Breech Presentation Guideline

(including ECV, Breech Birth and Emergency procedures)

Guideline information

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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.
This policy uses the term "women" to reflect that maternity and reproductive care are sex-based health needs. It applies equally to all people who are pregnant or have recently given birth, including trans men and non-binary people. Care must be delivered in an inclusive, respectful and responsive way.

To be read in conjunction with:
RCOG Management of Breech Presentation (Green top Guideline 20b.2017)
Management of Breech Presentation- opens in a new tab

External Cephalic Version and Reducing the Incidence of Term Breech Presentation (Green-top Guideline No. 20a) External Cephalic Version and Reducing the Incidence of Term Breech Presentation (Green-top Guideline No. 20a) | RCOG -opens in a new tab

Patient information :
Breech baby at the end of the pregnancy
Breech baby at the end of pregnancy | RCOG -opens in new tab

Owning group: Maternity Working Control Document Group 30/04/2026
Executive Director job title: Clinical Lead Obstetrician

Reviews and updates:
1.0 – New Guideline
2.0 – Review
3.0 – 05/04/2024
4.0 – 30.4.2026

Keywords: Breech, ECV

Glossary
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

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Scope

This guideline applies to midwives, obstetricians, anaesthetists and paediatricians who care for patients presenting at term (including nulliparous women from 36 weeks) 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. term.

Aim

This guideline supports clinician in diagnosing and managing care and support for women with breech presenting fetus at term including ECV, mode of breech birth and emergency procedures/ manoeuvres.

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 regarding 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

Specific Considerations

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.

Note : In these babies caesarean birth should be advised

Alongside the consultation, all women should receive the RCOG patient information leaflets Breech baby patient information leaflet -opens in a new tab .

External Cephalic Version (ECV)

Absolute contraindications for ECV

- Where caesarean birth is already indicated for another reason (includes >1 previous caesarean section, relative contraindications for ECV, classical caesarean, previous myomectomy, low lying placenta, maternal medical conditions with risks at vaginal delivery)
- Uterine anomaly
- Low lying placenta
- Current vaginal bleeding or recent history of APH in the last 7 days
- Severe hypertension/ preeclampsia requiring expedited delivery
- Abnormal CTG
- Ruptured membranes
- Rhesus immunisation
- Multiple pregnancies (**except** for use in managing birth of 2nd twin, after birth of first twin)
- Where mother declines or is unable to give informed consent

Relative contraindications

- Small-for-gestational-age / Fetal Growth Restricted with abnormal Doppler
- Major fetal anomaly
- Pre-eclampsia
- Oligohydramnios
- Scarred uterus (1 previous caesarean)

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

Timing of gestation 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

Pre-procedure guidance

All Women should be provided with RCOG written information (ECV Leaflet) Breech baby patient information leaflet -opens in a new tab

Counselling

- Women should be informed that the success rate is approximately 50%.

- Women should be informed that the risk of complications of ECV leading to unplanned caesarean birth is very small 0.5%
- Women should be informed that after successful ECV, 3-5 % of babies may turn back
- Discuss further management plans if ECV fails (possibility of a vaginal breech birth or planned caesarean birth) and document in the notes.

ECV Practitioner

ECV should only be performed by a trained practitioner **or** by a trainee working under direct supervision by a Trained Practitioner

ECV procedure

External Cephalic Version should only be performed on the labour wards in GGH and BGH where facilities for monitoring and surgical delivery are available
(see **Appendix 1** for ECV flow chart)

- Written informed consent to be obtained
- Fasting /standard pre-op prep for CB is not recommended prior to ECV but for stabilising ECV prior to induction advise to fast.
- Check Maternal rhesus status
- Record Maternal clinical observations and clinical palpation
- Perform CTG for minimum of 20 minutes to ensure fetal well-being.
- Perform USS to confirm breech presentation
- Position patient in the dorsal position lying on the bed with a slight tilt to the left or right side. Some practitioners also tilt the bed, placing the women partly head down.
- Consider Terbutaline 250mcg (subcutaneous / IV slowly) as it has been shown to increase success rate (caution – watch for palpitations and warn patient of possible nausea).
- Perform ECV.

