University Hospitals Sussex
NHS Foundation Trust

Management of Breech Presentation and ECV

Maternity Protocol: MP046

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Contents

1 Introduction

Breech presentation is defined as a fetus in longitudinal lie with the buttocks, legs or feet in the lower uterine segment closest to the cervix.

The incidence of breech presentation decreases with advancing gestational age from approximately 20% at 28 weeks of gestation to 16% at 32 weeks of gestation.
The incidence of breech at term is 3–4%.

Perinatal mortality and morbidity are increased with breech presentation compared with cephalic presentation irrespective of route of delivery.

1.1 Types of breech presentation

- Frank or extended breech – breech with extended legs and flexed hips.
- Complete or flexed breech – hips and knees remain in a flexed attitude but feet are not below the fetal buttocks.
- Footling breech – legs and thighs are both extended so one or both feet become the presenting part.
- Kneeling Breech – one or both knees are presenting.

2 Antenatal management of suspected breech presentation

2.1 Pregnant women / people who have suspected breech presentation prior to 36 weeks gestation should be informed that the majority of babies will turn to cephalic by 37 weeks and only 3-4% will remain breech.

2.2 Pregnant women / people with suspected breech presentation >36 weeks gestation should be referred to the Day Assessment Unit (DAU).
An appointment in DAU can be made at the next available time (ideally within a week) when convenient for the woman for a presentation scan by the DAU or on-call obstetrician or a midwife with scanning skills.

3 Antenatal management of confirmed breech presentation

3.1 All pregnant women / people with confirmed breech presentation at term should be directed to the RCOG leaflet: 'A Breech Baby at the end of Pregnancy''.

3.2 Breech baby at the end of pregnancy patient information leaflet (rcog.org.uk)

3.3 Those with confirmed breech presentation should be seen by an obstetric consultant or registrar to discuss their options: ECV, vaginal breech birth or elective Caesarean section after 39 weeks of gestation.

3.4 External cephalic version (ECV) should be offered unless there is an absolute contraindication to vaginal birth (see section 4.4).

3.5 ECV should be booked on the LSCS calendar online for gestation of 36 weeks pregnant (for nulliparous) or 37 weeks (for multiparous).

3.6 Pregnant women / people who would like more information should be offered an antenatal clinic appointment with a consultant obstetrician and / or consultant midwife at the next available appointment.

4 External cephalic version (ECV)

External cephalic version is the manipulation of the fetus, through the maternal abdomen, to a cephalic presentation. The rationale behind ECV is to reduce the incidence of breech presentation at term and therefore the associated risks, particularly of avoidable caesarean section.

4.1 Consultation and Consent for ECV

Pregnant women / people should be informed that:

4.1.1 The overall success rate of ECV is approximately 50% (40% for nulliparous, 60% for parous).

4.1.2 After an unsuccessful ECV attempt at 36+0 weeks of gestation or later, only a few babies presenting by the breech will spontaneously turn to cephalic presentation (3-7%)

4.1.3 Few babies revert to breech after successful ECV (3%).

4.1.4 A successful ECV reduces the chance of caesarean section

4.1.5 Labour after ECV is associated with a slightly increased rate of caesarean section and instrumental delivery when compared with spontaneous cephalic presentation.

4.2 Pregnant women / people should be counselled that with appropriate precautions, ECV has a very low complication rate.

4.2.1 Although most women tolerate ECV, they should be informed that ECV can be a painful procedure (75% experience mild, 33% moderate, 5% very high pain)

4.2.2 Risks of ECV, which must be discussed and documented include:

- Cord Prolapse: 0.18% (1.8 in 1000)
- Placental abruption 0.09% (<1 in 1000)
- Additional procedure – Emergency caesarean section 0.5% (5:1000)
- Fetal bradycardia / non-reassuring CTG: Unknown significance

4.2.3 Written consent should be completed using the sticker (Appendix 1)

4.2.4 Pregnant women / people who decline ECV should be given information about their birth options (see section 5)

4.3 Complementary therapies

4.3.1 Pregnant women / people may wish to consider the use of moxibustion for breech presentation at 33–35 weeks of gestation, under the guidance of a trained practitioner.

4.3.2 Pregnant women / people should be advised that there is no evidence that postural management alone promotes spontaneous version to cephalic presentation.

4.4 Exclusion criteria for ECV:

4.4.1 Pregnant women / people should be informed that ECV after one caesarean delivery appears to have no greater risk than with an unscarred uterus. The decision to perform ECV in this situation may vary across clinician and cases, therefore please inform the oncall consultant obstetrician for that day.

4.4.2 Women with BMI >35 have a lower chance of successful ECV although this is not necessarily a contraindication.

4.4.3 **Absolute** contraindications for ECV that are likely to be associated with increased mortality or morbidity:

- Where caesarean birth is required, e.g. placenta praevia
- Antepartum haemorrhage within the last 7 days, placental abruption
- Severe pre-eclampsia
- Abnormal cardiotocography
- Abnormal fetal dopplers
- Major uterine anomaly
- Ruptured fetal membranes
- Multiple pregnancy (except for twin 2 – after delivery of twin 1)

4.4.4 Relative contraindications where ECV might be more complicated:

- Small-for-gestational-age fetus with normal doppler parameters (< 10th Centile)
- Mild to moderate pre-eclampsia or pregnancy-induced hypertension
- Oligohydramnios
- Scarred uterus (e.g. two or more previous LSCS, subserosal or intramural myomectomy, septum resection)
- Rhesus isoimmunisation

4.4.5 Unstable Lie

With an unstable lie, ECV is reasonable in the course of a stabilising induction. There are limited data on this procedure, but potential risks include cord prolapse, transverse lie in labour and fetal heart rate abnormalities. ECV should only be performed if there is a valid indication for induction.

