Mid Essex Hospital Services NHS
NHS Trust

MANAGEMENT OF BREECH BIRTH	CLINICAL GUIDELINES Register No: 04269 Status: Public

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Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records 09079 Management of Normal Labour and Prolonged Labour in Low risk Patients 04280 External cephalic version (ECV) 04254 Management of Multiple Pregnancy 09044 Roles and responsibilities of staff when arranging an elective caesarean section 04264 Management of emergency lower segment caesarean section 07045 Management of episiotomy

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1.0	Karen Bartholomew	November 2002
2.0	Ron Kempster	February 2006
3.0	Dr Geeta	June 2008
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6.0	Sarah Moon	16 October 2017
6.1	Anita Dutta - Removal of point 6.21 referring to Burns-Marshall Method	10th October 2018

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1.0 Purpose

1.1 This guideline is aimed at all health care professionals working in the acute hospital setting who share in the provision of antenatal, intrapartum and postpartum care, including obstetricians, anaesthetists, paediatricians and neo-natal staff, midwives and trainees in the above professions.

1.2 This guideline is intended to assist professionals in providing timely evidence based practice, ensuring optimum care and outcome for mother and baby.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Background

3.1 The incidence of breech presentation decreases from about 20% at 28 weeks of gestation to 3–4% at term, as most babies turn spontaneously to the cephalic presentation. Persistent breech presentation may be associated with abnormalities of the baby, the amniotic fluid volume, the placental localization or the uterus. There is higher perinatal mortality and morbidity with breech than cephalic presentation, due principally to prematurity, congenital malformations and birth asphyxia or trauma.

3.2 The Royal College of Obstetricians and Gynaecologists recommend planned caesarean section is better than planned vaginal birth for the term fetus in the breech presentation. Perinatal mortality, neonatal mortality and serious neonatal morbidity are significantly lower where planned caesarean section is undertaken.

4.0 Antenatal Management

4.1 Patients should be offered the options for an ECV, vaginal breech delivery and/or caesarean section.

4.2 Women with a breech presentation at term 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 delivery.

4.3 Women who have a breech presentation at term following an unsuccessful or declined offer of ECV should be counselled on the risks and benefits of planning a vaginal breech delivery versus planning a caesarean section.

4.4 Patients should be informed of the benefits and risks, both for the current and for future pregnancies of planned caesarean section versus planned vaginal delivery for breech presentation at term.

4.5 Patients should be informed that planned caesarean section carries a reduced perinatal mortality and early neonatal morbidity for babies with a breech presentation at term compared with planned vaginal birth.

4.6 Women should be informed that when planning delivery for a breech baby, the risk of perinatal mortality is approximately 1.0/2000 with caesarean section after 39+0 weeks of

gestation; and approximately 2.0/1000 with planned vaginal breech birth. This compares to approximately 1.0/1000 with planned cephalic birth.

4.7 Patients should be advised that planned caesarean section for breech presentation does not carry any additional risk to long-term health outside pregnancy.

4.8 Women should be informed that maternal complications are least with successful vaginal birth; planned caesarean section carries a higher risk, but the risk is highest with emergency caesarean section which is needed in approximately 40% of women planning a vaginal breech birth.

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

4.10 Clinicians should counsel women in an unbiased way that ensures a proper understanding of the absolute as well as relative risks of their different options.

4.11 Following the diagnosis of persistent breech presentation, women should be assessed for risk factors for a poorer outcome in planned vaginal breech birth. If any risk factor is identified, women should be counselled that planned vaginal birth is likely to be associated with increased perinatal risk and that delivery by caesarean section is recommended.

4.12 External Cephalic Version
(Refer to the guideline for external cephalic version (ECV); register number 04280)

- Offered from 36 weeks for nulliparous and from 37 weeks for multiparous
- Patients should be counselled that ECV reduced breech presentation at term and lowers the chances of having caesarean section
- Overall success rate of ECV is 50% (40% for Primigravidae and 60% for multigravidae)

4.13 Factors regarded as unfavorable for vaginal breech birth include the following:

- Other contraindications to vaginal birth (i.e. placenta praevia, compromised fetal condition)
- Clinically inadequate pelvis
- Footling or kneeling breech presentation
- High estimated fetal weight (more than 3800 grammes)
- Low estimated weight (less than 10^{th} centile)
- Hyper-extended fetal neck on ultrasound
- Evidence of antenatal fetal compromise
- Previous caesarean section

4.14 The role of pelvimetry is unclear and does not form part of the investigation process.

4.15 The presence of a skilled birth attendant is essential for safe vaginal breech birth.

4.16 Units with limited access to experienced personnel should inform women that vaginal breech birth is likely to be associated with greater risk and offer antenatal referral to a unit where skill levels and experience are greater.

