Standard Operational Procedure for the Management of Breech Presentation Including External Cephalic Version (ECV)

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Status: Ratified

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1. Purpose/Background:

This document provides guidance on the caring for women with a breech presentation

2. Scope:

This document is for use by all obstetricians and midwives and it applies to all women cared for by the Maternity Services at St Mary's Hospital.

3. Responsibilities

It is the responsibility of all Midwifery Nursing and medical staff to:

- Access read understand and apply this SOP
- Attend any mandatory training pertaining to the SOP

It is the responsibility of the department to:

- Ensure the SOP is reviewed as required in line with trust and national recommendations
- Ensure the SOP is accessible to all relevant staff

4. Procedure:

4.1 External Cephalic Version (ECV)

- Women with a breech presentation at term should be offered external cephalic version (ECV) unless there is an absolute contraindication. They should be advised on the risks and benefits of ECV and the implications for mode of delivery.
- Women with a breech presentation at 36-37 weeks should be referred to the next consultant clinic for the discussion of ECV and birth options.
- Absolute contraindications for ECV are:
    - Multiple pregnancy
    - Significant ante-partum haemorrhage
    - Rupture of membranes
    - Fetal abnormality
    - Hyperextended head
    - Other indication for CS exists

- ECV must be undertaken on the Labour ward by an experienced practioner. There should be provision for close fetal monitoring and a facility for immediate CS.
- Prior to the ECV
    - The woman may be booked from 36 weeks
    - She should fast from 6am on the morning of the procedure
    - A cardiotocograph (CTG) should be performed to confirm fetal well being
    - A scan should be performed to confirm presentation
- Procedure
    - The woman's bladder should be emptied
    - The procedure should not be continued for more than 10mins
    - The procedure should be abandoned if it is painful for the woman
    - If the baby becomes distresses at any point the staff should be prepared to proceed to CS
- Following the procedure
    - CTG should be performed to assess fetal well being
    - A scan should be performed to confirm success of the procedure.
    - Anti-D should be given to women who are Rhesus negative. However If the woman is Rh Neg and has had the cff DNA test, she will only require anti-D if the baby is predicted to be positive.
    - Details of the procedure (including duration) must be documented in the notes.
    - If the procedure has been successful the woman can return to midwifery led care and await spontaneous labour. A midwife appointment should be given for one week to check the presentation.
    - If unsuccessful, the mode of delivery should be discussed and a management plan formulated. This should be documented in both her hand held and hard copy notes.

4.2 Vaginal Breech Birth

- Clinicians should counsel women in an unbiased way that ensures a proper understanding of the absolute as well as relative risks of their different options.
- Women should be informed that when planning delivery for a breech baby, the risk of perinatal mortality is approximately 0.5/1000 with caesarean section after 39+0 weeks of gestation; and approximately 2.0/1000 with planned vaginal breech birth. This compares to approximately 1.0/1000 with planned cephalic birth.
- A woman requesting a vaginal breech birth should be cared for in a hospital setting.
- A vaginal breech birth may be undertaken when the baby is in the flexed or extended legs presentation following a full discussion with the woman.
- The woman may be offered an ultrasound scan and estimated fetal weight.
- An individualised management plan for the birth will be made between the woman and the consultant. This must be documented in her notes.
- Induction of labour should not be offered.

4.2.1 Management of Labour

First stage of labour

- Inform obstetric registrar on admission
- Site intravenous cannula, take and send bloods for full blood count and group and save.
- Continuous CTG monitoring should be used
- An Epidural is often recommended but not essential
- Give oral antacids as per current policy
- Membranes should be left intact for as long as possible. If there is a spontaneous rupture of membranes a cord prolapse or footling presentation should be excluded.
- Slow progress in labour must be discussed with the consultant.
- Fetal blood sampling can be taken from the buttocks of the baby if required.

- The Special care Baby unit (SCBU), on call anaesthetist and paediatrician should be notified when the woman is approaching the second stage of labour.

Second stage of labour

- Delivery should be conducted by consultant or registrar, although others may do so under their direct supervision.
- A member of the paediatric team should be present at the birth with the on-call anaesthetist immediately available.
- There should be early recourse to CS if there is a delay in progress or evidence of fetal compromise.
- Delay with the legs may require popliteal pressure: delay with the arms, Lovset's manoeuvre.
- It is not necessary to bring a loop of cord down as this may provoke umbilical arterial spasm.
- No traction should be applied to the baby during birth, and the body should be allowed to hang until the nape of the neck is visible
- The head should be delivered slowly either by modified Mariceau-Smellie-Viet manoeuvres or Neville Barnes forceps.
- Cord gases should be taken after delivery.

4.3 Undiagnosed breech

- If a woman presents with an undiagnosed breech presentation in labour the consultant obstetrician on call must be contacted.
- Decisions regarding the options for vaginal birth or emergency CS will depend upon the woman's choice, the gestation and condition of the baby, the type of breech presentation and the progress of labour.

4.4 Undiagnosed breech at home

- Wherever possible the woman should be transferred to hospital by ambulance unless it is felt that it would be likely that the baby would deliver in transit.
- The maternity unit must be contacted and request:

    - 2nd midwife to attend
    - Paramedic ambulance to attend
    - On call obstetrician informed
    - LW Coordinator informed
- Position for delivery is at the woman's and midwives discretion; however an upright position, either kneeling or sitting, is the position of choice in most studies.
- Ensure that the cervix is fully dilated before active pushing is commenced
- Support the birth as previously stated
- Following the birth, transfer to the maternity unit should be considered if there is a clinical need, i.e. evidence of fetal compromise, difficulty with the birth or at the woman's request.

4.5 Elective CS

- Elective CS should be discussed as one of the options for birth for all women who have had a failed ECV and for those women for whom ECV has not been appropriate.
- Delivery should be planned at 39 weeks gestation to minimise the risk of neonatal respiratory morbidity
- Confirm breech presentation by ultrasound prior to CS

5 Implementation/training/awareness

- This is a review of a current document and it formalises current practice.
- Once ratified it will be available in all clinical areas within the Maternity Unit and on the intranet.
- All new, reviewed and ratified documents are notified to staff via the monthly maternity newsletter

6. Auditable Standards

What aspects of compliance with the document will be monitored	What will be reviewed to evidence this	How and how often will this be done	Detail sample size (if applicable)	Who will coordinate findings	Which group or report will receive findings
Documentation of discussion of options for breech presentation	Maternal Notes	Yearly	All Breech Presentations	Audit Midwife	MCEG

7. Related Documents:

Guidelines/SOP's:

- Anti d for sensitising events
- Cff DNA
- Epidurals
- CS
- Home Births

Patient Information:
None

Trust Policies/Procedures:
None

8. References:

- Green Top guidelines RCOG The management of Breech Presentation (20b) - revised April 2017; www.RCOG.org.uk

9. DISCLAIMER

It is the responsibility of staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

Version History

DOCUMENT HISTORY					
Date of Issue	**Version No.**	**Next Review Date**	**Date Approved**	**Director Responsible for Change**	**Nature of Change**
Feb 07	1	Feb09	Feb 07		New document
June 09	1.1				
29th Dec 09	2	December 2011	29th Dec 09		Maternity CSG
April 2014	3	29th April 2017	29th April 2014	Executive Director of Nursing and Workforce	Reviewed no changes
April 2017	4	November 2019	April 2017	Amanda Pearson	Reviewed, no changes
March 2020	SOP v1	March 2023	26th March 2020	MCSG	Reviewed, amended and converted to SOP