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Term Breech Presentation and Birth

Introduction and Aim

- To provide guidance for the multidisciplinary team of professionals caring for a woman with a term baby in a breech presentation

Objectives

- To identify the clinical management required for women with a breech baby booked to give birth in UHW.
- To give individualised care and support for women with a breech presentation and improve the outcome for mother and babies.

Scope

This document is for use by all the Cardiff and Vale University Hospitals NHS Trust employees working in and alongside the Women's Health Directorate caring for all women with a breech baby.

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	
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Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**

1	Oct 2005	*Oct 2005*	New Document
2	Feb 2008	Feb 2008	Reviewed and amended by D Bebb, P Amin
3	Feb 2011	Feb 2011	Reviewed and amended by D Bebb, P Amin
4	Dec 2013	Dec 2013	Reviewed and amended by P Amin, A Holmes
5	Dec 2018	Apr 2019	Reviewed and amended by A Oyler, R Penketh, A Robb, M Beard
6	April 2021	April 2021	Amendments made to limit length of active second stage, by MPF.

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2 Key Recommendations

- Ensure breech presentation is detected by 36 and refer to clinic.
- Offer ECV to all appropriately selected mothers.
- Where ECV fails, or is inappropriate/declined, discuss mode of birth including caesarean section and planned vaginal birth for antenatally diagnosed breech presentation.
- Where breech presentation is detected in labour, caesarean section should not be routinely offered if labour is advanced.
- Appropriately trained personnel should supervise vaginal breech birth.

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3 Background

Breech presentation complicates up to 4% of term births.
It is more common in the following: preterm birth, abnormal uterine shape, a baby with known anomalies, multiple pregnancy and if there is a previous history of breech presentation.
Since the publication of a multicentre randomised controlled trial suggesting elective caesarean was safer than vaginal birth, the incidence of vaginal breech birth has declined and clinical skills have diminished.
However, vaginal breech birth remains occasionally inevitable and more recent studies have suggested that with appropriate selection and management, the outcomes of vaginal breech delivery can be nearly a safe as cephalic vaginal birth (Impey, 2017, a)

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3.1 Aims

- To provide guidance for the multidisciplinary team of professionals caring for a woman with a baby in a breech presentation.
- To identify the clinical management required for women with a term breech baby booked giving birth in UHW.
- To give individualised care and support for women with a term breech presentation and improve the outcome for mother and babies.

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3.2 Scope

This document is for use by all the Cardiff and Vale University Hospitals NHS Trust employees working in and alongside the Women's Health Directorate caring for all women with a breech baby.

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4 Executive Summary

4.1 Identification of breech presentation and co-factors

- Determine presentation by abdominal palpation at 35-36 weeks Perform ultrasound to confirm diagnosis.
- Refer all singleton pregnancies with a confirmed breech presentation, to the antenatal clinic for a discussion with a Senior Obstetrician around plan of care (ST 6-7 / Consultant).

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4.2 Prevention of breech presentation at birth

- Effectiveness of moxibustion unclear (Impey at all, 2017, b)
- Ensure ECV is appropriate
- Offer ECV to all consenting eligible women
- ECV is only to be performed by appropriately trained or supervised personnel
- Ensure safety of fetus at all times
- Offer a 2nd attempt +/- tocolysis if ECV fails on 1st attempt

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4.3 Planning mode of birth for term breech presentation

- Discuss the evidence at level appropriate for parents
- Where criteria for vaginal breech birth are met, offer this as an alternative to a planned caesarean section.

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4.4 Management of vaginal birth with term breech presentation

- Ensure appropriately trained personnel are available.
- Preference is for a spontaneous labour onset and Induction of labour is not recommended (Impey et al, 2017, a)
- Continuous fetal monitoring is recommended.
- Passive second stage of ≤90 minutes in the presence of a stable FH is recommended.
- Delay active pushing until breech visible.
- It is recommended that birth should be complete within 6 minutes of the bitrochanteric diameter (rumping) being born or 3 minutes from umbilicus – therefore good quality documentation and timekeeping are essential. It is essential for one of the attendants in the room to scribe.
- Once active pushing is commenced delivery should be accomplished or imminent within 60 minutes, otherwise caesarean section is recommended. **(New 2021)**
- Recommend caesarean section if progress poor (breech not visible within 90 mins of passive second stage) or abnormal EFM before active second stage (unless buttocks visible and progress is rapid). **(New 2021)**

