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**Literature search results**

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**Search details**

Unstable lie of the foetus in pregnancy and labour. External version, malpresentation, stabilisation and induction of labour.

**Resources searched**

NHS Evidence; TRIP Database; Cochrane Library; CINAHL; EMBASE; MEDLINE; Google Scholar;

*Database search terms*: (unstable ADJ3 (lie* OR lying OR orient*)), "unstable lie", (unstable ADJ6 lie)

*Evidence search string(s)*: “unstable lie”

*Google search string(s)*: “unstable lie”

**Summary**

There is very little published research concerning unstable lie in pregnancy. Please see below for the results that I found from CINAHL, EMBASE and Medline databases.

**Guidelines and Policy**

**RCOG**

*Umbilical cord prolapse*, 2008

From p. 3

With transverse, oblique or unstable lie, elective admission to hospital after 37+6 weeks of gestation should be discussed and women should be advised to present quickly if there are signs of labour or suspicion of membrane rupture.
External cephalic version and reducing the incidence of breech presentation, 2006
From p. 4
With an unstable lie, ECV is only logical in the context of a stabilising induction. There are few available data on this procedure, which should only be performed for a valid indication and may be associated with a significant intrapartum complication rate.

Evidence-based reviews
Nothing found

Published research – Databases

1. Large desmoid tumour causing unstable lie in pregnancy.
   **Author(s)** Kumar R, Lynch P
   **Citation:** Journal of Obstetrics & Gynaecology, May 2012, vol./is. 32/4(395-6), 0144-3615;1364-6893 (2012 May)
   **Publication Date:** May 2012
   **Source:** Medline
   Available in fulltext from Journal of Obstetrics & Gynaecology at EBSCOhost

   **Author(s)** Sharma JB
   **Citation:** Archives of Gynecology & Obstetrics, April 2009, vol./is. 279/4(481-7), 0932-0067;1432-0711 (2009 Apr)
   **Publication Date:** April 2009
   **Abstract:** OBJECTIVE: To evaluate new maneuvers developed by the author for fetal palpation in late pregnancy and comparing them with traditional Leopold's maneuvers.METHODS: A total of 224 women with term pregnancy who underwent abdominal palpation by Sharma’s modified Leopold's maneuvers developed by author using fingers, hands and forehand for better palpation were evaluated and compared with Leopold's Maneuver.RESULTS: The mean age was 24.5 years, mean parity 2.2, mean gestation 38.2 weeks. Sharma's modified Leopold's pelvic maneuver could correctly diagnose occipito-anterior position in 95.0% cases as compared to 84.4% by Leopold's maneuvers (P=0.04), while it could correctly diagnose occipito-posterior position in 96.3% cases as compared to 66.6% by Leopold's maneuvers (P=0.0012). In breech presentation also Sharma's modified Leopold's fundal maneuver could correctly diagnose presentation in all cases as compared to 92.9% by Leopold's maneuvers. While in a transverse and oblique lie, Sharma's right and left lateral maneuvers could correctly diagnose presentation as well as position of acromion in all cases (100%).CONCLUSION: The new maneuvers for fetal palpation appear to be very simple and accurate method for making out fetal presentation and position in late pregnancy.
   **Source:** Medline
   Available in fulltext from Archives of Gynecology & Obstetrics at EBSCOhost

3. Turning breech babies after 34 weeks: a review.
   **Author(s)** Cohain JS
   **Citation:** MIDIRS Midwifery Digest, 01 September 2007, vol./is. 17/3(373-375), 09615555
   **Publication Date:** 01 September 2007
   **Abstract:** Accurate identification of the presentation of the fetus as term approaches is very important for the management and outcome of the birth. Using the term 'unstable lie' might be seen as a baseless excuse for inducing labour after the baby turns from breech to head down, reflecting a lack of understanding of
gravity and the physiological limits of fetal mobility. There are a range of techniques for turning a term breech baby. These include: external cephalic version (ECV) using hands and ultrasound only, acupuncture point stimulation by needle or moxibustion, chiropractic 'Webster' technique, hypnotherapy, and 'special exercises'. Fifty to sixty percent of fetuses in the breech position at 34 weeks will turn to a cephalic presentation by themselves by 38 weeks. Therefore, to be considered effective, a technique for turning the breech at 34 or 35 weeks must turn the baby and keep it in the required position more than 60% of the time. Only ECV with an experienced practitioner has been documented to have a greater than 50% average success rate at 37 weeks. During ECV, women can experience the fetus turning by hand as quick but very painful. Other techniques have not been reported with the same effectiveness and require more time investment.

