Breech Birth

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1. Purpose of guideline

This guideline establishes the care of women and their babies presenting with breech birth within Auckland District Health Board (ADHB).

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2. Introduction

Approximately 3 - 4% of singleton births involve a breech presentation. Experience with vaginal breech birth is reducing in “westernised” healthcare settings with the trend towards caesarean section.

Vaginal breech births do still occur in L&B including second twins and all practitioners need both an understanding of mechanisms of birth and skills in safe conduct of such a birth.

Term breech trial

- overall absolute risk of perinatal mortality 1:200, morbidity 1:20
- risks of vaginal breech birth may have been overstated

With strict criteria before and during labour, planned vaginal birth of the singleton breech at term remains a reasonable option to offer to selected women (Goffinet et al for the PREMODA study group)

In order to individualise care, a full and frank discussion with the women and her partner on the risks of the vaginal breech birth and caesarean birth should be undertaken and documented. Patient pamphlet should be reviewed (MOH).

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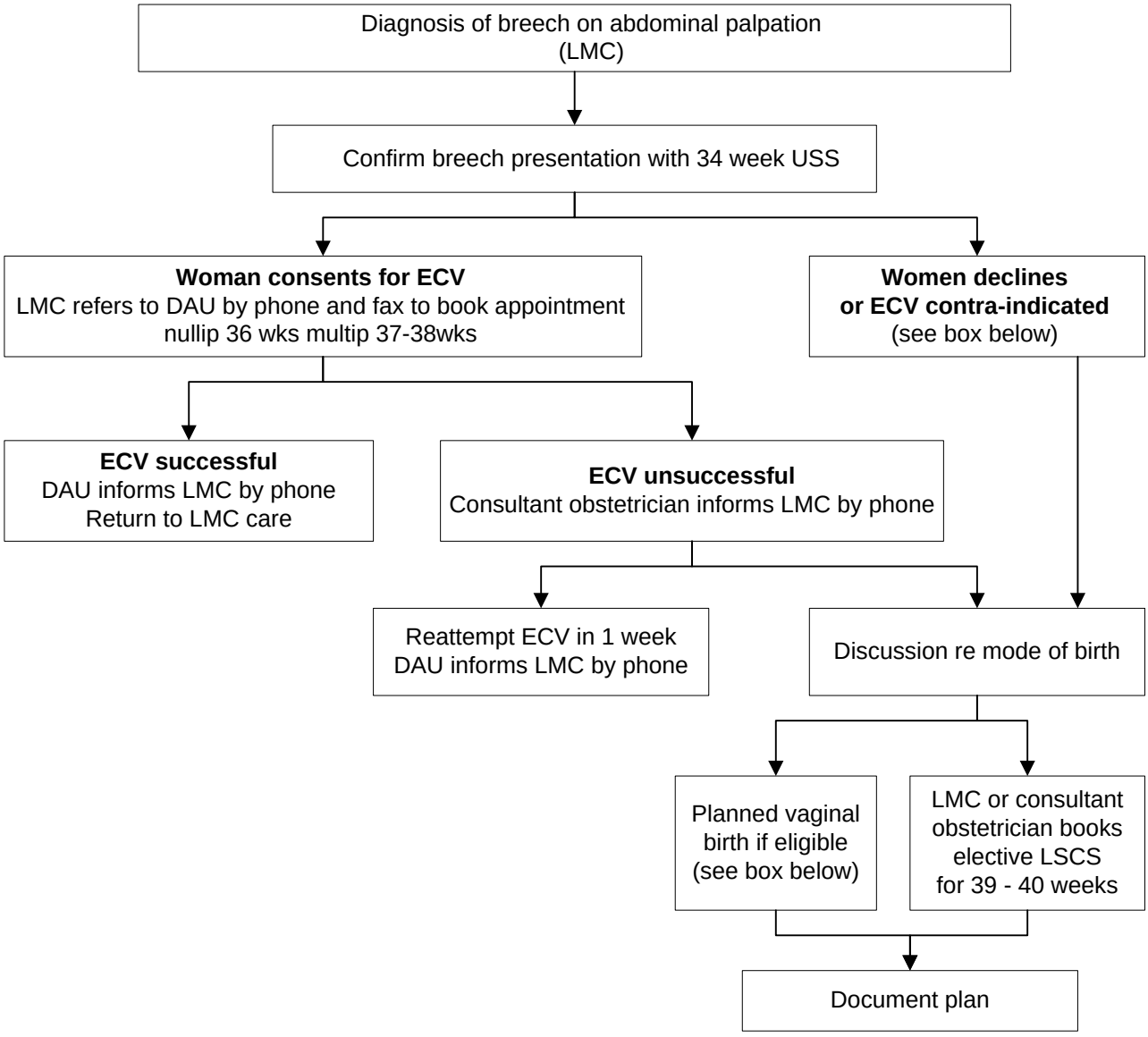
3. Diagnosis of breech flowchart



Absolute contra-indications for ECV

- LSCS is planned on other grounds
- Multiple pregnancy
- Placenta praevia
- Oligohydramnios
- Abnormal Dopplers

Eligibility for planned vaginal birth

- EFW 10-75% customised centile
- Normal liquor
- >= 37 weeks gestation
- Head flexed
- Not footling/knee presentation

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4. External cephalic version (ECV)

ECV must be performed by suitably trained health professionals where there is facility for emergency caesarean section if needed. There is low risk of complications, with approx 0.5% requiring an emergency LSCS. The success rate was 47% at ADHB in 2010.