- Upright/ all fours' positions are encouraged for uncomplicated birth, if personnel experienced in its use are present.
- It is essential that there is clear, good progress in established labour, a first stage of labour of 7 hours or a 1 cm an hour is expected. The vast majority of women have much shorter labours with breech presentation baby than a cephalic baby. The PREMODA trial (2006) found that N=1825 vaginal breech births only 1.4% had a labour of longer than 7 hours. 82% of labours were less than 6 hours (Goffinet et al,

2006). 99.8 % of women also had an active second stage of less than 60 minutes. **(New 2021)**

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4.5 Management of term breech birth undiagnosed prior to labour

Caesarean section in advanced or rapidly progressing labour should not be routine and only offered if woman able to make informed consent.
If time available, check for suitability for vaginal birth and if latter appropriate and woman consents, transfer women to Delivery Suite for labour and delivery.
Intrapartum management as above.

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5 Detection of breech presentation

- Referral to the antenatal clinic for discussion of ECV will be predominantly from the midwife sonographers and patients should be given the RCOG patient information leaflet.
- There remains a significant spontaneous version rate to and from breech presentation after the 36-week USS, particularly in multiparous women.
- Women should be offered a referral for discussion around ECV. ECV can be booked by telephoning delivery suite where diary is kept
- Ideally nulliparous women should be 36 completed weeks gestation at the time of referral; multiparous women should be 37 completed weeks. There is no upper gestation limit for when ECV can be offered, but contraindications may be more common (Impey et al, 2017, b)

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6 External cephalic version

6.1 Suitability for ECV

If a breech presentation is detected, the scan should record the placental site, estimated fetal weight, liquor volume, type of breech (e.g., extended) and position of back and documented in the notes.

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6.2 Contraindications to ECV

ECV is usually contraindicated in presence of:

- Absolute indication for caesarean section e.g., Placenta previa Major or other indications for caesarean section.
- 2+ previous caesarean sections
- Rupture of membranes
- Oligohydramnios (deepest pool of liquor <20mm)
- Rhesus or another antibody isoimmunisation
- Uterine abnormality other than minor small septum
- Recent vaginal bleeding
- Pre-eclampsia
- Previous feto-maternal haemorrhage
- SGA <10th centile of EFW with umbilical artery resistance index (RI) >95th centile.
- An abnormal cardiotocograph (CTG).
  (Impey et al, 2017, b)

In practice <10% of women should be ineligible.

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6.3 Consent for ECV

- Women should be provided with the RCOG patient information leaflet ‘breech baby at term’, ideally prior to attending for ECV.
- Women should be counselled that with appropriate precautions, ECV has a very low complication rate.
- ECV is very safe, with a 0.5% risk of emergency caesarean section in the 4 hours following the ECV and a neonatal morbidity and mortality equivalent to a baby that has always been cephalic.
- The risk of spontaneous reversion following successful ECV is <3%
- The chance of spontaneous version following an unsuccessful ECV is 3-7%

- That the overall chance of success is approximately 50% (Nationally)
- That the risk of emergency caesarean section or instrumental delivery in labour following ECV is slightly higher than in babies that have always been cephalic That ECV can be uncomfortable and can be ceased if not tolerated.
- That 1:50 will be admitted overnight for reasons of cord/feet presentation or CTG anomaly for observation.
- The reported risk of emergency caesarean section within 24 hours is approximately 0.5%, with the indication in over 90% being vaginal bleeding or an abnormal CTG following the procedure (Impey et al, 2017, b)

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6.4 Conduct of ECV

A normal CTG should be obtained prior to ECV. ECV should be conducted on Delivery Suite, or in a dedicated Breech ANC, with an ultrasound machine and facilities for cardiotocography in the room. Fasting and intravenous (IV) access should not be routine.

The health professional performing the procedure should be experienced or acting under supervision of someone with this experience. ECV is usually attempted no more than 4 times with a maximum ECV time of 10 minutes.

