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OBSTETRIC TORSION, PATHOGENESIS, MECHANISM, MODERN CLINICAL DIAGNOSIS

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Abstract: Obstetric rotation is an operation that can change the position of the fetus from an unfavorable position to a favorable one for the process of childbirth, always only longitudinal. There are the following methods of obstetric version: external version to the head, less often to the pelvis; internal rotation with full opening of the cervical os - classical or timely, rotation.

External rotation of the fetus is performed by a doctor only through the abdominal wall using external means without any impact from the vagina. Indications: transverse and oblique positions of the fetus, lower view of the fetus. Conditions for the procedure: good fetal mobility (if the waters break, rotation is not indicated); normal pelvic dimensions (true conjugate not less than 8 cm); absence of indications for early termination of labor (fetal asphyxia, premature detachment of the placenta, etc.).

Key words: Obstetric rotation, mechanism, pathogenesis, pathology and normal course.

Introductory part: External version can be performed without anesthesia, especially in women who have given birth to multiple babies. In the oblique position of the fetus, sometimes it is enough to lay the woman in labor on the side on which the presenting part is tilted. For example, if the fetus is in a left oblique position (head to the left), the woman is placed on her left side. In this position, the lower part of the uterus, together with the buttocks of the fetus, is tilted to the left, and the head - in the opposite direction, towards the entrance to the pelvis.

If the fetus is in a clearly transverse position, special external methods are required to turn it. 30 minutes before the operation, the woman in labor is injected subcutaneously with 1 ml of a 1% solution of promedol (to slightly relax the uterine muscles so that subsequent manipulations do not cause unnecessary discomfort). The woman in labor lies on her back on a couch (preferably hard), her legs are slightly bent and pulled to her stomach. The obstetrician, sitting sideways on the edge of the couch, places both hands on the woman's stomach in labor so that one hand is on her head, holding it from above, and the other on the pelvic end of the fetus, by the lower buttocks (Fig. 1). Holding the fetus in this way, they press the fetal head with one hand in the direction of the entrance to the pelvis, and with the other push the pelvis up, to the bottom of the uterus. All these manipulations are carried out firmly, but very carefully, and are allowed only during pauses, when the uterus is completely relaxed; When contractions occur, the obstetrician's hand holds the fetus in an occupied position.

Research methods and materials: General rules of external prophylactic rotation in thoracic presentations (in the direction of the arrows): move the buttocks back, the back to the head, the head to the entrance to the pelvis.

External cephalic version for the chest, called prophylactic version, is performed by a doctor in a hospital setting at 34-36 weeks of pregnancy. General rules for prophylactic rotation - see Figure 2. After rotation, the pregnant woman should be monitored regularly. If the cephalic view is replaced by a quadruped again, the rotation is repeated immediately.

The following method is proposed to prevent the appearance of the chest and correct it with cephalia. The following exercises are prescribed to a pregnant woman (from 29 to 40 weeks): lying on a bed (sofa), she should alternately turn first to one side, then to the other, staying on each side for 10 minutes. The exercises are repeated 3-4 times (on average, each session lasts 60-80 minutes), the exercises are performed 3 times a day before meals. After several sessions (usually within the first 7

days), the fetus turns head down. After the head is fixed, to prevent the recurrence of the appearance of the chest, the pregnant woman is recommended to lie on her side and back, corresponding to the position of the fetus, and also wear a tightening bandage. The pregnant woman should visit a doctor at least once a week. In case of relapse, additional classes are held.

Results: Classical internal rotation is performed by a doctor. In emergency situations, when it is impossible to call a doctor, a classical internal version can be performed obstetrician. When performing an internal obstetric version, one hand is inserted into the uterus, and the second is inserted through the abdominal wall of the woman in labor to help the first. Classical internal rotation is indicated in the transverse position of the fetus, as well as in presentations that are dangerous for the mother (for example, frontal) and in head presentations (for example, posterior-parietal). With classical rotation, you can turn the fetus from the transverse position (sometimes longitudinal) to the head and feet. Rotation in the head is currently of no practical importance. Conditions for rotation: full opening of the cervical os, full mobility of the fetus. Contraindication to internal rotation is a developed transverse fetal position.

