Sultanate of Oman
Ministry of Health
The Royal Hospital
Department of Obstetrics and Gynecology

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Title: Breech Presentation in Pregnancy and Delivery

1.0 Introduction

Breech presentation occurs in 3–4% of term deliveries and is more common preterm. It is associated with uterine and congenital abnormalities, has a significant recurrence risk and is more common in nulliparous women.

Lack of experience has led to a loss of skills essential for these deliveries. Conversely, caesarean section can have serious long-term consequences

2.0 Breech presentation at term

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.

3.0 External Cephalic Version (ECV)

3.1 Timing -

- ECV should be offered at term from 37+0 weeks of gestation.
- In nulliparous women, ECV may be offered from 36+0 weeks of gestation
- There is limited evidence to guide the number of attempts at ECV. No more than four attempts are advised, for a maximum of 10 minutes overall. (RANZCOG)

3.2 Contraindications -

- There is limited evidence concerning contraindications for ECV. Only placental abruption, severe pre-eclampsia, and abnormal foetal doppler or cardiotocography (CTG) are supported by any evidence.
- ECV is contraindicated where an absolute reason for Caesarean Section already exists (e.g. placenta praevia major).
- Other contraindications include -
- multiple pregnancy (except after delivery of a first twin),
- where there is rhesus isoimmunisation,
- current or recent (less than 1 week) vaginal bleeding,
- rupture of the membranes
- where the mother declines the procedure.
- ECV should be performed with additional caution where there isoligohydramnios or hypertension

3.3 ECV with previous Caesarean Section

The role of ECV with a previous Caesarean Section has been controversial. The largest analysis concluded that ECV is safe and successful in women with one previous Caesarean delivery and appears to have no greater risk than with an unscarred uterus.

3.4 Counselling and procedure

- Women should be informed that the success rate of ECV is approximately 50%. Few babies revert to breech after successful ECV.
- A successful ECV reduces the chance of Caesarean Section.
- Women should be counselled that with appropriate precautions, ECV has a very low complication rate.
- ECV should be performed where facilities for monitoring and surgical delivery are available
- Following ECV a CTG is recommended
- Women undergoing ECV who are D negative should be offered anti-D.

4.0 Mode of Delivery for persistent Breech presentation

- Women who have a breech presentation at term following an unsuccessful ECV or those who have declined ECV should be counselled on the risks and benefits of planned vaginal breech delivery versus planned Caesarean Section.
- Selection of appropriate pregnancies and skilled intrapartum care may allow planned vaginal breech birth to be nearly as safe as planned vaginal cephalic birth
- A woman's choice of delivery mode should be respected, and written consent obtained
- The discussion and chosen plan should be well documented in the notesincluding risks that perinatal or neonatal mortality or short term serious morbidity may be higher than if a cesarean delivery is planned (ACOG)

4.1 Counselling

- Women should be informed that planned Caesarean Section leads to a small reduction inperinatal mortality compared with planned vaginal breech delivery.
- In appropriately selected women and with obstetricians skilled in vaginal breech birth, perinatal mortality is between 0.8 and 1.7/1000 for planned vaginal breech birth and between 0 and 0.8/1000 for planned Caesarean Section
- Regardless of planned mode of delivery, cerebral palsy occurs in approximately 1.5/1000 breech births, and any abnormal neurological development occurs in approximately 3/100
- They should be informed that planned vaginal breech birth increases the risk of low Apgar scores and short-term complications, but has not been shown to increase the risk of long-term morbidity.
- A planned Caesarian Section at terms carries a small increase in immediate complications for the mother compared with planned vaginal birth.
- An emergency Caesarean Section may be needed in approximately 40% of women planning a vaginal breech birth.
- Women should be counselled that Caesarean Section increases the risk of complications in future pregnancy including trial of vaginal birth after Caesarean Section, complications at repeat Caesarean Section and the risk of an abnormally invasive placenta.

