PIPADOR REVISION

MRCOG Part 1 Revision Notes

Unstable Lie

CLINICAL MANAGEMENT • LECTURE 474

VISUAL EXAMINATION REVISION NOTES

2026 Edition

474

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Unstable Lie

Definitions, causes, assessment and management of unstable and transverse lie, including cord prolapse

≥ 37 wk	Cord prolapse	Praevia	Stabilising IOL
Changing lie	Main risk	Must exclude	Option

■ KEY FACTS: Learning objectives

- Define unstable, transverse and oblique lie.
- Describe causes, risks and assessment.
- Describe management options including admission, ECV, stabilising induction and caesarean section, and management of cord prolapse.

474.1 Key definitions

Term	Definition
Lie	Relationship of the long axis of the fetus to the long axis of the uterus: longitudinal, transverse or oblique
Unstable lie	Frequently changing fetal lie and presentation beyond 37 weeks (some use 36 weeks)
Transverse lie	Fetal long axis perpendicular to the uterine axis — shoulder/arm may present
Oblique lie	Fetal axis at an angle — head or breech in an iliac fossa
Stabilising induction	Correction of lie (ECV) followed by controlled artificial rupture of membranes and oxytocin, usually in theatre
Cord prolapse	Descent of the umbilical cord through the cervix alongside or past the presenting part after membrane rupture

■ IN PLAIN ENGLISH: Unstable lie

A baby that keeps changing position near term has **nothing fixed in the pelvis** — if the waters break, the **cord can slip out first**. Management focuses on finding a cause and planning a safe birth.

