REVIEW OF COMPOUND PRESENTATION

by

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Introduction

Since there has been a paucity of cases in the literature on compound presentation, it seemed reasonable to review and report experience of 3 years to know the incidence, aetiology, prognosis and treatment of this complication.

The commonest variety of compound presentation is head with hand presentation. The other rarer varieties include head with foot, head, hand and foot, breech, hand, shoulder and foot.

The simultaneous attempt at engagement of more than one part of the foetus results in obstruction to progress of labour and in most of the cases favourable termination does not usually occur.

Premature rupture of the foetal membranes and prolapse of umbilical cord are frequent. Sometimes due to obstruction, rupture of uterus.

Predisposing factors for compound presentation are: (1) Prematurity; and (2) conditions that prevent complete filling and occlusion of the pelvic inlet by presenting part e.g., multiparity, pelvic tumours, significant degree of pelvic contraction, placenta previa.

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Material and Method

The present study includes 50 cases of compound presentation managed at Zenana Hospital, Jaipur during the period 1976-77 and 1978.

The history taking, general examination obstetrical examination, duration of labour and management were studied and foetal outcome noted.

The aim of study was to evaluate in which stage the patients usually come for treatment, what symptoms promote them to seek medical advice, the complications encountered during labour and afterwards, foetal outcome, perinatal morbidity and mortality.

Discussion

It is a retrospective study of compound presentations. Total number of deliveries during this period was 19710 and total number of compound presentations was 50, so the incidence of this presentation was 1 in 394 deliveries.

TABLE I

Incidence as Reported by Other Authors

Authors	Year	Incidence
Bhatt & Trivedi	1964	1 in 631
Clark et al.	1968	1 in 1260
Bhaskar	1971	1 in 144
Palanichamy	1974	1 in 134
Present Series	1976-78	1 in 394

The incidence of compound presentations as reported by other authors is given in Table I. In most of our cases causes of compound presentation were prematurity and multiparity with lax abdominal wall. In few cases contracted pelvis and placenta previa were the cause. Sweeney and Knapp (1961) postulated 3 important factors prematurity, twins and unfixed presenting part for compound presentation.

The commonest variety of compound presentation in the present study was head with hand, 21 cases (Table II). Head with hand is common because as a whole vertex presentation is present in 90 per cent of cases and if head remains high as in grand multi, contracted pelvis and prematurity, any small foetal part may descend to fill the deficient space, because hand is in close proximity to head, it descends first.

Bhatt (1964) studied 75 cases, out of which in 50 cases the presentation was vertex and hand. Weissberg *et al* (1973) reported 17 cases of vertex and hand, out of 36 cases. Palanichamy (1976) had given a series of 90 cases, 68 were vertex with hand.

TABLE II
Varieties of Compound Presentation

Type	Cases	
	Number	Per cent
Vertex with hand	21	42.0
Foot with hand	15	30.0
Vertex with foot	10	20.0
Vertex, food and hand	4	8.0

Compound presentation is also related to parity. It is most commonly found in multiparous as shown in Table III. Bhatt reported 34 cases in 4th gravida.

Weissberg *et al* (1973) found compound presentation in 23 grand multiparas out of 36 cases.

TABLE III
Parity

Parity	Cases	
	Number	Per cent
Primipara	7	14.0
2nd gravide	13	26.0
3rd gravida	8	16.0
4th gravida	7	14.0
Grand multi	15	30.0

The diagnosis of compound presentation was made in the first stage of labour in 32 cases and in the second stage of labour in 18 cases. It is impossible to diagnose this condition by abdominal palpation. Skiagram may occasionally reveal the condition but as patients came late in labour, skiagram was not possible and vaginal examination was the only method of diagnosis of compound presentation. Cord may be found together with any of the presenting part. In Goplerud's (1953) series, 29 cases were diagnosed in the first stage of labour and 34 cases were diagnosed in the second stage of labour. Bhatt (1964) diagnosed 49 cases in first stage and 14 cases in 2nd stage of labour.

Management

Different views are held regarding the management of compound presentation. Some believe in "wait and watch" policy and claim good results in terms of foetal survival and spontaneous labour. They also believe that interference increases the foetal loss (Bhatt, 1964).

Management depends on the complications present, the adequacy of the pelvis, the condition of the infant, stage and progress of labour and the condition of the mother (Nettles and Brown, 1962).

If presentation is diagnosed before rupture of membranes postural treatment by raising the foot end of the bed and patient is made to lie on the opposite side of the

presenting part (Mudaliar and Menon, 1968).

In the present series, only in 3 cases this type of treatment was possible as they came early in labour before rupture of membranes.

If diagnosis is made after rupture of membranes and if associated with any complication then early interference is required. In our series, the incidence of abnormal labour is shown in Table IV.

TABLE IV

Incidence of Abnormal Labour in Compound Presentation

Type of delivery	Bhose & Lokenath (1961)	Rohit Bhatt (1964)	Palani-chamy (1976)	Present Series (1976-78)
Breech delivery	18.8	13.30	16.6	28.0
IPV with breech extraction	28.5	1.66	3.3	10.0
Bipolar version	1.1	—	—	2.0
Forceps delivery	0.4	4.0	19.1	6.0
LSCS	1.0	1.3	10.0	14.0
Caesarean hysterectomy	—	—	—	2.0
Willet traction	3.3	7.3	—	2.0
Craniotomy	8.8	2.7	6.6	—

Breech delivery was the treatment in 14 cases. Out of these, 10 cases were vertex with foot and 4 with vertex, foot and hand. In these cases foot was brought down and patient was delivered as breech.

In 5 cases internal podalic version with breech extraction was done. Lower segment caesarean section was done in 7 cases. Foetal distress and cord prolapse were the indications in 5 cases and in the other 2 cases presentation was head, hand and foot where hand and foot could not be pushed up.

One patient came with rupture uterus, caesarean hysterectomy was done. Presentation in this case was head, foot and hand.

Eighteen cases had normal delivery. In most of these cases presentation was vertex and hand. In 10 cases reposition of prolapsed foetal part was done and the patient delivered normally. Remaining 8 cases had spontaneous normal delivery and no interference was done.

In the present study, the number of stillborn babies were 26. Cord prolapse with absent pulsations was present in 10 cases, 1 came with rupture uterus, 1 case was of accidental haemorrhage with absent foetal heart sounds. In rest of the cases causes of stillborn babies were prolonged labour and prematurity.

Perinatal morbidity and mortality increase in compound presentation because of prematurity and prolonged labour. Out of 50 cases, 26 were stillborn, 11 died within 7 days of birth. Seven were premature, 3 were asphyxiated at the time of birth and expired within 2-3 hours, died due to aspiration pneumonia.

Summary and Conclusion

The incidence of compound presentation was 1 in 394 deliveries.

The commonest variety of compound presentation was head with hand (21 cases) and the next common was foot with hand (15 cases). Majority of cases were multipara.

The diagnosis was made late in labour in most of the cases as patients came late.

The incidence of abnormal labour was more (64.0 per cent).

Perinatal morbidity and mortality increased in compound presentation. Twenty-six were stillborn babies and 11 babies died after birth. The causes in most of the cases were cord prolapse, prolonged labour and prematurity.

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