Breech Presentation, External Cephalic Version (ECV) And Breech Presentation In Labour Clinical Guideline V2.0

10th August 2018
1. **Aim/Purpose of this Guideline**
This guideline gives guidance to midwives and obstetricians on the management of a suspected breech presentation in the antenatal period, options for the management of a confirmed breech presentation including external cephalic version (ECV) and the management of a breech presentation in labour.

2. **The Guidance**

2.1. The incidence of breech presentation decreases from 20% of all pregnancies at 28 weeks to 3-4% at term.

It is recognised that there is higher perinatal mortality and morbidity involved with breech presentation (regardless of delivery), due principally to prematurity, congenital malformations and birth asphyxia/trauma.

Elective Caesarean Section has been suggested as a means of reducing perinatal morbidity/mortality associated with breech delivery. Risk of perinatal/neonatal death and short-term neonatal morbidity appears to be reduced with elective Caesarean section in the Term Breech Trial (RR 0.33, 95% CI 0.19–0.56). However a 2 year follow up data from this trial suggests, based on long term outcomes, there is no evidence to recommend planned Caesarean Section. (RR 1.09, 95% CI 0.52–2.30). Decreased neonatal deaths in the Caesarean Section group were balanced by an increase in babies with neurodevelopmental delay. There has since been criticism of the Term Breech trial – particularly participant selection and intrapartum care. This led to the larger PREMODA trial comparing outcomes of 2526 planned vaginal breech studies with 5579 planned caesarean sections. Again there was a significant increase in low Apgars at 5 mins (OR 3.2); however there was no difference in neonatal admissions, mortality or serious morbidity. (New 2018)

It is recognised that some women will choose to deliver vaginally, and some labour too quickly even when an Elective Caesarean has been planned – 10% of planned sections delivered vaginally in the Term-Breech Trial.

2.2. **Antenatal management**

2.2.1 If breech presentation is suspected at 36 completed weeks gestation a presentation scan for the next available scan slot should be organised via Fetal Medicine Administrator (01872 252682)

2.2.2 If breech presentation is confirmed full biometry should be undertaken and an assessment of liquor volume

2.2.3 If the biometry and liquor volume are normal and there are no contraindications to ECV this should be offered to all women. An ECV leaflet (Appendix 3) should be given and an appointment made on delivery suite
2.2.4 An ECV should be offered from 37/40, with no upper gestation and from 36/40 in nulliparous women.

2.2.5 If the woman declines an ECV or if there are contraindications then the woman should be referred for further counselling re mode of delivery. If she is <38 weeks an appointment should be made in the consultant obstetric clinic, if >38 weeks the referral should be made to DAU.

2.2.6 If ECV is unsuccessful then the consultant conducting the ECV will discuss further options with the woman. These include:
   - Repeat ECV attempt
   - Vaginal breech delivery
   - Elective Caesarean section

2.2.7 If ECV is successful and there are no risk factors for the woman then she will be discharged to midwife led care, to continue with plan of care. Ensure the woman has a further antenatal appointment booked.

2.2.8 If the woman has opted for a vaginal breech delivery then labour should not be induced unless the decision is made by a consultant.

2.3. External Cephalic Version (ECV)

2.3.1 Contraindications to ECV

   There is no clear consensus on contraindications to ECV. There is no evidence of greater risk in women with one previous caesarean section over those with an unscarred uterus, and therefore can be offered to women aiming for VBAC. (New 2008)

   Contraindications in the literature include:
   - Caesarean delivery is required for other reason
   - Antepartum Haemorrhage within the last 7 days
   - Major Uterine Anomaly
   - Ruptured Membranes/oligohydramnios
   - Multiple Pregnancy
   - Abnormal dopplers or suspected fetal compromise on CTG
   - Severe Pre-eclampsia
   - Major Fetal Anomalies

2.3.2 Management of ECV

   - Women should be counselled that about 50% of ECV attempts will be successful
   - ECV should be performed on delivery suite but the woman does not need to be nil by mouth (NBM)
   - MEOWS must be recorded prior to procedure and a normal CTG recorded
   - On Admission an ultrasound scan to confirm presentation, fetal position and nuchal cord
ECV can be attempted a maximum of 3 times over 10 minutes
Tocolysis can be given and is shown to increase success rates: Terbutaline 250mcg subcutaneously is used
CTG and maternal observations should be repeated after an attempt whether successful or not
If mother is rhesus negative then give Anti-D and send a Kleihauer (new 2018)

