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When Your Baby is Breech

This information is provided with assistance from the Internet publications by Dr D.E. Tucker MRCOG www.womens_health.co.uk , Dr M Greenfield MD and The British Medical Journal. It has been modified by Dr M Brinsmead as a consequence of his three decades of experience in dealing with this problem.

How common are Breech Babies?

Most babies are born head first but, at the end of pregnancy, around 3-4% are found to be breech. Earlier in pregnancy, breech presentation is more common - about 20% of babies at 28 weeks are breech, and 15% at 32 weeks. Before term, which is defined as 37 completed weeks, it doesn't matter if the baby is breech, as there is always a good chance that he or she will turn spontaneously. Some babies do turn by themselves after 37 weeks, but it is much less likely, and some decisions need to be made from the options available. A few breech babies are discovered for the first time after labour has begun.

Why is a Breech Baby a Problem?

To put it simply the largest part of the baby is coming last. With the normal and headfirst presentation of a baby there are usually a number of hours of labour during which time the head will mould and shape itself to pass through the mother's pelvis. For a reasonable number of these births it becomes obvious from lack of progress in the labour that the baby's head is not fitting optimally. For these babies there is usually ample time to provide assistance, usually by means of a Caesarean section. However, for a breech baby the baby's head needs to negotiate the mother's pelvis in a time frame that is measured in minutes rather than hours. Because the umbilicus and its lifeline has already delivered before the head there is limited time and opportunity to assist the birth and a greater risk of fetal injury or oxygen deprivation.

A breech birth is not more painful or even more difficult for mothers. It is simply more hazardous for the baby. The Royal College of Obstetricians and Gynaecologists (UK) concludes that planned Caesarean section lowers the risk to the baby but increases the risk to the mother. It is worth looking at these risks in detail:

For every 1000 women with a baby in the breech position prospective and randomized studies (the best scientific evidence available) suggests that attempting vaginal birth will result in death or serious damage to 33 babies whereas, if planned Caesarean section is performed, then 16 babies will experience the same problems. But this also means that 96.7% of babies born normally as a breech will be fine and healthy. There is also no evidence that vaginal breech birth carries any long term risk to a baby.

In France and Belgium a prospective observational study of some 2526 women with a breech baby, when carefully selected as suitable for vaginal birth and cared for by an experienced team, 71% of the mothers delivered normally and there was no benefit for the babies if a planned Caesarean section was performed.

The risk of illness or adverse outcome is increased by some 30% for mothers when Caesarean section is performed. If we consider readmission to hospital after the birth as an indicator of risk to the mother then 22 women in every 1000 would require this after a vaginal birth but 30 would require it after a Caesarean birth. See the Information Sheet about Caesarean Risks.

Types of Breech Presentation

There are 3 types of breech position:

- Extended or frank breech - hips flexed, with the thighs against the chest, and feet up by their ears. I refer to this as "baby in the pike position" (if you are familiar with springboard diving).
- Flexed breech - hips flexed with thighs against the chest, but knees also flexed with the calves against the back of the thigh and feet just above the bottom. I refer to this as "baby in the tuck position".
- Footling breech - as for the flexed breech above, but hips not flexed so much so that the feet are below the bottom. In some cases the baby may be in a standing position with knees extended as well.

In general obstetricians are in agreement that, for a term singleton pregnancy, the safest and most appropriate breech for a vaginal birth is the frank breech.

When the Doctor or Midwife Suspects a Breech Presentation

If a baby is thought to be breech at 36 weeks, it is best to first do a scan to check the following things:

- First to confirm that it is indeed a breech position. There is not a great deal of point in doing this before 36 weeks because there is still a reasonable chance that the baby could turn and another scan will then be needed at 37 – 40 weeks depending on the options chosen (see below).
- It is worthwhile also checking the placental location and for any major fetal abnormality. These problems are usually, but not always, excluded by the scan performed at around 18-22 weeks of pregnancy.
- The next thing is to check out the type of breech presentation (see above). It is also usual to make an estimate of the baby's weight and to check the amount of amniotic fluid around the baby. It is desirable to check whether the baby's neck is extended and looking upwards i.e. stargazing.
- Finally it is desirable to see if there are any loops of cord around the baby's neck. This is not always 100% diagnostic.

So what are the Options?

If a baby is confirmed to be in breech presentation after 36 weeks then mothers have one of three options:

1. To plan for a vaginal birth of a breech baby

   An obstetrician will advise whether this is a good option for you. In general it is desirable that the baby be in a frank breech position and have an estimated weight of less than 4000g (about 8½ pounds). Delivery in

a hospital that has immediate access to Caesarean birth is required. Mothers and their families need to be aware that a Caesarean birth can be required at any time during the vaginal birth attempt.

