Breech Presentation at Term and External Cephalic Version

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Guideline to be followed by (target staff): For use with all pregnant women during the antenatal period.

To be read in conjunction with the following documents:
- Multiple Pregnancy and Birth Guideline

Are there any eCARE implications?

CQC Fundamental standards:
Regulation 9 – person centered care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

The aim of this guideline is to aid decision making regarding the route of delivery and choice of various techniques used during delivery for women presenting with a breech baby. This is based on the Royal College of Obstetricians and Gynaecologists Green-top Guideline No. 20a.

Executive Summary

In breech presentation the fetus lies with it's buttocks in the lower pole of the uterus.

The incidence of breech presentation decreases from about 20% at 28 weeks of gestation to 3–4% at term.

Persistent breech presentation may be associated with abnormalities of the baby, the amniotic fluid volume, uterus and the placental localisation such as cornual placenta position, short umbilical cord.

All staff require regular training on identification and management of breech presentation including external cephalic version

Guidelines for the management of breech presentation must be made available to, and discussed with, all maternity staff as part of their routine training, continuing professional development and practice

1.0 Roles and Responsibilities:

- Doctors – decision making, discussion, planning and providing care.
- Midwives – decision making, antenatal care.

2.0 Implementation and dissemination of document

This guideline is available on the Trust intranet and has followed the full guideline review process prior to publication.

3.0 Processes and procedures

3.1 When breech presentation is diagnosed antenatally

There are 3 potential management options:

- External Cephalic Version (ECV)
- Elective Caesarean Section
- Vaginal Breech delivery

3.2 ECV

External cephalic version (ECV) is the manipulation of the fetus, through the maternal abdomen, to a cephalic presentation and should be offered as the first option to all women carrying a singleton breech baby, where absolute contraindications for the ECV have been ruled out.

ECV reduces the caesarean section rate by lowering the incidence of breech presentation. (RR 0.55,95% CI 0.33–0.91, risk difference 17%, NNT 6)

Success rate varies from 30% up to 80% in different studies. Average success rate is quoted as between 40% for primigravidas to 60% for multiparous women.

Race, parity, uterine tone, liquor volume, engagement of the breech and whether the head is palpable, and the use of tocolysis, all affect the success rate. The highest success rates are seen with multiparous, non-white women with a relaxed uterus, where the breech is not engaged and the head is easily palpable.

3.2.1 When should ECV be offered?

ECV should be offered to all women with an uncomplicated breech presentation from 36 weeks in in any parity.

There is no upper time limit on the appropriate gestation for ECV but the later it is done the less likely it is to be successful.

ECV has a very low complication rate.

3.2.2 The following are considered to be contraindications to ECV

Absolute

- When caesarean delivery is required
- Multiple pregnancy (except delivery of 2nd twin)
- Antepartum haemorrhage within seven days
- Placenta praevia
- Major uterine abnormality
- Abnormal cardiotocography

Relative

- Small for gestational age fetus with abnormal fetal dopplers
- Major fetal anomalies
- Oligohydramnios
- Scarred uterus
- (Rh) Isoimmunisation

3.3 Potential complications of ECV

- Placental abruption
- Uterine rupture
- Feto-maternal haemorrhage
- Fetal bradycardia and a nonreactive cardiotocograph

3.4 Procedure

- ECV is booked through the ADAU Co-ordinator.
- ECV is performed by a trained Obstetrician on Labour Ward/ ADAU after counselling on the procedure, success rate, risks, benefits and complications.
- A written consent should be taken.
- A CTG should be undertaken prior to ECV – CTG should be normal for ECV to proceed
- All women must have an ultrasound prior to ECV to record liquor volume, position of fetal head and back and placental site in the notes.
- ECV is a relatively safe procedure, however; isolated cases of placental abruption and uterine rupture have been reported. Transient fetal Bradycardia is a common occurrence during the procedure.
- Fasting is not required before ECV.
- Consider the use of tocolysis as this has been shown to improve the success rate. Terbutaline 0.25 mg SC can be used as a tocolytic.
- ECV is attempted for no more than 3 times or no more than 2 minutes with a regular check on the fetal heart throughout the procedure.
- ECV can occasionally be a painful procedure. If the woman is in considerable discomfort or in pain during the procedure, then it is advised to stop the procedure.
- At the end of the procedure the presentation is checked by ultrasound and a cardiotocograph using Dawes Redman Criteria is performed.

After a successful ECV, women can go home if CTG meets Dawes Redman criteria and continue their care with the original care provider.

If CTG does not meet Dawes Redman criteria, woman should be reviewed as per Fetal Monitoring Guideline and consider admission.

