Document Control

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CONTENTS

1. Purpose

1.1. The purpose of this document is to detail the process for best practice guidelines for breech presentation management.

Although incidence of breech presentation is approximately 20% at 28 weeks, most fetuses turn spontaneously resulting in an incidence of 3-4% at term. Multiple pregnancy increases the risk of breech presentation. Other influencing factors include pelvic tumours, uterine abnormalities (a septum or uterine fibroid), previous breech, high parity and placenta praevia.

Whatever the mode of delivery, breech presentation is a signal for potential fetal morbidity and mortality for varied reasons including prematurity, congenital malformations, birth asphyxia or trauma. Fetal growth restriction may also predispose to breech presentation because the reduction in liquor volume restricts fetal movement and thus the fetus is trapped in the position it adopted in the second trimester. In this case the potential for poor perinatal outcome is further increased.

1.2. This guideline applies to Obstetricians and Midwives.

1.3. Implementation of this guideline will ensure evidence based management of breech presentation.

2. Definitions

Definition

2.1. ECV – External Cephalic Version.

3. Responsibilities

3.1. All cases of Breech presentation at 36 weeks and beyond must be referred to the obstetrician.

3.2. All Midwives and Obstetricians are responsible for;

- Acting as an effective advocate for the woman by providing her with appropriate evidence based information so that she can make an informed choice about mode of delivery.
- Ensuring that appropriate and prompt referral is made to ensure the woman has every option available in management of the breech presentation.
- Ensuring that any referrals made are followed up effectively.
- Ensuring that ECV is undertaken by the appointed skilled clinician in a clinically appropriate location.
- Ensuring vaginal breech delivery is made available in clinically appropriate situations and conducted with appropriate supervision.

4. Management of breech presentation

General Principles

If breech presentation is suspected on palpation from 34 - 36 weeks gestation, the mother should be referred to the Unit for a diagnostic ultrasound scan within 1 week. If breech is confirmed on scan, the following features should be assessed:

- Type of breech presentation
- Location of fetal back in relation to maternal back
- Estimated fetal weight
- Liquor volume
- Location of placenta
- Inspection of head / neck

4.1. If breech presentation is confirmed, referral should be made prior to 37wks gestation to a Senior Obstetrician in ANC/DAU for a management plan.

- There is no evidence for routine recommendation of postural regimes to convert the breech to cephalic (e.g. knee-chest position). However these exercises do no harm and may prove beneficial psychologically.
- Women may wish to consider the use of moxibustion by a trained practitioner for breech presentation at 33–35 weeks of gestation.

Please see Appendix A for ‘Diagnosis of the breech presentation’.

Antepartum Breech presentation management.

4.2. ECV – External Cephalic Version.

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

Women should be counselled about the success rate (40% for nulliparous and 60% for multiparous). The success of ECV is enhanced by using a tocolytic agent – proven for Salbutamol and Terbutaline, not with Nifedipine or GTN. Women should be counselled that with appropriate precautions, ECV has a very low complication rate. Although case reports of placental abruption and large feto-maternal haemorrhage exist, complications associated with ECV are very rare. The reported risk of emergency caesarean section within 24 hours is approximately 0.5%, with the indication in over 90% being vaginal bleeding or an abnormal CTG following the procedure. Women should be informed that few babies revert to breech after successful ECV. Women should be informed that labour after ECV is associated with a slightly increased rate of caesarean section and instrumental delivery when compared with spontaneous cephalic presentation.

Criteria for ECV

While there is no general consensus on the eligibility for, or contraindications to, ECV. ECV should be offered at term from 37+0 weeks of gestation. In nulliparous women, ECV may be offered from 36+0 weeks of gestation. Success with ECV has been reported at 42 weeks gestation. ECV can be undertaken in early labour, provided the membranes are intact. Women should be informed that ECV after one caesarean delivery appears to have no greater risk than with an unscarred uterus.

