OP, Brow and Face Presentations

Learning Objectives

Review the following Learning Objectives as an organized beginning to your study of this module. As you read the Learning Objectives, note keywords that will aid you in finding the information in the texts. When you complete the module, revisit this list and check for areas that require further investigation.

• Understand the relationship between the baby’s head and the pelvis when the baby is in the Occiput Posterior (OP), Brow and Face cephalic presentations.

• Understand the likely resolution of Brow and Face cephalic presentations in birth.

• Identify when and how OP position is problematic.

• Differentiate between truly problematic aspects of OP positions and the holistic approach to OP as a variation of normal birth.

• Understand when the expertise of a midwife can be of benefit during an OP labor and identify a variety of support techniques and holistic methods to apply when appropriate.

• Identify head molding in the infant and the corresponding cephalic presentations.

• Identify the long arc and short arc rotations of the fetal head in the pelvis.

• Identify and demonstrate the cardinal movements of birth in OP, Brow and Face cephalic presentations.

• Review First Stage Labor and Second Stage Labor modules.

Study Sources

The following texts are recommended for completion of this module. Use them to cross-reference and build a more comprehensive understanding.

Using keywords from the Learning Objectives, search the index. Read those pages listed, and read the chapter in which they are found. Establish a context for the information so that you understand how other topics are related. In addition, read the chapter headings in the Table of Contents, and flip through each text to familiarize yourself with the content of chapters. As you work through Study Group modules, you will eventually read each text in its entirety.

*Oral Tradition and Living Knowledge are critical to understanding the dilating phase of labor and its accompanying variations, and key to the integration of supporting the mother/gestational parent’s comfort and stability, and facilitating change in baby’s position, station and in maternal cervical dilation.*

-Human Labor and Birth, Oxorn and Foote

-Holistic Midwifery, Vol. I, II, Frye

-Varney’s Midwifery

-Myles Textbook for Midwives

-Birth Emergency Skills Training, Gruenberg

-Understanding and Teaching Optimal Foetal Positioning, Sutton and Scott

-Belly Mapping Workbook, Tully

-The Labor Progress Handbook, Simkin

Online Resources

See NMI website OP, Brow and Face Presentations module web resources section for current online study sources for this module.

Related Topics

First Stage

Charting

Rupture of Membranes

Fetal Heart Rate Patterns

Second Stage

Transporting

Newborn Exam

Note

*Please read before answering the questions:*

Clarification on vocabulary that describes the baby’s position in relationship to the mother/gestational parent’s pelvis: there are Presentations and there are Presenting Parts, and there are Positions. These words are not synonyms but instead describe specific characteristics of fetopelvic relationships indexed to fetal position. Mashed into common use with Presentation, Presenting Part, and Position are Lie, Denominator, Attitude, and Flexion.

**Cephalic Presentations** include **Occiput Anterior** positions and **Occiput Posterior** positions. Both OA and OP positions feature the Vertex as the Presenting Part, both have the Occiput as the Denominator and the Attitude is Flexion.

*Also Cephalic Presentations:* the **Military** Attitude is un-flexed with the median part of the Vertex as the Presenting Part and the Occiput as Denominator; the Attitude of Partial Extension features the **Brow** as Presenting Part with the Forehead (frontum) as the Denominator; the Attitude of Complete Extension features the **Face** as Presenting Part and the Chin (mentum) as the Denominator.

Short Answer Questions

1. Define OP Cephalic Presentation (graphic optional).

2. Define Brow Cephalic Presentation (graphic optional).

3. Define Face Cephalic Presentation (graphic optional).

4. What percentage of babies will emerge:

a. OP?

b. Brow?

c. Face?

5. Explain the difference between long arc rotation and short arc rotation of the baby’s head position during OP, Brow or Face labor.

6. What is the denominator in a Brow Position (also referred to as Brow Presentation)?

7. With a Brow Position, what landmark will you likely feel during an internal exam?

8. What is the most likely resolution of a Brow Position?

9. What can you do to support a Brow Position to resolve?

10. What is the denominator in a face position (also referred to as Face Presentation)?

11. How does the presenting diameter of a face position compare with occiput anterior (OA) and posterior (OP) cephalic presentations?