If ECV is unsuccessful, arrange a date for elective caesarean section if she wishes or arrange a clinic appointment with a consultant if further discussion on mode of birth is necessary.

Rh negative women should have anti D administered. Kleihauer testing is unnecessary.

All women should be made aware that they should return to Labour Ward if they experience abdominal pain, reduction in fetal movements, vaginal bleeding and onset of labour.

3.5 Elective caesarean section

Elective Caesarean section appears to be associated with reduced early neonatal morbidity and perinatal mortality compared to vaginal breech delivery.

However, there is no evidence that the longterm health of babies with a breech presentation delivered at term is influenced by how the baby is born.

Elective Caesarean Section should be booked at 39+ week gestation.

An ultrasound should be carried out on the day of caesarean section to confirm presentation. If fetus has turned to cephalic presentation vaginal delivery should be offered.

3.6 Vaginal Breech Delivery

Women should be assessed carefully before selection for vaginal birth.

IOL with breech presentation should not be offered

3.6.1 Factors unfavourable for vaginal breech delivery

- Other contraindications to vaginal birth (e.g. Placenta praevia, compromised fetal condition)
- Clinically inadequate pelvis
- Large baby on ultrasound (usually defined as larger than 3800 g)
- Growth restricted baby (usually defined smaller than 2000 g)
- Hyperextended fetal neck in labour (diagnosed with ultrasound)
- Previous caesarean section
- Footling breech presentation

If the mother wishes to consider a trial of vaginal breech delivery, an assessment of fetal size should be made by ultrasound at term.

The decision regarding mode of birth must be made following discussion between the expectant mother and relevant Consultant. Discussions and decision should be clearly recorded in the antenatal records.

An ultrasound should be carried out on admission to confirm presentation.

3.6.2 Undiagnosed breech presentation in labour

- Up to one third of breech presentations can be undiagnosed until in labour
- The Obstetric Registrar must attend as soon as practical
- Review current and previous pregnancy histories to identify potential risk factors. Clinically assess the size of the baby. Confirm presentation by ultrasound scan whenever possible.
- The woman must be given appropriate information and counselled to enable her to make an informed choice between vaginal birth or emergency caesarean.
- Mode of birth for any woman with an undiagnosed breech must be discussed with the on-call Consultant. A consultant must attend if the registrar is not experienced to deliver breech vaginally.
- **All discussions and decisions must be recorded in the maternal records.**

3.6.3 When vaginal birth is anticipated

- The Registrar must ensure that a clear plan of action is documented and then inform Consultant on-call
- Consider IV access
- Consider commencing antacid prophylaxis
- Commence continuous fetal monitoring (see fetal monitoring guideline)
- Perform VE after SROM to exclude cord prolapse
- Remember that fresh meconium in the first stage of labour must be regarded to have the same significance as with cephalic presentation
- Progress in labour should be as expected for parity
- Upright maternal positon aids descent
- Fetal blood sampling from the buttocks during labour is not advised
- FSE (attached to buttock) can be used if fetal heart cannot be effectively monitored abdominally.
- Epidural should be considered.
- Diagnose and respond to slow progress or failure to progress in labour
- Emergency caesarean section should be considered if there is poor progress in 1st stage and 2nd stage of labour
- Labour augmentation is not recommended
- Episiotomy should be performed if indicated to facilitate the birth
- Breech Extraction is an option in the birth of the second twin with breech presentation but only by an experienced Obstetrician

3.6.4 Second stage

- Hands off the breech unless timings indicate intervention
- Obstetric Registrar must be called to attend, and on call Consultant if needed
- Full dilatation must be confirmed by vaginal examination
- Discourage pushing until breech is visible on the perineum
- Paediatric SHO to be present in the room during birth
- Paediatric Registrar and Anaesthetist should be aware of imminent birth
- Mother in upright, all fours or lithotomy position
- The bladder should be emptied
- No traction to be applied to the breech.
- The breech, legs and abdomen should deliver spontaneously. Rotation of the shoulders may be required by Lovset manoeuvre (rotation of the baby to facilitate delivery of the arms) only if expected timings of delivery of 2 minutes from buttocks to shoulders has been extended.
- Suprapubic pressure by an assistant could be used if required to assist flexion of the head.
- Delivery of the head must be controlled and may need to be delivered with either the Piper's Forceps or NB Forceps or the Mariceau-Smeille –Veit /Burns –Marshall maneuvers

3.7 Management of the preterm breech and twin breech

- Routine caesarean section for the delivery of preterm breech presentation should not be advised.
- The mode of birth of the preterm breech presentation should be discussed with consultant on-call on an individual basis and with the woman and her partner.
- Where there is head entrapment during a preterm breech delivery, lateral incisions of the cervix should be considered.

