Breech Presentation at Term

Guideline information

Guideline number: 601

Classification:
Clinical

Supersedes:
Previous Version

Local Safety Standard for Invasive Procedures (LOCSSIP) reference:
N/A

National Safety Standards for Invasive Procedures (NatSSIPs) standards:
N/A

Version number:
3.0

Date of Equality Impact Assessment:
Pending

Approval information

Approved by: Maternity Working Control Document Group

Date of approval:
25/01/2024

Date made active:
05/04/2024

Review date:
25/01/2027

Summary of document:
This guideline covers diagnosing and managing breech presenting fetus at term including ECV.

Scope:
This guideline applies to midwives, obstetricians, anaesthetists and paediatricians who care for patients presenting at term with a baby in a breech presentation and patients presenting in labour with an undiagnosed breech presentation in acute hospitals, in midwifery-led units and the patient's home.

The guidance below uses the term 'woman' (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women's health and reproductive services. Therefore, this should include people who do not identify themselves as women but who are pregnant or have recently given birth. Obstetric and Midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identify does not align with the sex that they were assigned at birth.

To be read in conjunction with:
Detail any approved Health Board policy/procedures which must be read in conjunction with

Patient information:
Include links to Patient Information Library

Breech baby at the end of the pregnancy

Breech baby at the end of pregnancy | RCOG

Owning group:
Maternity Working Control Document Group
25/01/2024

Executive Director job title:
Clinical Lead Obstetrician

Reviews and updates:
1.0 – New Guideline
2.0 – Review
3.0 - Review

Keywords
Breech, ECV

Glossary of terms
ECV External Cephalic Version
Frank Breech: Presenting part is the buttocks. Also known as extended breech.
Complete Breech: Presenting part is the buttocks and the feet. Also known as flexed breech.
Footling Breech: Presenting part is one or two feet with the knees extended

Contents

Scope

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The guidance below uses the term 'woman' (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women's health and reproductive services. Therefore, this should include people who do not identify themselves as women but who are pregnant or have recently given birth. Obstetric and Midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identify does not align with the sex that they were assigned at birth.

Aim

This guideline covers diagnosing and managing breech presenting fetus at term including ECV, Antenatal and Intrapartum care

This guideline applies to midwives, obstetricians, anaesthetists and paediatricians who care for patients presenting at term with a baby in a breech presentation and patients presenting in labour with an undiagnosed breech presentation in acute hospitals, in midwifery-led units and the patient's home.

Antenatal Counselling

Women with suspected breech presenting baby after 36/40 should be referred to have a departmental scan for presentation. If breech presentation is confirmed, EFW and DVP should also be assessed to help with counselling the woman about her birth options.

Women presenting with a confirmed breech presentation at term should be offered External Cephalic Version (ECV) unless there is an absolute contraindication.(see Paragraph 2.1)

Women who have a breech presentation at term following an unsuccessful or declined offer of ECV should be counselled on the absolute and relative risks and benefits of planned vaginal breech delivery versus planned caesarean section, in an unbiased manner. The counselling needs to focus on both the baby as well as the mother.

Information about the baby

Women should be informed that planned caesarean birth leads to a reduction in perinatal mortality (death) (0.5/1000 after 39 weeks) compared with planned vaginal breech birth (2.0/1000) This compares to 1.0/1000 for a planned cephalic birth.

Selection of appropriate pregnancies and skilled intrapartum care may allow planned vaginal breech birth to be nearly as safe as planned vaginal cephalic birth.

Women should be informed that planned vaginal birth increases the risk of low Apgar scores and short-term complications, but has not been shown to increase the risk of long-term morbidity.

Women should be informed that the reduction in risk to baby is only linked to pre-labour Caesarean birth and that Caesarean in labour (specially in advanced labour) does not necessarily reduce the risk to baby

Further Information for Women
Women should be informed that a planned caesarean birth for breech presentation at term carries a small increase in immediate complications for the mother compared to a planned vaginal birth.

Women should be informed that caesarean section increases the risk of complications in future pregnancy, including the risks of scar rupture in future pregnancy, the increased risk of complications at repeat caesarean birth, the increased risk od still birth in future pregnancy, and the risk of an abnormally invasive placenta.

Specific consideration
Women should be informed that a higher risk planned vaginal breech birth is expected in the following circumstances:

- Hyperextended neck on ultrasound.
- High estimated fetal weight (more than 3.8kg).
- Low estimated weight (less than 10th centile).
- Footling presentation.
- Evidence of antenatal fetal compromise.