Source: CINAHL
Available in print at Lincoln County Hospital Professional Library

Author(s) Sullivan CA, Harkins D, Seago DP, Roberts WE, Morrison JC
Citation: Southern Medical Journal, February 1998, vol./is. 91/2(155-8), 0038-4348;0038-4348 (1998 Feb)
Publication Date: February 1998
Abstract: BACKGROUND: The incidence of second twin delivery by cesarean section and whether obstetric parameters are predictive should be studied. METHODS: In this retrospective study, all vertex-vertex twin deliveries during a 48-month period were reviewed. RESULTS: During the study period, 106 sets of vertex-vertex twins were identified. In 68 pairs, both were delivered vaginally (group 1), and 21 pairs were born via cesarean section. In the 17 pairs in group 2, the first infant was delivered vaginally and the second by cesarean section because of fetal distress in 6 cases (35%), cord prolapse in 6 (35%), abnormal/unstable lie in 4 (23%), and abruptio placenta in 1 case (6%). The only maternal factor associated with abdominal delivery for twin B was greater maternal age. When cesarean delivery was required for twin B, a longer interval between deliveries and a lower Apgar score were noted. CONCLUSION: Cesarean birth of twin B is a more common clinical event than previously reported but is not easily predicted by obstetric parameters.
Source: Medline
Available in fulltext from Southern Medical Journal at EBSCOhost

5. Obstetric behavior and ultrasonic uterine characteristics of oligomenorrheic women.
Author(s) Stampe Sorensen S, Lenz S, Karlsen J
Citation: Acta Obstetricia et Gynecologica Scandinavica, 1988, vol./is. 67/5(447-53), 0001-6349;0001-6349 (1988)
Publication Date: 1988
Abstract: Two groups of age-, parity-, and pregnancy-matched women, viz. 78 with oligomenorrhea (A) and 78 with normal menstrual intervals (B), plus all women with regular menstruation but in whom severe Mullerian malformations had been diagnosed during the same period (C) were followed in a prospective study to detect complications, sonographic changes, and the serum oxytocinase concentration during pregnancy and labor. Among the matched groups A and B, ultrasonic scanning revealed uterine changes in 45% and 9%, respectively (p less than 0.0005) during the 2nd trimester. Among the oligomenorrheic women who had HSG, fairly mild Mullerian malformations were found in 40%. The sonographic method in these mild and moderate anomalies had its limitations, and the findings were interpreted in several cases as fibroma or contractions. Complications occurred in 51% of the group A women who carried their pregnancies to term versus 20% in group B (p less than 0.0005). Among the primiparae the
complication rates were 47% and 22%, respectively (p less than 0.025). Bleeding in early pregnancy (25%), an unstable fetal lie (28%), malpresentations (14%), and premature contractions or delivery (11%) were more common in group A (p less than 0.05-0.01). On stratification of the oligomenorrheic group without or with Mullerian anomalies (A1 and A2) the overall complication rates were 55% and 73%, respectively, and 86% in group C. Mutually, these differences are not statistically different, but all differ significantly from the control group (B) (p less than 0.005).(ABSTRACT TRUNCATED AT 250 WORDS)