Tocolysis (Inhaled salbutamol – taken via spacer or subcutaneous terbutaline 250mcg) can be used if no contraindications such as (arrhythmias, significant cardiac disease, beta-blocker usage), for a primary or a repeat attempt at ECV.

Nitrous Oxide can be used for discomfort during the procedure, spinal or epidural analgesia should not normally be used, but may be considered in cases of excessive discomfort with option of proceed to caesarean section if fails. The woman can choose to abandon the procedure at any time if she finds it too uncomfortable and revaluate her birth options.

Ultrasound should be used intermittently to check the position of the baby and the fetal heart rate. Ultrasound should be used to confirm the success or failure of ECV.

Cardiotocography should be performed immediately after the ECV and should not be considered satisfactory until accelerations have occurred and a normal trace is obtained.

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6.5 After ECV

Women who are rhesus negative should receive anti-D following the procedure (antiD guideline, 2017), a Keilhauer should also be taken, and the woman advised to contact the Obstetric Assessment Unit the following day where the result will be reviewed regarding the need for further anti-D.

Transient CTG abnormalities are common just after ECV. If a fetal bradycardia is seen, maternal left lateral position should be adopted. If the FHR is <100 within 5 minutes of completion, senior medical advice should be obtained urgently. All criteria for a normal CTG should be achieved by 60 minutes, and if they are not, senior medical advice should be obtained.

The fetal head is often high after ECV. If the cord or a limb is seen below the head after completion it should be re-inspected on ultrasound, after mobilisation, at 30- 90 minutes. If still present, consider admission to hospital for observation and further discussion of options and plan for delivery made.
Women should be warned that they should return immediately to the hospital if they experience vaginal bleeding or excessive pain. Bleeding after ECV, even with a normal CTG, should normally prompt a category 2 caesarean section if breech, or urgent induction if the baby is cephalic.

Induction in the first 72 hours after ECV should usually be avoided if possible as it is more likely to fail.

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7 Mode of birth for breech presentation

If ECV is declined, contraindicated or fails, mode of birth should be discussed.

7.1 Planning mode of birth

Women should be counselled in an unbiased way that ensures a proper understanding of the absolute, as well as, relative risks of their different options. This discussion should take account of individual risk profile that includes a review of previous obstetric and medical history including their reproductive intentions.

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7.2 Counselling regarding mode of birth

Women should be informed that:

- With appropriate selection and intrapartum care, planned term vaginal breech birth is associated with 2/1000 risk of mortality, which is slightly more than planned cephalic vaginal birth (1/1000) and more than elective CS at 39 weeks (0.5/1000).
- There is an increased risk of low Apgar scores and short-term complications with planned vaginal birth but not an increased risk of long-term childhood morbidity
- Caesarean section whether planned or emergency may increase the childhood risk of chronic immune disorders such as diabetes and asthma
- Maternal complications are lower in a successful vaginal birth
- Maternal complications are higher in a planned caesarean section
- Caesarean section increases the risk of complications in future pregnancy, including the risks of opting for vaginal birth after caesarean section and an abnormally invasive placenta.
- Maternal complications are greatest with emergency caesarean section in labour.
- Emergency caesarean section rates are approximately 40% in women planning a vaginal breech birth.
- Epidural analgesia may reduce success in vaginal breech birth. Women should be informed that the effect of epidural analgesia on the success of vaginal breech birth is unclear, but that it is likely to increase the risk of intervention (see analgesia section page 10) (Impey et al, 2017a).

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7.3 Factors affecting the safety of vaginal breech birth

- Assessment should include a careful review of past obstetric history and an antenatal ultrasound by an experienced sonographer to check estimated weight, leg position, attitude of the neck, and parameters of health (e.g., liquor volume) Delivery by planned caesarean section should be recommended if the following risk factors are identified:

- EFW>90th centile
- EFW<10th centile
- Hyperextended fetal neck
- Footling breech (no presenting part in pelvis)

If a vaginal breech birth is chosen or the woman is uncertain, a further Obstetric Consultant antenatal clinic appointment should be offered.

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7.4 Caesarean section

If a caesarean is to be performed, this can be booked at the time of the antenatal clinic or ECV, for 39+0 weeks at the earliest unless there is an indication for preterm delivery. Women should be counselled of the 10% chance of labour prior to this gestation and a plan for this made and documented in the hand-held notes.

