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TRUST CLINICAL GUIDELINE

Breech Management (including the role of External Cephalic Version)

OVERVIEW

This guideline provides evidenced based guidance for staff to follow on the process to follow for external cephalic version (ECV) and the management of a vaginal breech birth.

This guideline is for use by:

- Obstetricians
- Midwives
- Ultra-sonographers

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Breech Management Guideline (including the role of External Cephalic Version)

1.0 Introduction

This guideline aims to:

- Provide evidence based guidance for staff on the use of External Cephalic Version (ECV) to manage a breech presentation at term.
- Provide guidance for staff when undertaking a vaginal breech birth.
- To ensure optimal outcome for the pregnant woman or birthing person and baby.

2.0 Definitions and abbreviations used in this document

ECV - External Cephalic Version	MIS - Maternity Information System
CTG - Cardiotocography	LSCS - Lower segment caesarean section
APH - Antepartum Haemorrhage	MCG - Micrograms
ODP - Operating Department Practitioner	VBAC - Vaginal birth after caesarean section
ARM - Artificial rupture of membranes	SROM - Spontaneous rupture of membranes

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.

3.0 Duties and Responsibilities

All midwives and obstetricians	<ul style="list-style-type: none"> • To access, read, understand and follow this guideline. • To use their professional judgement in application of this guideline. • To be aware of current recommendations.
Maternity managers	<ul style="list-style-type: none"> • To ensure the guideline is reviewed three yearly and aligns with national standards. • To ensure the guideline is accessible to all relevant staff.

4.0 Breech presentation at the end of pregnancy (RCOG)

There is a useful information page for pregnant women and birthing people on the RCOG website detailing the options available with associated leaflets for ECV and caesarean birth. Staff should signpost pregnant women and birthing people to this page, or if required, print the information for them.

5.0 Antenatal management of suspected breech presentation

Breech presentation should be suspected clinically if the head is ballotable at the fundus of the uterus, or if the fetal heart is heard high in the abdomen.

All pregnant women and birthing people with a suspected breech presentation after 36 weeks gestation must be referred to the antenatal clinic/day assessment unit for a presentation scan.

If breech presentation is confirmed, the pregnant woman or birthing person should be seen by a consultant obstetrician or a specialist registrar to discuss their options: ECV, vaginal breech birth or elective Caesarean birth after 39 weeks of gestation.

Give pregnant women and birthing people the RCOG leaflet [Breech baby patient information leaflet \(rcog.org.uk\)](https://www.rcog.org.uk/leaflets/breech-baby-patient-information-leaflet)

ECV should be offered unless there is a contraindication (including but not limited to pregnant women and birthing people in labour, pregnant women and birthing people with a uterine scar or abnormality, fetal compromise, ruptured membranes, vaginal bleeding or medical conditions, or other reasons which would be a contraindication to vaginal birth).

If a vaginal birth is being considered, a growth scan needs to be performed. There is insufficient evidence to recommend pelvimetry to aid the decision on mode of birth. Vaginal breech birth is considered as safe if the fetal weight is less than 3.8kg, and more than 10th centile on the individualised estimated fetal weight chart.

Pregnant women and birthing people who wish to birth against recommended advice should be given an appointment with both an obstetric consultant and consultant midwife. The discussion and outcome must be documented on MIS.

For cases diagnosed with breech presentation antenatally, the agreed mode of birth should be stated clearly in the antenatal documentation on MIS.

Pregnant women and birthing people should be informed that the current best evidence suggests no benefit to postural management of breech presentation. Pregnant women and birthing 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.

Pregnant women and birthing people should be informed that the recommended course of action may be changed if clinical circumstances change (for example, if the baby turns spontaneously to a cephalic presentation, or if they present in advanced labour).

The pregnant woman or birthing person's views are paramount in the decision making process. Clinicians should take into individual circumstances and assessment of risks and benefits will vary from individual to individual. Counselling should be clear, comprehensive and unbiased so that the pregnant woman and birthing person is in a position to make an informed decision that is best for them.

6.0 External Cephalic Version (ECV)

Pregnant women and birthing people with a confirmed breech presentation after 36 completed weeks of gestation should be offered ECV unless there is an absolute contraindication. They should be advised on the risks and benefits of ECV and the implications for mode of birth.

