BREECH PRESENTATION

BACKGROUND INFORMATION

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 a planned vaginal breech birth in the short term. Long term follow-up at 2 years has not found neonatal neurological outcomes or maternal outcomes differing between women who had a ELUSCS compared to vaginal breech birth. A large study conducted in the Netherlands following the TBT study found that the rapid increase in caesarean section rates resulted in substantial improvements in perinatal outcomes leading to halving of perinatal mortality rates, and ever greater reductions in the incidence of perinatal birth trauma. However, the view remains that if the application of strict criteria before and during labour is met, planned vaginal delivery of a singleton breech at term is a reasonable management option.

External cephalic version (ECV) from 36 weeks has been shown to decrease the incidence of breech presentation at term and consequently reduce the ELUSCS rates. It is seen as a safe procedure provided it is performed in a setting where caesarean section can be performed if necessary. A meta-analysis looking at risk for performing an ECV indicates that fetal death risk is 1 per 5000 procedures; risk for serious complications was 6.1%, and risk for requiring caesarean was 0.35%. However, a large cohort study found that performing an ECV may carry a higher risk for caesarean section of 0.5%.

A recent large multi-centre randomised study found that ECV initiated at 34-35 weeks gestation compared with 37 weeks or more increases the probability of cephalic presentation at birth, however it does not reduce rate of caesarean sections, and it may increase the risk rate for preterm birth.

KEY POINTS

1. ELUSCS for a singleton breech at term has been shown to reduce perinatal or neonatal mortality rates and serious neonatal morbidity rate in the first 6 weeks of life.
2. Long-term follow-up at 2 years showed neurological infant outcomes do not differ by planned mode of delivery even in the presence of serious short term neonatal morbidity.
3. ELUSCS is not associated with substantially better or worst outcomes for women 2 years after birth when compared to planned vaginal singleton breech birth at term.
4. All women with a singleton breech presentation with no contra-indications to the procedure should be offered an ECV. Success rates for ECV are approximately 40% in nulliparous women and 60% in multiparae women.
5. A woman attending a low-risk midwifery antenatal clinic, and who is found to have a breech presentation at 35-36 weeks gestation shall be referred for obstetric medical review prior to 37 weeks gestation.
6. Careful case selection and labour management in a modern obstetrical setting may achieve a level of safety similar to ELUSCS. Planned vaginal singleton breech birth is an option for women who have no maternal or fetal contra-indications to this mode of delivery.
7. The mode of birth for pre-term breech presentation is made based according to individual clinical situations, and the decision is made after discussion with the team Consultant and the woman.

**ANTENATAL MANAGEMENT**

Breech presentation may require different options for management:

- ECV
- Elective caesarean section
- Planned breech vaginal birth
- Undiagnosed antenatal breech presentation presenting in labour

- Refer women with a breech presentation between 35-36 weeks gestation for medical obstetric review as near as possible to 36 weeks gestation.
- If there are no contra-indications the woman should be offered an ECV between 36-37 weeks gestation. An ECV at 34-36 may be performed with Consultant approval. The woman should be advised of the risk for preterm birth associated with performing ECV at this gestation.
- Prior to booking an ECV explanation about the procedure shall be given including risks, side-effects, and outcomes.
- Ultrasound examination should be performed to assess presentation (type of breech, exclude hyperflexion of the head), placental location, amniotic fluid volume and to exclude any fetal and uterine anomalies.
- The procedure is performed in the Maternal Fetal Assessment Unit (MFAU).
- Depending on the maternal decision regarding mode of delivery obtain written consent:
  - ELUSCS on the MR295 ‘Generic consent form”
  - ECV on the MR295.75 ‘Consent form for external cephalic version’
- See Clinical Guideline External Cephalic Version for detailed information about the procedure and contraindications.

**EXTERNAL CEPHALIC VERSION**

ECV for uncomplicated term breech presentation should be offered to nulliparous women from 36 weeks gestation, and for multiparous women from 37 weeks gestation if there are no contra-indications to the procedure.

See:

- Clinical Guideline External cephalic version

**ELECTIVE CAESAREAN SECTION**

ELUSCS should be booked for women who elect this mode of birth.

**UNDIAGNOSED BREECH PRESENTING IN LABOUR**

The decision regarding mode of delivery will depend on gestation, stage of labour or imminent birth, and parental wishes after consultation with the obstetric team. Following counselling and ensuring the criteria are met for a safe vaginal breech birth, a woman may choose this option of birth.

**DIAGNOSED BREECH BOOKED FOR E.L.U.S.C.S PRESENTING IN LABOUR**

The management plan may be adjusted depending on the gestation, clinical situation and consultation with the woman and her obstetric team. Proceed to ELUSCS if breech presentation is verified, and the woman confirms her request for this mode of delivery.
CRITERIA RECOMMENDED FOR A PLANNED VAGINAL BREECH TERM BIRTH

- The woman has completed a consent form after counselling regarding risks and outcomes of a breech birth compared to an ELUSCS.
- Availability of an experienced obstetrician/doctor trained in breech delivery.¹
- The woman should have a clinically adequate pelvis.¹,³
- Exclusion of a growth restricted fetus¹,³ or macrosomia³-⁶
- Exclusion of a footling or kneeling breech¹. The breech should be in the frank or complete breech position.
- The fetus has a flexed head¹
- Estimated fetal weight is between 2500g and 3800g¹,¹⁰
- Immediate theatre facilities should be available for caesarean section if required.
- No previous caesarean section.
- No fetal anomaly incompatible with vaginal birth³
- Absence of fetal or maternal compromise
- Continuous fetal heart rate monitoring during labour.¹

Note: for criteria and management of a vaginal breech birth see Clinical Guideline, Section B 2.10.3 Breech – Labour and Birth Management

Pre-term Breech – Vaginal Birth
The mode of birth is decided by the woman and the Obstetric team following discussion based on individual circumstances.¹

REFERENCES