The procedure will be abandoned if:

- Attempts at a forward roll or backward flip is unsuccessful **OR**
- There is maternal intolerance to the procedure

Note – If ECV unsuccessful and no tocolytic has been used, consider repeating after administering relevant tocolytic

Post procedure

- Check if ECV has been successful by performing USS after the procedure
- Repeat CTG for 30 minutes to ensure fetal well-being.

NOTE: *A transient (less than 3 minutes) fetal bradycardia after ECV is not uncommon but should instigate continuous monitoring in a left lateral position,* **if persistent and not improving after 6 minutes, should prompt preparation for category I caesarean section**

- Monitor pulse, BP and vaginal loss
- If mother is rhesus negative (or if cffDNA screening and baby result is Rh positive) will require Kleihauer and offered prophylactic anti-D). **Dose administration**: minimum of 500 iu is recommended within 72 hours
- Complete ECV Audit proforma (see appendix 2)

Analgesia is not routinely offered but may be considered for a repeat attempt or for women unable to tolerate ECV without analgesia.

Ongoing Management

- If ECV is successful, patients should be managed as usual for a cephalic presentation.
- Appointment should be made in a week's time with midwife for a presentation scan to confirm cephalic presentation.
- Should baby have reverted to a breech presentation a further ECV may be considered.

If ECV is unsuccessful, the woman should be offered the choice of either:

- Repeat ECV (at the consultant's discretion)
- Planned Caesarean Birth (see paragraph 1)
- Planned Vaginal birth

Discharge Home

The woman may be discharged home if

- Maternal observations normal
- CTG classified as normal
- Obstetric team satisfied with fetal and maternal condition

Discharge information

Instruct woman to phone triage or return to the hospital if any of the following occurs:

- Vaginal bleeding/ Any clinical signs of APH
- Abdominal pain
- Altered fetal movements
- Any concerns

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.
- There is currently no evidence that postural management alone promotes spontaneous version to cephalic presentation

Unstable lie: arranging an inpatient ECV / Stabilising Induction

Unstable lie refers to the frequent changing of fetal lie and presentation in late pregnancy (usually refers to pregnancies > 37 weeks' gestation) With adequate clinical assessment, confirmation of presenting fetal part's position, and use of appropriate obstetric interventions, women should be supported to attempt a trial of labour and achieve a vaginal birth where appropriate.

External version can be considered to correct lie before a stabilising induction. A stabilising induction is a higher risk procedure and may involve a controlled artificial rupture of membranes in theatre. A stabilising artificial rupture of membranes (ARM) should be done with caution

Please ensure the woman and ward staff have specific instructions regarding fasting prior to procedure.

Contact labour ward to identify an appropriate day to perform the procedure (based on consultant availability) and the clinical situation. Ensure is “booked” in LW diary.

Note: Bladder distention can cause a changing fetal lie; encourage the woman to void before performing any procedures

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

Planned Vaginal Breech Birth

Women should be advised that planned and unplanned vaginal births should take place on the obstetric unit in Glangwili Hospital.
Women who wish to birth outside of guidance should be referred to their named consultant and the consultant midwife and an individualised care plan should be completed

Management of vaginal 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.

First stage of labour

- The first stage of labour should be managed according to the same principles as with a cephalic presentation. However, the following should be taken into consideration:
- Discuss care plan and management options, confirm that Vaginal breech birth remains the preferred option.
- On-call consultant obstetrician and delivery suite coordinator should be informed of admission and plan. Anaesthetist, theatre staff and neonatal team should also be informed
- Intravenous access and preoperative procedures are not routinely required for vaginal breech birth. Consider IV access if other risk factors are present
- Discuss woman’s preferred choice of analgesia. Epidural is not routinely required for vaginal breech birth.
- RCOG recommend that CTG monitoring should be recommended due to the improved outcomes at birth in a fetus who has not become hypoxic during labour. Therefore, CTG monitoring should be offered.
- Where CTG is declined, intermittent auscultation should be performed as for a cephalic presentation, with conversion to CTG if any abnormality is detected.
- Membranes should be left intact for as long as possible due to the increased risk of cord prolapse, amniotomy should only be performed if necessary and this should be following discussion with the on-call consultant obstetrician.
- The passage of meconium, except at the point of birth, has the same significance as in cephalic presentation.
- if slow progress and infrequent contractions are present Augmentation of slow progress using Oxytocin and infrequent contractions can be considered after review, a robust assessment and plan of care by the on call obstetric consultant. A caesarean section should be considered and discussed in the event of slow/stalled progress.

