# Breech presentation management

## CLINICAL GUIDELINE

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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**Important Note**:

The Intranet version of this document is the only version that is maintained.

Any printed copies should therefore be viewed as ‘Uncontrolled’ and as such, may not necessarily contain the latest updates and amendments.

## AIM/OBJECTIVE OF GUIDELINE

This guideline covers the identification and management of the fetus presenting by the breech to improve care and ensure consistent and accurate identification and management.

## SCOPE

This guideline is intended to be used by Obstetric and Midwifery staff to promote safe practice, reduce adverse outcomes in planned and unplanned vaginal breech births, external cephalic version, and caesarean birth. This guideline is based on evidence which demonstrates improved outcomes and is intended to inform best practice.

## ROLES/RESPONSIBILITIES

It is recommended that all staff likely to attend breech births complete regular training in the management of breech birth. Sources of this are: Midwifery Core Mandatory Training, K2 Emergency training, PROMPT, SCOTTIE, RCOG Vaginal Breech Birth.

## GUIDELINE

### SITUATION
This guideline is intended for use by clinicians attending patients who are found to have a fetus presenting by the breech. It will consider identification, pathways, recommendations, care plans, information sharing and consent.

### BACKGROUND
Until 2024 NHS Greater Glasgow and Clyde has had three guidelines that clinicians could access to find guidance on the management of breech pregnancy and intrapartum care, all of which had expired.

### ASSESSMENT
Approximately 20% of fetuses are breech presentation at 28 weeks, though this reduces to 3-4% by term. There is an increased incidence of breech presentation in multiple pregnancies. Other factors which increase the likelihood of breech presentation are uterine abnormalities (such as a septum, tumours or fibroids), previous breech, high parity and placenta praevia. Breech presentation is a risk factor for potential morbidity and mortality whatever the mode of birth, including prematurity, congenital malformation, birth asphyxia or trauma. Fetal growth restriction (FGR) may also predispose a fetus to breech presentation due to a decreased liquor volume restricting fetal movement into a cephalic presentation in second trimester. Vaginal breech births will continue, not merely because of a failure to detect breech presentation and the limitations of ECV, but for reasons of maternal choice.

### RECOMMENDATION
Emerging evidence supports the development of a streamlined guideline to consider the various situations and settings clinicians could find themselves in, and this guideline is designed to be used to inform practice.

### Investigations and Identification

If breech presentation is suspected on palpation from 34-36 weeks' gestation, the patient should be referred for a confirmation ultrasound scan within one week. If breech is confirmed on scan the following features should be assessed.

- Type of breech presentation

- Location of fetal back in relation to maternal back
- Estimated fetal weight
- Liquor volume
- Location of placenta
- Inspection of head/neck

If confirmed, breech presentations should be referred to a senior obstetrician prior to 37 weeks' gestation for discussion of a management plan to support informed decision making by the woman.

**Antenatal management**

Three potential pathways will now be considered for discussion with the woman;

- External Cephalic Version (ECV)
- Planned caesarean birth
- Vaginal breech birth

The risks, advantages, and issues to consider must be discussed to ensure the patient is able to make an informed decision. 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 [1].

'Selection of appropriate pregnancies and skilled intrapartum care may allow planned vaginal breech birth to be nearly as safe as planned cephalic birth' [1]. It has found that lack of choice in location and position of birth has led to an increase in requests for homebirth by women with a breech presentation [2]. Therefore, counselling of women should consist of a discussion around choices and maternal preferences.

This discussion should include four key elements:

- What the preferences of the woman are and why
- What are the choices available
- What are the unbiased risks and benefits of each choice discussed in absolute terms (not only percentages)
- What is the woman's potential individual risk and benefit with each choice

Women should be informed that when planning birth for a breech baby, the risk of perinatal mortality is approximately

- 0.5/1000 with caesarean birth after 39+0 weeks gestation
- 2.0/1000 with planned vaginal breech
- 1.0/1000 with planned cephalic vaginal birth

Women should also have a clear understanding that a caesarean birth may be required in the event of a stalled physiological planned vaginal birth.
The woman's preferences should be recorded in BadgerNet under 'Intrapartum management plan'.

**External Cephalic Version**

Women should be informed that the success rate of ECV is approximately 50%; success for a nulliparous woman is 40% and for multiparous is 60% [3].

The risks are not deemed to be increased should the woman have previously had one caesarean birth.

ECV should be offered from 36 weeks' gestation in nulliparous and 37 weeks in multiparous women. There is no upper gestational limit for when ECV can be offered, and gestation does not appear to impact ECV success rates.

There is no consensus on the eligibility for, or contraindications to, ECV. However, consideration should be given to the following:

- Placenta Praevia
- Major uterine anomaly
- Abnormal CTG
- Rhesus Iso-immunisation
- Current/ recent bleeding
- Ruptured membranes / oligohydramnios
- Suspected or confirmed fetal growth restriction
- Morbid obesity
- Major fetal anomaly
- Unstable lie

Women should be informed of the chance of adverse outcomes following an ECV and the chances of success, to support them to make a fully informed decision. The reported risk of emergency or unplanned caesarean birth within 24 hours of ECV is approximately 0.5%, with the indication in over 90% being vaginal bleeding or an abnormal CTG following the procedure [3]. Further risks to be considered include transient fetal bradycardia and non-reactive CTG, placental abruption, cord entanglement, uterine rupture, feto-maternal haemorrhage.