Prior to elective caesarean section, a bedside ultrasound examination should be performed to ensure the presentation is not cephalic. If it is, the caesarean section should not usually be performed. This situation is rare, particularly in nulliparous women after a failed ECV.

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8 Unanticipated breech presentation

If birth is imminent, it should not be conducted in theatre unless there are fetal concerns. For conduct of a vaginal breech birth see below.

8.1 34+ weeks

When women are in early labour, management should depend on the stage of labour, whether factors associated with increased complications are found, availability of appropriate clinical expertise and informed consent.

Women near or in active second stage of labour, including those with a footling breech (feet presenting below level of buttocks, rather than heel felt at level of buttocks), should **not** be offered an emergency caesarean section unless there is a clear indication that this will be safer for the mother or the baby. Where time and circumstances permit, the position of the fetal neck and legs should be estimated using ultrasound.

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8.2 Preterm

(<34 weeks): see Preterm Birth Guideline.

8.3 Borderline viability

(<26 weeks). Caesarean should not normally be undertaken in the fetal interest: see Preterm Birth Guideline.

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9 Conduct of term vaginal breech birth

Active support for the mother is of paramount importance in aiding labour progress and allowing calm, controlled vaginal birth.

9.1 Team Organisation

It is vital that there is excellent communication and teamwork between the multidisciplinary team on delivery. A discussion should take place between the senior midwife and the consultant or ST6 or 7 when planning the care of the woman who opts for a vaginal breech birth. Part of the planning should be establishing the most appropriate trained /experienced health professional to conduct the birth which should be a midwife or obstetrician. Continuous support and communication should be maintained throughout on progress of labour and birth.

The on-call anaesthetists should be aware if the woman has any issues with difficult cannula siting or a difficult airway. **(New 2021)**

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9.2 Present at the birth

- A midwife experienced/trained in vaginal breech birth should care for the woman during labour and conduct the birth.
- If a less experienced or junior midwife is caring for the woman during labour, a senior or more experienced midwife should oversee the labour and should conduct/supervise the birth.
- A senior obstetrician (Obstetric Consultant or ST6 or 7) will attend the birth should the midwife need help in an emergency. They will usually be accompanied by a trainee obstetrician.
- A Neonatologist (Registrar) **(New 2021)** should be present for the birth of the baby.

All obstetricians & midwives who may be required to supervise/conduct vaginal breech births should be familiar with the recommended timings and management of breech birth and techniques that can be used to assist the birth.
If time allows, the senior midwife and the senior obstetrician should plan the birth away from the labouring woman prior to the start of active second stage so that both are clear of their respective roles.

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9.3 Where should vaginal breech birth take place?

Birth in UHW Delivery Suite is recommended for planned

vaginal breech birth where there are facilities for immediate caesarean section. During active second stage, anaesthetic, neonatal and operating staff should all be available in case rapid caesarean is required. **(New 2021)** However birth in an operating theatre is not routinely recommended
A quiet calm atmosphere is helpful to support the woman and for labour to progress.

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9.4 Analgesia

- Where possible, options for analgesia should be discussed with the woman prior to the onset of labour
- Massage, mobilisation, TENS and Nitrous Oxide are methods of pain relief that can be recommended for a vaginal breech birth
- Immersion in water can be considered for first stage only, a vaginal breech birth is not currently recommended in water.
- Parenteral opiates can be used in the same way as for cephalic presentation but are best avoided late in labour.
- Epidural analgesia should not be routinely administered to women opting for vaginal breech birth. Regional anaesthetics increase the risk of intervention and may prevent effective maternal effort making spontaneous birth without early manoeuvres very unlikely. ~~V~~aginal breech birth is usually easier if a mother is able to bear down effectively and an epidural may interfere with this (RCOG GTG, 2017). A less interventionist approach advocates a calm atmosphere with continuous support as a means to avoid epidural analgesia. (Hodnett et all 2013). The woman should be counselled to make an informed choice and balance the risks of intervention with her analgesic preferences, for women who choose to have an epidural a low/light dose epidural which allows mobilisation should be available.

When discussing options for pain relief, the women should be told that the interventions which may be required to assist the birth, could cause discomfort but local anaesthesia can be used to reduce discomfort.