4.5 Undertaking an ECV

4.5.1 All ECV are to be undertaken on Labour ward.

4.5.2 All ECVs should be undertaken by obstetricians trained and competent to do so.

4.5.3 The standard preoperative preparations for caesarean section (starving or pre-meds) are not recommended for those undergoing ECV, as their risk of emergency caesarean is less than that of a low-risk labouring woman / person.

4.5.4 Routine use of regional analgesia or neuraxial blockade is not recommended, but may be considered for a repeat attempt or for women unable to tolerate ECV without analgesia.

ECV Procedure

- Admit to labour ward at allotted time.
- Observations of temperature, pulse and blood pressure
- Ensure theatre available
- Scan to confirm breech presentation
- Perform 20 minute CTG prior to ECV to confirm fetal wellbeing
- Trust consent form (using ECV sticker, **Appendix A**) signed prior to procedure
- Bladder should be emptied
- Administer tocolysis 15-20 minutes before ECV- Terbutaline s/c 250 micrograms (mcg)
- Monitor fetal heart intermittently thoughout ECV
- Scan to confirm success
- Abandon ECV if too painful
- Perform 30 minute CTG following procedure (whether successful or not)
- Perform Kleihauer test and administer Anti D 1500 units if woman rhesus negative and the fetus is D positive on cfDNA testing
- Document procedure and outcome within antenatal record using the ECV proforma (**Appendix B**) and scan to Badgernet (until the form is embedded)

4.5.5 Following a successful ECV the obstetrician should refer the pregnant women / person back to midwifery led care.

4.5.6 Following an unsuccessful ECV, the obstetrician should offer the pregnant women / person the choice of a second ECV with a different clinician.

4.5.7 If a second ECV is declined then information about options should be given. Planned LSCS should be advised and planned vaginal breech birth offered.

5 Information for those with persistent breech, or declining ECV

5.1 Clinicians should counsel pregnant women / people in an unbiased way that ensures a proper understanding of the absolute and relative risks of their options.

5.2 Risks to baby

Pregnant women / people should be informed that

5.2.1 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.

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.

5.2.2 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
2.0/1000 with planned vaginal breech birth.
1.0/1000 with planned cephalic birth.

5.2.3 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.

5.3 Risk to mother / parent

Pregnant women / people should be informed that

5.3.1 Maternal / parental complications are least with successful vaginal birth

5.3.2 Planned caesarean section for breech presentation at term carries a small increase in immediate complications for the mother / parent compared with planned vaginal birth.

5.3.3 The risk for maternal / parental complication is highest with emergency caesarean section (which is needed in approximately 40% of those planning a vaginal breech birth.)

5.3.4 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.

5.3.5 Pregnant women / people 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.

5.4 There should be an individualised assessment of the long-term risks of caesarean section based on individual risk profile and reproductive intentions, and counselled accordingly.

5.5 All pregnant women / people should be supported to make a fully informed choice as to their care & birth options

5.6 All information given, discussions and choices offered must be clearly documented, by the person giving it, in the maternal notes / Badgernet

6 Those choosing an elective LSCS for breech presentation

6.1 Pregnant women / people who make an informed choice to have their baby delivered by elective LSCS should be booked as near to 39-weeks gestation as possible.

6.2 The pregnant woman / person should be informed that if the baby turns to cephalic presentation at any point prior to surgery, the LSCS should not proceed. On admission for caesarean, breech presentation should be confirmed on USS. If the baby has turned cephalic the LSCS should not proceed and the pregnant woman / person should return to midwifery led care and aim for a vaginal birth. If the pregnant woman / person requests to continue with caesarean this must be discussed with consultant on the labour ward.

6.3 The pregnant woman / person should be informed that if they go into labour before their booked LSCS date they should contact labour ward immediately. Unless birth is imminent they should be offered a LSCS, but should also be made aware there may not be opportunity to perform a LSCS and a vaginal birth may occur.

6.4 See Maternity Protocol MP050 Caesarean Section (LSCS) for details of LSCS procedure.

7 Pregnant women / people choosing a vaginal breech birth

7.1 Antenatal Assessment

7.1.1 Pregnant women / people opting for vaginal breech delivery should be referred to the consultant midwife clinic and / or the consultant obstetric clinic.

7.1.2 There should be a thorough assessment for risk factors for a poorer outcome in planned vaginal breech birth. Higher risk planned vaginal breech birth is expected where there are independent indications for caesarean section and in the following circumstances:

- Hyperextended neck on ultrasound.
- High estimated fetal weight (more than 3.8 kg).
- Low estimated weight (less than tenth centile).
- Footling presentation.
- Evidence of antenatal fetal compromise.

7.1.3 If any risk factor is identified, pregnant women / people should be counselled that planned vaginal birth is likely to be associated with increased perinatal risk and that delivery by caesarean section is recommended

7.1.4 All information given, any discussion or decisions made and referrals offered should be documented clearly in the notes by the clinician providing care. (Appendix C – Counselling proforma)

7.2 Birth Plan

7.2.1 A detailed birth plan should be made with the pregnant women / person following discussion with a consultant midwife and consultant obstetrician.