Women should be informed that after an unsuccessful ECV attempt at 36+0 weeks of gestation or later, only a few babies presenting by the breech will spontaneously turn to cephalic presentation and occurs in only 8% of primigravid women after 36 weeks of gestation [3].

Women should be informed that few babies (approx. 3%) revert to breech after successful ECV [3].

Women should be informed that labour after ECV is associated with a slightly increased rate of caesarean birth and instrumental birth when compared with spontaneous cephalic presentation. [3].

ECV should be performed where facilities for monitoring and surgical birth are available.

The standard preoperative preparations for caesarean birth e.g. fasting administration of anaesthetic premedication or insertion of intravenous access (unless for tocolysis) are not recommended for women undergoing ECV.

## ECV Procedure

ECV should only be performed by a trained practitioner or by a trainee working under direct supervision.

The procedure for an ECV should be explained to women to gain informed consent. They should be informed that the procedure could be painful and will be suspended if they withdraw consent at any time.

Prior to performing the ECV the woman should have a minimum of 20 minutes of normal CTG [4], a full set of maternal observations, an ultrasound to confirm presentation, and written consent. A further CTG should be performed following ECV, whether it is successful or not, to establish normal CTG.

Rhesus D-Negative women should be offered Anti-D immunoglobulin [5]. A dose of Anti-D 500IU should be given and a Kleihauer test sent in case a further dose of Anti-D is required.

Once ultrasound has confirmed the type of breech presentation, position of fetal back and liquor volume a tocolytic can be administered to promote uterine relaxation e.g. 250mcg of terbutaline administered subcutaneously [3]. Betamimetics should not be used in women with significant cardiac disease or hypertension and will not be effective in those taking beta-blockers. Side effects which may be experienced are maternal palpitations, tachycardia, flushing, tremor or occasional nausea.

An ECV procedure is performed by the following steps:

1. One hand is used to lift the breech out of the maternal pelvis and the other hand is used to flex the fetal head.
2. Attempt rotation – forward roll initially and backward roll if unsuccessful.
3. The process can be quick in parous patients and take more time in primigravida.
4. Rotation can be attempted in stages.
5. Check FH with US transducer every few minutes to ensure no fetal compromise.
6. No more than four attempts are advised, for a suggested maximum of 10 minutes overall [3].
7. Following ECV an abdominal palpation and ultrasound should be performed to confirm fetal presentation.

Following successful ECV, the patient can be transferred back to the previous care pathway before identification of breech presentation. If unsuccessful, counsel again regarding planned caesarean birth from 39 weeks' gestation if no indication for earlier birth or a possible vaginal breech birth.

## Breech Labour and Birth

Women should be informed that induction of labour (IOL) is not usually recommended with breech presentation [1]. Augmentation of slow progress with oxytocin should only be considered if the contraction frequency is low in the presence of epidural analgesia [1].

To treat dystocia, augmentation should usually be avoided as adequate progress may be the best evidence for adequate feto-pelvic proportions. However, if epidural analgesia has been used and the contraction frequency is low its use should not be excluded.

**Contraindications to recommendation of vaginal breech birth**

- Other contraindications to vaginal birth (e.g. placenta praevia, compromised fetal condition)
- Estimated fetal weight >3800g / >90$^{th}$ centile
- Growth restricted baby on ultrasound (<2000g or <10$^{th}$ centile)
- Hyperextension of the fetal neck in labour (diagnosed on ultrasound)
- Footling, kneeling or part-kneeling breech
- Lack of the presence of a clinician trained in vaginal breech birth

**Identification of breech in labour**

**In a community maternity unit or at home**
It is recommended that women with diagnosed breech presentations should birth in an obstetric led unit, with ease of access to theatre should complications arise. If timing allows, it is recommended that transfer from home or from a community maternity unit be arranged and ambulance requested to attend immediately. Preparations for neonatal resuscitation should also be made. However, some women will choose to birth at home or in a birthing unit. Midwives should maintain a low threshold for recommending transfer to obstetric led unit.

**In hospital**
If caesarean birth was planned, yet the woman is admitted in labour, delay in care should be avoided. Confirm presentation by ultrasound, including fetal head extension, leg position. Discussion of options with woman by senior obstetric staff and proceed to unplanned caesarean birth if woman still consents.

If vaginal breech was planned, confirm presentation, by ultrasound, including fetal head extension and leg position. Previous scan assessment of estimated fetal weight should be reviewed. Maternal consent to continue if still wishing vaginal breech birth should be sought. Written consent should already have been obtained. If unplanned breech, written consent is recommended including documentation of discussion as above.

If a woman chooses to give birth vaginally it is highly recommended that a clinician is present with experience in managing vaginal breech birth. All babies should be delivered within 7 minutes of the buttocks “rumping” - i.e. the breech remains visible on the perineum between contractions. Fetal monitoring once the umbilicus is delivered is not possible with the transducer held to the woman’s abdomen.

