Vaginal Breech birth

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Lecturer in Practice

Breech: is where the fetal buttocks is the presenting part.
Occurs in 15% of pregnancies at 28wks reducing to 3-4% at term
Usually associated with:

- **Uterine & pelvic anomalies** - bicornuate uterus, lax uterus, fibroids and cysts
- **Fetal anomalies** - anencephaly, hydrocephaly, multiple gestation, oligohydraminous and polyhydraminous
- **Cornually placed placenta** (probably the commonest cause).

Diagnosis: by abdominal examination or vaginal examination and confirmed by ultrasound scan

Vaginal Breech VS. Caesarean Section

Trial by Hannah et al (2001) found CS to produce better outcomes than vaginal breech but does acknowledge that may be due to lost skills of operators

Therefore recommended mode of delivery is CS

Limitations of trial by Hannah et al have since been highlighted questioning results and conclusion (Kotaska 2004)

Now some advocates for vaginal breech birth when selection is based on clear prelabour and intrapartum criteria (Alarab et al 2004)

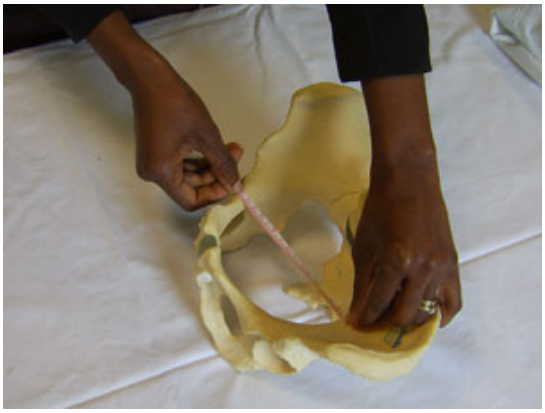
Breech birth is u sually not an option except at clients choice

Important considerations are size of fetus, presentation, attitude, size of maternal pelvis and parity of the woman

NICE recommendation: External cephalic version (ECV) to be considered and offered if appropriate

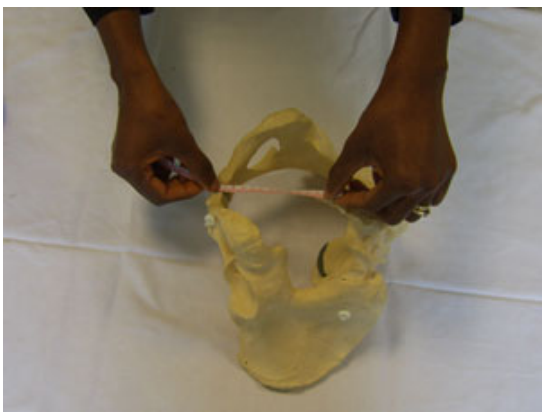
Vaginal Breech birth

Anterior posterior diameter of the pelvic brim is 11 cm



Oblique diameter of the pelvic brim is 12 cm

Transverse diameter of the pelvic brim is 13 cm



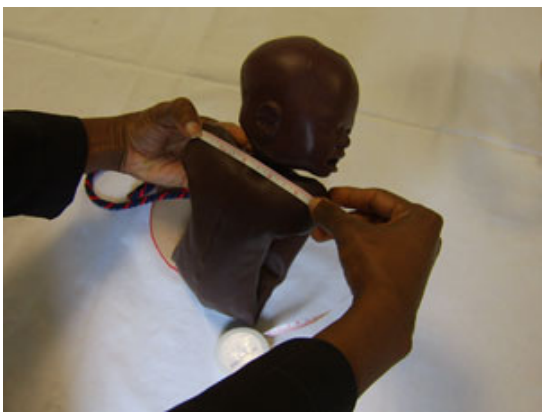
Anterior posterior diameter of the outlet is 13 cm