5.0 Intrapartum Management for Planned Vaginal Breech Delivery

5.1 **First Stage** - offer ECV during early labour, if not offered before or for an antenatally undiagnosed breech.

5.2 Where a woman presents with an unplanned vaginal breech 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.

5.3 Labour induction for breech presentation may be considered if individual circumstances are favourable but must be reviewed by the obstetric consultant on call and ultimately would be a 'case based' consultant decision.

5.4 Women should be informed that induction of labour is not usually recommended. Augmentation of slow progress with oxytocin should only be considered if the contraction frequency is low in the presence of epidural analgesia. If indicated, discuss with obstetric consultant on call.

5.5 Ensure all professionals are informed i.e. obstetric registrar, who should inform the duty on-call obstetric consultant, the paediatrician, the neonatal unit and the anaesthetist.

5.6 The patient should be resident in the 'high risk' room on Delivery Suite in case of possible emergencies.

5.7 All breech labours should be treated as a trial of labour having a higher incidence of needing an emergency caesarean section. An intravenous cannula should be sited and blood taken for group and save.

5.8 There is a higher risk of cord prolapse in breech presentation. Membranes should be left intact for as long as possible.

5.9 Women 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.Epidural analgesia should not be routinely advised; patient should have a choice of analgesia during breech labour and birth.

5.10 Women should be informed that while evidence is lacking, continuous electronic fetal monitoring may lead to improved neonatal outcomes. Continuous electronic fetal heart rate monitoring should be offered to patient with a breech presentation in labour. Vaginal examinations should be performed 4 hourly or more frequently if indicated.

5.11 Fetal blood sampling from the buttocks during labour is not advised.

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

5.13 Caesarean section should be considered if there is delay in the descent of the breech at any stage in the second stage of labour.

5.14 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.

5.15 Where time and circumstances permit, the position of the fetal neck and legs, and the fetal weight should be estimated using ultrasound, and the woman counselled as with planned vaginal breech birth.

6.0 Second Stage

6.1 Women near or in active second stage of labour should not be routinely offered caesarean section.

6.2 All maternity units must be able to provide skilled supervision for vaginal breech birth where a woman is admitted in advanced labour and protocols for this eventuality should be developed

6.3 Delivery should be conducted by an experienced obstetrician or midwife under the direct supervision from the obstetric registrar and/or consultant on call. Birth in a hospital with facilities for immediate caesarean section should be recommended with planned vaginal breech birth, but birth in an operating theatre is not routinely recommended.

6.4 Women should be informed that adherence to local guidance for management of breech reduces the chances of early neonatal morbidity.

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

6.6 The patient and her partner should be prepared for vaginal breech birth and for the presence of a paediatrician, anaesthetist and obstetric registrar. The Neonatal Unit is warned of the imminent delivery.

6.7 Either a semi-recumbent 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 semi-recumbent position may become necessary.

6.8 The bladder should be emptied and sterile drapes used.

6.9 Episiotomy is justified.
(Refer to the guideline for ‘Management of episiotomy’; register number 07045)

6.10 **“Hands Off”** - the breech should then be allowed to descend as the mother pushes with her contractions. The buttocks will continue to deliver by gravity and with maternal effort.

6.11 The legs should deliver themselves unless an extended breech in which groin traction may be required. (In selective cases, clinician should place a finger in the popliteal fossa and gently flex the knee, thus bringing the legs down).

6.12 As the baby emerges, a warm towel should be wrapped around the body.

6.13 Unless the umbilical cord appears taut and stretched, there is no need to pull it down.

6.14 Keep fetal back to anterior. Do not twist or jerk the fetal body and allow the shoulders to enter pelvis by maternal push mostly. In some cases gentle traction at fetal pelvic girdle can be undertaken. The arms will usually be flexed across the chest.

(Refer to Appendix A for diagram to illustrate the second stage management for planned vaginal breech).

6.15 Flexed arms across fetal chest are delivered spontaneously with maternal push and gentle traction. Should the delivery of the shoulder get delayed as in extended arms or nuchal position of the fetal arms, this will require extra assistance / manoeuvre.

6.16 The extended or nuchal arms should be delivered by sweeping them across the baby's face and downwards or by the Lovset's manoeuvre (180 degree rotation of the baby to facilitate delivery of the arms).

6.17 Lovset's manoeuvre - Hold the baby by the hips and turn half a circle, keeping the back uppermost and applying downward traction at the same time, so that the arm that was posterior becomes anterior and can be delivered under the pubic arch.

6.18 Assist delivery of the arm by placing one or two fingers on the upper part of the arm. Draw the arm down over the chest as the elbow is flexed, with the hand sweeping over the face.

