



CLINICAL PRACTICE GUIDELINE

Breech Presentation

This document should be read in conjunction with the [Disclaimer](#)

Background

Breech presentation occurs in 3% to 4% of pregnancies at term.¹ 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.^{1,2} Long term follow-up at 2 years has not found neonatal neurological outcomes or maternal outcomes differing between women who had an ELUSCS compared to vaginal breech birth.^{3,4} 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.^{6,7} 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.^{1,5,8}

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.^{6,9} 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%.¹¹ However, a large cohort study found that performing an ECV may carry a higher risk for caesarean section of 0.5%.^{1,12}

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.¹³

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.^{2,6}
2. Long-term follow-up at 2 years showed neurological infant outcomes do not differ by planned mode of birth even in the presence of serious short term neonatal morbidity.⁶

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.^{3,4}
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 multipara women.⁵
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. If breech diagnosis is made after 37 weeks, obstetric review / counselling is required, and an ultrasound should be performed to assess for fetal or maternal causes of the malpresentation, and fetal growth / wellbeing.¹
7. Careful case selection and labour management in a modern obstetric setting may achieve a level of safety similar to ELUSCS.⁶ Planned vaginal singleton breech birth is an option for women who have **no maternal or fetal contra-indications** to this mode of delivery. Women who meet [the criteria for a planned vaginal breech birth](#) who develop complications which are contraindications to a planned term breech birth, must be referred to the team consultant for review and counselling on the day. If after hours or the consultant is not available the woman must be referred to MFAU/Labour and Birth Suite, for review by the Senior Registrar.
8. The Consultant / Senior Registrar must have an informed discussion with the woman (and her support person if available) including options, recommendations and the possible outcomes.
9. This conversation and the final decision should be clearly documented in the notes by the medical officer with the appropriate level of seniority undertaking the counselling.
10. The mode of birth for preterm 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
 - Antenatally undiagnosed breech presentation presenting in labour
1. Refer women with a breech presentation between 35-36 weeks gestation for medical obstetric review as near as possible to 36 weeks gestation.
 2. If there are no contra-indications the woman should be offered an ECV¹ between 36-37 weeks gestation. An ECV at 34-36 may be performed with Consultant approval and the woman should be advised of the risk for preterm birth associated with performing ECV at this gestation. ECV may be

attempted after 37 weeks if the diagnosis is delayed, albeit with a lower success rate.

3. Prior to booking an ECV, explanation about the procedure shall be given including risks, side-effects, and outcomes. Note: An ECV is inappropriate if a caesarean is indicated for other reasons.¹
4. 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.¹
5. The procedure is performed in the Maternal Fetal Assessment Unit (MFAU).
6. Depending on the maternal decision regarding mode of delivery, obtain written consent¹⁴:
 - For a Non-Elective Caesarean on the MR295: 'Generic consent form' bearing in mind that it is not possible to confirm the nature of the uterine incision prior to commencement of surgery, especially in the setting of fetal malpresentation.
 - ECV on the MR 295.75: 'Consent form for External Cephalic Version'
7. See KEMH Clinical Guideline, O&M, Complications of Pregnancy: Abnormalities of Lie/ Presentation: 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:

- KEMH Clinical Guideline, O&M, Complications of Pregnancy: Abnormalities of Lie/ Presentation: [External Cephalic Version](#) for detailed information about the procedure and contraindications
- KEMH Clinical Guideline, O&M, Complications of Pregnancy: Abnormalities of Lie/ Presentation: External Cephalic Version: [ECV- MFAU – Quick Reference Guide](#).

Elective Caesarean Section

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

A woman whose only indication for CS is breech presentation, should not be transferred to the theatre suite until the presentation has been confirmed with bedside ultrasound by a WNHS credentialed practitioner.

Undiagnosed Breech Presenting in Labour

The decision regarding mode of delivery will depend on gestation, stage of labour or imminent birth, maternal and fetal risks, and parental wishes after consultation with the obstetric team.¹ An intrapartum ultrasound should be performed if possible.¹

Following counselling and ensuring [the criteria](#) are met for a vaginal breech birth, a woman may choose this option of birth.¹ However, it should be stated here that a woman may choose her method of birth, regardless of risks.

If the diagnosis of breech presentation is made in advanced labour, the lack of opportunity to assess for contraindications for vaginal breech delivery may increase the risk of adverse perinatal outcomes. However, this risk should be balanced against the risk of difficult caesarean section at advanced cervical dilatation when decisions regarding the appropriate mode of birth are made.

Diagnosed Breech Booked for Caesarean section 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 Caesarean section if breech presentation is verified, **only if** 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 elective caesarean section.¹
- Availability of a consultant obstetrician trained in breech delivery for the entire labour process, including arrangements for shift changes & fatigue.⁵
- The woman should have a clinically adequate pelvis.^{1, 4-6}
- Exclusion of a growth restricted fetus^{5, 6} or macrosomia^{3, 4, 6} Estimated fetal weight is between 2500g and 3800g^{5, 10}
- Exclusion of a footling or kneeling breech.⁵ The breech should be in the frank or complete breech position.¹
- The fetus has a flexed head^{1, 5}
- Immediate theatre facilities should be available for caesarean section if required, including skilled anaesthetic staff & neonatal resuscitation facilities.¹
- No previous caesarean section.
- No fetal anomaly incompatible with vaginal birth^{5, 6}
- Absence of fetal or maternal compromise
- Continuous fetal heart rate monitoring during labour.⁵
- Spontaneous onset of labour.

Note: For criteria and management of a vaginal breech birth see KEMH Clinical Guidelines, O&M, Complications of Pregnancy, Abnormalities of Lie/ Presentation: [Breech – Vaginal Birth Management](#) and [Breech Vaginal Birth QRG](#)

Pre-term Breech – Vaginal Birth

The mode of birth is decided by the woman and the Obstetric team following discussion based on individual circumstances.⁵



References and resources

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Related policies

WA Health [Consent to Treatment Policy 2016](#)

Related WNHS policies, procedures and guidelines

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