At NDDH, women eligible for ECV will be singleton pregnancy, 37 weeks gestation and above. ECV will only be performed on CDS by a senior Obstetrician who has been trained to perform ECV.

Contraindications to ECV

- ECV is contraindicated where an absolute reason for caesarean section already exists (e.g. placenta praevia, severe preeclampsia).
- Multiple pregnancy (except after delivery of a first twin).
- Rhesus isoimmunisation
- Vaginal bleeding (less than 1 week previously)
- Abnormal electronic fetal monitoring (EFM)
- Rupture of the membranes
- Mother declines or is unable to give informed consent.
- ECV should be performed with additional caution where there is oligohydramnios or hypertension.

Please see Appendix A for ‘Diagnosis and Types of breech presentation’.

Prerequisites for ECV

- ECV should only be performed by a trained practitioner or by a trainee working under direct supervision.
- ECV at NDDH will be undertaken on Central Delivery Suite where ultrasound, CTG and theatre facilities are immediately available if required.
- Ultrasound examination prior to ECV to exclude causes of breech presentation such as Polyhydramnios, Hydrocephalus, Placenta Praevia, and to check presentation and position of fetus.
- Standard preoperative preparations for LSCS are unnecessary for women having ECV.

ECV Procedure

- Advise the woman that ECV may be painful and that the procedure will be suspended if they wish.
- Prior to ECV complete
  - ⇨ minimum 30mins CTG assessed using an Antepartum CTG assessment sticker and defined as normal.
  - ⇨ a full set of maternal observations all of which should be normal. Any concerns should be addressed prior to the procedure.
  - ⇨ USS to confirm presentation and position of fetal back.
- During the ECV procedure
  - ⇨ Monitor the fetus by ultrasound or 5oppler during rest periods whilst procedure is undertaken.
  - ⇨ You may use Trendelenburg position.
- Abandon the ECV procedure if
  - ⇨ there is no success achieved by 15-20 minutes.
  - ⇨ if the woman experiences pain.
  - ⇨ if fetal bradycardia occurs - stop the procedure. If bradycardia continues - revert the fetus to breech presentation. If fetal bradycardia persists - prepare for Caesarean Section. If during preparation time, the fetal heart recovers, reconsider options, involving the woman in decision making.
- After ECV complete
  - ⇨ minimum 30mins CTG assessed using an Antepartum CTG assessment sticker and defined as normal.
  - ⇨ a full set of maternal observations all of which should be normal prior to discharge.
  - ⇨ USS to confirm presentation and position of the fetus.
  - ⇨ Discharge after 1 hour if asymptomatic and normal CTG.
- Rhesus negative mothers should be offered Anti-D immunoglobulin. (Kleihauer testing should not be necessary (RCOG 2010)).
- Myometrial relaxant is optional for multips and recommended for primips. If indicated, give SC bolus terbutaline 0.25mg. The woman should be advised of adverse effects of terbutaline and 3 lead ECG monitoring should be in progress to monitor the woman throughout.

Follow up after ECV

If successful, presentation should still be confirmed by ultrasound scan prior to delivery to eliminate reversion to breech presentation. If unsuccessful, further attempt at ECV and mode of delivery needs to be discussed with the woman.

Women who have a breech presentation at term following an unsuccessful or declined offer of ECV should be counselled on the risks and benefits of planned vaginal breech delivery versus planned caesarean section. Discussion should include the advantages and disadvantages of each option. A record of this discussion and the woman's decision on mode of delivery should be entered in the hand held notes.

Planning mode of delivery

The decision for mode of delivery will be made between the senior Obstetrician and the woman. It will involve a full discussion about the risks associated with both vaginal and operative deliveries in addition to the contraindications for vaginal delivery of the breech.

Please see Appendix A for 'Diagnosis and Types of breech presentation'.

What information about the baby should be given to women with breech presentation at term regarding mode of delivery?

