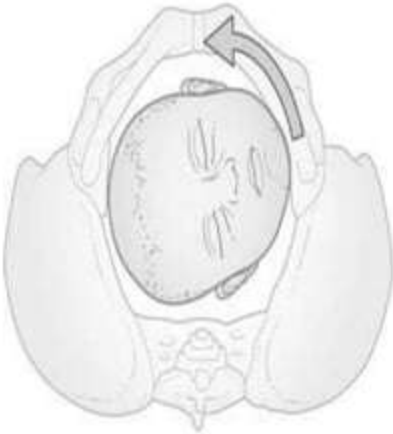
rare

Secondary

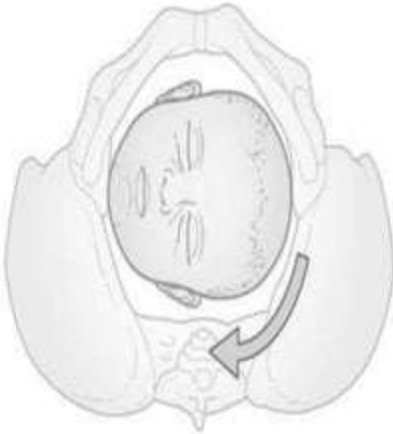
caused by extension during labour

POSITIONS

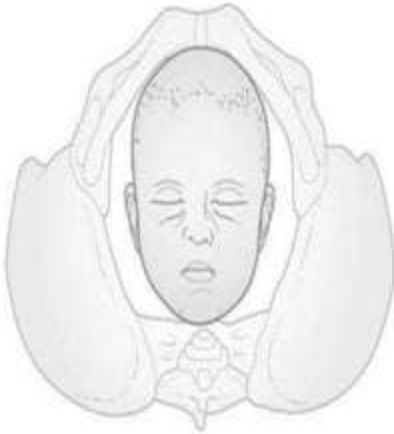
- Left mentoanterior[LMA]
- Right mentoanterior[RMA]
- Right mentoposterior[RMP]
- Left mentoposterior[LMP]
- Mentoanterior-70%
- Mentoposterior-30%



Left mentoanterior



Right mentotransverse



Mentoposterior

INCIDENCE

- 1 in 500
- Anything that interferes with flexion can cause face presentation

AETIOLOGY

- Maternal factors
- Fetal factors

Maternal factors

- Contracted pelvis
- Obliquity of uterus
- Multiparity & pendulous abdomen

fetal factors

- Anencephaly & iniencephaly
- Cord around the neck
- Tomours of neck like congenital goiter
- Spasms of stenocleidomastoid muscle
- Dolicocephalic head

DIAGNOSIS

- Very rarely made before labour
- It has little significance
- Made by both abdominal & vaginal examination

Abdominal examination

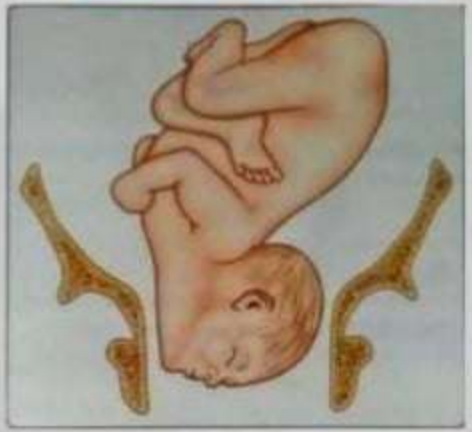
- In mentoanterior

  limbs-anterior-felt easily

  back-posterior-difficult to felt
- Head remains high

PALPATION

MENTO ANTERIOR



MENTOPOSTERIOR

- Cephalic prominence:occiput
  felt on the same side of back
- Groove b/w head & back –prominent
- FHS are transmitted through chest & heard well anteriorly in mentoanterior

Vaginal examination

- Conical bag of membranes
- Chin,mouth,nose,malar eminences,and supraorbital ridges are felt
- In mentoanterior-chin is in one anterior quadrant & forehead in the opposite posterior quadrant

- Vaginal examination should be done gently & without cream to avoid injury to the eyes

MECHANISM OF LABOUR :

MENTOANTERIOR POSITION :

1.ENGAGEMENT

2.DECENT WITH INCREASED EXTENSION

3.INTERAL ROTATION

4.FLEXION

5.RESTITUITION AND EXTERNAL ROTATION

Engagement

The engaging diameter is submentobregmatic.

In face presentaion the biparital diameter is 7cm behind the face unlike in vertex presentation which is about 3-4 cm.

The biparital diameter will pass through the inlet only when the face is low down in the perinium .

