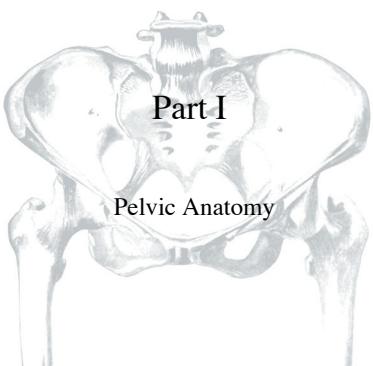


Vaginal Birth

**Birth Stages,
Pelvic Shapes,
and
Cranial Molding**



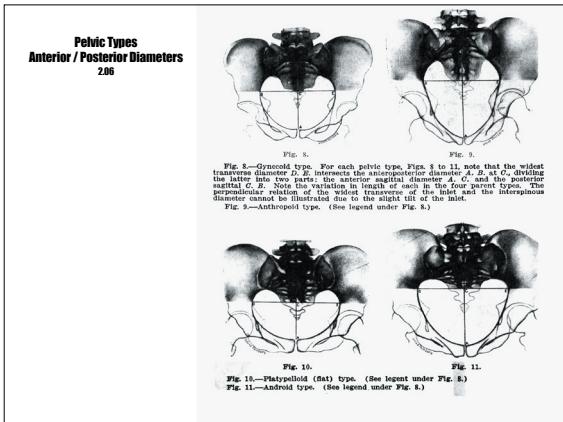
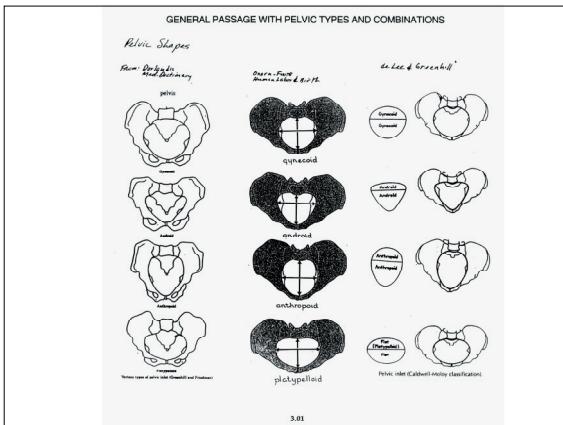
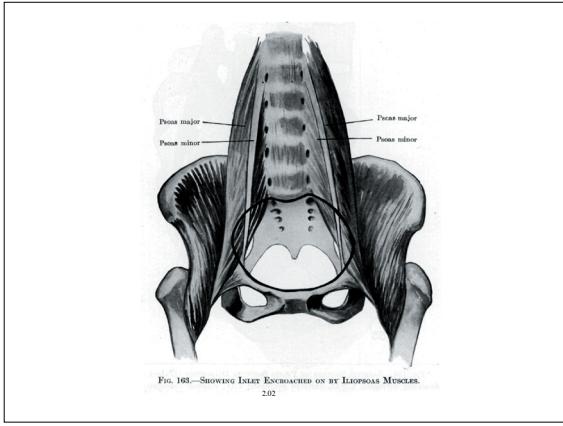
PELVIC ANATOMY



FIG. 159—NORMAL FEMALE PELVIS.

This specimen selected from several thousand by Trousseau of Paris as "the normal European female type" is perhaps slightly radiotic.

2.01



**1943 Report of Calwell, Moloy, D'Esopo
Findings of Anglo-European Women:**

41.4% Gynecoid
32.5% Android
23.5% Anthropoid
2.6% Platypelloid

**British Grey's Anatomy Reported 1979
%s for Black Women:**

42.1% Gynecoid
15.7 Android
40.5% Anthropoid
1.7 Platypelloid

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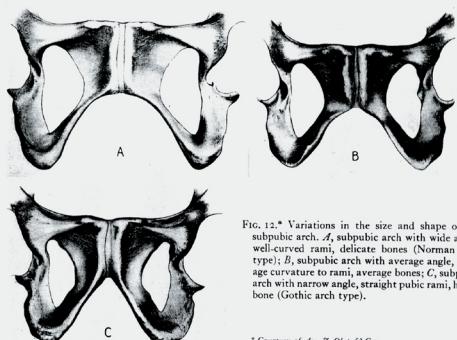


FIG. 12.* Variations in the size and shape of subpubic arch. *A*, subpubic arch with wide angle; curved rami, delicate bones (Norman type); *B*, subpubic arch with average angle, a slight curvature to rami, average bones; *C*, subpubic arch with narrow angle, straight pubic rami, thick bone (Gothic arch type).