External cephalic version (ECV) is the manipulation of the fetus, through the maternal or birthing person's 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 birth.

- Pregnant women and birthing people should be informed that the overall success rate of ECV is approximately 50%.
- ECV should be offered after 36+0 weeks in nulliparous pregnant women and birthing people and from 37 weeks in multiparous pregnant women and birthing people.
- ECV must be booked by telephoning the Labour Ward.
- All pregnant women and birthing people undergoing ECV should be offered detailed information ([RCOG leaflet](#)) concerning the risks and benefits of the procedure.
- Written informed consent should be gained and clearly documented in MIS.

Pregnant women and birthing people should be informed that labour after ECV is associated with a slightly increased rate of caesarean birth and instrumental birth when compared with spontaneous cephalic presentation. Pregnant women and birthing people should also be informed that even if the ECV is successful there is a small chance (15%) that the baby may revert spontaneously to a breech presentation.

Although most pregnant women and birthing people tolerate ECV they should be informed that ECV can be an uncomfortable procedure but they will be able to request that the procedure is stopped at any time. Routine use of regional analgesia is not recommended but may be considered for a repeat attempt or for pregnant women and birthing people unable to tolerate the procedure.

ECV must be performed on the labour ward where cardiotocography (CTG) and theatre facilities are available. A CTG should be performed before and after the procedure. Kleihauer testing is necessary and prophylactic Anti-D immunoglobulin 1500 units should be offered to Rhesus-negative pregnant women and birthing people if the fetus is D positive on cfDNA testing. This must be ordered and available prior to admission.

6.1 Contraindications to ECV

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 Doppler
- Major uterine anomaly
- Ruptured membranes
- In active labour

- There is fetal compromise
- The pregnant woman or birthing person has any other medical conditions (for example, severe hypertension) that would make external cephalic version inadvisable.
- Multiple pregnancies (except birth of second twin).

Relative contraindications where ECV might be more complicated:

- Small-for-gestational-age fetus with normal Doppler parameters (< 10th Centile on estimated fetal weight chart).
- 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.

6.2 Risks of ECV

- Risk of emergency caesarean within 24hrs (for fetal distress/APH) 0.5%.
- Placental separation
- Cord entanglement
- Pre-labour rupture of membranes
- Uterine rupture
- Iso-immunisation in Rhesus negative pregnant women and birthing people.

Pregnant women and birthing people should be informed that these complications are very rare and studies have not showed an increase in low cord pH levels and neonatal admissions and no increase in fetal deaths due to the procedure. New evidence shows that there is no increased risk for pregnant women and birthing people with one previous caesarean birth.

6.3 ECV procedure

- Admit to labour ward at allotted time.
- Advise the patient they do not have to be fasted pre-procedure.
- 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.
- Summon obstetric consultant (ECV must be performed by an appropriately trained obstetrician - this may be a senior registrar who has completed RCOG-approved training in ECV.)
- Trust consent form signed prior to procedure.
- Bladder should be emptied.
- Consider use of tocolysis 15 minutes before ECV either:
Terbutaline s/c 250 micrograms (mcg) **or**
Salbutamol s/c 250 micrograms (mcg)
- Abandon ECV if too painful.

- Perform 30 minute CTG following procedure (whether successful or not). Scan to confirm success.
- Perform Kleihauer test and administer Anti D 1500 units if the pregnant woman or birthing person rhesus negative and the fetus is D positive on cfDNA testing.
- Document procedure and outcome in MIS.
- Arrange community midwife or USS follow up 7 days after procedure to confirm cephalic presentation.

6.4 Unsuccessful ECV

- The possibility of a further attempt should be discussed (tocolysis should be considered where an initial attempt at ECV without tocolysis has failed). Regional anaesthetic can be offered if first attempt too painful without anaesthetic.
- Birth options must be discussed by a senior obstetrician prior to discharge, either:
 1. The pregnant woman or birthing person can be booked for elective LSCS at 39 weeks, or
 2. Planned vaginal birth if EFW <3800g and no other contraindications.

6.5 Factors known to increase and decrease the likelihood of successful ECV

Increase Success	Decrease Success
<ul style="list-style-type: none"> • High provider experience • Multiparity • Increased maternal age • Non-engagement of the breech • Pre-procedural tocolysis • Low maternal body weight Posterior placenta • Flexed (complete) breech Polyhydramnios 	<ul style="list-style-type: none"> • Nulliparity • Maternal obesity • Extended (frank) breech • Footling breech

6.6 Alternatives/Adjuncts to ECV

Pregnant women and birthing people may enquire as to the opinions of clinical staff on adjunctive measures to encourage cephalic version. Generally, where performed or overseen by suitably trained personnel, the following strategies are not believed to be harmful and therefore may be utilised by pregnant women and birthing people who wish to consider them, on the understanding that they are not offered within UH Sussex hospitals.

- *Moxibustion* – ancient Chinese therapy involving the burning of dried mugwort over a specific acupuncture point. It is hypothesised that this encourages production of placental oestrogens and prostaglandins which in turn stimulate uterine contractility and fetal activity. In a 2023 Cochrane review, the evidence for most outcomes was low to moderate certainty (Coyle et al. 2023). Though acknowledged a reduction in non-vertex presentation, need for oxytocin and birth by caesarean birth where it is combined with other techniques including acupuncture and postural management. Evidence supports the

use of moxibustion between 33 and 35 weeks of gestation under guidance of a trained professional.

- *Postural management* – a further 2012 Cochrane review on the effectiveness of postural management strategies failed to demonstrate benefit in the reduction of non-vertex presentation or caesarean birth rate though highlighted that the limited number of studies on the subject were of insufficient size to draw any definitive conclusion and highlighted a need for further research in this area.

7.0 Information to be given to pregnant women and birthing people when counselling about birth options

- Discussion of birth options including risks and benefits and any patient information given should be documented on MIS.
- Counselling should be unbiased and ensure proper understanding of the absolute as well as relative risks of different options.
- Planned caesarean birth for breech at term carries a small increase in immediate complications to the pregnant woman or birthing person vs planned vaginal birth but overall short term maternal morbidity is extremely low regardless whether birth is by elective caesarean or vaginal breech.
- Maternal and birthing people complications are least with planned vaginal birth. Planned caesarean birth has a higher risk, but the risk is highest with emergency caesarean birth (needed in approximately 40% of vaginal breech births).
- Explain risk of planned caesarean birth for future pregnancies (risks related to VBAC, increased risk of surgical complications, abnormally invasive placenta, small increase of stillbirths in future pregnancies, although this last may not be causal).
- Pregnant women and birthing people should be given an individualised assessment of long term risks of caesarean birth based on their individual risk profile and reproductive intentions.
- The risk of emergency caesarean birth in labour for pregnant women and birthing people planning a vaginal breech birth is around 40% but may be a little lower in parous than nulliparous pregnant women and birthing people.
- Perinatal mortality is 2.0/1000 with planned vaginal breech vs 1.0/1000 with planned cephalic birth vs 0.5/1000 with planned caesarean birth (this last being lowest due to reduction in the risk of stillbirth after 39 weeks, avoidance of intrapartum risks and avoidance of risks associated with vaginal breech birth).
- Planned vaginal breech increases the risk of low Apgar scores and serious short-term complications, but does not increase long-term morbidity.
- Selection of appropriate pregnancies and skilled intrapartum care may allow planned vaginal breech birth to be nearly as safe as planned vaginal cephalic birth. However, the widely adopted practice of recommending caesarean birth for breech babies since the term breech trial (despite its flaws) has resulted in widespread deskilling of the midwifery and obstetric workforce and this may compromise fetal outcomes.

8.0 Presentation of breech baby in labour

- Breech presentation in labour should be suspected under the following conditions:
 - Fetal head ballotable in the fundus of the uterus. On vaginal examination the head is not felt in the pelvis (buttocks or feet may be felt).
 - Thick meconium is present after rupture of membranes.
 - Cord prolapse.
 - Abnormal CTG.
- Immediate bedside ultrasound scan should be performed to assess presentation Where a pregnant woman or birthing person presents with an unplanned breech in labour, management should depend on the stage of labour, whether factors associated with increased complications are found, availability of appropriate clinical expertise and informed consent.
- Pregnant women and birthing people near or in active the second stage should not routinely be offered a caesarean birth.
- Where time and circumstances permit, the position of the fetal neck and legs and the fetal weight should be estimated using ultrasound and the pregnant woman or birthing person counselled as per planned vaginal breech birth
- If a footling presentation is diagnosed intrapartum, strong consideration should be given to birth by caesarean birth irrespective of gestation. This is because a footling presentation is more likely to be associated with a cord prolapse when the membranes rupture. If the membranes rupture spontaneously in the presence of a footling presentation, a vaginal examination must be performed immediately to exclude cord prolapse.

9.0 Information to be given to pregnant women and birthing people when counselling about birth options when the breech presents in labour

- NICE recommends discussing the possible benefits and risks of vaginal birth and caesarean birth including an increase in the chance of serious medical problems for the pregnant woman or birthing person with caesarean birth, and for the baby with vaginal birth, including what it may mean for them and the baby if such problems did occur.
- Pregnant women and birthing people should be advised that any benefit of caesarean birth in reducing the chance of complications for the baby may be greater in early labour.
- Pregnant women and birthing people should be offered a choice between continuing labour and caesarean birth.
- These recommendations may be different from the advice that the pregnant woman or birthing person may have been given before labour but this is because the balance of risks to the pregnant woman or birthing person and baby have changed in labour.

10.0 Induction and augmentation

- Induction of labour is not usually recommended since induction of labour with a breech presentation is associated with higher caesarean birth rates and perinatal morbidity.
- Augmentation of slow progress with oxytocin should only be considered if the contraction frequency is low in the presence of epidural analgesia. This is a consultant decision only.

11.0 Vaginal breech birth

With the low rate of vaginal breech births in the developed world, experience is being lost.

6% of pregnant women and birthing people with breech presentation still have a vaginal breech birth as they present too late so it is advisable to be prepared.

The essential components for planning of safe vaginal breech birth are appropriate case selection, management according to a strict protocol and the availability of skilled attendants.

11.1 Factors unfavourable for vaginal breech birth

Following the diagnosis of persistent breech presentation, pregnant women and birthing people should be assessed for the following risk factors which are unfavourable for vaginal breech birth:

- Other contraindications to vaginal birth (e.g. placenta praevia, compromised fetal condition).
- Hyperextended neck on ultrasound.
- Footling or kneeling breech presentation.
- Estimated fetal weight (>3.8kg).
- Low estimated fetal weight (<10th centile) on estimated fetal weight chart.
- Evidence of antenatal fetal compromise.
- Lack of presence of a clinician trained in vaginal breech birth.

Pregnant women and birthing people with risk factors for increased perinatal risk should be advised that birth by caesarean birth is recommended. The role of pelvimetry is unclear and currently not recommended as an adjunct to decision making.

Home breech birth is associated with an approximately 10-fold higher risk of perinatal mortality than well-supported vaginal breech birth in hospital with facilities for immediate recourse to emergency birth.

Use appropriate local checklist where available.

11.2 Types of vaginal breech births

- **Spontaneous breech birth:** No traction or manipulation of the infant is used. This occurs predominantly in very preterm, often pre viable deliveries, but can also occur in term deliveries.
- **Assisted breech birth:** This is the most common type of vaginal breech birth. The infant is allowed to spontaneously deliver up to the umbilicus, and then manoeuvres are initiated to assist in the birth of the remainder of the body, arms and head.
- **Breech extraction:** The fetal feet are grasped, and the entire fetus is extracted. Total breech extraction should be used only for a non-cephalic second twin; it should not be used for a singleton fetus because the cervix may not be adequately dilated to allow passage of the fetal head. Total breech extraction for the singleton breech is associated with a birth injury rate of 25% and a mortality rate of approximately 10%.

