**Vaginal Breech birth**

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**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, oligohydraminos and polyhydraminos  
- **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 usually 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
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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
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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
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
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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
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Anterior buttock escapes under the symphysis pubis and posterior buttock sweeps perineum

Buttocks are born. Restitution occurs to mother's 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
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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
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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
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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
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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
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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
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
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References and further reading:


