

MATERNITY GUIDELINES

Breech presentation

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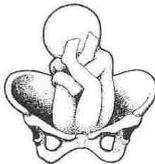
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1. Overview

When the fetus lies longitudinally with the buttocks in the lower pole of the uterus the presentation is breech. This is usually determined by abdominal or vaginal examination and confirmed by ultrasound scan. The incidence of breech presentation at term is approximately 3%.

2. Types of breech

- Frank breech – hips flexed, knees extended, buttocks presenting
- Flexed breech – hips flexed, knees flexed, buttocks and feet presenting
- Footling breech – hips extended, knees extended, feet presenting



Extended or Frank Breech

Flexed or Complete Breech

Footling Breech

Fig 1 Types of breech

3. Management of breech presentation at term

There are three management options:

1. External Cephalic Version and if unsuccessful then one of the following
2. Vaginal breech delivery
3. Elective Caesarean Section

External Cephalic Version (ECV) – see antenatal guideline 34

5. Vaginal versus Caesarean Delivery

The breech presentation has greater perinatal mortality and morbidity, and a greater risk of subsequent handicap whatever the mode of delivery. The Term Breech Trial, published in 2000, had an immediate and major impact on management of breech presentation. The appropriateness of this change continues to be debated. Now that longer-term follow-up has occurred a summary of the current position is that:

There is widespread use of elective caesarean section for the term breech, both for singletons and the presenting twin.

Planned caesarean section reduced perinatal mortality and early neonatal morbidity (1.6% versus 3.3%) in the largest RCT (The Term Breech Trial) to date. However by two years of age there were no differences in outcome between planned caesarean section and vaginal breech delivery groups.

- Women should be informed that the reduced risk is due to three factors: the avoidance of stillbirth after 39 weeks of gestation, the avoidance of intrapartum risks and the risks of vaginal breech birth, and that only the last is unique to a breech baby.

- Women should be informed that planned vaginal breech birth increases the risk of low Apgar scores and serious short-term complications, but has not been shown to increase the risk of long-term morbidity.
- Women should be informed that maternal complications are least with successful vaginal birth; planned caesarean section carries a higher risk, but the risk is highest with emergency caesarean section which is needed in approximately 40% of women planning a vaginal breech birth.
- Caesarean section still carries a small increase in risk of immediate serious surgical complications and an as yet unquantified risk of complications in subsequent pregnancies. This includes the risks of opting for vaginal birth after caesarean section, the increased risk of complications at repeat caesarean section and the risk of an abnormally invasive placenta.
- Skills in vaginal breech delivery are diminishing.

The final decision as to the mode of delivery of the term breech therefore requires careful and individualised discussion between the mother and her obstetrician. Selection of appropriate pregnancies and skilled intrapartum care may allow planned vaginal breech birth to be nearly as safe as planned vaginal cephalic birth. Clinicians should counsel women in an unbiased way that ensures a proper understanding of the absolute as well as relative risks of their different options. This should be appropriately documented.

Breech presentation at term is not an indication for induction of labour *per se*.

5.1 Indications for Caesarean Section

- Other contraindication to vaginal birth eg placenta praevia
- Fetal weight of 3800g or greater by clinical examination and or scan estimation
- Growth restricted (<2000g at term) or clinically compromised fetus
- Hyperextension of the fetal head by USS
- Maternal request
- Footling breech–(not in RCOG)
- RCOG states role of pelvimetry unclear

6. Breech Presentation in Labour

In this situation the Specialist Registrar or Week on Service Consultant should be informed.

Diagnosis of breech presentation in labour is not a contraindication for vaginal breech delivery.

Once the presentation has been confirmed the mode of delivery should be discussed, ideally including the above information.

Some women will labour too quickly to allow caesarean section to be undertaken safely, therefore women near or in second stage of labour should not be routinely offered caesarean section.

- It is recommended that a vaginal breech should take place in hospital with facilities for category 1 CS. This may require transfer in labour from home if homebirth planned.
- Mode of delivery must be discussed with the woman. Explain risks and benefits and type of analgesia during labour and delivery.

6.1 Management of a term vaginal breech delivery

The following principles should be adhered to:

- Where time and circumstances permit, the position of the fetal neck and legs, and the fetal weight should be estimated using ultrasound, and the woman counselled as with planned vaginal breech birth.
- Continuous electronic fetal monitoring should be conducted once labour is established. A FSE may be applied if required.
- Establish IV access and take bloods for FBC and group and save.
- Prepare the delivery room and neonatal resuscitaire
- Ensure prerequisites for assisted vaginal delivery available, i.e. delivery packs, forceps, lithotomy supports.
- There is no absolute indication for epidural analgesia and should not be routinely advised; the usual indications as per a cephalic presentation should be applied
- Fetal blood samples can be taken from the buttock, but there is insufficient evidence to be confident that these results are valid
- Augmentation of labour is not usually recommended
- Augmentation of slow progress with oxytocin should only be considered if the contraction frequency is low in the presence of epidural analgesia
- ARM should be performed with caution

- Following SRM, a VE must be performed to exclude cord prolapse
- If there is any delay in the progress of labour or in the descent of the breech in second stage caesarean section should be considered.
- Active pushing should not be encouraged until the breech is visible at the perineum
- Breech extraction and episiotomy should not be used routinely
- Delivery must be carried out in the presence of an experienced Specialist Registrar or Consultant who is skilled in vaginal breech delivery.
- Delivery in lithotomy position is recommended
- A neonatologist should be present at the delivery.
- The anaesthetist should be present on labour ward and theatre staff should be on stand-by.