11.3 First stage of labour

- Discuss the risks of breech vaginal birth to the pregnant woman or birthing person and partner.
- In early first stage in cases of previous vaginal birth the possibility of an ECV may be offered by the consultant as long as the membranes are intact.
- Discuss epidural analgesia, and inform pregnant women and birthing people that the effect of epidural analgesia on the success of vaginal birth is unclear, but it likely increases the risk of intervention.
- IV access and bloods taken for full blood count, group & save and urea & electrolytes.
- Regular assessment by obstetrician or senior midwife.
- Advise pregnant women and birthing people that continuous CTG is recommended as it may lead to improved neonatal outcomes. Persistent decelerations in the fetal heart rate or evidence of umbilical cord prolapse should prompt immediate caesarean birth if vaginal birth is not imminent.
- Administer antacid prophylaxis.
- Anaesthetist must be available.
- Paediatrician must be available.
- ARM only if presenting part is applied well to the cervix. The fetal membranes should be left intact as long as possible.
- VE immediately after SROM (to exclude cord prolapse).
- Poor progress despite good contractions suggests that the pelvis is inadequate.
- Augmentation should only be considered if the contraction frequency is low in the presence of epidural analgesia. The decision for augmentation must be made by the consultant.
- Fetal blood sampling from the buttock is not advised.
- The on-call obstetric consultant should be informed about pregnant women and birthing people in labour with a breech presentation as early as possible.

11.4 Second stage of labour

- Pregnant women and birthing people near or in active second stage of labour should not be routinely offered caesarean birth, as attempting the latter where the breech is very low is likely to be associated with increased perinatal and maternal risk.
- Adequate descent of the breech in the passive second stage is essential for encouragement of the active second stage.
- Consider LSCS if there is delay in the active second stage.
- Routine birth in theatre is not recommended, as this is likely to increase stress in the pregnant woman and birthing person and there is no evidence of benefit on feto-maternal or birthing person outcomes.
- Labour ward co-ordinator should ensure the following staff members are present for birth:
 - Obstetric consultant/registrar
 - 2 midwives
 - Paediatrician
 - Anaesthetist & ODP (on the labour ward)
- Either a semi recumbent or an all-fours position may be adopted for birth and should depend on maternal or birthing person preference and the experience of the attendant. There is some emerging evidence that birth on all fours or upright may improve outcome

but this is currently insufficient to be recommended. Pregnant women and birthing people choosing to birth on all fours should be advised that recourse to semi recumbent position may become necessary if assistance is needed from a practitioner who is more experienced in breech birth in the semi-recumbent position.

- Confirm full dilatation by vaginal examination.
- A passive second stage to allow the descent of the breech to the perineum prior to active pushing is recommended. If the breech is not visible within 2 hours of the passive 2nd stage, caesarean birth should normally be recommended.
- Catheterised, bladder empty.
- Infiltration of the perineum with local anaesthetic should be performed in all breech births where time allows, as the breech descends towards the perineum. This is to facilitate painless episiotomy which should be considered when buttocks distend the vulva.
- The breech can be left to birth spontaneously if progress is made and fetal heart within normal parameters.
- If there is not progressive descent of the presenting part, consider performing manoeuvres (see below) to assist birth. Fetal traction should be avoided: if there is expulsive delay after the nape of the neck is visible then suprapubic pressure from above is very likely safer than traction from below.
- Ensure fetal back is anterior. Where assistance is required for breech birth, grasping the fetal pelvis to allow rotation of the back to anterior is helpful and avoids fetal trauma (avoid pressure on the fetal abdomen).
- Assistance is usually required if there is evidence of poor fetal condition or a delay of >5 min from birth of the buttock to the head, or of >3min from the umbilicus to the head.
- Nuchal arm (rare) may require additional manoeuvres such as Lovset's manoeuvre (rotation of the baby to facilitate birth of the arm).
- Flexed arms should birth spontaneously or can be swept across the baby's face and downwards by Lovset's manoeuvre.
- If the legs do not birth spontaneously, pressure can be applied to the popliteal fossae to facilitate birth.
- Allow the body to hang - this increases flexion of the head.
- Make sure FHR is monitored with external transducer if necessary.

You must see the nape of the neck before proceeding with birth of the head - if the nape of the neck is not visible, suspect an entrapped head at the pelvic inlet - see [Section 11.6](#)

- When the nape of the neck is visible the after coming head can be delivered manually by Mauriceau-Smellie-Veit manoeuvre, or traction forceps such as Neville Barnes or Simpson forceps may be applied to the head with the assistant raising the body by the feet while avoiding hyperextending the neck. Burns-Marshall technique is not advised due to concern over extension of the fetal neck.
- An alternative is the Bracht manoeuvre – following spontaneous birth to the umbilicus, the body is grasped with both hands keeping the legs flexed against the baby's abdomen and, without traction, is brought up against the symphysis pubis, frequently accompanied by suprapubic pressure.
- Suprapubic pressure can also be applied to guide the head into the pelvis.
- Paired cord blood samples should be taken for analysis.