2.4. Vaginal Breech Delivery

2.4.1. Information for women

- Maternal complications are lowest with a successful vaginal delivery, greater with elective caesarean and highest with an emergency caesarean (required in up to 40% of women planning vaginal birth).
- Women should be given an individualised assessment of long term risks of caesarean section based upon individual risk factors and reproductive intentions.
- Women should be informed that when planning delivery for a breech baby, the risk of perinatal mortality is approximately 0.5/1000 with caesarean section after 39+0 weeks of gestation; and approximately 2.0/1000 with planned vaginal breech birth. This compares to approximately 1.0/1000 with planned cephalic birth.
- Women should be informed that planned vaginal breech birth increases the risk of low Apgar scores and serious short-term complications, but has not been shown to increase the risk of long-term morbidity.

2.4.2. Selection of patients for vaginal breech delivery

The following factors increase the perinatal risk of planned vaginal breech birth and a caesarean section should be recommended.

- Footling presentation
- Hyperextension of the fetal neck
- Estimated fetal weight >3.8kg or below 10th centile.
- Evidence of fetal compromise
- Previous Caesarean section

2.5. Intrapartum management of vaginal breech – (flow chart Appendix 4)

- Plan for delivery must be clearly documented in the mother’s notes
- Care should be given by an experienced obstetrician and midwife
- Aim of management is to ensure mother and fetus are in good condition at the start of the second stage of labour
- Continuous fetal monitoring in labour STAN can be used but the ECG complex will need to be inverted (the monitor should alert you to this). (new 2018)
• Unless the labour is progressing rapidly, any fetal concerns in the first stage should prompt delivery by caesarean section.
• Augmentation should only be used for poor contraction pattern in the absence of an epidural and no evidence of secondary arrest, and after discussion with the consultant obstetrician.
• Upright positions are recommended for the 1st stage of labour to encourage optimal progress
• Early assessment by an anaesthetist is recommended.
• Women should be offered the same options for pain relief in labour; however epidural analgesia is likely to increase the risk of intervention and should not be offered routinely.
• Ranitidine 150mg orally 6 hourly

2.5.1 Management of delivery

• An experienced Obstetrician should be the lead professional at delivery
• An anaesthetist to be present on delivery suite
• A member of the neonatal team should be present for delivery
• Passive second stage, to allow descent to perineum prior to pushing, for a maximum of 2 hours. (new 2018)
• Semi-recumbent or all fours position is appropriate according to the experience of the attendant and maternal preferences
• If assistance is required semi recumbent maybe more appropriate as most training in assistance (e.g. PROMPT) is in this position. (new 2018); manoeuvres can be performed in all fours but only if the birth attendant has the adequate skills and experience and should not delay changing the woman’s position if more appropriate to provide assistance (new 2018)
• Aim for ‘hands off’ delivery unless signs of delay (>5mins from buttocks to head) or fetal compromise (new 2018)
• If delay due to extension of fetal neck suprapubic pressure may be applied to aid flexion (new 2018)

2.6. Management of preterm breech

• There is insufficient evidence to support routine Caesarean Section for preterm breech deliveries; mode of delivery for pre-term delivery should be individualised to woman and her partner
• Caesarean section in spontaneous labour at the limits of viability is not routinely recommended (new 2018)
• It is particularly important for pre-term breech deliveries that the second stage is confirmed by vaginal examination before pushing. If unable to prevent pushing before full dilatation then an epidural should be encouraged
• If there is head entrapment during a pre-term (or term) breech delivery, incisions to the cervix at the orientation of 10 o’clock and 2 o’clock should be considered
2.7. Management of twin breech

For the first twin presenting as breech, Caesarean delivery has been demonstrated to improve neonatal Apgar score at 5 minutes (OR 0.33, 95% CI 0.17–0.65) but has failed to show any other benefit. A Caesarean Section however may prevent the complication of ‘interlocking’ if the second twin is vertex, although this complication is extremely rare. There is insufficient evidence to support the routine delivery of the second twin in breech presentation by Caesarean Section.

2.8. Management of undiagnosed breech in labour

- If breech presentation in labour is suspected in the community setting, call ‘999’ for a paramedic ambulance. If on the birth unit inform the deliver suite co-ordinator and arrange transfer
- Make an assessment of the stage of labour and whether delivery is imminent
- The preference is to transfer to Consultant unit if estimated time allows
- If delivery imminent call for a second midwife, if not already present, and prepare for a vaginal breech delivery
- If delivery imminent in the birth centre call the Obstetric Registrar and neonatal SHO to attend
- If delivery not imminent, discuss findings with the woman and advise immediate transfer to the consultant unit by ambulance and midwife escort

2.9 Consultant unit - management of undiagnosed breech in labour

- An ultrasound scan must be performed to confirm presentation (and if possible assessment of fetal position, extension of fetal neck)
- Inform consultant on for delivery suite/on call
- Management should depend on risk factors, stage of labour, rate of progress and woman’s preferences (The Term Breech trial is irrelevant in labour) (new 2018)
- Women near or in second stage of labour should not routinely be offered a caesarean section (new 2018) if the woman is >8cm dilated and is not keen on a vaginal breech delivery then she needs to be informed that she will be transferred to theatre and re-examined with good analgesia. If fully dilated and the breech is advancing rapidly then she should be encouraged to continue for a vaginal breech delivery as proceeding with a caesarean section in this situation is likely to involve more risks.
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Outcomes of the suspected and confirmed breech pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Audit Midwife</td>
</tr>
<tr>
<td>Tool</td>
<td>See auditing tool Appendix 3</td>
</tr>
<tr>
<td>Frequency</td>
<td>Yearly</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Maternity Patient Safety Forum and Clinical Audit Forum</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>If discrepancies are identified an action plan will be developed and monitored by the Maternity Patient Safety Forum and Clinical Audit Forum</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Any changes to practice will be managed as per the action plan and communicated through a change in the Patient Safety Newsletter</td>
</tr>
</tbody>
</table>

4. Equality and Diversity

4.1 This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

4.2 **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
<table>
<thead>
<tr>
<th>Brief summary of contents</th>
<th>This guideline gives guidance to midwives and obstetricians on the management of a suspected breech presentation in the antenatal period, options for the management of a confirmed breech presentation including external cephalic version (ECV) and the management of a breech presentation in labour.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggested Keywords:</td>
<td>Breech, presentation, delivery, birth, external, cephalic, version, ECV, undiagnosed, tocolytic, Terbutaline, vaginal, Caesarean</td>
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<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>10&lt;sup&gt;th&lt;/sup&gt; August 2018</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Breech Presentation, External Cephalic Version (ECV) And Breech Presentation In Labour Clinical Guideline V1.3</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Maternity Guidelines Group Obs and Gynaec Directorate Divisional Board PRG</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Tunde Adewopo</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
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</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td><strong>Lead confirming approval by specialty and divisional management meetings</strong></td>
<td>Name: Caroline Amukusana</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>Signature of Executive Director giving approval</strong></td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td><strong>Publication Location (refer to Policy on Policies – Approvals and Ratification):</strong></td>
<td>Internet &amp; Intranet ✓ Intranet Only</td>
</tr>
<tr>
<td><strong>Document Library Folder/Sub Folder</strong></td>
<td>Clinical / Midwifery and Obstetrics</td>
</tr>
<tr>
<td><strong>Links to key external standards</strong></td>
<td>None</td>
</tr>
</tbody>
</table>

**Related Documents:**


Collea JV, Chein C, Quilligan EJ. The randomised management of term frank breech presentation; a study of 208 cases. Am J Obset Gynec 1990; 137: 235-244.


Royal College of Obstetricians and Gynaecologists Clinical Green Top Guidelines for External Cephalic Version and Reducing the Incidence of Breech presentation March 2017

Hofmeyr GJ. Interventions to help external
Breech Presentation, External Cephalic Version (ECV) and breech presentation in Labour Clinical Guideline V 2.0

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>All midwives and obstetrics will attend the training in obstetric multidisciplinary emergencies (TOME) day, annually, where they will receive an update in the management of a vaginal breech delivery.</td>
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</table>

**Version Control Table**

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
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<tr>
<td>February 2005</td>
<td>V1.0</td>
<td>Initial document</td>
<td></td>
</tr>
<tr>
<td>Feb 2008</td>
<td>V1.1</td>
<td>Document reviewed, no change</td>
<td></td>
</tr>
<tr>
<td>July 2012</td>
<td>V1.2</td>
<td>Reviewed, updated and amalgamated with external cephalic version guideline</td>
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<tr>
<td>June 2015</td>
<td>V1.3</td>
<td>Reviewed, no changes required</td>
<td>Karen Watkins Consultant Obstetrician</td>
</tr>
<tr>
<td>August 2018</td>
<td>V2.0</td>
<td>Full review. Please see new 2018 in body of text</td>
<td>Helen Le Grys Speciality Registrar</td>
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All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

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## Appendix 2. Initial Equality Impact Assessment Form

*This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.*

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Directorate and service area: Obs and Gynae Directorate</th>
<th>Is this a new or existing Policy?</th>
<th>Telephone: 01872 252879</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breech Presentation, External Cephalic Version (ECV) And Breech Presentation In Labour Clinical Guideline V2.0</td>
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</tbody>
</table>

**Name of individual completing assessment:**

Helen Le Grys

1. **Policy Aim***

Who is the strategy / policy / proposal / service function aimed at?

This guideline gives guidance to midwives and obstetricians on the management of a suspected breech presentation in the antenatal period, options for the management of a confirmed breech presentation including external cephalic version (ECV) and the management of a breech presentation in labour.

2. **Policy Objectives***

To ensure pregnant women with a breech presentation receive appropriate and timely care.

3. **Policy – intended Outcomes***

To achieve best possible outcome for the woman and the baby.

4. **How will you measure the outcome?***

Compliance Monitoring Tool

5. **Who is intended to benefit from the policy?***

All women presenting with a breech presentation over 36 weeks gestation

6a Who did you consult with

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
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</tbody>
</table>

b). Please identify the groups who have been consulted about this procedure.

- Maternity Guidelines Group
- Obs and Gynae Directorate
- Divisional Board
- PRG

*Please record specific names of groups*
What was the outcome of the consultation? | Guideline agreed
---|---

7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy **could** have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tbody>
<tr>
<td>Age</td>
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<td></td>
<td>X</td>
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<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
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<td>X</td>
<td></td>
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<tr>
<td>Race / Ethnic communities /groups</td>
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<td>X</td>
<td></td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
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<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
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<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
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<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this **excludes** any policies which have been identified as not requiring consultation. **or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No |
---|-----|----|
|     | X   |
9. If you are **not** recommending a Full Impact assessment please explain why.

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen Le Grys</td>
<td>10/08/2018</td>
</tr>
</tbody>
</table>

| Names and signatures of members carrying out the Screening Assessment | 1. Helen Le Grys | 2. Human Rights, Equality & Inclusion Lead |

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**Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead**  
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

**This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.**

A summary of the results will be published on the Trust’s web site.

Signed **Sarah-Jane Pedler**  
Date **10th August 2018**
Appendix 3

Monitoring Compliance and Effectiveness

Guideline Audit Tool

<table>
<thead>
<tr>
<th>Applicable Guideline</th>
<th>Breech Presentation, External Cephalic Version (ECV) And Breech Presentation In Labour Clinical Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Register Number</td>
<td>(For audit use)</td>
</tr>
<tr>
<td>Process</td>
<td>Retrospective</td>
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<tr>
<td>Audit Date</td>
<td>(For audit use)</td>
</tr>
<tr>
<td>Auditor</td>
<td>(For audit use)</td>
</tr>
</tbody>
</table>

### Audit Questions ECV

1. If breech on scan was full biometry undertaken and liquor volume assessed?
2. Any contraindications for ECV present?
3. If biometry and liquor volume were normal and no contraindications was ECV offered?
4. Was CTG completed before ECV?
5. Was CTG repeated post ECV attempt regardless of success?
6. Was ECV successful?
7. If Rhesus negative was anti-D given and a Keilhauer sent?
8. If unsuccessful were repeat ECV, vaginal breech and ELCS discussed?

### Audit Questions breech at delivery

1. Was the breech position detected prior to labour?
2. If detected in labour at what dilatation was it noted?
3. Was a doctor present for the breech delivery?
4. Were the neonatal team called prior to the delivery?
5. What was the mode of delivery?
6. Were cord gasses taken?
7. Was admission to the neonatal unit required?
8. If admitted to the neonatal unit why?