Oblique and transverse lie

Oblique Lies

In oblique positions, the head presses eccentrically on the pelvic entrance and its part exceeds the lateral edge. The longitudinal axis of the fetus then presses obliquely on the longitudinal axis of the uterus.

Causes

The most common cause of oblique positions of the fetus is associated with **cephalopelvic disproportion**. They can also be caused by placenta praevia, myoma praevium, a relatively shortened umbilical cord, etc. The first period of labor can then be complicated by a greater outflow of amniotic fluid, which can even cause umbilical cord herniation.

Diagnostics

In the first **Pawlik palpation** we find a lateral **deviation pressing on a large part of the fetus**. The oblique lie is often referred to as the **transitional lie**, as it changes to a transverse or head-long position after the amniotic fluid has flowed.

Division

- **The oblique lie is favorable** - the head extends beyond the frontal linea terminalis and the back of the fetus leans into the pelvic entrance. If the position is converted to a longitudinal head position, the head enters the pelvic inlet in flexion.
- **Unfavorable oblique lie** - the head of the head extends beyond the lateral edge of the entrance and the fetal abdomen is tilted into the pelvic entrance. If the position is converted to a longitudinal head position, the head enters the pelvic inlet in deflection.

We will confirm the final prognosis of the next procedure during childbirth using an ultrasound examination.

Management of Labour

Caesarean section is most often indicated, but there are cases when we can give birth vaginally. We then follow the procedure below:

1. We will increase uterine activity with medication,
2. if the amniotic fluid has not drained away, a diruption of the sac of membranes is performed during contractions, if the head presses centrally,
3. if the oblique position is transformed into a position with the longitudinal head and the conditions for a per ves naturel birth are met, we will try for it,
4. if the oblique position turns into a transverse position, we terminate the birth by caesarean section.

We continuously monitor the fetus .

Transverse Lies

In transverse positions, we find the **fetal head resting on one iliac crest** and **the pelvic end of the fetus on the other iliac crest** . The axis of the entire fetus is located arcuately across and perpendicular to the longitudinal axis of the uterus. Both the oblique and transverse positions are classified as pathological positions..

Causes

The most common causes of transverse fetal position include **placenta praevia**, multiple pregnancy, polyhydramnios, uterine fibroids, relatively shortened umbilical cord, narrowed umbilical cord, etc.

Diagnostics

With **Pawlik's palpation** we find **an empty lower uterine segment**. The overall **shape of the uterus is ovoid**. The maximum echo can be found at the level of the umbilical line, in I. position on the left side, in II. standing on the right side. During the internal examination, the vaginal vault is empty or we can feel small parts of the fetus, during the outflow of amniotic fluid, and the pressing arm.

Clinical Course

In the last trimester of pregnancy, many fetuses get into the transverse position, but are then turned into the longitudinal position by contractions, only part of the fetus remains in the transverse position. Premature outflow of amniotic fluid worsens conditions for the fetus, uterine contractions force the fetus into a smaller space and **hypoxia may develop**.
Spontaneous vaginal birth can only be carried out in very **small stillborn fetuses**, the so-called double body birth occurs , when the head is pushed into the abdomen and passes through the birth canal parallel to the body.
Another option for spontaneous birth via the vaginal route is **spontaneous evolution** - i.e. the transverse position changes into a longitudinal position with the pelvic end just before birth.

Management of Labour

For **live singleton fetuses, a caesarean section** is planned and spontaneous onset of labor is not expected.

Fatal Turns in Transverse Lie

If the fetus is in a transverse position and the woman wants to give birth spontaneously vaginally, the doctor can try to turn the baby by external**or internal palps** and thus turn the baby into a longitudinal position with the head or pelvic end. However, there is a need to warn and the mother must sign an informed consent to the possible risks associated with external and internal palpation.

External Palpation

Turning from a transverse position to a longitudinal head is usually less successful, but there are situations where doctors have succeeded in turning. However, it may happen that even with a successful rollover, the fetus will take a transverse position again after a certain period of time.
There are possible risks of premature separation of the placenta with an unrecognized short umbilical cord.
Successful turning over can be achieved at the beginning of labor, when after turning over to the longitudinal position with the head, we perform diruption of the sac of membranes, so the head descends into the birth entrance. Then we place the woman on her side, where the head was leaning.
If the birth of twins results in the second twin turning into a transverse position after the birth of the first, then cesarean section is preferred, due to the greater risks of continuing the birth through the spontaneous vaginal route.

Internal Palpation

Nowadays, when the second fetus is miscarried after the birth of the first twin, the route of caesarean section is chosen. Another way is in the situation when the fetus dies. Assuming the integrity of the fetus, we can choose vaginal surgical procedures to turn the fetus into a longitudinal position. However, if **the mother is at risk of a complication**, such as the development of disseminated intravascular coagulation, we terminate the delivery of a stillborn fetus by **caesarean section**.

Links

Related Articles

- Pregnancy
- Birth

References

- HÁJEK, Zdeněk, Evžen ČECH and Karel, and collective. MARŠÁL. *Obstetrics.* 3.revised and supplemented edition of the edition. Prague. 2014. 576 s. ISBN 978-80-247-4529-9.