1. Aim/Purpose of this Guideline
1.1. 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 widely 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/truma.

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.
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. Vaginal Breech Delivery

2.2.1. Selection of patients for vaginal breech delivery
- No contraindications to vaginal birth (e.g. Placenta Praevia, severe SGA)
- The presentation is frank (hips flexed and knees extended) or complete (hips flexed and knees flexed, but feet not below the buttocks)
- No evidence of cephalopelvic disproportion or other complications associated with mechanical difficulties at birth
- No evidence of hyperextension of the fetal head
- Presence of a clinician trained in vaginal breech delivery
2.2.2. Contraindications to vaginal breech delivery
- Poor obstetric history
- Pelvic abnormality
- Previous Caesarean Section
- Medical maternal condition e.g. Diabetes, Pre-eclampsia
- Fetal weight estimated at over 3500g or below 2000g

2.3. Antenatal management
- If breech presentation is suspected at 36 completed weeks gestation a presentation scan for the next available scan slot should be organised via maternity reception x 2739
- If breech presentation is confirmed full biometry should be undertaken and an assessment of liquor volume
- 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. The date and time should be recorded on the Information Sheet.
- ECV should be performed as close to 37 weeks as possible but after 36 weeks. The woman does NOT need to be nil by mouth (NBM) for the procedure. See 2.4 for further details.
- 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.
- 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
- 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.
- If the woman has opted for a vaginal breech delivery then labour should not be induced unless the decision is made by a consultant

2.4. External Cephalic Version (ECV)

2.4.1. Selection for ECV
- Singleton pregnancy
- Breech presentation (confirmed by ultrasound)
- After 36 completed weeks, it is most likely to be successful close to this time

2.4.2. Contraindications to ECV
- Caesarean delivery is required for other reason
- Antepartum Hemorrhage within the last 7 days or recurrent APH in pregnancy
- Major Uterine Anomaly
- Ruptured Membranes
- Multiple Pregnancy
- Small-for-gestational-age fetus with abnormal Doppler parameters
- Pre-eclampsia
- Oligohydramnios
- Major Fetal Anomalies
- Scarred Uterus (relative CI – discuss with consultant before booking)

2.4. Management of ECV
- Women should be counselled that about 50% of ECV attempts will be successful
- BP & pulse must be checked 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, Kleihauer test not necessary

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 monitoring of fetal wellbeing and progress in labour
- Early assessment by an anaesthetist is recommended. There is no evidence that epidural anaesthesia is essential.
- Ranitidine 150mg orally 6 hourly
- Fetal blood sampling from the buttocks is not advised due to an insufficient evidence base for this technique
- Specialist Registrar should be the lead professional at delivery
- An anaesthetist to be present on delivery suite
- An episiotomy can be performed to facilitate delivery
- A member of the neonatal team should be present for delivery

2.6. Management of preterm breech
- ECV before 37 weeks has not been shown to offer any benefits
- 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
- 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, lateral incisions to the cervix 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. Community setting - management of undiagnosed breech in labour
- If breech presentation in labour is suspected in the community setting, call ‘999’ for a paramedic ambulance
- Make an assessment of the stage of labour and whether delivery is imminent
- If delivery imminent call for a second midwife, if not already present, and prepare for a vaginal breech delivery
- If delivery not imminent, discuss finds 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
- On arrival to the consultant unit an ultrasound scan must be performed to confirm presentation
- A review by the Senior Registrar should be sought and there should be a discussion with the woman regarding her options for delivery
- The results of the term breech trial do not apply in this situation and counselling should reflect this
- The risks of caesarean section in advanced labour need to be taken into account when counselling re options
- Inform consultant on for delivery suite/on call
- 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>Maternity Risk Management Midwife</td>
</tr>
<tr>
<td>Tool</td>
<td>Number of women receiving a presentation scan</td>
</tr>
<tr>
<td></td>
<td>Number of women where breech is confirmed</td>
</tr>
<tr>
<td></td>
<td>Number of accepted ECV's</td>
</tr>
</tbody>
</table>

