UNSTABLE LIE AT OR NEAR TERM

BACKGROUND INFORMATION

An unstable lie is when the fetal presentation repeatedly changes beyond 37 weeks gestation. It is more common in parous women. Maternal causes include high parity, placenta preavilia, pelvic contracture, pelvic tumours, uterine malformations, 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).\(^1\)

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.\(^1\)

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’.

ANTEPARTUM MANAGEMENT

- If a woman is attending a low risk midwifery antenatal clinic and is found to have an unstable lie at term the midwife needs to contact the team Consultant/Senior Registrar to discuss management. The next antenatal appointment needs to be with an obstetric medical antenatal team.
- Investigate for causes of unstable lie. Ultrasound assessment may be required.
- Formulate a plan for the mode of birth and document on the MR004 Obstetric Special Instruction Sheet.
- Advise the woman to contact the hospital if she commences labour or has spontaneous rupture of membranes (SROM).
- Inform the woman about risk of cord prolapse and management if this occurs at home or in the hospital.
- 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 women 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.

- 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.1
- 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 labour1
  - induce labour following team Consultant review.1
- If the lie remains unstable, a stabilising induction may be an option 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 contraindications. A stabilising artificial rupture of the membranes may then be performed.
- Assess the presentation of the fetus frequently until the presenting part is well into the pelvis.
- If SROM occurs perform a 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