The Shrewsbury and Telford Hospital NHS Trust

Standard Operating Procedure (SOP)

SOP Title	**Brow Presentation – In Labour**		
SOP Number	006		
Centre	Women and Children's		
Version Number	3		
Effective Date	21st August 2023	Review Date	August 2026
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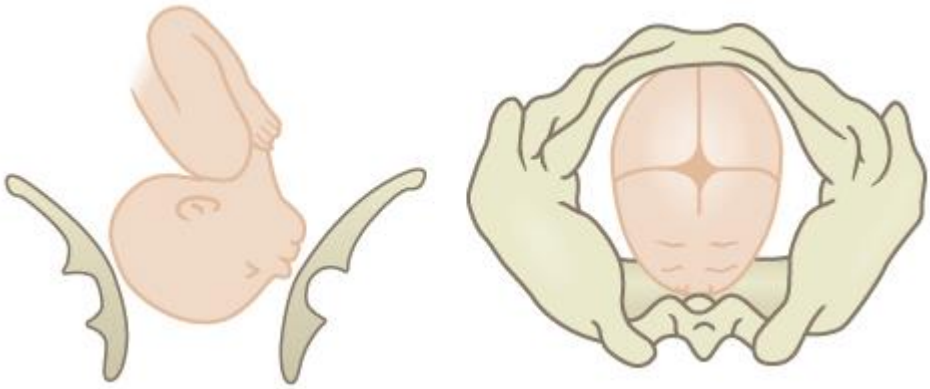
Approved by	Maternity Governance		
Approval date	21st August 2023		
Distribution	Maternity		
Location	Maternity Services		

Document Control				
Version	Date	Author	Status	Comments
1	27th Sept 2013	Emma Biggs	New	New Standard Operating Procedure
2	28/11/16	Paula Pryce	Review	Full version review
2.1	Jul-22	Jacqui Bolton	Review	No changes
2.2	Jul-23	Louise Weaver	Update	Audit & Monitoring paragraph updated to reflect new process
3	Jul-23	Lauren Taylor	Review	Full version review

SOP Objectives	• To understand the importance of the correct diagnosis and position of the presenting part. • To give guidance on the management of a brow presentation, once diagnosed in labour.
Scope	The incidence of a brow presentation is rare and is about 1 in 1500 – 3000 deliveries. Once diagnosed, the labour will be managed in accordance with this SOP.

Audit/Monitoring	Compliance with this guideline / SOP will be audited as part of the Shrewsbury and Telford Hospital NHS Trust's five-year rolling programme of NICE and local guideline audits, unless circumstances require an earlier or more frequent audit. The audit will be carried out against the auditable standards and the results of the audit will be reported and acted on in accordance with the Trust Clinical Audit Policy (CG25).
References	Edmounds, K. (2012) Dewhurst's Textbook of Obstetrics and Gynaecology 8th edition. Wiley and Blackwell. Hacker, N F, Moore, J G, Gambone, J G. (2010) Essentials of Obstetrics and Gynaecology 5th Edition. Marino, T (2012) Face and Brow Presentation. Medscape Reference http://emedicine.medscape.com/article/262341-overview#showall

Number	Brief
1	**Introduction** In Brow Presentation the head is half-extended and presents to the pelvis with the largest diameter (mento- bregmatic diameter = 13cm). 
2	**Mechanism of a Brow Presentation** The head engages transversely at the pelvic brim. For brow presentation to occur the neck extends (rather than flexion as required for vertex presentation). Brow presentation is regarded as an unstable presentation. With uterine contractions and pressure of the maternal pelvis on the fetal head can cause: • Further neck extension to a face presentation – if this rotates to mento-anterior a face presentation can potentially deliver vaginally • Neck Flexion to a vertex presentation – vaginal delivery is then possible, although usually OP presentation. • Brow presentation persists – vaginal delivery is not possible. Cephalopelvic disproportion requires caesarean for delivery. Strong data is scant, however approximately 50% of brow presentations may change to face or vertex presentation. It does not follow that all of those that change will lead to a vaginal delivery.
3	**Diagnosis** • Diagnosis is usually made late in the second stage of labour. • If the diagnosis is uncertain after physical examination ultrasound scan (USS) may be helpful. Diagnosis by USS is made if fetal orbits are visualised just below the symphysis pubis, which differs from a typical occipito-posterior position.

4	**Management of Labour** • In a suspected or diagnosed brow presentation escalate to the Tier 2 or Tier 3 Obstetrician. If the woman is in labour at an MLU or home, transfer to delivery suite will be recommended. The woman will be informed that vaginal birth will not occur if brow presentation persists. Discuss the options of: • Caesarean section • Continuing with labour. • Continuous electronic fetal monitoring advised. • If there is delay in progress or fetal concerns caesarean section will be advised. • If the presentation does not revert to vertex presentation or mento-anterior face presentation Caesarean section will be advised. If continuation with labour is intended, it would still be advisable to prepare for a caesarean (complete the consent process, anesthetic review, Iv access, FBC, G&S etc.) as there is a high chance of caesarean. Brow presentation in labour should not be augmented with oxytocin. If labour is not progressing and/or brow presentation persists this represents cephalopelvic disproportion and requires caesarean. Persisting in labour will increase caput, molding and risk maternal and fetal injury. Instrumental delivery or manual attempts to alter presentation are contraindicated. Brow presentation may be identified at the time of ARM for induction. A tier 3 decision will be made as to whether a trial of oxytocin can be considered to generate uterine contractions to encourage the unstable brow to a potentially deliverable presentation.
5	**Complications in Labour** Maternal and fetal complications associated with obstructed labour including uterine rupture and fetal trauma if brow presentation is not diagnosed or labour is mismanaged.
6	**Following delivery** Recognition and appropriate management of brow presentation do not result in increased serious maternal or neonatal morbidity. Discussion and debrief of the parents may be required with specific reference to the low incidence of brow presentation.