Second stage of labour

- On call anaesthetist should be informed of second stage
- Second stage may be confirmed by vaginal examination.
- Ensure Neonatal resuscitation equipment is set up and accessible and paediatrician should be present during a vaginal breech birth in hospital
- 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.
- Adequate descent of the breech in the passive second stage is a prerequisite for encouragement of the active second stage. (RCOG 2017). Encourage the woman to adopt a comfortable position for birth. A semi-recumbent or "Upright all fours position" may be considered, depending on the skills of the midwife or obstetrician involved.
- Birth should be achieved mainly by maternal effort and with a 'hands off the breech' approach. Manoeuvres should only be used if there is a delay in progression and/or evidence of poor fetal condition.
- Use of the Physiological Breech Birth algorithm (**see appendix 4**) predicts the timings that determine if the birth requires assistance and interventions/ manoeuvres needed to deliver a breech baby safely, which occurs within a timeframe of under seven minutes. Utilise Manoeuvres as outlined in **appendix 3** if there is a delay in the normal progress of birth. 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.
- The basic principle is to avoid unnecessary interference. "Hands off the breech!" until it has birthed as far as the umbilicus.
- Avoid handling of umbilical cord to reduce risk of vasospasm. Only release a loop of cord if it is under tension.
- The sacrum should be allowed to descend to the pelvic floor without active pushing.
- If episiotomy is indicated it should be performed when buttocks are distending the perineum to allow further manoeuvres which may be necessary to assist birth.
- Ensure that breech proforma is completed. Manoeuvres for Assisted Vaginal Breech Birth All manoeuvres used during breech birth should be clearly documented including which arm/ leg (right or left) is manoeuvred.
- Collect cord gases where possible, regardless of the APGAR Scores.

Unplanned Vaginal Breech Birth

- Where a woman presents with an unplanned vaginal birth labour, management and mode of birth should be individualised based on; cervical dilatation, station of the presenting part, type of breech presentation, fetal wellbeing, whether factors associated with increased complications are found and availability of an appropriate clinician skilled in vaginal breech delivery.
- 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 and therefore not recommended (RCOG 2017)

If decision for vaginal birth confirmed:

- Follow the PROMPT Algorithm for Unplanned Vaginal Breech Birth (appendix 5)
- Complete Datix following birth
- Debrief: discuss and explain events to parents after birth

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.

Breech Birth Position

Consideration should be given to supporting women to adopt upright positions for birth e.g. 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.

Unplanned Breech in Community Setting

If Diagnosed at Home

- Follow the community Prompt Algorithm for the management of vaginal breech (see appendix 6)

On diagnosis of a breech presentation in labour at home, an ambulance MUST be called immediately via 999 with a view to transferring the woman to hospital with paramedic support.
Avoid rupturing the membranes but if ruptured a vaginal examination should be performed to assess:

- Cervical dilatation
- Position and type of breech presentation (sacro-posterior position is rare but very difficult to deliver).
- Determine station of the breech
- If the birth is imminent the midwife should immediately call for back up support by 999 and inform the labour ward of the situation.
- Labour ward should be informed of the transfer and reason so that appropriate staff can be alerted at the receiving unit i.e., obstetrician, anaesthetist and paediatrician.
- All observations and actions taken should be recorded in the labour notes and on Prompt algorithm (a scribe can be used if the midwife is busy (e.g. ambulance technician).
- A copy of the ambulance records should be filed in the woman's hospital notes.
- In the event of spontaneous birth, the basic principle is to avoid unnecessary intervention. "Hands off the breech"

Imminent birth en-route - the ambulance should stop and pull over

• The woman should adopt most appropriate position depending upon the availability of space and skills of the midwife.

