# Maternity: Management of Breech Presentation

**Document Registration Number:** HNELHD CG 13_01

## Sites where Clinical Guideline applies
All HNE Health Maternity Services

## This Clinical Guideline applies to:

1. **Adults**
   - Yes

2. **Children up to 16 years**
   - Yes. Potential for all maternity care guidelines to apply to girls under 16 years.

3. **Neonates – less than 29 days**
   - Yes - Approval gained from the Children Young People and Families Network on 27 February 2013

## Target audience
Providers of maternity and newborn care in HNE Health facilities. Includes: Obstetricians, GP Obstetricians, Paediatricians, Midwives, medical and midwifery students

## Description
This guideline is designed to provide evidence-based recommendations for management for breech presentation at term which should be individualised on a case by case basis.

## Keywords
Vaginal birth, breech presentation, external cephalic version (ECV), labour, maternity, malpresentation, term, prenatal

## Replaces Existing Guideline?
No

## Related Legislation, Australian Standards, NSW Health Policy or Circular, EQuIP Criterion, other HNE Health Documents, Professional Guidelines, Codes of Practice or Ethics:

## Position responsible for Clinical Guideline Governance
Dr Henry Murray, Women’s Health & Maternity Clinical Network Leader

## Clinical Guideline Contact Officer
Robin Skewes, CMC Area Maternity Services

## Contact Details
Robin.Skewes@hnehealth.nsw.gov.au
Ph: 6767 7318 or Mob: 0427 655 327

## Date authorised
19 March 2013

## Authorising body
Dr Henry Murray, Women’s Health & Maternity Clinical Network Leader

## This Clinical Guideline contains advice on therapeutics
No

## Issue Date
20 March 2013

## Date for review
20 March 2016

## TRIM number
13/54-1-2
GLOSSARY

<table>
<thead>
<tr>
<th>Acronym or Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACM</td>
<td>Australian College of Midwives</td>
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<tr>
<td>Breech presentation</td>
<td>The fetal part entering the pelvic inlet is buttocks and/or feet</td>
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<td>External cephalic version (ECV)</td>
<td>Turning a breech presentation by manipulation through the abdominal wall and uterus resulting in a cephalic presentation</td>
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<tr>
<td>CTG</td>
<td>Cardiotocograph</td>
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<tr>
<td>RCOG</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
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<tr>
<td>RANZCOG</td>
<td>Royal Australian &amp; New Zealand College of Obstetricians and Gynaecologists</td>
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GUIDELINE SUMMARY

This document establishes best practice for HNE Health. While not requiring mandatory compliance, staff must have sound reasons for not implementing standards or practices set out within the guideline, or for measuring consistent variance in practice.

Introduction

This clinical guideline will present HNE Health maternity care providers with an evidence-based approach for management of breech presentation at ≥ 36 weeks. The aim of the guideline is to provide:

- choice for women who have a breech presentation at ≥ 36 weeks
- appropriate offering of external cephalic version (ECV)
- a pathway for safe management when ECV unsuccessful
- a pathway for safe management of planned vaginal birth
- a pathway for management of unexpected breech presentation in labour

Situation – Risk Statement

The incidence of caesarean section for breech presentation has increased markedly in the last 12 years since the publication of the Term Breech Trial (TBT). Consequently, midwifery and obstetric expertise in management of vaginal breech birth has significantly diminished¹.
There has been extensive international critique of recommendations made from the TBT. There is now high level evidence that with the use of sound selection criteria and a cautious, consistent level of care for women choosing a vaginal birth for breech presentation at term, there is no difference in perinatal mortality or serious neonatal morbidity between a trial of labour and planned caesarean section. The main difference in outcomes is the lower 5 minute Apgar score in the trial of labour group.

**Risk Category:** Clinical Care & Patient Safety.

**Background**
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. It is more common where there has been a previous breech presentation.

ECV has become an important component of the prenatal management of breech presentation. RANZCOG, RCOG, NSW Health Policy Directive Towards Normal Birth in NSW (PD2010_045) and current best evidence all support ECV for breech presentation at term, providing there are no contraindications. The success rates for ECV are approximately 40% in nulliparous women and 60% in multiparae women. This procedure is known to lower the caesarean section rate.

**Assessment**
Breech presentation at term is ACM Category C and requires referral to a medical practitioner.

When a woman has been diagnosed in the antenatal period with having a breech presentation ≥36 weeks, confirmation of presentation by obstetric ultrasound should be performed and the presence of fetal congenital anomaly excluded.

**Recommendations**
1. Women with breech presentation at term need to be given consistent, evidence-based information to be able to make an informed choice regarding management options, including access to ECV, vaginal breech birth or planned caesarean section.
2. Provide option of access to ECV and planned vaginal breech birth in facilities where there is appropriate expertise when not available locally.

**MANAGEMENT GUIDELINE**

**Selection criteria**
1. For a woman with suspected breech presentation, it is recommended that pre-labour or early labour ultrasound should be performed to assess type of breech presentation, fetal growth and estimated weight, and attitude of fetal head.
2. Contraindications to labour include:
   a. Cord presentation
   b. Evidence of placental insufficiency, including fetal growth restriction or any abnormal fetal welfare studies, including CTG
   c. Any presentation other than a frank or complete breech with a flexed or neutral head attitude
   d. Fetal anomaly incompatible with vaginal delivery
   e. Obstetric or medical complications likely to be associated with mechanical difficulties at birth
3. Reported estimated fetal weight (EFW) via ultrasound should be considered in conjunction with clinical assessment of fetal size. Vaginal breech birth may be offered when the EFW is between 2500-3800gms.
### Setting and Consent

1. In the absence of a contraindication to vaginal birth, a woman with a breech presentation should be informed of the risks and benefits of a trial of labour and elective caesarean section, and informed consent should be obtained. A woman's mode of birth choice should be supported.

