

Opening the Pelvic Brim with Walcher's Position

by Gail Tully

This past year, two labors I attended benefited (meaning we avoided a cesarean each time) from a technique shared over 100 years ago by Dr. Walcher. The first of these mothers labored for her third homebirth after four previous cesareans. She'd had a hard time getting her first baby into her pelvis (lying in bed) and was given a c-section at 3 cm and three more cesareans after the first. Umm hmm. So, I was honored to help at her first homebirth, her fifth child. He also took a long time to engage; beginning posterior, a variety of positions eventually got him through. Her second homebirth occurred after a long latent phase—but before her midwife arrived.

Helping her again with her seventh baby, after many hours in labor and several techniques, she began to say that the baby she was carrying might have to come by cesarean. Concerned, I asked if I might do an internal exam. After all her work, she was at 2 cm, and no wonder. I could barely reach the baby's head—if it even was the head, I thought. There was so little to feel I couldn't be sure if it was parietal bone, brow or even an arm crossing the anterior brim of the pelvis. Hmm. But none of these possible baby parts were even in the pelvis! Externally, I reassured myself; the head centered above the brim. (The internal shape was so like a rectangle!) The baby was waiting to get into the pelvis but not able to, in spite of the strong contractions. The mother's pelvic inlet was at a steeper angle than usual, altering the angle that the baby needed to enter the pelvis.

I said, "You're doing everything so well; you're relaxing well; you're moving instinctively. Your baby's head, though, is on the pubic bone and needs a little help to get into the pelvis. These contractions are strong because your uterus is trying to aim the baby into your pelvis. There is a technique you can do...It's not comfortable, but it often works in three contractions. It should bring the head into the pelvis and with the head in the pelvis you'll begin dilating and the baby will come down."

I modulated my voice to be calming, open and gently positive. Not really a promise, but very confident. After all, I was about to ask her to get into a really challenging position. I'd better sound like I knew what I was doing!

Walcher's position, also called the Trochanter Roll, opens the anterior-posterior (AP/front to back) diameter of the brim to its largest potential. (See Illustration 1.) There may be some flattening of the sacrum, moving the sacral promontory out of the way, but I don't know of any radiologic studies on this position. The mother lays on her back either with her legs entirely hanging off the high bed, feet in the air, or she lies over a large firm roll under her trochanters (those large knobs at the head of the femurs). The trochanters are found just below the hip joint. This is at the top of the thigh (not the sacrum) and is just below the horizontal crease of the south end of the buttocks. Twelve to fifteen inches is the usual diameter of the tight roll of blanket or the final height of the squashed pillow pile. Lying on her back over the trochanter roll makes the pubic bone become the highest bone in the body, though the tummy rises up above the risen symphysis.

I asked her to try Walcher's position through three contractions, though after two she said, "Enough!" I generally say three because with any position used with the intent of making room in the pelvis, my assumption is that first one may not always be done quite in the "right" position, as the mother is often still getting into position as the contraction begins. You could also say to the mom that the first one lets the uterus and the baby become aware of the added room. The second contraction allows the baby to take advantage of that added room. And the third contraction is for insurance. Staying in the position for the third contraction makes up for the first one if during the first one the pelvis wasn't quite open enough. A larger baby may need even more than three contractions to engage, as in this example, or to

rotate or to descend with other techniques. The baby came into the pelvis and she was 4 cm dilated within the hour. Seven hours later, she had a quick second stage and fine birth of a healthy, strong baby.

Illustration 2 shows the pelvis before and after the trochanter roll. The light gray shows the pubic bone and sacral promontory in a pelvic brim with a 9.5 cm AP diameter. The light gray pelvis demonstrates the position of the pelvis before Walcher's. The dark gray shows the same pelvis in Walcher's position. The AP diameter is given as a guesstimated 12.5 cm. Radiological imaging could measure the real change in the AP diameter. The sacrum may flatten and move the promontory posterior (back). The pubic bone is the highest bone in the body when the trochanters are draped over the 15 inch roll of bedding. See the outline of the fetal head now engaged in the dark gray pelvis.

The second mother who used Walcher's was a petite first-time mother who began struggling during her labor. She was in the portable birth pool in her living room. I noticed her instinctively moving into the Walcher's position in the tub, but not staying in it through a contraction. That movement told me something. When I see women do this, I've found their babies above the brim in spite of strong, seemingly active labor. Her labor was strong but not advancing so her midwife asked her to come out of the tub. She was about 4 cm and had been for seven hours.

Her midwife had once been my apprentice and our friendship gave me allowances I wouldn't assume I had in all other settings. What I mean is, I couldn't keep my hands off or my mouth shut. I went palpating for the reason for the delay and found the little one in the Right Occiput Posterior (ROP) position—the baby's back was at the right and forehead at the brim, and I could palpate an arm overlapping the symphysis, at the bladder, knees above the indent in her abdomen.

Illustrations provided by author

Normally quite hands off, her midwife did an internal and found both fontanels in reach—telling us the chin was not tucked (not flexed, but extended). She flexed the chin using two or three contractions to readjust the angle of the head by simply holding her two rather long fingers in front of the anterior fontanel and bracing the forehead. As the contraction bore down upon the resistance of her fingers (making a false pelvic floor) the chin flexed. The head didn't rotate but the midwife felt it

of the water while still on her knees. (See Illustration 3.)