* Courtesy of *Am. J. Obst. & Gynec.*

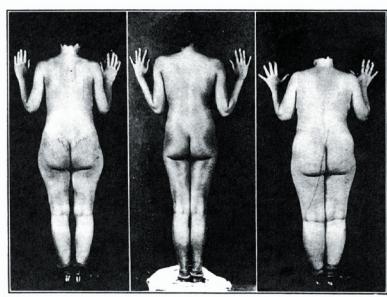


Fig. 13.—Physical form versus pelvic type.

A. The gynecoid type. Note the narrow shoulders and narrower waistline. The hips are broad. The lower legs are well curved and tend to be slender.

B. The android type. The shoulders are broad and the hips narrow. The legs are straight and slender.

C. The android type. Posteriorly, the body is square. The waistline is thicker than the hips. The legs are straight and slender. The hip width is preserved throughout the lower legs into the calves, the ankles, and the feet.

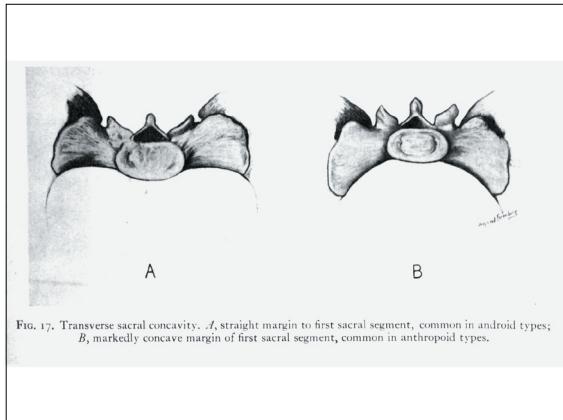


FIG. 17. Transverse sacral concavity. *A*, straight margin to first sacral segment, common in android types; *B*, markedly concave margin of first sacral segment, common in anthropoid types.

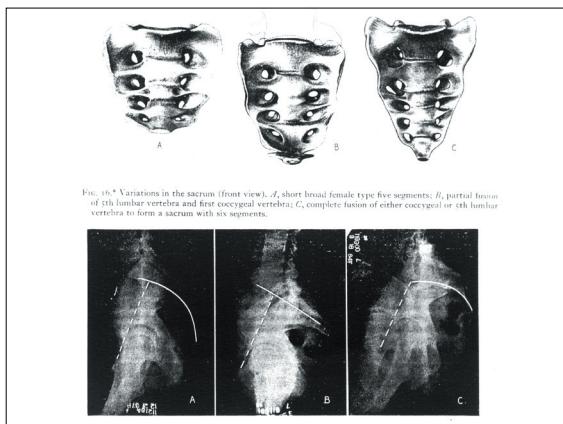


FIG. 18. Variations in the sacrum (front view). *A*, short broad female type five segments; *B*, partial fusion of 5th lumbar vertebra and first sacral vertebra; *C*, complete fusion of either coccygeal or 5th lumbar vertebra to form a sacrum with six segments.