Training

A senior doctor should be present for *ALL* vaginal breech births in the hospital setting , 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 hospital and community Midwives

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

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Appendix 1 Hywel Dda ECV flow chart

Hywel Dda External Cephalic Version

- Arrange ECV Appointments via Labour ward in GGH and BGH

All women must be given the RCOG Breech baby patient information leaflet

ON DAY OF ECV PROCEDURE

- May have normal diet on day of admission (unless for stabilising ECV and induction)
- Obtained informed written consent for procedure
- ECV to be performed on labour wards with CTG and ultrasound facilities are available

Prior to ECV monitor fetal heart with CTG and ensure classified as normal

Abandon the procedure if ;

- Attempts at a forward roll or a backward flip are unsuccessful
- If there is maternal intolerance to the procedure
-

Tocolysis can be offered to increase the chance of success

Dose: Subcutaneous terbutaline 250 micrograms can be routinely administered prior to ECV procedure

Regional anaesthesia or neuraxial blockade is not routinely offered but may be considered for a repeat attempt or for women unable to tolerate ECV without analgesia.

POST PROCEDURE

Regardless of whether ECV is successful or not:

- Monitor fetal heart with CTG
- Monitor maternal BP , pulse and any vaginal loss
- When maternal blood group is Rhesus negative: if cffDNA is not performed or if cffDNA baby blood group result is Rh positive obtain a maternal blood group and antibodies screening sample and request a Kleihauer test and request prophylactic Anti D 500 units within 72 hours of procedure.

If ECV is unsuccessful offer the woman choices of:

- Repeat ECV (at consultant discretion)
- Planned vaginal birth
- Planned caesarean birth
- If woman opts for planned caesarean birth book from 39 weeks

NOTE: If ECV successful, arrange presentation scan in one week.

Women may discharged home provided

- The fetal CTG is classified as normal
- Maternal observations are normal
- The obstetric team is satisfied with fetal and maternal wellbeing

Advise the woman to phone Triage if she has :

- Vaginal Bleeding or any signs of APH
- Abdominal pain
- Altered or reduced movements
- Any concerns

Appendix 2. HDD External Cephalic Version Audit proforma

Hywel Dda External Cephalic Version (ECV) Audit Proforma

To be completed following discussion with patient

- ✓ Ensure that recent ultrasound has been performed, and report states fetal growth, liquor and nature of breech
- ✓ Aim for ECV at 36/40 for nullipara and 37/40 for multipara
- ✓ May have normal diet on day of admission for ECV

Refer to the Health Board ***601 Breech presentation at term Guideline*** for guidance and contraindications for ECV

Finding at time of Antenatal consultation	
Patient ID.	Gravida and Gestation
	Consultant informed Y/N: Name:
Patient counselled regarding options of vaginal birth , ECV or caesarean birth	
RCOG patient information leaflet given	
If ECV were unsuccessful does patient wish to proceed with: (please circle)	Vaginal birth Planned caesarean birth Unsure at this time
USS Findings : Flexed/ extended breech	
Liquor volume	
Growth Centile	
Placental position	
Rhesus Group	Maternal
	Baby cffDNA screening result :

Findings at time of ECV	
Ultrasound position at start	
Tocolytics used and route	
If ECV not attempted - reason	
If ECV not successful- why not	
Midpoint monitoring performed	
Outcome	
Further plan of care;	
Name of Clinician undertaking ECV:	
Is Mother is Rhesus negative -	Yes / No
has cffDNA screening been completed	Yes/ No
If CffDNA screening result :	**If Negative** – Anti D **not** required
	If Positive – Anti D **is** required
If cffDNA screening not performed	Anti D to be given
Anti D administered and dose	Given by Dose given