7.2.2 The birth plan should shared with pregnant woman / person, the consultant obstetrician, the matron and labour ward leads.

7.2.3 There should be clear documentation in the Badgernet notes.

7.2.4 Pregnant women / people should be informed that induction of labour is not recommended (see Section 7.5)

7.3 Place of Birth

7.3.1 Pregnant women / people should be recommended to have their labour and birth in an obstetric unit with access to theatres for immediate caesarean section and neonatal support.

7.3.2 Birth in an operating theatre is not routinely recommended.

7.3.3 Following discussion about risks and benefits according to the best available evidence, those who make an informed decision about having their baby at home should be referred to the consultant midwife, where a clear birth plan can be agreed, documented and shared to the team and the pregnant woman / person.

7.3.3.1 The midwife providing care at home must update the labour ward coordinator by phone on a regular (2hrly) basis.

7.3.3.2 If delay during labour is suspected the midwife should advise transfer into the maternity unit immediately by '999' Cat 1 Response

7.3.3.3 Discussion with the Manager on call/Matron at the discretion of the LWC if concerns regarding skill mix, staffing levels as per escalation policy.

7.4 Pre-labour advice (for those opting for planned vaginal breech birth)

Women should be advised to phone the maternity unit labour ward:

7.4.1 Immediately if they have spontaneous rupture of membranes (SROM)
If women phone the maternity unit reporting SROM, they should be asked the usual questions relating to fetal movements and colour of liquor. They should be invited in for a review at the earliest opportunity (due to the increased risk of cord prolapse).

7.4.2 If they are concerned about fetal movements

7.4.3 They want advice or guidance

7.4.4 Midwives should invite women into labour ward or triage earlier than they would for women with cephalic babies (rationale: Breech labours are often rapid and there are additional risk factors such as cord prolapse that need to be considered).

7.4.5 If birth is planned at home then a midwife should attend to assess and provide support earlier in the labour.

7.5 Induction of labour

7.5.1 Induction of labour is not recommended if a woman's baby is in the breech position

7.5.2 Only consider induction of labour for babies in the breech position if:

- Birth needs to be expedited, **and**
- External cephalic version is unsuccessful, declined or contraindicated, **and**
- The woman chooses not to have a planned caesarean birth.

7.5.3 Discussion of the benefits and risks associated with induction of labour must be reviewed by an obstetric consultant and the consultant midwife. The MDT discussion and plan should be documented on Badgernet.

8 Planned Vaginal Breech Birth - Intrapartum Care

8.1 General Considerations

Where there is undiagnosed breech in labour please refer to section 9

It is recognised that experience and skill of the health professional can have an impact on the perinatal outcome and it is strongly recommended that there is a multidisciplinary team approach to labour and birth care.

If the team on the labour ward do not feel able to support the birth plan, the woman / person should be informed as such and offered a caesarean section / re-discussion of options.

8.2 Once labour is established it is recommended that:

8.2.1 The labour ward Co-ordinator and obstetric registrar must be informed to reviews the notes, birth plan and situation.

8.2.2 The Consultant Obstetrician must be informed and should attend when requested to support the team

8.2.3 The Neonatology team must be informed

8.2.4 Plans of care for labour and birth are made with the mother, midwife providing care and on call obstetric registrar with reference to the antenatal birth plan documented on Badgernet.

8.2.5 Women should be encouraged to agree to a multidisciplinary approach especially if complications arise, and this should be documented in the birth plan.

8.2.6 Care should be provided by a midwife who is competent and confident with breech labour and birth care with support from the labour ward coordinator ad obstetric team

8.2.7 The midwife providing labour care frequently (at least 2 hourly) updates the on call obstetric registrar and labour ward co-ordinator on the clinical situation, progress and maternal and fetal wellbeing.

8.2.8 Any deviations from the expected norm are noted by the midwife and the on call Obstetric Registrar and labour ward co-ordinator informed immediately.

8.2.9 Should a deviation from norm occur the on call obstetric registrar must review the clinical situation and lead clinical care with support and discussion with the midwifery staff. The on call Consultant Obstetrician should be informed and, if required, attend to provide support and guidance

8.2.10 Birthing women / people should be asked to allow less experienced midwives or doctors to observe the birth of their baby to help maintain skills in vaginal breech delivery

8.2.11 If labour and birth is planned at home then the midwife providing care should call the labour ward coordinator every 2 hours to update on progress and wellbeing, or immediately should a deviation from normal occur. Birthing women / people should be strongly advised to be transferred to the maternity unit if a deviation from norm is identified.

8.3 Fetal Monitoring

8.3.1 All birthing women / people should be offered and advised to have continuous CTG in established labour. (Should be informed that while evidence is lacking, continuous fetal monitoring may lead to improved neonatal outcomes and is recommended)

8.3.2 If women make an informed choice to have intermittent auscultation this should be undertaken as per protocol & NICE guidelines.

8.3.3 If IA is being undertaken and there are concerns about progress in labour, CTG should again be recommended.

8.3.4 If there are concerns about the fetal heart during decent of the breech in the second stage then LSCS or assistance should be considered.

8.4 Meconium

8.4.1 Passage of fresh meconium is more common during a labour with a breech presentation especially in the late first and second stages and does not require any intervention if the CTG is normal.

8.4.2 If there is no CTG as the women has made an informed choice to have intermittent auscultation, then a CTG should again be recommended at this point

8.4.3 Meconium stained liquor prior to labour is still suggestive of fetal distress

8.5 Maternal observations

8.5.1 Should be performed the same as in any labour.

8.5.2 Abdominal palpation and vaginal examinations should be offered 4 hourly throughout labour in the expectation that progress will be observed.

