

Breech Presentation Guideline

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Brief Summary of Document:	To ensure that babies who present in the breech position are delivered safely vaginally and do not come to any avoidable harm.
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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.
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To be read in conjunction with:	813 - Intrapartum Electronic Fetal Monitoring Guideline 655 – Operative Vaginal Delivery Guideline 634 – External Cephalic Version Guideline
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Owning group	Obstetric Documentation Review Group
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Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New guideline	24.10.2017
2	Full review – minor changes	26.9.2019

Glossary of terms

Term	Definition
CTG	Cardiotocography
ECV	External Cephalic Version
FSE	Fetal scalp electrode

Keywords	Breech presentation
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1. INTRODUCTION

Breech presentation occurs in 3-4% of term deliveries and is more common preterm. It is associated with uterine and congenital abnormalities, has a significant recurrence risk and is more common in nulliparous people. Term babies presenting in breech position have worse outcomes than cephalic ones, irrespective of mode of delivery.

2. AIM

The aim of the guideline is to ensure that babies who present in the breech position are delivered safely vaginally and do not come to any avoidable harm.

3. OBJECTIVES:

The aim of the guideline is achieved by:

- Providing appropriate antenatal care.
- Providing antenatal risk assessment.
- Following the guideline for the management breech vaginal birth in labour.

4. SCOPE

This guideline applies to midwives, obstetricians, anaesthetists and paediatricians who care for patients presenting at term with a breech presentation and patients presenting in labour with an undiagnosed breech presentation, in acute hospitals.

5. GUIDELINE

5.1. Antenatal care

- People presenting with a breech presentation at term should be offered External Cephalic Version (ECV) unless there is an absolute contraindication (there is no consensus on absolute contraindications for performing ECV – only placental abruption, severe preeclampsia, and abnormal doppler or cardiotocography (CTG) are supported by evidence RCOG GT 20a 2017).
- People 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:

People should be informed that planned caesarean section leads to a small reduction in perinatal mortality (0.5/1000 after 39 weeks) compared with planned vaginal breech delivery (2.0/1000). This compares to 1.0/1000 for a planned cephalic birth. This reduction in risk is due to three factors, of which only the last is unique to a breech birth: the avoidance of stillbirth after 39 weeks, the avoidance of intrapartum risks and the risks of a vaginal breech birth.

Any decision to perform a caesarean section needs to be balanced against the potential adverse consequences that may result from this.

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

People should be informed that planned vaginal birth increases the risk of low apgar scores and serious short-term complications (fractures of the clavicle or haematomata), but has not been shown to increase the risk of long-term morbidity.

Information About People:

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

People should be informed that maternal complications are least with a 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 people planning a vaginal breech birth.

People should be informed that caesarean section increases the risk of complications in future pregnancy, including 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.

People should be given an individualised assessment of the long-term risks of caesarean section based on their individual risk profile and reproductive intentions, and counselled accordingly.

People should be informed that caesarean section has been associated with a small increase in the risk of stillbirth for subsequent babies although this may not be causal.

PARENTS SHOULD BE INFORMED THAT THE EXPERIENCE OF CLINICIANS TO SUPPORT BREECH BIRTH IS LIMITED

- Following the counselling the mother should receive the RCOG patient information leaflet: <https://www.rcog.org.uk/globalassets/documents/patients/patient-informationleaflets/pregnancy/breech-baby-patient-information-leaflet.pdf>

5.2. Antenatal risk assessment related to breech position

Following the diagnosis of persistent breech presentation, people should be assessed for risk factors for a poorer outcome in planned vaginal breech birth. If any risk factor is identified people should be counselled that planned vaginal birth is likely to be associated with increased perinatal risk and that delivery by caesarean section is recommended.

People should be informed that a higher risk planned vaginal breech birth is expected where there are independent indications for caesarean section and 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.

The role of pelvimetry is unclear, and therefore should be considered with care.

5.3. Labour

The essential components of planned vaginal breech birth are; appropriate case selection, management according to appendix 1 (Management of Breech Presentation in Labour in Hospital) and the availability of skilled attendants.

The presence of a skilled birth attendant is essential for a safe vaginal breech birth. Units with limited access to experienced personnel should inform people that vaginal breech birth is likely to be associated with increased risk and offer antenatal referral to a unit where skill levels and experience are greater.

All obstetricians and midwives should be familiar with the techniques that can be used to assist vaginal breech birth. The choice of manoeuvres used, if required to assist the delivery of the breech, should depend on the individual experience/preference of the attending obstetrician or midwife.

