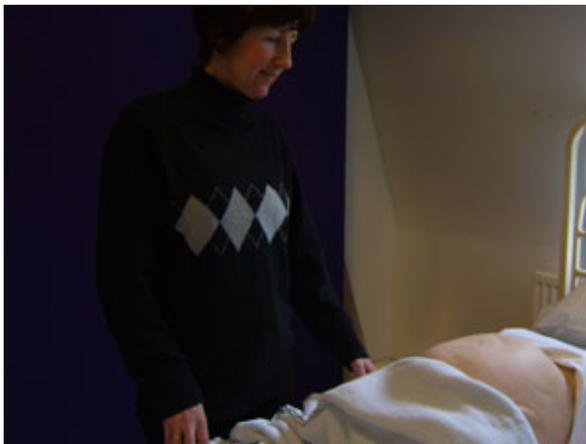


# Abdominal examination

The abdominal examination consists of:

- 1 - Preparation for this
- 2 - Inspection
- 3 - Fundal palpation,
- 4 - Lateral palpation
- 5 - Pelvic palpation
- 6 - Auscultation
- 7 - Documentation and decision making



## Preparation

It is important to carry out the usual essential care skills such as:  
Introduce yourself to the woman  
Consult the antenatal notes  
Determine the level of risk and the maternity care needs of the woman  
Respect hygiene measures and the privacy of the woman.



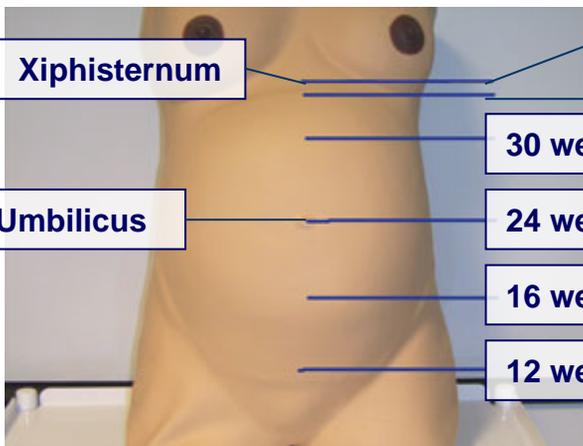
## Inspection

The woman's abdomen is inspected for its shape. This can indicate size and lie of the fetus, the amount of amniotic fluid and sometimes fetal movement may be noticed. Obvious scars will be seen and this information may be significant.



## Fundal height

Fundal height is measured to estimate whether this is in keeping with the expected date of birth. This can be done using landmarks i.e. xiphisternum, where the fundal height can be measured by fingerbreadths in relation to this, and the period of gestation is calculated.



36 weeks

## Fundal height

40 weeks

Xiphisternum

30 weeks

Umbilicus

24 weeks

16 weeks

12 weeks



## Fundal palpation

Using the flat interior of the tips of the middle fingers of both hands the fundus is palpated to identify the fetal pole (cephalic or breech). If no pole is located the lie is not longitudinal.



## Fundal palpation

Fundal palpation is carried out to find out the lie and presentation of the fetus. Things which influence the fundal height are: maternal parity, size, full bladder, the lie and the number of fetusses. To determine what is found in the fundus a hand is placed on the abdomen below the xiphisternum and gently moved downwards until the fundus is felt.



Alternatively a measuring tape is used keeping the graduated side downwards so as not to influence the reader.



The antenatal notes are that consulted to see if the growth is normal.



## Lateral palpation

Lateral palpation assesses the main body of the uterus to confirm the lie and identify the fetal position. The fetal back is usually firmer and more regular in form than the other side of the fetus i.e. the abdomen and the limbs. One hand is placed on one side of the uterus to apply pressure, whilst the other attempts, using the flats of the fingertips, to identify what is found in the opposite side.



For example: images on the left demonstrate the practitioner applying pressure, using the left hand, then progressing down the length of the uterus with the right.



# Abdominal examination



## Lateral palpation

The same manoeuvres are then carried out on the other side of the uterus, that is the right hand held firmly on the mothers left side of the uterus and the flats of the insides of the fingertips identify the shape and form of the right side of the uterus.

See images on the left.

Lateral palpation also provides insight into the size of the fetus, the tone of the uterus, amniotic fluid volume and also whether fetal movements are present.



## Pelvic palpation

Pelvic palpation is used to identify the presentation, that is the part of the fetus lying in the lower pole of the uterus, over the pelvic brim. It can be determined whether:

- the fetus is flexed or extended
- the presenting part is engaged or not
- the presenting part is mobile (ballotable), or engaging

To carry out pelvic palpation both hands are used. One hand is placed on either side of the presentation and pressure is applied. The presentation can be felt. It may help if the woman takes a deep breath and blows out.

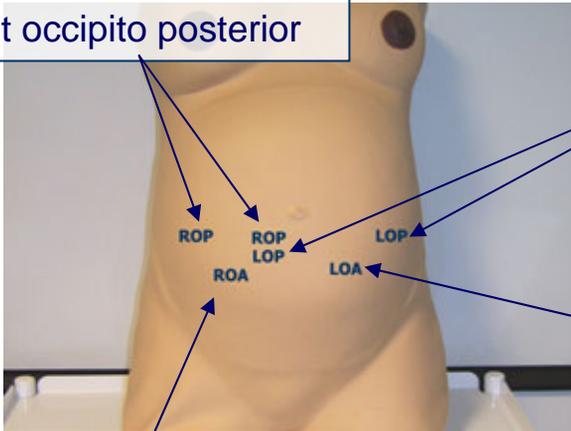
Engagement of the presentation is assessed according to the passage of the widest diameter of the presenting part through the pelvic brim.



## Auscultation

Locating the fetal presentation and lie will be helpful to show where to place the stethoscope to listen to the fetal heart. The approximate points of fetal heart sounds are shown on the image below.

right occipito posterior



left occipito posterior

left occipito anterior

right occipito anterior

The fetal heart is assessed for its presence, its rate and its regularity. The normal heart rate is between 110 & 150 beats per minute. This is easy to distinguish from the maternal heart rate, which must also be assessed to determine that the fetal heart is actually being listened to.

Following the procedure the findings are discussed with the mother and documentation and follow up carried out as appropriate.



## Records

Records of the abdominal examination should include the following features: the fundal height, the lie, presentation and degree of engagement, the position (if identified), the fetal heart rate and whether fetal movements are felt.

## Abdominal examination during pregnancy

Abdominal examination provides the woman with information that pregnancy is progressing well. She can be reassured regarding fetal growth and fetal wellbeing. Other examinations and tests are used in conjunction with the abdominal examination, for example ultrasonic scan.

## Abdominal examination during labour

Abdominal examination can be undertaken to assess progress and to help make decisions regarding the care required by the woman during labour. This examination is used with other information for example: input from the woman findings from vaginal examination and other maternal and fetal information (blood tests, scans, other information gathered).

Reasons for carrying out abdominal examination in labour are to determine the gestational age, the lie, the position, presentation and engagement of the fetal head and to listen to the fetal heart. The progress of labour is assessed as is descent and rotation of the presenting part.

Abdominal examination is always carried out prior to auscultation and before fetal monitoring (CTG). It is also done before performing the vaginal examination.

It is important to carry out abdominal examination between multiple births, for example, after the first twin and the first and second triplet. This helps in the appropriate management and decision making of these more complex birthing situations.

Author: Adela Hamilton, Senior Lecturer in Midwifery