8.5.3 The position and descent of the sacrum should be noted at each assessment.

8.5.4 Assessment of the presenting part is vital as a breech can change from being flexed or extended to footling to knee presentation as labour progresses; this may impact on labour progress and risk of cord prolapse and must be considered in care planning. If a footling breech is discovered during labour a LSCS should be recommended unless birth is imminent.

8.6 IV Cannula

An intravenous cannula is recommended on admission in labour only where difficulty with IV access is anticipated e.g. raised BMI.

8.7 Birthing Position

8.7.1 Birthing women / people should be encouraged to adopt an upright position and be mobile in labour. Either a dorsal (semi-recumbent using the foot rests with the bottom of the bed removed) or all-fours position may be adopted for delivery and should depend on the preference of the birthing person, and the experience of the attendant.

8.7.2 If the all-fours position is used, women should be advised that recourse to the semi-recumbent position may become necessary.

8.8 Pain Relief

8.8.1 All birthing women / people have the full range of pain relief options available to them.

8.8.2 An epidural is not mandatory.

8.8.3 All should be informed that the effect of epidural analgesia on the success of vaginal breech birth is unclear, but that it is likely to increase the risk of intervention.

8.8.4 There is no current evidence to support or refute the use of the pool for labour and birth but there is very limited experience of this in this Trust and is not recommended.

8.9 Support
Birthing women / people should feel calm, in control and supported during their labour and birth; this will promote the release of oxytocin, promote contractions and promote good labour progress.

8.10 Documentation
All discussions, information and care plans should be documented clearly on Badgernet.

9 Intrapartum assessment and management of those presenting with an undiagnosed breech presentation in labour

9.1 Where a pregnant woman / person presents with an unplanned vaginal breech labour, management should depend on the stage of labour, whether factors associated with increased complications are present, availability of appropriate clinical expertise and informed consent.

9.2 Birthing women / people near or in active second stage of labour should not be routinely offered caesarean section.

9.3 Where labour is progressing rapidly, there is a balance of risks: attempting caesarean section where the breech is very low is likely to be associated with increased perinatal and maternal risk; assessment should include what is feasible.

9.4 Attempts at vaginal delivery in theatre with spinal anaesthesia or caesarean section with the breech on the perineum are likely to be associated with both increased perinatal and maternal risk.

9.5 Where time and circumstances permit, the position of the fetal neck and legs, and the fetal weight should be assessed using ultrasound, and the birthing woman / person counselled as with planned vaginal breech birth.

9.6 All maternity units must be able to provide skilled supervision for vaginal breech birth where a birthing woman / person is admitted in advanced labour.

10 Progress and Delay in the First Stage of Labour

Progress in labour is linked to perinatal outcome; a well progressing labour is more likely to suggest a good outcome at birth.

10.1 The first stage of labour should be managed according to the same principles as with a cephalic presentation.

10.2 There should be lower tolerance for slow or static progress in breech labours than cephalic labours and a low threshold for advising LSCS.

10.3 Progress of labour should be assessed frequently through strengths, length and frequency of contractions, maternal / parental behaviour and cervical dilatation and documented on the partogram.

10.4 Slow progress should be discussed with the on-call obstetric team who may decide that an examination by a doctor and/or examination 2 hourly is required to monitor progress.

10.5 If SROM occurs during labour the midwife should assess the colour of liquor, assess fetal wellbeing and recommend a palpation and vaginal examination to exclude cord prolapse.

10.6 To reduce the risk of cord compression, amniotomy is reserved for definite clinical indications.

10.7 Augmentation of slow progress with oxytocin should only be in discussion with the consultant obstetrician.

11 Care during the Second Stage of Labour - General Principles

11.1 The full MDT (including neonatal team) should be informed that second stage has commenced.

11.2 The neonatal resuscitaire should be brought into the room, prepared and room warmed for the birth. The neonatologist should be present at birth unless declined by the birthing woman / person.

11.3 The labour ward coordinator and on call Obstetric Registrar should be informed of the onset of the second stage and should be available on labour ward where possible.

11.4 A passive second stage to allow the descent of the breech to the perineum prior to active pushing is recommended (see section 12)

11.5 If the breech is not visible within 2 hours of the passive second stage, caesarean section should be recommended.

11.6 Women who start pushing spontaneously should be offered a vaginal examination to assess cervical dilation, presenting part and confirmation there is no cord presention / prolapse.

11.7 The midwife / doctor should watch for signs of descent and progress (anal dilation, birthing person' s behaviours/communication, contractions, visual presenting part) throughout the second stage of labour.

12 Progressive Descent of the Breech

There should be expected progressive descent of the breech in the second stage of labour.

12.1 Urgent Obstetric Registrar or Consultant review/referral is required if delay occurs eg:

- There are poor contractions or maternal pushing
- The breech is above the ischial spines after one hour of passive second stage
- The breech is not visible after 2 hrs of passive second stage
- If the breech does not descend with active pushing
- The buttocks are undelivered within 30mins of pushing
- An expected frank breech becomes a footling breech
- Fetal heart rate abnormalities

12.2 There should be a low tolerance for poor progress and clinicians should consider recommendation of a LSCS if delay occurs. Delay at this stage often precedes delays in later stages which can be more challenging to manage.