Vaginal Breech birth

Oblique diameter of the outlet is 12 cm

Transverse diameter of the outlet is 11 cm

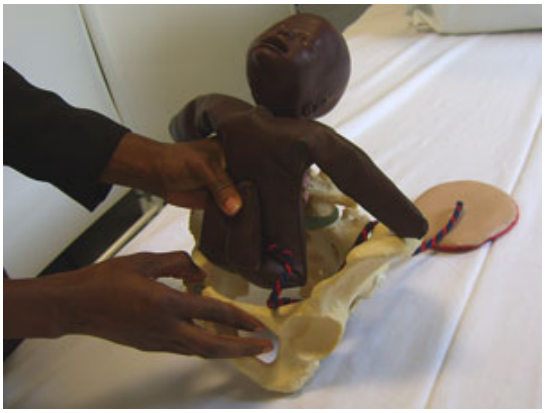
Bitrochanteric diameter is 10 cm



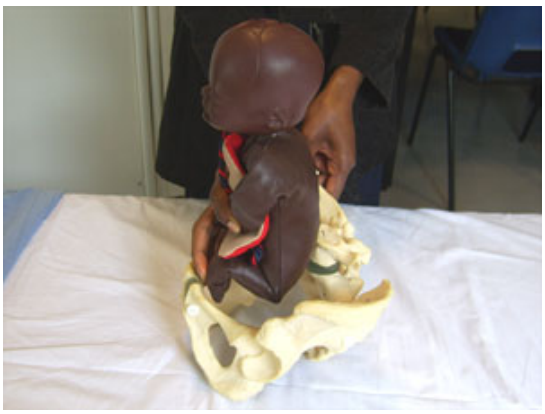
Bisacromial diameter is 11 cm

Vaginal Breech birth

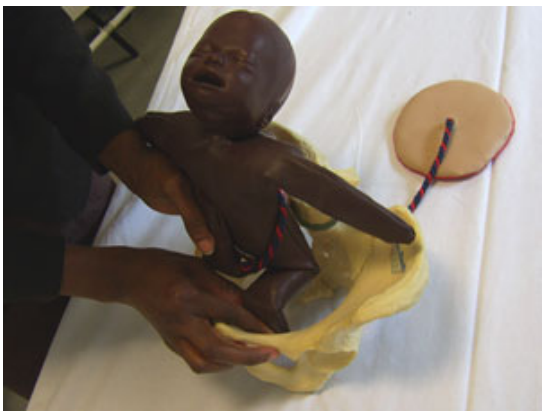
Types of breech



Extended or Frank Breech – occurs in 60% - 70% of breech births, least associated with cord prolapse



Flexed or complete breech



Footling or incomplete Breech – one or both legs may be extended

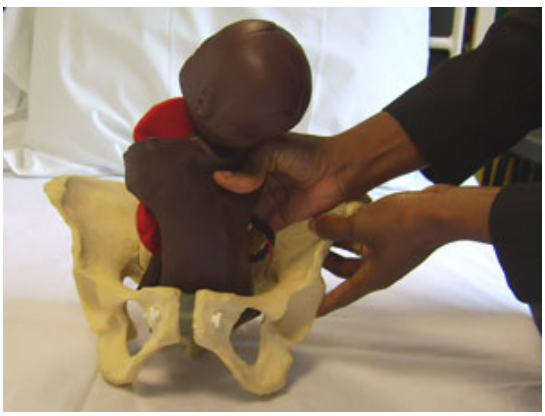
Hospital Management

Obstetric team to be present at birth:
Midwife Coordinator,
Obstetric registrar and Neonatologist.
Anaesthetist available on labour ward
Cannulate client and send bloods
Epidural analgesia should be offered when in established labour
Continuous electronic fetal monitoring