If a woman is admitted in labour with a fetal breech presentation and aiming a vaginal breech birth the following steps should be undertaken:

- Inform on-call consultant obstetrician, anesthetist and neonatal staff.
- Obtain IV access: 14G cannula
- Obtain written consent including options of emergency interventions (breech extraction and caesarean birth)
- Analgesia – Women have choice of analgesia during labour and birth. Epidural should not be routinely advised for vaginal breech birth. Women should be advised that an epidural is likely to increase the need for intervention. Pudendal block, or perineal infiltration of local anaesthetic, could be considered if epidural not being used. Use of a birth pool is contraindicated for breech birth, though could be found to be of value by women in first stage of labour.
- Monitor regularly that there is adequate progress and descent of the presenting part.

- Women should be informed that while evidence is lacking, continuous electronic fetal monitoring may lead to improved neonatal outcomes [1]
- Where CTG is declined, intermittent auscultation should be performed as for cephalic presentation with conversion to CTG if abnormality is detected.
- Membranes should remain intact as long as possible to avoid the risk of cord prolapse. Amniotomy, should not be required if a vaginal breech birth is proceeding well. Following spontaneous rupture of membranes, a vaginal examination may be required, to ensure the cord has not prolapsed.
- Augmentation is not usually recommended, as delay in labour is an indication for robust risk assessment and a plan of care from on-call consultant obstetrician.
- **Caesarean birth should be considered and discussed with the woman in the event of slow or stalled progress**.

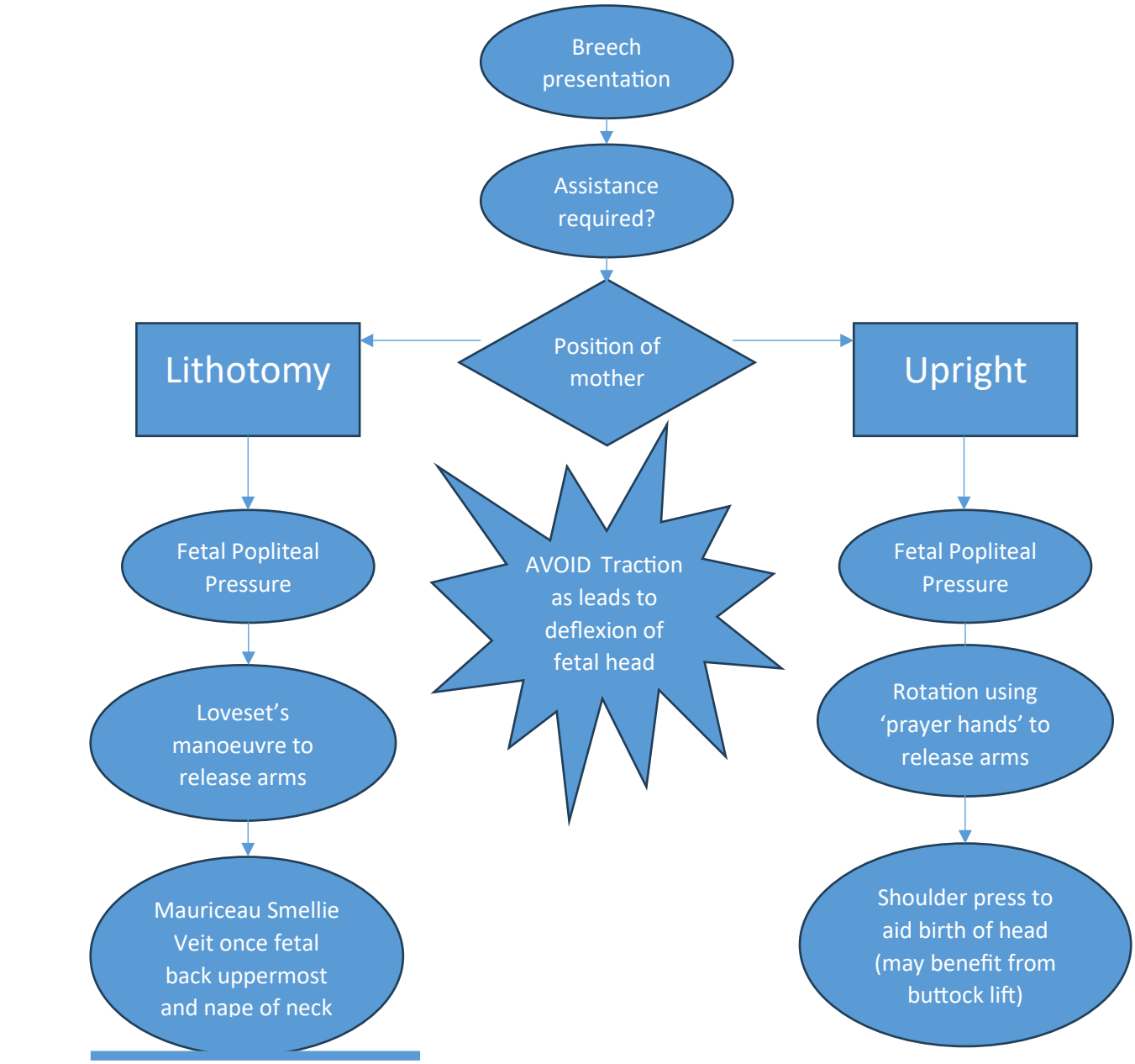
It is recommended that all midwives and obstetricians who could attend breech births attend training in 'all fours' or upright breech [6] and lithotomy positions for birth. The position the woman adopts should depend on the woman's preference and the experience of the clinician.

