Breech presentation

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-Should my feet be up or down?
At term, breech presentation persists in approximately 3 to 5 percent of singleton deliveries.
Definition
- longitudinal lie
- breech or lower extremity presenting
- cephalic pole in the uterine fundus

Types
- frank  - flexed hips, extended knees
- complete- flexed hips, flexed knees
- footling  - extended hip(s)
<table>
<thead>
<tr>
<th>Factors associated with breech presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous term breech presentation</td>
</tr>
<tr>
<td>Premature labour</td>
</tr>
<tr>
<td>High parity</td>
</tr>
<tr>
<td>Multiple pregnancy</td>
</tr>
<tr>
<td>Polyhydramnios</td>
</tr>
<tr>
<td>Oligohydramnios</td>
</tr>
<tr>
<td>Uterine anomalies</td>
</tr>
<tr>
<td>Pelvic tumour or fibroids</td>
</tr>
<tr>
<td>Placenta praevia</td>
</tr>
<tr>
<td>Hydrocephaly/anencephaly</td>
</tr>
<tr>
<td>Fetal neuromuscular disorders</td>
</tr>
<tr>
<td>Fetal head and neck tumours</td>
</tr>
</tbody>
</table>
ROUTE OF DELIVERY

- Multiple factors aid determination of the best delivery route for a given mother-fetus pair. These include:
  - fetal characteristics,
  - maternal pelvic dimensions,
  - coexistent pregnancy complications,
  - provider experience,
  - patient preference,
  - hospital capabilities
  - gestational age.
Factors Favoring Cesarean Delivery of the Breech Fetus

- Lack of operator experience
- Patient request for cesarean delivery
- Large fetus: > 3800 to 4000 g
- Apparently healthy and viable preterm fetus either with active labor or with indicated delivery
- Severe fetal growth restriction
- Fetal anomaly incompatible with vaginal delivery
- Prior perinatal death or neonatal birth trauma
- Incomplete or footling breech presentation
- Hyperextended head
- Pelvic contraction or unfavorable pelvic shape determined clinically or with pelvimetry
- Prior cesarean delivery
- No contraindication to vaginal birth
- No prior cesarean deliveries – Prior cesarean is a relative contraindication
- Gestational age ≥36 weeks.
- Spontaneous labor
- Staff skilled in breech delivery and immediate availability of resources and facilities for safe emergency cesarean delivery
Labor management

- Perform a vaginal examination and/or ultrasound examination on admission
- Leave the membranes intact
- Most experts recommend continuous electronic fetal heart rate monitoring
- Monitor and record labor progress, as with a cephalic presentation
- Neuraxial analgesia is useful
Labor Management

- A provider skilled in the art of breech extraction
- An associate to assist with the delivery,
- Anesthesia personnel who can ensure adequate analgesia or anesthesia when needed
- An individual trained in newborn resuscitation.
Ultrasound Assessment

Before or in early labor

- confirm lie and type of breech
- assess head position
- obtain estimate of fetal weight
- assess for IUGR and congenital anomalies
- assess amniotic fluid volume
- confirm placental localization
Don’t forget

- want help
Vaginal Breech Delivery

- Fetal monitoring should be continuous
- VE to exclude cord prolapse if SROM
- Syntocinon maybe used for latent not in active phase, with caution, consider c/section if slow progress/failure to progress.
- Second stage up to 90 min (30-60)
Vaginal Breech Delivery

- Most senior obstetrician present at delivery
- Although epidural recommended, this is not essential and may cause prolonging of second stage
- Benefit of Epidural in preterm breech, to prevent pushing in absence of full dilatation
Vaginal Breech Delivery

- Basic principle:
  - Sit on hands
  - Do not interfere
  - Avoid traction on baby
- Active pushing should be encouraged when breech descends to pelvic floor
- Episiotomy may be needed, if so, do not do too soon, wait for anus to be visible
Spontaneous Expulsion

- spontaneous expulsion to the umbilicus
- the sacrum should be gently guided anteriorly
- singleton breech extraction is contraindicated
- C/S is indicated for failure of descent or expulsion
- Hurry up & Wait!
- DON’T PULL!
- traction deflexes the fetal head
- may cause nuchal arm
Figure 9.2. Delivery of fetal legs
Deliver Legs by lateral rotation of thighs and flexion of knees - keep sacrum anterior
Lovsett's Manoeuvre
Figure 9.8.
Nuchal arm
Vaginal Breech Delivery
Delivery of Arms
- good maternal pushing
- deliver when winging of scapulae seen
- rotate arm to anterior
- sweep humerus across the chest and deliver
- rotate other arm anterior and repeat to deliver
Smellie-Veit Manoeuvre
Delivery of the head
Vaginal Breech Delivery
Burns-Marshall technique
Figure 9.7.
Kielland forceps delivery of the head
Vaginal Breech Delivery
Head entrapment

- Uterine relaxant (terbutaline, TNG)
- Symphysiotomy
- Zavanelli
- Duhrssen incisions (2, 10, 6)
Box 9.3. Fetal risks associated with vaginal breech birth

Intrapartum death
Intracranial haemorrhage
Brachial plexus injury
Rupture of the liver, kidney or spleen
Dislocation of the neck, shoulder or hip
Fractured clavicle, humerus or femur
Cord prolapse
Are any of the following present?
- Contraindication to labor or vaginal birth
- Previous cesarean delivery (relative contraindication)
- Gestational age <36 weeks
- Need for induction of labor
- Ultrasound examination showing any of the following:
  - Fetal breech
  - Estimated fetal weight <2000 or >4000 grams
  - Fetal anomaly that might result in dystocia
  - Hyperextension of fetal head

Yes | No
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Are the following available?
- Obstetric provider skilled in breech delivery
- Personnel and facility resources for emergency cesarean delivery
- Pediatric provider to perform neonatal resuscitation

No | Yes
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- Discuss risk and benefits of vaginal versus cesarean delivery
- Recommend cesarean delivery

- Discuss risks and benefits of vaginal versus cesarean delivery
- Suggest cesarean delivery

Patient opts for cesarean delivery | Patient opts for vaginal delivery
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Do any of the following occur during labor?
- Slow progress
- Non-reassuring fetal heart rate pattern

Yes | No
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- Avoid iatrogenic rupture of membranes, if possible.
- Avoid assisting the delivery until maternal efforts have resulted in expulsion of the fetus at least to the umbilicus.
- At that time:
  - Apply suprapubic pressure to promote head flexion and descent.
  - Maternal expulsive efforts alone should be adequate to deliver the buttocks, lower trunk, and lower limbs if not extended. If lower limbs are extended, use the Pinard maneuver to facilitate their delivery.
  - Use standard maneuvers to deliver shoulders and arms if they do not deliver spontaneously with maternal expulsive efforts (McRoberts position, Mauriceau-Smellie-Velt maneuver, and/or Piper forceps if needed). The fetal legs are supported, but the trunk should be no more than 45 degrees above horizontal to avoid traction on the cervical spine.
Key learning points

- The importance of continuous electronic fetal monitoring in labour (even if decision has been made to perform a caesarean section).
- Confirmation of full dilatation.
- Await visualisation of the breech at the perineum before encouraging active pushing.
- Limited intervention is the key – avoid traction.
Thank you