In these caesarean birth should be advised

Alongside the consultation, all women should receive patient information leaflets on :
Breech at Term, ECV, and Planning a Caesarean birth

External Cephalic Version

Contraindications
ECV should not be offered when a Caesarean birth is already planned for another reason.

ECV is generally considered to be contraindicated in:

- Multiple pregnancy (except for the second twin, after the birth of the first twin)
- Suspected or confirmed Placental Abruption
- Abnormal electronic fetal monitoring (EFM)
- Rupture of the membranes
- Severe Preeclampsia
- Abnormal umbilical artery doppler

Women should be informed that ECV after one caesarean delivery appears to have no greater risk than with an unscarred uterus.

Counselling

- Women should be informed that the success rate is approximately 50%.
- Women should be informed that the risk of complications leading to emergency caesarean is very small 0.5%
- Women should be informed that after successful ECV, less than 3% of babies turn back.

Timing of ECV

- For Nulliparous women the optimal timing for ECV is from 36+0/40
- For Parous women the optimal timing for ECV is from 37+0/40
- There is no upper limit to the gestation where ECV can be offered

Technique

- Fasting is not recommended prior to ECV
- Before ECV is preformed, fetal wellbeing and presentation should be confirmed by ECG and USS
- Terbutaline 250mcg SC is thought to increase the success rate of ECV
- After ECV attempt the presentation and the wellbeing of the fetus should be confirmed again using USS and CTG
- It is not uncommon for a CTG to show a transient deceleration <3minutes following ECV
- Women with Rhesus Negative status should have Kleihauer test and be offered Anti-D
- Regional analgesia may be considered in but may be considered for a repeat attempt or for women unable to tolerate ECV without analgesia
- Following unsuccessful ECV the woman should be offered the choice of either a repeat ECV, Planned Vaginal birth, or Planned Caesarean Birth (see paragraph 1)

Alternative of ECV

- Women may wish to consider the use of **Moxibustion** for breech presentation at 33–35 weeks of gestation, under the guidance of a trained practitioner.

Planned Caesarean Birth for Breech Presentation

Planned Caesarean birth should be offered no sooner than 39/40 weeks. There is no upper limit to the timing of Caesarean. However, if the next available slot is after 42/40 the woman should be discussed with the on call Consultant and Labour Ward Co-ordinator to decide the appropriate date for Category 3 Caesarean.

Planned Vaginal Breech Birth

- Birth in a hospital with facilities for immediate caesarean section should be recommended with planned vaginal breech birth, but birth in an operating theatre is not routinely recommended.
- Women should be informed that although there's no evidence, CTG may lead to improved fetal outcome.
- The first stage of labour should be managed according to the same principles as with a cephalic presentation.
- Augmentation of slow progress using Oxytocin and infrequent contractions can be considered after a Consultant review (see Oxytocin use for slow progress in labour guidelines)
- If the mother has an epidural in situ RCOG guidance recommends 2 hours for passive descent providing the fetal heart is within normal parameters and there is evidence of constant progress.
- For the birth of breech baby a semi-recumbent or an all-fours position may be adopted.
- Intervention is needed if there is a delay in the birth of the baby's head more than 3 minutes from the birth of the umbilicus or 5 minutes from the birth of the buttocks
- See Appendix 1 for different manoeuvres.

Women should be advised that planned vaginal birth should take place on the obstetric unit in Glangwili Hospital.

Women wishing to birth outside of guidance should be referred to their named consultant and the consultant midwife and an individualised care plan should be completed

Breech diagnosed in Labour

- Women in or near second stage of labour should not routinely be offered a Caesarean Birth as there is no evidence to support better outcome for baby or mother.

- Routine unplanned caesarean birth for a breech diagnosed in labour is not recommended. The mode of birth should be individualised based on cervical dilatation, station of the presenting part, type of breech presentation, fetal wellbeing and availability of an operator skilled in vaginal breech delivery.

Preterm Birth
Consider caesarean birth for women presenting in suspected, diagnosed or established preterm labour between 26+0 and 36+6 weeks of pregnancy with breech presentation.

- Caesarean birth for breech presentation in spontaneous extreme preterm labour (before 26 weeks) is not recommended as the outcome is unlikely to improve.