5.0 Safety of vaginal breech delivery

5.1 Labour selection criteria

If any risk factor for a poorer outcome, in case of a planned vaginal breech birth, is identified, women should be counselled accordingly and delivery by Caesarean Section recommended.

5.2 Contraindications to planned vaginal breech birth

- Where there are independent indications for caesarean section

- 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.
- Foetal anomaly likely to interfere with vaginal delivery

6.0 Vaginal breech delivery

6.1 Planned vaginal breech birth

- During planned vaginal breech birth, a clinician experienced in vaginal breech birth should supervise the first stage of labour and be present for the active second stage of labour and delivery
- **The essential components of planned vaginal breech birth are appropriate case selection,management according to a strict protocol and the availability of skilled attendant**

6.2 Breech presentation in labour

- Where a woman presents with an unplanned Breech presentation 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.
- Upon admission in labour, ultrasound should be performed to confirm Breech presentation, assess type of breech, flexion of the foetal head, and foetal growth.
- Women near or in active second stage of labour need not be routinely offered Caesarean Section. Where labour is progressing rapidly, assessment should be made while balancing against the risks of a second stage Caesarean Section, especially if the breech is very low in the pelvis.

7. 0 Labour management

7.1 Induction and augmentation of labour

- Induction of labour is not usually recommended. However, although data are limited, induction of labour with breech presentation does not appear to be associated with poorer outcomes than spontaneous labour
- Oxytocin augmentation is only acceptable to correct weak uterine contractions in presence of epidural analgesia.
- Generally augmentation of labour should be avoided as adequate progress may be the best evidence for adequate fetopelvic proportions
- If progress in labour is poor despite adequate contractions, Caesarean Section is recommended

7.2 Foetal monitoring

- During planned vaginal breech birth, continuous electronic foetal monitoring is recommended in labour. When membranes rupture, immediate vaginal examination should be done to rule out a prolapsed cord.

7.3 **Second stage of labour**

- An obstetrician skilled in vaginal breech birth should be present during the active second stage and breech delivery–Senior Specialist level.
- Adequate descent of the breech in the passive second stage is a prerequisite for encouragement of the active second stage
- Effective maternal and uterine contractions are essential for safe delivery. When vaginal delivery is imminent, oxytocin infusion may be helpful to ensure adequate uterine contractions between delivery of the body and the head
- Foetal traction during vaginal breech birth should be avoided. Any foetal manipulation should only be applied after spontaneous delivery to the level of the umbilicus.

- Perform episiotomy when the breech is in the perineum, with care to protect the fetal part
- The foetal head may deliver spontaneously, with the assistance of suprapubic pressure, by Mauriceau-Smellie-Veit manoeuvre, or with the assistance of Piper forceps. It is recommended that an assistant be available to assist with any necessary procedures.

All obstetricians and midwives should be familiar with the techniques that can be used to assist vaginal breech birth. The choice of manoeuvres used, for assisted vaginal breech delivery depend on the individual experience or preference of the attending doctor.

8.0 **Management of the Preterm Breech**

- 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.
- Labour with a preterm breech should be managed as with a term breech.
- In case of head entrapment, incisions in the cervix may be used, with or without tocolysis
- Planned caesarean section is recommended for pretermbreech presentation where delivery is planned due to maternal and/or fetal compromise

9.0 Management of twin pregnancy with a Breech presentation

9.1 First twin in breech presentation

- The evidence is limited but planned Caesarean Section for a twin pregnancy where the presenting twin is breech is recommended.
- However, in case a woman with breech first twin, presents in spontaneous labour, the mode of delivery should be individualized based on cervical dilatation and findings.

9.2 Second twin in breech presentation

- Routine Caesarean Section for Breech presentation of the second twin is not recommended in either term or preterm deliveries.
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10.0 References

Management of Breech presentation – RCOG green top guideline 20b, 2017

Management of Breech presentation – BJOG, June 2017

Management of Breech presentation at term – SOGC clinical practice guideline Aug 2019

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