12. What is “back labor”?

Questions Requiring Longer, Thoughtful Answers

13. What effect might a baby in an OP cephalic presentation have on a labor?

14. Why might it be difficult to determine what position a baby is in when doing an internal exam?

15. Describe the head molding which occurs in an infant positioned

a. Posteriorly

b. Brow

c. Face

16. a. With a Cephalic Face Presentation, which direction must the denominator

be oriented?

b. Where does the back of the baby’s head need to be in a Cephalic Face Presentation?

c. With a Cephalic Face Presentation, what part of the pelvis accommodates the back of the baby’s head?

17. Describe the position of the baby’s sagittal suture when the head is Cephalic Presentation:

a. with occiput transverse anterior asynclitic.

b. with occiput transverse posterior asynclitic.

c. How is the baby’s head positioned in relationship to the maternal ischial

spines?

d. How is the position of the baby’s head documented in relationship to the

maternal ischial spines?

18. What midwifery skills may be needed when handling a Cephalic Face Presentation?

19. What midwifery skills may be needed when handling a Cephalic Brow Presentation?

20. What homeopathic remedy would be supportive in healing the bruised tissue on the face of a baby born in Brow or Face Presentation?

21. Describe how you measure progress during a labor that seems to be affected by the position of the baby.

22. Describe the midwifery expertise implemented during a difficult posterior labor.

a. List specific support measures and techniques that may support the baby making a position change.

b. List the midwifery care details that support the laboring mother/gestational parent’s wellbeing.

23. If the mother/gestational parent is on hands and knees, what will you see as the baby’s head emerges in an OP position?

Practical Scenarios

24. Your client is having their third baby. They did not have “back labor” during their previous births. This time, the baby’s head is asynclitic and posterior. The client feels best while walking and elevating their right leg during contractions.

a. What is your impression of what these movements are providing for your client’s laboring progress?

b. What is your midwifery plan?

22. Labor has taken a while to become established. Anna has now been in active labor for three hours. You perform this exam with Anna upright but semi-reclining because she has pain in her back if she reclines further. Upon vaginal exam, you identify that Anna is dilating more in the back half of her cervix, with a thick rubbery anterior portion of cervix. Her baby’s head is positioned so that you feel a long ridge of bone extending from the front edge of her cervix to the furthest reach you can follow. Her abdomen has a palm-sized indentation just above her umbilicus.

a. What is the position of Anna’s baby?

b. Anna’s baby’s head is in what position, including attitude?

c. Explain why her cervix is dilating asymmetrically.

23. Tammy and Rae have been married for eight years. They are welcoming their family’s fourth child. Tammy is the birth mother of two of their children, ages 5 and 9. Their 15-year-old child was born to Rae during a previous marriage. For Tammy’s second birth the baby was born posterior. This pregnancy has been carried by Tammy and has been uncomplicated. During third trimester the baby’s position has been palpated as either LOP or LOT (Left Occiput Posterior or Left Occiput Transverse). At 38+2 (38 weeks and 2 days gestation) the baby’s head has remained high and ballotable.

Tammy’s labor was start-and-stop for the initial 24 hours. With a rotating labor support team there was committed attention given to Tammy’s rest, hydration, and nutrition. Rather than being regarded as prodromal labor, Tammy’s labor activity was instead attributed to the baby’s position: abdominal palpation revealed the top of the baby’s head was just even with the pelvic brim (not engaged in the pelvis), with the occiput identified as the cephalic prominence (because the prominence was on the same side of the mother’s uterus as the baby’s back). Labor support also focused on moderate activity to move the baby into a more favorable position. The baby’s head was too high to anticipate feeling landmarks of the baby’s skull, and contractions had not organized themselves into a serious pattern that would indicate dilation of the cervix. Therefore vaginal exams had been postponed. Midwives believed the baby was initially in a Median Vertex, or “Military” Attitude, or could shift to presenting with a brow (aka frontum) position. For either position, the anticipation was for baby to reposition to either OP or maybe fully extend to Face position.