BREECH PRESENTATION, EXTERNAL CEPHALIC VERSION (ECV) AND BREECH PRESENTATION IN LABOUR - CLINICAL GUIDELINE
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Reporting arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yearly</td>
<td>Maternity Risk Management Forum and Clinical Audit Forum</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action on recommendations and Lead(s)</th>
<th>If discrepancies are identified an action plan will be developed and monitored by the Maternity Risk Management Forum and Clinical Audit Forum</th>
</tr>
</thead>
</table>

| Change in practice and lessons to be shared | Any changes to practice will be managed as per the action plan and communicated through a change in the Risk Management Newsletter |

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>BREECH PRESENTATION, EXTERNAL CEPHALIC VERSION (ECV) AND BREECH PRESENTATION IN LABOUR - CLINICAL GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>18&lt;sup&gt;th&lt;/sup&gt; June 2015</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>18&lt;sup&gt;th&lt;/sup&gt; June 2015</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>18&lt;sup&gt;th&lt;/sup&gt; June 2018</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Karen Watkins  
Obs and Gynae Directorate |
| Contact details: | 01872 252729 |
| Brief summary of contents | 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. |
| Suggested Keywords: | Breech, presentation, delivery, birth, external, cephalic, version, ECV, undiagnosed, tocolytic, Terbutaline, vaginal, Caesarean |
| Target Audience | RCHT | PCH | CFT | KCCG |
| Executive Director responsible for Policy: | Medical Director |
| Date revised: | 18<sup>th</sup> June 2015 |
| This document replaces (exact title of previous version): | Breech Presentation in the Antenatal Period, and Breech Delivery - Clinical Guideline for Management |
| Approval route (names of committees)/consultation: | Maternity Guidelines Group  
Obs and Gynae Directorate  
Divisional Board for noting |
| Divisional Manager confirming approval processes | Head of Midwifery |
| Name and Post Title of additional signatories | Not Required |
### Related Documents:

- Royal College of Obstetricians and Gynaecologists Clinical Green Top Guidelines for the Management of Breech Presentation December 2006.
- Royal College of Obstetricians and Gynaecologists Clinical Green Top Guidelines for External Cephalic version (ECV) and Breech Presentation in Labour - Clinical Guideline

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.

<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>
</thead>
<tbody>
<tr>
<td>February 2005</td>
<td>1.0</td>
<td>Initial document</td>
<td></td>
</tr>
<tr>
<td>Feb 2008</td>
<td>1.1</td>
<td>Document reviewed, no change</td>
<td></td>
</tr>
<tr>
<td>July 2012</td>
<td>1.2</td>
<td>Reviewed, updated and amalgamated with external cephalic version guideline</td>
<td></td>
</tr>
<tr>
<td>18th June 2015</td>
<td>1.3</td>
<td>Reviewed, no changes required</td>
<td>Karen Watkins Consultant Obstetrician</td>
</tr>
</tbody>
</table>

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

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy)</th>
<th>BREECH PRESENTATION, EXTERNAL CEPHALIC VERSION (ECV) AND BREECH PRESENTATION IN LABOUR - CLINICAL GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Is this a new or existing Policy?</td>
</tr>
<tr>
<td>Obs and Gynae Directorate</td>
<td>Existing</td>
</tr>
<tr>
<td>Name of individual completing assessment:</td>
<td>Telephone: 01872 252879</td>
</tr>
<tr>
<td>Elizabeth Anderson</td>
<td></td>
</tr>
</tbody>
</table>

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) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?  
No

b) If yes, have these *groups been consulted?  
N/A

C). Please list any groups who have been consulted about this procedure.  
N/A

7. The Impact  
Please complete the following table.

<p>| Are there concerns that the policy could have differential impact on: |
|---|---|
| Equality Strands: | Yes | No |
| Rationale for Assessment / Existing Evidence |</p>
<table>
<thead>
<tr>
<th>Age</th>
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</thead>
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<tr>
<td>Sex (male, female, transgender / gender reassignment)</td>
<td>X</td>
</tr>
<tr>
<td>Race / Ethnic communities / groups</td>
<td>X</td>
</tr>
<tr>
<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
<td>X</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>X</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>X</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>X</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 service redesign or development