474.2 Causes and risks

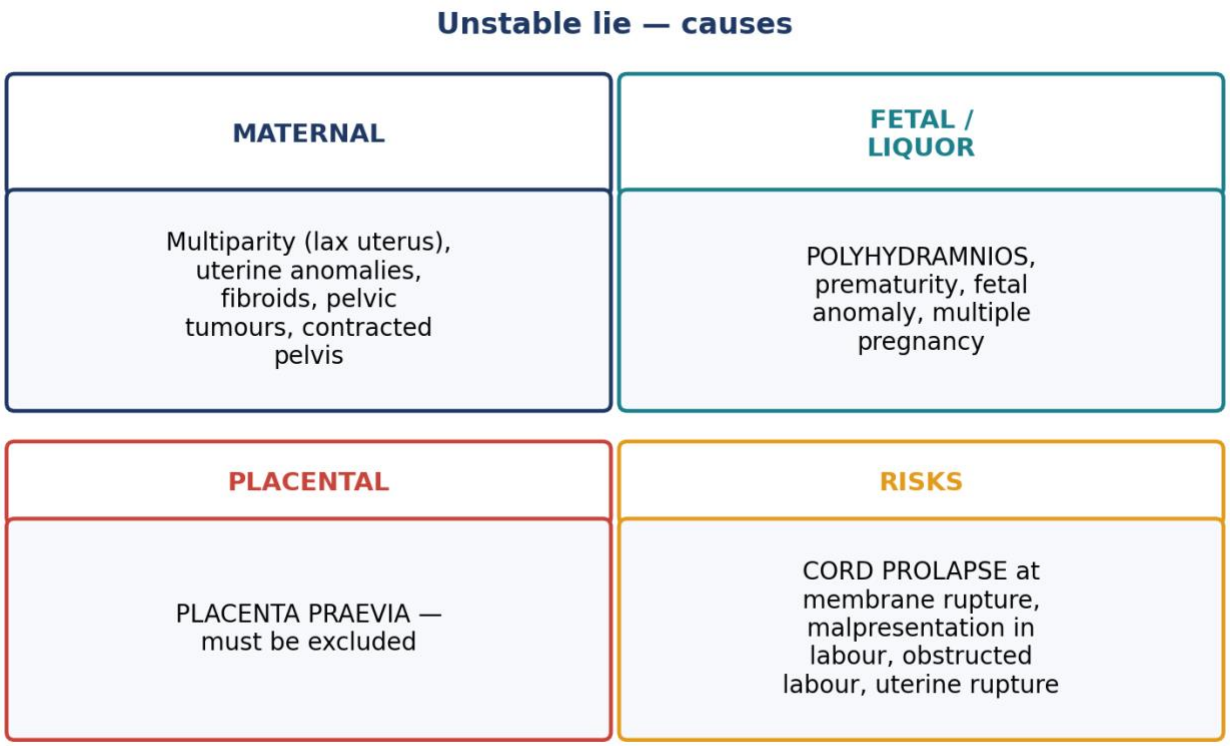


Figure 474.1 — Causes and risks of unstable lie

474.3 Management

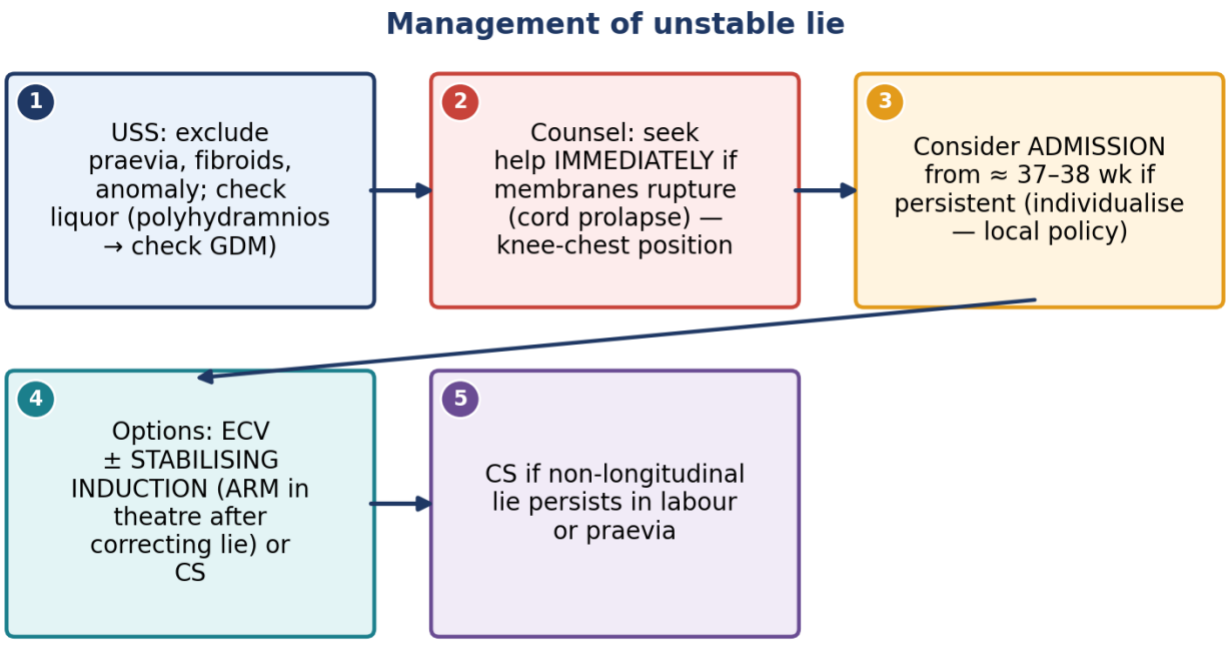


Figure 474.2 — Management of unstable lie

Option	Details
Investigation	USS: placental site (praevia), fibroids, uterine anomaly, fetal anomaly, liquor (polyhydramnios → GDM testing)
Expectant	• Many stabilise by 37–38 weeks

Option	Details
	• Advise to attend immediately with SROM/contractions
Admission	• Consider from ≈ 37–38 weeks if lie remains unstable (immediate access to theatre if SROM) — individualised • Outpatient care may be appropriate for some
ECV	Can be attempted for transverse/oblique lie (unless contraindicated)
Stabilising induction	At ≈ 39 weeks: correct lie, controlled ARM in theatre with oxytocin, ready for CS
Caesarean section	• Persistent non-longitudinal lie at term or in labour, praevia, failed stabilisation • Transverse lower-segment or classical incision may be needed (back-down transverse lie)

474.4 Cord prolapse (RCOG GTG 50)

- Diagnosis: cord felt or seen below/beside the presenting part; FHR bradycardia/variable decelerations after SROM.
- Actions: call for help
  - Avoid handling the cord
  - **Elevate the presenting part** (manually or by filling the bladder with 500–750 mL saline), knee-chest or left lateral head-down position
  - Tocolysis (terbutaline) if delay.
- Birth: **category 1 CS** (decision-to-birth target ≤ 30 min) unless vaginal birth is imminent and quicker (instrumental).
- Prevention: avoid ARM with a high/unstable presenting part; controlled ARM only when indicated.

■ COMMON PITFALLS

Performing ARM with an unstable/high presenting part outside theatre.

Missing placenta praevia as the cause.

Not advising the woman what to do if waters break.

474.5 Must-know summary

■ EXAM TIP

- Unstable lie = changing lie beyond 37 wk; transverse/oblique lie = non-longitudinal.
- Causes: multiparity, polyhydramnios, praevia, fibroids, uterine/fetal anomalies, prematurity.
- Main risk: cord prolapse — advise immediate attendance; consider admission from 37–38 wk.
- Options: ECV, stabilising induction (ARM in theatre) or CS; cord prolapse → elevate presenting part, category 1 CS.

■ MNEMONIC / MEMORY AID

Causes — 'Placenta, Polyhydramnios, Parity, Pelvic masses, Prematurity'.