**Normal mechanisms for breech**

As with any other spontaneous labour, continuous one to one midwifery care should be provided at all times. A calm environment that promotes positive hormonal feedback mechanisms to support effective contractions and good progress should be provided. This will include provision of equipment and space to be active and upright, low lighting, the option of the woman's own choice of music and the continuous presence of birth partners of their choice. Women should be supported to use their own resources to manage their labour pain and coached as appropriate with relaxation and breathing techniques. Labour should progress in the normal way and care should be documented accordingly.

Progress during labour

- Membranes should be left intact
- If there are signs that labour is not progressing in the first stage of labour a full clinical assessment should be undertaken and discussed with the women including a discussion of an alternative mode of birth i.e. caesarean birth.
- Second stage should be confirmed by vaginal examination.
- If labour has progressed to the second stage but there is subsequently a delay in the descent of the breech this should be discussed with the woman including the option of caesarean birth.
- The breech should be allowed to descend to the pelvic floor ideally without active pushing. Adequate descent of the breech in the passive second stage is a prerequisite for encouragement of active second stage.
- 'Rumping' will occur when both buttocks are visible between contractions and at this point the 7-minute clock should start and progress should be continuous (if the foot/leg/both are born first, the 7-minute clock commences from when the buttocks are both visible between contractions).
- Maternal effort should be encouraged and pushing should be continuous (i.e. active pushing should not be delayed until the next contraction).
- If progressing normally a "hands-off" approach can be employed.
- It should take no more than 4 minutes for delivery of the umbilicus and if taking longer than 4 minutes then manoeuvres should be instigated and continued until birth.
- Emergency manoeuvres should be dependent on maternal position and clinician experience so both lithotomy and upright birth positions are presented in this guideline.
- A neonatal clinician should be present during birth in hospital.




Further manoeuvres which could be considered by medical staff depending upon experience.

Burns Marshall manoeuvre or forceps assistance.
Obstructed birth – Emergency Caesarean birth
Exceptionally use of Symphisiotomy

**Manoeuvres for assisted vaginal breech birth**
All manoeuvres used during assisted vaginal breech birth should be clearly documented including which arm / leg (right or left) is manoeuvred.

**Extended legs**

Frank breech legs should be born within a few seconds of each other. If there is a delay and assistance is required, then apply gentle pressure with 2 fingers in the popliteal fossa flexing the extended leg towards the baby's abdomen.

**Extended arms - Lovset's Manoeuvre**

If the baby's arms are not folded across the chest they are likely to be stretched up alongside the head. Loveset's Manoeuvre is used to rotate the body to bring the posterior shoulder into an anterior position to be delivered under the pubic arch.

- Hold the baby firmly but gently around the bony pelvis
- Rotate the body (without traction) 180 degrees (aim to keep the fetal back uppermost)
- Posterior shoulder is now lying under the symphysis pubis.
- Splint the humerus and draw it down over the chest with elbow of fetus flexed to facilitate the birth.
- Rotate the baby back 180 degrees (keeping the back uppermost)
- The second arm can be drawn down in the same manner.

**Nuchal Arm**

In this position, the shoulder is extended and elbow flexed so that the forearm is trapped behind the occiput – often under the symphysis at the pelvic inlet. The fetal trunk should be rotated in the direction of the fetal hand. The occiput therefore rotates past the arm and with further rotation flexion of the shoulder should occur and allow delivery of the arm.

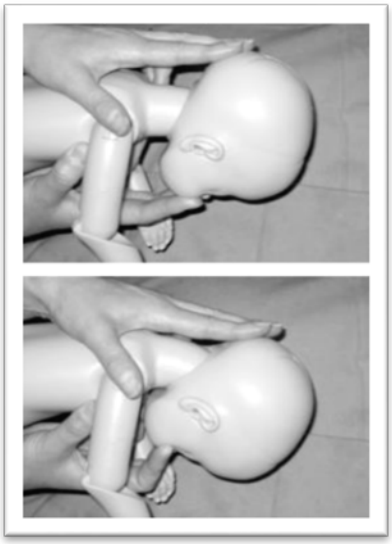
**Delayed engagement of the after coming head**

Suprapubic pressure by an assistant should be used to assist flexion of the head. If it is suspected that the head is stuck at the pelvic outlet rather than inlet then the Mariceau-Smellie-Veit manoeuvre should be considered. If the Mariceau-Smellie-Veit manoeuvre is not successful then birth of the after-coming head with forceps should be considered.

