HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

Document ID: MATY016	Version: 1.0
Facilitated by: Eleanor Martin, Educator	Last reviewed: February 2015
Approved by: Maternity Quality Committee	Review date: February 2018

Breech Presentation Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Purpose

The purpose of this policy is to

- provide safe and consistent care to women whose baby is presenting breech
- establish a local approach to care that is evidence based
- inform good decision making

Scope

- All obstetric staff employed by the Hutt Valley DHB
- All midwifery staff employed by the Hutt Valley DHB
- All Hutt Valley DHB maternity access agreement holders
- Anaesthetic staff
- Neonatal staff

Background

Breech presentation occurs in 3 to 4 % of term pregnancies. (New Zealand Guidelines group, 2004. RCOG, 2006).
The incidence of breech presentation decreases with advancing gestational age. In acknowledging that breech presentation is a malpresentation it can pose added risks to birth.

It is agreed that practitioners have become less skilled / less experienced in vaginal breech birth post findings of the now famous Hannah et al randomised multi centre clinical trial of 2000. There is no data available on the expertise of midwifery practitioners in facilitating breech birth in New Zealand (New Zealand Guidelines Group, 2004).

Version from Breech Presentation to Cephalic Presentation

In light of the above any intervention which induces the breech baby to turn ought to be encouraged.
(Refer to Protocol)

Management of the woman experiencing a breech presentation in the antenatal period

Breech presentation diagnosed < 34 weeks

- No action required

Breech diagnosed by LMC >34 weeks

- Ultrasound examination to confirm breech presentation
- Referral category: Consultation Code 4016

After a detailed clinical examination of the woman the obstetrician will discuss findings with the woman

- Any clinical contraindications for a planned vaginal birth including skill of staff and local facility factors
- Recommend a plan with the woman and LMC
- Assess suitability for ECV (refer to ECV protocol)
- Inform woman of available evidence to facilitate decision making
- Document findings, plan and information discussed with the woman
- Communicate ongoing plan with LMC

Mode of Birth

The optimum mode of delivery for woman in advanced labour remains unclear and needs further research

- Planned caesarean section birth for breech presentation

Book an elective C/S at 39 + weeks. This is booked at secondary care clinic in the MAU.
Scan before surgery to confirm presentation
At C/S the uterus should be assessed for any abnormalities.

- Planned vaginal birth for breech presentation

Clear documentation of the discussion which occurred between the woman, LMC and the specialist obstetrician shall be in the clinical records before the onset of labour.
A care plan of management agreed by all parties will be in the clinical record.
On admission please notify the obstetrician, paediatric RMO, anaesthetist and theatre.
Labour with a breech is not very different from labour with a vertex and it continues if there is progressive dilation and descent of the breech.
There is no evidence that epidural anaesthesia is essential (Draycott et al, 2008).
Recommendations:

First stage of labour

- Continuous electronic foetal monitoring should be offered. There should be a low threshold for continuous foetal monitoring in breech birth. There is not much research in this area but CEMACH noted that there was clinical evidence of hypoxia in most breech babies and delays in staff response to foetal compromise. This should be a joint decision during labour (CESDI, 2000).
- Low threshold for consultation especially regarding progress of labour.
- Use of partogram
- IV cannula in situ, bloods for CBC and group & hold taken and sent.
- Vaginal assessment to confirm full dilatation

- Augmentation of labour may be undertaken at the discretion of the obstetric specialist.
- If a spontaneous rupture of membranes occur a vaginal examination is performed to exclude a cord prolapse
- Paediatric RMO is called for the birth
  (RCOG, 2006)

Second stage of labour
Remember hands off the breech
The breech birth should be undertaken by the most skilled practitioner. Position of the mother relies on the position the attendant is most familiar with.

Key Points
- If there is any delay in second stage a caesarean section should be considered
- The baby may be held over the bony prominences of the pelvis if obstetric manoeuvres required
- Keep the back of the baby uppermost or back of baby on the same side as mother's abdomen
- Avoid handling the umbilical cord
- If arms do not deliver use Lovesett's manoeuvre
- Use flexion techniques to deliver the baby's head. Maurice-Smellie-Veit grip or adaptation of that
- If spontaneous birth of the head does not follow, an assistant may apply suprapubic pressure to the mother to assist flexion of the baby's head.
- May need forceps to after coming head

A specialist obstetrician should be on the floor to safely address any difficulties that may arise delivering the after coming head.

Management of breech presentation diagnosed for the first time in labour
Even in the presence of optimal antenatal care there will still be women presenting with a baby in a breech position.

When a breech is diagnosed for the first time in labour the informed choice and consent must be clearly documented

Recommendations:

- Referral Guideline : Consultation Code 5006
- Breech presentation should be confirmed by ultrasound, if not visible
- Mode of delivery may be dictated by circumstances e.g. prolapsed cord, increased maternal risk of emergency caesarean section
- There should be immediate access to paediatric RMO and Caesarean section facilities.
  (RANZCOG, 2009)

A decision for continuing labour is that it is

- The preferred choice of the woman.

References

CCDHB OB IP-02 ID 178 (2010) Breech presentation (singleton foetus) management of. CCDHB: Author.

Draycott, T., Winter, C., Crofts, J. &Barnfield, S. (Eds.) (2008.) PROMPT. Practical Obstetric Multiprofessional Training Course Manual. United Kingdom: North Bristol NHS Trust.

Hannah, M.E., Hannah, W. j., Hewson, S.A., et al (2000) Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. *The Lancet* 356, 1375-1383.

New Zealand Govt. (2011). Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000. Wellington: New Zealand Govt.

New Zealand Guidelines Group (2007) Care of Women with Breech Presentation. New Zealand Guidelines Group.

Maternal and Child Health Research Consortium (2000). Confidential Enquiry into Stillbirths and Deaths in Infancy (CEMACH). 7th annual report. London: Author

Royal College of Obstetricians and Gynaecologists (RCOG) (2006). The Management of Breech Presentation. UK: Author.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists RANZCOG (2009). Management of the Term Breech Presentation. College statement **C-Obs 11** Australia: Author.

Appendix 1

Section 88, Levels of Referral

The following are taken from the Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000. Practitioners are referred to the original document for the full text.

Risk	Referral Category
Pregnancy	
▪ Malpresentation	Consultation

Risk	Referral Category
Labour and Birth	
▪ Breech Diagnosed in labour	Consultation

The LMC must recommend to the woman that a consultation with a specialist is warranted given that her pregnancy, birth, labour and puerperium is or may be affected by the condition.
Where consultation occurs, the decision regarding ongoing care, advice to the LMC on management, and any recommendation to subsequently transfer care must involve three way conversation between the specialist, the LMC and the woman. This should include discussion on any need for and timing of specialist review.
The specialist will not automatically assume responsibility for on going care. This will vary with the clinical situation and the wishes of the woman.
A consultation may result in a transfer of clinical responsibility. In this event, the consulting specialist formally notifies the LMC of the transfer and documents it in the woman's record.

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).