Guideline for breech presentation and vaginal breech birth

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The guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant.

1.0 Introduction

A breech presentation is defined when a baby is in a longitudinal lie with the buttocks or feet presenting at the pelvic brim and the head occupying the upper pole of uterus.

- The incidence of a breech presentation at term is 3-4% (where term is defined as 3742 weeks)
- It is associated with uterine and congenital abnormalities, has a significant recurrence risk and is more common in nulliparous women
- Term babies presenting in the breech presentation have worse outcomes than cephalic babies, irrespective of the mode of delivery (RCOG 2017).

2.0 Objective

To ensure:

- The most appropriate management of a vaginal breech delivery is instigated when diagnosed in the antenatal period as per best practice Management of Breech Presentation (wiley.com)
- A consistent and evidence-based approach to the management of a planned vaginal breech delivery
- A consistent and evidence-based approach to the management of a vaginal breech delivery diagnosed in labour

3.0 Scope

All members of the clinical multidisciplinary team involved in the provision of maternity/obstetric care will be aware of the contents of this document and be able to implement it within their professional scope of practice.

4.0 Main body

4.1 Antenatal diagnosis

Breech presentation at term will be confirmed by ultra-sound scan:
- If a breech presentation is suspected by a community midwife the woman will be referred to the Antenatal Day Unit for a presentation scan
- If a breech is suspected on the maternity unit, presentation will be confirmed either in the Ultrasound department or on the maternity unit using the portable ultrasound

Once diagnosis is made, clinicians will counsel women in an unbiased way that ensures an informed choice can be reached. All women must receive the RCOG leaflet ‘Breech baby at the end of pregnancy’ (RCOG 2017) (Appendix one).

4.2 External cephalic version (ECV)

Women with a breech presentation at term will be offered an ECV unless there is an absolute contraindication (See 4.3). They should be advised on the risks and benefits of ECV and the implications for mode of delivery. (RCOG 2017)

Definition

ECV involves manipulating the fetus through the maternal abdomen from a breech to a cephalic presentation.
ECV will be offered to women with uncomplicated pregnancies with a breech presentation at term.

Absolute contraindications	**Relative contraindications**
These are associated with increased risk of mortality or morbidity: • A Caesarean section delivery is advocated • Small for gestational age fetus with abnormal Doppler • Oligohydramnios • Evidence of antepartum haemorrhage in the last seven days • Abnormal CTG • Rhesus iso-immunisation • Major uterine anomaly • Ruptured membranes • Multiple pregnancy (except delivery of second twin) • Medical conditions such as Hypertensive disease, pre-eclampsia	These may lead to complications: • LSCS/Uterine scar • Major fetal anomalies • Unstable lie

Informed choice

Women who fit the criteria will be given the following information to facilitate informed choice:
• ECV reduces the chance of a breech presentation at delivery –spontaneous version rates for Nulliparous women are approximately 8% after 36 weeks gestation. Spontaneous reversion to a breech position following a successful ECV is > 5% • Attempting an ECV for a breech presentation lowers the chances of having a Caesarean • Success rates vary nationally from 30-80%. Generally, a success rate of 40% for nulliparous women and 60% for multiparous can be used. However, the rates will be influenced by maternal, fetal and organisational factors • Attempting an ECV has a low complication rate but the potential problems will be explained: ○ Placental abruption ○ Uterine rupture ○ Feto-maternal haemorrhage ○ Transient changes in the fetal heart rate • The woman will be advised that the procedure could be uncomfortable but will be stopped at her request

For the ECV procedure please refer to Appendix 2

4.3 Options for mode of delivery and associated risk of perinatal mortality

Modes of delivery and associated risk of perinatal mortality RCOG (2017)		
Elective Caesarean section after 39+0 weeks	**Planned vaginal breech delivery**	**Planned vaginal cephalic delivery**
Approximately 0.5/1000 with caesarean)	Approximately 2.0/1000 births.	Approximately 1.0/1000

Caesarean section

Any decision to perform a caesarean section needs to be balanced against the potential adverse consequences that may result from this. Women will also be made aware of the potential impact on future pregnancies that a caesarean scar may have (Vaginal Birth After Caesarean section (VBAC)) and the risks associated with any surgical procedure. The clinician must also explain the potential risks of an abnormally invasive placenta.

Vaginal delivery

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). Women will 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
The woman can be offered a birth thoughts clinic appointment if she wishes to discuss this further.

