When Your Baby is Breech

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 (only 1 in 16), 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 extent of this hazard and its optimal management was a matter of some debate by obstetricians before a landmark study was completed in 2001. It was called the Term Breech Trial and it is worth taking a few minutes to examine this study in some detail.

The Term Breech Trial

This randomised controlled trial was carried out in 121 centres in 26 countries and involved 2088 women with a non-footling singleton breech presentation. Selection of cases was on the basis of estimated fetal size (<4000 g), no obvious contraindication to vaginal delivery (such as placenta praevia), and no identified anomaly in the fetus. An experienced obstetrician was available for delivery in each centre. Predefined labour management allowed induction and the use of Syntocinon for normal obstetric indications. Acceptable progress was up to 18 hours for the first stage, 2 hours before pushing, and 1.5 hours of pushing in the second stage. The results were similar whether labour was induced, augmented, or prolonged, and in women with different levels of attendants’ experience.

The term breech trial provided unequivocal evidence that women with a breech presentation at term who plan a caesarean section will have a baby less likely to die or have a serious outcome (in the neonatal period) than those who plan a vaginal delivery (relative risk 0.33, 95% confidence intervals 0.19 to 0.56). The results showed a 1% increased risk of perinatal death and a 2.4% increased risk of serious neonatal morbidity when a vaginal birth was planned. However, the risk to the mother becomes significant: relative risk of maternal morbidity (1.29, 95% confidence intervals 1.03 to 1.61).

No study has considered long term outcomes. Future morbidity has not been assessed beyond the index pregnancy and is particularly a concern in pregnancies with a scarred uterus. Longer-term effects on the babies are also unknown, but this
analysis is planned. It is also worth noting that almost 97% of babies will not be seriously compromised as a result of planning a vaginal breech birth.

**Types of Breech Presentation**

In general obstetricians are in agreement that, for a term singleton pregnancy, the only form of breech delivery that is safe and appropriate for vaginal birth is the frank (baby in a “pike” position), feet up near the ears 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 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 and occurred 50% of the time during the term breech trial.

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**

   * See this Centre’s Information Sheet “Risks Associated with Caesarean Birth”

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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.

**When is External Cephalic Version Done?**

External cephalic version (ECV) is not usually done before about 37 weeks of gestation. 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 right up until the onset of labour – and sometimes even after labour has commenced.**

**Does it Hurt the Mother or Baby?**

For the mother there is a degree of discomfort as the head of the bed may be tilted down (and even sometimes a few faint bruises!) as the baby is lifted through the abdominal wall out of the pelvis and encouraged to somersault. However, it should not be painful and you will always be given the opportunity to ask that the attempts be stopped if it is painful or unpleasant.

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 comprises an intravenous injection of an adrenaline-like drug to the mother. In fact it is a 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.

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

An injection of Anti-D is required 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 about postural management for breech presentations? A thorough review of 5 studies involving around 392 women showed NO effect of postural management influences correcting a breech presentation.

Moxibustion

A Chinese medicine involving burning a herb close to the skin, near acupuncture point Bladder 67 (Zhiyin) at the TIP of the 5th toe has been investigated. 3 trials involving 597 women – poorly designed trial (review in Adelaide) but it did reduce the need for ECV by almost 50% and significantly reduced the need for oxytocin for women who had vaginal deliveries by 75%. Better studies are needed

What if the ECV is Unsuccessful?

If the attempt at external cephalic version is unsuccessful then you will still have the option of an elective Caesarean birth or attempting vaginal breech birth. However, 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), and as one who participated in the planning and conduct of the Term Breech Trial, I recommend that every woman and her partner carefully studies the contents of this Information Sheet before they decide what is best for them. I 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 will recommend that in the first instance. There is very little risk. In 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.

With assistance from Internet publications by Dr D.E. Tucker MRCOG www.womens_health.co.uk, Dr M Greenfield MD and The British Medical Journal

The Cochrane Library – www.cochrane.com.au

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