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CASE REPORT

VAGINAL DELIVERY OF A COMPOUND BREECH PRESENTATION – A CASE REPORT

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ABSTRACT

Compound presentations are rare obstetric events. Incidence of compound presentation is 1 in 500 to 1 in 1000 deliveries (1), and incidence of breech presentation is 3-4% of all deliveries (2). Hence, it makes compound breech presentation a rare obstetric event. Providers should have strategies to deal with such situations if any interventions are required.

INTRODUCTION

A second gravida with previous normal vaginal delivery was referred to our hospital with breech presentation in active labour. On arrival, viable breech presentation was confirmed on scan. Patient was getting good uterine contractions and clinically fetal weight was around 2.8 kgs, patient was fully dilated, with intact membranes (membranes were not ruptured as mode of delivery was not yet discussed with the patient and attenders). Patient and the attenders were willing for vaginal breech delivery.

When membranes ruptured spontaneously, to our surprise right hand of fetus came out of introitus, vaginal examination was repeated, it was a compound breech presentation with, extended breech at +1 station and right hand of the fetus coming out of introitus. Patient and attenders were explained about the risk of compound breech presentation and advised for caesarean section. Patient and attenders did not give consent for caesarean section. Hence, after explaining the risk, patient was allowed for vaginal delivery. With good uterine contractions hand of the fetus was coming out of the introitus, but breech was not descending.

Paediatrician was informed. Manoeuvres used to bring down breech were unsuccessful. Initially groin traction was tried, but not much of a descend was appreciated. Attempt to reach popliteal fossa of the fetus was made, it was possible to reach the knee joint but it seemed that relaxation would make the procedure more comfortable to the patient. Patient was then shifted to operation theatre, consent for caesarean section also taken in case vaginal attempt fails. Paediatrician and anaesthetist were informed of the change in plan.

Under general anaesthesia, patient was kept in low lithotomy position (so that it will be easy for vaginal procedure, and in case it fails we can proceed for caesarean section without any time delay in changing the position of the mother). Scrub nurse was ready with the casesarean instruments as well, a surgeon was scrubbed ready for caesarean section. Under general anaesthesia it was much easier to reach fetal popliteal fossa, but the fetal foot did not fall with it. Episiotomy was given. Now attempt was made to reach the foot, right foot of the fetus was grabbed and carefully brought out of pelvic inlent and finally out of introitus. Same procedure was repeated, and the other leg delievered. Gently, with fetus held in pelvic grip, fetal back was turned anterior, as the right upper limb was already out, left shoulder was delivered without much trouble. Finally, aftercoming head was delievered by Burns Marshalls technique, baby cried at birth. Cord was clamped and cut.

Baby handed over to the paediatrician. It was a female baby weighing 2.73 kgs. Episiotomy was sutured in layers. Baby did not have any fractures or external injuries. Once mother came out of anaesthesia, she was shifted to ward and baby was breast fed. Mother was kept in ward for 24 hrs after delivery. Both mother and baby were in good health at the time of discharge.

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DISCUSSION

Compound presentation involves the prolapse of an extremity along with the more traditional presenting part. It is difficult to establish the exact incidence as spontaneous correction occurs in many cases. Most common is hand or arm beside vertex; there can also be foot, or both hand and foot alongside vertex. Prolapsed hand beside breech is the fourth possibility.

Management of compound presentation is debatable. Most of the times the presenting part itself will push the extremity aside and fetus will retract the extremity as labour progresses. If the descent of the presenting part is slowed due to extremity, then the extremity can be gently pushed upwards. All such efforts will fail, if the extremity becomes the leading part, then with contractions usually it will not recede and ischemia of the part becomes unavoidable (3).

In case of compound presentations, the mechanism of labour is that of the presenting part. Mechanism of labour in this case, was that of extended breech that has got arrested just below the level of ischial spines. Once groin traction failed in above case, Pinard's maneuver was attempted. Even when this failed, author tried to hold the foot of the fetus and tried to convert extended breech to the footling breech. Another leg was delivered like the first one. Rest of the delivery was just like breech extraction.

Two most important points in this delivery were anaesthesia and then the positioning of the patient for delivery. General anaesthesia gave the relaxation required for the intra uterine manipulation. Positioning of the patient in low lithotomy was selected to aid in Zavanelli maneuver, in case the vaginal attempt fails. With this position there wouldn't be any time delay in positioning the patient, in case caesarean is required.

CONCLUSION

Majority of hospital deliveries are completed without compilcations, but some difficult situations like shoulder dystocia, breech presentation and uterine inversion, are associated with a high risk of complications and require the obstetric skills and manual aids to solve certain intrapartaum complications (4-6). Very few reports on these issues, suggest the need for continuous education and drills to acquire skills in managing such obstetric emergencies. Patients presenting like this, there is no scientific data to support decision making and the care givers must be ready to take unconventional steps to tackle such situations for the best maternal and fetal outcome.

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