Worcestershire Acute Hospitals NHS Trust

Breech Presentation Guideline (including ECV, Breech Birth and Emergency procedures)

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

3-4% of pregnancies remain in the breech position at term.

1 in 6 pregnancies with a breech presentation are not diagnosed until in labour. It is important that skills in conducting vaginal breech births are maintained as skills may be required not just for above indications but breech vaginal birth due to maternal choice.

This guideline covers all women with breech presentation.

This guideline is for use by the following staff groups:

All Maternity Staff providing Antenatal/Intrapartum care.

Lead Clinician(s)

Approved by *Maternity Governance Meeting* on: 19th January 2024

Review Date: 19th January 2027
This is the most current document and should be used until a revised version is in place

Key amendments to this guideline

Date	Amendment	Approved by:
19/01/2024	Full Review with updates to PROMPT Guidance.	MGM

Antenatal Management

Women with a confirmed breech presentation should be reviewed at 36 weeks by an experienced member of staff to discuss on-going options for birth.

The three options for management of breech at term are:

- External cephalic version (ECV)
- Planning for elective caesarean section
- Planning for vaginal breech birth

Clinicians should counsel women in an unbiased way that ensures a proper understanding of the absolute as well as relative risks of their different options. (RCOG 2017).

The BRAIN acronym (as laid out in the antenatal guideline) should be utilised for ALL breech counselling and this should be documented in the Badgernet record.

Selection of appropriate pregnancies and skilled intrapartum care may allow planned vaginal breech birth to be nearly as safe as planned vaginal cephalic birth. (RCOG 2017). Counselling of women should consist of a discussion around choices and maternal preferences for her on going care and birth. This discussion should include 4 key elements:

- what are the preferences of the woman and why
- what are the choices
- what are the unbiased risks and benefits of each choice discussed in absolute terms (not only percentages)
- what is the woman's potential individual risk and benefit with each option

These options should be discussed fully with the woman and her preference should be recorded in the notes. She should be offered the ECV information leaflet and RCOG breech presentation at birth leaflet and she should have a chance to discuss these with her healthcare professional. This discussion should be recorded in free text in the maternal notes.

Women should be informed that when planning birth for a breech baby, the risk of perinatal mortality is approximately:

- 0.5/1000 with caesarean section after 39+0 weeks of gestation
- 2.0/1000 with planned vaginal breech birth
- 1.0/1000 with planned cephalic birth.

Women should be informed of the following:

- Planned caesarean section for breech presentation at term carries a small increase in immediate complications for the mother compared with planned vaginal birth. (See caesarean section guideline)
- Maternal complications are least with 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 women planning a vaginal breech birth. (RCOG 2017)
- 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.

- Women 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. (BRAIN)
- Caesarean section has been associated with a small increase in the risk of stillbirth for subsequent babies although this may not be causal. (New 2017)

Planning the mode of birth will depend upon:

- preference of the woman
- estimated fetal weight (greater than 3.8kg)
- hyperextended head (found on scan only)
- footling presentation
- severe fetal growth restriction
- previous obstetric history (previous caesarean section)
- placental location

External Cephalic Version (ECV)

Women with a breech presentation at term should be offered ECV unless there is an absolute contraindication. There is limited evidence available for contraindications to ECV; However, the following are supported by evidence:

- Placental Abruption
- Severe Pre-Eclampsia
- Abnormal CTG
- Abnormal Doppler
- If an absolute reason for caesarean section exists (e.g Placenta Praevia Major)
- Multiple Pregnancy (except following delivery of the first twin)

ECV following one caesarean section birth does not appear to have a greater risk when compared to ECV with an unscarred uterus. Therefore, previous caesarean section should not be considered a complete contraindication to ECV.

They should be advised on the risks and benefits of ECV and the implications for mode of birth.

Success rates of ECV vary, but in a large series, 47% of women following an ECV attempt had a cephalic presentation at birth.
Overall success rates are:

- Multiparous women 60%
- Nulliparous women 40% (RCOG 2017)

Women who have a breech presentation at term should be counselled on the risks and benefits of planned vaginal breech birth versus planned caesarean section.