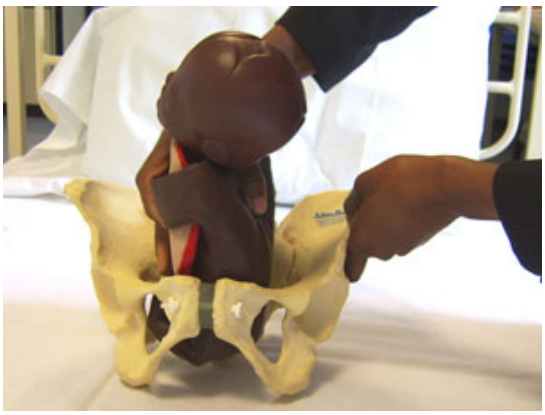
Vaginal Breech birth

Delivery

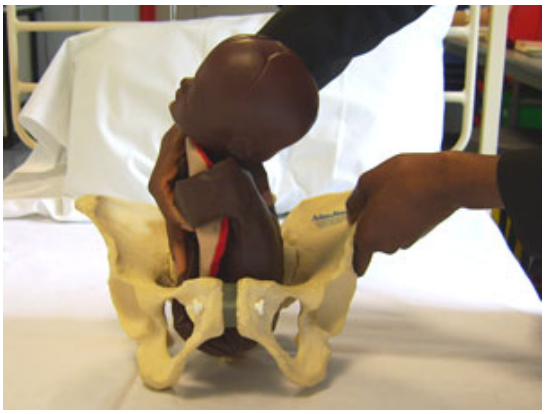
Avoid pushing before full dilatation
Assess for and perform episiotomy if required when anus stays in view between contractions
Hands off until there is reason to assist
Position of choice: Lithotomy or all fours if in the community



Sacrum (bitrocanteric diameter 10cms) enters the pelvic brim in the left sacro-anterior position

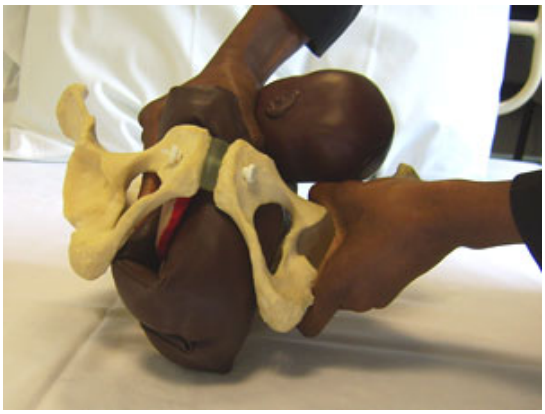


Descent of the presenting part with contractions and flexion

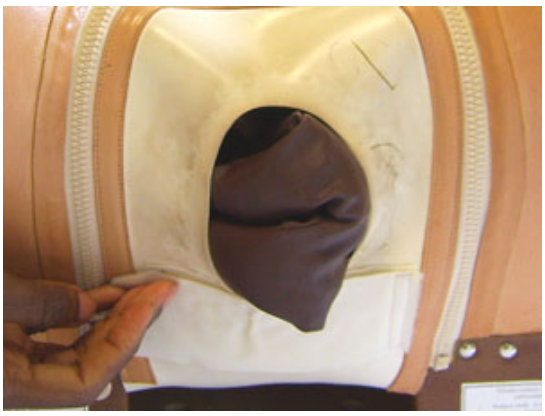


Anterior buttocks reaches pelvic floor and rotates 1/8th of a circle into the anterior posterior diameter