Source: Medline

6. Obstetric problems in the grand multipara: A clinical study of 1330 cases
Author(s) Al-Sibai M.H., Rahman M.S., Rahman J.
Citation: Journal of Obstetrics and Gynaecology, 1987, vol./is. 8/2(135-138), 0144-3615 (1987)
Publication Date: 1987
Abstract: In a retrospective survey of 1330 women who had seven or more viable pregnancies, a higher incidence of anaemia, pregnancy induced hypertension, diabetes mellitus, breech delivery, unstable lie, antepartum and postpartum haemorrhage were found. The perinatal mortality rate (62/1000 deliveries) in the series was three times that of the hospital obstetric population. Stillbirths accounted for two-thirds of the perinatal deaths. Caesarean section was performed in 11.4 per cent of the deliveries. The maternal mortality rate of 0.075/1000 was four times the overall incidence in the hospital. Grand multiparity continues to be a high risk factor in obstetrics.
Source: EMBASE

7. The obstetric performance of the grand multipara.
Author(s) Chang A, Larkin P, Esler EJ, Condie R, Morrison J
Citation: Medical Journal of Australia, March 1977, vol./is. 1/10(330-2), 0025-729X;0025-729X (1977 Mar 5)
Publication Date: March 1977
Abstract: The computerized records of all women delivered between July, 1974, and June, 1975, at the Mater Mothers' Hospital were analysed, and the obstetric complications associated with grand multiparity were examined. Hypertension, preeclampsia, unstable lie, malpresentation and retained placenta are found to be more common in women of high parity. The low morbidity associated with these conditions in the data may have been related to the close supervision and active management carried out. Anaemia remained more frequent in the grand multiparous women despite modern antenatal care. Hypertension in the grand multiparous women could not be explained by age in the data presented. The cause for hypertension in this group of women remains obscure. Newborn babies of grand multiparas developed neonatal jaundice more frequently. The association between jaundice and oxytocic usage in the data only partially accounted for this observation.
Source: Medline

8. Constriction ring dystocia.
Author(s) Kaye CH
Citation: Canadian Medical Association Journal, March 1974, vol./is. 110/5(535-8), 0008-4409;0008-4409 (1974 Mar 2)
Publication Date: March 1974
Abstract: A case of constriction ring dystocia in a 40-year-old multiparous white woman is described. She was postmature; the fetus occupied an unstable lie for which no cause could be demonstrated clinically or radiologically; during the course of an inert labour every third fetal heart sound was abnormal. At cesarean section it appeared that no lower uterine segment had formed and extreme thickness of the myometrium was encountered.
Author(s) Banjoko MO
Citation: Nigerian Medical Journal, January 1973, vol./is. 3/1(34-6), 0300-1652;0300-1652 (1973 Jan)
Publication Date: January 1973
Source: Medline

10. Induction of the unstable lie by amniocentesis.
Author(s) Ward GD
Citation: Journal of Obstetrics & Gynaecology of the British Commonwealth, September 1971, vol./is. 78/9(828-9), 0022-3204;0022-3204 (1971 Sep)
Publication Date: September 1971
Source: Medline

11. The management of the unstable lie in late pregnancy.
Author(s) Edwards RL, Nicholson HO
Citation: Journal of Obstetrics & Gynaecology of the British Commonwealth, August 1969, vol./is. 76/8(713-8), 0022-3204;0022-3204 (1969 Aug)
Publication Date: August 1969
Source: Medline

12. Unstable lie in pregnancy and in labour.
Author(s) Bancroft-Livingston G, Gordon H
Citation: Postgraduate Medical Journal, February 1967, vol./is. 43/496(92-6), 0032-5473;0032-5473 (1967 Feb)
Publication Date: February 1967
Source: Medline
Available in fulltext from Postgraduate Medical Journal at National Library of Medicine
Available in fulltext from Postgraduate medical journal at Highwire Press

13. AETIOLOGY AND TREATMENT OF THE OBLIQUE, TRANSVERSE AND UNSTABLE LIE OF THE FOETUS WITH PARTICULAR REFERENCE TO ANTENATAL CARE.
Author(s) MACGREGOR WG
Citation: Journal of Obstetrics & Gynaecology of the British Commonwealth, April 1964, vol./is. 71/(237-44), 0022-3204;0022-3204 (1964 Apr)
Publication Date: April 1964
Source: Medline