

## 2 COMPLICATIONS OF PREGNANCY

### 2.10 ABNORMALITIES OF LIE / PRESENTATION

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2.10.1 Breech presentation  
Section B  
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#### 2.10.1 BREECH PRESENTATION

##### BACKGROUND MANAGEMENT

Breech presentation occurs in 3% to 4% of pregnancies at term. The randomised multicentre Term Breech Trial (TBT) showed that a planned elective caesarean section (ELUSCS) reduces the risk for adverse perinatal outcomes or serious maternal morbidity when compared to planned vaginal breech birth in the first 6 weeks postnatally.<sup>1</sup> A large Netherlands study found after the TBT there was a rapid increase in caesarean section rates resulting in substantial improvements in perinatal outcomes leading to halving of perinatal mortality and even greater reductions in the incidence of perinatal birth trauma.<sup>2,3</sup>

The TBT found that there was a lower risk of adverse perinatal outcome due to labour in the planned caesarean group (0.3% ) compared with the planned vaginal birth group (2.1%).<sup>4</sup> The decreased perinatal morbidity results from reduced risk factors related to avoidance of the labour process, and the vaginal birth itself<sup>4</sup>. However, a later follow-up study found that by performing an ELUSCS when compared to allowing a vaginal breech birth is not associated with reducing the risk of mortality or neurodevelopment delay in children at 2 years of age. This is because most children with serious morbidity survive and develop normally.<sup>5</sup> An additional study also found that maternal outcomes 2 years after birth are similar for both modes of delivery.<sup>6</sup>

External cephalic version (ECV) has been shown to decrease the incidence of breech presentation at term and consequently reduce ELUSCS rates. It is seen a safe procedure provided it is performed in a setting where a caesarean section can be performed if necessary. A meta-analysis looking at risk with performing an ECV indicates that fetal death risk is 1 per 5000 procedures; risk for serious complications was 6.1%, and risk for requiring a caesarean was 0.35%<sup>7</sup>, but another recent large cohort study found that performing an ECV had higher 0.5% risk rate for emergency caesarean.<sup>8</sup>

##### KEY POINTS

- ELUSCS compared to vaginal breech birth reduces the risk of adverse perinatal outcomes and maternal morbidity in the first 6 weeks postpartum.<sup>1</sup> However, studies of 2 year follow-up found an ELUSCS is not associated with a reduction in risk for death or neurodevelopment delay in a child, and maternal outcomes are similar for both groups.<sup>6</sup>
- All women with a singleton breech presentation with no contra-indications to the procedure should be offered ECV. Success rates for ECV are approximately 40% in nulliparous women and 60% in multiparae<sup>9</sup>.
- If an ECV is contraindicated, declined or unsuccessful, a discussion with the woman shall be undertaken regarding mode of birth, with the risks and benefits outlines of an elective caesarean section versus a planned vaginal breech birth.
- A woman attending a midwifery clinic for antenatal care and found to have a breech presentation at 35-36 shall be referred for obstetric medical review prior to 37 weeks gestation.

- The mode of birth for pre-term breech presentation is made based on individual clinical situations, and discussion between the team Consultant and the woman.

## ANTENATAL MANAGEMENT

- Refer all women attending midwifery clinics with a breech presentation from 35-36 weeks gestation to attend medical obstetric review at near as possible to 36 weeks gestation.
- If there are no contra-indications the woman should be offered an ECV between 36 to 37 weeks gestation. ECV at 34-36 may be performed with Consultant approval.
- Prior to booking an ECV the women should have the procedure explained with discussion about risks, side-effects and outcomes.
- Ultrasound examination should be performed to assess presentation (diagnose the type of breech and exclude hyperflexion of the head), placental location, amniotic fluid volume, and any major fetal anomaly.
- The procedure is booked and performed in the Maternal Fetal Assessment Unit (MFAU). This allows transfer to theatre should an emergency caesarean be necessary.
- Depending on the women's decision regarding mode of birth obtain written consent for an ELUSCS on the MR295 'Generic consent form', or for an ECV on the MR295.75 'Consent form for external cephalic version'.
- See Clinical Guidelines, Section B 2.10.2 External Cephalic Version for detailed information and contraindications to ECV.

## PLANNED VAGINAL BIRTH FOR THE TERM BREECH

The following criteria should be met in order to consider a vaginal breech birth:

- The woman should have counselling about risks and outcomes involved in a planned vaginal breech birth compared to an ELUSCS
- availability of a suitably experienced Obstetrician<sup>9</sup>
- the woman should have a clinically adequate pelvis<sup>9</sup>
- estimated fetal weight is between 2500g and 3700g
- the breech is a frank or complete breech<sup>9</sup>
- the fetus has a flexed head
- immediate availability of theatre facilities for a Caesarean section
- absence of fetal or maternal compromise
- normal progress in labour
- the use of continuous fetal heart monitoring in labour<sup>9</sup>
- the woman should not have had a previous caesarean section<sup>9</sup>
- Previous caesarean section is a relative contraindication and would not be recommended.

## PRE TERM BREECH – VAGINAL BIRTH

The mode of birth shall be discussed on an individual basis with the woman and the Obstetric team.<sup>9</sup>

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