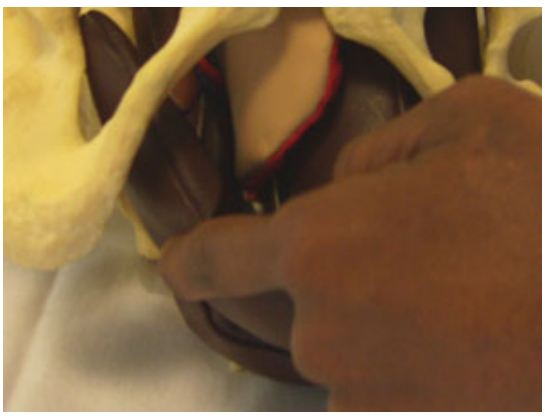
Vaginal Breech birth



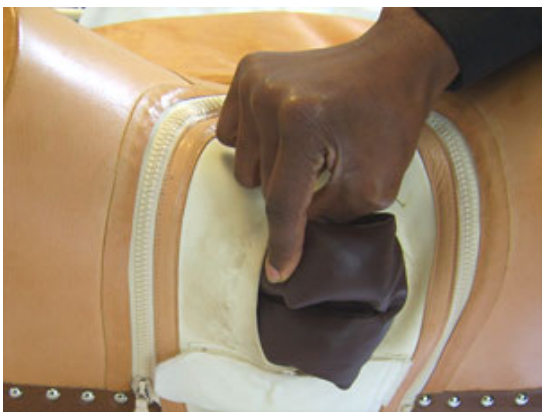
Anterior buttock escapes under the symphysis pubis and posterior buttock sweeps perineum



Buttocks are born. Restitution occurs to mothers right. Legs will usually be born with further contractions.
Babies with legs extended might require assistance

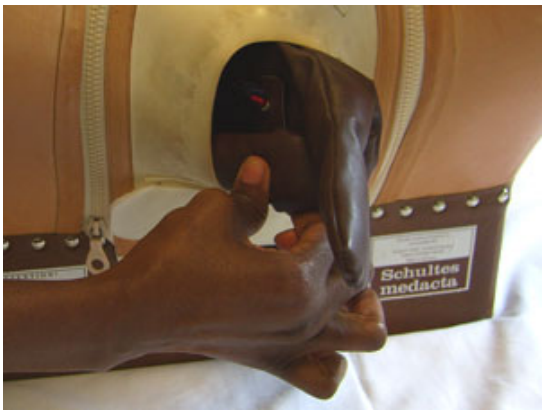


When popliteal fossae present at vulva flex knee by placing index finger in popliteal fossa



Sweep leg outwards abducting hip slightly

Vaginal Breech birth



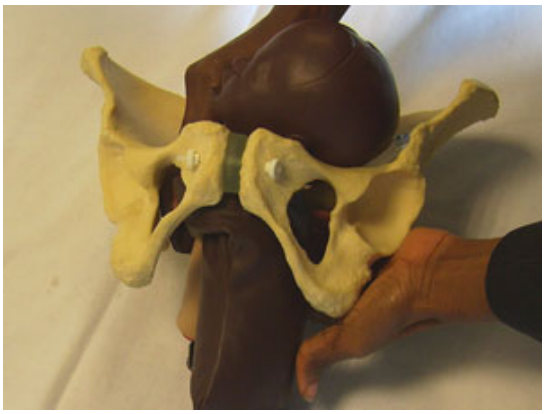
Repeat manoeuvres with second leg

Second leg is born

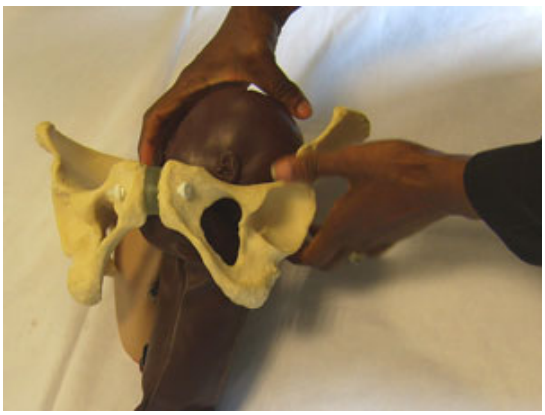
Hands off – allow breech to deliver with contractions and maternal effort

Shoulders (bisacromial diameter 11cms) now enter the pelvis in the left oblique diameter