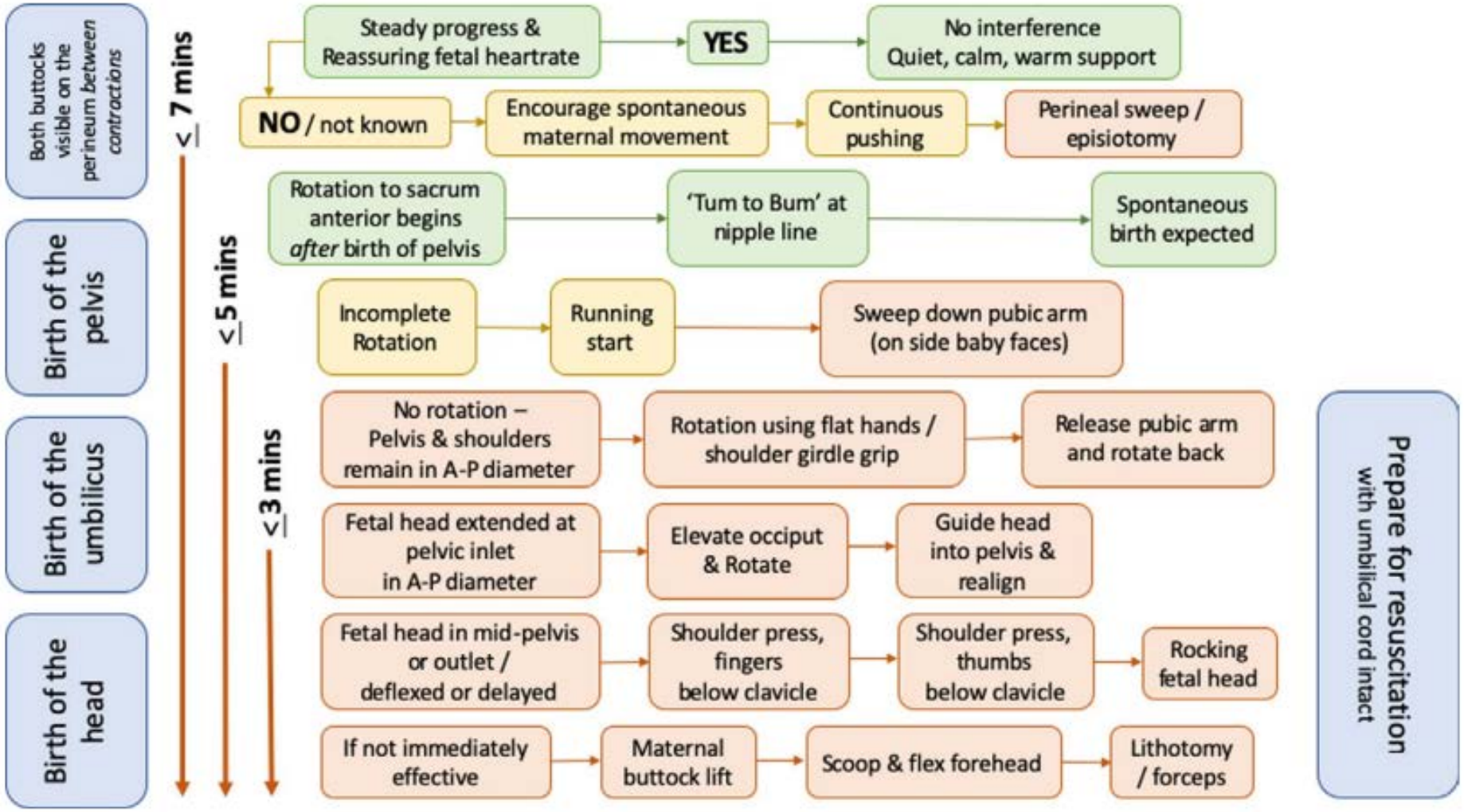
**Mauriceau Smellie Veit**

- Place the baby along your forearm supporting the baby's chest with the palm of your hand

