Guideline for Difficult Delivery of Fetal Head at Caesarean Section

N.B.  Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.
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1 Executive Summary

This document is a clinical guideline designed to support safe and effective practice.

1.1 Scope of guideline

This guideline applies to all clinicians working within maternity services.

1.2 Essential Implementation Criteria

Auditable standards are stated where appropriate.

2 Aims

To provide support for clinical decision making.

3 Responsibilities

The Maternity Management team.

4 Training

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical supervision.

5 Monitoring and Effectiveness

Local service Improvement Plan will guide monitoring and effectiveness.

6 Appendices
Appendix 1 GUIDELINE FOR DIFFICULT DELIVERY OF FETAL HEAD

1. Caesarean section in second stage
   - V/E and try to disengage the fetal head prior to c/s
   - Patient is placed in a Lloyd Davies position (modified lithotomy)
   - Vaginal assistant pushes the head upwards prior to uterine incision in between uterine contractions
   - At c/s slowly pass the hand deep into the lower segment and slowly lift the head out.
   - Make sure that your hand is far enough down so that the head does not become laterally hyperflexed during extraction
   - If still undelivered
     - Right handed surgeon standing in the right should pass the left hand behind the baby’s head (The opposite in case of a left handed surgeon standing in the left)
   - If still undelivered

2. Obstructed labour

For deeply engaged head

Pull method
This involves delivering the breech first. In most cases this can be carried out through a transverse incision in the uterus. Incision may need to be increased to a ‘J’ / inverted ‘T’. The hand is passed through until a leg is reached. Then either the leg or the breech is delivered. The rest of the delivery will be as for a breech delivery for a c/s.

Modified Patwardhan’s method can also be used for deeply engaged head where disimpaction is unsuccessful. This involves delivering the anterior shoulder by hooking through the axilla followed by posterior shoulder. Then to deliver the baby by breech.

Landesman Abdominovaginal delivery - Woman is placed in the Whitmore position (a modified lithotomy). An assistant introduces their hand into the vagina to push the head up, the surgeon at the same time places an upward traction on the shoulders to help in dislodging the head.
3

High head

Can use Terbutaline – 250 μgm s/c or Nitroglycerine - 800μgm as 2 puffs s/l to relax the uterus

Fundal pressure/ fixing the fetal head by the assistant until the head has been grasped by the surgeon

If still not delivered

Kiwi cup or Wrigley’s forceps can be used

Can also be delivered by pull method as breech

4

Entrapped head in breech presentation, particularly in preterm or oligohydramnios.

Ask the anaesthetist to administer uterine relaxant (Terbutaline - 250μgm s/c or Nitroglycerine- 800μgm – 2 puffs )

Ensure that both abdominal and uterine incisions are adequate

Attempt to pass your hand alongside the baby’s head and apply wrigley’s forceps

Extension of incision to a ‘J’ or inverted ‘T’

Please note – Following difficult delivery of fetal head it is essential to check the bladder and if bladder injury is suspected – check with methylene blue and document in the case notes
(Dr R Khan/ Dr D A MacBean/ Mrs Parveen, 08/2009)

References:

1. MOET Course manual, 2006