**CLINICAL PRACTICE GUIDELINE**

# Breech Presentation (Uncomplicated Term) – Planned Vaginal Birth

**This document should be read in conjunction with the Disclaimer**

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## Background Information

Vaginal breech birth can be associated with a higher risk of perinatal mortality and short-term neonatal morbidity compared to birth by elective caesarean section[1], however study of long term follow-up at 2 years found that the neonatal neurological outcomes did not differ between either mode of birth even in the presence of serious short-term morbidity.[2]

Complications of vaginal breech birth include Erb's palsy, fractures to the clavicle, humerus or femur, and dislocation of the hips or shoulders. Trauma to the abdominal structures may occur if the fetal abdomen is grasped incorrectly, some bruising may be noted especially to male genitalia,[3] and other complications such as cerebral haemorrhage or fractures, or spinal cord injury are additional risks.[1]

## Key Points

1. Planned term vaginal breech birth is a reasonable option provided there are no fetal or maternal contra-indications and the strict criteria is followed. The presence of an Obstetrician competent in breech delivery and facilities for immediate caesarean section are required[4].

2. Women planning a breech birth who develop complications which are contraindications to a planned breech birth must be referred for review by the team consultant. If the consultant is unavailable or after hours, the woman must be reviewed in MFAU / Labour and Birth Suite by the Senior Registrar. The Consultant / Senior Registrar must have discussions with the woman and the junior medical staff.

3. 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.

4. 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.

5. The Consultant Obstetrician is informed at the onset of labour, when the woman's cervix is fully dilated, and if there are concerns with maternal-fetal wellbeing or labour progress
6. The paediatric team is informed at the onset of labour, and should be present for the birth as per KEMH Clinical Guideline Paediatric Team Attendance for 'At Risk' Births- LBS QRG
7. Clinical pelvic examination should be performed to assess pelvic adequacy when assessing suitability for vaginal breech birth.
8. Induction of labour is not recommended and is considered non-standard management[2].
9. Augmentation of labour is not recommended but may be appropriate in the presence of uterine dystocia provided the consultant obstetrician is confident there is no fetopelvic disproportion[1, 2].
10. Continuous cardiotocograph monitoring during labour should be performed[4].
11. A vaginal examination should be performed if rupture of membranes occurs[2], or to confirm full dilatation prior to a woman pushing, ensuring she does not have a premature urge to push.
12. Cervical dilatation during *active* labour should occur at a rate of at least 1cm per hour.
13. The woman should not be encouraged to actively push until the breech has reached the pelvic floor and she has a strong urge, or the buttocks are on view.
14. If birth is not imminent after 1 hour of active pushing for a nullipara woman, or ½ hour for a multipara woman, a caesarean section should be initiated.
15. Breech extraction is not recommended during the breech birth of a singleton fetus.
16. Third stage oxytocic should not be administered until the fetal head is delivered.

**Definition of an uncomplicated breech presentation**

- Flexed or extended fetal legs.
- 37-42 weeks (women should be advised of risks associated with prolonged pregnancy).
- No evidence of cephalopelvic disproportion (CPD).
- Clinical estimation of the fetus >2.5kg or < 3.8kg.
- Well flexed head.
- No anticipated pelvic obstruction to birth.

**On Admission – management for women in labour**

1. Confirm the fetal presentation as flexed or extended breech of uncomplicated term breech and exclude contra-indications for vaginal breech birth by ultrasound.
2. Inform the Consultant Obstetrician.
3. Notify the paediatric team.
4. Commence cardiotocography (CTG) for continuous fetal heart rate monitoring.

5. Perform a digital vaginal examination to assess progress, and exclude cord presentation / prolapse.
6. Collect blood for a group and hold.