A short time later I checked and couldn't palpate the arm at the brim anymore and we thought the baby had rotated. Several hours later, she began a long second stage, even getting out of the tub for a while for gravity. She got back in the tub once crowning commenced and gave birth. Moving the mother during crowning made me worry that we'd interrupt shoulder rotation. Her baby had a

is not needed often, just when the baby can't get into the brim even in the presence of strong contractions. I suspect it might work for bilateral shoulder dystocia at the inlet as well.

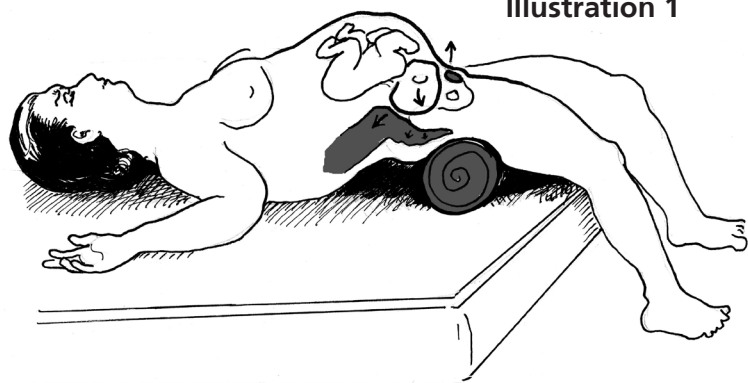


Illustration 1

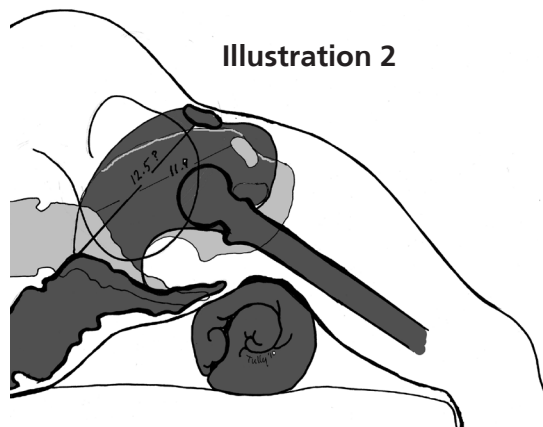


Illustration 2

wiggling. I took wiggling as a good sign that the baby now had room. It was a tough internal exam, and though neither of us will manipulate a cervix I believe helping flex the posterior head took hours off her labor. Labor certainly hadn't advanced with very strong contractions before that little maneuver. Sigh. We had already made many suggestions, as well as honored her movement. It was her discouragement that led us to investigate and suggest these two interventions: flexing the head and then helping it to engage via Walcher's.

The birthing mother wanted to be in the birthing tub. (Who wouldn't, after that!) I was hoping to help the baby engage and was going to suggest the Walcher's position, but saw her need to find comfort in the pool. Then I remembered a first-time mom some years ago who did Walcher's position pool-style. This is a way to open the angle of the brim while on hands and knees in the pool. The mother's knees are as far away from her own belly (and so her spine) as they can be while still holding her head above water. In the pool version of Walcher's, the mom starts on hands and knees, and then moves her knees further away from her head, even lifting her feet out

compound presentation which avoids true shoulder dystocia while lending another, though generally lesser, challenge in its place. Her baby's arm was wrapped around her neck, hand opened to the back. I suppose the arm stayed in one place as the ROP baby did her long arc rotation to the Occiput Anterior (OA) without bringing the arm along. I occasionally see a wrapped arm, left behind as the rest of the occiput posterior (OP) baby rotates in labor to OA before emerging.

Walcher's is a position in which the pelvic brim is opened to its widest angle away from the spine. The pubic bone is as far forward from the spine as possible, giving the OP baby with an extended head room to engage. Walcher's position

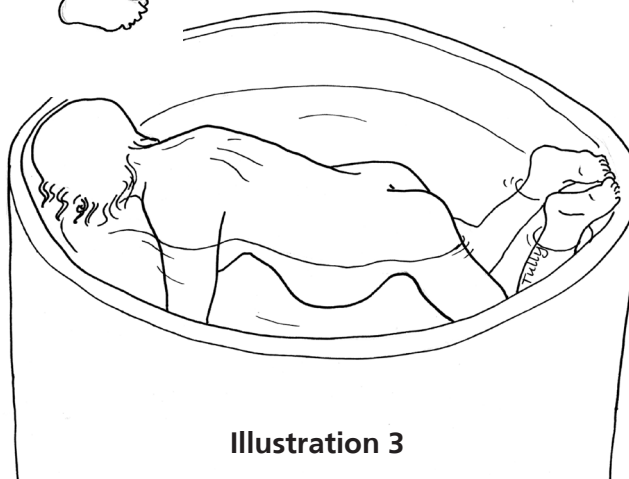


Illustration 3

First, see if the mother finds her own way. If not, gently suggest an appropriate technique. As soon as labor progresses, merge back into the murmuring shadows, cooing a bit, in love with the birth.



Gail Tully, CPM, mixes observation with practical help while seeking an intuitive connection with the mother and her birth. Tully has developed SpinningBabies.com and Belly Mapping to help us understand how maternal structural balance affects fetal position and how fetal position affects labor. Spinning Babies is the active part of patience. From Minnesota, Tully travels and hosts online talks about Spinning Babies and resolving shoulder dystocia. Visit Spinning Babies on Facebook and see the belly paintings.