The following is recommended:

- ECV should only be undertaken by experienced practitioners or trainee practitioners under direct supervision. The ECV should take place in Labour Ward following an ultrasound scan to confirm breech presentation.
- ECV should be offered from 36 weeks in nulliparous women and from 37 weeks in multiparous women.
- ECV should preferably be performed on a specific day during working hours in labour ward. Activity on labour ward should be safe to perform the ECV in case of requiring emergency caesarean section

- The procedure should be explained to the woman again to ensure informed consent
- Semi-sitting position to prevent aorto-caval syndrome.
- CTG should be performed before and after ECV even baby remains in breech position.
- Uterine relaxant should be prescribed by the person undertaking the ECV and administered before the procedure.
- Clinical and ultrasound examination should be performed to confirm presentation of the baby.
- If patients' blood group is Rhesus negative 500 units of anti-D should be given

Complications of ECV

ECV is rarely associated with complications. Large studies such as Tong et all (2012) and Collins et al (2007) suggest a 0.5% immediate caesarean section rate with no excess perinatal morbidity and mortality. (RCOG 2017)

Intrapartum Care

Planned (Elective) Caesarean Section for Breech Presentation

- Decision of mode of birth should be made by the women following unbiased, and fully informed discussion with a consultant obstetrician.
- If caesarean section is planned for breech presentation only, it should be booked after 39 weeks of gestation as per elective section guidance.
- An ultrasound scan should be performed before transfer to theatre to confirm presentation. The woman should have been informed that, in the case of confirmed cephalic presentation, where breech was the only indication for caesarean section, that the caesarean section will be cancelled, and the woman advised to return home and await spontaneous labour. Counselling around the plan of care if the baby is cephalic should have been addressed in the initial counselling period and a preference recorded, this should be revisited if the baby is cephalic and time and space should be given for the woman to think and discuss her options with her family/birth partners, some women find it helpful to have this discussion away from the ward area and this should be encouraged.
- If labour starts before the booked surgery date, an emergency caesarean section should only be performed following an ultrasound scan to confirm presentation, assessment, and further discussion with the woman.

Planned Vaginal Breech Birth (VBB)

Counselling and care planning should have taken place in the antenatal period for all women planning a VBB. This care plan should be reviewed on initial assessment in labour and a risk assessment should take place, considering all current risk factors.

If there are any risk factors present that impact the care plan, these should be discussed with the woman. All adjustments to the plan need to be discussed and agreed with the woman.

The woman's preferences should be taken into consideration throughout all discussions of care and a relationship should be built to ensure informed consent is maintained throughout the labour and birth process.

The medical team should be informed that the woman has presented in labour.

Unplanned Vaginal Breech Birth

If Diagnosed at Home

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 (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. OBJ
- 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.
- See below for different manoeuvres for vaginal breech birth.

If breech presentation suspected/diagnosed in hospital

- Where a woman 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. (RCOG 2017)
- Women near or in active second stage of labour should not be routinely offered caesarean section. (RCOG 2017)
- Where time and circumstances permit, the position of the fetal neck and legs, and the fetal weight should be estimated using ultrasound, and the woman counselled as with planned vaginal breech birth. (RCOG 2017)

If woman chooses trial of vaginal breech birth, on-call consultant should be informed, who may need to be present for birth if the midwife or registrar is not sufficiently experienced in vaginal breech birth.

Management of vaginal breech birth

1st Stage of labour:

Labour Care should be managed as per cephalic presentation. However, the following should be taken into consideration:

- Discuss care plan and management options, confirm that VBB 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.
- Augmentation is not usually recommended in the case of a breech birth, if slow progress is present a robust assessment and plan of care should be made by the on-call consultant obstetrician. A caesarean section should be considered and discussed in the event of slow/stalled progress.
- **Ensure Neonatal resuscitation equipment is set up and accessible.**

2nd stage

- 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, if in hospital, set resuscitaire transwarmer to 100%.
- 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. "Upright all fours position" may be considered depending on the skills of the midwife or obstetrician involved.
- 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**.**
- **"Hands off the breech" until it has birthed as far as the umbilicus.**
- Only release a loop of cord if it is under tension.