In women without an epidural or ineffective epidural, the equipment needed for a pudendal block and perineal infiltration should be prepared in readiness for birth.

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10 Management of labour in a term vaginal breech birth

10.1 Monitoring in labour

Continuous wireless electronic fetal monitoring (CEFM) by cardiotocography (CTG) should be recommended.

Using an electrode is not advocated, breech birth experts are opposed to this method due to concerns that application could cause the fetus to arch away and cause a morrow reflex resulting in nuchal arms. The first stage must be completely normal to proceed safely. A caesarean section should be considered if there are any concerns regarding fetal wellbeing.

Delivery by caesarean section should usually be recommended i**f the CTG is abnormal/ pathological prior to the active second stage of labour/ 'crowning' of the buttocks.** As with cephalic presentation this should take account of the prior progress and anticipated speed of delivery.

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10.2 First Stage

The first stage of labour should be managed according to the same principles as for a cephalic presentation, with the caveat that normal progress for a breech labour is quicker than a cephalic labour. **(New 2021)** Vaginal examination should not be performed more frequently, particularly in second stage.

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10.2.1 Maternal positioning

Positioning for birth should be discussed during her birth planning appointment, and facilitated to choose the position she would like to adopt for labour and birth.

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10.2.2 Upright positions in labour

The woman should be informed that being upright, mobile and active is best for the first stage of labour, walking, kneeling or using a birthing ball are examples. If the woman does not wish to adopt these positions, then left lateral position should be considered as preferable rather than semi-recumbent. Adopting these positions assist the fetus to engage into the maternal pelvis.

10.2.3 Amniotomy

To reduce the risk of cord compression the membranes should be kept intact for as long as possible and amniotomy reserved for definite clinical indications.

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10.3 Syntocinon

Augmentation should usually be avoided as adequate progress may be the best evidence for adequate feto-pelvic proportions (RCOG, 2017) use of Syntocinon is not currently supported in UHW.

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10.4 Second Stage

10.4.1 Standing

Standing for birth is not recommended because of the risk of placental abruption.

10.4.2 All fours

This position improves pelvic dimensions for birth and is favoured by many experienced advocates of vaginal breech birth for second stage, all fours position is associated with a shorter second stage and lower rates of perineal trauma (Impey, 2017, a)

- Throughout the first stage of labour upright positions have been recommended to assist engagement. In the second stage of labour an upright or all fours can be adopted.
- It is important to support the mother's choice of position and to adopt the position she finds most comfortable

In all fours position (on hands and knees) the pelvic brim of the pelvis is narrowed and the outlet of the pelvis is opened which makes this ideal for gravity to assist the descent of the fetus through the maternal pelvis.

- As the diameter of the brim of the pelvis is thought to be reduced in all fours position this should not be encouraged before the breech has engaged properly.

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10.4.3 Passive Stage

It is recommended that the breech be allowed to descend to the perineum prior to active maternal effort. **A maximum time frame of 90 minutes from the start of second stage to**

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the breech being visible is recommended. Vaginal examination should be minimised but is recommended to aid caesarean section decision is an absence the adequate descent.

10.4.4 Active 2nd stage

The active phase is associated with cord compression in many breech fetuses. This phase should be as short as possible.

Active pushing should **not occur** before the breech becomes visible at the perineum.

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- When the breech is visible, work with the woman and her urge to push. (women may appear to push continuously)
- Do not intervene or discourage maternal effort if there is good advancement.
- Directed pushing is not usually necessary.
- Spontaneous birth of the breech by maternal effort without intervention will occur in a significant percentage of breech births.
- It is recommended that birth should be complete within 6 minutes of the bitrochanteric diameter (rumping) being born or 3 minutes from umbilicus.
- Once active pushing commences, delivery should be accomplished or imminent within 60 minutes, otherwise caesarean section is recommended. **(New 2021)**
- During active second stage, anaesthetic, neonatal and operating staff should all be available in case rapid caesarean is required. **(New 2021)**

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11 Management of delivery in a term vaginal breech birth

11.1 Principles

- Understand the breech mechanism of birth.
- Avoid unnecessary intervention and use timely intervention if the birth mechanism does not materialize.
- Limit disruption in the room as this is anxiety provoking to the mother and may affect her contraction pattern.
- Tactile stimulation of the fetus may result in reflex extension of the arms and head increasing the risk that spontaneous birth will not occur and thus requiring further interventions to assist the birth.
- Traction must not be applied as this may prevent necessary rotation
- Do not pull down a loop of cord. This will not relieve cord compression and may tighten the loop higher up around the baby. Handling of the cord should be avoided
- Episiotomy is a clinical decision, not recommended routinely.
  Intervention is recommended if there is arrest of descent of the breech at any time after the cord insertion becomes visible or in evidence of reducing fetal tone, perfusion or colour.