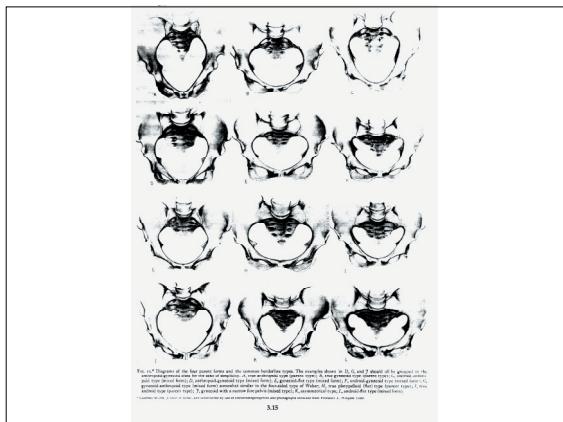
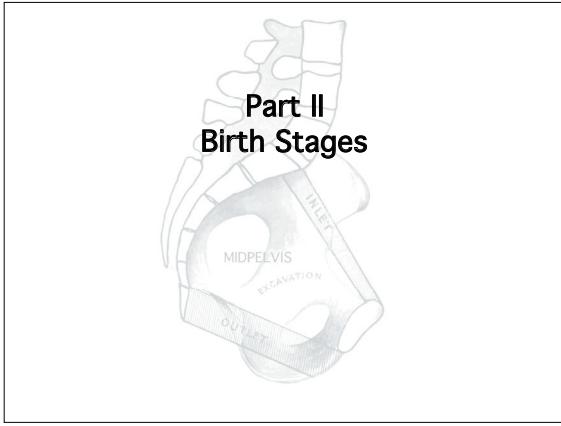
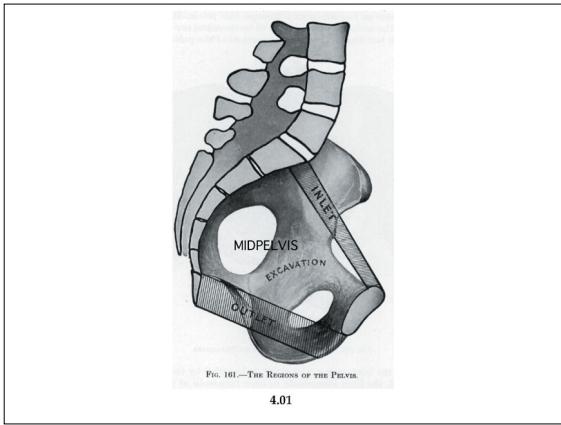
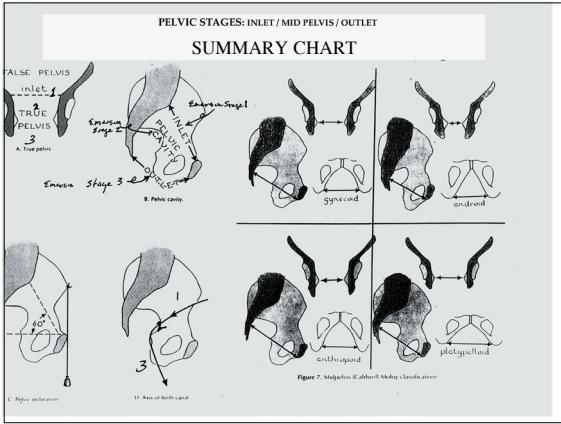
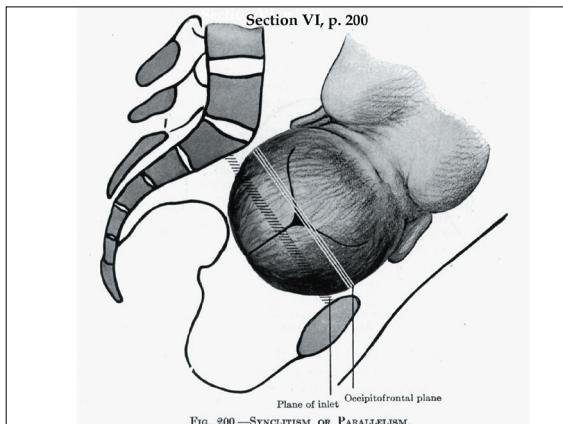
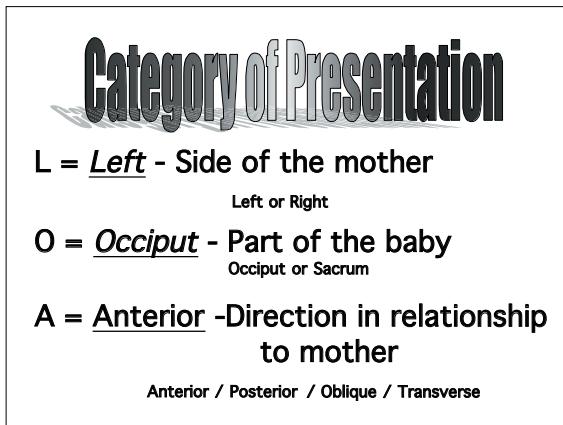
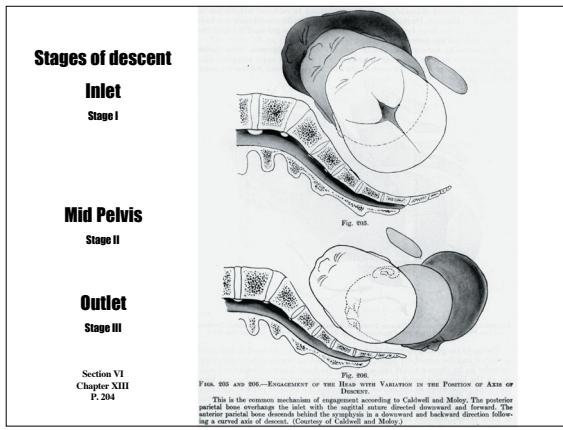