- A paediatrician should be present during birth in hospital.
- The basic principle is to avoid unnecessary interference. Hands off the breech!
- Ensure that breech proforma is completed.
- Collect cord gases where possible, regardless of the APGAR Scores.
- Utilise Manoeuvres as outlined below if there is a delay in the normal progress of birth.

Documentation of timings and any manoeuvres should be entered into breech birth form on Badgernet as per appendix 1.

Preterm Breech
There is much debate as to the appropriate mode of birth for pre-term breech <34 weeks the Consultant should be informed if there is time prior to delivery to be able to risk assess the situation appropriately.

In Labour:
Women should be informed that routine caesarean section for breech presentation in spontaneous preterm labour is not recommended. The mode of birth should be individualised based on the stage of labour, type of breech presentation, fetal wellbeing, and availability of an operator skilled in vaginal breech birth.

Labour with a preterm breech should be managed as with a term breech. (RCOG, 2017)

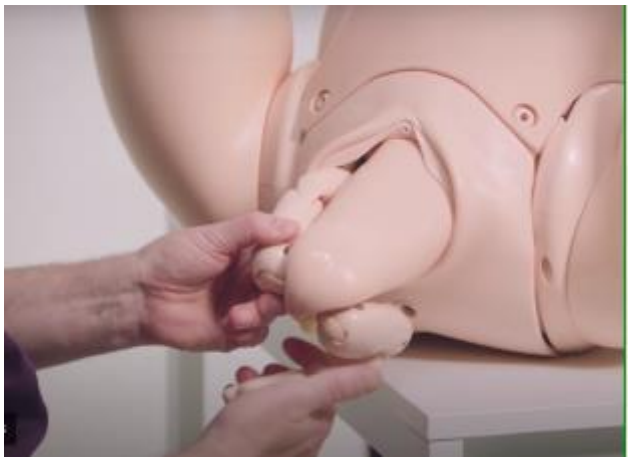
Not in Labour:
Women should be informed that planned caesarean section is recommended for preterm breech presentation where birth is planned due to maternal and/or fetal compromise. (RCOG, 2017)

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.

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.

Extended Legs Occasionally in a primigravid woman the legs of the delivering breech may be extended, splinting the breech. This can lead to delay in the descent of the buttocks. You need to assist in birth of the legs:

- Place a finger in each of the baby's groins
- Apply gentle pressure to assist descent of the buttocks
- Apply gentle pressure behind the knees when the popliteal fossa is seen which will aid birth of the legs



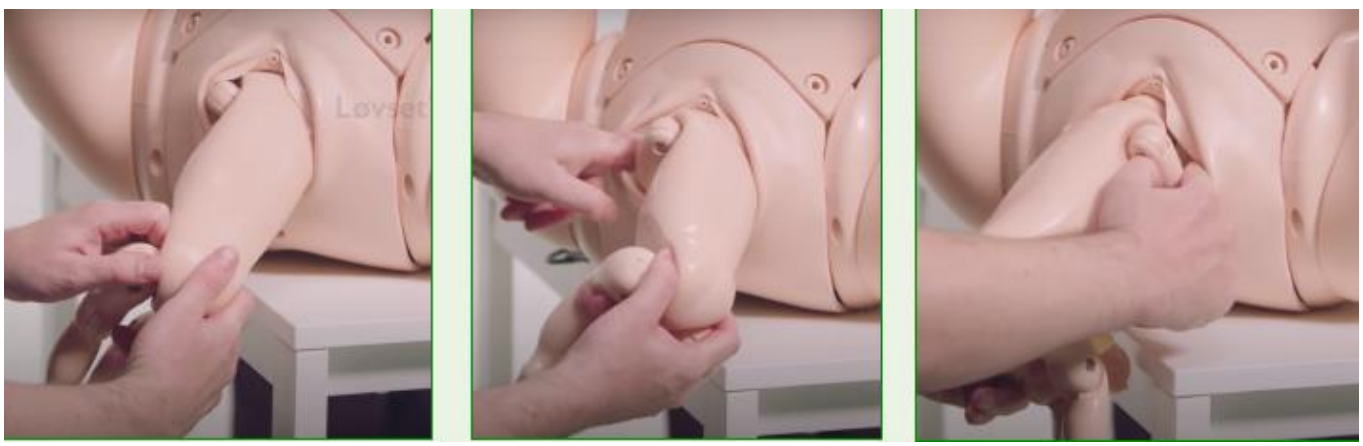
Allow 'HANDS OFF' birth of buttocks and legs. If assistance is required, apply gentle pressure behind baby's knees.