12.3 If LSCS is declined by the mother then the consultant must be informed to be present.

12.4 Oxytocin IVI may only be considered by the consultant.

12.5 If the baby has been born past the level of the umbilicus then the manoeuvres described in section 13 should be employed rather than a LSCS.

13 Active second stage and assisted vaginal breech manoeuvres

These manoeuvres can be undertaken with or without contractions present but the birthing woman / person should be encouraged to push once the legs and arms have been released and/or the head has been flexed.

13.1 Adequate descent of the breech in the passive second stage is a prerequisite for encouragement of the active second stage.

13.2 In general, intervention to expedite breech birth is required if there is evidence of poor fetal condition or if there is a delay of more than 5 minutes from delivery of the buttocks to the head, or of more than 3 minutes from the umbilicus to the head

13.3 In total, from **'rumping' i.e. crowning of the buttocks, to delivery of the baby** should be **no longer than 7 minutes**.

13.4 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.

13.5 A semirecumbent or an all-fours position may be adopted for delivery and should depend on maternal preference and the experience of the attendant. If the latter position is used, women should be advised that recourse to the semirecumbent position may become necessary.

13.6 While involuntary pushing may occur earlier, encouragement of maternal effort should not start until the breech is visible.

13.7 Once the buttocks have passed the perineum, significant cord compression is common.

13.8 Once buttocks are on the perineum start documenting on the breech delivery proforma (Appendix D)

13.9 Where birth is progressive, with good descent and normal fetal monitoring, a 'hands-poised' or 'hands off' approach.

13.10 Tactile stimulation of the fetus may result in reflex extension of the arms or head, and should be minimised.

13.11 Traction should never be applied to the breech in any circumstance as this increases the chances of extended arms and difficulty in head delivery.

13.12 Intervention only when appropriate and timely where progress is not made and care must be taken in all manoeuvres to avoid fetal trauma - the fetus should be held around the pelvic girdle (i.e holding bony, not soft tissues) and the neck should never be hyperextended.

13.13 Selective rather than routine episiotomy is recommended.

13.14 Signs that delivery should be assisted include lack of tone or colour, or delay, commonly due to extended arms or an extended neck.

14 Delay with the Body of the Baby

Once the breech has passed over the perineum (rumping), descent of the body should be visible with each contraction and pushing

The descent from here should be with the baby in a sacro-anterior position – this will be seen as 'tum to bum' position if in all fours. It may be necessary to rotate the baby to this position after rumping. If there is no or very poor descent with a contraction and good pushes then the obstetric registrar should immediately attend & review and the on call consultant obstetrician must be informed.

14.1 Delay with Legs:

Find the popliteal area (behind the knee) and apply gentle pressure to encourage the leg to flex) and abduct the legs out in the direction of the hip and deliver.
There should be no downward traction with this manoeuvre

14.2 Delay with the Arms:

A vaginal examination should be performed to exclude the possibility of extended arms above the head.
If arms are not deliverable then the Lővset's manoeuvre should be undertaken, taking care to hold the baby by the bony pelvis / prominences to minimise trauma to the baby.

Lovsett's manoeuvre:
Rotate the baby by 90' to bring the anterior shoulder underneath symphysis pubis, to engage and deliver anterior arm
Rotate 180' counter-rotation to engage the posterior arm, which is then delivered.

*tip: use left finger to release left arm and right hand to release right arm

14.3 Delay in delivery of the after-coming head:

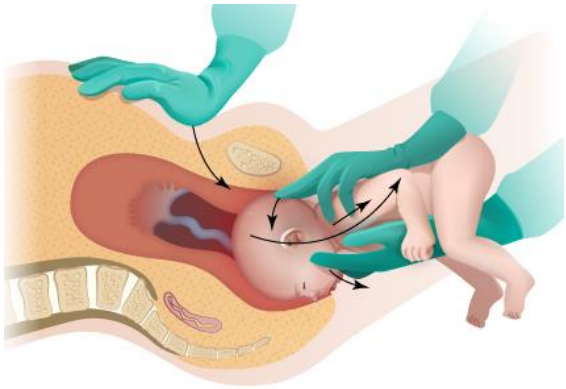
Mauriceau-Smellie-Veit (MSV) manoeuvre should be undertaken to encourage flexion of the fetal head.

The fetus is placed in a 'horse-riding position' on the inner aspect of the non-dominant forearm.

Two fingers of that hand should be placed over the malar prominences (cheek bones) .
NB Fingers should not be placed inside the fetal mouth as this may be associated with jaw traction and subsequent dislocation or even fracture.

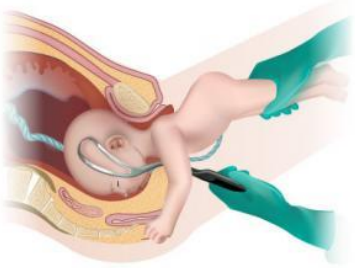
The dominant hand should be placed over the fetal back with middle finger on the fetal occiput to promote flexion and the index and ring fingers on each of the fetal shoulders to promote traction.

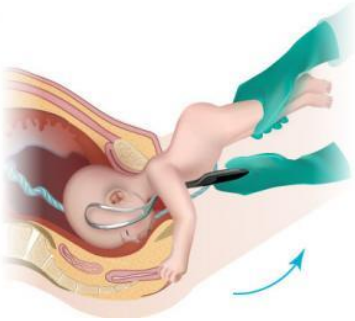
Both hands are used to promote flexion of the head. The fetal body is raised upward in an arc completing delivery (whilst maintaining neck flexion)



An assistant may apply **suprapubic pressure** to further promote flexion (note the difference in position of the hand applying pressure is different to that used for shoulder dystocia).

