PERSISTENT GLABELLAR PRESENTATION

by

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Glabellar presentation refers to a position of partial extension of the head midway between a brow and a face. It is often transitory and spontaneously gets converted into a face or rarely a brow presentation. Rarely the glabellar presentation persists. In such a situation the engaging diameter is the mid-supramaxillary vertical which varies between 10 to 11.25 cm. This engaging diameter is larger than the submentobregmatic diameter (about 9.5 cm), but smaller than the verticomental diameter (about 13.25 cm.). Unlike in a brow presentation, spontaneous delivery is sometimes possible in a glabellar presentation. However, the possibility of spontaneous outcome is always much smaller in a glabellar presentation than in a face presentation.

Material and Methods

This report is based on the records of 25 consecutive cases of glabellar presentation managed in Tirunelveli Medical College Hospital, Tirunelveli, over a period of about 5½ years from 1-10-1969 to 30-4-1975. During this period, there were 10346 deliveries. During the same period, there were also 60 cases of face presentation and 41 cases of brow presentation. This gives an incidence of 1 in 414 deliveries for glabellar presentation compared to 1 in 172 deliveries for face and 1 in 252 deliveries for brow presentations.

Observations

The age and parity are shown in Table I Forty per cent of the patients were primiparas and 24 per cent were grandmultiparas. All these patients were admitted as unbooked emergency cases and in all, the membranes had ruptured outside. In 60 per cent the cervix was already fully dilated at the time of admission.

TABLE I
Age and Parity

Parity	20 yrs. & less	21-29 yrs.	30-39 yrs.	40 yrs. & over
Primis	5	5	–	–
Para I to IV	–	5	4	–
Para V & over	–	–	3	3

The maternal complications are shown in Table II. Inlet contraction was present in 5 cases (20%). One patient was admitted with incomplete rupture of uterus. There was evidence of impending rupture of uterus in 6 cases (24%). Five patients (20%) had gross intra-partum sepsis. Cord prolapse, intrapartum

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TABLE II
Maternal Complications

Complications	No. of cases
1. Inlet contraction	5
2. Premature rupture of membranes	17
3. Gross intra-partum sepsis	5
4. Threatened rupture of uterus	6
5. Rupture of uterus	1
6. Cord prolapse	1
7. Intrapartum eclampsia	1
8. Maternal death	1

eclampsia and placenta praevia were present in one case each.

The nature of delivery is shown in Table III. Spontaneous vaginal delivery

TABLE III
Nature of Delivery

Nature of delivery	No. of cases
L. Natural	2
Mid-forceps	2
Craniotomy	2
Lower segment section	16
Caesarean hysterectomy	2
Subtotal hysterectomy	1

occurred in only 2 cases and mid-forceps was required in 2 cases. Safe vaginal delivery was therefore possible in only 16% of cases, compared to 76 per cent for anterior positions of face and 24 per cent for transverse and posterior positions of face. Craniotomy was done in two cases. Caesarean section was required in 64 per cent and in 8 per cent caesarean hysterectomy was done because of gross intrapartum sepsis. In one case, subtotal hysterectomy was done for incomplete rupture of uterus.

There was one maternal death (4%). This patient was admitted with gross intrapartum sepsis and threatened rupture of uterus, after being badly handled outside, and was delivered by craniotomy.

The average birth weight was 2.95 kg. Table IV shows the birth weight of the

TABLE IV
Birth Weight

Birth weight	No. of cases
2.0 — 2.5 Kg.	6
2.6 — 3.0 Kg.	14
3.1 — 3.5 Kg.	4
3.6 — 4.0 Kg.	1

babies. Four babies were lost (16%) and in all, the mother was admitted with gross intrapartum sepsis.

Comments

Glabellar presentation is a rare, but important malpresentation. It is generally believed that the mechanism of delivery is almost similar to that of face presentation. (Mudaliar and Menon, 1968). The denominator is the upper jaw and the engaging diameter is the mid-supramaxillary vertical diameter. The head is in a position of partial extension between a brow and a face. On vaginal examination, the supraorbital ridges, the glabella, the malar eminences and supra-maxillary bone will be palpated. Unlike in a brow presentation, large anterior fontanelle will not be easily within reach, and unlike in a face presentation, the lower lip and chin will not be within reach. In glabellar presentation, the caput will be confined to the supraorbital ridges, the glabella, the malar eminences and supra-maxillary bone. There will be no caput over the anterior fontanelle, lower lip and chin.

Glabellar presentation may be transitory early in labour and may get converted into face or rarely brow presentation. In cases where the upper jaw rotates

to the front, delivery may be spontaneous. However, the possibility of spontaneous outcome is always much less in a glabellar than in a face presentation. Persistent glabellar presentation is an unfavourable presentation. There may be considerable delay in a large number of cases and in some, the presenting part may not descend at all. Moreover, in a significant number of cases, this malpresentation is as a result of an associated inlet contraction.

Our observations clearly indicate that persistent glabellar presentation very often results in obstructed labour with very high risks to the mother and the foetus. It is therefore imperative to distinguish glabellar presentation from face presentation.

The principles underlying the management of glabellar presentation are much the same as those for face presentation. X-ray pelvimetry may be useful to establish or rule out pelvic contraction. If any significant degree of pelvic contraction is present, caesarean is indicated. If the pelvis is normal, vaginal delivery may be anticipated. However, when there is delay in descent of the presenting part, caesarean section is the most dependable procedure and is usually indicated provided the child is alive. If the child is dead, craniotomy is the procedure of choice. Some authors advocate conversion of the glabellar presentation into a full face presentation. However, this is likely to be traumatic to both foetus and mother and such a procedure rarely merits consideration in present day obstetrics.

Summary

The maternal and foetal prognosis in 25 consecutive cases of persistent glabellar presentation managed in Tirunelveli Medical College Hospital, Tirunelveli over a period of about 5½ years have been reviewed. Our observations indicate that persistent glabellar presentation is an unfavourable presentation with very high risks to the mother and foetus. The principles underlying the management of this malpresentation have also been outlined.

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