Birth Position
Consideration should be given to supporting women to adopt upright positions for birth eg. mother kneeling, hands/knees, on a birthing stool, standing as affords physiological advantages to labour (RCOG, 2017. Banks, 2007, Evans, 2012, Louwen et al., 2012). In the event that manoeuvres are required these should be performed as per the experience and training if the individual facilitating the birth.

Training

A senior doctor should be present for *ALL* vaginal breech births, the Consultant Obstetrician should be informed and consideration should be given to the Consultant Obstetrician attending

Delay in the birth of the after coming head is an obstetric emergency.

Regular training including Breech station in PROMPT Cymru should be undertaken by all Obstetricians and MWs

Attending additional courses should be supported by the department i.e. physiological breech training

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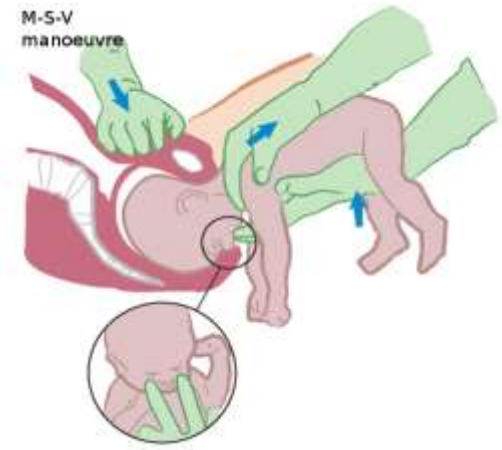
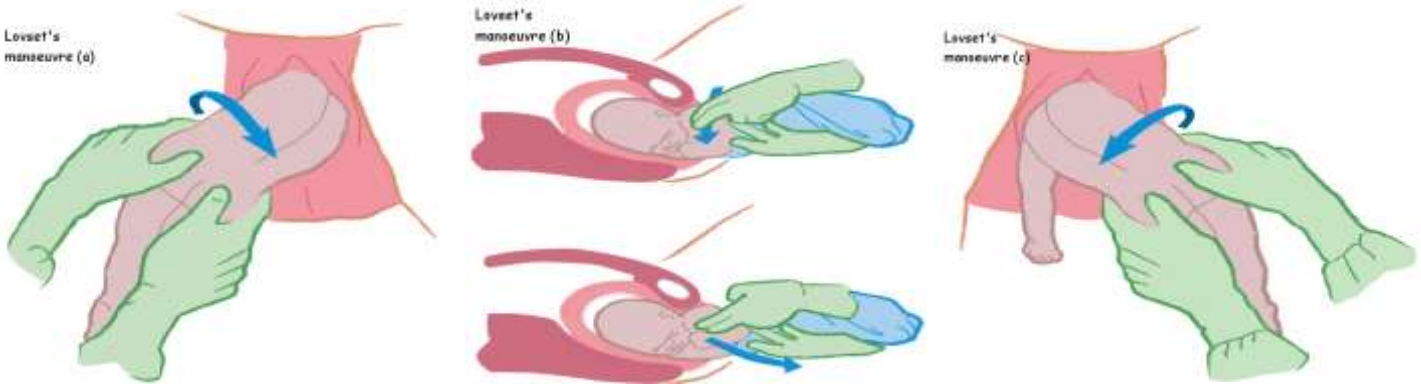
Appendix 1 – Breech birth manoeuvres

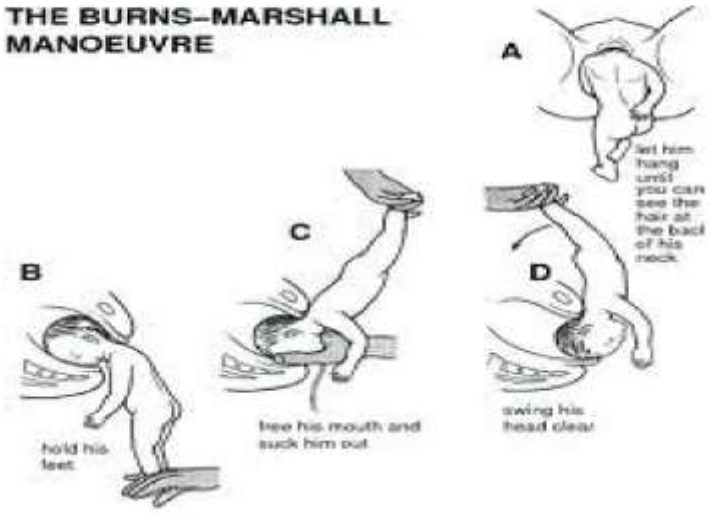
Mauriceau–Smellie–Veit maneuver (MSV) This procedure entails suprapubic pressure by one obstetrician on the mother/uterus, while another obstetrician inserts left hand in vagina, palpating the fetal maxilla using the index and middle finger and gently pressing on the maxilla, bringing the neck to a moderate flexion. The left hand's palm should rest against the fetus' chest, while the right hand can grab either shoulder of the fetus and pull in the direction of the fetus' pelvis



