DIAGNOSIS OF PELVIC OUTLET.

1. History

- Medical history of rickets, tuberculosis, fractures, poliomyelitis
- Previous vaginal delivery of average sized baby in good condition excludes a contracted pelvis.
- Previous difficult vaginal delivery
  - difficult instrumental delivery
  - birth asphyxia
  - still birth

then possibility of ~~contraction of~~ CPD → cephalopelvic disproportion

2. General Examination

A contracted pelvis should be suspected in the presence of short stature, abnormal waddling gait, pendulous abdomen and deformities of the limbs or spine.
Women with small pelvis are in general short.

3 Abdominal Examination.

A mobile head in a nullipara at term should raise the suspicion of CPD, although the most common cause is in occipito posterior position.

4. Pelvic assessment or clinical pelvimetry.

pelvis assessed by vaginal examination

[internal pelvimetry
External pelvimetry.

techniques:

- pelvic brim measured. (dist. b/w iliopectineal lines ∟ estimate pelvic inlet).
- Sacral prominence measured. (~~dist b/~~ size of mid pelvis.
- Ischial spine measured. (dist b/w ischial spines. ∟ estimate pelvic outlet).
- Finger breadth measured.]

5. Assessment of CPD.

* Munro Kerr - Mullers method.
* Head fitting test by Mullers & Hillis.

In clinical practice, the fetal head is the best pelvimeter.
relative size of fetal head to pelvis more imp than absolute size of pelvis.

- only helpful in active labour.
- only disproportion at brim can be detected
- Not useful to detect midpelvic or outlet contraction.

Munro Kerr - Mullis method

→ bimanual method
→ patient is in modified dorsal position, legs flexed, bladder and bowels empty
→ left hand over abdomen pushes head to pelvis
other ~~toes~~ had inserted vaginally estimate whether vertex reaches level of ischial spines
→ best done at onset of labour
→ only assess disproportion of inlet
→ if head can be pushed down at ~~but~~ to level of spines, there is no disproportion.
→ if head can be pushed down a little but not upto spines and the thumb of right hand is flush with symphysis pubis, there may be moderate degree of CPD.
→ if head cannot be pushed down at all and parietal bone across the symphysis pubis as detected by thumb of right hand - minor degree of CPD

Muellis - Millis head fitting test

→ semi recumbent position
45° tilt
legs semiflexed at thigh & knee.
→ Obstetrician grasps fetal head with fingers of left hand at pushes it downwards and backwards into the pelvis.
Smooth - no CPD
if head flush or overrides pubic bone - CPD present.

points to be noted.
Outlet - subpubic angle
subpubic arch.
Transverse diameter.

6) Radiopelvimetry and MRI

gives a precise assessment of pelvic measurements
not done in practice because pelvic capacity is only one of the factors that determine a successful outcome of labour
if employed a single exact lateral film is taken

MRI - no radiation exposure but not popular.

7) Pointers towards CPD in labour -

→ prolonged labour despite augmentation with oxytocin
→ Head remaining high at full dilatation
→ Cervix loosely applied to the head
→ Excessive caput or irreducible mouldity of the fetal head