Women will be informed if they have any of the risk factors (see table below) then a vaginal delivery could be associated with increased perinatal risks and poorer outcomes.

Factors associated with a high-risk vaginal breech birth, leading to poor outcomes and high chance of failure. These women will be advised to have a Caesarean section
• Independent indications for caesarean section • Hyperextended fetal neck identified on ultrasound • High estimated fetal weight (> 3.8kgs) • Low estimated fetal weight (< 10th centile on individual GROW chart) • Footling presentation • Evidence of antenatal fetal compromise

For successful vaginal breech birth and good outcomes:
• Ensure appropriate case selection i.e. no risk factors • Adhere to guidelines- Women will be informed that following these reduces the chances of early neonatal morbidity • Ensure availability of skilled attendants • Ideally a vaginal breech delivery will take place in hospital where there are facilities for immediate caesarean section if required

Refer to the vaginal breech delivery risk factor check list above when deciding mode of delivery. Induction of labour is not recommended.

4.4 Breech presentation in labour

Inform the Obstetric registrar who will liaise with the Obstetric Consultant on call.

Management will depend on the stage of labour, risk factors, availability of appropriate clinical expertise and informed consent

If possible and feasible an ultrasound scan will be performed to determine the position of the fetal neck and legs and estimated fetal weight.
Consider vaginal breech birth dependent upon risk factors and maternal wishes considering any unfavourable clinical features as listed above.
Women in or near active second stage of labour will not routinely be offered a caesarean section.

Please note: In all cases (where delivery is not immediate) for a vaginal delivery to be considered the presentation of the fetus must be either frank (hips flexed, knees extended) or complete (hips flexed, knees flexed but feet above the fetal buttocks). A footling breech presentation will be delivered by Caesarean section.

4.5 Delivery by Caesarean section

If the decision is made to deliver the baby by Caesarean section after considering the risk factors and woman's choice, the category will be decided on an individual basis as follows:

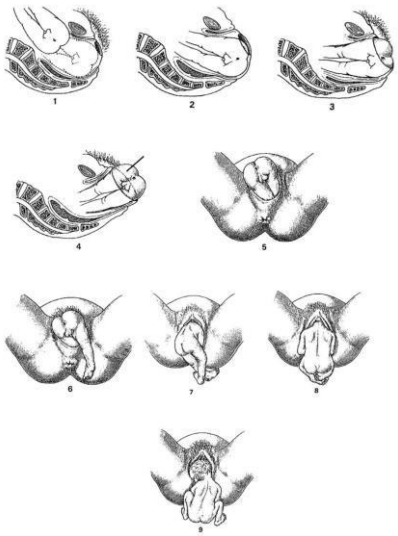
- A Category 1 if there is evidence of fetal compromise i.e. immediate threat to life of fetus
- A Category 2 if there is no evidence of fetal compromise i.e. no immediate threat to life but requires delivery

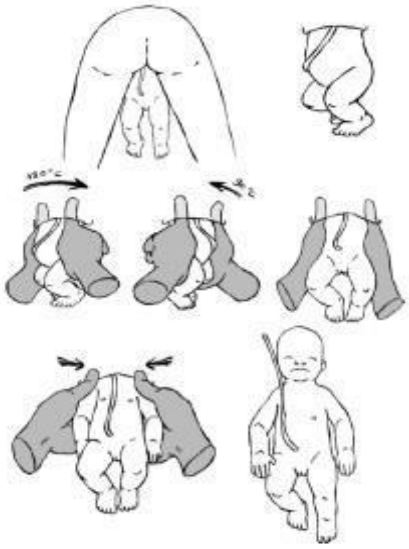
4.6 Vaginal breech delivery

Vaginal breech delivery is classed as a high risk labour; management of care will be decided following consultation with senior obstetricians, midwifery staff, anaesthetic team, paediatric team and the woman.
Where possible, intervention is kept to a minimum but close supervision is required.