If not initially successful then following should be attempted:





- **Use of forceps**

Forceps should be considered if the head has not delivered within 2–3 minutes of attempting the MSV manoeuvre.

Long handled forceps - Kielland's forceps or NB-forceps should be the instrument of choice.
Wrigley's forceps should not be used for vaginal breech delivery.

An episiotomy should be considered / performed if indicated to apply forceps blades facilitate delivery.

An assistant should gently lift and support the baby without applying traction. The baby can be wrapped in a towel to keep it warm.

The forceps should be applied in the same manner as is used for cephalic presentation.
Delivery of the fetal head should be controlled and slow; gentle downward traction should be applied and upward traction should commence when the fetal chin reaches the perineum.

- **Symphysiotomy**

In the rare event of head entrapment a symphysiotomy should be undertaken by senior obstetrician after discussion and agreement with the Consultant Obstetrician (if the obstetrician has the knowledge, skills and experience to perform this manoeuvre)

15 Physiological Breech Birth

Physiological breech birth is usually performed in the 'All-Fours' or upright position.
It is **not** a complete 'hands-off' approach - as per delivery in lithotomy, it is important that the time from 'rumping' to delivery remains within 7 minutes, with correct application of manoeuvres where delay occurs.

Where trained / experienced, manoeuvres which may be used are essentially the same as in lithotomy but in a different orientation:

15.1 Delay with the body:
- Ensure that the baby is 'tum-to-bum' - rotate if not
- Encourage maternal movement or 'wiggle'

15.2 Delay with the arms:
- Reverse moanouvre similar to Lovsets – rotate to 90' and deliver the arm which is now the 'pubic arm' (i.e is anterior arm in relation to the mother / parent), then rotate back 180' and deliver the remaining pubic arm.
-

Image credit: Shawn Walker – Breech Birth Network

15.3 Delayed after-coming head:
- Maternal / Parental Buttock-lift – if descent is impeded by the perineum tight on the baby's forehead (bregma), an assistant can augment the manoeuvre by lifting the woman's buttocks up and out. This lifts the perineum over the bregma and is especially helpful when the mother / parent is obese, or the perineum is especially tight.

16 Management of the preterm breech

16.1 Planned caesarean section is recommended for preterm breech presentation where delivery is planned due to maternal and/or fetal compromise.

16.2 Caesarean section for breech presentation in spontaneous preterm labour is not routinely recommended.

16.3 Mode of delivery should be individualised based on the stage of labour, type of breech presentation, fetal wellbeing and availability of an operator skilled in vaginal breech delivery.

16.4 Caesarean section for breech presentation in spontaneous preterm labour at the threshold of viability (22–25^{+6} weeks of gestation) is not recommended.

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

16.6 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.

17 Management of the twin pregnancy with a breech presentation

17.1 Pregnant women / people should be informed that the evidence is limited, but that planned caesarean section is recommended for a twin pregnancy where the presenting twin is breech.

17.2 Routine emergency caesarean section for a breech first twin in spontaneous labour, however, is not always 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.

17.3 Routine caesarean section for breech presentation of the second twin (where twin 1 is cephalic) is not recommended in either term or preterm deliveries

18 Organisational and governance to support and guide a vaginal breech delivery service

18.1 It is recognised that maintaining competence in assisting a vaginal breech birth is challenging where regular exposure and experience is limited.

18.2 The skills of the attending clinicians at the time of a breech birth should be made clear to the birthing woman / person in order to aid in their decision making process.

18.3 Skills and drills training should be provided using adequate simulation equipment should to rehearse the skills that are needed during vaginal breech birth

18.4 All doctors and midwives are expected to attend skills and drills training in vaginal breech birth at least once per year.

18.5 Experience in vaginal breech delivery is considered competent if performed approximately every 6-months – regardless of number of previous breech deliveries attended.

18.6 It is important to recognise that the most skilled person on the delivery suite for managing the vaginal breech may not the obstetrician –this should be discussed within the MDT and with the woman/ person in labour to establish the safest birth plan for them.

18.7 All counselling for vaginal breech birth must be given in line with the guidance and proforma / checklist in appendix x.

18.8 Yearly audit of vaginal breech deliveries should be carried out.

19 References / Useful Links

RCOG Green Top Guideline No 20b: Management of Breech Presentation
Management of Breech Presentation (Green-top Guideline No. 20b) (rcog.org.uk)

RCOG Green-top Guideline No. 20a: External Cephalic Version and Reducing the Incidence of Term Breech Presentation
External Cephalic Version and Reducing the Incidence of Term Breech Presentation (rcog.org.uk)

NICE Guidance NG 207, 2021: Inducing Labour
Recommendations | Inducing labour | Guidance | NICE

StratOg: Breech presentation | eLearning (rcog.org.uk)

PROMPT – Practical Obstetric Multi-professional Training
PROMPT Training videos | PROMPT Maternity Foundation

Physiological Breech Birth
https://breechbirth.org.uk/

Appendix A: ECV consent sticker

Name of procedure: External Cephalic Version (ECV)

Benefits: Turn baby to more favourable position to allow normal vaginal delivery

Risks:

- Maternal discomfort 75%, mild/moderate 33%, Very high pain 5%
- Cord Prolapse: 0.18% (1.8 in 1000)
- Placental abruption: 0.09% (0.9 in 1000)
- Additional procedure: Emergancy Caesarean Section: 0.5% (5:1000)
- Fetal bradycardia/non reasurring CTG: Unknown significance

Appendix B: ECV Profoma

Patient Sticker

Gravida…….. Parity…….. EDD……. Gestation …… BMI ……..
Blood group …… Anti-D in pregnancy Yes / No
Medications / Allergies ……
Relevant obstetric history / previous deliveries
……..
Any contraindications to ECV (refer to protocol section) Yes / No
(if yes which, document reasons for continuing ECV)
……..