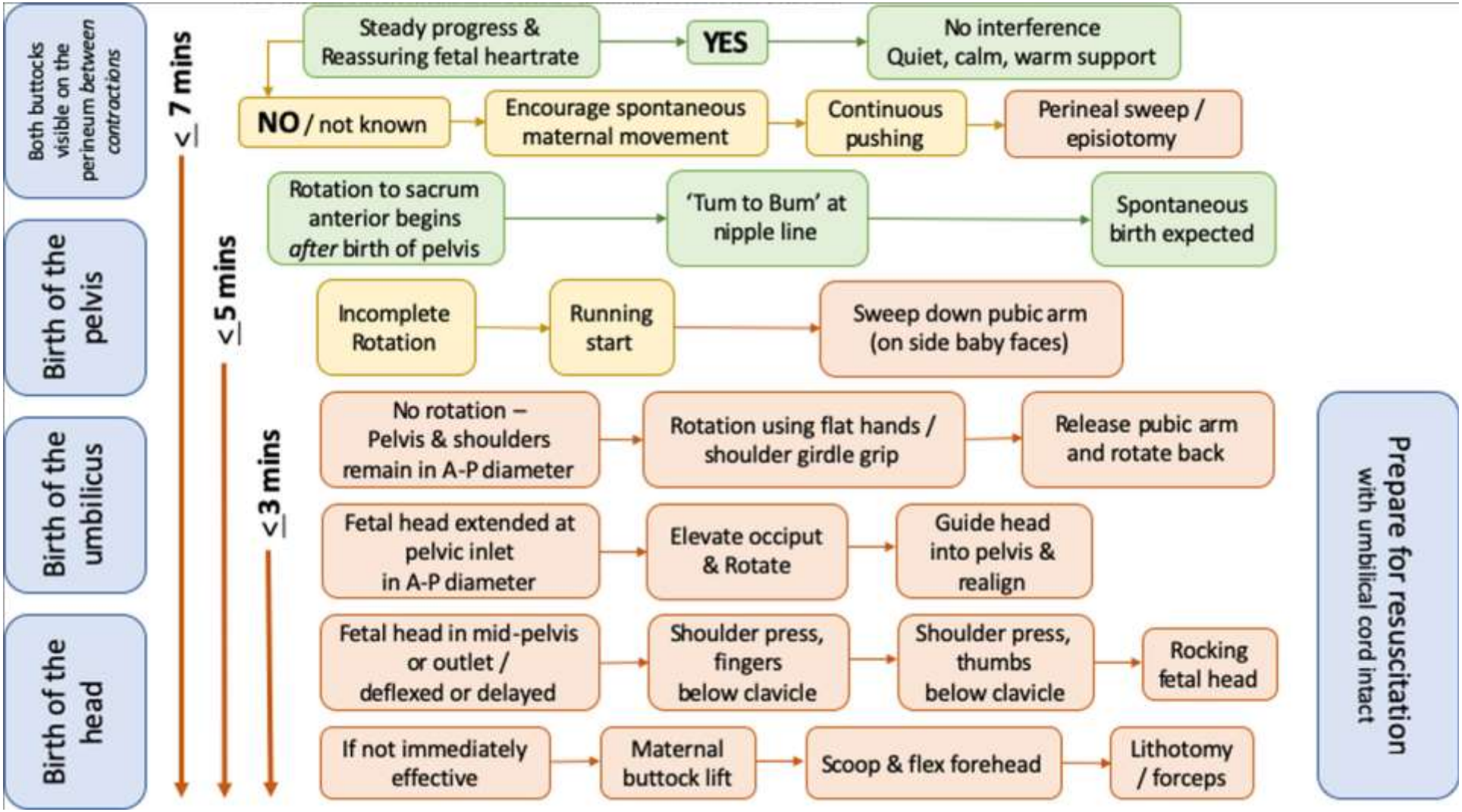
Løvset's Manoeuvre involves rotation of the trunk of the foetus during a breech birth to facilitate delivery of the extended foetal arms and the shoulders. Baby is held by the pelvic bone not the flanks.