First stage of labour The first stage of labour will be managed in accordance with the guideline for -normal labour with the following caveats:	
Bloods	• Gain intravenous access and send bloods for Full Blood Count (FBC); Group and Save
Fetal monitoring	Assess fetal wellbeing with continuous electronic fetal monitoring • Evidence of fetal hypoxia in the first stage of labour may indicate that the fetus will not tolerate the stresses of the second stage where cord compression may occur • Hypoxia can lead to loss of fetal tone • Good fetal tone enables an easier breech delivery
Medication	Administer oral Omeprazole 40mg every twelve hours
Progress	Allow labour to progress naturally but review progress a minimum of four hourly Augmentation for inadequate progress is not recommended as adequate progress is thought to be evidential of adequate fetopelvic Proportions Augmentation may be considered following epidural analgesia if contraction frequency is low (< 4 in 10) If progress is slow consider Caesarean section
Artificial Rupture of	Avoid ARM unless there is a definite clinical indication which outweighs the associated risk of cord compression
Membranes (ARM)/ Spontaneous Rupture of Membranes (SROM)	If SROM occurs perform a vaginal examination to exclude a cord prolapse
Analgesia	Discuss pain relief with the woman: • Epidural analgesia can be considered however advise women that it may increase the risk of intervention as a vaginal breech delivery is easier to achieve if the woman is able to bear down effectively in the second stage

Second stage of labour The delivery will be performed/supervised by either a senior midwife or obstetrician	
Communication	The Anaesthetist and the Paediatrician must be present on the Birthing Centre when the delivery is imminent The obstetric theatre team must be on stand by The registrar must inform the consultant obstetrician and depending on the experience of the registrar the consultant may need to be present
Delivery	Full dilation of the cervix must be confirmed Ensure the bladder is empty Active pushing will not be encouraged until the breech has descended to the perineum. If the breech is not visible within 2 hours from full dilation a Caesarean section is recommended Ideally the woman will adopt either a semi-recumbent or a forward-facing position (all-fours position or squatting) for delivery If manoeuvres are required, the woman may be asked to adopt a semi recumbent position, unless the practitioner is skilled in performing manoeuvres in a forward-facing position Allow spontaneous decent of the presenting part
When to intervene	A hands-off approach to the delivery is required, however assistance (without traction) may be necessary once the umbilicus is delivered if: • The fetal back starts to rotate into a posterior position (keep the baby's bum to the mum's tum) • There is a delay (> 5 minutes from the delivery of the buttocks to the head or > 3 minutes from delivery

	of the umbilicus to the head) • There is evidence of poor fetal condition (poor colour and tone) • There are extended arms • The neck is extended Minimum handling of the descending breech is advised but if required the baby will be gently grasped around the bony prominences of the pelvis
Delivery in a semi-recumbent position **Include pictures** 	If the legs do not deliver spontaneously apply gentle popliteal pressure to facilitate flexion of the knee If possible allow spontaneous delivery of the arms. Once the scapula is delivered, the arms can be brought down by inserting a finger in the elbow and flexing the arms across the chest. If this is not possible use Lovset's manoeuvre to facilitate descent and delivery The baby will be allowed to hang until the nape of the neck is visible Use the Mauriceau-Smellie-Veit Manoeuvre to facilitate deliver of the baby's head

Delivery in a forward-facing position (all fours or up right) 	Allow the legs to deliver spontaneously (if one leg slips down before the other it may indicate that full rotation to a sacro-anterior position has not occurred and assistance may be needed to deliver the arms) Once the legs have delivered the abdomen and umbilicus will be clearly visible A sternal crease on the baby's chest indicates that the arms are in front and may deliver with the next contraction (If full rotation has not occurred - manoeuvres may be required to deliver the arms) As the head engages the baby will rotate slightly and one arm delivers under the pubic arch. The baby will then rotate in the other direction and the other arm is released (occasionally both arms are delivered together without rotation) At this stage the woman may experience the urge to lower her bottom to the surface on which they are
	kneeling which maintains and promotes flexion of the head The baby may also spontaneously pull its knees up into a fetal position which also prompts flexion and allows the head to deliver If the head does not deliver with the next contraction manoeuvres will be required

4.7 Entrapment of the after coming head

Entrapment of the after coming head is an Obstetric emergency requiring the involvement of the senior obstetrician, midwifery staff, paediatric and theatre team:

- Inform the woman what is happening
- Place the woman in McRoberts position
- Supra-pubic pressure may be employed to encourage flexion of the head
- Forceps may be applied to the head to facilitate delivery

Entrapment of the fetal head may occur if the cervix is not fully dilated resulting in the necessity for surgical incisions of the cervix at 2, 6 and 10 o'clock.

This may also occur at a caesarean section, in this case a vertical uterine extension will be performed to facilitate delivery with or without tocolysis.

4.8 Breech presentation in a preterm infant

Care will be given as for a term breech in labour.

