Breech

Contents

1. Overview

Purpose

To provide guidance on the care and management for women who have a baby in breech presentation.

Scope

To provide recommended best practice for all WDHB Midwives, Obstetricians and Maternity access holders.

2. Background

Approximately 3-4% of singleton babies present breech. Vaginal breech birth has significantly declined due to the results of the "Term Breech Trial" (Hannah et al. Lancet, 2000). Despite the research being criticised on methodological grounds, as many as 90% of breech babies are now born by caesarean section.

A further consequence of The Term Breech Trial has been a reduction in training opportunities for obstetric and midwifery staff. Both Obstetricians and Midwives need to understand the mechanisms of breech birth and have the technical skills to manage breech birth safely.

With strict criteria before and during labour, planned vaginal birth of the singleton breech at term is an option that can be offered to carefully selected, well counselled women (Goffinet et al for the PREMODA study group).

3. Antenatal management

The MOH Referral Guidelines state that the LMC must recommend to women with a breech presentation that a consultation with a specialist is indicated by 36 weeks. *See Appendix 1.*

- External Cephalic Version (ECV) increases the likelihood of a vaginal birth. All women with an uncomplicated breech pregnancy should be offered information around ECV. (Provide 'Turning your breech baby' information leaflet).
- An individualised assessment and a three way planning discussion with the woman, her LMC and the Obstetrician around the risks of vaginal breech birth and caesarean birth should be undertaken and documented.

- Women should be informed of the evidence around planned vaginal breech birth as well as planned caesarean for breech presentation at term.

3.1 Contraindications for External Cephalic Version (ECV)

Absolute contraindications:

- Where LSCS is planned for other reasons
- Multiple pregnancy (except delivery of second twin)
- Placenta praevia
- Abnormal CTG
- Ruptured membranes
- Major uterine anomaly
- Antepartum Haemorrhage within the last 7 days
- A history of placental abruption
- Unavailability of emergency LSCS staff/facilities
- Severe pre-eclampsia or HELLP Syndrome

Relative contraindications:

- Small for gestational age fetus with abnormal Doppler parameters
- Proteinuric pre-eclampsia
- Oligohydramnios
- Major fetal anomalies
- Scarred uterus
- Unstable lie
- Established labour

Other factors may be taken into account by the maternity care team and a decision around ECV made on an individual basis.

Note: Different practitioners may have different preferences around when an ECV is best performed. Ideally for primigravid women this could be undertaken at 36 weeks and at 38 weeks for a multiparous woman. The timing of an ECV may be individualized by the practitioner.

4. Management of breech presentation at term

4.1 Planned caesarean section at term

- Ensure woman has relevant information around the risks and benefits of planned caesarean at term vs vaginal breech birth
- Ensure the woman has been offered an opportunity to discuss ECV
- USS immediately prior to caesarean to confirm baby has remained in a breech position

If labour commences prior to the booked date of planned caesarean, confirm that the baby is still in a breech position, preferably by USS. Assess progress of labour, descent of presenting part and make an individual decision with the woman about the plan for either vaginal breech or emergency caesarean, based on the availability of a skilled practitioner.

4.2 Planned vaginal breech birth at term

For a woman who has requested a vaginal breech birth, the woman should be counselled about the risks and benefits of planned vaginal breech birth in the intended location and clinical situation.

- Ensure woman has relevant information around the risks and benefits of planned caesarean at term vs vaginal breech birth
- Ensure the woman has been offered an ECV

The single factor known to improve the safety of vaginal breech birth is the presence of a skilled and experienced clinician at the birth. Attendants should counsel women about their level of experience and take it into account when a woman requests a vaginal breech birth which may be complicated by the above criteria. The availability of an obstetrician or midwife with skill and experience facilitating vaginal breech births should be made clear during counseling, and a back-up plan made if such a person is not available during the birth.

Contraindications to a planned vaginal breech birth include:

- EFW < 2.5kg
- EFW > 75th customized centile
- Gestation < 37 weeks
- Reduced or increased liquor volume
- Extension of the fetal head
- A uterine scar
- Cord presentation on VE
- A breech presentation that is neither Frank (legs extended) nor Complete (one or both legs folded)
- Inability to provide facilities for an emergency LSCS
- Inappropriately prepared and/or experienced clinicians available for the birth
- Fetal anomaly incompatible with vaginal birth

5. Intrapartum management of breech presentation

On admission, consultation with the obstetric team on call is required.

