Clinical Practice Guideline Abdominal Palpation in Pregnancy

Peninsula Care Goal Safe

Target Audience
Registered Midwife, Doctor, Student Midwife or Student Doctor under the direct supervision of a registered midwife or obstetric doctor

Purpose
Inspection, palpation and auscultation are the fundamentals to the abdominal examination. It allows the practitioner to determine the appearance, fundal height, lie, presentation, position and attitude of the fetus. It also determines the descent of the presenting part, fetal heart rate and any abnormalities.

Routine measurement of Symphyseal Fundal Height (SFH) is recommended for pregnant women from 24 weeks gestation to assess fetal growth and wellbeing. Symphyseal fundal height has a wide variation in predicting accuracy of fundal height measurement for small for gestational age babies however deviations of growth trajectory in SFH measurement should be a trigger for further investigations into fetal wellbeing.
Maternal obesity, abnormal fetal lie, large fibroids, polyhydramnios can contribute to limited predictive accuracy of fetal growth and wellbeing, in these cases additional surveillance is warranted[1].

Indications
- Abdominal assessment (including SFH measurement from 24 weeks gestation) is recommended as part of the assessment for any woman that presents for outpatient or inpatient care in pregnancy,
- Palpation should be part of the daily assessment of antenatal. It should also be performed if the clinical status of antenatal women deteriorates in any way during their admission.

Precautions/Contradictions
- History of ante partum haemorrhage
- Severe (acute) abdominal pain

If necessary, perform a **GENTLE** palpation.
Palpation should only occur with the woman's verbal consent, following explanation of the procedure.
Palpation should only occur when appropriate privacy is ensured and the woman has given permission for other individuals (including visitors, family, clinicians and students) to be present.

Requirements
- Sonicaid to identify the fetal heart rate.
- Aqueous gel
- Tape measure
- Tissues

Guideline
- Ensure privacy
- Explain the procedure to woman
- Woman should be encouraged to empty bladder prior to the procedure
- Perform hand hygiene

Inspection- noting

- Review medical record noting any history of uterine abnormality (e.g.bicornuate uterus), uterine fibroids or multiple pregnancy
- The size and shape of the abdomen
- Contour of the abdominal walls
- Skin changes- e.g. striae gravidarum
- Presence of scars
- Muscle tone
- Fetal movements

Palpation- To be performed gently with warm hands, and during labour, not during a contraction.

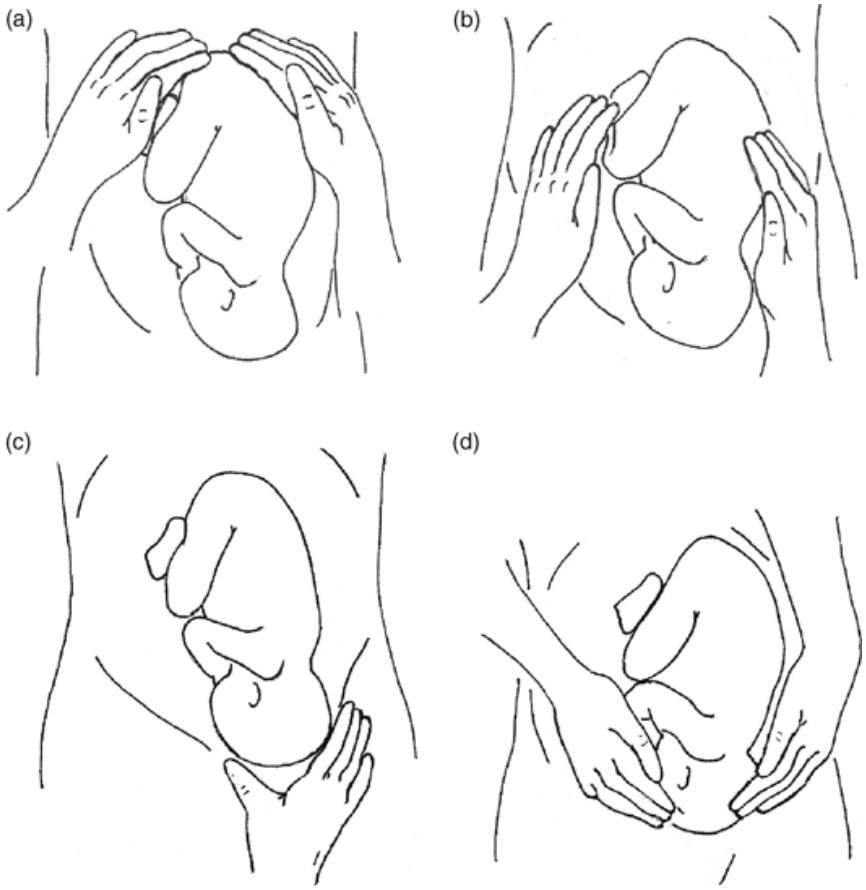
- Fundal height measurement from 24 weeks gestation
    - A consistent approach to measurement increases accuracy between clinicians improves accuracy.
        - Palpate the fundus to identify the upper limit (note that due to fetal lie this may not be centre of the abdomen)
        - Use the tape measure with the cm marks on the underside of the tape
        - Secure the tape at the top of the fundus with one hand
        - Measure from the top of the fundus to the top of the pubic symphysis
        - The tape measure should stay in contact with the skin.
        - Note the measurement. Do not repeat the measurement.
        - Document the fundal height on the Birthing Outcome System
        - Review the SFH growth chart for consistency of trajectory
        - Escalate to a senior clinician if there is a deviation in the growth trajectory of the SFH.
    - Late onset fetal growth restriction is a leading cause of stillbirth at term. Any variation in growth trajectory should trigger investigations for fetal wellbeing. Growth scans for estimated fetal weight are of little value from 36 weeks gestation. Fetal Umbilical Artery Doppler, Amniotic Fluid Index, and clinical assessment along with maternal perception of fetal growth and movements should provide the rationale for shared decision making about timing of birth.
    - If the fundal height is >2cm below expected but the ultrasound shows normal growth, an obstetric opinion is advised to assess the need for follow up imaging.