The obstetric consultant will decide on the mode of delivery following individual risk assessment based on:

• The stage of labour

• The type of breech presentation

• Fetal wellbeing

• Availability of skilled operators

Routine caesarean section is not advised

Caesarean section for a breech presentation between 22+0- 25+6 weeks is not recommended. The woman and her partner will be involved in the decision making process

Please note- A planned caesarean section is recommended for a preterm delivery where the woman is not in labour but delivery is advocated for maternal/fetal compromise.

5.0 Roles and responsibilities

5.1 Midwives

To ensure that women are able to make an informed decision regarding the best possible management of a breech presentation at term.
To provide care for women in accordance with appropriate guidance from diagnosis to delivery.

5.2 Obstetricians

To provide the woman with information required to make an informed decision regarding the management of a breech presentation at term.
To provide care for women in accordance with appropriate guidance from diagnosis to delivery.

5.3 Paediatricians

To attend delivery when their presence is requested

5.4 Anaesthetists

To attend when their presence is requested and provide analgesia/anaesthesia to the women for operations and procedures as appropriate.

Documentation

Documentation will be completed in accordance with Trust and Maternity policies and NMC requirements.

6.0 Associated documents and references

RCOG Green top guideline No. 20a (March 2017). External Cephalic Version and Reducing the Incidence of Term Breech Presentation
https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.14466

RCOG Green top guideline No. 20b (March 2017). Management of Breech Presentation
https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.14465

7.0 Training and resources

Training will be delivered as outlined in the Maternity Training Needs Analysis. This is updated on an annual basis.

8.0 Monitoring and audit

Any adverse incidents relating to the management of breech presentation and breech birth will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the governance midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for the management of breech presentation and vaginal breech birth will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

9.0 Equality and Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1

Breech baby at the end of pregnancy patient information leaflet | RCOG

Appendix 2

Procedure for ECV

Timing	Can be performed after 37 weeks (can be scheduled for 36 weeks gestation if it is not possible to schedule the procedure for 37 weeks
Location	Will be performed on the Birthing Centre with its facilities for emergency delivery
Booking	Dates and times for the procedure are booked via the Antenatal Day Unit. Booking is usually done directly with the relevant Consultant's secretary who has access to their diary and will be instigated by the area wishing to arrange the ECV. BBC and ANDU need to be informed of ECV appointment
Ultrasound scan	The woman will have an ultrasound scan prior to the procedure: • This is arranged by and reviewed on the Antenatal Day Unit • The scan will be performed within 7 days prior to the ECV
Inform the woman	The woman is asked to fast (from 7am if the ECV is to be performed in the afternoon) prior to the procedure in case surgical intervention is required.
Communication	Inform anaesthetist and theatre staff of the procedure
Procedure	A CTG will be performed before and after the procedure to monitor fetal wellbeing Advise the woman to empty her bladder Tocolysis may be used with clinical discretion The mobile scanner will be available If required i.e. rhesus negative mother with rhesus positive fetus maternal Kleihauer will be sent and Anti D administered following the procedure.

Appendix 3 Glossary of terms

ANDU	Antenatal Day Unit
ARM	Artificial Rupture of Membranes
BBC	Barnsley Birth Centre
CTG	Cardiotocography
ECV	Eternal Cephalic Version
FBC	Full Blood Count
GROW	Gestation Related Optimal Weight
LSCS	Lower Segment Caesarean Section
SROM	Spontaneous Rupture of Membranes
VBAC	Vaginal Birth After Caesarean

Appendix 4 (must always be the last appendix)

Version	Date	Comments	Author

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Women's Business and Governance Meeting	19/04/24
CBU 3 Overarching Governance Meeting	22/05/24

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	**Guideline**
Document title	**Guideline for the management of breech presentation and vaginal breech birth**
Document author (Job title and team)	**Practice Educator Midwife/ Guideline group**
New or reviewed document	**Reviewed**
List staff groups/departments consulted with during document development	**Consultant obstetricians, senior midwives**
Approval recommended by (meeting and dates):	**Women's Business & Governance 19/04/24** **CBU 3 Business and Governance meeting 22/05/24**
Date of next review (maximum 3 years)	**24/02/2027**
Key words for search criteria on intranet (max 10 words)	**Vaginal, breech, delivery**
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the FINAL version of this document	**Name: Juliette Thompson** **Designation: Governance Midwife**