HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology		
Document:	Multidisciplinary Policy and Procedure		
Title:	Management of Breech Presentation at Term		
Applies To:	All Obstetrics and Gynecology Staff		
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1. PURPOSE:

1.1 To Standardize the health care provided to patients with breech presentation at term.

2. DEFINITIONS:

2.1 **Breech Presentation**– is defined as a fetus in a longitudinal lie with the buttocks or feet closest to the cervix.

3. POLICY:

3.1 Cases of breech presentation should be seen in OPD by the consultant to decide upon plan of management.
3.2 The mother should be counselled regarding the pros & cons of vaginal versus abdominal breech delivery.
3.3 Method of delivery is individualized for every patient according to: parity, fetal size, health status, associated risk factors, fetopelvic disproportion, gestational age of the fetus, etc.
3.4 Upon admission to L.W. the consultant should be informed to set the plan of management.
3.5 Assisted breech delivery should be conducted by clinically privileged specialist or the Consultant on-duty.
3.6 There is no place for "Breech extraction" for singleton breech.
3.7 If elective C.S. decided should be done at 39–40 weeks to give time for spontaneous cephalic version.
3.8 External cephalic version (ECV) is encouraged and its practice depends upon the experience of the treating physician.
3.9 Woman should be assessed carefully before selection for vaginal breech birth and a written consent should be taken.
3.10 Delivery should be conducted in operating room with the attendance of the pediatrician and the anesthetist.
3.11 Labor induction for breech presentation may be considered if individual circumstances are favorable.
3.12 Woman should have a choice of analgesia during breech labor and birth.
3.13 Factors regarded as unfavorable for vaginal breech birth include the following:
- 3.13.1 Other contraindications to vaginal birth (e.g. placenta previa, compromised fetal condition).
- 3.13.2 Clinically inadequate pelvis.
- 3.13.3 Footling or kneeling breech presentation.
- 3.13.4 Large baby (usually defined as larger than 3600g).
- 3.13.5 Growth-restricted newborn (usually defined as smaller than 2000g).
- 3.13.6 Hyper extended fetal neck in labor (diagnosed with ultrasound).
- 3.13.7 Lack of presence of physician trained in vaginal breech delivery.
- 3.13.8 Previous caesarean section.

3.14 An undiagnosed breech presenting in labor should be discussed with the senior registrar/ Consultant on call.
3.15 Unbooked breech presentation presented in labor should be counselled regarding mode of delivery and written consent for vaginal delivery should be taken.

3.16 Detailed intrapartum ultrasound to be performed (expected fetal weight and congenital anomalies to be exclude if not performed earlier).

3.17 Gravid mother can be allowed to have vaginal delivery if presented in advance stage of labor and delivery is imminent or to multifetal gestation, if second non-vertex.

3.18 Presentation of the mother in advanced labor with no maternal or fetal distress even if caesarean section originally planned can be allowed to have vaginal delivery. (Current 2003)

4. PROCEDURE:

4.1 The registrar should be available to confirm the diagnosis. Confirmation of full dilatation should be undertaken by the obstetric registrar.

4.2 Continuous electronic fetal heart monitoring should be employed.

4.3 Caesarean section should be considered if there is a delay in the descent of the breech at any stage in the second stage of labor.

4.4 Oxytocin use to be decided by senior registrar or Consultant.

4.5 Vaginal Breech Delivery

- 4.5.1 Delivery should be conducted in the lithotomy position.
- 4.5.2 If the type of breech is unknown, a vaginal examination should be performed following rupture of membrane to exclude a footling breech.
- 4.5.3 Episiotomy should be performed when indicated to facilitate delivery.
- 4.5.4 The pediatrician must be presented at delivery, and the anesthetist available on operationgroom.
- 4.5.5 The senior registrar should supervise the delivery if undertaken by the junior registrar or resident.
- 4.5.6 No traction should be applied while the newborn is being delivered and the body is allowed to hang. The operator should be guide the body to keep sacrum anterior.
- 4.5.7 The Mauriceau-Smellie-Veitmaneuver should be considered, if necessary, displacing the head upward and rotating to the oblique diameter to facilitate engagement.
- 4.5.8 The after coming head may be delivered with forceps, the Mauriceu-Smellie-Veit Maneuver or the Burns-Marshall method.
- 4.5.9 ECV may be considered and offered if this is acceptable to the woman provided that she is 37 weeks gestation, the membranes are intact, there is no contraindication to ECV and the clinician is suitability experienced in performing ECV.
- 4.5.10 Women presenting in advanced labor with undiagnosed breech presentation should be counselled regarding the risks and benefits of vaginal breech delivery and emergency caesarean section.
- 4.5.11 Diagnosis of breech presentation for the first time during labor should not be contraindication for vaginal breech birth.
- 4.5.13 Breech extraction should never be undertaken except in the case of a second twin or a dead fetus.
- 4.5.14 Caesarean section is the mode of delivery for footling breech.

4.6 Management of the preterm breech and twin breech.

- 4.6.1 Routine caesarean section for the delivery of preterm breech presentation should not be advised.
- 4.6.2 The mode of delivery of the preterm breech presentation should be discussed on an individual with a woman and her partner.
- 4.6.3 Where there is head entrapment during a preterm breech delivery, lateral incision of the cervix should be considered.
- 4.6.4 For the first twin in breech presentation, it would be reasonable to use data from singleton breech presentation as a proxy to assist decision making.
- 4.6.5 Routine caesarean section for twin pregnancy with breech presentation of the second twin should not be performed.

4.7 Documentation

- 4.7.1 All details of care should be clearly documented, including details of counselling and the identity of all those involved in the procedures.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurse
6.3 Midwife

7. APPENDICES:

7.1 Labor and Delivery Nursing Initial Admission Assessment Form
7.2 Partogram

8. REFERENCES:

8.1 RCOG Guideline No 20B. The management of breech presentation. December 2006.
8.2 Obstetrics and Gynecology, an evidence base text for ROCG, 2004.
8.3 American collage of Obstetrician and Gynecologist. ACOG Committee Opinion No. 340, Mode of term singleton breech delivery. Obstetric Gynecology 2006, 108: 235-237.
8.4 CBAHI Standard 3rd Edition 2016.
8.5 MOH, Guidelines for Obstetrics and Gynecology, Clinical Policies and Procedures.

9. APPROVALS:

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