619 To deliver the second arm, turn the baby back half a circle, keeping the back uppermost and applying downward traction, and deliver the second arm in the same way under the pubic arch.(Refer to appendix B for diagram to illustrate Lovset's manoeuvre)

6.20 After coming Head - suprapubic pressure by an assistant should be used to assist flexion of the head. The Mauriceau-Smellie-Veit manoeuvre should be considered. The baby's body is straddled across the clinician's left forearm with the palm supporting the baby's chest then put the index and ring fingers over the baby's malar bones of the face. Two fingers of the other hand presses over the occiput to flex the head. Raise the baby, still astride the arm, until the mouth and nose are free. (Refer to appendix C for diagram to illustrate the Mauriceau Smellie Veit manœuvre)

6.21 Following delivery of the baby and handing over to the paediatrician, syntometrine 1 millilitre (ml) intramuscularly (as per protocol) is given. The third stage and placental delivery is as usual. Episiotomy should be sutured immediately as indicated. (Refer to the guideline for 'Normal labour and prolonged labour for low risk patients'; register number 09079)

6.22 Assistance, without traction, is required if there is delay or evidence of poor fetal condition.

7.0 Problems with Delivering Breech

7.1 Nuchal or extended arms – Follow Lovset's manoeuvre or go for delivery of posterior shoulder.

7.2 Aftercoming head – follow Mauriceau Smellie Veit manœuvre. Piper's forceps for aftercoming head (if not delivered by the above method). If conservative methods fail, symphysiotomy or caesarean section should be performed for entrapped head.

8.0 Management of the Preterm Breech and Twin Breech

8.1 Women should be informed that routine caesarean section for breech presentation in spontaneous preterm labour is not recommended. The 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.

8.2 Women should be informed that caesarean section for breech presentation in spontaneous preterm labour at the threshold of viability (22–25+6 weeks of gestation) is not routinely recommended.

8.3 Women should be informed that planned caesarean section is recommended for preterm breech presentation where delivery is planned due to maternal and/or fetal compromise.

8.4 The mode of delivery of the preterm breech presentation should be discussed on an individual basis with the patient and her partner.

8.5 Labour with a preterm breech should be managed as with a term breech

8.6 Where there is head entrapment, incisions in the cervix (vaginal birth) or vertical uterine incision extension (caesarean section) may be used, with or without tocolysis.

9.0 Management of the Twin Pregnancy with a Breech Presentation

9.1 Women should be informed that the evidence is limited, but that planned caesarean section for a twin pregnancy where the presenting twin is breech is recommended.

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

9.3 Routine caesarean section for breech presentation of the second twin is not recommended in either term or preterm deliveries.

9.4 If the lie of the second twin is oblique or transverse then external cephalic version can be considered. If the breech is a longitudinal lie, do not attempt version. If a breech presentation is diagnosed (for the second twin) then deliver as described above.
(Refer to the ‘Management of multiple pregnancy’; registration number: 04254)

9.5 Internal Podalic Version should be performed by a skilled obstetrician, which is followed by breech extraction.
(Refer to the ‘Management of multiple pregnancy’; registration number: 04254)

10.0 Staff and Training

10.1 All midwifery and obstetric staff must attend yearly Mandatory training which includes skills and drills training, to include breech delivery
(Refer to ‘Mandatory training policy for Maternity Services (incorporating training needs analysis. Register number 09062)

10.2 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.

10.3 Simulation equipment should be used to rehearse the skills that are needed during vaginal breech birth by all doctors and midwives.

10.4 Guidance for the case selection and management of vaginal breech birth should be developed in each department by the healthcare professionals who supervise such births. Adherence to the guidelines is recommended to reduce the risk of intrapartum complications.

10.5 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

11.0 Infection Prevention

11.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

11.2 All staff should ensure that they follow Trust guidelines on infection prevention. All invasive devices must be inserted and cared for using High Impact Intervention guidelines to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

12.0 Professional Midwifery Advocates

12.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

13.0 Audit and Monitoring

13.1 The risk management lead will review all risk event forms and complaints. Any immediate training or educational issues relating to lack of compliance with this guideline will be addressed on a one to one basis.

13.2 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

13.3 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

13.4 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

13.5 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

13.6 Key findings and learning points will be disseminated to relevant staff.

14.0 Guideline Management

14.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

14.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

14.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

14.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

15.0 Communication

15.1 A quarterly 'Maternity Newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

15.2 Approved guidelines will be disseminated to appropriate staff quarterly via email.

15.3 Regular memos are posted on the 'Risk Management' notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

16.0 References

Royal College of Obstetricians and Gynaecologists (2017) Management of breech presentation. RCOG Guideline No. 20b March.

