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Case Report on Face Presentation: A Rare Clinical Presentation and Vaginal Delivery in Rivers State University Teaching Hospital, Nigeria.

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ABSTRACT

Background: Face presentation, where the fetal chin is the presenting part during delivery, is a rare occurrence, affecting about 0.1-0.2% of births. This condition often arises from maternal factors like multiparity and specific pelvic shapes and is more common among black and multiparous women.

Case: This case report shares the story of a 36-year-old woman who presented at 39 weeks of gestation with face presentation in active phase of labour. Haven identified that the fetus is in mento anterior, the labour was allowed to progress. At the second stage of labour, she was encouraged to bear down, and with the aid of a mediolateral episiotomy, she successfully delivered a live female baby that weighed 2.6 kg, with good Apgar scores. The postpartum period was smooth.

Conclusion: This case highlights the potential for successful vaginal deliveries in face presentation when in mento anterior. It illustrates the importance of attentive care and monitoring in labour, as complications like prolonged labour, obstructed labour and fetal distress can arise.

INTRODUCTION

Face presentation is an obstetric event rarely encountered in clinical practice and often requires special attention due to its unique characteristics. It is associated with severe face oedema, bruising, or ecchymosis in newborns, typically resolving within 24 to 48 hours[1]. A longitudinal lie and complete extension of the fetal head on the neck, with the occiput in contact with the upper back, distinguish face presentation[2].

Face presentation occurs in 0.1-0.2% of deliveries but is more common in black and multiparous women[3]. Exact knowledge about the fetal position and level is important for correctly managing this malpresentation. On diagnosis, around 60% of cases are in the mentum anterior position, 25% are mentum posterior, and 15% are mentum transverse4; most malpositions rotate spontaneously into mentum anterior[3].

A vaginal birth at term is possible only if the fetus is in the mentum anterior position. In a Finnish study, Gardberg *et al.* found that 7/12 (58%) cases of face presentation were delivered by Cesarean section[4]. A deep, transverse occiput position (TOP) may lead to the arrest of labour. The management of malpositions occurring at full dilatation has been discussed for decades, and expectant management, rotational forceps, vacuum extraction, Cesarean section or manual rotation are possible options[1,5].

CASE PRESENTATION

A 36-year-old businesswoman with a tertiary level of education, G4P1+2, was admitted into the labour ward of the Rivers State University Teaching Hospital (RSUTH) on 10/6/2024 on account of labour pain of three hours duration at 39weeks, with spontaneous rupture of membranes while on admission.

Index pregnancy was registered for antenatal care in RSUTH at 36 weeks GA. Her height is 1.58m, weight was 58kg, random blood sugar was 5.9mmol/l, she was seronegative to HIV1&2, Veneral Disease Research Laboratory Test was non-reactive, Hepatitis B surface antigen and Hepatitis C viral antibody were negative, her packed cell volume was 33%, her Hb-Genotype is AA, Blood group: O Rh D positive. An obstetric scan showed a singleton viable fetus with an estimated fetal weight of 3.1kg, adequate liquor volume, and a fundally placed placenta. She was compliant with her routine medications, and her antenatal period was uneventful. She had a vaginal delivery in 2019 of a set of twins at term, live female babies of birth weight 1.4kg and 2.0kg, respectively, with good Apgar scores. The babies were breastfed exclusively, and the puerperium was normal. The babies were duly immunised for age. They are alive and well.

Her past gynaecological, medical and surgical histories were not significant. Physical examination revealed a young woman who was in intermittent painful distress, not pale, anicteric, acyanosed, and afebrile, with no pedal oedema. Her respiratory rate was 24 cycles per minute, and her chest was clinically clear. The cardiovascular examination showed a pulse Rate of 74 beats per minute and blood pressure of 142/85mmHg. Her abdomen was enlarged and moved with respiration. The fundal height was 36 weeks, with a singleton fetus in a longitudinal lie and cephalic presentation; the descent was 3/5th palpable per abdomen, and the fetal heart sound was heard at 140 beats per minute. Pelvic examination revealed a normal vulva and vagina, the cervical OS was fully dilated, and the fetal membranes were absent. The gloved examining fingers felt the fetal mouth and nose with the chin in the anterior position, the pelvis was adjourned adequate for vaginal delivery, and the liquor was clear. A diagnosis of a primipara with face presentation in the second stage of labour was made. Following an urge to apply pressure, she was encouraged to bear down with each contraction. With the help of a mediolateral episiotomy, she achieved a spontaneous vaginal delivery of a live female baby weighing 2.6kg. The baby's APGAR score was eight in the first minute and nine in the fifth minute. The placenta was delivered by controlled cord traction, and it was complete. The episiotomy was repaired under local infilteration with 0.5% lidocaine in 2 layers with vicryl 0, haemosthesis was secured. The estimated blood loss was 300ml. The baby was examined and was normal. The post-delivery packed cell volume was 38%. She and her baby were discharged home in a stable clinical state.

At the 6th-week postpartum visit, she had no complaints. The episiotomy wound had healed properly, and the baby was being breastfed, immunized completely for age, and weighed 3.7kg. She had a pap smear done and was discharged home.