All Operators to complete Proforma and file in ECV folder on Labour Ward

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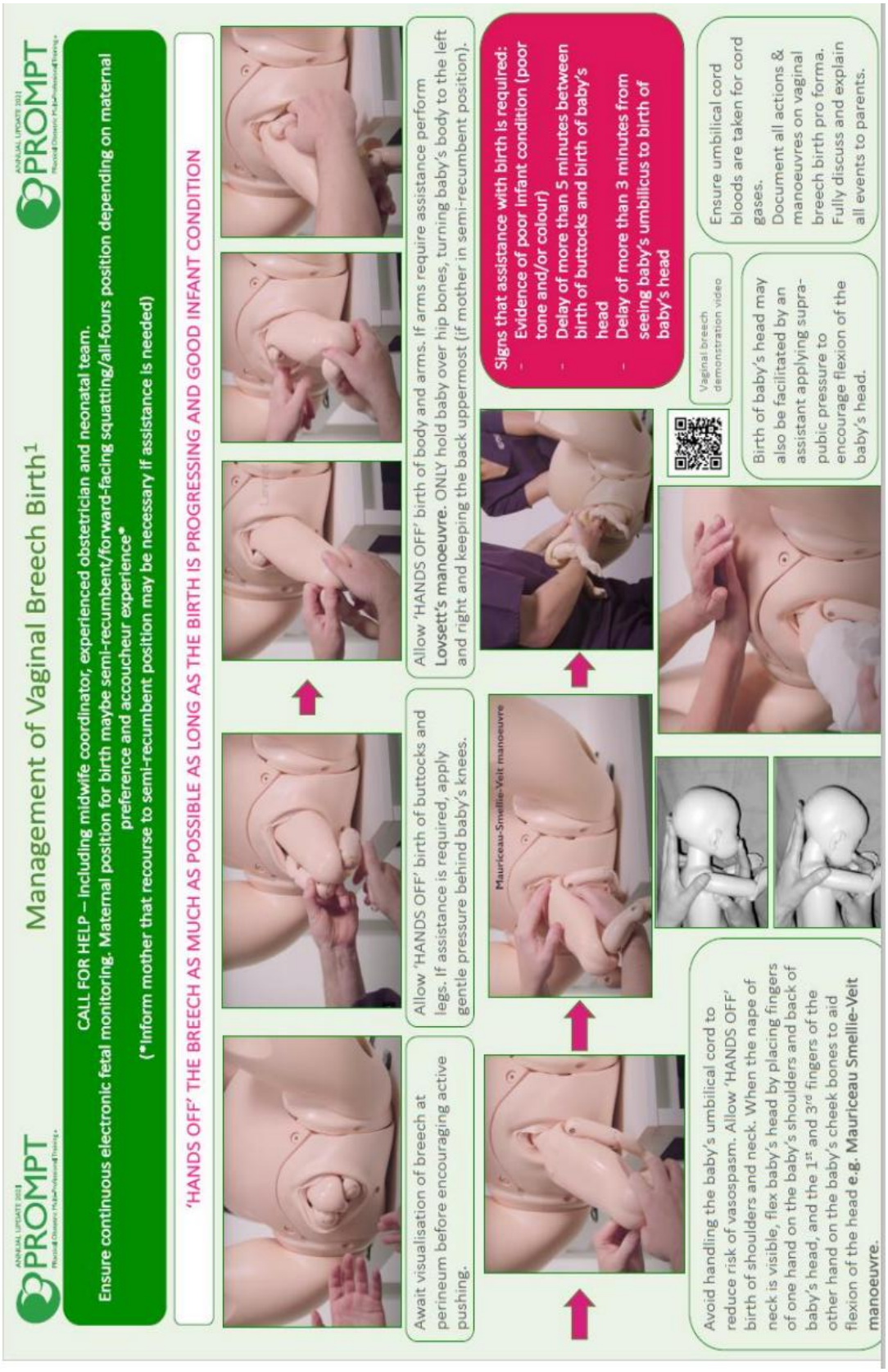