Women should be informed that planned caesarean section leads to a small reduction in perinatal mortality compared with planned vaginal breech delivery. Any decision to perform a caesarean section needs to be balanced against the potential adverse consequences that may result from this.

Women should be informed that the reduced risk is due to three factors: the avoidance of stillbirth after 39 weeks of gestation, the avoidance of intrapartum risks and the risks of vaginal breech birth, and that only the last is unique to a breech baby. Women should be informed that when planning delivery for a breech baby, the risk of perinatal mortality is approximately 0.5/1000 with caesarean section after 39+0 weeks of gestation; and approximately 2.0/1000 with planned vaginal breech birth. This compares to approximately 1.0/1000 with planned cephalic 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. [RCOG, 2017]

What information should be given to women having breech births about their own immediate and future health?

Women should be informed that planned caesarean section for breech presentation at term carries a small increase in immediate complications for the mother compared with planned vaginal birth. Women should be informed that 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.

Women should be informed that 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 informed that caesarean section has been associated with a small increase in the risk of stillbirth for subsequent babies although this may not be causal.

Women should be informed that induction of labour is not usually recommended.

Routine LSCS for PRE-TERM singleton breech presentation should not be advised. The Term Breech study is available only for management of term singleton pregnancies – the same evidence cannot be reasonably extrapolated to preterm deliveries.

Planned LSCS for a twin pregnancy where the presenting twin is breech is recommended.

Planned Vaginal Breech Delivery

Women who have a breech presentation at term following an unsuccessful or declined offer of ECV should be counselled on the risks and benefits of planned vaginal breech delivery versus planned caesarean section.

The essential components of planned vaginal breech birth are appropriate case selection, management according to a strict protocol and the availability of skilled attendants. Units with limited access to experienced personnel should inform women that vaginal breech birth is likely to be associated with greater risk and offer antenatal referral to a unit where skill levels and experience are greater.

N.B See 4.4 Contraindications to vaginal breech delivery.

Planned Elective LSCS

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. This assessment and plan should be clearly documented in the woman's notes.

The elective LSCS should be booked through Antenatal Clinic according to the standard booking procedure for all EL.LSCS.

Intra-partum Breech presentation management.

Labour with a preterm breech should be managed as with a term breech.

4.3. 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. Please see Appendix A for 'Diagnosis of the breech presentation'.

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. Selection of appropriate pregnancies and skilled intrapartum care may allow planned vaginal breech birth to be nearly as safe as planned vaginal cephalic birth.

Care should be taken in assessing the presenting part with the breech presentation. Where a foot is visible or felt as the presenting part, the buttocks must be promptly located. If they are not immediately coinciding with the foot, therefore visible alongside the foot or felt in conjunction with the foot, vaginal delivery is contraindicated and the clinician should immediately recommend delivery by LSCS and proceed (with consent) without delay.

The decision to proceed with labour and vaginal breech delivery should be discussed between the on- call Consultant Obstetrician and the woman. The woman then makes an informed choice about her mode of delivery. A record of the discussion and decisions made should be written in the intrapartum notes.

ECV in labour.

ECV can be undertaken in early labour, provided the membranes are intact.

Contraindications to Vaginal Breech Delivery

Vaginal breech birth is contraindicated with:

- Hyperextended neck on ultrasound.
- High estimated fetal weight (more than 3.8 kg).
- Low estimated weight (less than tenth centile).
- Footling presentation.
- Twin pregnancy where the first twin is breech presentation.
- Evidence of antenatal fetal compromise.
- Where there are independent indications for caesarean section.
- Sacro-posterior position (fetal back to maternal back)
  Please see Appendix A for 'Diagnosis and Types of breech presentation'.

N.B. The role of pelvimetry is unclear. The presence of a skilled birth attendant is essential for safe vaginal breech birth.

Routine emergency LSCS for a breech first twin in spontaneous labour, however, is not recommended. The mode of delivery 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 delivery.

Routine LSCS for breech presentation of the second twin is not recommended in either term or preterm deliveries.

