Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

Management of Breech Presentation (after 36 weeks)

Originator:	Labour Ward Forum
Date Approved (revised):	February 2019
Approved by:	W&CH Quality & Safety Group
Date for Review:	January 2022

The incidence of breech presentation decreases from about 20% at 28weeks to 3-4% at term, as most babies turn spontaneously to the cephalic presentation. It is widely recognised that there is a higher perinatal mortality and morbidity with breech presentation principally due to prematurity, congenital malformations and birth asphyxia or trauma. Breech presentation whatever mode of delivery, is a signal for potential fetal handicap and this should inform antenatal, intrapartum and neonatal management. Caesarean section for breech presentation is suggested as a way of reducing the associated fetal problems**.**

1. Breech diagnosed antenatally after 36 weeks

- All women with a breech presentation diagnosed after 36 weeks should be referred to a consultant clinic.
- Arrange ultrasound to confirm presentation, check position of the fetal legs (flexed, extended, or footling) and whether there is evidence of cord round the neck.
- Suitable women should be offered external cephalic version
- If ECV is contraindicated, benefits and risks of Caesarean Section versus Vaginal delivery should be discussed both for current and future pregnancies.
- Inform women that planned caesarean section leads to a small reduction in perinatal mortality compared with planned vaginal breech birth. Any decision to perform a caesarean section needs to be balanced against the potential adverse consequences that may result from this.
- Inform women that there is no evidence that the long term health of babies with a breech presentation delivered at term is influenced by how the baby is born.
- The management plan should clearly be written in the notes.

Management of preterm singleton breech

- Routine caesarean section for breech presentation in spontaneous preterm labour is not recommended. The mode of birth should be individualised, based on the gestation, stage of labour, type of breech presentation, fetal wellbeing and availability of an operator skilled in vaginal breech birth.

Management of twin pregnancy with breech presentation

- Evidence is limited, but if the presenting twin is a breech presentation, then planned caesarean section is recommended.
- Routine emergency caesarean section for a breech presentation of the first twin in spontaneous 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 birth.

1.1 External Cephalic Version

Contraindications for ECV: (RCOG Guideline No. 20)

Placenta praevia
Multiple pregnancy
APH
Severe hypertension
Ruptured membranes
Very large baby (>4500g)
Severe polyhydramnios
Severe IUGR

Booking of ECV:

- Contact Labour ward and arrange ECV on a day when a suitable consultant is available
- Inform the Consultant performing the ECV
- Provide patient with ECV leaflet

Management if ECV fails:

Discuss further options with patient. This includes offering another ECV, preparing for vaginal delivery or organising Caesarean Section

1.2 Vaginal Delivery

- Some patients may wish to opt for a vaginal delivery. ABMU HB support this provided the risk have been clearly explained and an experienced 'accoucheur' is available. RCOG (2017), suggest the presence of a skilled birth attendant is essential for a safe vaginal breech birth. Please explain to patient that sometimes the staff are not comfortable with managing a vaginal breech delivery.
    - RCOG (2017), green top guidelines suggest when planning a vaginal breech birth, the woman should be informed that the risk of perinatal mortality is approximately 0.5/1000 with caesarean section after 39 weeks of gestation and approximately 2.0/1000 with a planned vaginal breech birth.
    - Women should be informed that planned vaginal breech birth increases the risk of low Apgar scores and serious short-term complications, but has not been shown to increase the risk of long-term morbidity.

Contraindication to Vaginal Breech Delivery: (RCOG Guideline No. 20)

Major placenta praevia
Clinically inadequate pelvis
Footling or kneeling breech presentation
Large baby (≥3800g)
Growth-restricted baby (≤2000g)
Hyperextended fetal neck (diagnosed with ultrasound or x-ray)
Absence of a clinician trained in vaginal breech delivery
Evidence of antenatal compromise
Previous caesarean section

2. Undiagnosed breech in labour

- Confirm diagnosis with USS- get second opinion if in doubt. Discuss mode of delivery including vaginal breech delivery with patient
- Inform consultant on-call regarding planned mode of delivery
- Ensure adequate documentation

- Avoid routine caesarean section for the delivery of preterm breech presentation. The mode of delivery in such cases should be made on an individual basis following discussion with the patient by senior clinician

2.1 Trial of vaginal breech (also see appendix one)

1. Ensure experienced obstetrician present and neonatal team present for birth. Inform Consultant on call and inform Anaesthetist.
2. Continuous electronic monitoring of fetal heart rate is vital.
3. Fetal blood sampling from the buttocks during labour is not advised
4. Women should be informed that induction of labour is not usually recommended. Augmentation of slow progress with oxytocin should only be considered if the contraction frequency is low in the presence of epidural analgesia.
5. 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. However Epidural is advisable in cases of preterm breech to avoid pushing through an incompletely dilated cervix. Liaise with on-call anaesthetist.
6. Leave membranes intact and following SROM perform examination to rule out cord prolapse.
7. Encourage woman into semi-recumbent / all fours position.
8. “HANDS OFF” THE BREECH AS MUCH AS POSSIBLE
9. Await visualisation of breech at perineum before encouraging active pushing. Evaluate the need for episiotomy when the perineum is distending and emphasise that it is only indicated to facilitate the birth.
10. Allow “HANDS-OFF” birth of buttocks and legs. If legs require assistance, apply gentle pressure behind baby’s knees.
11. Avoid handling the umbilical cord, as handling will increase vasospasm.
12. Allow “HANDS-OFF” birth of body and arms. If arms require assistance perform Lovsetts manoeuvre, ONLY hold baby over hip bones (pelvic girdle), turning baby’s body towards the left and right and keeping the body uppermost to release arms.