FIG. 19. Diagrams of the sacrum front types. The examples shown in *D*, *G*, and *J* should all be present in the human population. *A*, normal sacrum; *B*, sacrum with 5th lumbar vertebra; *C*, sacrum with 4th lumbar vertebra; *D*, sacrum with 3rd lumbar vertebra; *E*, sacrum with 2nd lumbar vertebra; *F*, sacrum with 1st lumbar vertebra; *G*, sacrum with 5th sacral vertebra; *H*, sacrum with 4th sacral vertebra; *I*, sacrum with 3rd sacral vertebra; *J*, sacrum with 2nd sacral vertebra; *K*, sacrum with 1st sacral vertebra; *L*, sacrum with 6th sacral vertebra.









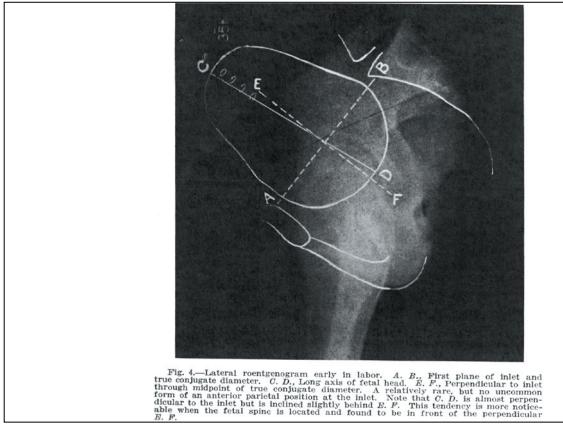


Fig. 4.—Lateral roentgenogram early in labor. *A*, *B*, First plane of inlet and true conjugate diameter. *C*, *D*, Long axis of fetal head. *E*, *F*, Perpendicular to inlet through midpoint of true conjugate diameter. Note that *C*, *D*, and *E*, *F* are all perpendicular to the inlet, but no unequivocal form of an anterior parietal position at the inlet. Note that *C*, *D*, and *E*, *F* are all perpendicular to the inlet, but is inclined slightly behind *E*, *F*. This tendency is more noticeable when the fetal spine is located and found to be in front of the perpendicular *E*, *F*.

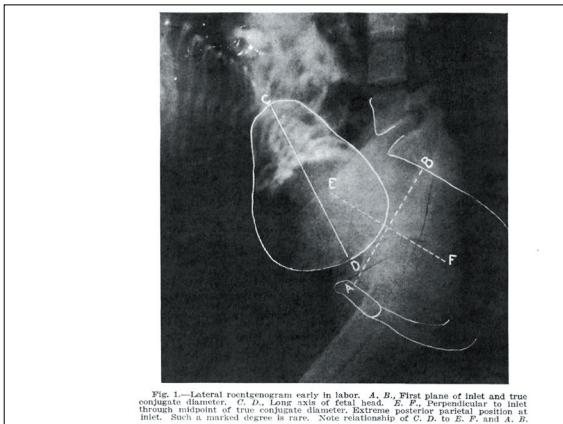
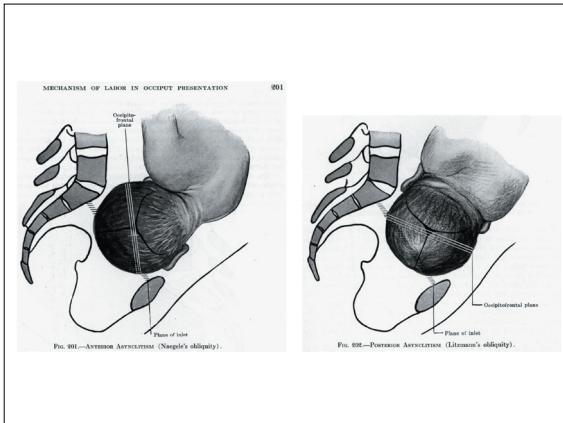