Women near or in active second stage of labour should not be routinely offered caesarean section.

First stage of labour

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. Where contraindications to vaginal delivery are found, the clinician should immediately recommend delivery by LSCS and proceed (with consent) without delay.

Care should be taken in assessing the breech presentation and position. Where a foot is visible or felt as the presenting part, the buttocks must be promptly located. If they are not immediately coinciding with the foot (therefore visible alongside the foot or felt in conjunction with the foot) vaginal delivery is contraindicated and the clinician should immediately recommend delivery by LSCS and proceed (with consent) without delay.

An ultrasound scan should be used to determine the position of the fetal back, neck and legs in addition to location of the placenta. Where time and circumstances permit, the fetal weight and liquor volume can be assessed to further aid clinical decision making about mode of delivery.

Please see Appendix A for 'Diagnosis of the breech presentation'.

Progress in labour to be carefully monitored. Adequate descent of the breech in the passive second stage is a prerequisite for encouragement of the active second stage. Slow progress in the breech is a cause for concern and should be considered as an indication to intervene surgically without delay.

Continuous electronic fetal monitoring is recommended as it may lead to improved neonatal outcomes.

Fetal Blood Sampling (FBS) is not indicated under any circumsatnces. If there is a concern about the fetal heart rate or progress, delivery should be completed without delay.

Labour with a preterm breech should be managed as with a term breech.

Second stage of labour

All obstetricians and midwives should be familiar with the techniques that can be used to assist vaginal breech birth. The choice of manoeuvres used, if required to assist with delivery of the breech, should depend on the individual experience/preference of the attending doctor or midwife.

Location of delivery will depend on the woman's choice and the clinical picture. If delivery is impending, the woman should be made safe in that environment with appropriate expertise. Where time permits, theatre is the optimum location so that operative delivery can be quickly achieved if necessary.

Where contraindications to vaginal delivery are found, the clinician should immediately recommend delivery by LSCS and proceed (with consent) without delay. Please see Appendix A for 'Diagnosis of the breech presentation'.

Care should be taken in assessing the breech presentation and position.. Where a foot is visible or felt as the presenting part, the buttocks must be promptly located. If they are not immediately coinciding with the foot, therefore visible alongside the foot or felt in conjunction with the foot, vaginal delivery is contraindicated and the clinician should immediately recommend delivery by LSCS and proceed (with consent) without delay.

It is essential that the assessing clinician fully determines the position as well as the presentation from the outset as this will also determine mode of delivery. The position of the baby's back is paramount in the decision to proceed for vaginal delivery. The back should ideally be sacro-anterior, lateral is satisfactory however a sacro-posterior position in the term complete or frank breech is a contraindication for vaginal delivery.

An ultrasound scan should be used to determine the position of the fetal back, neck and legs in addition to location of the placenta. Where time and circumstances permit, the fetal weight and liquor volume can be assessed to further aid clinical decision making about mode of delivery.

Please see Appendix A for 'Diagnosis of the breech presentation'.

An experienced obstetrician, anaesthetist, ODA and paediatrician should all be informed and present on the labour ward for delivery. Confirm that cervix is fully dilated before active pushing commences. The lithotomy position is advised (RCOG) as most clinicians are experienced with this position. Breech extraction should not be used routinely.

Progress in labour to be carefully monitored. The clinician needs to make sure that progress is being continually made and that the CTG assessment features are all within normal parameters. **Delivery should be achieved mainly by maternal effort – hands off the breech.** However, assistance, without traction, is required if there is delay or evidence of poor fetal condition.