8. Please indicate if a full equality analysis is recommended.  Yes No

9. If you are not recommending a Full Impact assessment please explain why.

N/A

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Elizabeth Anderson</td>
<td>Karen Watkins</td>
</tr>
</tbody>
</table>

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
A summary of the results will be published on the Trust’s web site.
Signed: Elizabeth Anderson

Date: 18th June 2015
Appendix 3:

Information Leaflet - ECV - External Cephalic Version

As your baby has been found to be in the breech position (i.e. lying bottom-first in the womb) you have been offered ECV. This is because we know that vaginal breech birth is more complicated than normal birth.

**What is external cephalic version (ECV)?**

This is a procedure in which the doctor tries to turn the baby by applying gentle pressure on your abdomen with their hands. This helps the baby turn a somersault in the womb to lie head-first. The procedure does not hurt your baby as it is protected from the pressure by your abdominal wall (skin, fat tissue and muscle), your womb and the water that surrounds the baby.

**What is the main benefit of ECV?**

ECV increases the likelihood of having a vaginal birth.

**What are the chances of it working?**

ECV is successful for up to half of all women (50%). The chance of success is likely to be less if this is your first baby or if you are near your due date.

Relaxing the muscles of the womb with medication during an ECV is likely to improve the chance of success. This medication will not affect the baby. You can help by trying to relax your abdominal muscles.

ECV can be done right up until you give birth but the later it is done the less likely it is to work.

**Is ECV safe for me and my baby?**

ECV is generally safe and does not cause labour to begin. But, like any medical procedure, complications can sometimes occur.

About 1 in 200 (0.5%) babies need to be delivered by emergency caesarean section immediately after an ECV because of bleeding from the placenta and/or changes in the baby’s heartbeat. The risk of requiring a caesarean section however during a normal...
labour is much higher than this, so you should not be alarmed by this possibility. The baby’s heart will be monitored before and after the ECV to check for any changes. The ECV will be carried out on delivery suite so the baby can be delivered quickly if necessary. This is however very unlikely.

If you have Rhesus negative blood group then an anti-D injection will be required because there is a chance a small amount of your baby’s blood may mix with yours as a result of the procedure.

**Is ECV painful?**
ECV can be uncomfortable. You should tell the doctor if it is too painful so they can stop or move away from that area.

**Is there anything else I can do to help my baby turn?**
There is no scientific evidence that lying down or sitting in particular position can help your baby to turn.

**What if ECV is unsuccessful?**
If the baby does not want to turn, the doctor or midwife will discuss your options for delivery. If you opt for a caesarean section a date for this can be arranged on the day of the ECV

**Date of ECV:**………………………………

**Time:**………………………………………

Please take this leaflet away with you, so you can refer to it at a later stage.

If you have any questions you can either ask your midwife or ask the doctor who will be performing the ECV
Appendix: 4:

**BREECH LABOUR ALGORITHM**

Initial assessment by Obstetric Registrar
Vaginal examination at SROM to exclude cord prolapse
**DISCUSS WITH CONSULTANT**

ashtra

**PARTOGRAM**
Continuous cardiotocography
Assess progress 4 hourly

**Normal progress**
See progress in labour guideline

**Abnormal Progress**
Consider Syntocinon
Discuss with Consultant first

**Abnormal progress 2nd STAGE**
Poor descent
Discuss with Consultant

**Abnormal CTG**

**Significant Fetal acidosis**

**Abnormal Progress**
See progress in labour guideline

**Normal Progress to 2nd STAGE**
Allow 1 hour for descent if epidural SpR to reassess after 1 hour of active 1st stage.

**Obs. Reg, Anaesthetist, Paediatrician in Attendance**
Prepare for vaginal delivery

**Emergency lower segment caesarean section**