11.5 Complications of breech birth

- Cord prolapse (higher risk with footling or complete breech) Fetal head entrapment (See [section 11.6](#)).
- Overly rapid descent of after-coming head leading to rapid compression/decompression causing intracranial haemorrhage.
- Cervical spine injuries associated with hyperextension.
- Delay in birth, leading to asphyxia due to cord compression and placental separation.
- Traumatic injuries including fractures of the humerus, femur or clavicle, brachial plexus injury (Erb-Duchenne palsy).

11.6 Entrapped head (rare emergency)

- This may occur due to an incompletely dilated cervix or entrapment behind the pelvic brim.
- If the cervix is not fully dilated, incise it with scissors at 4 and 8 o'clock position, taking care not to cut the baby.
- For entrapped head behind the pelvic brim, apply suprapubic pressure and/or McRoberts manoeuvre.

11.7 Preterm breech

- Inform pregnant women and birthing people that routine caesarean birth for breech presentation in spontaneous preterm labour is not recommended unless there is suspected maternal or birthing person or fetal compromise.
- The mode of birth should be individualised based on the stage of labour, type of breech presentation, fetal wellbeing and availability of an operator skilled in vaginal breech birth.
- Labour with a preterm breech should be managed as with a term breech.
- Where there is head entrapment, incisions in the cervix (vaginal birth) or vertical uterine incision (caesarean birth) may be used with or without tocolysis. Incising the cervix carries a high risk of serious maternal morbidity and should only be done where other manoeuvres have failed to achieve birth.
- Pregnant women and birthing people in preterm labour at the threshold of viability (22-25+6 weeks) should be informed that caesarean birth is not routinely recommended since there is no evidence for improved neonatal outcome over vaginal breech birth.
- If birth is planned for preterm breech presentation due to maternal and /or fetal compromise then a planned caesarean is recommended.

11.8 Twins

- Planned caesarean birth is recommended when the presenting twin is breech.
- Routine emergency caesarean birth for a breech first twin in spontaneous labour is not recommended. The mode of birth should be individualised based on cervical dilatation, station of presenting part, type of breech, fetal wellbeing and availability of skilled operator.
- Routine caesarean birth for breech presentation of the second twin is not recommended in either term or preterm births.

12.0 Caesarean birth

Most infants in a breech presentation at term will be born by caesarean birth, either as a primary maternal choice or following unsuccessful ECV. Confirmation of presentation by ultrasound immediately before surgery should be undertaken, as spontaneous reversion to cephalic occurs in around 8% of cases (although only 3–7% where ECV has been attempted and unsuccessful; rates of reversion to breech following successful ECV are similarly ~3%). (RCOG, 2017).

It is good practice to discuss such an eventuality at the time of initial counselling and ensure a clear plan is documented in the event this should occur. Many pregnant women and birthing people will have made extensive preparation around their date for caesarean birth and to continue with this may, at the time, be the most appealing choice, even though the indication no longer persists. Similarly, advance discussion and documentation of the pregnant woman and birthing person's wishes in the event of spontaneous labour prior to caesarean birth is recommended.

While most breech births at caesarean birth are straightforward, additional steps may be required in some cases, and largely mimic those described for VBB (e.g. Løvset or Mauriceau-Smellie-Veit manoeuvres). Extension of the uterine incision following delivery of the body and/or the use of forceps, is occasionally required to release an entrapped fetal head. Avoidance of hyperextension of the neck and undue pressure on the thorax/abdomen are similarly recommended for safe caesarean breech birth. (RCOG, 2017)

13.0 Follow up for baby

Babies known to have been in the breech position after 36 weeks or born breech should be offered an ultrasound examination of the hips at around 6 weeks of age to exclude developmental dysplasia of the hips. This will be organised as part of the NIPE process.

14.0 Physiological breech birth

Physiological breech birth describes an approach to vaginal breech centred on the optimisation and restoration of the normal physiological process. Intervention, if required, is performed in response to specific clinical indications, which are themselves based on evidence of what is considered 'normal' breech birth physiology.