**See the following two pages for planned vaginal breech management in the first stage and second stage of labour.**

**Flow Chart – Planned Term Singleton Vaginal Breech Birth**

See KEMH Clinical Guideline Breech Vaginal Birth – Quick Reference Guide

**First Stage Management**

Care is the same as in cephalic presentation, with some additional care for the management of an uncomplicated term breech presentation.

| Action | MANAGEMENT IN FIRST STAGE | ADDITIONAL INFORMATION |
|---|---|---|
| Monitoring labour progress | Cervical dilation should be **1cm per hour from 4cm** for all women regardless of parity.<br>In the absence of adequate progress in labour, caesarean section is recommended. | The Consultant Obstetrician should be advised of any delay in progress. |
| Augmentation | Not normally considered, however may be only used in individualised special circumstances for uterine dystocia[5] if there is no clinical suspicion of CPD. The decision for use is only made with consultant obstetrician approval. | Poor progress may be a risk factor for difficulty with delivery of the after coming head[6].<br>Intact membranes prevent risk for cord prolapse and artificial rupture of membranes is not recommended[3]. |
| Fetal Surveillance | Continuous CTG[4] | |
| Vaginal Examination | • With spontaneous rupture of membranes<br>• To confirm full dilatation if a woman has an urge to push.<br>• Monitor routine progress of labour and more frequently as the situation requires. | Excludes cord prolapse[7].<br>This confirms full dilatation of the cervix in the event of an urge to push. |
| Analgesia | Allow the women to choose.<br>An epidural may be an option if the woman has a premature urge to push[8]. | |
| Bladder | Monitor 1-2 hourly | A full bladder may |

| Action | MANAGEMENT IN FIRST STAGE | ADDITIONAL INFORMATION |
|---|---|---|
| Management | | impede descent of the breech. |
| Hydration | Fasting in not routinely required. Confirm medical recommendation. | Confirm with obstetric team hydration management. |
| Maternal Positioning | An upright position can be encouraged[8]. | An upright position may aid the descent of the breech[7]. |
| Additional Equipment | • Availability of the real time ultrasound machine | |
| Medical notifications | Notify the Consultant Obstetrician:<br>• At full dilatation<br>• If poor progress of labour<br>• If concerns of maternal-fetal wellbeing | |

**Second Stage Management**

| Action | MANAGEMENT IN SECOND STAGE | ADDITIONAL INFORMATION |
|---|---|---|
| Confirm second stage | Perform a vaginal examination to confirm full dilatation prior to pushing. | Confirms that the woman is able to push if she has the urge. |
| Pushing | Encourage active pushing when the woman has a strong urge, or the buttocks are on view. | |
| Monitoring progress | Birth should be imminent after one hour of active pushing in a nullipara, and after ½ hour for a multipara.<br>In the absence of adequate progress in second stage, caesarean section is recommended[6]. | The consultant obstetrician should be immediately notified of any delay in progress. |
| Fetal Surveillance | Continuous CTG[4] | |
| Bladder Management | Consider urinary catheterisation prior to birth if the bladder is not emptied. | |

| Action | MANAGEMENT IN SECOND STAGE | ADDITIONAL INFORMATION |
|---|---|---|
| Position for birth | Dorsal or lithotomy | Following maternal consent the practitioner should utilise the maternal position with which they are familiar[6]. |
| Equipment | • Breech towel (warmed)<br>• Lithotomy stirrups if necessary<br>• Neville-Barnes' and Wrigley's Forceps immediately available | |
| Analgesia | As indicated. | |
| Episiotomy | Not routine – should be performed when indicated to facilitate birth[6]. | |
| Birth principles | • **No** breech extraction<br>• Traction/ fetal breech manoeuvres on breech are to be avoided unless necessary to expedite delivery of a partially expelled fetus in a timely fashion.<br>• Gentle suprapubic pressure may aid flexion of the head[6].<br>• Do not handle / manipulate the cord.<br>• Extended arms may be delivered by the Løvset manoeuvre.[2, 8] Nuchal arms may be reduced with reverse Løvsets.<br>• Aftercoming head may be delivered spontaneously, with forceps, or by the Mariceau-Smellie-Veit manoeuvre.<br>• A small towel wrapped around the fetal hips is useful. | Can cause extension of the head and nuchal displacement of the arms.[7]<br>May cause spasm of the cord[8].<br>Rapid birth of the head can cause sudden compression and risk for tentorium cerebelli tear.[3]<br>Preserves warmth and provides a grip on the skin. |
| Paediatrician | Contact the paediatric team to be present for the birth. | |
| Oxytocin for 3rd stage | **Withhold** until the head is born. | |

## References and resources


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## Related WNHS policies, procedures and guidelines

Breech Presentation

Breech Presentation- Planned Vaginal Birth (Quick Reference Guide)

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| Standards Applicable: | NSQHS Standards: 1 Governance, 9 Clinical Deterioration, |

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