1.0 INTRODUCTION

Vaginal breech births can be as safe for mother and baby as cesarean birth with careful case selection, labour management and the presence of an experienced obstetrician and a person fully skilled in neonatal resuscitation. In 2000 the Term Breech Trial was published. This multicentre randomized controlled trial identified that cesarean section was the safest method for delivering a term breech fetus. Although the results of the Trial identified no long-term neonatal morbidity differences between infants delivered via cesarean birth or vaginal birth, there was a significant difference in short-term morbidity between infants delivered by cesarean section (0.4%) versus infants delivered vaginally (5.1%). There was no difference in maternal morbidity or mortality between the two methods of delivery.

The Term Breech Trial results led to a world-wide push to delivery breech fetuses by caesarean section. Although cesarean births are deemed safe, a balance needs to be reached between the safety of future births after cesarean with the immediate safety of the current infant in mind. In addition, if a vaginal delivery is contemplated there must be a health care provider present with experience in vaginal breech births.

2.0 MANAGEMENT OPTIONS

Careful case selection and labour management allows for management options of the term breech. Full discussion of the risks of trial of labour and elective cesarean delivery must take place between the primary care provider and the patient. The woman’s choice with regards to mode of delivery must be respected.

2.1 Transfer of care to an obstetrician.

2.2 Obtain informed consent

2.3 External Cephalic Version (ECV) may be attempted (with informed consent) for those breech presentations in which no contraindication exists (classical uterine scar, placenta previa, etc.) This should be done at or after 37 weeks, and in a labour/delivery or fetal assessment unit. (Refer to Edmonton Zone Women’s health Program Clinical Guidelines for External Cephalic Version).

2.4 Trial of labour

2.5 Elective cesarean birth

3.0 SELECTION CRITERIA FOR VAGINAL DELIVERY OR TRIAL OF LABOUR

3.1 Ultrasound during pre or early labour to:

- Verify type of breech presentation (Frank or complete breech with both hips flexed)
- Assess fetal growth
- Estimate fetal weight (Weight should be between 2500 g and 3800 g)
• Assess attitude of fetal head (Neutral or flexed attitude)

3.2 Availability of continuous electronic fetal monitoring

3.3 Availability of an operating room with equipment and personnel ready to perform a timely cesarean section if required (Timely means approximately 30 minute timeline)

3.4 Presence of an obstetrician experienced in vaginal breech birth

3.5 Presence of a practitioner skilled in advanced neonatal resuscitation at delivery

4.0 CONTRAINDICATIONS TO TRIAL OF LABOUR

4.1 Pre or early labour ultrasound not available

4.2 Breech presentation other than frank or complete breech

4.3 Fetal growth restriction (fetal weight less than 2500 g at term)

4.4 Fetal macrosomia (fetal weight greater than 3800 g)

4.5 Clinically inadequate maternal pelvis

4.6 Fetal anomaly incompatible with vaginal birth

4.7 Cord presentation

4.8 Hyperextended fetal neck in labour

4.9 Presence of contraindications to vaginal birth

4.10 Previous cesarean birth

4.11 Lack of consent

5.0 FIRST STAGE, ACTIVE PHASE OF LABOUR MANAGEMENT

5.1 Pelvic examination to rule out clinically inadequate pelvis

5.2 Electronic fetal monitoring

• Continuous fetal monitoring preferred during first stage of labour

• Continuous fetal monitoring mandatory during second stage of labour

5.3 Spontaneous rupture of membranes

• If patient is not in a hospital facility, should make her way to a hospital with obstetrical services immediately

• If patient is in hospital, a health care provider should do an immediate vaginal exam to rule out cord prolapsed

5.4 Artificial rupture of membranes without deep engagement of presentation part requires a clear indication and careful monitoring

5.5 Expected progress in labour as part of the breech labour management

• 0.5 cm dilation/hour in the active phase of labour

• “It would seem prudent to expect cervical dilation from 5 to 10 cm to take a maximum of 7 hours” (p562)

5.6 Cesarean section is recommended in the absence of labour progress for two hours despite adequate uterine contractions

5.7 Use of Oxytocin

• Labour induction may be considered if individual circumstances are favorable
• Labour augmentation is not recommended – but may be justified in selected cases (i.e. primary uterine inertia/hypotonic contractions). However, poor progress in established labour may be an indication of fetopelvic disproportion.

6.0 SECOND STAGE OF LABOUR MANAGEMENT

6.1 It is important that an experienced practitioner diagnose the time of full dilation of the cervix to enable assessment and documentation of labour progress

6.2 Electronic fetal monitoring
   • Continuous fetal monitoring is mandatory during second stage of labour
   • Variable decelerations can be expected due to cord compression with descent of the fetus

6.3 Second stage of labour in a breech delivery can be divided into the passive phase (fetal descent without active pushing) and the active phase (further fetal descent with active pushing)
   • A woman in the active phase of the second stage of labour needs to be in or near an operating room where a timely cesarean section can be performed

6.4 The overall length of second stage can last up to 2 ½ hours
   • The passive phase can last up to 90 minutes
   • The active phase can last up to 60 minutes
   • Cesarean section is recommended with lack of progress or if second stage of labour extends beyond these times

6.5 Total breech extraction should not be performed as a delivery method in the term singleton breech

6.6 Assisted breech delivery (Piper forceps or via maneuvers such as Mauriceau-Smellie-Veit maneuver) may be required to deliver the after coming head

6.7 Suprapubic pressure may need to be applied after crowning to maintain flexion of the fetal head

7.0 DOCUMENTATION AND COMMUNICATION

7.1 Document the discussion that took place with regards to options for labour and delivery management

7.2 Document the plan of care in the patient chart

7.3 Communicate plan of care with labour and delivery unit

7.4 Obtain informed consent
8.0 REFERENCES