Tammy’s labor established an active pattern, and for the past 4 hours contractions have been strong, every 5 minutes lasting about a minute. Tammy reports feeling rectal pressure at the height of the contractions. Midwives and parents discuss the risks and benefits of a careful vaginal exam and Tammy requests a vaginal exam. Between contractions, the vaginal exam is provided using a sterile glove internally and external abdominal palpation with the midwife’s other hand. Membranes are identified intact and loose. Tammy’s cervix is stretchy and dilated at least 5 cm and about 75% effaced. The baby’s position is LOP with Brow as Presenting Part, the head dipping beneath the pelvic brim and slightly ballotable. At the end of the exam a contraction begins and the bag of membranes tightens and extends against the midwife’s fingers into Tammy’s vagina, firmly holding the cervix open.

a. What fetal skull landmarks are identified by the midwife?

b. What explains the rectal pressure that Tammy is feeling?

c. Based on the midwife’s findings during the vaginal exam, what position(s)

would you encourage for Tammy?

d. What would you hope would be accomplished by your positional

suggestion?

Tammy is on the toilet; as soon as she finishes urinating she feels a gush of water. Her rectal pressure increases significantly.

e. If you were Tammy’s midwife, how would you respond?

Another 90 minutes have passed. Tammy is lying on her most comfortable side, resting between strong regular contractions. The midwife listens to FHT and hears a baseline in the 130’s. The midwife continues to listen, and during the next contraction the FHR increases to the 150’s. After three contractions, the midwife listens to FHT again and checks Tammy’s BP and pulse. The next time the midwife listens to FHT the baseline is 120 and as a contraction begins there is an immediate deceleration to 108, 96, and Tammy responds to an urge to push, bearing down while breathing deeply and holding her own leg up.

f. If you were Tammy’s midwife, what would you do now?

Projects

24. To better visualize the mechanics of these cephalic presentations, use a model and Human Labor and Birth to demonstrate the cardinal movements of birth in OP, Brow and Face positions.

25. Discuss with midwives their methods of support for posterior labor. Research articles on the subject. Make a resource list of possible actions to initiate with clients during posterior labor.

26. Practice the use of rebozo or other cloth “sifting” techniques in preparation for use in turning OP babies. See if a workshop is offered near you; there are also numerous online demonstrations. What have you observed in practice?

28. Gather a few trusted friends to experiment with the practice of Chunging. Experience Chunging for yourself and consider how this technique might be applied to labor. Write a brief commentary on your personal experience with Chunging.

29. Draft practice guidelines for Brow and Face Presentations in your own practice. Include reference to your transport plan as needed. Submit this draft and include it later in your Practice Guidelines projects (in the Charting and Practice Guidelines Module.)

Skills

Following are excerpts from the NMI forms for assessment of midwifery skills, which include all skills identified and required by NARM. Review the following skills and consider how they each relate to the content of this module. If you are currently working with a preceptor, take this opportunity to focus on these areas. During Supervised Primary Care you will formally evaluate these skills together using the NMI form *Preceptor Evaluation/Student Self-Assessment of Midwifery Skills.*

3. Maternal Health Assessment:

D. Assesses fetal weight, size, lie, or lightening

E. Assesses correlation of weeks gestation to fundal height

4. Labor, Birth and Immediate Postpartum

B. Evaluates and supports a laboring mother during the first stage of labor by assessing:

1. Maternal physical and emotional condition based upon assessment of:

a) vital signs,

b) food and fluid intake/output,

c) dipstick urinalysis for ketones,

d) status of membranes,

e) uterine contractions for frequency, duration and intensity with a basic intrapartum examination,

f) fetal heart tones,

g) fetal lie, presentation, position and descent with:

1) visual observation,

2) abdominal palpation,

3) vaginal examination,

h) effacement, dilation of cervix and station of presenting part,

i) maternal hydration and/or vomiting by administering:

1) fluids by mouth,

2) ice chips,

3) oral herbal/homeopathic remedies,

4) deep immersion in warm water