Chapter 28

BREECH PRESENTATION

Types of Breech Presentation

1. Complete – 5-10% - Hips flexed, knees flexed (foot may be adjacent to or just below buttocks)
2. Footling or incomplete – 10-30% - one or both hips extended, foot or knee presenting
3. Frank – 50 – 70% - hips flexed, knees extended

Incidence:

Breech presentation affects 3 – 4% of all pregnant women reaching term. The earlier the gestation, the higher the percentage of a breech presentation. At 28 weeks gestation approximately 24% of fetuses are in the breech presentation.

The SOGC Recommends

Term breech management involves 3 options: External Cephalic Version (ECV), Caesarean Section (C/S), or Assisted Vaginal Breech Delivery.

External Cephalic Version:

The ideal time to carry out an ECV is between 34-36 weeks gestation
ECV should not be attempted before 34 weeks gestation

Prerequisites

1. Singleton pregnancy
2. Gestation > 34 weeks
3. No contraindication to labour
4. Fetal well-being established prior to procedure (i.e., non-stress test or biophysical profile)
5. Amniotic fluid volume adequate
6. Availability of u/s
7. Position of fetus known prior to procedure
8. Facilities and personnel available for immediate caesarean section

Contraindications

Disclaimer

The Southwestern Ontario Maternal, Newborn, Child & Youth Network (MNCYN) has used practical experience and relevant legislation to develop this manual chapter. We recommend that this chapter only be used as a reference document at other facilities. We accept no responsibility for interpretation of the information or results of decisions made based on the information in the chapter(s)

Absolute:

1. Any contraindications to labour
2. Antepartum hemorrhage
3. Some major fetal anomalies
4. Multiple gestation (except delivery of second twin)
5. Ruptured membranes

Relative:

1. Oligohydramnios
2. Hyperextension of the fetal head
3. 2 or more previous caesarean sections
4. Morbid obesity
5. Active labour
6. Uterine malformation
7. Fetal anomaly

Procedure:

1. Obtain informed consent
2. Must be performed in a facility with the ability to carry out immediate intervention, including a caesarean section if needed
3. 20 minute non-stress test or biophysical profile should be carried out and must be normal
4. Ultrasound examination should be performed to confirm the position. Real-time u/s is also done intermittently during the procedure to check progress and monitor the FHR
5. Abdomen may be lubricate with ultrasound gel or powder to make the procedure easier.
6. Direction of rotation should be so that the baby "follows its nose"

Practitioners are encouraged to ensure that this information is conveyed to women who are contemplating breech vaginal birth and that they obtain an informed and documented consent.

The risks of LSCS should also be discussed and documented. When scheduling a LSCS it is important to ensure that accurate dating and presentation of the fetus are confirmed just prior to undertaking the Caesarean section.

Management of the Unplanned Vaginal Breech Birth

Disclaimer

The Southwestern Ontario Maternal, Newborn, Child & Youth Network (MNCYN) has used practical experience and relevant legislation to develop this manual chapter. We recommend that this chapter only be used as a reference document at other facilities. We accept no responsibility for interpretation of the information or results of decisions made based on the information in the chapter(s)

- Appropriate fetal health surveillance
- Anaesthetist should be notified and come to attend birth
- NRP provider with airway skills should be present at the birth
- Maternal bladder should be emptied just prior to birth, if possible
- Piper forceps should be available for the after-coming head
- Ideally, a physician experienced with breech birth should be involved
- Experienced nursing staff should be available
- Deliver the breech as an assisted breech. Breech extraction must not be performed.
- For a woman with suspected breech presentation, pre – or early labour ultrasound should be performed to assess type of breech presentation, fetal growth and estimated weight, and attitude of fetal head. If ultrasound is not available Caesarean section is recommended

Technique

1. Empty bladder
2. Summon anaesthesia and have him/her attend
3. Ensure adequate analgesia, if possible.
4. Spontaneous descent and expulsion to the umbilicus should occur with maternal pushing only. **DO NOT PULL ON THE BREECH!**
5. Ensure that the sacrum is in an anterior position. May be facilitated if needed.
6. Episiotomy may be considered once the anterior buttock and anus are "stretching" the perineum. This is the best time to do an episiotomy.
7. Extract the legs when the popliteal fossae are visible (Pinard's manoeuvre).
8. With a warm towel, grasp the baby by the anterior and posterior iliac spines with gentle downward traction with mother pushing until the scapulae are visible. Do not pull on the breech or compress the abdomen. Maintain flexion of the foetal head by keeping the body below the horizontal. If necessary, flex the baby's head with a hand suprapubically.
9. Rotate the body to facilitate delivery of the arms by sweeping the anterior humerus across the chest of the fetus (Loveset manoeuvre). Rotate other arm anterior and repeat.
10. Support the baby to maintain the head in a flexed position. Suprapubic pressure may help. Maternal expulsive efforts should be encouraged.
11. The body should be supported in a horizontal position.

Disclaimer

The Southwestern Ontario Maternal, Newborn, Child & Youth Network (MNCYN) has used practical experience and relevant legislation to develop this manual chapter. We recommend that this chapter only be used as a reference document at other facilities. We accept no responsibility for interpretation of the information or results of decisions made based on the information in the chapter(s)

12. The Mauriceau-Smellie-Veit manoeuvre can be used to deliver the head in flexion. The fetal body is placed astride the operator's forearm. The middle finger is placed in the fetal mouth and the other fingers support the maxilla encouraging flexion. The other hand is placed on the fetal back with the middle fingers against the occiput. Gentle traction is exerted in a downward and outward direction to ensure a controlled release of the head.
13. Use Piper forceps for the after coming head if needed.

References

1. Society of Obstetricians and Gynecologists of Canada (SOGC), Alarm Course Syllabus, 22nd ed., 2015-2016

Disclaimer

The Southwestern Ontario Maternal, Newborn, Child & Youth Network (MNCYN) has used practical experience and relevant legislation to develop this manual chapter. We recommend that this chapter only be used as a reference document at other facilities. We accept no responsibility for interpretation of the information or results of decisions made based on the information in the chapter(s)