Extended Arms
If the baby's arms are not folded across the chest they are likely to be stretched up alongside the head. You need to rotate the baby's body to bring the posterior shoulder into an anterior position to be delivered under the pubic arch using Lövsets Manoeuvre.

Lovsett's Manoeuvre

- Hold the baby firmly but gently around the pelvis.
- Rotate the body 180°
- Keep the baby's **BACK UPPERMOST**
- The posterior shoulder is now lying under the symphysis pubis.
- Splint the humerus and draw it down over the chest with the elbow flexed to facilitate birth.
- Rotate the baby back through 180° KEEPING THE **BACK UPPERMOST**
- The second arm can be delivered in the same way.

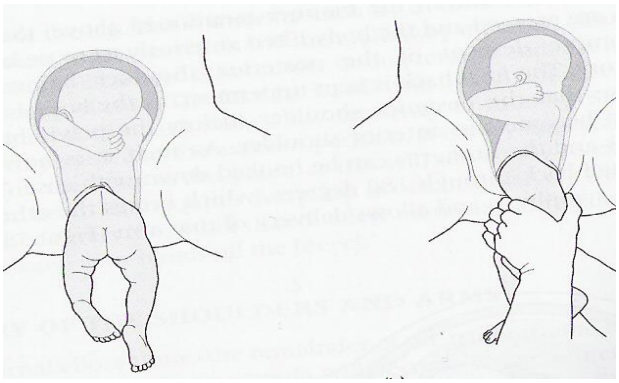
Lovsett's manoeuvre for birth of extended arms



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

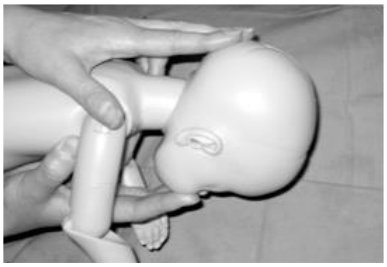
Nuchal Arm

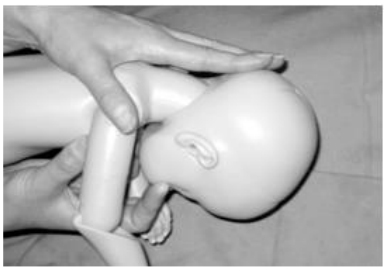
In this position, the shoulder is extended and elbow flexed so that the forearm is trapped behind the occiput. This usually occurs due to inappropriate traction and rotational manoeuvres at an earlier stage in the birth. To overcome this problem fetal trunk is rotated in the direction of fetal hand. The occiput thus rotates past the arm and, with further rotation; flexion of the shoulder should occur and allow birth of the arm.

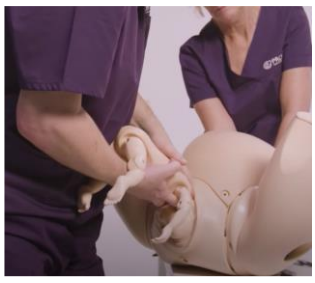


Birth of after coming Head of Breech (Mauriceau Smellie Veit)

- Controlled birth of the head is vital to avoid any sudden change in intracranial pressure. You can assist birth of the head using Mauriceau Smellie Veit manoeuvre.
- Place the baby over your forearm supporting the baby's chest with the palm of your hand.
- NB: **Do NOT put finger in baby's mouth –** there is a risk of causing trauma and will not aid flexion of the head. Place your first and second fingers on the baby's cheek bones.
- With the other hand place your first and third fingers over the baby's shoulders to apply traction, whilst the middle finger presses on the occiput to aid flexion and descent.
- When the face distends the perineum apply upward traction until the mouth and nose are free, the head can now be delivered slowly.