2. To plan a Caesarean Birth

   Many women and their medical advisors choose this option. It is a reasonable option but everyone needs to be mindful of all of the implications of this decision. I recommend that you read carefully about the short and long term problems associated with a Caesarean birth and give serious consideration to the third option described below.

3. To attempt external cephalic version

What is External Cephalic Version?

External cephalic version is a turning of a baby from breech to the head-down position while it's still in the mother's uterus. To achieve this a doctor uses his or her hands on the outside of your abdomen (tummy) in order to turn the baby *(as illustrated below).*

When is External Cephalic version Done?

External cephalic version (ECV) is not usually attempted before 37 weeks of gestation if you have had a baby before and 36 weeks if this is your first baby. The reasons are several. First it gives those babies who are going to turn themselves every chance to do so. And there is also less chance of a baby turning back. However, the principal reason is the wish to have a mature baby in the unlikely event that a complication arises and immediate delivery is required.

It is for this same reason that ECV should only be done in a place where there are facilities for immediate Caesarean birth should this be required.

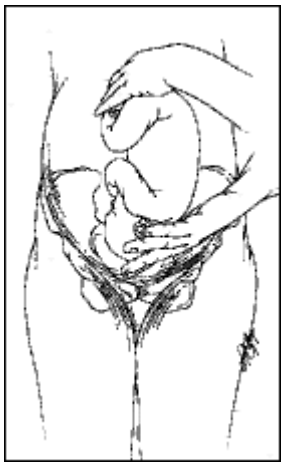
ECV can be done at any time after 37 weeks and right up until the onset of labour; sometimes even after labour has commenced.

Does External Cephalic Version Hurt the Mother or Baby?

For the mother there is a degree of discomfort because the head of her bed may be tilted down and pressure is applied to the baby through the abdominal wall. There may even be a few faint bruises because the baby's buttocks are disengaged from the pelvis and firm pressure is required to encourage the somersault. However, it should not be *painful*. About one woman in 20 (5%) find attempted ECV very painful. You will be given the opportunity to ask that the attempts be stopped if it is painful or unpleasant to the point that you do not wish to continue with the attempt to turn your baby.

Beginning the forward roll. The doctor places his or her hands on the abdomen, moving the baby up out of the pelvic bones.

Picture 2. The baby is turned either forward or backward ...



Picture 3. ... until the baby is in the head-down position.

In order to increase the safety of the procedure for the baby a number of precautions are usual. It is desirable to monitor the baby's heart rate before and after the procedure. Ultrasound scans are also very useful to check that all is well.

Most doctors who perform ECV also like to use uterine tocolysis. This refers to the use of a drug to relax the uterus. One method involves the intravenous injection of an adrenaline-like drug to the mother. In fact it is the drug that is used to relax the uterus when there is premature labour so there is plenty of information concerning its safety for pregnant women and babies in utero. This injection causes a racing pulse and sometimes palpitations.

Complications

External cephalic version has a small risk of the following complications:

- Starting labour
- Premature rupture of the membranes
- Premature separation of the placenta
- Fetal distress requiring emergency caesarean delivery

Emergency Caesarean section is required in about one in every 200 attempts at ECV (0.5%). An injection of Anti-D will be offered if the mother is Rhesus negative.

How Successful is External Cephalic Version?

The success of ECV depends on several factors including the position of the baby (babies in the "tuck position" are easier to turn than babies in the "pike position"), the shape and configuration of the mother's abdomen and the amount of fluid around a baby.

Overall ECV is about 60% successful for mothers who have been pregnant before but only about 40% successful if it is your first pregnancy.

What if the ECV is Unsuccessful?

If the attempt at external cephalic version is unsuccessful then you will still have the option of planning a Caesarean birth or attempting a vaginal breech birth.

If the ECV is successful then it effectively solves the problem of the breech presentation. You may need to remain in hospital for an hour or so of observation and a routine check up in a week should confirm whether the baby is still head down (as it is about 97% of the time).

A Personal Testimony

As an obstetrician who has delivered many breech babies (both as a vaginal birth and by Caesarean section), I recommend that every woman and her partner carefully studies the contents of this Information Sheet before they decide what is best for them. Your own doctor will be happy to provide expert advice and will also accept whatever decision you make.

There are a few instances when attempting an ECV is not a good idea but, in most other situations, I recommend that in the first instance. There is very little risk. In my many years of experience with external cephalic version I have only once had to perform an emergency Caesarean section when the waters broke a short time after an unsuccessful attempt. On the other hand, when the ECV is successful then the benefits are enormous.

Studies have proven that the practice of ECV significantly reduces the requirement for Caesarean section.

Max Brinsmead. Revised January 2010