Fig. 1.—Lateral roentgenogram early in labor. *A*, *B*, First plane of inlet and true conjugate diameter. *C*, *D*, Long axis of fetal head. *E*, *F*, Perpendicular to inlet through midpoint of true conjugate diameter. Extreme posterior parietal position at inlet. Such a marked degree is rare. Note relationship of *C*, *D*, to *E*, *F*, and *A*, *B*.

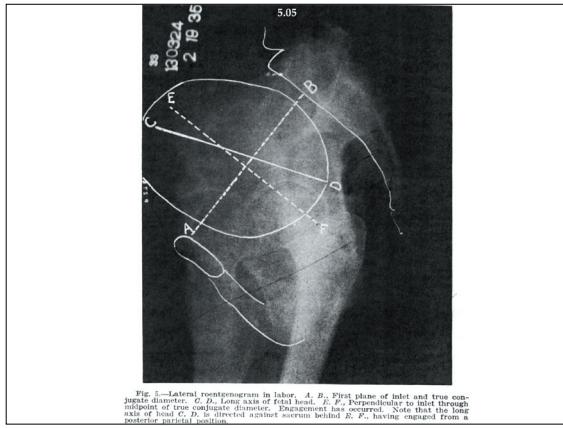


Fig. 1.—Lateral roentgenogram in labor. A, B, First plane of inlet and true conjugate diameter. C, D, Long axis of fetal head. E, F, Perpendicular to midline of fetal head. Note that C, D, passes through midpoint of true conjugate diameter. Engagement has occurred. Note that the long axis of the fetal head is rotated almost vertical behind B, E, having engaged from a posterior parietal position.

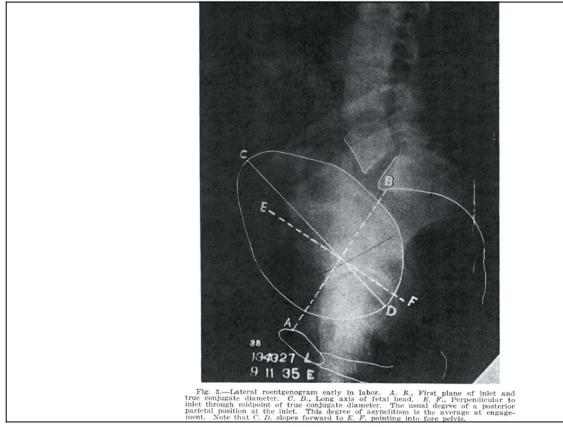


Fig. 2.—Lateral roentgenogram early in labor. A, B, First plane of inlet and true conjugate diameter. C, D, Long axis of fetal head. E, F, Perpendicular to midline of fetal head. Note that C, D, passes through midpoint of true conjugate diameter. Engagement has occurred. Note that C, D, shows forward to E, F, indicating anteversion.