Seventy four percent of women who had a successful ECV achieved a vaginal birth at ADHB in 2010.

All women with a breech presentation at term, and no contraindication to ECV, should be informed about and offered ECV (RANZCOG).

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a) Booking an ECV

- Give ECV pamphlet to woman (can print off ADHB website)
- At 34 weeks if known, or when diagnosed after 34 weeks, phone DAU to book ECV
- FAX to DAU
  - DAU Referral form (CR8791)
  - dating USS
  - USS confirming breech presentation
- An appointment should be organised for 36 weeks for nullips or 37 – 38 weeks for multips
- If > 38 weeks, an appointment should be organised as soon as possible

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b) Absolute contra-indications for ECV

- LSCS is planned on other grounds
- multiple pregnancy
- placenta praevia
- oligohydramnios
- abnormal Dopplers

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c) Relative contra-indications for ECV

- Ante-partum haemorrhage (dependent upon cause, severity and gestation at which APH occurred)
- Uterine structural anomalies (dependent upon anatomy)

Note:

- Previous caesarean section is **NOT** a contra-indication to ECV
- SGA with normal liquor and Dopplers is **NOT** a contraindication to ECV

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5. Eligibility for planned vaginal birth

- EFW 10 – 75% customised centile
- Normal liquor
- >= 37 weeks gestation
- Head flexed
- Not footling/knee presentation

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6. Management of breech that is first diagnosed in labour

Early diagnosis of breech presentation is imperative to enable optimal management. This involves an abdominal palpation and vaginal examination on admission.

Confirmation of presentation should be made by portable USS by a suitably trained person if there is any doubt.

Breech presentation in labour requires urgent referral for consultation to consultant obstetrician on call.

In determining the preferred mode of birth, the obstetrician should consider:

- management of breech presentation diagnosed in labour is **NOT** the same as the management of planned vaginal breech birth as per term breech trial
- gestational age and other eligibility criteria for vaginal breech birth as above
- whether caesarean section (CS) can be effected prior to spontaneous vaginal birth without the need for undue haste that might further endanger the mother and the baby
- fetal well being as determined by CTG
- increased fetal risks of vaginal breech delivery
  - possibility of undiagnosed congenital abnormalities
  - undiagnosed hyperextension of the fetal head (RANZCOG)
- increased maternal risks of emergency CS
- anaesthetic considerations such as no group and screen or the non fasted woman
- potential technical difficulties delivering the fetus at CS if the breech is very low in the pelvis

All aspects of the discussion regarding mode of delivery in this context must be fully and contemporaneously documented.

- informed consent should be obtained from the woman
- best practice is a three way conversation between the woman, her LMC and the obstetrician

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7. Management of breech presentation in labour and birthing suite (L&B)

On admission, consultation with the obstetric team on call is required.

Labour

- Advise and admit to L&B when in established labour
- Review birth plan and ensure competent personnel available
- IV luer, group and hold
- Continuous CTG monitoring in established labour (FSE not contraindicated if required)
- Good support, adequate analgesia (inclusive of epidural) of the woman's choice
- Syntocinon augmentation should be used if advised by consultant obstetrician

Birth

- Ensure full dilation confirmed by vaginal examination
- Availability of a suitably experienced obstetrician in the room during second stage
- Consider passive descent of breech into pelvis if epidural
- Neonatal staff members present at birth
- Anaesthesia team on call and clinical charge midwife (CCM) notified of imminent birth
- Plan should be re-evaluated if not born after 60 minutes of active pushing

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8. Supporting evidence

- Breech: ten years on from the term breech trial Zuschmann O&G 12 (4) 2010
- Goffinet et al (for the PREMODA study group)
- Hannah ME, Hannah WJ, Hewson SA. Planned caesarean versus vaginal birth from breech presentation (Term Breech Trial) Lancet 2000
- Kotaska. A. BMJ 329 (7473) p.1039-42 2004
- New Zealand Guidelines Group: Breech presentation evidence based guideline 2004
- RANZCOG Management of the Term Breech Presentation C-Obs 11 College statement
- RCOG green top 20b
- SOGC Vaginal delivery of breech presentation (2009)

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9. Associated ADHB documents

- Access Holders in Women's Health
- Caesarean Section (CS) – Pre, Peri & Post-Op Care
- Fetal Heart Rate - Intrapartum - Surveillance
- Resuscitation of Newborns
- Postpartum Haemorrhage

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10. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this ADHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

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11. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or the Clinical Policy Advisor without delay.

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