Breech – Antenatal and Intrapartum Vaginal Birth Guidance

Author: Louise-Emma Shaw

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Introduction

Breech presentation is associated with poorer perinatal morbidity and mortality than a cephalic birth (Increase in mortality of 1:1000 births). The incidence of breech decreases as gestation increase, with about 20% of foetuses in breech presentation at 28 weeks falling to 3-4% at 37 weeks. A breech presentation is more likely where there are uterine anomalies e.g. bicornuate uterus, nulliparous women, previous breech birth, and prematurity. This guideline is to guide management of a breech presentation detected antenatally at term, and intrapartum. This guideline is not intended to be used for women who are planning a caesarean birth irrespective of fetal presentation, e.g. placenta praevia.

Breech Presentation at 36 weeks gestation

Women suspected of having a breech presentation at 36 weeks should be referred for a presentation scan. This can be done through the midwife sonography service at Singleton Hospital (see SOP Midwifery scanning). Where breech presentation is confirmed women should be referred to the antenatal day assessment unit for review by the obstetric team for counselling.

First line recommendation is for external cephalic version (ECV) for women with no contraindications. (See External Cephalic Version Guideline on Wisdom). The process should be explained and supported by written information (Breech baby at the end of pregnancy patient information leaflet | RCOG). If successful women can then continue with their routine care. If unsuccessful on the first attempt then a second attempt may be offered.

Options for birth should also be discussed with the women regardless of whether she agrees to ECV or not. Again supporting written information should be provided (Breech baby at the end of pregnancy patient information leaflet | RCOG). Discussions are birth options should take into account maternal and fetal risk factors such as BMI, parity and previous birth outcomes. Discussion should include:

1) Planned Caesarean Section. Operative risks and impact on future pregnancies should be discussed, alongside the small reduction in perinatal short term morbidity and mortality compared to vaginal breech birth (mortality of 0.5:1000 with Caesarean section versus 2:1000 with vaginal birth). Caesarean birth should be planned from 39 weeks, and a scan should be performed immediately before to confirm breech presentation persists. Women should be told that if the baby has turned to cephalic presentation the caesarean section is no longer indicated and women should be supported to plan a vaginal birth.
2) Vaginal breech birth. Where there are skilled birth attendants the perinatal mortality is approximately 2:1000 births (compared to 0.5:1000 caesarean breech births). Short term morbidity and low Apgar scores are more likely with a vaginal birth but long term morbidity is not increased compared to caesarean birth. Women planning a vaginal breech birth should labour spontaneously and be advised to birth on an obstetric unit with obstetric and

neonatal attendance. Vaginal breech birth is not advised for EFW over the 97th centile or under the 3rd centile, or with a footling breech presentation.

Intrapartum Breech presentation

All staff should receive training on vaginal breech births through annual attendance on PROMPT. This currently teaches birth in the semi recumbent position. However, where staff are comfortable in supporting physiological breech birth in all fours then this is an acceptable alternative. Manoeuvres in all fours position should only be used by those who have received specific training.

Where breech is diagnosed for the first time during the intrapartum period there should be a discussion regarding the pros and cons of a vaginal birth compared to caesarean section birth as that expected antenatally, and the lack of evidence to support a clear recommendation for route of birth. This discussion should also take into account the any additional complexity, parity, stage of labour and rate of progress when counselling, especially in advanced labour where operative risks are higher. Women near or in active second stage of labour should be informed of the increased risk with caesarean section in advanced labour, both for baby (difficult birth) and for mother (trauma and haemorrhage).

Any woman diagnosed with malpresentation in labour, including breech, should be recommended to birth on the obstetric unit, with midwifery, obstetric and neonatal staff in attendance for birth. Where breech presentation is suspected in a midwifery led setting then the labour ward co-ordinator should be informed, and a decision made regarding safe transfer to the obstetric unit. The on-call Obstetric Consultant should be informed of any woman in labour with a confirmed breech presentation at the earliest opportunity.

During labour continuous electronic fetal heart monitoring is advised, because of the higher rates of intrapartum events like cord prolapse, as well as the higher morbidity rate. The birthing pool on labour ward can be recommended for the 1st stage of labour, with telemetry, where there are no other contraindications to water immersion. Women should be advised to leave the pool for the 2nd stage of labour. Where concerns around fetal wellbeing arise fetal blood sampling is NOT advised, birth by caesarean section is recommended.

Progress in labour should be in line with national recommendations. Oxytocin should only be used where contraction frequency is low following insertion of an epidural. Oxytocin is not recommended to be used for labour dystocia.