Breech delivery

- As the buttocks are distending the perineum, consider if an episiotomy is necessary. Episiotomy should be performed when indicated to facilitate delivery or when forceps delivery for the after coming head is planned.
- The buttocks are born spontaneously.
- Do not pull on the fetus
- Let the breech advance under maternal effort alone.
- Delivery of legs
- Legs will deliver spontaneously and the feet will spring free, however if there is a delay in advance of the breech:
- The legs of a frank breech may be delivered by inserting a finger behind the knee to flex the knee and abduct the thigh.
- Umbilical cord
- If the umbilical cord is under a lot of tension - gently pull a loop of cord down - avoid handling if at all possible.
- Trunk and arms (Lovset manoeuvre)
- The fetal trunk may deliver quickly without assistance, the back should be kept sacro-anterior (the back should not be allowed to go posterior, lateral is satisfactory). Descent should be allowed to occur with maternal effort. The arms should deliver spontaneously if they are in a flexed position across the chest. If the shoulder blades are visible and the arms do not deliver spontaneously - the operator will need to do Lovset's manoeuvre or if room permits by sweeping the arms across the baby's face and down.

Lovset's manoeuvre

- Grasp the fetal hip bones using both hands with thumbs over the sacrum (do not handle the abdomen or chest).
- Gentle traction should be applied downwards combined with rotation of the fetal body.
- Fetal back must be uppermost where mother is in semi-recumbent position (FETAL BACK FACING THE MOTHER'S FRONT).
- Rotate fetal position through 90 degrees (this splints the fetal posterior arm across its face and changes it to an anterior position).
- If the arm does not at this point deliver spontaneously - draw the now anterior arm down in front of the chest - If possible splint the humerus with two fingers before hooking finger around antecubital fossa to deliver arm.
- Rotate the baby back 180 degrees in the opposite direction, keeping the back uppermost and deliver the second arm as previously described.
- Once the arms have been delivered.

Delivery of the head

- 'The head must be allowed to move through the pelvis in a transverse position until it rotates spontaneously to bring the occiput under the symphysis pubis with the back anterior' (Chadwick 2002,).
- If the head does not engage in the pelvis spontaneously, it is recommended the head is delivered by the modified Mauriceau Smellie Veit (MSV) method as this aids head flexion. Nape of the neck should be visible before MSV. If this is unsuccessful, suprapubic pressure by assistant can be considered.

Mauriceau Smellie Veit (MSV)

- With the operator's upper hand, the middle finger should be placed upon the fetal occiput, the fingers either side should be placed on the shoulders.
- The operator's lower hand and forearm should be placed beneath the fetus, with the index finger and middle finger placed upon the maxillae. (DO NOT place finger in the fetal mouth as this could damage the jaw).
- Flexion of the head is achieved by finger pressure upon the occiput and maxillae.
- Combined maternal expulsive effort and some downward traction by the operator on the shoulders will assist the delivery. Proceed until the sub-occipital region is seen and then the 'head is pivoted around the symphysis pubis' (Chadwick 2002). This manoeuvre can be used when there is extension of the fetal head and advance of the fetus is delayed.

Other delivery methods

- Obstetricians may deliver the head by Burns Marshall manoeuvre or assisted by forceps. Ensue nape of the neck is visible before Burns Marshall Manoeuvre is attempted.
- If forceps delivery undertaken – long straight handled forceps – e.g., Kiellands may be requested.
- Obstructed delivery of aftercoming head should be managed by LSCS or exceptionally symphisiotomy.

- Cervical head entrapment during a preterm breech delivery can be managed by cervical incisions at 2 O' clock and 10 O' clock positions. (Lateral incision will risk damage to the uterine vessels / ureters and anterior incisions risk damage to the bladder). Such incisions will require exploration and repair under GA.

After delivery

Transfer baby to resuscitaire to the care of attending paediatrician and assist in resuscitative measures if required.

Complete cord gases.

Management of breech birth in the community

A midwife may be faced with having to deliver a breech presentation - either planned or unplanned. The principles of managing the mechanism of the breech delivery are the same as in hospital - namely hands off the breech. If the delivery is planned, midwives still have a duty to attend the birth. Prior discussion and plans should have taken place, including notification of the appropriate manager and the Consultant involved in the woman's care.

In the unplanned situation and delivery soon to happen - stay with the woman and prepare to deliver at home.