The technique of internal classical rotation of the legs in transverse positions. Three stages should be distinguished: 1) insertion of the hand, 2) finding and grasping the leg, and 3) the actual rotation of the fetus. In the transverse position of the fetus, it is recommended to insert the hand corresponding to the pelvic end of the fetus, counting on the side of the obstetrician.

In the anterior view of the transverse position (back to front), the fetus should be grasped by the lower leg (grasping the leg that is located above can easily lead to a posterior view, which is inconvenient for labor management); In the posterior views of the transverse position, the upper leg should be grasped (Fig. 3), since it is easier to transfer the posterior view to the anterior view. Two methods are recommended for searching for the fetal leg: “short” - the hand is moved directly to the fetal leg, and “long” - the hand is moved along the back of the fetus to the buttocks, then along the thigh, to the corresponding leg. Always grasp one leg with your whole hand (Fig. 4) or with two fingers (Fig. 5). When searching for the leg with the hand lying on the abdominal wall (the "outer" hand), assistance is provided by the hand inserted into the uterus (the "inner" hand). The "outer" hand lies in the fetal pelvis and lowers it to the pelvic inlet to meet the "inner" hand.

As soon as the fetal foot is found and grasped, the "outer" hand should be moved from the pelvis to the head and pushed against the bottom of the uterus (Fig. 6). If this is not done and the hand is left in the same position and pressed against the tip of the pelvis, the head may become compressed - a complication that threatens complete failure of the turn.

Discussion: Rules for turning the fetus (turning itself): traction (traction) is performed outside the contractions; traction is performed downwards, towards the perineum (with traction on oneself, especially upwards, the symphysis interferes); traction is applied until the knee comes out of the genital slit. The rotation is completed when the leg is extended to the knee and the fetus has taken a longitudinal position.

In addition, if there are no contraindications, labor can be left to the forces of the body and carried out in the same way as with incomplete breech presentation. Currently, most obstetricians adhere to a different tactic: in the interests of the fetus, an operation is performed to extract the fetus from the pelvic cavity immediately after the rotation is performed

In the cephalic view, the internal classical rotation of the fetus in the foot is carried out according to the same rules as in the transverse position of the fetus.

Indications: the need for immediate termination of labor. The hand corresponding to the small parts of the fetus is inserted into the vagina and uterus as deep as possible (up to the elbow), counting from the obstetric side. When inserting the hand into the uterus, it is necessary to first push the head to the side and, especially, and most importantly, do not forget to immediately move the "outer" hand from the pelvis to the head after the legs are grasped. In such cases, pinching the head is especially inconvenient.

It is easy to confuse the foot with the hand during the head-to-toe obstetric rotation. To avoid this, you need to insert your hand deeper, and then, while holding the foot, pay attention to the heel tubercle, which serves as a difference between the foot and the hand.

Conclusion: Complications during obstetric rotation and assistance with them. 1. Prolapse of the umbilical cord. The fallen part is not put back, since the closed part usually falls back. A loop should be put on the fallen cord so that it does not fall on the head in the future. 2. The obstetric rotation is unsuccessful because traction is applied incorrectly (not down, but towards itself or up). 3. The obstetric version is incorrect - it is performed during contractions, while it should be performed outside the contractions. 4. A breech head ("outer" hand did not move after holding the leg from the pelvic end to the head). First of all, you need to carefully try to push the head. If this does not work, you need to bring the other leg together (create more space in the uterine cavity) and try to push the head again. If this also fails, the head should be punctured. 5. Crossing of the legs: The leg resting on the symphysis, crossing with the leg lowered down, prevents the fetus from turning. The second leg should also be brought together.

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