WOMEN AND NEWBORN HEALTH SERVICE
King Edward Memorial Hospital

COMPPLICATIONS OF PREGNANCY

ABNORMALITIES OF LIE/PRESENTATION

UNSTABLE LIE AT OR NEAR TERM

Keywords: abnormal lie, unstable lie, transverse lie, oblique lie, high presenting part, polyhydramnios

BACKGROUND INFORMATION

An unstable lie is when the fetal presentation repeatedly changes beyond 36 weeks gestation. It is more common in parous women. Maternal causes include high parity, placenta praevia, pelvic contracture, uterine malformations, pelvic tumours, and a distended maternal urinary bladder. Fetal causes of unstable lie include polyhydramnios, oligohydramnios, multiple pregnancy, fetal macrosomia, and fetal abnormalities (e.g. hydrocephaly, abdominal distension, fetal death). If the membranes rupture when there is an unstable lie, regardless of whether the woman is contracting there is significant risk for cord prolapse, especially if the lie is oblique or transverse, or if the presenting part is high above the pelvic inlet. If lie is not longitudinal when labour commences a compound presentation may result, or the pelvis may remain empty which can lead to fetal distress and other complications.

KEY POINTS

1. The Obstetric Team Consultant shall be advised of all women with an unstable lie at or near term.
2. A management plan shall be formulated and documented on the ‘MR004 Obstetric Special Instruction Sheet’.

ANTENATAL MANAGEMENT

1. If a woman is attending a low risk midwifery antenatal clinic and is found to have an unstable lie at term the midwife shall contact the team Consultant/Senior Registrar to discuss management. The next antenatal appointment needs to be with an obstetric medical antenatal team.
2. Investigate for causes of unstable lie. Ultrasound assessment may be required.
3. Conduct clinical assessment for the size of the fetus and the pelvis. Ultrasound assessment may be required in addition.
4. Formulate a plan for the mode of birth, and document on the MR004 Obstetric Special Instruction Sheet.
5. Advise the woman to contact the hospital if she commences labour, or has spontaneous rupture of membranes (SROM).
6. Inform the woman about risks of cord prolapse and management if this occurs at home or in the hospital.
7. Provide written advice for the woman (to be given to the St. Johns Ambulance crew) describing management in the event of spontaneous rupture of membranes.
**BIRTH MANAGEMENT OPTIONS**

After discussion with the woman who has an unstable lie, one of the 3 birth options should be decided:

- Elective Caesarean Section
- Expectant management – if no contraindications, await onset of labour
- Active management – perform external version of the fetus to longitudinal lie and then commence an induction of labour.

1. If a woman lives a long distance from the hospital, admission at 38-39 weeks gestation – allows daily observation of lie and presentation and availability of immediate assistance should SROM, cord prolapse, fetal distress, or labour occur.²,³

2. If spontaneous resolution to a longitudinal cephalic lie eventuates management options include:
   - a presentation which remains cephalic for 48 hours may be discharged home after review by the team Consultant and await spontaneous labour²
   - induce labour following team Consultant review.²

3. If the lie remains unstable, a stabilising induction may be an option¹, ³ after review by the team Consultant.

**BIRTH MANAGEMENT FOR A WOMEN IN LABOUR WITH AN UNSTABLE LIE ON ADMISSION**

- Perform a palpation.
- Auscultate the fetal heart rate
- Assess for SROM
- Inform the obstetric medical team including the Senior Registrar

**LABOUR MANAGEMENT**

- External cephalic version may be performed in early labour provided there are no contra-indications. A stabilising / controlled artificial rupture of the membranes (ARM) may then be performed.¹ **Note:** Prior to controlled ARM, the woman should have an empty rectum and bladder, as these can interfere with the descent of the presenting part.¹
- Assess the presentation, lie and descent of the fetus frequently¹ until the presenting part is well into the pelvis.
- If SROM occurs perform a vaginal examination (VE) to exclude cord prolapse or malpresentation.
- Conduct continuous fetal heart rate monitoring in labour.
- Obtain intravenous access and take blood for a full blood count, group and hold- the woman is at increased risk for caesarean section, and possible post-partum haemorrhage particularly if polyhydramnios is present.
REFERENCES / STANDARDS

National Standards – 1- Care Provided by the Clinical Workforce is Guided by Current Best Practice Legislation -
Related Policies - KEMH Clinical Guidelines, Obstetrics & Midwifery:
- Complications of Pregnancy: Abnormalities of Lie: Breech Presentation; Rare Presentations
- Intrapartum Care: Artificial Rupture of the Membranes (ARM)

Other related documents – MR004 Obstetric Special Instruction Sheet

RESPONSIBILITY

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