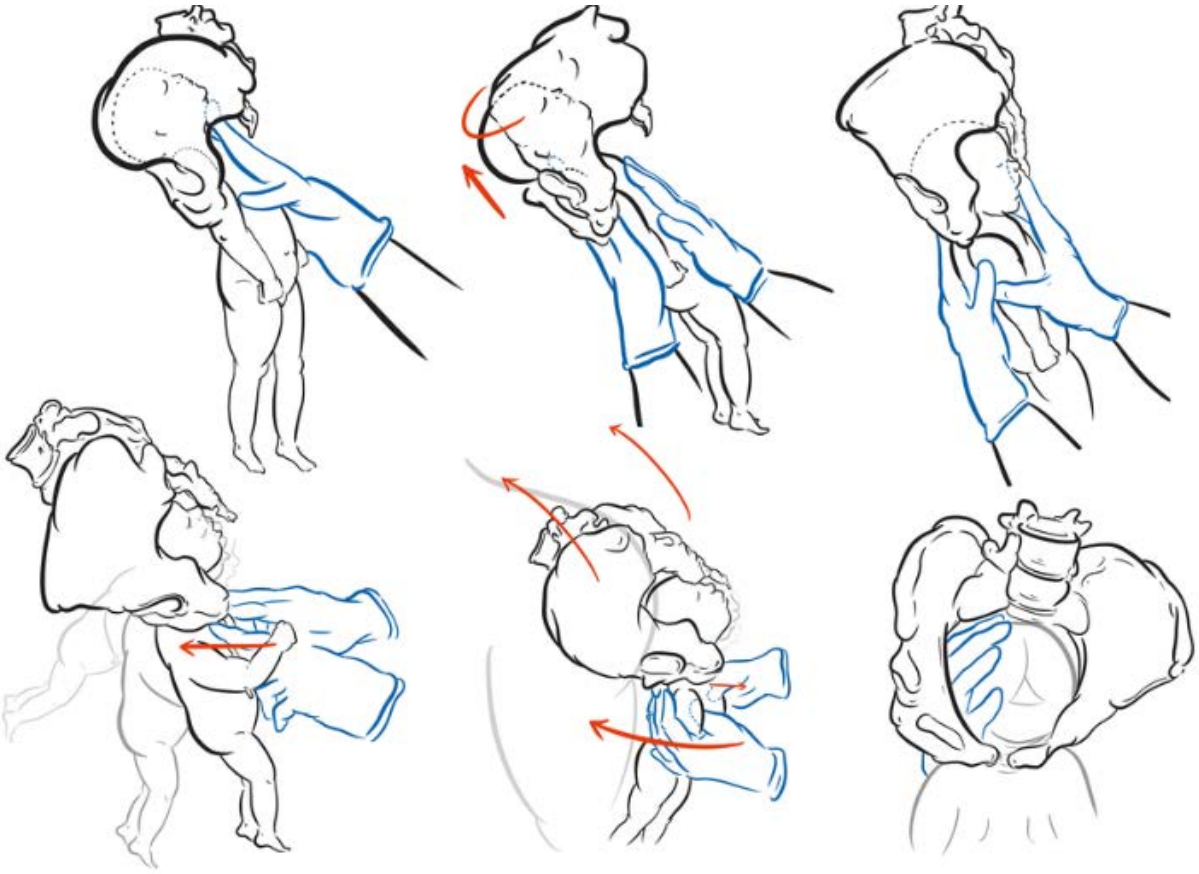
- NB do not put your finger in the baby's mouth to avoid trauma associated with this.
- Place your first and second fingers on the baby's cheek bones
- With the other hand place your first and third fingers over the baby's shoulders and use the middle finger to press on the occiput to aid flexion and descent
- When the face distends the perineum apply upward traction until the mouth and nose are free, the head can now be birthed slowly

**Pysiological Breech birth algorithm** [7] Designed by Shawn Walker, RM PhD, version: Nov 2019 [Colour figure can be viewed at wileyonlinelibrary.com]



**Upright manoeuvres for removal of the head, with woman in upright position**



Assisting the birth of the head in physiological breech births. Head at the pelvic inlet: Elevate and rotate (top): (1) The birth attendant runs a finger up to identify that the chin is high; the head is extended and trapped at the inlet to the pelvis. (2) Using “flat hands” (also called “**prayer hands**”), the birth attendant shifts one hand onto the chest of the newborn. Another hand, on the back of the newborn, shifts up to elevate and lift the occiput off the maternal pubic bone. If necessary, the occiput would be rotated at this point into oblique or transverse to assist engagement. (3) Once engaged in the pelvis, the neonatal head is flexed and realigned in the pelvis. The head is then delivered by a **shoulder press** or variation of Mauriceau. Head in the midpelvis or outlet: Shoulder press (bottom) flexes the fetal head by moving the newborn's shoulder girdle and body toward the maternal abdomen, much like supine manoeuvres to deliver the head. The pubic bone becomes a fulcrum, which lifts the occiput as the head pivots around the maternal sacral curve. This is performed either by pressing on the fetal chest, just below the clavicle, or with thumbs on the fetal chest and fingers wrapped around the shoulders. **Buttock lift** augments the effectiveness of shoulder press by slightly elevating the maternal sacrum, enlarging the anterior-posterior diameter of the pelvic outlet, and sweeping the perineum over the newborn's forehead. Scoop and flex can be used if the above are not successful, or to align the head in the pelvis. The birth attendant sweeps one hand over the parietal bone and flexes the head down by pressing on the sinciput (forehead). Drawings by Merlin Strangeway, Drawn to Medicine [Colour figure can be viewed at wileyonlinelibrary.com]

**Application of Forceps to After Coming Head**

In up to 20% of cases forceps may be required to deliver the fetal head.

- The head is generally direct OA or no more than 15° left or right.
- Assistant should gently lift and support the baby without undue traction. Its body can be wrapped in a towel to keep it warm
- Select Mid-Cavity forceps, e.g. Andersons or Simpsons. **Do not** use Wrigley's forceps.
- Apply forceps using a standard approach. Once the first blade is applied any lateral deviation can usually be corrected to DOA.
- Once the forceps are applied, check application and lock as next contraction commences
- Gentle downward traction
- Start upward traction once chin on perineum (evaluate for episiotomy if not already done; usual care and angulation)
- Controlled and slow delivery of head
- Transfer baby to waiting paediatric team
- Paired cord sample pHs should be obtained
- Deliver placenta and repair perineum
- Complete record in patient's notes

**Vaginal Breech Birth – Head Entrapment**

Fetal head entrapment during vaginal breech birth is an obstetric emergency.

It is typically associated with preterm vaginal breech birth when the fetal buttocks and trunk pass through an incompletely dilated cervix. The uterus subsequently contracts and clamps tightly around the fetal head.