Vaginal Breech birth

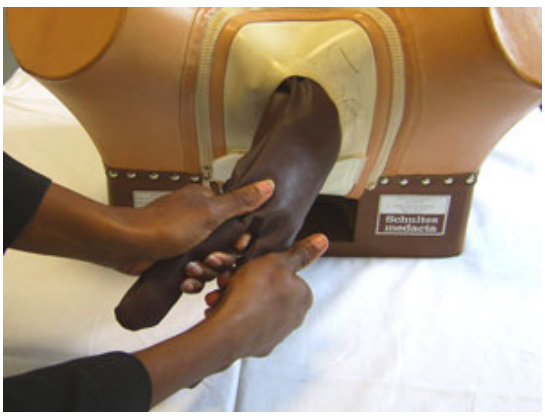


Anterior shoulder rotates 1/8 and escapes under the symphysis pubis



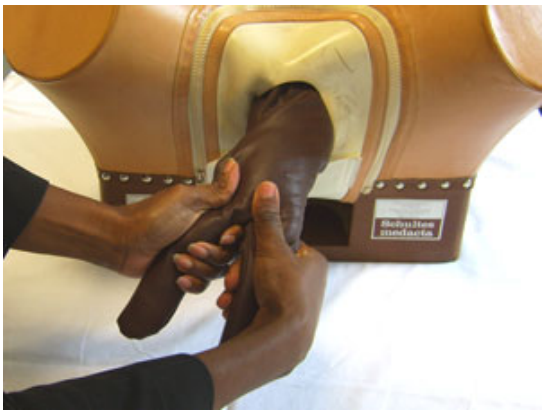
Posterior shoulder sweeps perineum
Arms will usually be born spontaneously if flexed across chest

Looping of cord no longer advocated
Some advocate 15mins from delivery of buttocks to delivery of head to prevent effects of cord compression



Where arms are extented ‘Loveset’ manoeuvre will be performed to assist there delivery

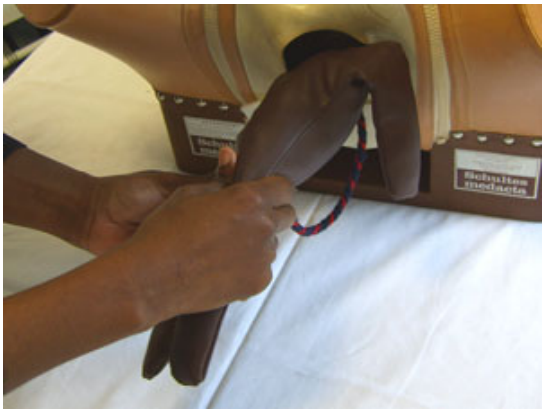
Vaginal Breech birth



Place hands around thighs with thumbs over buttocks pointing along spine

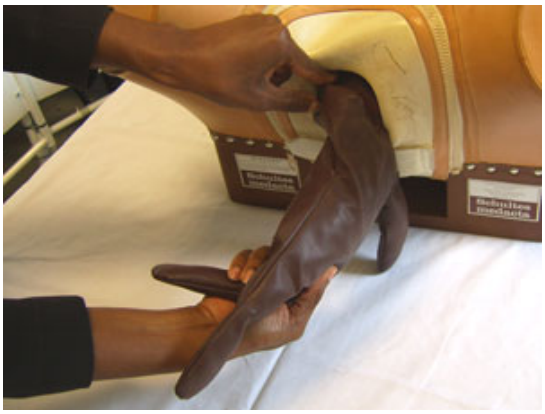
Rotate through 180 degrees with back uppermost applying gentle traction