The choice of manoeuvres that may be needed to assist with the birth of the breech will depend on the maternal position and the individual experience/preference of the attending doctor or midwife.

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11.1.1 Lithotomy

Most obstetricians have experience in this position, if there is no attendant experienced at all fours breech birth then this position should be adopted. It may also be required if the attendant needs to do manoeuvres with which they are less experienced in while the mother is on all fours, or which require lithotomy e.g., forceps.

Therefore, if a woman chooses a forward-facing position, she should be made aware she may be required to change into lithotomy, in which case she will be assisted to change her position.
If an operator with experience of undertaking manoeuvres with the mother in a forward position is available then these should be performed without delay. Clear dialogue or roles and responsibilities prior to the birth are mandatory between the midwifery and obstetric leads in attendance.

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11.2 Procedures for All Fours birth for 37-42 weeks' gestation

It is vital to understand both the mechanism of spontaneous breech birth and the signs that may indicate that the baby is compromised.

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11.2.1 An 'ideal' all fours breech birth

Recommend upright/all fours position when the anterior buttock is visible at the perineum. Directed pushing is not usually necessary and should not occur before this point, work with the woman and her urge to push, do not intervene or discourage if there is good advancement and no concerns with fetal wellbeing.

The anterior buttock delivers

- The posterior buttock will sweep the perineum and deliver by lateral flexion
- The baby will begin to rotate to direct Sacro-anterior
- Rotation will continue to direct Sacro-anterior and the baby's spine will flex backwards against the maternal pubic bone. If extended the legs will deliver
- A small rotation to left Sacro-anterior and back to right Sacro-anterior will deliver the anterior and posterior arms respectively.
- The baby will be seen to perform a tummy tuck where all 4 limbs will flex, this results in flexion of its head within the maternal pelvis and the chin and face become visible at the perineum.
- The woman will usually drop forward to complete all fours due to the sensation of head flexion within her pelvis. This will move the maternal sacrum over the baby's head and birth will be complete.
  Pass the baby underneath the mother, leave the cord intact to provide continued oxygenation for adaption at birth.

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11.3 Critical signs for Fetal wellbeing

During the second stage of labour, it will become difficult to monitor the fetal heart, however fetal wellbeing can be established by observing the following signs, and should be documented in the medical notes.

Reperfusion of fetal tissues within 3 seconds of traversing the perineum indicates good blood flow

- A pink/blue colour of the fetus as it is born is normal, blue/white or white indicates reduced perfusion and compromise
- Pointy' toes and clenched fists indicate good fetal tone

- Normal cord perfusion indicates good blood flow to the baby; a white cord suggests occlusion and potential compromise

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11.4 Birth

11.4.1 Reassuring Signs

- A bulging full perineum
- Once the breech is 'crowned/rumped', birth should be complete within 6 minutes.
- Spontaneous rotation to direct sacro-anterior indicates flexed arms
- A chest with a 'cleavage' indicates flexed arms
- A bulging perineum following the birth of the arms indicates a flexed head

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11.4.2 Non-Reassuring Signs

- Descent without rotation in left sacro-lateral or right sacro-lateral
- Delivery of the posterior arm under the maternal sacrum indicates a nuchal or extended anterior arm.
- A barrel shaped chest or abdomen indicates nuchal arm(s) and in some cases an extended head.
- A floppy perineum casting a shadow on the baby's neck suggests a deflexed and extended head.