**Management of Entrapment at Vaginal Breech Birth**

- Inform anaesthetist, paediatric staff, senior midwife
- Attempt Mauriceau-Smellie-Veit (MSV) manoeuvre
- Rotate baby to sacrum transverse
- McRobert's manoeuvre
- Suprapubic pressure
- Start tocolysis with GTN

**1. Emergency cervico-uterine relaxation**

Maternal IV cannula requires to be sited prior to administration of GTN (the drug may cause profound drop in BP)

Sublingual GTN via metered pump:

- Nitrolingual pump spray should be primed before using it by pressing the nozzle once.
- 1 – 2 sprays (400-800 micrograms) administered as spray droplets beneath the tongue (do not inhale). Ask woman to close her mouth after spray is administered.
- Repeat after 5 minutes if hypertonus is sustained.

Haemodynamic monitoring, a rapidly running I.V. infusion and immediately available ephedrine and phenylephidrine are mandatory prior to the use of GTN

Cautions:

- Nitrates may increase intraocular pressure and so should be used with caution to glaucoma.

Contraindications:

- Uncorrected hypovolaemia
- Severe anaemia (Hb<60 g/L)
- Increased intracranial pressure
- Constrictive pericarditis /pericardial tamponade
- Hypersensitivity to GTN. Nitrates, coconut oil, ethanol, glycerol, monocarprylocaproate, peppermint oil

General Anaesthesia with a high-end tidal concentration of volatile agent will often produce useful relaxation of the cervix

Once the third stage is complete, a Syntocinon infusion should be commenced.

Incisions at 2 + 10 o'clock are usually sufficient. Take great care to **only** cut the cervix [8]

**3. Emergency Surgical Option: Symphysiotomy Technique**

1. Lithotomy position for patient
2. Analgesia
3. Catheterise bladder (indwelling)
4. Incise skin above the symphysis with a solid scalpel. The top of the symphysis is probed with the tip of the scalpel to identify the non-bony joint.
5. The urethra is kept displaced from the midline by a finger in the vagina pushing the catheterised urethra laterally.
6. The scalpel, held at an angle 30 degrees from the horizontal, is advanced vertically towards the vagina until the sharp tip is sensed by the intravaginal finger. Divide the joint by a sawing action.
7. When the separation of the joint is felt remove the catheter, apply forceps and deliver the fetal head.
8. An episiotomy and traction towards the sacral aspect of the pelvis relieves pressure on the unsupported urethra.
9. After a symphysiotomy it is essential to refer to physiotherapy and orthopaedics for follow up as there can be significant morbidity.

**Caesarean Birth for Breech Presentation**

Breech presentation is a common indication for Caesarean birth.

It is sometimes difficult to deliver the after-coming head (ACH) at caesarean birth and this is more common with patients with oligohydramnios.

The following steps and considerations should be followed.

1. Read the notes and gain maximum information about type of breech presentation (i.e. extended, flexed), placental site and fetal size.
2. Remember that the baby may be big as well as breech!
3. Make an appropriate skin incision: err on a larger incision than you might make for a Cephalic presentation. The shape of the Head may be unusual (doliocephalic, brachycephalic)
4. Remember that there is no point in making a large skin incision and then a narrower sheath incision - make as much room as you can. Lateral incision of the peritoneum may help.
5. Establish where the fetal back lies.
6. Once the uterotomy is made, as the baby is being drawn down, get your assistant to follow the head with their hand: this encourages neck flexion and reduces chance of head extension.
7. Once the body is delivered deliver the ACH in the manner described for vaginal birth.
8. If there is entrapment do not simply pull harder.
9. Consider Wrigley's Forceps to ACH if there is enough room and deliver as per vaginal breech instructions.
10. Identify where the entrapment is:
    - Skin: enlarge incision with care: a scalpel is best, pointing sharp edge away from baby.
    - Sheath: digital extension if possible, scissors before scalpel.
    - Uterotomy: try digital extension. If not use scissors with aim to create a "J" to avoid damage to broad ligament vessels.
    - Remember forceps to ACH may now work.
    - Consider GTN
    - If all else fails, a vertical uterotomy (inverted T) may be necessary: beware the anterior placenta!
11. Paired cord pH samples
12. Careful documentation.
13. Explain to patient what happened. This is of particular importance if a uterotomy is extended and VBAC is no longer a future option.

**Internal podalic version (IPV)**

This may be necessary to deliver:

- a second twin at CS or at a vaginal birth
- if there is an immediate need to deliver baby.
- Transverse lie at caesarean birth

Documentation will inevitably be retrospective and must be clear.

**Method of IPV**

A fetal foot is identified by recognizing a heel through intact membranes. The foot is grasped and pulled gently and continuously lower into the birth canal (or through uterotomy at CS). The membranes are ruptured as late as possible. The baby is then delivered as an assisted breech or breech extraction with pelvi-femoral traction, Lovset's manoeuvre to the shoulders if required and a controlled delivery of the head. This procedure is easiest when the transverse lie is with the back superior or posterior. If the back is inferior or if the limbs are not immediately palpable, do not panic, follow the curve of the back and down and round to find the leg. Confirm you have a foot before applying traction.

If ultrasound is immediately available to an experienced sonographer this may help identify where the limbs are.

A few seconds of calm consideration and accurate assessment will almost certainly result in an effective delivery manoeuvre.