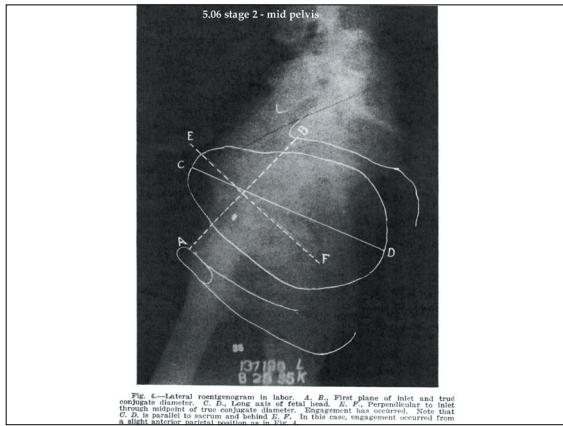
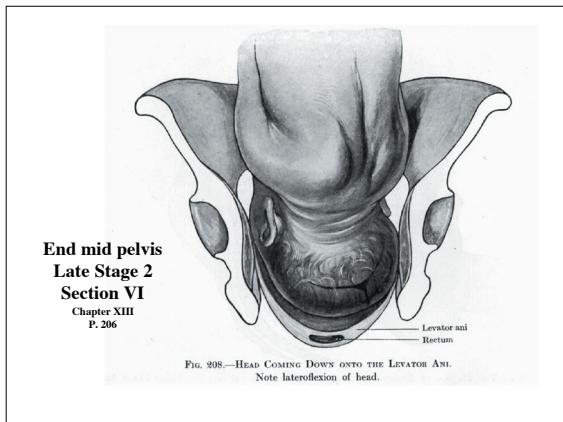
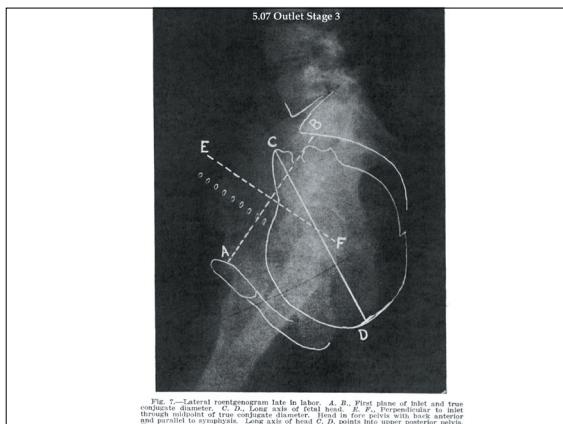
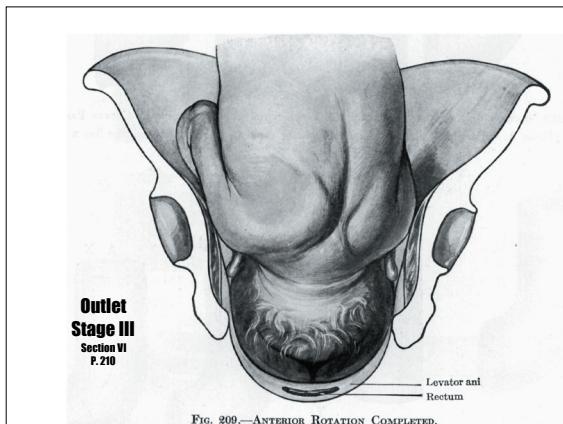


Fig. 4.—Lateral roentgenogram in labor. A, B, First plane of inlet and true conjugate diameter. C, D, Long axis of fetal head. E, F, Perpendicular to midline of fetal head. Engagement has occurred. Note that C, D, passes through midpoint of true conjugate diameter. Engagement has occurred. Note that C, D, is slightly anterior to B, E, and passes through midpoint of true conjugate diameter. In this case, engagement occurred from a slight anterior parietal position as in Fig. 2.