Admission observations

Maternal : BP ……. Mat pulse ……. Mat temp. ……. Urinalysis …….
Covid screen …….

Antenatal CTG sticker

Fetal: Position on palpation ……..

USS:
Fetal position ……
Legs – extended (frank) / flexed (complete) / Footling
Head – flexed / extended
Liquor – DVP ……..
Placental position ……

Clinician Performing ECV (name / sign)
…….. Grade ……
Consent form completed: YES / NO
Time terbutalline (250mcg s/c) given ……

ECV Procedure

Time started …… Time completed …… FH checked during procedure YES / NO

Number of attempts at Forward roll: …… Backward roll: _____

ECV successful YES / NO If no, second attempt offered YES / NO

Post-ECV

Mat BP ……. Mat pulse …….

Antenatal CTG sticker

Anti-D given YES / NO

Ongoing plan:
Repeat ECV ☐ Date Booked …….
Elective Caesarean ☐ Date Booked …….
Vaginal breech birth ☐ Follow up booked…….
(Please document discussion according to the birth options proforma)

Appendix C: Breech Decision Making Toolkit

	Y / N	Discussion / Decision
We have discussed the recommendation for ECV - Benefits: overall success rate of ECV ~50% , 3% babies revert to breech after successful ECV, successful ECV reduces chance of caesarean - Risk: Pain, fetal distress requiring CS, rare- placental abruption. Labour after ECV has slightly increased rate of CS and instrumental delivery		
We have discussed the risk of perinatal mortality for breech delivery : - 0.5/1000 with caesarean section after 39+0 weeks of gestation; - 2.0/1000 with planned vaginal breech birth - 1.0/1000 with planned cephalic birth		
We have discussed vaginal breech birth		
- Increased risk of perinatal mortality (as above) - Increased risk of low Apgar scores and serious short-term complications, (no increase the risk of long-term morbidity)		
- Maternal complications are least with successful vaginal birth, highest with emergency caesarean section (40% of women planning a vaginal breech birth)		
- Advise delivery in an obstetric unit with continuous fetal monitoring in labour		
- Level of skill and competency in safe delivery of vaginal breech is variable on each shift and may not be suitable to support vaginal delivery on a particular day.		
We have discussed planned caesarean section		
- Small reduction in perinatal mortality compared with planned vaginal breech delivery 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.		
- Small increase in immediate complications for the mother compared with planned vaginal birth (infection, bleeding, VTE)		
- Increased risk of complications in future pregnancy (VBAC, complications at repeat caesarean section, abnormally invasive placenta, slightly increased risk of stillbirth)		

Individual Risk Assessment –

FETAL	
Hyperextended neck on ultrasound	
High estimated fetal weight (more than 3.8 kg).	
Low estimated weight (less than tenth centile).	
Footling presentation.	
Evidence of antenatal fetal compromise.	

MATERNAL	
Previous LSCS	
Raised BMI	
Maternal age >40years	
Other obstetric complication in previous or current pregnancy	

If any risk factor is identified, planned vaginal birth is likely to be associated with increased perinatal risk and delivery by caesarean section is recommended. If wishes to continue vaginal delivery must be discussed with obstetric consultant.

Summary of discussion / final plan / deviation from usual guidance

Information for pregnant women and people regarding potential change in birth plans:
There may be situations where the agreed birthing plans will need to change:

- If opting for caesarean section, if the baby has turned cephalic at the time of the planned caesarean date, the procedure should be cancelled and a further discussion for birth planning / vaginal delivery.
- If you have a planned caesarean booked but you go into spontaneous labour then you should call to the department where they will invite you in for a caesarean as an emergency procedure
- If opting for vaginal breech, please be aware that in some circumstances (fetal distress and / or staff competency, poor progression) it will not be appropriate to facilitate safe vaginal birth and you will be advised to have an emergency caesarean.
-

Declaration of
Staff member name and grade:
I have provided the information relative to breech delivery and the recommended options. I have provided an information leaflet. The above documentation in representative of the discussions and birth plan

Pregnant woman / person
I feel fully informed of the regarding breech birth options and I understand the benefits and risks for both options.
My birth choice is vaginal breech / elective caesarean (delete as appropriate).
I am aware that I can change my birth preference at any point and can contact …….. in the event of this.

Breech Decision Making Tool and Consent (Labour)

NB: the numbers quoted are for 'planned' vaginal breech birth and 'planned' caesarean.
Risks for unplanned vaginal breech and emergency caesarean are both increased
Individual risk assessment must be quickly undertaken.