**References**


1. RCOG 2017 20b Management of breech presentation
2. SCHAFER, R., et al, 2023. "I had no choice": A mixed-methods study on access to care for vaginal breech birth. *Birth*
3. RCOG 2017 20a External Cephalic Version and Reducing the Incidence of Term Breech Presentation
4. NICE 2022 NG229 Fetal Monitoring in Labour
5. NHS GG&C guideline Anti-D Immunoglobulin Administration Following Potentially Sensitising Events and Routine Antenatal Anti-D Prophylaxis in RhD Negative Women (559)
6. FARIN, A., et al, 2023. Training for breech deliveries with the mother in an upright position: An innovative adaptation of a simulation model. *European Journal of Obstetrics, Gynecology, & Reproductive Biology,* 280, pp. 108-111.
7. Walker S, Scamell M, Parker P (2016) Principles of physiological breech birth practice: A Delphi Study. Midwifery. 43:1-6.
8. PROMPT 2nd edition


**Further Reading**


FARD, D., et al, 2023. Comparing forces on the fetal neck in breech delivery in lithotomy versus all-fours position: a simulation model. *Archives of Gynecology & Obstetrics,* 308(1), pp. 91-99.

# VAGINAL BREECH DELIVERY ALGORITHM

"HANDS OFF BREECH" IS ONLY APPROPRIATE IF **PROGRESS NORMAL:**

IF ASSISTING DELIVERY - CONTINUE UNTIL BABY OUT

AIM FOR **CONTINUOUS PUSHING** - DO **NOT** WAIT FOR CONTRACTIONS

- Start the clock when Breech visible on perineum between contractions (breech is rumping)
- Aim for **7 minutes** for delivery - If delay, clinical lead should ensure clinician has performed manoeuvres as below by **calling out list**
- Once trunk delivered fetal wellbeing should be assessed by colour and tone of body - **Listening to FH through abdomen is not useful and could be misleading**
- If progress not adequate: Consider switch from all 4s/upright to lithotomy

| | | | | | |
|---|---|---|---|---|---|
| Date and time of "**RUMPING**": | | | Time of Emergency call: | | |
| Position of woman before/during birth (circle as appropriate): | | | On all 4s ◻ | Upright ◻ | Lithotomy ◻ |
| **Staff present** | **Time arrived** | | **Staff present** | **Time arrived** | |
| Midwifery lead | | Lead/scribe? Y/N | Obstetric lead (consultant or middle grade) | | Lead/scribe? Y?N |
| Neonatal team | | | Anaesthetic team if required | | |

| Stage | Progress | Problem | Action (only record times if manoeuvre required) | | time |
|---|---|---|---|---|---|
| ***Lithotomy*** | | | | | |
| **Rumping** (visible between contractions) | **TIME (mins)** 0 | **Halt of progress** | Abduct hips | | |
| | | | Episiotomy | | |
| | | | Consider CS | | |
| **Birth of buttocks** | 2 | **Incomplete rotation** to sacro-anterior (SA) : R/L SA pos **Delay of ext legs** | Abduct Maternal hips | | |
| | | | Assist baby legs (flex at knees) | | |
| | | | Anticipate problems with arms, may need assistance | | |
| **Birth of umbilicus** | 4 | **No rotation to SA:** (shoulders remain in AP diam: S Lat) Nuchal Arm delay at pubic symphysis) | Lovset's manoevre if no nuchal arm | | |
| | | | **Nuchal arm:** | Internal rotation to SP (prayer hands) + release anterior arm; rotate back to SA | |
| | | **Head delayed** at Pelvic inlet | Suprapubic pressure to rotate head | | |
| | | | Elevate occiput and rotate to oblique then guide back into pelvis | | |
| **Birth of head** | 7 | **Rotation complete** to SA but head delayed at pelvic outlet /mid pelvis | Mariceau-Smellie-Veit | | |
| | | | Forceps (Assistant lift baby up and apply forceps under body) | | |

| Stage | Progress | Problem | Action (only record times if manoeuvre required) | | time |
|---|---|---|---|---|---|
| ***All 4s/ Upright*** | | | | | |
| **Rumping** (visible between contractions) | **TIME (mins)** 0 | **Halt of progress** | Squat back | | |
| | | | Lunge leg ("running start") | | |
| | | | Episiotomy | | |
| | | | Consider CS | | |
| **Birth of buttocks** | 2 | **Incomplete rotation** to sacro-anterior (SA) : R/L SApos **Delay of ext legs** | Running start Mother | | |
| | | | Assist baby legs (flex at knees) | | |
| | | | Anticipate problems with arms, may need assistance | | |
| **Birth of umbilicus** | 4 | **No rotation to SA:** (shoulders remain in AP diam: S Lat) Nuchal Arm delay at pubic symphysis) | Lovset's manoevre if no nuchal arm | | |
| | | | **Nuchal arm:** | Internal rotation to SP (prayer hands) + release ant arm; rotate back to SA | |
| | | **Head delayed** at Pelvic inlet | Elevate occiput and rotate to oblique then guide back into pelvis | | |
| **Birth of head** | 7 | **Rotation complete** to SA but head delayed at pelvic outlet /mid pelvis | Shoulder press | | |
| | | | Buttock lift | | |
| | | | Scoop and flex | | |