Where a people presents with an unplanned vaginal breech 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.

5.3.1. First stage of labour

Where time and circumstances permit, the position of the fetal neck and legs, and the fetal weight should be estimated using ultrasound, and the people counselled as with planned vaginal breech birth.

Induction of labour is not recommended, but augmentation of slow progress with low contraction frequency in the presence of an epidural may be considered.

Epidurals may increase the risk of intervention and although continuous electronic fetal monitoring may lead to improved neonatal outcomes, evidence to support this outcome is lacking.

The mother must be reviewed by the Consultant Obstetrician on call

5.3.2. Second stage of labour

Adequate descent of the breech in the passive second stage is a prerequisite for encouragement of the active second stage.

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

People in or near the active second stage of labour should not be routinely offered a caesarean section.

Assistance without traction, is required if there is delay or evidence of poor fetal condition.

- **Delivery of the buttocks to delivery of the umbilicus should be no longer than 2 minutes.**
- **Progress from delivery of the umbilicus to delivery of the head should be no longer than 3 minutes.**

The Consultant Obstetrician on call must be informed and immediately available for advice and present for delivery if requested

5.3.3 Position for delivery

For the delivery of breech baby a semi-recumbent or an all-fours position may be adopted; this should depend on maternal preference and the experience of the attendant. If the latter position is used, people should be advised that recourse to a semi-recumbent position may become necessary.

All fours position: Clinicians must be aware that the baby's body must be supported either by the buttocks resting on the bed or resting on the clinician's arm to avoid hyper-extension of the head

Refer to Appendix 2 for information on the manoeuvres to assist deliver of the breech in an upright position. <http://breechbirth.org.uk/2013/05/mechanisms-of-upright-breech-birth>

- The mother should be advised that continuous fetal heart monitoring is recommended to assess fetal well-being during labour
- The fetal heart should be classified as normal throughout the first and second stages of labour.
- **Any deviation from normal will require immediate referral to the Consultant Obstetrician**
- The application of a fetal scalp electrode (FSE) is recommended in the second stage of labour.
- Assessment of fetal well-being by observation of fetal tone, colour and pulsation of the umbilical cord is **not** appropriate and likely to prove inaccurate.

6. REFERENCES

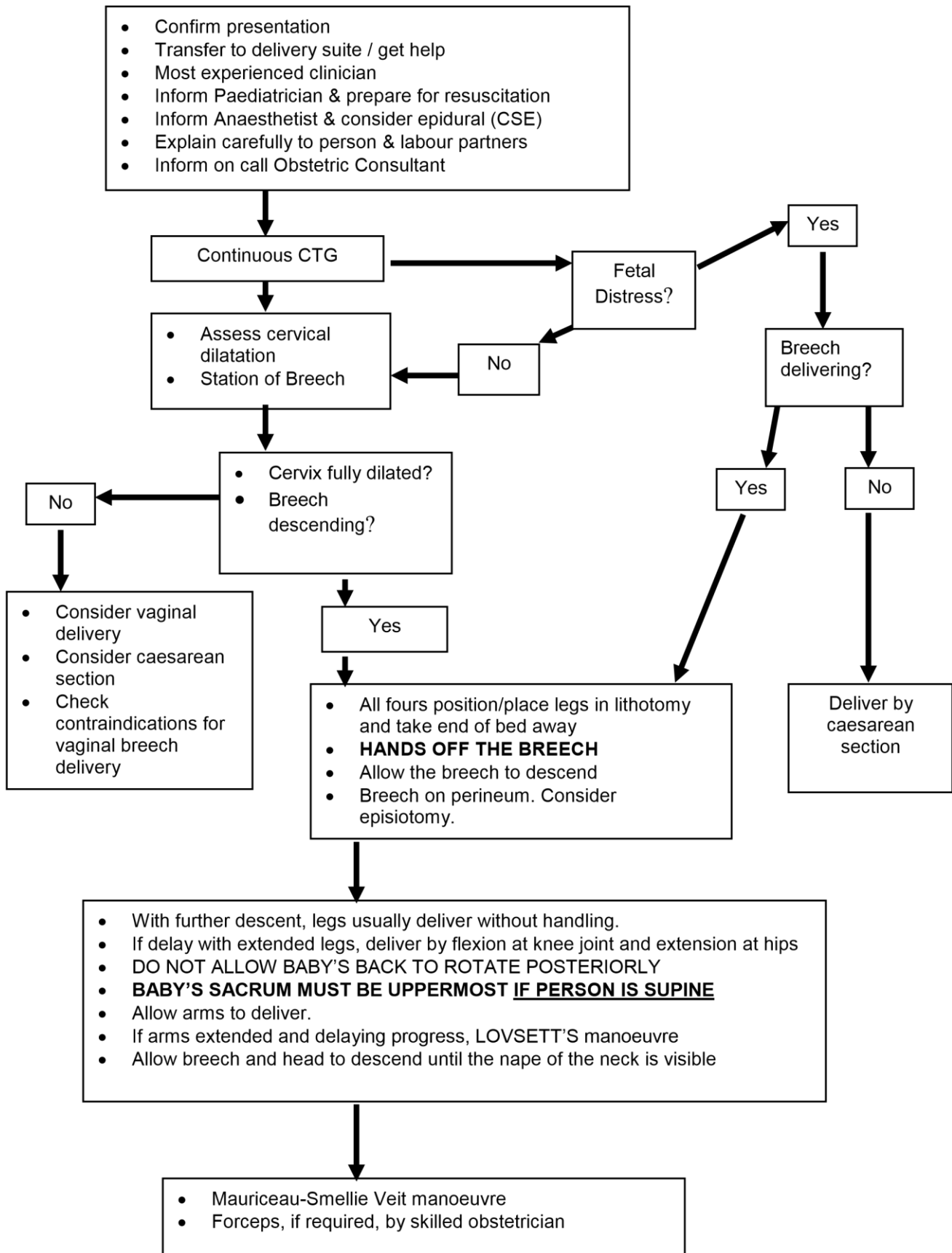
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7. **APPENDIX 1 – HOSPITAL PROCEDURE FOR MANAGEMENT OF BREECH PRESENTATION IN LABOUR**