Where a midwife/obstetrician considers themselves competent and trained to support breech birth in active positions (upright and on all fours for example) then they can work in partnership with the pregnant woman or birthing person to help them achieve this. The professional must act within their scope of competence and in line with their professional standards and sphere of practice (NMC/GMC). See [Appendix 1](#) for the physiological breech birth algorithm (Walker et al, 2016).

A delay of 90 seconds or more at any stage following birth of the fetal pelvis is likely to require intervention. Thus, a more cautious approach is required in supporting vaginal breech birth using physiological principles than is recommended by RCOG guidelines, which suggests intervention either where 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.

15.0 Training

Details of staff training for vaginal breech birth are contained within Maternity Education Strategy UHSC072.

Monitoring the effectiveness of this guideline

Issue being monitored	Monitoring method	Responsibility	Frequency	Reviewed by and actions arising followed up by
Breech Birth	Case review	Patient Safety Team	As indicated by DATIX	Clinical Governance Lead

Guideline Version Control Log

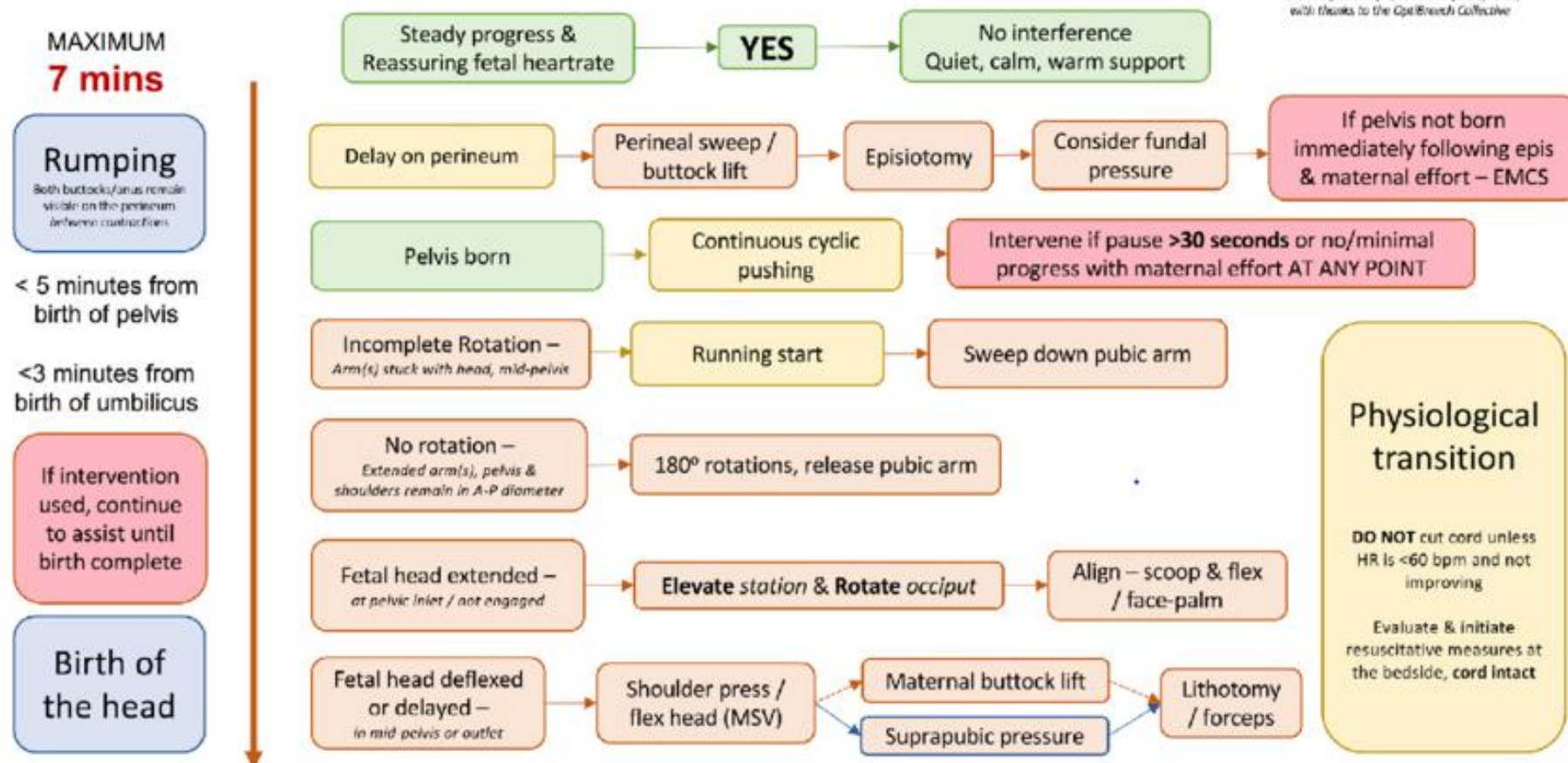
Change Log – Breech Management

Version	Date	Author(s)	Reason for change
1.0	June 2011	Consultant Obstetrician	New Trust guideline
2.0	August 2013	Consultant Obstetrician	Updated to include management of a vaginal breech birth
3.0	December 2017	Consultant Obstetrician	RCOG update and 3 yearly consultant review.
4.0	January 2018	Consultant Obstetrician	Addition of Breech Proforma, discussion list and patient records sticker.
5.0	October 2020	Ahmed Sanad, Obstetric Trainee	Updated with NICE guidance and review of evidence.
6.0	February 2024	Ahmed Elgarhy, Obstetric Consultant	Addition of factors of success of ECV and alternatives/adjuncts to ECV. Caesarean section for breech and physiological breech. Proformas & stickers removed as now documented on MIS.

Appendix 1: Physiological breech birth algorithm

Physiological Breech Birth Algorithm

by Shawn Walker RM PhD

Adopted June 2022 from original, published in
Reitter A, Halliday A, Walker S (2020), Birth
with thanks to the Optibreech Collective

Due Regard Assessment Tool

To be completed and attached to any guideline when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	Does the document/guidance affect one group less or more favourably than another on the basis of:		
	Age	No	
	· Disability	No	
	· Gender (Sex)	No	
	· Gender Identity	No	
	· Marriage and civil partnership	No	
	· Pregnancy and maternity	No	
	· Race (ethnicity, nationality, colour)	No	
	· Religion or Belief	No	