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11.5 Assistance for an all-fours delivery

11.5.1 Considerations

- Do not assist or touch the baby until the umbilicus is visible.
- Even at this point, caesarean section should be considered if descent does not happen easily to umbilical level or if there are CTG concerns.
- Only proceed to assist with the birth if you are experienced or are in an emergency situation, i.e., unplanned breech MLU/Home birth
- If you need to actively assist after the baby has delivered to the umbilicus, anticipate that the baby will require resuscitation.

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11.5.2 How to actively assist when there is no descent after the umbilicus has delivered

- Gently hold the baby being aware of the proximity of the soft structures of the abdominal cavity
- Either with 1 hand flat against the rib cage and the other flat against its back or 2 fingers on the baby's shoulder blades and thumbs level with the clavicles.

- Disengage upwards to relieve the entrapped arm. This is critical to success
- Rotate the baby in the easiest direction it will go
- Rotate (no traction) the baby's body so that its abdomen faces the maternal sacrum. The arm may deliver after a 90◦ rotation. If not, continue the rotation to 180◦ and then return back to direct sacro- anterior. The anterior arm can then be swept over the baby's face if it has not spontaneously delivered

Or

- Rotate (no traction) the baby's body so that its abdomen faces the maternal pubic bone and continue the rotation round to direct sacro- anterior. Commonly the anterior arm will have delivered during this process. If not, sweep the arm over the baby's face.

It is possible the birth will then be spontaneous, but be prepared to continue to assist.

11.5.3 How to manage non-delivery of the head

11.5.3.1 Deflexed head

Suspected by seeing a shadow on the baby's neck from a floppy perineum in addition to a flat perineum

- **Either** if the tummy tuck does not happen, slide 2 fingers behind the baby's occiput and encourage flexion. Sliding 2 fingers up onto the baby's cheekbones and flexing the head can enhance this. The mother may then naturally drop forward to assist the birth.
- **Or** place 2 fingers on the baby's shoulder blades and thumbs level with the clavicles. Press the baby's shoulders towards the maternal pubis, this will pivot and flex the baby's head on the maternal pubic bone (Frank's nudge). When the chin becomes visible, ask her to push.
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11.5.3.2 Extended head

Suspected by seeing a shadow on the baby's neck from a floppy perineum in addition to a flat perineum, a barrel shaped fetal torso that is lifted towards the accoucheur, it is rare and thought to be 1:100 births.

Gently hold the baby with your thumbs in the sub-clavicular space and 2 fingers on shoulder blades.

- Disengage upwards
- Press gently into the sub-clavicular space and roll the shoulders forward
- Hold this for 5 seconds and the head should flex
- Suprapubic/fundal pressure may safely be employed once the head has been flexed
- If unsuccessful, gently push the baby's head to an oblique diameter of the maternal pelvic brim and repeat the process

Continue to assist as the head descends by pressing backwards on the baby's shoulder blades toward the maternal symphysis pubis (Frank's nudge), as this will encourage flexion of the head.

Delayed cord clamping maybe beneficial in resuscitation of the baby.

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11.6 Assistance for a Lithotomy delivery

Early intervention is indicated only to ensure that the baby sacrum is towards the mother's symphysis pubis ('Bum to Tum') and this should consist of gentle rotation without traction.

Manoeuvres should otherwise not be commenced until after the breech has delivered spontaneously to the level of the umbilical cord insertion.

If the breech is not delivering spontaneously the arms should be flexed across the chest or if nuchal should be delivered using Lovset's manoeuvre. If this fails it is usually because inadequate rotation or no (gentle) traction has been employed. The body can be moved to one side and a hand inserted to bring the arms across the face.

The body should normally be supported at this point and care taken that the baby does not fall. The head should be allowed to descend such that the nape of the neck should be visible. If simple maternal effort does not deliver the head, the Mauriceau Smellie Veit manoeuvre is favoured over the Burns Marshall technique, which **should be avoided**. Applying suprapubic pressure may help if there is difficulty.

It is recommended that birth should be complete within 6 minutes of the bitrochanteric diameter being born or 3 minutes from umbilicus, progress should be clearly documented in the notes.

If one contraction has failed to deliver the head, forceps should be applied, before the next contraction, with an assistant holding the baby up by the legs at 45 degrees to the maternal spine. With an episiotomy, delivery of the head is usually then straightforward.

