

## About this leaflet

This leaflet was produced by Emma Spillane, Senior Midwife and Breech Specialist at St George's Hospital in London, and Training Co-ordinator for Breech Birth Network, Community Interest Company.

A group of women who have experienced term breech pregnancies provided feedback and contributed to its development. Further feedback is welcome at the e-mail address below.

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# Breech Birth Options

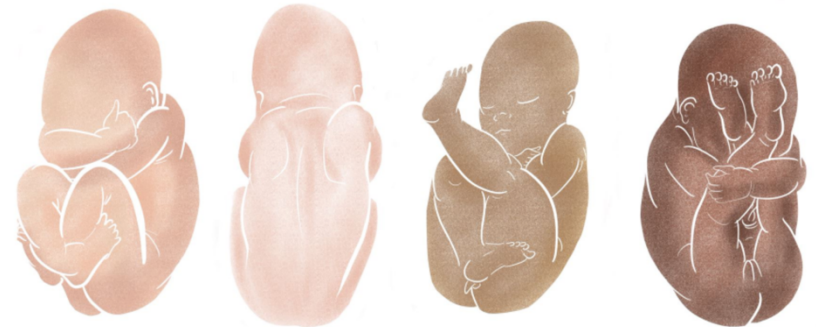


Image by Merlin Strangeway for  
Breech Birth Network, CIC

A baby in the “breech presentation” is when the bottom is down and the head is uppermost. You may feel your baby’s kicks lower down your abdomen and the head under your ribs. About 3-4% of babies present in the breech position at the end of pregnancy (RCOG, 2017). If it has been identified that your baby is breech then you will be referred to the breech clinic to discuss your options. These may include trying to turn your baby to a head down position, aiming for a vaginal birth or a planned caesarean section (CS).

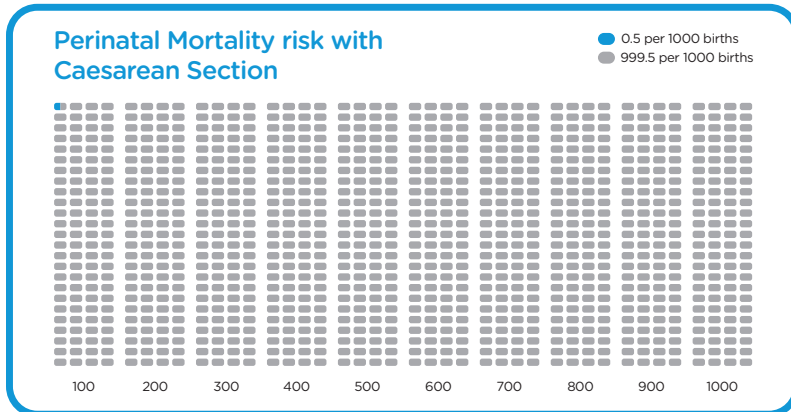
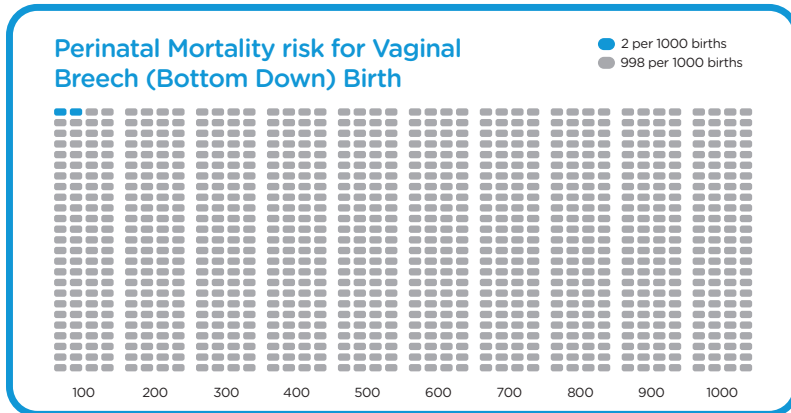
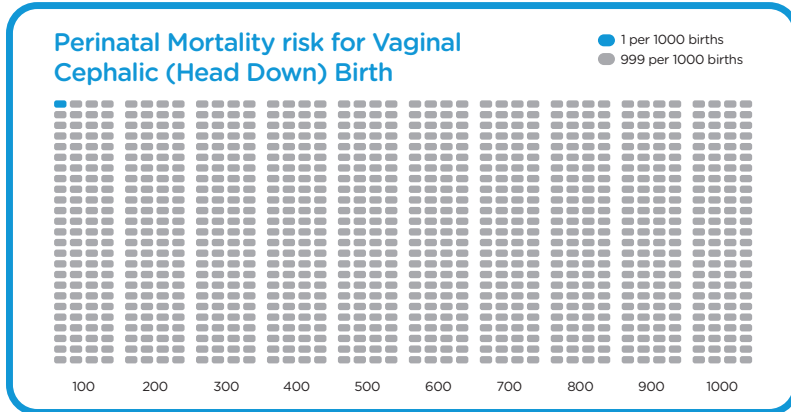
There are different types of breech presentation such as: **extended (frank) breech**, where the baby’s legs are straight up and the bottom is in the pelvis; **flexed (complete) breech**, where the baby’s legs and hips are bent and the bottom is in the pelvis; **incomplete**, where one leg is bent and the other is straight; **foot presentation** where the feet are lowest and the baby’s bottom is above the pelvis; and **knee presentation** where the knees are lowest in the pelvis.