To perform the preferred technique for consistency at Peninsula Health Stillbirth review the CRE Safer Baby Bundle SFH video https://vimeo.com/711466835/e8df8f1ae9

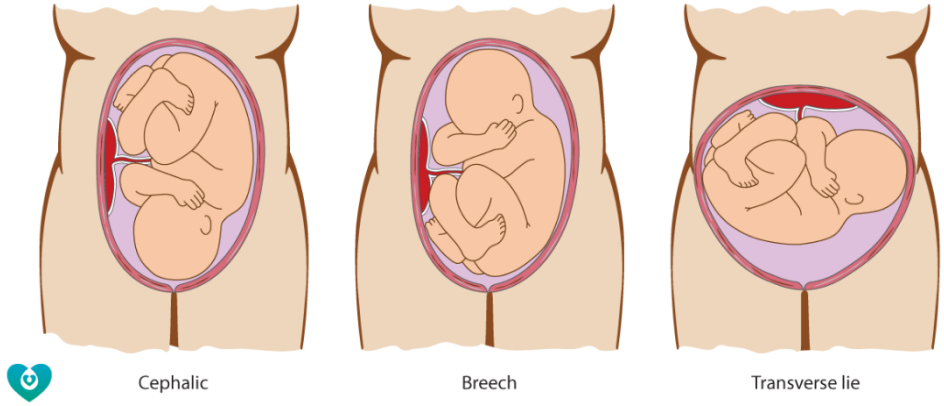
Palpation

a) Fundal palpation- to locate the upper pole of the fetus and note if cephalic or breech
b) Lateral palpation- to locate the fetal back, anterior shoulder and limbs
c) Pawlick's grip- to assess the presentation and engagement. This can be tender and some warning is appropriate. More relevant from 36/40 onwards.
d) Deep pelvic palpation (not performed if presenting part high and mobile or if known placenta praevia) - to assess the degree of mobility and flexion of the presenting part and the amount of presenting part above the brim of the pelvis. The clinician is turned facing the women's feet with the flats of the hands used to press into the suprapubic area. Again, this can be tender and may not be relevant before 36/40 [4].

Leopold's Manoeuvres [4]



- Fetal Lie - defined as the relationship between the long axis of the fetus and the long axis of the uterus
  - Most cases the fetal lie is longitudinal with the ovoid uterus
  - Oblique lie where the fetus lies diagonally across the long axis of the uterus
  - Transverse lie - where the fetus lies at right angles across the long axis of the uterus[2]



- Fetal Position - is the relationship between the denominator of the presentation (occiput in cephalic presentation, sacrum in breech presentation and mentum in face presentation) and the six points of the pelvic brim.
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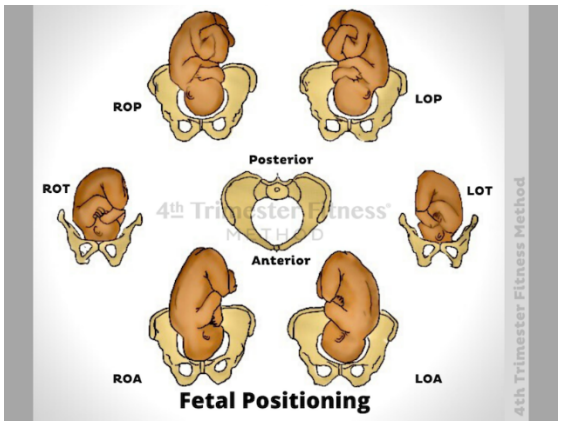