13. Allow “HANDS-OFF” birth of shoulders and neck. When the nape of neck is visable, flex baby’s head by placing fingers of one hand on the baby’s shoulders and back of 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).
14. Remember to document all actions and manoeuvres and fully explain the events to the parents.
15. Birth of the baby’s head may also be facilitated by an assistant applying suprapubic pressure to encourage flexion of the baby’s head.
16. If there is delay, the assistant should hold the body upwards to allow application of forceps. Delivery by Burns Marshall Technique is NOT advised due to the risk of overextension of the baby’s neck.
17. Manage third stage actively and inspect cervix and vagina for tears.

An excellent video is available onlineathttp://apps.who.int/rhl/videos/en/index.html

References:

1. The Management of Breech Presentation Clinical Green Top Guidelines (RCOG 2017)
2. Caesarean section versus planned vaginal birth for breech presentation at term. Randomised multicentre trial.Hannah ME, Hannah WJ, Hewson SA, HodnettED,Saigal S, Willan AR et al(Lancet 2000; 356: 1375-83)
3. Moet manual for managing obstetric emergencies and trauma(RCOG 2007)
4. PROMPT (Practical Obstetric Multi-Professional Training), Trainer’s Manual Third edition, 2018 C. Winter, J. Crofts, T. Draycott, N. Muchatuta. Cambridge university Press.

PROMPT

Appendix One

Management of Vaginal Breech Birth[1]

Appendix One

PROMPT

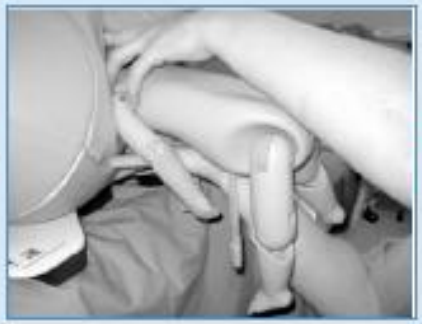
CALL FOR HELP – including midwife coordinator, experienced obstetrician and neonatal team.
Ensure continuous electronic fetal monitoring. Encourage woman into semi-recumbent/all-fours position*
(*Inform mother that recourse to semi-recumbent position may be necessary depending on accoucheur experience and preference of mother)

'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 legs require assistance 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 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 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).

Remember to document all actions and manoeuvres and fully explain the events to the parents.

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.

1. RCOG Green-Top Guideline No. 20b. Management of Breech presentation. March 2017

Appendix Two

Vaginal Breech Birth Scenario: Clinical Checklist

		Time	✔
Call for help	Activate emergency bell Request experienced midwife, experienced obstetrician and neonatologist		
	Request anaesthetist and theatre team to be on standby		
Position of mother	Place mother in semi-recumbent position, or consider forward-facing squatting/all-fours position if birth attendant skilled and trained		
Evaluate for episiotomy	Evaluate for episiotomy when perineum distended by baby's buttocks		
Birth of fetal body and lower limbs	Allow spontaneous birth of the buttocks (hands off)		
	Correct buttocks to sacroanterior		
	Allow spontaneous birth of legs (hands off) but, if not progressing, assist release of legs by applying pressure to popliteal fossae		
	Allow spontaneous birth of body (hands off) until lower scapulae visible		
Birth of arms	Allow spontaneous birth of arms (hands off)		
	If arms require assistance: Gently hold baby over bony prominences of pelvic bones (not abdomen)		
	Keep sacrum/spine anterior		
	Rotate trunk (Løvsett's manoeuvre) and sweep fetal arms down using one or two fingers		
Birth of head	Allow baby to hang so that shoulders and neck descend over next contraction until nape of neck visible (encourages flexion of head)		
	Assist birth of head using Mauriceau–Smellie–Veit or forceps placed on to head from *underneath* body		
Documentation	Persons present		
	Manoeuvres used		
	Timings of actions		

Maternity Services

Checklist for Clinical Guidelines being Submitted for Approval

Title of Guideline:	Management of Breech Presentation
Name(s) of Author:	Labour Ward Forum
Chair of Group or Committee approving submission:	Labour Ward Forum
Brief outline giving reasons for document being submitted for ratification	Update existing policy
Details of persons included in consultation process:	Labour Ward Forum
Name of Pharmacist (mandatory if drugs involved):	n/a
Issue / Version No:	2
Please list any policies/guidelines this document will supercede:	Management of Breech Presentation – Nov 2014
Date approved by Group:	7th February 2019
Next Review / Guideline Expiry:	February 2022
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	