The impact of epidural on the achievement of vaginal birth is unclear. It may be of benefit in providing good analgesia, especially if additional manoeuvres are required in second stage, but will limit mobility and movement that can support a physiological birth, as well as increasing the chance of labour dystocia. In preterm births there may be more benefit to women having an epidural, as it can reduce the urge to push through an incompletely dilated cervix (and thus reduce the potential risk of head entrapment).

Membranes should be left intact as long as possible. Following spontaneous rupture of membranes it is advisable to check for cord prolapse which is higher in malpresentation.

Women should be advised that there is a growing body of evidence to support vaginal breech birth in an all fours position as a first line management however semi-recumbent is also acceptable. The experience of the birth attendant is important and if manoeuvres are required the woman should be supported to adopt the position recommended by the birth attendant. This information should be discussed as soon as possible in labour. In either semi-recumbent and all-fours position only one back should be seen at any time (i.e. the fetal back in the semi-recumbent position, and the maternal back in the all-fours position).

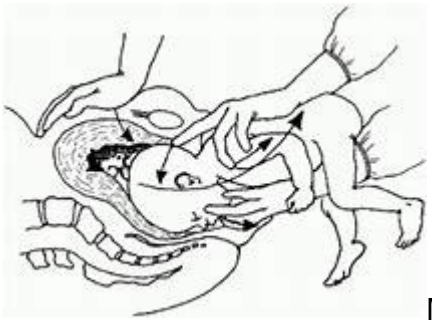
When the buttocks are visible and distending the perineum, an evaluation for the need of an episiotomy should be made. Episiotomy is advised if there are concerns with the CTG just prior to birth to expedite birth, or if there is delay in progression at this stage.

Whilst spontaneous progress is being made then “hands off” can be maintained. Where a delay in progress is identified once the breech starts to descend or where a sarcoposterior position is identified this is where additional manoeuvres are indicated. It is therefore important that a scribe is present to call out timings to avoid loss of situational awareness. Key points of progress are

- Once both buttocks are visible on the perineum between contractions. At this stage cord compression is more likely and monitoring of the fetal heart is more difficult as the chest enters the maternal pelvis and vagina. From this point birth should be achieved within 7 minutes. Delay on the perineum should be managed by episiotomy and perineal sweeping.

- Birth has occurred up to the line of the Pelvis: From this point birth should be achieved within 5 minutes. Women should be encouraged to push as the uterus is almost empty and so there is little to benefit from waiting for a contraction. Often the pelvis will deliver in the sacro-transverse position. Intervention is not required as long as rotation to sacro-anterior occurs with pushing by the nipple line. Should this not occur then a nuchal arm is likely, and controlled rotational manoeuvres (Lovesetts) should be used. Handling of the baby should occur over the bony prominences of the pelvis.
- Birth of the head: Once the body has delivered, the head sits in the vagina and the uterus initiates third stage. Birth of the head can be aided by MSV

(Mauriceau-Smellie-Veit) manoeuvres. Further delay can be managed with suprapubic pressure, or the birth aided by using Keillands forceps.


Mauriceau-Smellie-Veit manoeuvre

Following birth delayed cord clamping is advised. It is recommended that the neonatal team should be on labour ward for the birth due to a higher instance of; low apgar and the need for initial neonatal resuscitation in breech birth.

Preterm birth

Women in preterm labour are more likely to have a breech presentation, and a presentation scan should be undertaken when women present in preterm labour under 34 weeks gestation. There is no clear evidence of the best route of birth for preterm breech presentation, and the route of birth should be evaluated on an individual basis. In preterm labour cervical entrapment is more likely, due to the ability for the trunk to pass through an incompletely dilated cervix, and the relative size between head and trunk.

Cervical entrapment

Where cervical entrapment occurs incisions should be made to the cervix at the 2, 6 and 10 o'clock positions.

Documentation and care after birth

Documentation during a vaginal birth is important, and should include the timings of each key point of progress and any manoeuvres or actions taken using PROMPT CYMRU proforma. A Datix should be completed for each vaginal breech birth to allow monitoring of birth rates, complications and training needs.

Women should be offered a chance to discuss their birth postnatally.

References:

Management of the Labour Ward Course 2021: Management of breech presentation. Shaun Walker.

https://nwssp.nhs.wales/a-wp/prompt-wales breech delivery training video accessed 13/9/22

RCOG Green top guideline 20b 2017
https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.14465

Intrapartum Care for Healthy women and Babies. NICE clinical guideline CG190 2017 Overview | Intrapartum care for healthy women and babies | Guidance | NICE

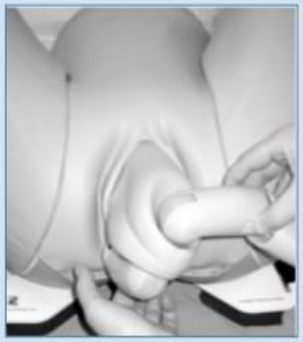
Management of Vaginal Breech Birth[1]

