NHS Lanarkshire

Guideline for delivery of Breech by Caesarean Section

1 Delivery of Breech by Caesarean Section

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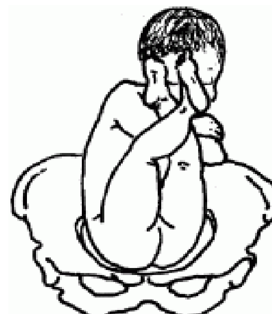
Type of Breech Presentation

There are four types of breech presentation. They are determined by the way in which the fetal legs are flexed or extended, and these have implications for the delivery

- **Complete or Flexed Breech:** The flexed breech occurs more commonly in the multigravid woman. Flexed breech is when the fetus sits with the thighs and knees flexed with the feet close to the buttocks. (see Diagram A)
- **Frank or Extended Breech:** This is the commonest type of breech presentation and occurs most frequently in the primigravid woman towards term: the fetal thighs are flexed, but the legs are extended at the knees and lie alongside the trunk, the feet being near the fetal head. (see Diagram B)
- **Footling presentation:** This type of breech is more likely to occur when the fetus is preterm, but is relatively rare. Footling breech is when one or both feet present below the fetal buttocks, with hips and knees extended. There is increased risk of cord prolapsed with attempt at vaginal delivery or is rupture of membranes.
- **Knee presentation:** This is the least common. This occurs when one or both knees present below the fetal buttocks, with one or both hips extended and the knees flexed.



The following minimise the operative risk during caesarean section and/ or manages the problem.

1. **Preoperative ward round**

   Introduce yourself to the woman, Read the notes carefully and gain maximum information about type of Breech (i.e. extended, flexed), placenta site, parity, gestation, any previous abdominal surgeries etc. Check latest ultrasound - Remember that the baby may be big as well as breech. Confirm presentation with portable ultrasound.

2. **Surgical Brief /Pause**

   Surgical Brief with team. **Contact the neonatal team** to be present at delivery if neonatal problems are anticipated

3. **Establish where the fetal back lies.**

4. **Make an appropriate skin incision:**

   Err on a larger incision than you might make for a Cephalic presentation. The shape of the Head may be unusual (doliocephalic, brachycephalic)

5. Remember that there is no point in making a large skin incision and then a narrower sheath incision. Make as much room as you can. Lateral incision of the parietal peritoneum may help.

6. Once entered into uterine cavity and breech is being delivered, **guide your assistant for fundal stabilisation** . This encourages neck flexion and reduces the chance of head extension.

7. Once the body is delivered deliver the after coming head in the manner described for vaginal delivery i.e. MSV manoeuvre to aid flexion of neck or forceps application

8. **If there is entrapment of the head**

   Do NOT simply pull harder- Identify where the entrapment is.

   Consider **Wrigley's Forceps** to after coming head if there is enough room and deliver as per instructions for vaginal breech.

   Skin-**carefully enlarge the skin incision** with scalpel

   Sheath – **extend the rectus sheath** with scissors

   Uterus – **extend the uterine incision** digitally or with scissors, (J-shaped)

   Tocolysis with 0.5 mg Terbutaline or GTN (spray of two puffs equivalent to 400 mcg per puff as first line.

   General Anaesthesia with a high end tidal concentration of volatile agent eg sevoflurane will often produce useful relaxation of the cervix
   GTN increases the risk of PPH.

   Retry applying the forceps

   If all fails- **consider inverted-T shaped incision or J shaped incision**

9. In case of difficulty in delivering the second twin or a singleton in transverse or oblique presentation, **internal podalic version** should be considered

Technique for Internal Podalic Version at Caesarean Section

- One hand is used to stabilise the uterus externally, and the other hand and forearm is introduced into uterus.
- A fetal foot/feet are identified by recognising a heel
- The foot is grasped and pulled gently and continuously through uterine incision at.
- The membranes are ruptured as late as possible.
- The baby is then delivered by breech extraction with pelvi-femoral traction
- Lovset's manoeuvre to the shoulders if required and a controlled delivery of the head.

If arm is extracted by mistake, it should be gently replaced and foot should be identified again

This procedure is easiest when the transverse lie is with the back superior or posterior. If the back is inferior or if the limbs are not immediately palpable, follow the curve of the back and down and round to find the leg. Confirm you have a foot before applying traction. This will minimise the risk of the unwelcome experience of bringing down a fetal hand and arm in the mistaken belief that it is a foot.

A few seconds of calm consideration and accurate assessment will almost certainly result in an effective delivery manoeuvres

10. After delivery- **ensure appropriate haemostasis** especially if J- or Inverted T incisions or tocolysis were required to aid the delivery
11. **Take Paired cord pH samples Document carefully** with timings of skin incision, entry to uterus , delivery of breech and delivery of head. **The neonatal condition at birth should be documented.**
12. **Surgical Sign Out**
13. **Surgical Debrief - if required**
14. **Explain to couple what happened**. This is of particular importance if a uterotomy is extended and VBAC no longer a future option.
15. Contact geographical consultant if postnatal follow up indicated.

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Date	**August 2020**
Ratified by:	**Maternity Clinical EffectivenessGroup(October 2020)**
Review date:	**October 2023**