VAGINAL BREECH DELIVERY

INTRODUCTION
• The incidence of breech presentation decreases from approximately 20% at 28 weeks’ gestation to 3–4% at term when most babies will turn spontaneously to the cephalic presentation.

After discussion with woman, consultant obstetrician will decide mode of delivery. Document discussion and decision clearly in maternal healthcare record.

DEFINITION
• Presentation of fetal buttocks or feet in labour

ANTENATAL MANAGEMENT
• Unless contraindicated, offer external cephalic version (ECV) preferably at 36–38 weeks’ gestation

CONTRAINDICATIONS TO ECV
Absolute
• Lower segment caesarean section (LSCS) to be performed for another reason (e.g. placenta praevia)
• >2 previous LSCS
• Severe pre-eclampsia/eclampsia
• Severe oligohydramnios (ECV usually impossible)
• Mean liquor pool <3 cm

Relative
• Intrauterine growth restriction (IUGR)
• Uterine scar
• Known Rh isoimmunisation

INDICATIONS FOR VAGINAL BREECH DELIVERY
• Maternal insistence
• Extreme prematurity
• Stillbirth
• Second twin
• Rapid progressive labour with insufficient time to perform caesarean section
• In some units, vaginal breech delivery is offered as an option

INTRAPARTUM MANAGEMENT
• Perform planned vaginal breech deliveries on consultant-led delivery ward with access to facilities for emergency caesarean section
• Planned vaginal breech delivery must only be undertaken by an experienced obstetrician or experienced midwife
• In an emergency situation, midwife is expected to manage delivery

First stage of labour
• On admission, inform obstetric registrar, who will discuss with consultant obstetrician
• Full intrapartum assessment by midwife/registrar
• Abdominal palpation
• Commence continuous electronic fetal heart monitoring. If difficulty recording fetal heart rate abdominally, use fetal scalp electrode applied to buttock only
• Vaginal examination
• Offer woman choice of analgesia for labour and delivery. Epidural anaesthesia not routinely advised
• Obtain blood for full blood count (FBC) and group & save
• Artificial rupture of membranes (ARM) not usually performed due to risk of umbilical cord prolapse
• Avoid oxytocic drugs
• Avoid use of fetal blood sampling during labour on a breech presentation
If delay or fetal compromise at any stage during labour, consider caesarean section

- Passage of meconium cannot be relied upon as an indicator of fetal distress

**Second stage of labour**

- Inform obstetric registrar/consultant and ask to attend for second stage of labour
- Undertake urinary catheterisation
- Perform vaginal examination to confirm fully dilated cervix and position of breech (particularly important preterm)
- Once full dilatation confirmed and active pushing commenced, assist into lithotomy position to enable breech delivery
- Call theatre team
- Request attendance of a neonatologist. See Neonatal resuscitation guideline
- Until presenting part is below the level of the ischial spines, discourage bearing down

**Delivery**

- Allow natural descent of fetal buttocks – **hands off**
- Evaluate the need for episiotomy; consider waiting until fetal anus visible over fourchette
- Ensure fetal spine rotates uppermost during delivery
- Encourage mother to actively push, to aid baby’s natural descent and ‘minimise handling’. Do not pull on baby’s body or legs, flexed breech legs usually deliver spontaneously
- If assistance required to deliver legs, once popliteal fossa visible, release legs by flexing at the knees
- Observe for anterior scapula and allow time for arms to release spontaneously. If assistance required, hook arms down from the elbow. If this is not sufficient, two fingers can be passed over the shoulder to push the humerus across the chest
  - if other shoulder does not deliver spontaneously, repeat manoeuvre
- Allow baby to hang until nuchal line visible. Deliver head using Mauriceau-Smellie-Veit manoeuvre – a combination of maxillary pressure and shoulder traction
- If an obstetrician is conducting delivery they may decide to deliver the head using forceps

**Post delivery**

- Obtain cord blood for venous/arterial testing and file and record result – see Umbilical cord sampling guideline
- Debrief parents

**Delayed engagement of the after coming head in the pelvis**

- Second attendant will perform supra pubic pressure to assist flexion of the head

**Obstructive delivery of the after coming head**

- If conservative methods fail, consider symphysiotomy or caesarean section

**Preterm breech**

- Discuss mode of delivery of a preterm breech on an individual basis with woman and partner wherever possible
- If labour well established, there may be no choice but to proceed to a vaginal delivery. In this case, **most senior person available** must carry out the delivery. Otherwise, where possible an ultrasound scan assessment of the fetal size will be made and a decision on the mode of delivery made by on-call consultant obstetrician
- Where there is entrapment of after coming head, consider lateral incision of cervix

**Documentation**

- Ensure clear documentation of:
  - procedure
  - help summoned
  - names and grades of personnel attending
  - timing of events
  - communication with woman