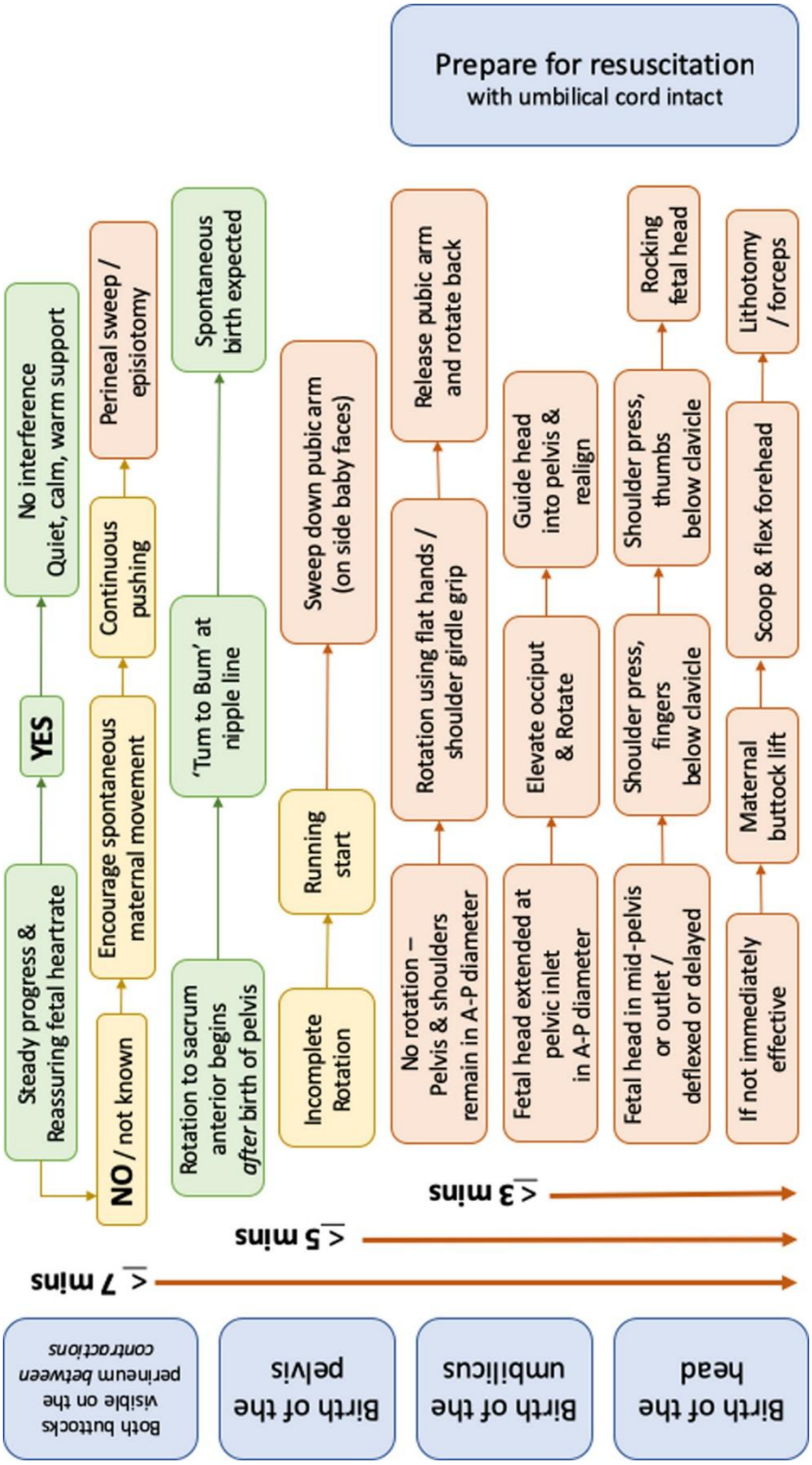
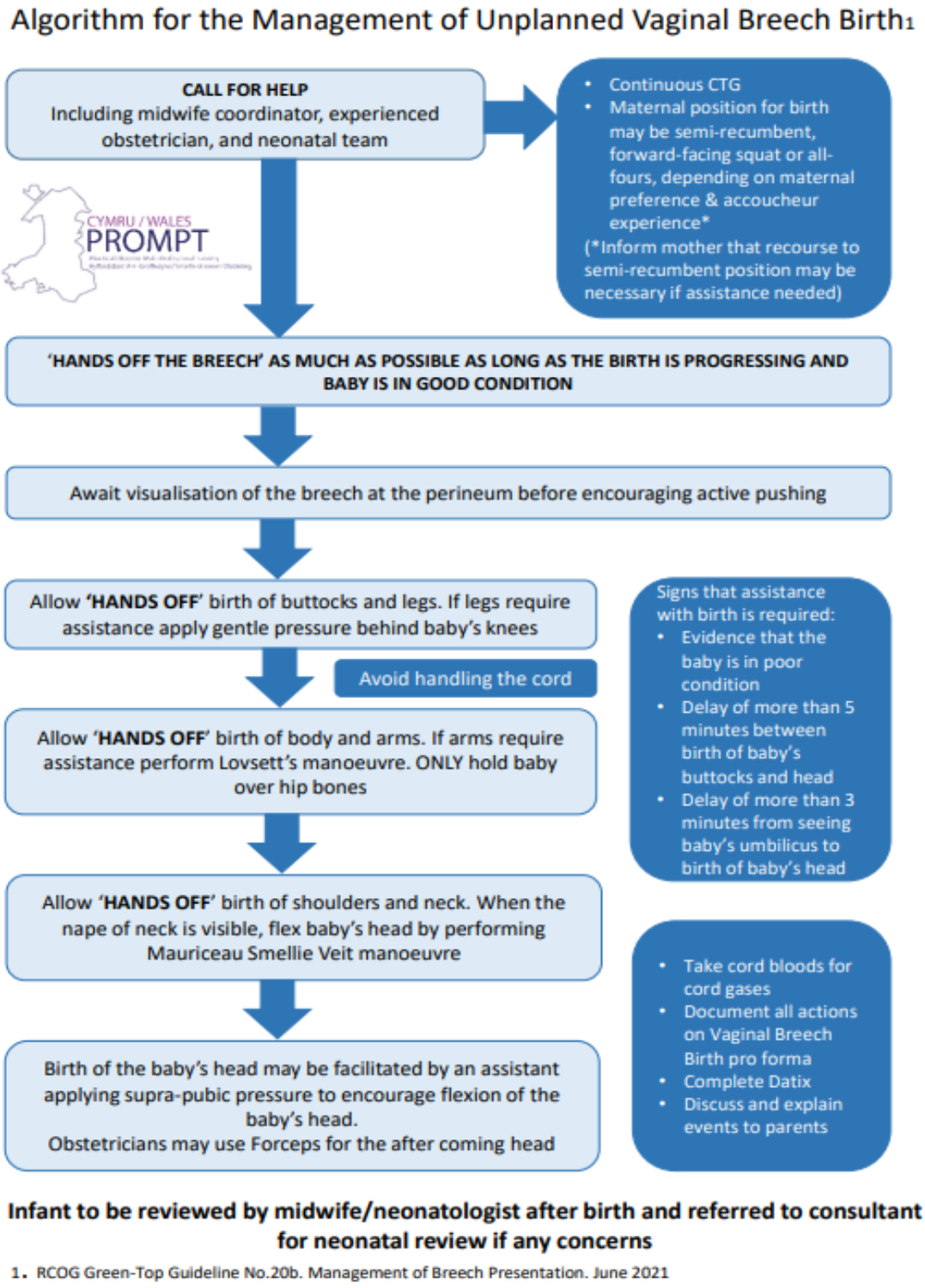
Appendix 3 PROMPT Breech birth manoeuvres



Appendix 4. Physiological Breech Birth Algorithm.



Appendix 5 – PROMPT Unplanned Vaginal Breech Birth Algorithm



Appendix 6. Community Prompt Algorithm for the management of vaginal breech.