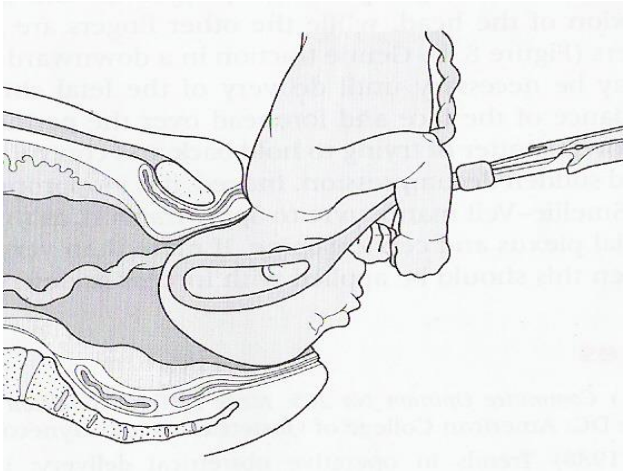




Forceps birth of the head (Hospital births)

An assistant should hold the baby just above the horizontal plane and forceps are applied below the body. It is important not to allow the fetal body to be raised much above the horizontal, as this risks hyperextension of and trauma to fetal cervical spine. As the head

is delivering, and once the fetal chin and mouth are visible, the forceps and the body of the fetus are raised together to complete birth.



Entrapped head after preterm breech birth.

- Catheterise the bladder.
- Perform McRoberts manoeuvre – this may release the head.
- Ask the assistant to apply firm suprapubic pressure to encourage flexion of the head.
- Additional Obstetric manoeuvres should only be performed by experienced obstetricians who are competent with using them.

Correct and Acceptable Fetal Manipulations

- ✓ Antecubital fossa (to flex elbow)
- ✓ Popliteal fossa (to flex knee)
- ✓ Pelvis (traction and rotation)
- ✓ Ankle (traction)

Incorrect and Unacceptable Fetal Manipulations

- Avoid the wrist or hand.
- Axilla
- Abdomen
- Chest

Maternal positioning for birth

Maternal position for birth may be semi-recumbent, forward facing squatting or all fours position depending on maternal preference and accoucheur experience. Inform woman that semi-recumbent may be necessary if assistance is needed. (PROMPT 2023)

Either a semi-recumbent or an all-fours position may be adopted for delivery and should depend on maternal preference and the experience of the attendant. If the latter position is used, women should be advised that recourse to the semi-recumbent position may become necessary. There are limited data in relation to position and outcome of delivery

in vaginal breech birth. Comparison of an upright position with historical data is favourable, with the rate of maternal perineal injuries being lower. In a cephalic presentation, an upright position is associated with a shorter second stage.

Delivery with the woman in a forward-facing position (squatting or all-fours) is the position favoured by many experienced operators claiming, particularly, that it is easier to observe for signs that the delivery will be more difficult.

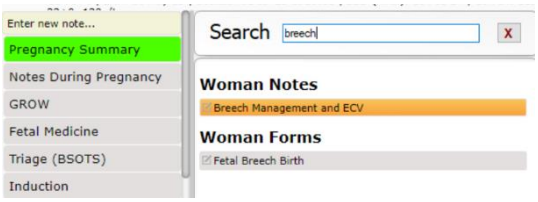
The principal difficulty with an all-fours position is when manoeuvres are required. Most obstetricians are more familiar with performing these in a difficult breech birth with the woman in the dorsal position. If a woman chooses a forward-facing position, they should be made aware that if interventions are required, they may be given assistance to move into a semi-recumbent position. Manoeuvres in an all-fours position can be performed, however, and if the operator has the skills of undertaking the manoeuvres with the mother in a forward position these should be performed without delay. (RCOG 2017)