CALL FOR HELP – including midwife coordinator, experienced obstetrician and neonatal team.
Ensure continuous electronic fetal monitoring. Maternal position for birth maybe semi-recumbent/forward-facing squatting/all-fours position depending on maternal preference and accoucheur experience*
(*Inform mother that recourse to semi-recumbent position may be necessary if assistance is needed)

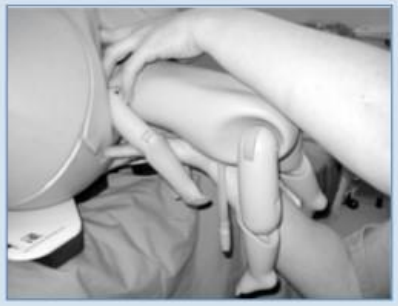
'HANDS OFF' THE BREECH AS MUCH AS POSSIBLE

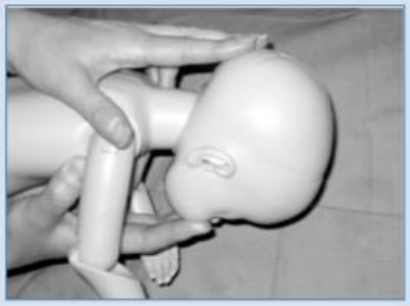
Await visualisation of breech at perineum before encouraging active pushing.

Allow 'HANDS OFF' birth of buttocks and legs. If assistance is required for baby's legs to be born, apply gentle pressure behind baby's knees.



Allow 'HANDS OFF' birth of body and arms. If arms require assistance perform Lovsett's manoeuvre, ONLY hold baby over hip bones (pelvic girdle), turning baby's body towards the left and right and keeping the back uppermost (if mother in semi-recumbent position) to release arms.





Allow 'HANDS OFF' birth of shoulders and neck. When the nape of neck is visible, flex baby's head by placing fingers of one hand on the baby's shoulders and back of baby's head, and the 1st and 3rd fingers of the other hand on the baby's cheek bones to aid flexion of the head (Mauriceau Smellie-Veit manoeuvre).

Birth of the baby's head may also be facilitated by an assistant applying supra-pubic pressure to encourage flexion of the baby's head.

Signs that assistance with birth is required:

- **Evidence of poor infant condition**
- **Delay of more than 5 minutes between birth of baby's buttocks and head**
- **Delay of more than 3 minutes from seeing baby's umbilicus to birth of baby's head**

Document all actions & manoeuvres, fully explaining all events to parents.

1. RCOG Green-Top Guideline No. 20b. Management of Breech presentation. May 2019

Community Algorithm for the Management of Vaginal Breech Birth

CYMRU / WALES PROMPT

Establish dilatation of the cervix

Time/comments

Birth imminent

CALL FOR HELP
Call 999 and inform Obstetric Unit

Time/comments

2nd midwife to prepare for newborn resuscitation

Time/comments

Assist into all fours or semi-recumbent position with buttocks at end of bed

Time/comments

Await visualisation of the breech at perineum then encourage active pushing.

Time/comments

Use controlled rotation to rotate fetal back to sacro-anterior IF required, holding baby over bony prominences of pelvic girdle.

Time/comments

Apply gentle pressure behind the baby's knees ONLY if required

HANDS OFF THE BREECH AS MUCH AS POSSIBLE. AVOID HANDLING THE CORD

Time of Birth

APGARS

If the head does not deliver spontaneously - perform the **Mauriceau-Smellie-Veit** manoeuvre. Application of supra-pubic pressure can be used to encourage flexion of the baby's head.

IF arms do not deliver, perform **Lovsett's** manoeuvre.

Birth **NOT** imminent

Time/comments

Transfer to obstetric unit

Time/comments

Signs that assistance with birth is required:

- Evidence of poor infant condition
- Delay of more than 5 minutes between birth of baby's buttocks & head - **Time buttocks born**
- Delay of more than 3 minutes from seeing umbilicus to birth of head - **Time umbilicus born**

Time/comments

Time/comments

Document all actions on proforma and complete DATIX Incident form

Algorithm for the Management of Unplanned Vaginal Breech Birth[1]

CALL FOR HELP
Including midwife coordinator, experienced obstetrician, and neonatal team

- Continuous CTG
- Maternal position for birth may be semi-recumbent, forward-facing squat or all-fours, depending on maternal preference & accoucheur experience*

(*Inform mother that recourse to semi-recumbent position may be necessary if assistance needed)

CYMRU / WALES
PROMPT

'HANDS OFF THE BREECH' AS MUCH AS POSSIBLE AS LONG AS THE BIRTH IS PROGRESSING AND BABY IS IN GOOD CONDITION

Await visualisation of the breech at the perineum before encouraging active pushing

