

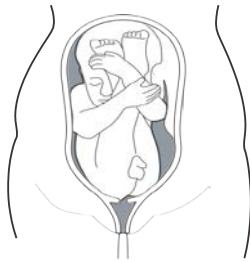
## Management of Breech Presentation in Pregnancy and External Cephalic Version

Breech presentation at term occurs in 3% of pregnancies. Options for management at that stage include External Cephalic Version, Elective caesarean section and vaginal breech delivery

### TYPES OF BREECH

#### 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.



#### 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.



#### 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 prolapse.



#### 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.

## **External Cephalic Version**

In many countries, including the UK, planned vaginal breech birth remains rare and attempts to prevent breech presentation at delivery remain important.

External cephalic version (ECV) is the manipulation of the fetus, through the maternal abdomen, to a cephalic presentation.

### **Success rates of ECV**

**The success rate of ECV is approximately 50%. Overall success levels are greater for multiparous women (60%) than for nulliparous women (40%).**

Labour after successful ECV is associated with a slightly increased rate of caesarean section and instrumental delivery when compared with spontaneous cephalic presentation. The risk of caesarean delivery may be greater with a shorter ECV to labour interval.

Use of tocolysis improves the success rates of ECV.

ECV should be offered from 36+0 in nulliparous patients and from 37<sup>+0</sup> weeks of gestation for multiparous patients.

There is no upper gestation limit for when ECV can be offered, but contraindications may be more common.

With an unstable lie, ECV is reasonable **only** in the course of a stabilising induction. ECV should only be performed if there is a valid indication for induction.

Potential risks include cord prolapse, transverse lie in labour and fetal heart rate abnormalities.

After an unsuccessful ECV attempt at 36<sup>+0</sup> weeks of gestation or later, only a few babies presenting by the breech will spontaneously turn to cephalic presentation.

Few babies revert to breech after successful ECV.

ECV performed pre term is not associated with a reduction in non-cephalic births

**Women should be informed that ECV after one caesarean delivery appears to have no greater risk than with an unscarred uterus.**

Women should be counselled that with appropriate precautions, ECV has a very low complication rate. The reported risk of emergency caesarean section within 24 hours is approximately 1 in 200 (0.5%) with the indication in over 90% being vaginal bleeding or an abnormal CTG following the procedure.

### **Potential risks of ECV**

1. Placental separation.

Concerns stem largely from observations and anecdotal accounts of procedures carried out pre term or without fetal monitoring

2. Direct fetal trauma.

Fetal deaths at term have been associated with the use of nitrous oxide or general anaesthetic.

3. Fetomaternal transfusion.

A detectable feto-maternal transfusion is reported in 0-28% of cases. Therefore rhesus negative women should be given anti-D

4. Changes in fetal heart rate.

These are common and usually transient with no association between these changes and various outcome measures

### **Contraindications to ECV**

#### **Absolute**

Any associated condition which requires a Caesarean section

Major Placenta praevia

Uterine anomaly

Significant antepartum haemorrhage

Multiple pregnancy (except after delivery of a first twin)

#### **Relative**

Rhesus iso immunisation

Minor antepartum haemorrhage

Ruptured membranes

Oligohydramnios

Intrauterine growth restriction

Pre-eclampsia

## **How could the uptake of ECV be increased?**

The uptake of ECV is best increased by timely identification of the baby presenting by the breech and provision of evidence-based information ideally from the woman's known care provider. The greatest impediment to the use of ECV is the non identification of breech presentation. The proportion of undetected breech presentation at term has been reported in as high as 20.0–32.5% of all breech presentations and these have worse outcomes. The possibility of breech presentation should always be considered at clinical examination although abdominal palpation has a sensitivity of only 70%.

Particular care should be taken with high-risk groups in the third trimester e.g. where a previous baby has been breech. Recurrence rate after one breech presentation is 9.9%. Access to a presentation scan after 36+0 weeks of gestation is helpful.

## **Management of breech presentation diagnosed in pregnancy**

If breech on scan or palpation <34 w, advise the woman that there is still a high chance the baby will turn to cephalic.

If breech on scan or palpation at > 34 weeks and elective caesarean section not planned for another obstetric indication arrange consultant appointment at 35-36 weeks if nulliparous and 36-37 weeks if multiparous. If still palpates as breech discuss ECV and provide patient information leaflet.

Arrange scan within 2 working days for confirmation. If breech confirmed in scan department after 36/37 w to refer directly to DCU who will arrange ECV appointment as soon as possible.

If declines ECV arrange for elective caesarean section at 39 weeks .

If ECV successful then arrange follow up appointment at antenatal clinic the following week to ensure that baby remains cephalic.

If ECV is unsuccessful or she declines ECV discuss the risks and benefits of elective caesarean section versus vaginal breech delivery. Elective CS should be booked for 39 weeks.

It is important to counsel the woman that an elective caesarean section may be cancelled if spontaneous version occurs. If the woman's preference is for a vaginal breech birth, this must be fully discussed and a clear plan documented in her electronic record.

## **External Cephalic Version**

On arrival to DCU if still palpates breech then commence CTG and offer analgesia – cocodamol 30/500 x 2 tabs or alternative if allergic 30 mins prior to planned procedure

Perform bedside ultrasound scan to determine type of breech and position of fetal back, LV and placental position

Administer terbutaline 0.5 mgs sc unless contraindicated

Hand placed to lift breech out of maternal pelvis and other hand used to flex fetal head. Attempt rotation – forward roll initial and backward roll if fails

The process can be quick in parous patients and take more time in primigravida. Rotation can be effected in stages. Check FH with US transducer every few minutes to ensure no fetal compromise. The procedure should take no more than 10 minutes from commencement of rotation.

Following procedure – whether successful or failed a repeat CTG should be undertaken.

Prophylactic Anti-D should be administered whether ECV is successful or not in appropriate Rhesus negative women

**Originated By: Dr Clare Willocks**

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Adapted from RCOG Green Top Guideline 20 a - External Cephalic Version and Reducing the Incidence of Term Breech Presentation

Pre ECV counselling checklist

Did patient receive patient information leaflet?

Yes/No

Discuss options:

- ECV
  - o Success rate approximately 50%
  - o After 36+0 the chance of spontaneous rotation to cephalic is low
  - o Small number of babies revert back to breech following successful ECV
  - o Reduces the rate of caesarean section
  - o Labour following successful ECV has slightly increased risk of caesarean section/instrumental delivery
  - o Very low complication rate including fetal distress/emergency c/section
  - o Can be a painful procedure (analgesia is provided)
  - o Procedure explained
  
- Vaginal breech delivery
  - o Slightly increased perinatal mortality in relation to planned caesarean section (2/1000 for vaginal breech vs 0.5/1000 for c/s)
  - o Increased risk of low Apgars and serious short term complications but has not been shown to increase the risk of long term morbidity
  - o Maternal complications are least with vaginal birth (risk of emergency c/section for vaginal breech is approx. 40%)
  - o Less experience with vaginal breech can impact outcome
  
- Elective caesarean section
  - o Increased maternal complications including return to theatre, damage to surrounding organs, PPH
  - o Increased risk to future pregnancies including stillbirth, invasive placenta, uterine rupture

Patient decision: .....

Document approved By Dr E Ferguson, Clinical Director, for local use April 2020