8. APPENDIX 2 - INFORMATION ON THE MANOEUVRES TO ASSIST DELIVER OF THE BREECH IN AN UPRIGHT POSITION.

Vaginal breech birth in all fours position

Information taken from [Mechanisms of upright breech birth | The midwife, the mother and the breech](#)

- The birth of the baby should be left to progress spontaneously as long as there is **CONSTANT PROGRESS** and there is no evidence of fetal compromise. Remember “hands off the breech”.
- The breech typically descends with the sacrum transverse, anterior buttock leading. On vaginal examination this will feel asynclitic- this is normal for breech. Maternal movements assist this process in the same way it assists cephalic descent. The buttocks will be born by lateral spinal flexion.
- The anterior buttock is born first followed by the baby’s anus and posterior buttock.
- The sacrum will rotate to sacro-anterior (the baby’s bottom should be in line with the mother’s front). If rotation is tending towards sacro-posterior this may be an indication for intervention (to gently rotate to sacro-anterior).
- The baby’s legs will be born spontaneously as long as there is descent with each contraction. If one leg slips down before the other this may indicate that fully internal rotation has not occurred and help with the arms may be needed.
- After the baby’s legs are born there will be a clear view of the umbilicus. Do not touch the cord but observe colour, tone and flexion/movement.
- **DELIVERY OF THE BUTTOCKS TO DELIVERY OF THE UMBILICUS SHOULD BE NO LONGER THAN 2 MINUTES**
- **PROGRESS FROM DELIVERY OF THE UMBILICUS TO DELIVERY OF THE HEAD SHOULD BE NO LONGER THAN 3 MINS**
- Reassuring sign: if you observe a sternal crease on the baby’s chest you know the arms are in front and should be born with the next contraction.
- Indication for intervention: If full rotation has not occurred and progress stops, you will need to assist with the birth of the arms.
- The baby will rotate slightly to release one arm below the pubic arch then rotate the other direction to release the other arm. Occasionally arms are born together without rotation.
- The baby should be facing upwards towards the mothers buttocks to enable the birth of the head.
- A well flexed head will pass easily through the pelvis. Commonly, people experience an urge to lower their bottoms to the surface on which they are kneeling. This maintains them and promotes flexion in the baby’s body and should not be interrupted.
- The baby may spontaneously pull their knees up into a fetal position. This also promotes flexion and helps the head to be born.
- If there is no descent with the next contraction – help to flex the head especially if the baby’s tone and colour are not ideal.

Clinicians must be mindful that there is a risk of premature placental separation in an upright or squatting position with a fundally situated placenta

Clinicians must be aware that if the mother adopts an *all fours* position the baby's body must be supported either by the buttocks resting on the bed or on the clinicians arm to avoid hyper-extension of the head

The mother should be informed of the need to accurately assess fetal well-being during labour by continuous assessment of the fetal heart

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