Allow **'HANDS OFF'** birth of buttocks and legs. If legs require assistance apply gentle pressure behind baby's knees

Avoid handling the cord

Allow **'HANDS OFF'** birth of body and arms. If arms require assistance perform Lovsett's manoeuvre. ONLY hold baby over hip bones

Allow **'HANDS OFF'** birth of shoulders and neck. When the nape of neck is visible, flex baby's head by performing Mauriceau Smellie Veit manoeuvre

Birth of the baby's head may be facilitated by an assistant applying supra-pubic pressure to encourage flexion of the baby's head.
Obstetricians may use Forceps for the after coming head

Signs that assistance with birth is required:

- Evidence that the baby is in poor condition
- Delay of more than 5 minutes between birth of baby's buttocks and head
- Delay of more than 3 minutes from seeing baby's umbilicus to birth of baby's head

- Take cord blood for cord gases
- Document all actions on Vaginal Breech Birth pro forma
- Complete Datix
- Discuss and explain events to parents

Infant to be reviewed by midwife/neonatologist after birth and referred to consultant for neonatal review if any concerns

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

Name:	Vaginal Breech Birth	PROMPT
DOB:	Documentation pro form	
Patient ID:	Person completing form Name/Signature/Designation:	Date:

START

Planned Vaginal breech birth? (please circle)	Y / N
Time of confirmation of Breech presentation: (if unplanned)	
VE findings at diagnosis of Breech presentation:	
Time assistance called for:	

PREPARE

Maternity team present at birth		Additional staff attending	
Name	Role	Name	Role

Bladder emptied	Y / N	Volume	Time
Time of full dilatation confirmed			Time
Maternal position for birth (please circle)			

Semi-Recumbent	Lithotomy	Side-lying	All fours	Kneeling	Standing	Squatting	Other

HANDS OFF THE BREECH UNLESS PROGRESS NOT AS EXPECTED/POOR FETAL CONDITION

> 5 Minutes *

PROGRESS

> 3 Minutes *

* A delay in the time until the head is born may warrant intervention

			TIME	
Baby's buttocks visible				
Fetal Heart Rate		CTG / Doppler / Pinard (please circle)	CTG: Normal Suspicious Pathological (please circle)	
Time active pushing commenced				
Episiotomy (if required)				
Baby's buttocks born				
Fetal heart rate		CTG / Doppler / Pinard (please circle)	CTG: Normal Suspicious Pathological (please circle)	
Legs spontaneously released?		Y / N	(if Yes)	
Pressure applied to popliteal fossae to assist release of baby's legs?		Y / N	Left Leg	Right Leg
Time Umbilicus visualised				
Position of breech (please circle)		Sacro-Anterior	Sacro-Posterior	
Controlled rotation of baby (holding over bony prominences of pelvis) to sacro-anterior		Y / N		
Time baby's arms released			Left Arm	Right Arm
Løvsett's manoeuvre to release baby's arms?		Y / N		

TURN OVER FOR ON-GOING MANAGEMENT

Patient Name: DOB: Patient ID:	Vaginal Breech Birth Documentation pro form	Date:

PROGRESS continued

				TIME
Time nape of neck visualised				
Head advancing				Y / N
Mode of birth baby's head (please circle):				
Spontaneous	Mariceau-Smellie -Veit manoeuvre	Assisted with ..... forceps	Suprapubic pressure applied Y/N	
Time of birth of baby				
Neonatologist present			Y / N	
Neonatologist's name:				
Apgar scores	1 min:	5 mins:	10 mins:	
Cord gases	Art pH:	Art BE:	Venous pH:	Venous BE:
Baby admitted to Neonatal Intensive Care Unit?			Y / N	

IMMEDIATE POST BIRTH CARE

	DOCUMENT DETAILS		
Debrief and document in notes	Debrief with woman and birth partner		
	Team debrief		
	Incident report required? (Y/N)	Y / N	

NOTES

Maternity Services

Checklist for Clinical Guidelines being Submitted for Approval

Title of Guideline:	Management of breech presentation
Name(s) of Author:	Louise-Emma Shaw
Chair of Group or Committee approving submission:	Antenatal Forum
Brief outline giving reasons for document being submitted for ratification	New policy
Details of persons included in consultation process:	Antenatal Forum
Name of Pharmacist (mandatory if drugs involved):	
Issue / Version No:	3
Please list any policies/guidelines this document will supercede:	Management of Breech Presentation
Date approved by Group:	
Next Review / Guideline Expiry:	
Please indicate key words you wish to be linked to document	Breech, cephalic, position, ecv
File Name: Used to locate where file is stores on hard drive	