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Once the shoulders are delivered, difficulties should be rare. Occasionally, however if the head does not descend, suprapubic pressure should be applied before the above manoeuvres are used to deliver the head.

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11.7 Breech extraction

This should not be employed except under exceptional circumstances for the singleton breech.

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11.8 Breech extraction for 2nd Twin:

It may achieve delivery of a second twin much more rapidly than caesarean section. The accoucheur must be experienced at the technique and if not, caesarean section is preferable. The indications are for delivery of a transverse lie or to expedite delivery of a breech in the presence of either a severe delay or severe fetal heart rate abnormalities.

Epidural or preferably spinal anaesthesia is indicated. Intact membranes are almost always required. One foot or two feet are grasped and brought down to the introitus. It is crucial to identify the foot by the heel so as not to pull an arm. The membranes are not ruptured until this point. With minimal traction and maximal maternal effort, the baby is then delivered as per an assisted breech birth. It is more likely that the arms will be nuchal, or the neck extended, and these should be anticipated.

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12 References

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12.1 Appendix – Vaginal Breech Birth Proforma

Birth plan, Term spontaneous labour – vaginal breech birth

Discussion date_____ Signature/designation

Antenatal discussion and planning (intra partum if undiagnosed)	
Women should be informed that:	Planned caesarean section provides no increased maternal risk in the current pregnancy
	Caesarean section increases the risk in the next pregnancy due to complications of repeat surgery and placental implantation problems
	There is a suggested 30-40% chance of caesarean section in labour with a breech presentation
	In rapid labour, caesarean section can carry increased risk for the mother
Women should be informed that for their baby:	Initial Apgar scores may be lower than a headfirst birth but that here is no evidence of poor long-term outcomes for their baby
	Significant poor outcome at birth is slightly higher in vaginal breech birth. Suggested to be 1:600 (about 1:1000 for a headfirst baby)
	Admission to special care with breathing problems is more common following a caesarean section compared to one born vaginally
	Caesarean section may be associated with childhood disorders of diabetes and obesity and other illnesses
	There is no evidence that caesarean section is safer for the baby in a rapidly progressing labour
Planning for vaginal breech delivery; women should be informed that;	
Early labour	Care is provided as in any spontaneous labour but an admission CTG is recommended.
Active first stage	Continuous EfM, no cannula, and normal labour care are standard. We encourage mobile active birth; Entonox, TENS, massage, immersion in water (for first stage ONLY). Epidural should be avoided. 1st stage onset will be recorded and confirmed from VE or labour signs. Once active pushing is commenced delivery should be accomplished or imminent within 60 minutes, otherwise caesarean section is recommended. **(New 2021)**

Passive second stage	We recommend EfM and a passive second stage of <90 minutes. We observe for second stage signs of sounds/natal line/descent, 'bulging' perineum. VE confirmation is not mandatory, but documentation of onset time is. We discourage pushing until presenting part is visible.
Active second stage	We have a designated birth leader and will have discussed when/if this should change
	We recommend upright/all fours position and only intervene if normal descent/rotation does not occur or with concerns of fetal well-being
	We need to help in some births and this can be managed in all upright/ all fours or lithotomy. Forceps are sometimes needed
	We will have a neonatal doctor attending the birth
	We delay cord clamping and encourage skin to skin unless there are concerns about the baby

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12.2 Appendix – Monitoring and Compliance

Compliance Standard	Monitoring Method	Frequency of Monitoring	Review Group/ Committee
Detection of breech presentation	% Of deliveries where the presentation is breech that were diagnosed before labour.	Annual	Breech working group, reportable to MPF.
Uptake of ECV	% Of women delivering a breech at term who had declined ECV.	Annual	Breech working group, reportable to MPF.
Success of ECV	% Of women referred for ECV, with a breech presentation, in whom the presentation was cephalic at delivery.	Annual	Breech working group, reportable to MPF.
Safety of ECV	% Of women who underwent ECV whose baby had possible ECV-attributable morbidity.	Annual	Breech working group, reportable to MPF.
Mode of delivery for undiagnosed (antenatally) breech presentation	% Of women with an undiagnosed breech presentation who delivered vaginally.	Annual	Breech working group, reportable to MPF.

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12.3 Appendix – RCOG patient information leaflet

https://www.rcog.org

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