2. The consent discussion and chosen plan should be well documented and communicated to maternity staff.

3. Women with a contraindication to a trial of labour should be advised to have a caesarean section. Women choosing to labour despite this recommendation have a right to do so and should not be abandoned. They should be provided the best possible in-hospital care.

### Labour management

1. Induction of labour is not recommended for breech presentation.

2. Radiologic pelvimetry is not necessary for a safe trial of labour. Good progress in labour is the best indicator of adequate fetal-pelvic proportions.

3. Oxytocin augmentation is acceptable in the presence of uterine dystocia, but should be used with caution as good labour progress is the best indicator of adequate fetal-pelvic proportions.

4. Continuous electronic fetal heart monitoring is recommended in labour. This can be interrupted for short periods of up to 15 minutes in the first stage when all is normal.

5. When membranes rupture, immediate vaginal examination is recommended to rule out prolapsed cord.

6. A passive second stage without active pushing may last up to 90 minutes, allowing the breech to descend well into the pelvis. Once active pushing commences, if the birth is not imminent after 60 minutes, caesarean section is recommended.

7. The active second stage of labour should take place in or near an operating room with equipment and personnel available to perform a timely caesarean section if necessary.

8. A person trained in advanced neonatal resuscitation must be in attendance at the birth.

### Birth technique

1. All maternity care providers should complete the mandatory maternity emergency/neonatal resuscitation program as part of FONT training once every three years, which has a theoretical and 'hands-on' breech birth training component.

2. The maternity care provider for a planned vaginal breech birth needs to possess the requisite skills and experience and an obstetrician should be present to supervise anyone in training.

3. An emergency caesarean section should be able to be performed within an approximate 30-minute timeframe.

4. Effective maternal pushing effort is essential to safe birth and should be encouraged.

5. Fetal traction should be avoided.

6. It is advisable that women are encouraged and supported in the use of upright positions in second stage e.g. upright kneeling, birth stool and all fours.

7. Spontaneous breech birth is preferable and assisted breech birth is acceptable. Total breech extraction is inappropriate for term, singleton breech birth.

8. The only clinical situation in which total breech extraction may be appropriate is for birth of a second twin.

9. Assisted breech birth may include the following manoeuvres:
   - Nuchal arms may be reduced by the Lovset manoeuvre.
   - At the time of birth of the after-coming head, an assistant should be present to apply suprapubic pressure to favour flexion and engagement of the fetal head if necessary.
   - The fetal head may birth spontaneously or with the assistance of suprapubic pressure and/or by use of the Mauriceau-Smellie-Veit manoeuvre.
   - Forceps may be applied to the after coming head in the appropriate clinical situation.
Undiagnosed breech presentation in labour

Undiagnosed breech presentation for the first time during labour should not be a contraindication for vaginal breech birth as vaginal birth may be preferable to caesarean section. In determining the preferred mode of birth an individualised approach is necessary and the following factors should be considered:

1. Expected time interval to birth.
2. Fetal wellbeing as determined by the CTG.
3. Type of breech presentation - this should be confirmed by ultrasound if available.
4. Risks associated with performing an emergency caesarean section include:
   - Anaesthetic considerations such as a non-fasted patient
   - Potential technical difficulties delivering the fetus at caesarean section if the breech is very low in the pelvis
5. Fetal risks of vaginal breech birth in this circumstance are potentially increased by:
   - Unavailability of appropriately skilled personnel
   - The possibility of undiagnosed congenital abnormalities
   - Undiagnosed hyper-extension of the fetal head

IMPLEMENTATION PLAN

1. List of new and revised Clinical Guidelines are posted on PPG Directory and listed in the CE News.
2. Staff education through mandatory education for all maternity care providers (FONT).
3. Emergency drills with documented attendance on an annual basis.

EVALUATION PLAN

1. The person or leadership team who has approved the clinical guideline is responsible for ensuring timely and effective review of the guideline.
2. Review will require a review of the most current evidence as well as a consideration of the experience of HNE Health staff in the implementation of the clinical guideline.
3. Data derived from monitoring and evaluation should inform the review of the clinical guideline either as required or as scheduled.

CONSULTATION WITH KEY STAKEHOLDERS

1. Mandy Hunter, CMC Maternity
2. Paula Richards, NUM Birthing Services Maitland
3. Janet Allen, Acting NUM Birthing Unit Maitland
4. Dr. Matthew Holland, O & G Fellow, John Hunter Hospital
5. Dr. Henry Murray, Clinical Leader, Women’s Health & Maternity Clinical Network
6. HNE Health visiting medical officers (VMOs) and staff specialists for maternity services
7. HNE Health midwives
8. Professor Trish Davidson, Clinical Leader, Children, Young People & Families Clinical Network
9. Consumer representatives
REFERENCES

5. NSW Health PD 2008_027 Maternity – Clinical Care and Resuscitation of Newborn Infants
6. Royal College of Obstetricians & Gynaecologists 2006 Guideline No. 20b Management of Breech Presentation

FEEDBACK

Any feedback on this document should be sent to the Contact Officer listed on the front page.