The head will get engaged when the face is distending the vulva

DESCENT WITH INCREASING EXTENSION

-DESCENT IS BROUGHT Y THE SAME FACTORS AS IN VEREX PRESENTATION

-WHEN A RESISTANCE IS ENCOUNTERED BY THE PROCESS OF EXTENSION

- THE OCCIPUT IS PUSHED BACK WHILE THE CHIN DSCENTS

INTERNAL ROTATION

-WITH FURTHER DESCENT THE CHIN WILL REACH THE PELVIC FLOOR AND ROTATES 45 DEGREE ANTERIORLY

-THE ANTERIOR ROTATION DOES NOT TAKE PLACE UNTIL THE FACE IS WELL APPLIED TO THE PELVIC FLOOR AND MAY BE DELAYED

FLEXION

THE HEAD IS BORN BY FLEXION .

THE CHIN PIVOTS UNDER THE PUBIC SYMPHYSIS PUBIS AND THE MOUTH ,NOSE , ORBIT , FOREHEAD , VERTEX AND OCCIPUT ARE BORN BY FLEXION

RESTITUTION AND EXTERNAL ROTATION

RESTITUITION AND EXTERNAL ROTATION OF THE CHIN OCCOURS TOWARDS THE SAME SIDE TO WHICH IT WAS ORIGINALLY DIRECTED AND SHOULDERS ARE BORN BY FLEXION

MECHANISM OF LABOUR IN MENTOPOSTERIOR

IN PERSISTANT MENTOPOSTERIOR THE NECK IS TOO SHORT TO SPAN 12CM OF ANTERIOR ASPECT OF SACRUM.

THE SHOULDER ALSO GET IMPACTED ALONG WITH THEHEAD MAKING DELIVERY IMPOSSIBLE .THE ENGAGING DIAMETER IS STERNOBREGMATIC.

HENCE THERE IS NO MECHANISM OF LABOUR FOR MENTOPOSTERIOR

CAUSES OF PROLONG LABOUR IN FACE :

1. FACE IS LESS EFFECTIVE DIALATOR OF CERVIX
2. NO MOULDING OF FACE
3. MORE CHANCES OF PREMATURE RUPTURE OF MEMBRANE
4. LONG INT.ROTATION IN MENTOPOSTERIOR
5. INT. ROTATION OCCOURS ONLY LATE IN THE SECOND STAGE

COMPLICATIONS

MATERNAL

FETAL

MATERNAL

1.PROLONGED LABOUR

2.INC. RISK OF OPERATIVE DELIVERY

3.OBSTRUCTED LABOUR IN PERSISTENT MENTOPOSTERIOR

FETAL

1.SWOLLEN AND OEDEMATOUS FACE

2.LARYNGEAL OEDEMA CAN ALSO OCCUR AND SO THE BABY SHOULD BE WATCHED CAREFULLY FOR THE FIRST 24 hrs TO DETECT ANY BREATHING DIFFULTIES

3.CONGENITAL ANOMALY LIKE ANENCEPHALY

4.BIRTH ASPHYXIA DUE TO CORD PROLAPSE AND PROLONGED LABOUR

MANAGEMENT OF LABOUR

1.THERE IS NO MECHANISM OF LABOUR IN MENTOPOSTERIOR AND CAESAREAN SECTION HAS TO BE DONE BUT IN SOME FORWARD ROTATION TAKE PLACE

2.IN MENTOANTERIOR IF THERE IS NO DISPROPORTION LABOUR CAN BE ALLOWED TO PROGRESS

3. CEPHALOPELVIC DISPROPORTION ANDOTHER COMPLICATION SHOULD BE EVALUATED AND IN SUCH CASES CAESAREAN SECTION SHOULD BE DONE

4.ANANCEPHALY AD OTHER ANOMALIES SHOULD BE RULED OUT

5.IF SEEN LATE IN LABOUR CAESAREAN SECTION OR OBSTRUCTED LABOUR SUPERVENESIS DONE EVEN IF THE BABY IS DEAD

6.CRANIOTOMY IS AN OPTION IF THE BABY IS NOT ALIVE .

7.LABOUR MANAEMENT REQUIRES CLOSE OBSERVATION OF LABOUR PROGRESSION BECAUSE CEPHALOPELVIC DISPPROPORTION ,DYSFUNCTIONAL LABOUUR AND PROLONGED LABOUR ARE VERY COMMON

8.ATTEMPTS TO CORRECT THE FACE TO VERTEX POSITION ARE RARELY SUCCESSFUL AND ARE ASSOCIATED WITH HOGH FETAL MORTALITY AND MORBIDITY AND MATERNAL MORBIDITY INC. CORD PROLAPSE /UTERINE RUPTURE ,AND CERVICAL SPINE INJURY

THANK YOU