- **Get help**
  Call an ambulance (Paramedics) and Labour Ward (use birth partners to do this if necessary). The co-ordinator should alert the appropriate staff and make necessary arrangements which may include transfer in if the presenting part is unfavourable for vaginal delivery (such as footling) or direct staff to the woman's home if delivery with appropriate position is immiment.

- **Keep calm**
  Follow the principles of management of the second stage and delivery of breech as described previously- hands off the breech and let the breech advance under maternal effort alone and controlled delivery of the aftercoming head. Have resuscitation equipment ready.

- **Suggested Positions**
  - ⇨ Semi-recumbent,
  - ⇨ adapted lithotomy position (use end of bed or settee and 2chairs),
  - ⇨ all fours position, can move to knee – chest position (Cronk, 2005)
  - ⇨ DO NOT use standing position (Steer 2002,Lewis 2002,Burvill 2005)

- **If there is delay in delivery of the head;**
  - ⇨ If the mother is in an all fours position - do an 'up-side down' Mauriceau Smellie Veit manoeuvre - flex the head - use middle finger to press the occiput forwards and the index and middle fingers of the opposite hand to apply gentle pressure on the cheek bones. Deliver the vault of the baby's head slowly.
  - ⇨ If in semi-recumbent modified Lithotomy position - try McRobert's position (as used for shoulder dystocia) and use Mauriceau-Smellie-Veit manoeuvre to control delivery of after coming head.

- **After delivery;**

- ⇨ Keep baby warm and provide newborn care as appropriate to the baby's needs in keeping with Trust guidance and the parent's wishes.
- ⇨ Make arrangements for transfer to unit for observation and or further treatment if necessary.
- ⇨ Complete all documentation in keeping with Trust guidance.

5. Monitoring Compliance with and the Effectiveness of the Guideline

Standards/ Key Performance Indicators

5.1. Key performance indicators comprise:

- Audit of ECV; compliance with guidance, successful ECV and EL.LSCS rates.
- Audit of Intrapartum Breech management, vaginal delivery and LSCS rates.

Process for Implementation and Monitoring Compliance and Effectiveness

5.2. The Breech Presentation, External Cephalic Version and Vaginal Breech Delivery Guideline implementation process will commence following ratification at the Maternity Guidelines meeting. New aspects of the guideline will be disseminated in practice and staff training.

Monitoring of implementation, effectiveness and compliance with these guidelines will be the responsibility of the Obstetric Labour Ward Lead. Where non-compliance is found, it must have been documented in the patient's medical notes.

6. References

- RCOG Green top guidelines on management of breech presentation and ECV published in March 2017
- Advanced Life Support in Obstetrics (UK) (2005) ALSO Provider Manual CD ROM Revised Fourth Edition. American Academy of Family Physicians
- Burvill S (2005) Managing Breech Presentation in the Absence of Obstetric Assistance. In Woodward V, Bates K, Young N (editors) (2005) Managing Childbirth Emergencies in Community Settings, Basingstoke, Hampshire, Palgrave Macmillan
- Chadwick J (2002) Malpresentations and malpositions. In: Boyle M (2002) Emergencies Around Childbirth: a handbook for midwives. Abingdon, Radcliffe Medical Press