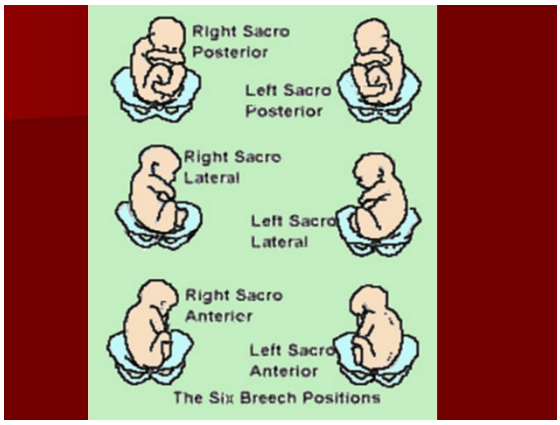

- Fetal engagement - occurs when the widest presenting diameter of the fetal head has passed through the brim of the pelvis.[2] Measured in fifths above the brim. Usually occurs from 36 weeks in a primigravid woman and may not occur until labour in a multigravid woman.
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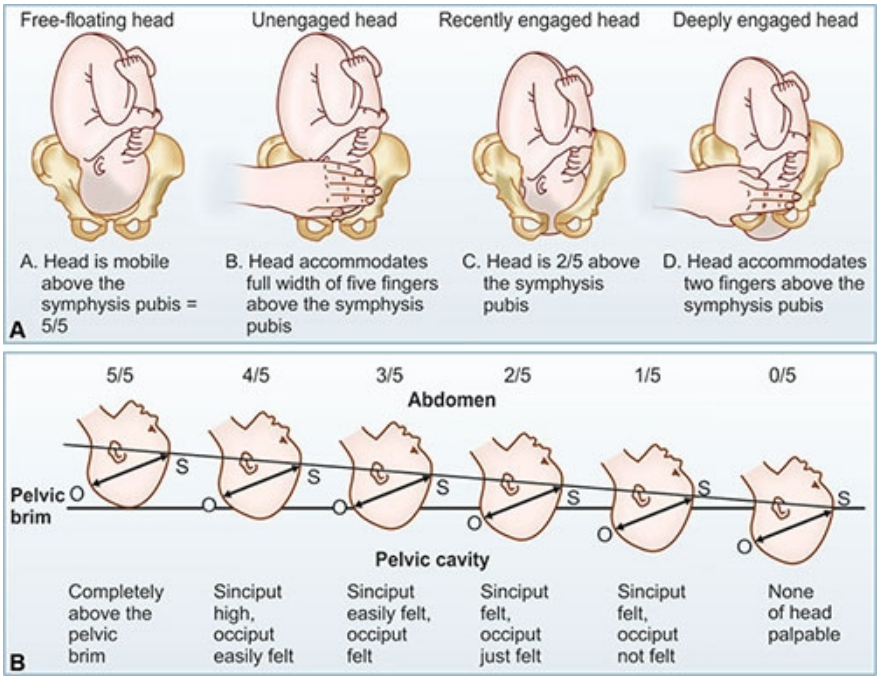

- Amniotic Fluid Estimation
  - Palpation suspicious of oligohydramnios may include uterus smaller than dates, compact and fetal parts may be easily palpated.
    - Associated with placental insufficiency, fetal renal abnormality, pre-labour rupture of membranes[3]
  - Palpation suspicious of polyhydramnios may include uterus larger than dates, stretched and shiny skin, uterus tense and difficult to palpate fetal parts.

- Associated with oesophageal duodenal atresia, multiple pregnancy, open neural tube defect, diabetes mellitus, anencephaly[3]

Auscultation
- Identify maternal pulse
- Locate the fetal heart. Note the rate, rhythm, character and location
- For twins, visualisation of two separate fetal heart beats with a portable ultrasound is recommended

Documentation
- Record the findings on all appropriate charts. Review previous growth trajectory and findings, Escalate any abnormal findings.

Key Aligned Documents
- Routine Pregnancy Care
- Labour and Birth Care
- Antepartum Haemorrhage (APH)
- Vaginal Breech Birth
- Twin Pregnancy (Antenatal and Intrapartum Care)
- Peninsula Care Clinical Governance Framework

Evaluation
Regular document revision and review of relevant VHIMS/RiskMan Reports

References

[1] Australian Government Clinical Practice Guidelines. Pregnancy Care. 2020 https://www.health.gov.au/resources/pregnancy-care-guidelines

[2] Myles Textbook for Midwives [16th edition] https://dokumen.pub/myles-textbook-for-midwives-16nbsped-978-0702051456.html Accessed 27/01/2023

[3] Abdominal Palpation. King Edward Memorial Hospital Clinical Practice Guideline https://www.kemh.health.wa.gov.au/~/media/HSPs/NMHS/Hospitals/WNHS/Documents/Clinical-guidelines/Obs-Gyn-Guidelines/Abdominal-Examination.pdf?thn=0 Accessed 27/1/2023

[4] Christian Gerhard Leopold (1894) Die Leitung der regelmäßigen Geburt nur durch äußere Untersuchung. Arch Gynäkol 45: 337–368

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