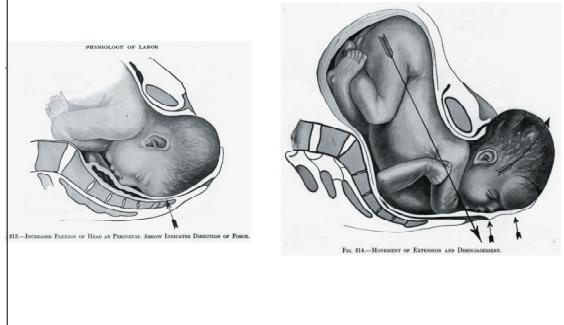






Outlet, Stage III

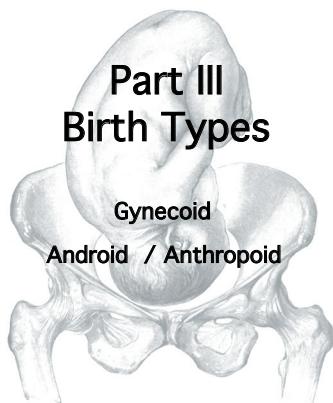
Section VI, Chapter XIII, p. 210



**Part III
Birth Types**

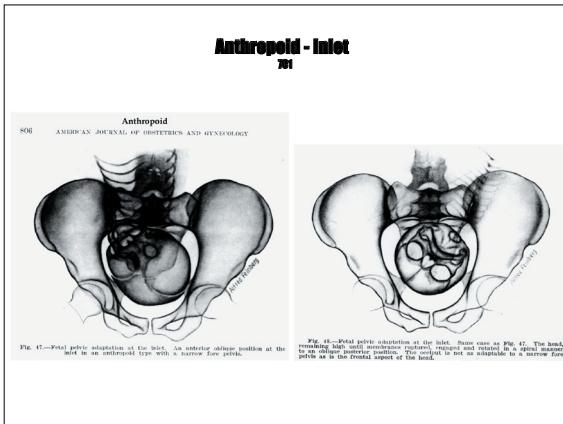
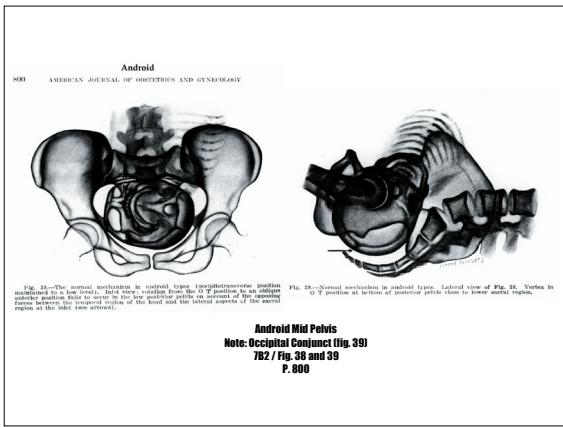
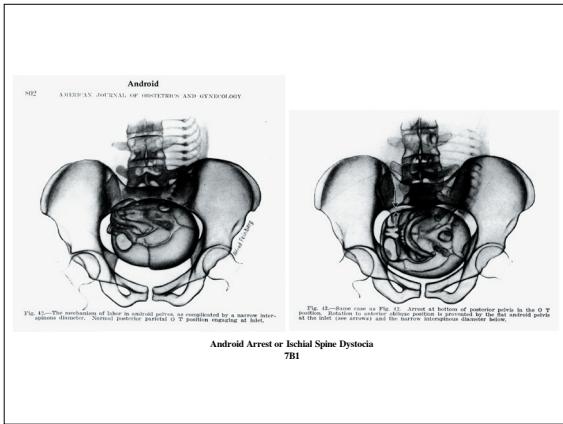
Gynecoid

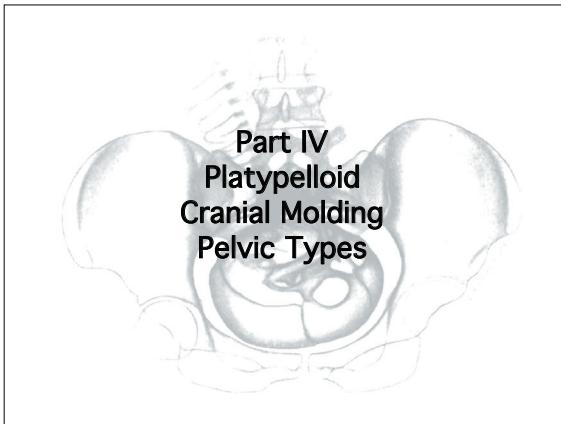
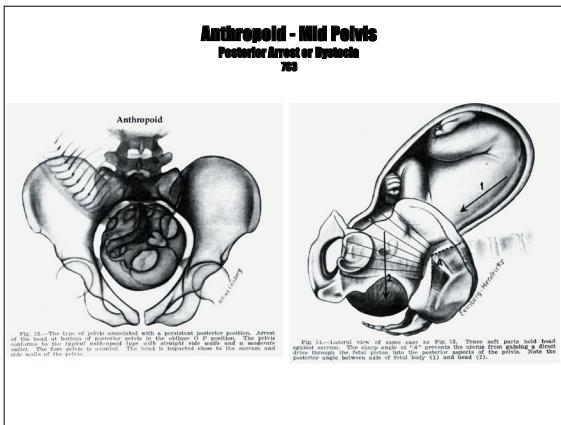
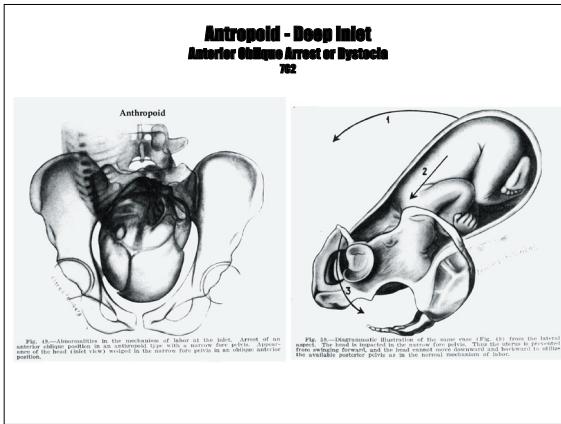
Android / Anthropoid