Locate arm and sweep across face and down chest to deliver

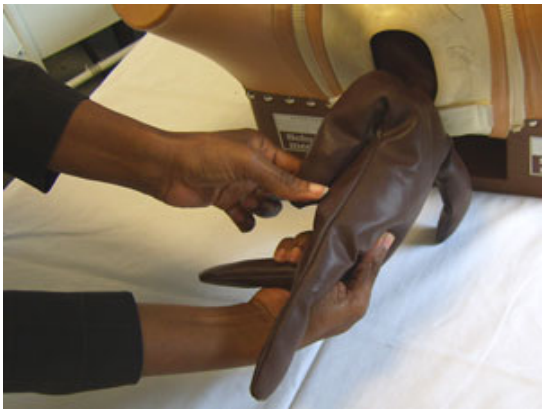


Repeat manoeuvre to deliver second arm

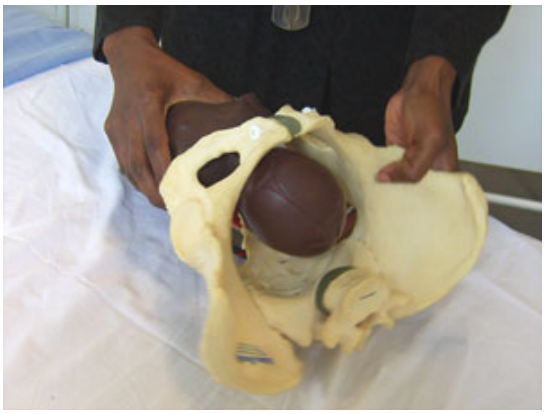
Vaginal Breech birth



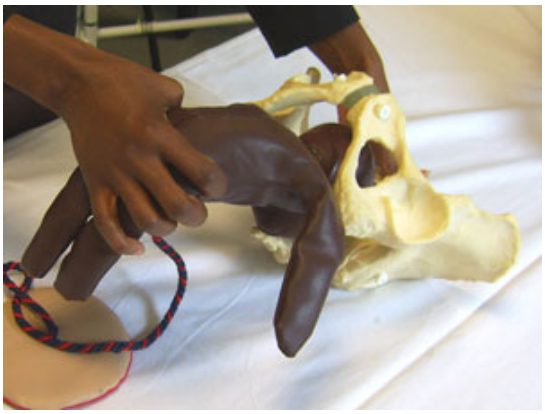
Locate arm and sweep across face and down chest to deliver



Once arms delivered hands off

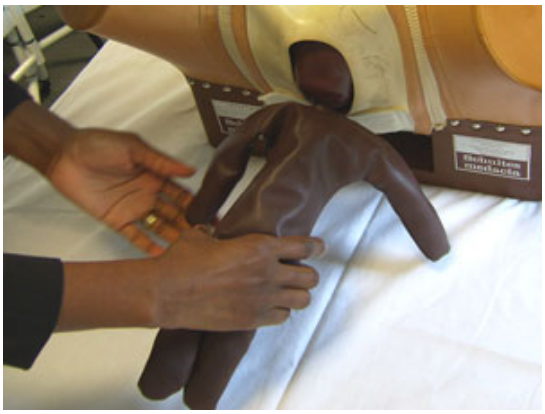


Head enters pelvic brim in the oblique or transverse diameter

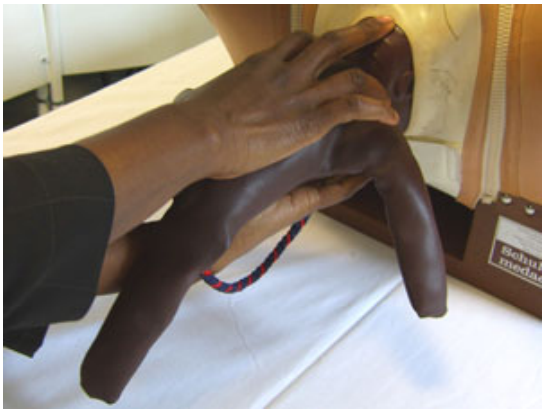


Occiput rotates forward accompanied by simultaneous external rotation of body to back uppermost

Vaginal Breech birth

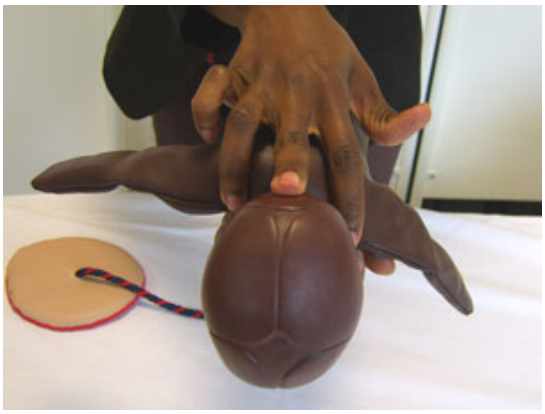


Hands off allow breech to deliver until nape of neck visible



Deliver head using Mauriceau Smellie Viet Manoeuvre

Drape baby over forearm placing 2 fingers on the malar eminencies (cheekbones)