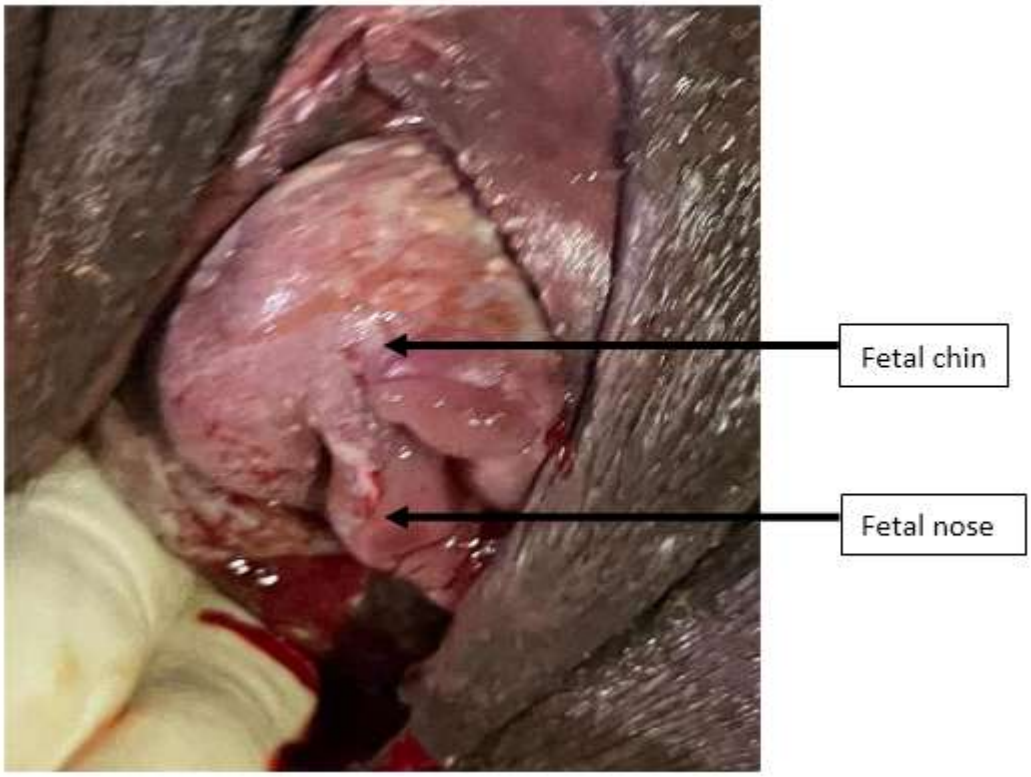

Figure 1: External View of Fetal Chin and Nose during Delivery

Figure 2: Face Presentation at Delivery

DISCUSSION

Face presentations are abnormal cephalic presentations, with the presenting part being the mentum resulting from hyperextension of the neck and the occiput reaching the back of the feuts[6]. It is extremely rare, occurring in about 1 in 600 births[7,8]. Various risk factors prevent flexion of the fetal head, resulting in face presentation. Maternal risk factors include contracted pelvis, platypelloid pelvis, multiparity, black origin and previous caesarean delivery. Fetal risk factors mostly implicated are anencephaly, several loops of umbilical cord around the neck, neck masses, fetal macrosomia and polyhydramnios[8]. Our patient was multiparous with no other implicated risks.

The diagnosis of face presentation is mostly clinical. It is diagnosed by carrying out a digital examination during the second stage of labour. The fetal chin, nose, orbital ridges, mouth, gums, and malar eminences can be palpated. Face presentation might also be incorrectly diagnosed as frank breech or brow presentations. In such situations, a bedside ultrasound scan is used to confirm the diagnosis[9]. However, the diagnosis does not alter the course of treatment and the end result[10].

Successful vaginal deliveries can occur in face presentation; however, the midwife or physician should be weary of brow presentation. It is important to appropriately counsel the mother and explain the risks and benefits of vaginal delivery before commencement of intervention[6]. Vaginal delivery is not optional for mentum posterior or transverse presentations. In those situations, the fetal brow pushes against the maternal pubic symphysis, and the short fetal neck is fully extended, resulting in the head being too large and impossible to navigate the maternal sacrum. A cesarean section is the only safe delivery method for mentum posterior face presentations. An attempt to convert face presentation to vertex by rotating the posterior chin to the anterior position—whether manually or with forceps—is highly dangerous and should be avoided[6]. The fetus should also be monitored closely as there are documented risks of cardiovascular compromise in face presentation[11].

As labour progresses, fundal pressure and amniotic fluid descent lead to fetal descent and hyperextension of the neck. The most important determinant of labour outcome is internal rotation, as mentum posterior presentations via vaginal delivery are difficult and almost impossible in some cases. Mentum anterior rotations however occur in some mentum posterior cases and result in continuous descent through the vaginal canal. The fetal mentum exerts pressure on the maternal symphysis pubis, leading to head delivery through flexion. The occiput faces the maternal back, followed by an external rotation. The shoulders are delivered just like in a vertex delivery[6].

The incidence of fetal complications following face deliveries has decreased due to caesarean sections, but are still present in some cases. The position of the fetal head makes engagement in the birth canal more difficult, often resulting in prolonged labour. This extended duration can trigger fetal distress and arrhythmias. If labour stalls or fetal distress is detected on CTG, an emergency cesarean section is necessary, which carries its own set of operative and post-operative risks. Additionally, prolonged labour and fetal position can cause significant neonatal face and skull oedema, potentially leading to swelling of the airway and respiratory distress after birth, which may require intubation[6].

CONCLUSION

Face presentation is a rare but important condition that poses unique challenges during childbirth. While some cases allow for a successful vaginal delivery, others, particularly those with mentum posterior or transverse positions, often require a caesarean section for maternal and fetal safety. It is crucial for healthcare providers to be aware of the various risk factors that can contribute to this situation and to ensure early diagnosis and appropriate interventions.

Open communication and counselling with the mother about the potential risks and options are vital. This not only helps her make informed decisions but also provides emotional support during what can be a stressful time. Continuous monitoring throughout labour is essential to address any signs of fetal distress swiftly. By prioritising understanding and compassionate care, we can improve outcomes and ensure a safer birthing experience for mothers and their newborns.

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