Elective Caesarean Section for Breech Presentation Guideline

The purpose of this guideline is to give guidance to maternity staff on the obstetric management of women undergoing C/S for breech presentation.

Background

The incidence of term, singleton breech presentation is around 3-4%. This affects almost 40,000 women annually in the UK alone. There has been an increasing reluctance, in the light of current research, to allow vaginal birth and for many an elective caesarean section is the favoured option.

Small number of women will go into labour before the date of their elective caesarean section. This may result in a vaginal breech delivery if things progress quickly, but if time allows a caesarean section will be carried out as planned.

However, it is important that women are clinically assessed on admission to prevent unnecessary procedures. This is important as any intervention has major consequences for women, their babies and the maternity services.

Consent

- Elective C/S leads to a small reduction in perinatal mortality compared with planned vaginal breech delivery. This is due to 3 factors:
  1. Avoidance of stillbirth after 39 weeks of gestation
  2. Avoidance of intrapartum risks
  3. Risks of vaginal breech birth

- Perinatal mortality is approximately 0.5/1000 with C/S after 39+0 weeks of gestation and approximately 2/1000 with planned vaginal birth. This compares to approximately 1/1000 with planned cephalic birth.

- Elective C/S 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.

- Elective C/S at term carries a small increase in immediate complications for the mother compared with planned vaginal birth.

- Please also refer to standard elective C/S consent form.

Procedure

- Elective C/S should be carried out around 39 weeks gestation.
- Follow elective C/S guidelines for antenatal preparation.
- All women who are to have elective procedure for breech presentation should be informed at the antenatal clinic that they would be clinically assessed on admission. If the presentation is then cephalic they should be offered the option to await spontaneous labour.
- Obstetrician should scan all women on the day, but prior to admission to theatre.
- If presentation is cephalic but not engaged – there is a possibility of unstable lie. Whilst it is in a favourable position, she may be considered for induction procedure to avoid malpresentation re-occurring. The woman must be given unbiased, but correct information and included in this decision.
- If presentation is cephalic and engaged, the woman generally should be discharged home and given a date to attend the antenatal clinic. The woman must be given unbiased, but correct information and included in this decision.

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Review Date: February 2024