Appendix 1 – Documentation

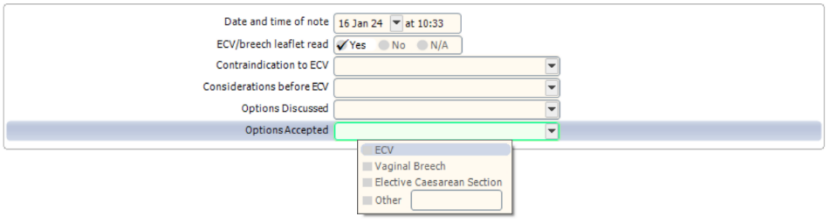
Documentation of ECV on Badgernet

This form should be completed at the point of the ECV procedure and at the point of antenatal discussions if ECV is declined.

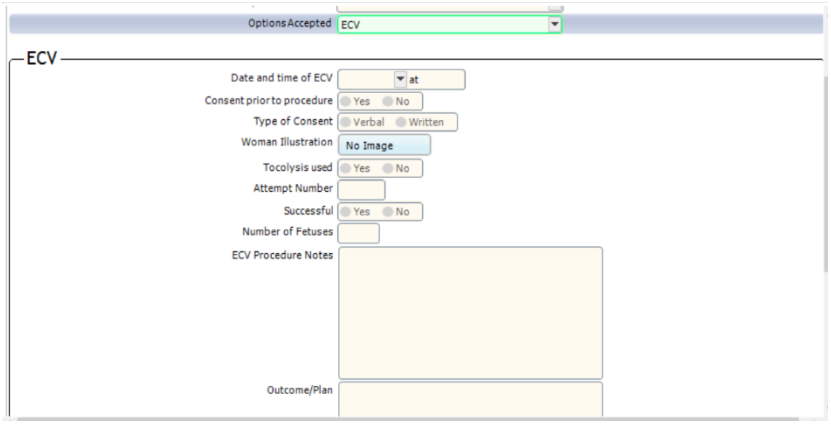
1) Search for breech and select the Breech Management and ECV note:



2) Complete drop down menus and select which options have been accepted.

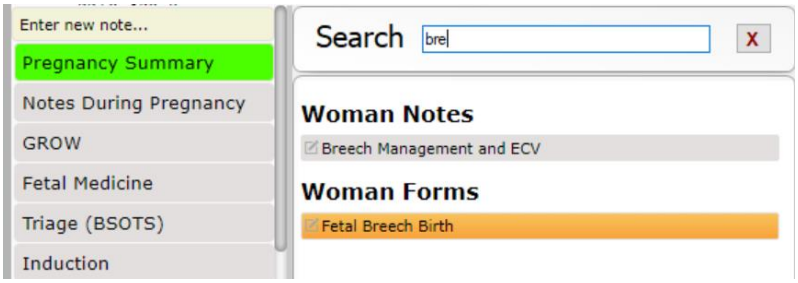


3) If ECV has been accepted a further form will appear below, this should be completed:

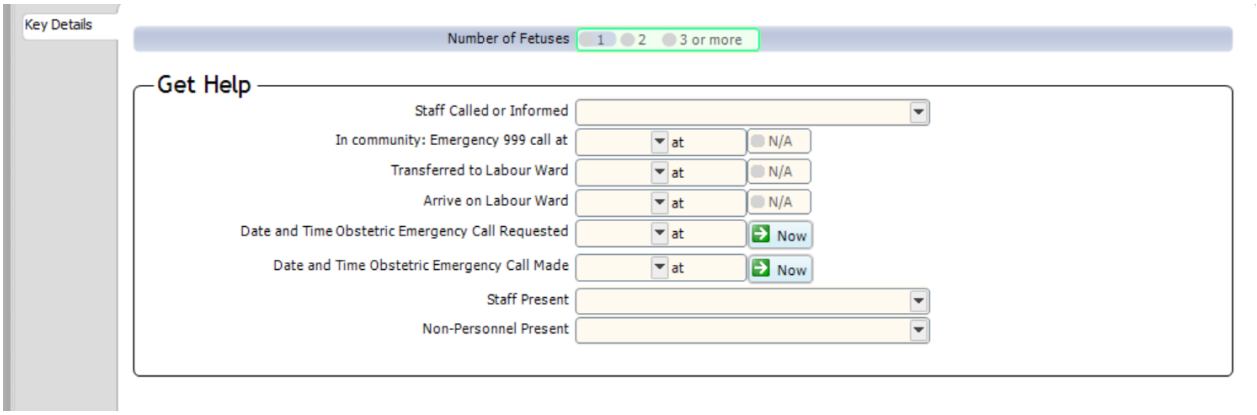


Documentation of breech birth on Badgernet
This form should be completed **in full** for every breech birth, planned or unplanned.

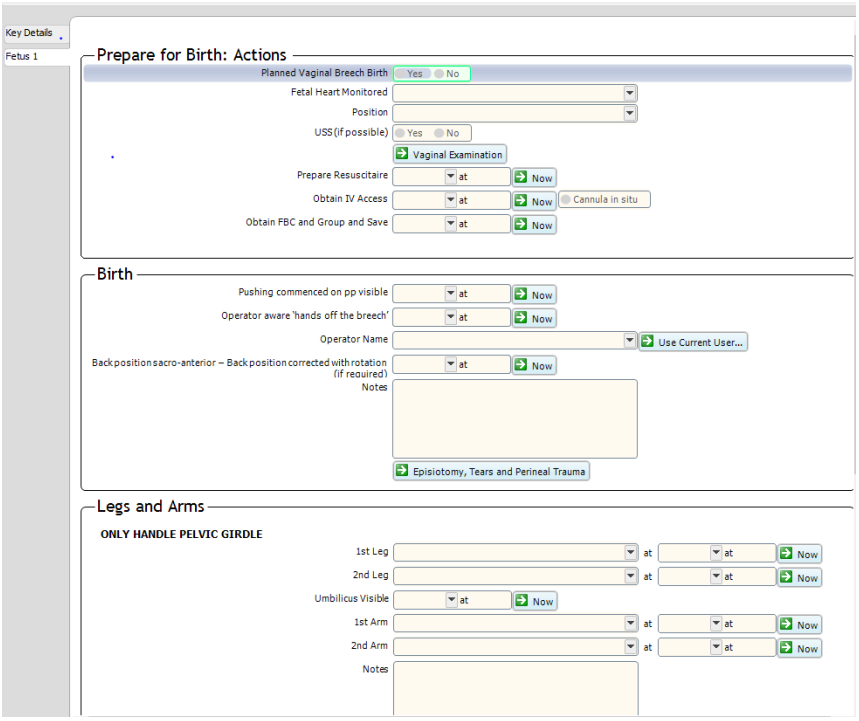
1) Search breech and select the fetal breech birth note:



2) Enter in the Key Details, ensuring number of fetuses is completed. Complete all fields that apply to the situation:



3) Once number of fetuses is ticked, the fetus note will appear along the side. This note is where you can enter all timings and any manoeuvres performed:


Key Details
Fetus 1
Prepare for Birth: Actions
Planned Vaginal Breech Birth
Yes
No
Fetal Heart Monitored
Position
USS (if possible)
Yes
No
Vaginal Examination
Prepare Resuscitaire
at
Now
Obtain IV Access
at
Now
Cannula in situ
Obtain FBC and Group and Save
at
Now
Birth
Pushing commenced on pp visible
at
Now
Operator aware 'hands off the breech'
at
Now
Operator Name
Use Current User...
Back position sacro-anterior – Back position corrected with rotation (if required)
at
Now
Notes
Episiotomy, Tears and Perineal Trauma
Legs and Arms
ONLY HANDLE PELVIC GIRDLE
1st Leg
at
at
Now
2nd Leg
at
at
Now
Umbilicus Visible
at
Now
1st Arm
at
at
Now
2nd Arm
at
at
Now
Notes