Labour

- Review birth plan and ensure competent personnel available
- Group and hold
- Continuous CTG monitoring in established labour (An FSE attached to the babys' buttock may be used if the abdominal trace is of poor quality.
- Good support, adequate analgesia (inclusive of epidural) of the woman's choice
- Labour should progress well i.e. – Cervical dilatation of 2cm over 4 hours
- Syntocinon augmentation is rare and only used if prescribed by a specialist obstetrician who is present in the unit.

Birth

- Ensure full dilation confirmed by vaginal examination
- Consider passive descent into pelvis
- Descent of buttocks to perineum within 2 hours from full dilation
- Suitably experienced obstetrician onsite during second stage
- Credentialed neonatal nurse and/or paediatrician available for the birth
- Anaesthetic team on call and clinical charge midwife (CCM) notified of imminent birth
- No breech extraction
- Plan should be re-evaluated if not born after 60 minutes of active pushing.
- Respect the mechanisms – remain hands-off as long as the birth is progressing in a safe and timely manner
- Restore the mechanisms – intervene in a timely manner if the birth is not progressing safely
- Gentle, controlled delivery of the head

- Adopt a facilitative approach to maternal positioning, supporting the mother to remain upright if she wishes

5.1 Management of breech presentation first diagnosed in labour

Early diagnosis of breech presentation is imperative to enable optimal management. This involves a physical examination during the first labour assessment. If breech is suspected then confirmation of presentation should be made by portable USS by a suitably trained person.

Breech presentation in labour requires urgent referral for consultation to a specialist obstetrician on call. In determining the preferred mode of birth, the obstetrician should consider:

- Management of breech presentation diagnosed in labour is **NOT** the same as the management of planned vaginal breech birth.
- Gestational age and other eligibility criteria for vaginal breech birth.
- Whether caesarean section (CS) can be achieved prior to spontaneous vaginal birth without the need for undue haste that might further endanger the mother and the baby.
- Fetal wellbeing as determined by CTG.
- Increased fetal risks of vaginal breech delivery.
- Possibility of undiagnosed congenital abnormalities.
- The possibility of undiagnosed hyperextension of the fetal head (RANZCOG).
- Increased maternal risks of emergency CS.
- Anaesthetic considerations such as a lack of group and screen or the nonfasted woman.
- Potential technical difficulties delivering the fetus at CS if the breech is very low in the pelvis.

Health professionals who lack significant experience to support a vaginal breech birth should make every effort to involve a skilled and experienced professional in the counselling process as well as the birth, for women who choose this option.

All aspects of the discussion regarding mode of birth in this context must be fully and contemporaneously documented.

- Informed consent should be obtained from the woman.
- A three way conversation between the woman, her LMC and the obstetrician is recommended best practice.

6. Postnatal concerns for baby following birth

Babies who present in the breech position, regardless of birth mode are at increased risk of Developmental Dysplasia of the Hips (DDH).

An assessment of the hips should be undertaken within 24 hours following birth and again at one week of age (See the 'Developmental Dysplasia of the Hips Pathway' available on the CeDDS website). If the initial exam is abnormal or the LMC is uncertain, a referral to the paediatric team is warranted.

If the initial hip assessment is normal, the LMC should refer the baby for a hip x-ray at 4 months with a copy to be sent to the GP.

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7. References

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5	Management of breech presentation at term (C-Obs 11) RANCOG statement reviewed July, 2016.
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9	Su et al. Term breech trial collaborative group: factors associated with adverse perinatal outcome in the Term Breech Trial. Am J Obstet Gynaecol. 2003.
10	Vaginal delivery of breech presentation. Society of Obstetricians and Gynaecologists of Canada, Clinical practice guideline No. 226. June 2009.
11	'Turning your breech baby' patient information leaflet available in Controlled Documents on the WDHB intranet and on Healthpoint.
12	\\nsh-deptdata\groups\Groups\Child Health\Paediatric_Clinical_Pathways\DDH_Developmental_Dysplasia_of_the_Hip\DDH_Clinical_Pathway.pdf

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Appendix 1: Antenatal management of breech presentation