- Cronk M (2005) 'Hands off that breech!' AIMS JOURNAL. 17, (1), pp2-4
- Donald WL and Barton JJ, (1990) Ultrasonography and external cephalic version at term**,** Am J Obstet Gynaecol, 162, pp1542-7
- Hannah ME, Hannah WJ, Hewson SA et al (2000) Planned Caesarean Section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. Lancet 356, pp1375-1383
- Hibbard BM, (1990) Principles of Obstetrics, London, Butterworth Heinmann, pp 557-575
- Hofmeyr G J, Kulier R. (1999) External cephalic version for breech presentation at term (Cochrane review). In: The Cochrane Library, (1999) Issue 3, Oxford, Update Software.
- Hofmeyer GJ and Sonnendecker EW (1983), Cardiotocographis changes after external cephalic version**,** Brit J Obstet Gynsecol 90**,** pp914-8
- Merscough P (1998) The practice of external cephalic version, Brit J Obstet Gynaecol, 105**,** pp1043-4
- Royal College of Obstetricians and Gynaecologists Clinical Guidelines: The Management of Breech Presentation**,** (September 2000)
- RCOG (2006)The Management of Breech Presentation Guideline No 20b
- RCOG (2006) External Cephalic Version and Reducing the Incidence of Breech Presentation Guideline No. 20a (Guideline reviewed 2010)
- Shuttler L (2009) Chapter 13 Breech Birth. In: Editors Vicky Chapman and Cathy Charles (2009) The midwife's labour and birth handbook. 2nd edition. Oxford, Blackwell Publishing Limited.
- Stevenson J (1993) More Thoughts on Breech. Midwifery Today, 26, pp24-25

Walkinsaw S (2009) Breech and Twin Delivery. In: Editors Warren R and Arulkumaran S (2009) Best Practice in Labour and Delivery. Cambridge, Cambridge University Press.

7. Associated Documentation

Caesarean Section Guideline

Appendix A

Diagnosis of the breech presentation

Diagnosis of the breech presentation will be completed using the technique appropriate to gestation and/or stage of labour.

Antepartum

Diagnosis of the breech during the antepartum period will be undertaken using abdominal palpation and ultrasound scan.

Ultrasound scan should conclude;

- Type of breech presentation
- Location of fetal back in relation to maternal back
- Estimated fetal weight
- Liquor volume
- Location of placenta
- Inspection of head / neck

Intrapartum

Diagnosis of the breech intrapartum will be determind by the stage of labour and signs of delivery. In general terms, diagnosis will be undertaken using one or all of the following; abdominal palpation, vaginal examination and ultrasound scan.

Vaginal examination should conclude;

- Cervical dilatation.
- Type of breech presentation; it is imperative the presenting part felt or visible are clearly described in the diagnosis and plan of management.

Ultrasound scan should conclude;

- Type of breech presentation
- Location of fetal back in relation to maternal back
- Location of placenta
- Inspection of head / neck

Where clinically appropriate, the clinician may also wish to consider;

- Estimated fetal weight
- Liquor volume

When completing the assessment and management plan, the senior Obstetrician should also check the most recent ultrasound scan for;

- Estimated fetal weight
- Liquor volume
- Location of placenta

Please see overleaf a visual descriptor of the types of breech presentation.

TYPES OF BREECH PRESENTATION

Complete breech

Legs folded with feet at the level of the baby's bottom.

Footling breech

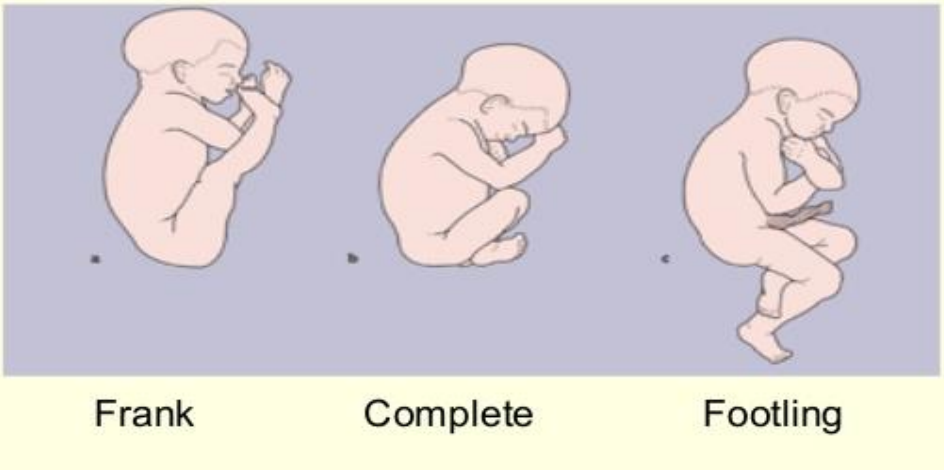
One or both feet point down so the legs would emerge first.