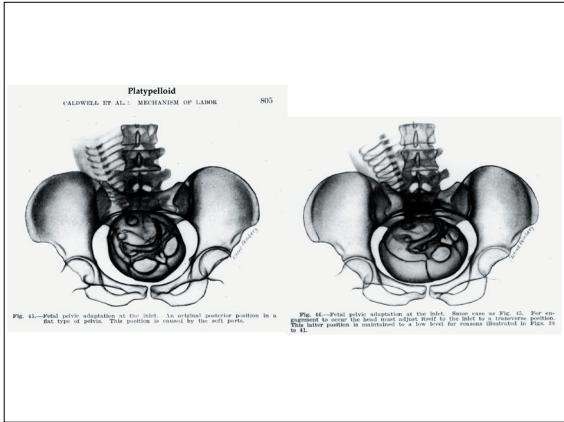


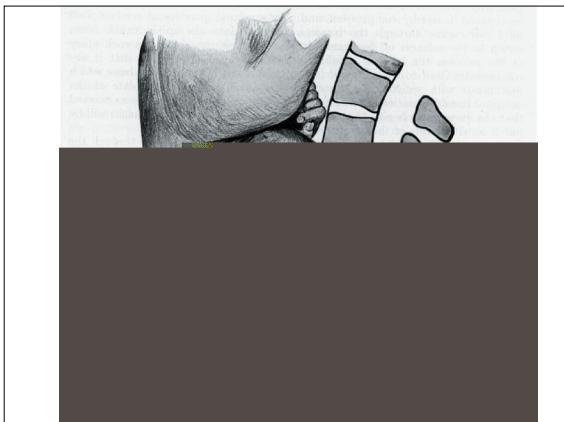
**Gynecoid
Right sided lie
P.7A1**

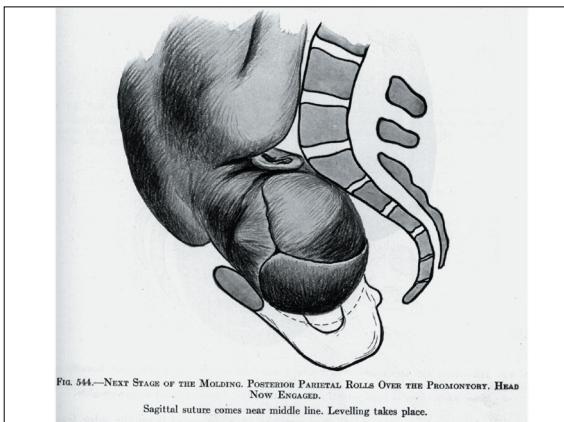












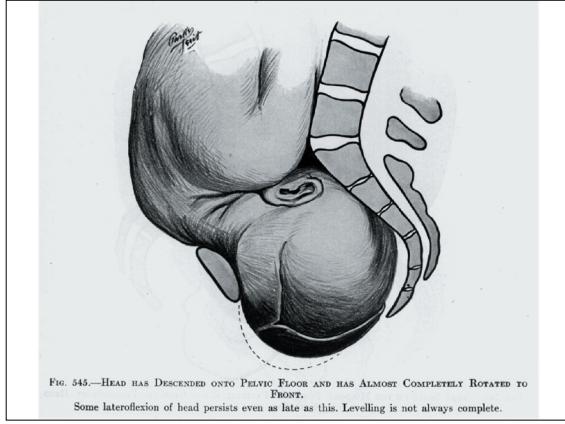


FIG. 545.—HEAD HAS DESCENDED ONTO PELVIC FLOOR AND HAS ALMOST COMPLETELY ROTATED TO FRONT.
Some lateroflexion of head persists even as late as this. Levelling is not always complete.