	Y / N	Discussion / Decision
We have discussed the risk of perinatal mortality for breech delivery : - 0.5/1000 with caesarean section after 39+0 weeks of gestation; - 2.0/1000 with planned vaginal breech birth - 1.0/1000 with planned cephalic birth		
We have discussed vaginal breech birth		
- Increased risk of perinatal mortality (as above) - Increased risk of low Apgar scores and serious short-term complications, (no increase the risk of long-term morbidity)		
- Maternal complications are least with successful vaginal birth, highest with emergency caesarean section		
- Advise delivery in an obstetric unit with continuous fetal monitoring in labour		
- Level of skill and competency in safe delivery of vaginal breech is variable on each shift – explain the current availability		
We have discussed caesarean section		
- reduction in perinatal mortality compared with vaginal breech delivery		
- increase in immediate complications for the mother compared with planned vaginal birth (infection, bleeding, VTE)		
- Increased risk of complications in future pregnancy (VBAC, complications at repeat caesarean section, abnormally invasive placenta, slightly increased risk of stillbirth)		

Individual Risk Assessment

FETAL	
Hyperextended neck on ultrasound	
High estimated fetal weight (more than 3.8 kg).	
Low estimated weight (less than tenth centile).	
Footling presentation.	
Evidence of antenatal fetal compromise.	

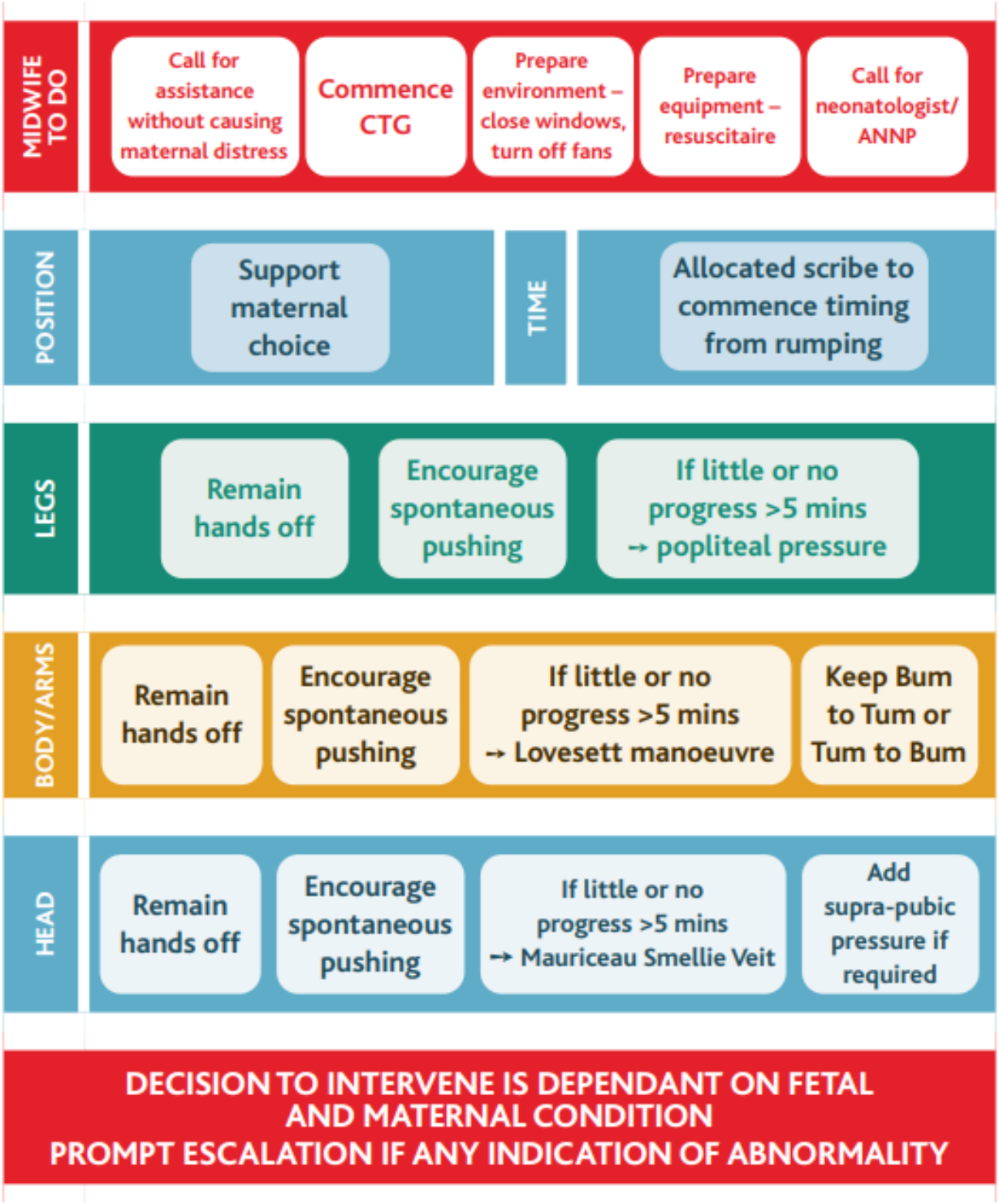
MATERNAL	
Previous LSCS	
Raised BMI	
Maternal age >40years	
Other obstetric complication in previous or current pregnancy	
Slow progress of labour thus far or in first (latent) phase	

If any risk factor is identified, planned vaginal birth is likely to be associated with increased perinatal risk and delivery by caesarean section is recommended.
Caesarean should be recommended for a unplanned vaginal breech presenting in the first stage of labour, but not in the rapidly progressing second stage of labour

Appendix D: Breech PROMPT Card

UNDIAGNOSED VAGINAL BREECH DELIVERY PROMPT CARD

NHS
Brighton and Sussex University Hospitals NHS Trust



Appendix E: Breech delivery proforma