	· Sexual orientation, including lesbian, gay and bisexual people	No	
2.	Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?	No	
3.	If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	NA	
4.	Is the impact of the document likely to be negative?	No	
5.	If so, can the impact be avoided?	NA	
6.	What alternative is there to achieving the intent of the document without the impact?	NA	
7.	Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the guideline should continue in its current form?	NA	
8.	Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA principles (fairness, respect, equality, dignity and autonomy)?	Yes	

If you have identified a potential discriminatory impact of this guideline, please refer it to [Insert Name], together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact uhsussex.equality@nhs.net 01273 664685).

Template Dissemination, Implementation and Access Plan

To be completed and attached to any guideline when submitted to Corporate Governance for consideration and TMB approval.

	Dissemination Plan	Comments
1.	Identify:	
	Which members of staff or staff groups will be affected by this guideline?	Midwives and obstetricians
	How will you confirm that they have received the guideline and understood its implications?	Dissemination through the usual Communication channels and highlighted at Safety Huddles.
	How have you linked the dissemination of the guideline with induction training, continuous professional development and clinical supervision as appropriate?	All new members of staff shown where to access Clinical documents that are relevant to their area of practice.
2.	How and where will staff access the document (at operational level)?	Accessed by staff via Sharepoint

		Yes/No	Comments
3.	Have you made any plans to remove old versions of the guideline or related documents from circulation?	Yes	Previous versions will be archived as part of the uploading to SharePoint process.
4.	Have you ensured staff are aware the document is logged on the organisation's register?	Yes	Dissemination plan includes notifying staff via email, safety noticeboards, departmental newsletter and social media.

Additional guidance and information

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Grady K, Howell C, Cox C, (2009) Managing Obstetric Emergencies and Trauma, the MOET Course Manual

Green P M, Walkinshaw S. (2002) Management of breech deliveries. The Obstetrician and Gynaecologist. The Journal For Continuing Professional Development From The Royal College Of Obstetricians & Gynaecologists. 4:(2).

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Walker, S., Scamell, M., Parker, P. (2016) Standards for maternity care professionals attending planned upright breech births. Midwifery. 34:7-14.