6.2 Vaginal breech – assisted manoeuvres

- When handling the baby, ensure that support is provided over the bony prominences so that risk of soft tissue damage is reduced
- Spontaneous delivery of the limbs and trunk is preferable. Legs may need to be released by applying pressure to popliteal fossae
- Consider correcting position of buttocks to sacroanterior position
- Avoid handling the umbilical cord as it may spasm
- If arms do not deliver spontaneously, use the Lovsett's manoeuvre

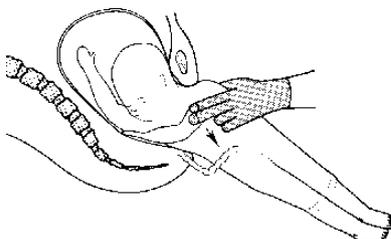


Fig2. Lovsett's manoeuvre

- Allow baby to hang until nape of neck is visible
- If the head does not deliver spontaneously an assistant may apply suprapubic pressure to assist flexion of head
- The accoucher should perform the Mauriceau-Smellie-Viet manoeuvre

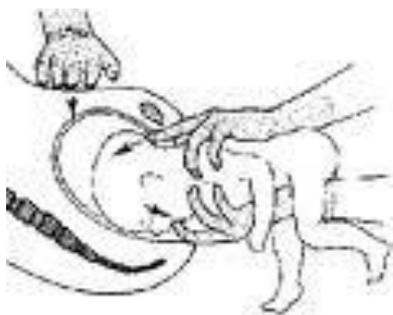


Fig 3. Mauriceau-Smellie-Viet manoeuvre

- Alternatively , the head can be delivered using forceps by an experienced clinician

6.3 Complications and potential solutions

Failure to deliver after coming head:

If conservative methods fail to deliver the head symphysiotomy or CS should be performed

Head entrapment:

Major cause is delivery of preterm infant through an incompletely dilated cervix. The cervix will need to be incised at 10 and 2 o'clock to avoid cervical neurovascular bundles.

Nuchal arms:

To deliver nuchal arms, the fetal trunk must be rotated to enable the fetal face to turn towards the symphysis pubis. This reduces the tension on the arm and allows delivery using Lovsett's manoeuvre.

Cord prolapse:

More common with footling breech. Prevention better than cure hence recommendation for CS. Amniotomy should be performed with caution.

6.4 Management of pre-term breech in labour

The results of the Term Breech Trial should not be extrapolated to the preterm breech. There is a lack of clear evidence that caesarean section is preferable to vaginal delivery and the mode of delivery should be decided after appropriate discussion with the woman, her partner and her obstetrician. However, women should be informed that planned caesarean section is recommended for preterm breech presentation where delivery is planned due to maternal and/or fetal compromise.

7. Undiagnosed Breech Presentation in Labour at home

7.1 Management:

- Every effort should be made to transfer the woman to hospital by ambulance as quickly as possible, regardless of gestation.
- A second midwife should be called to be in attendance at the delivery. The benefit of calling a paramedic should also be considered. To request a **Category 1** emergency ambulance, state “midwife attending homebirth” and give reason for call. Be clear about what you are asking for, stay calm and professional.
- The midwife/paramedic should site a cannula to enable easy IV access should emergency caesarean section be necessary on arrival at hospital.
- Central Delivery Suite should be informed giving details of parity, gestation etc. to allow time for preparation of appropriate personnel (obstetric registrar, neonatal team, anaesthetist) and equipment.
- The estimated time of arrival (ETA) at the Maternity Unit should be given if possible.
- If labour is progressing rapidly there may be no time for transfer to hospital, so the midwife will need to prepare for delivery.
- The midwife should employ recognised measures and manoeuvres to facilitate the safe breech delivery of the baby
- Either a semi-recumbent or an all- fours position may be adopted for delivery and should depend on maternal preference and the experience of the attendant.
- Resuscitation and assessment of the baby should be carried out in accordance with normal practice
- The woman and her partner should be kept fully informed of the situation. They need to be aware that their co-operation will be essential for the safety of both mother and baby.

8. Following delivery at home

Transfer to hospital should be considered according to the condition of both mother and baby.

9. Record Keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.

All entries must have the **date and time** together with **signature and printed name**.

Monitoring and Audit

Auditable standards:

Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:

Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Frequency of audit:

Continuous

Responsible person:

Obstetrician

Cross references

Antenatal Guideline 31 - Maternity Hand Held Notes, Hospital Records and Record Keeping

Antenatal Guideline 44 – Guideline development within the Maternity Services

References

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Hannah ME, Hannah WJ, Hewson SA, Hodnett ED, Saigal S, Willan AR. Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. Term Breech Trial Collaborative Group. **Lancet** 2000; 356:1375-83.

Early ECV trial: <http://www.utoronto.ca/miru/eecv2/>

Tim Draycott, Cathy Winters, Jo Crofts and Sonia Barnfield 2012 **PROMPT Practical Obstetric Multiprofessional Training.** RCOG Press, London

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