Frank breech

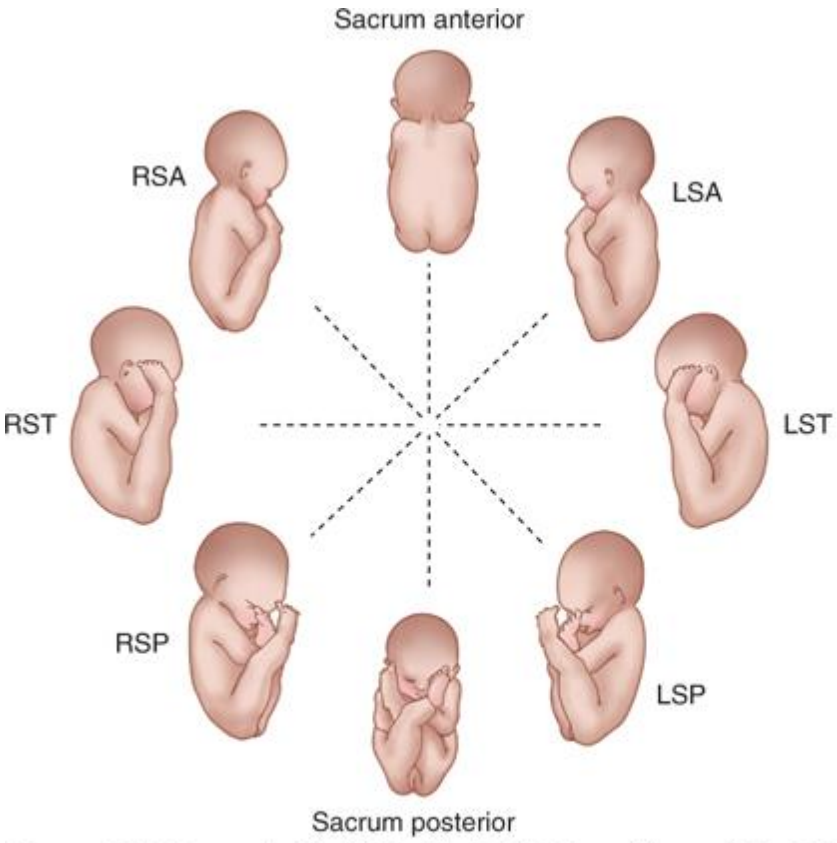
Legs point up with feet by the baby's head so the bottom emerges first.

Variations of presentation;

1. Per vaginal examination -
    a. the kneeling or part kneeling breech is rarely seen. LSCS is recommended without delay.
    b. both fore-coming feet can be felt and/or seen <u>without</u> immediate location of the buttocks. This should be treated as a footling breech presentation and LSCS is recommended without delay.
    c. both fore-coming feet can be felt and/or seen <u>WITH</u> immediate location of the buttocks. This is a complete breech and can be delivered vaginally in accordance with the woman's wishes, the skills of the clinician and the concordant appropriate clinical findings.



POSITIONS OF BREECH PRESENTATION



Source: G. D. Posner, Jessica DY, A. Black, G. D. Jones: Human Labor & Birth, 6th Edition
www.obgyn.mhmedical.com

Mode of delivery and positions of breech presentation;

- the complete or frank breech has 8 variations of position.
- it is essential that the assessing clinician fully determines the position as well as the presentation from the outset as this determines mode of delivery. The position of the baby's back is paramount in the decision to proceed for vaginal delivery.
- Contraindications to vaginal delivery in relation to presentation/position are;
    - sacro-posterior position of the term complete or frank breech presentation,
    - the kneeling or part kneeling breech,
    - footling breech.