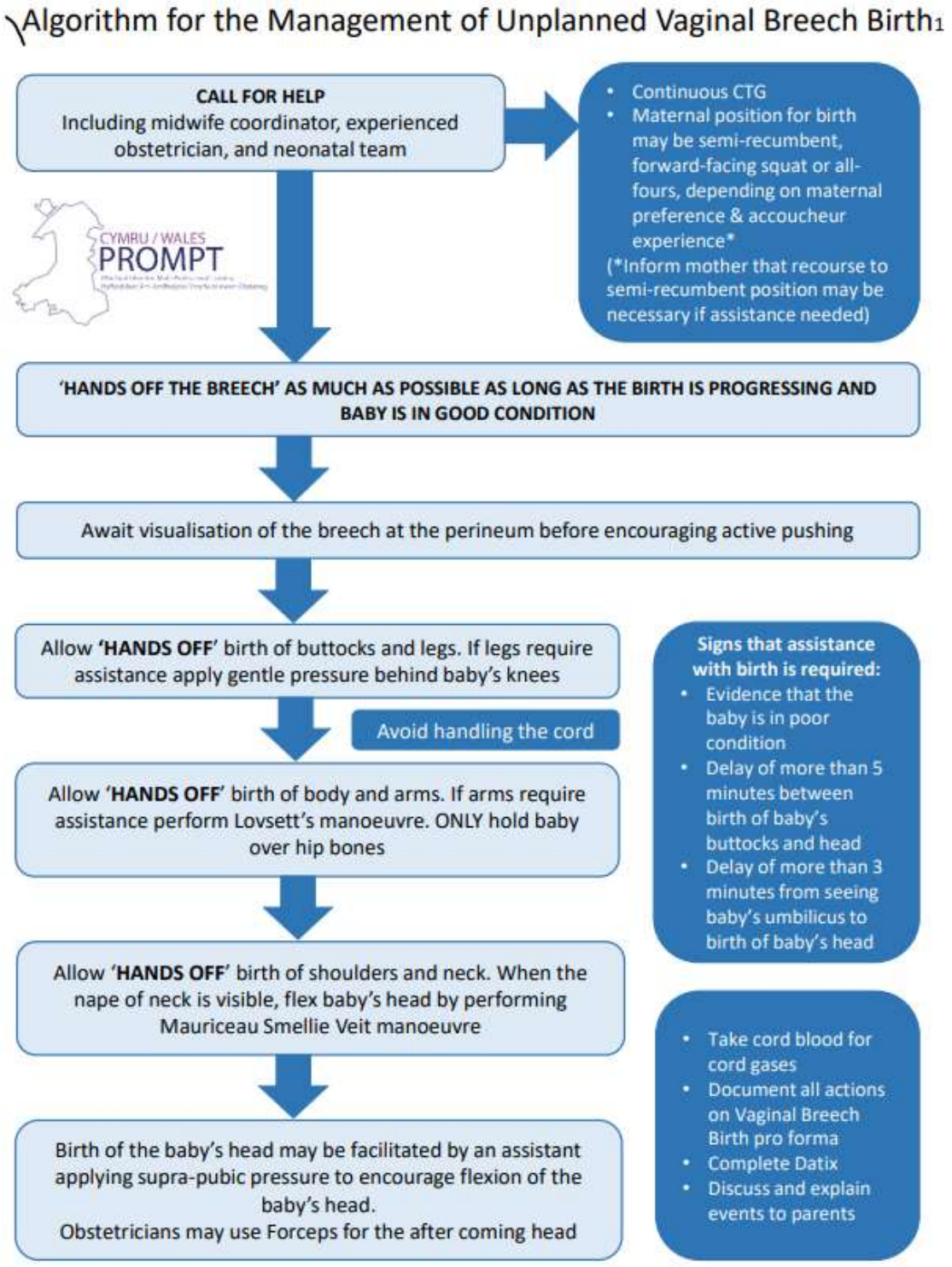
Images from www.thecarecourse.ca


THE BURNS–MARSHALL MANOEUVRE
A
let him hang until you can see the hair at the back of his neck
B
hold his feet
C
free his mouth and suck him out
D
swing his head clear

Appendix 2 – Physiological Breech Birth Algorithm



Appendix 3 – PROMPT Unplanned Vaginal Breech Birth Algorithm



1. RCOG Green-Top Guideline No.20b. Management of Breech Presentation. June 2021