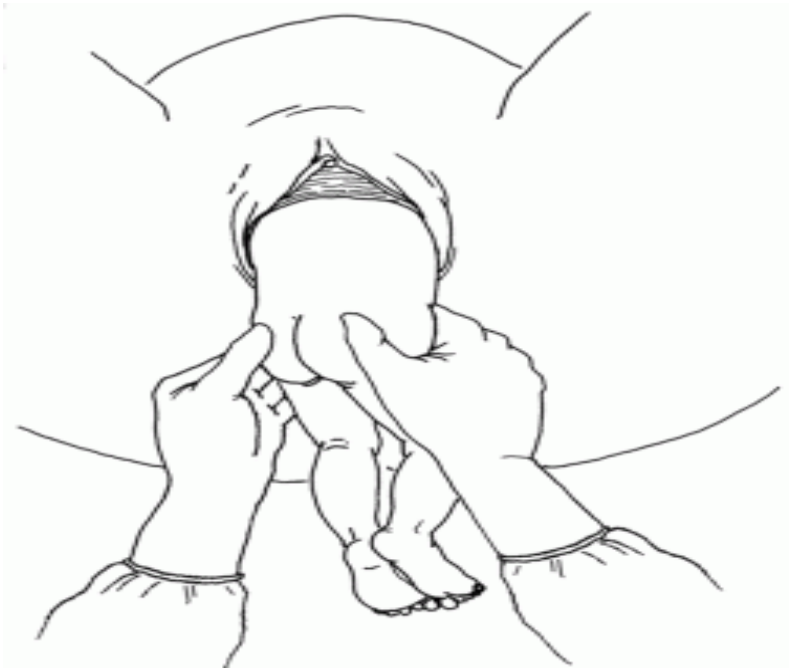
Glezerman M. (2006) Five years to the term breech trial: the rise and fall of a randomized controlled trial. British Journal of Obstetrics and Gynaecoogy. vol:194; pp20–25.
Confidential Enquiry into Stillbirths and Deaths in Infancy. (2000) *7th Annual Report*. London: Maternal and Child Health Research Consortium. [www.cemach.org.uk/publications/7th_Report.pdf].

Su M; Hannah W J; Willan A; Ross S; Hannah M E. (2004) Term Breech Trial Collaborative Group. Planned caesarean section decreases the risk of adverse perinatal outcome due to both labour and delivery complications in the Term Breech Trial. British Journal of Obstetrics and Gynaecology; vol:111; pp1065–74.

Appendix A

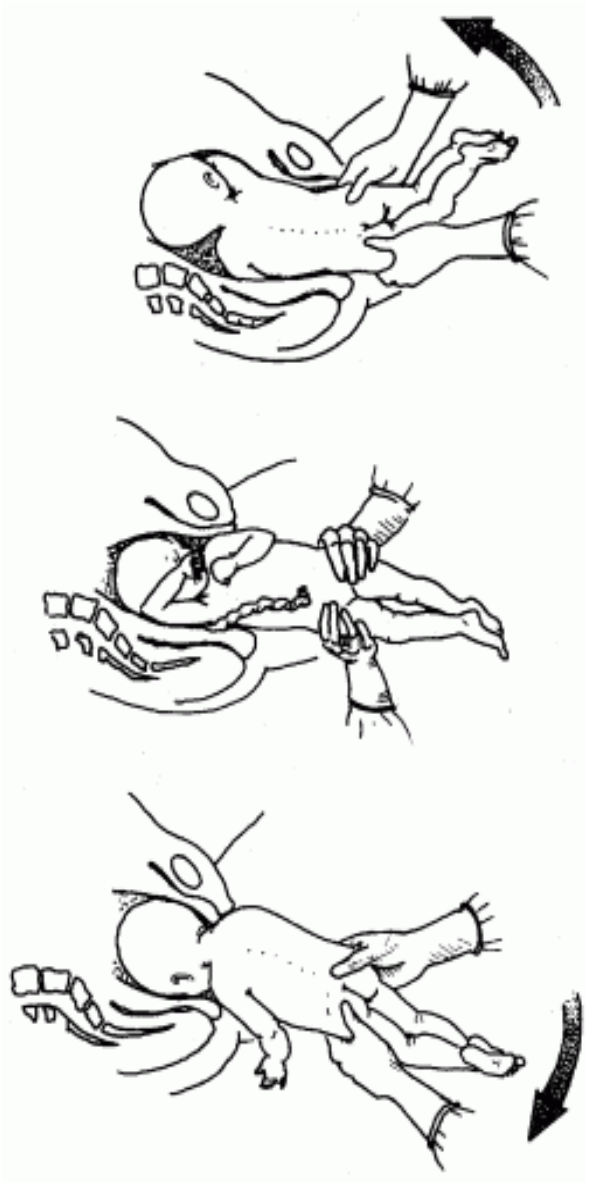
Diagram to illustrate the second stage management for planned vaginal breech

Hold the baby at the hips, but do not pull



Appendix B

Diagram to illustrate lovset's manoeuvre



Appendix C

Diagram to illustrate the Mauriceau Smellie Veit manoeuvre