Place index finger of other hand on occiput of baby to maintain flexion

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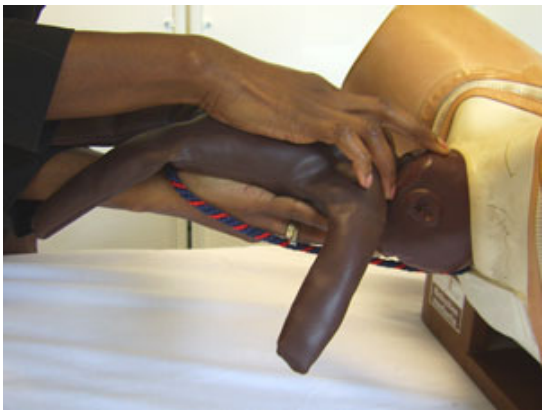
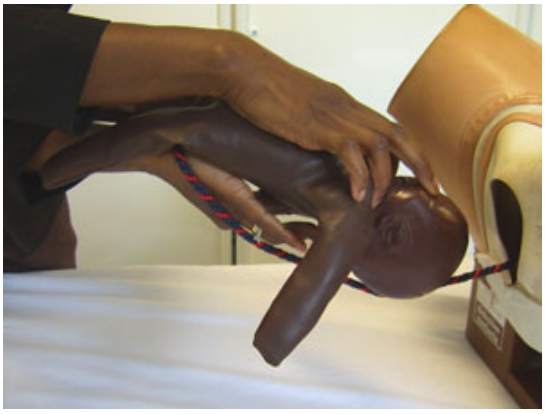
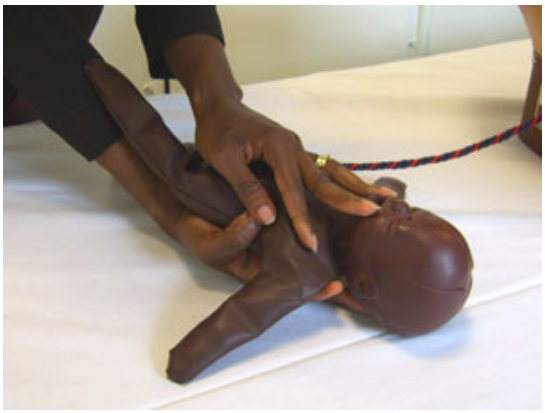


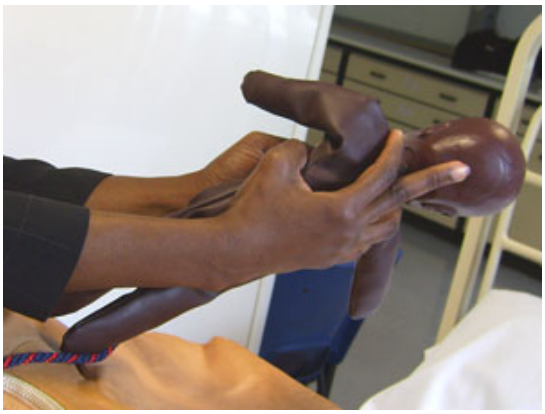
Apply gentle traction and deliver baby in a controlled manner maintaining flexion of the fetal head at all times



Once delivery is complete:



Baby can be put down so cord can be clamped and cut



Baby can be handed to mother

Vaginal Breech birth

References and further reading:

Alarab, M. Regan, C. O'Connell, M.P. Keane, D.P. O'Herlihy, C. & Foley, M.E. (2004) Singleton Vaginal Breech Delivery at Term: Still a Safe Option**. *Obstetrics & Gynecology*** Volume 103, Pages 407-412

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