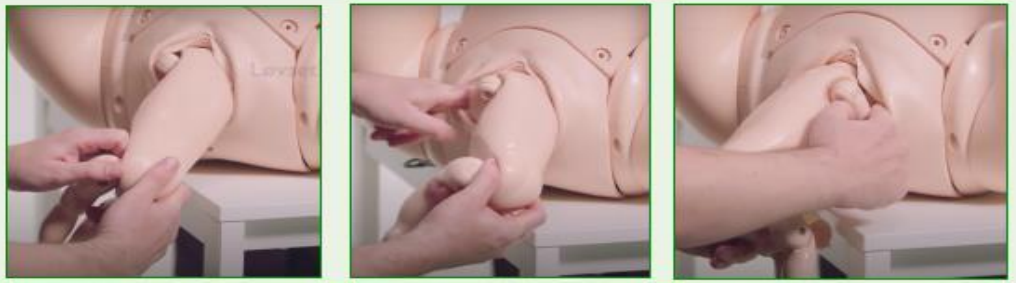
Management of Vaginal Breech Birth[1]

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)

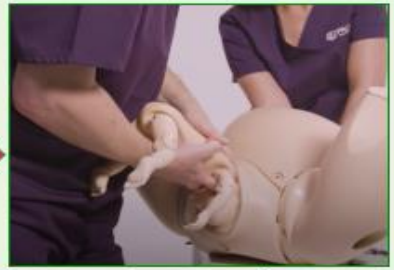
'HANDS OFF' THE BREECH AS MUCH AS POSSIBLE AS LONG AS THE BIRTH IS PROGRESSING AND GOOD INFANT CONDITION

Await visualisation of breech at perineum before encouraging active pushing.

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

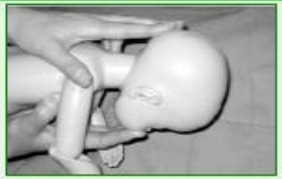


Allow 'HANDS OFF' birth of body and arms. If arms require assistance perform **Lovsett's manoeuvre**. ONLY hold baby over hip bones, turning baby's body to the left and right and keeping the back uppermost (if mother in semi-recumbent position).



Signs that assistance with birth is required:
- **Evidence of poor infant condition (poor tone and/or colour)**
- **Delay of more than 5 minutes between birth of buttocks and birth of baby's head**
- **Delay of more than 3 minutes from seeing baby's umbilicus to birth of baby's head**

Avoid handling the baby's umbilical cord to reduce risk of vasospasm. 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 **e.g. Mauriceau Smellie-Veit manoeuvre**.



Vaginal breech demonstration video

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

Ensure umbilical cord bloods are taken for cord gases.
Document all actions & manoeuvres on vaginal breech birth pro forma.
Fully discuss and explain all events to parents.

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Breech Delivery	Datix/Badgernet – when cases of breech delivery occur (rare event)	ADHOC	Maternity Governance	Maternity Governance/QSRM	ADHOC
	ECV	Process and counselling on Badgernet	2x a year	Maternity Governance	Maternity Governance	2 x a year

References

Tong Leung VK, Suen SS, Singh Sahota D, Lau TK, Yeung Leung T. External cephalic version does not increase the risk of intra-uterine death: a 17-year experience and literature review. J Matern Fetal Neonatal Med2012;25:1774–8

Collins S, Ellaway P, Harrington D, Pandit M, Impey LW. The complications of external cephalic version: results from 805 consecutive attempts. BJOG 2007;114:636–8

RCOG Green-top guideline:External Cephalic Version and Reducing the Incidence of Term Breech Presentation (Green-top Guideline No. 20a) Impey LWM, Murphy DJ, Griffiths M, Penna LK on behalf of the Royal College of Obstetricians and Gynaecologists. External Cephalic Version and Reducing the Incidence of Term Breech Presentation. BJOG 2017; 124: e178–e192.

RCOG Green-top Guideline: Management of Breech Presentation (Green-top Guideline No. 20b) Impey LWM, Murphy DJ, Griffiths M, Penna LK on behalf of the Royal College of Obstetricians and Gynaecologists. Management of Breech Presentation. BJOG 2017

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
All Maternity and Obstetric Staff – Newsletter and Guidelines Forum
Governance Meeting Members

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Quality Governance Meeting Guidelines Forum