3.8 Management of the twin breech

- If 1st twin is breech presentation the mode of delivery should be discussed and agreed between the woman and her consultant.
- Routine caesarean section is not indicated if 1st twin is cephalic presentation and 2nd twin is breech presentation.
- The presentation of 2nd twin at delivery is not always predictable. If 2nd twin is breech at 2nd stage external cephalic version if membrane is intact or vaginal breech delivery or internal podalic version if membrane has ruptured should be tried. Emergency caesarean section for 2nd twin should be considered if there is fetal distress or failed ECV or internal podalic version.

3.9 Rationale for main recommendations

To ensure that the correct advice and effective communication has been adopted by staff who are dealing with management of women known to have breech presentation.

4.0 Statement of evidence/references

References:

Impey L. and Pandit M. (2005) *Tocolysis for repeat external cephalic version in breech presentation at term: a randomized, doubleblinded, placebo-controlled trial* in BJOG. Volume 112 Issue 5 Page 627. May 2005.

The Management of Breech Presentation Guideline Royal College of Obstetricians and Gynaecologists Guideline 20b Dec 2006

External cephalic version and reducing the incidence of breech presentation Guideline Royal College of Obstetricians and Gynaecologists Guideline 20a 2010

5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
6	2018		
7	10/2021	**N. Singh/ Janice Styles**	**Complete review**

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Women's digital review group	Maternity	04/11/21			

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
• Mode of birth discussed in the patients notes • Percentage of planned vaginal birth that take place vaginally • Rate of birth trauma during breech delivery • Training programs for improving vaginal breech delivery skills • Proportion of women with breech offered ECV • Success rate of ECV Complications of/after ECV			Annually	

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women and children	Department	Maternity
Person completing the EqIA	Erica Puri	Contact No.	
Others involved:	Yes	Date of assessment:	
Existing policy/service	Yes	New policy/service	

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*For example: community midwives, phlebotomists, all staff*

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?
meeting
How are the changes/amendments to the policies/services communicated?
Email and meetings
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA	11/2024		

Appendix 1

External cephalic version Proforma

Surname:
Forename:
DOB:
Hospital No:
Or affix Patient Label

Complete at booking of ECV

Gestational age:	
Parity:	
Previous mode of delivery:	
BMI:	
Medical co-morbidities:	
Date of last scan:	
Placental site:	
Rhesus status:	
ECV patient info leaflet given:	

Complete on admission pre ECV

Gestational age:	
Presentation on bedside scan:	

	Yes	No
Consent:		
CTG:		
Terbutaline prescribed		

Post ECV:

	Yes	No
Anti D given if Rh negative:		
If successful, date for routine IOL requested electronically:		
If unsuccessful, date for c-section requested electronically:		
Consented for c-section:		
Advice TCI if reduced fetal movements or labour:		

Appendix 2

Undiagnosed Vaginal Breech Proforma

Patients name: ……MRN: …… Drill: Yes ☐ No ☐

Assigned Midwife…….....Date and time of diagnosis:……..

Cervical dilatation at diagnosis……Presentation: Extended ☐ Complete ☐ Footling ☐

Mode of delivery discussed ☐ Consented to: Vaginal breech ☐ LSCS ☐

Called for help	Name	Time called	Time arrived
Senior Midwife			
Registrar			
SHO			
Anaesthetist			
ODP			
Paediatrician			
Consultant Obstetrician			
Scribe			
Others (Please list)			

Management of Vaginal Breech delivery	Yes	Performed by	Time performed
Time fully dilated			
Time buttocks visible			
Fetal back anterior			
Episiotomy required			
Spontaneous delivery of the legs			
Legs delivered by flexion and abduction			
Spontaneous delivery of the arms			
Lovsetts Manoeuvre			
Nuchal arms			
Spontaneous delivery of the head			
Mauriceau-Smellie-Veit Manoeuvre			

Time of delivery…… Maternal position for vaginal delivery: Lithotomy ☐ All fours ☐ Other ☐

Neonatal condition

Resuscitation required: Yes ☐ No ☐ Birth injury noted at delivery: Yes ☐ No ☐

Weight:…….g Admitted to NNU: Yes ☐ No ☐

Apgar: 1 minute…… Apgar: 5 minutes…….. Apgar: 10 minutes……

Cord pH: Arterial pH…….. BE…….. Venous pH…… BE……

Datix form completed by:……..Radar number…….. Document and Debrief: Yes☐ No ☐