Babies can present in the breech position for many different reasons such as a low-lying placenta or fibroids. It is important to identify any complications which may have resulted in your baby presenting in the breech position so we can best discuss with you the safest recommendations for birth. Most breech presentations occur by accident though, for example, the baby simply runs out of space in the womb to turn to a head down position. You will be offered an ultrasound scan to enable us to identify any significant concerns.

## References

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## Variations of Breech Presentation



### Frank Breech

Hip joints flexed, knees extended

### Flexed Breech

*Complete*

Both hip joints flexed, both knees flexed

*Incomplete*

Both hip joints flexed, one knee flexed, one knee extended

*Incomplete / 'Dropped Foot' in labour*

One hip flexed, one hip extended

### Kneeling Breech

One or both hips extended, one or both knees flexed and presenting

### Standing / Footling Breech

Both hip joints extended, both knees extended, fetal pelvis not engaged. Increased risk of perinatal mortality (death) with this presentation from 2:1000 to 3:1000 births compared to frank, complete and incomplete breech presentations.

*Illustrations by Kate Evans*

### **Will my baby turn on Their own?**

If this is your first baby or you have had a baby in the breech presentation before it is less likely that your baby will turn head down on their own after 34 weeks gestation. The extended (frank) breech position also reduces the likelihood of your baby turning head down.

If this is not your first baby and you have had a head down baby before, there is an 80% chance that your baby will turn head down before 37 weeks gestation. After 37 weeks gestation there is still a 33% chance your baby will turn head down. However, you may like to think about your options and make a birth preference plan in case your baby does not turn on their own.

### **Can my baby be turned head down?**

During your consultation we will discuss with you the services which we offer in the hospital to turn your breech baby to a head down position.

### **External Cephalic Version (ECV)**

External cephalic version (ECV) is a procedure to turn your baby to a head down position with pressure on the abdomen. The procedure itself only takes about 10 minutes, but we will monitor your baby before and after for 20-30 minutes.

Attempting ECV will increase your chances of having a vaginal birth and lower the chances of a CS. ECV is a common and safe procedure. ECV success rates differ in each hospital due to experience of clinicians and number of ECVs performed, but it can be successful up to 50% of the time. If your baby is turned head-down with an ECV, you will still have an increased risk of an instrumental or CS compared to if your baby turned on their own.

with a planned first CS are very rare providing you are fit and healthy. If you have a planned CS for a breech baby you also have a very good chance of a successful vaginal birth after CS (VBAC) in the next pregnancy.

Women having a vaginal breech birth have a 60% chance of a successful birth. The success is dependent on many factors including the skill of the practitioner facilitating the birth. Many CS are performed because induction is not usually offered for vaginal breech births.

Overall risks of complications for mothers are lowest with vaginal birth (1.9%), followed by pre-labour CS (2.6%), CS in early labour (4.4%) and CS during active labour (6.0%). Similarly, a pre-labour CS offers more potential benefit to your baby. Because of this, if spontaneous labour starts prior to a planned CS and you are found to be in the advanced first stage or second stage of labour, a vaginal breech birth may be a safer option than a CS.

Complications can arise with breech birth at the time of the birth which may require manoeuvres to resolve. If you are birthing in an upright position, we may need to ask you to turn over onto your back to help the baby be born, and this may include the use of forceps for the aftercoming head. However, this is not an uncommon birth outcome. The current rate of instrumental births in this hospital for head-first babies is [X].

In summary, we feel you can feel confident to make the choice that is right for you. The most likely outcome, regardless of how you choose to give birth, is a healthy baby and healthy mother.

## What are the benefits and risks of these choices?

The current RCOG (2017) guidelines state the following risks of perinatal mortality (death) to your baby (see infographic):

Planned CS – 0.5 per 1000 births (0.05%);  
Cephalic (head down) vaginal birth – 1 per 1000 births (0.1%);  
Breech vaginal birth – 2 per 1000 births (0.2%).

Research into the long-term effects of vaginal breech birth has shown no difference in long-term outcomes (death or neurodevelopmental delays at two years of age) for babies born either by caesarean section or vaginal breech birth. It is very rare for a healthy full-term baby to die, even in breech births. Even those babies who are unwell in the early days following birth usually grow up to be healthy.

Planning a vaginal breech birth may reduce the risks of complications for the mother in this birth and future births. The risks of CS to the mother are:

- Excessive bleeding;
- Wound infection (this is common and can take several weeks to heal);
- Blood clots in the legs which can travel to the lungs (you would be prescribed a medication to reduce this risk);
- Damage to the bowel or bladder (0.1%) or to your ureter, the tube connecting your kidney to your bladder (0.03%).

A CS has long term effects, including increased risks in future pregnancies for mothers and babies. However, serious risks

Before your ECV you will have an ultrasound to confirm your baby is well grown and has enough fluid. This will also confirm the exact position of your baby. The procedure will be performed on [Delivery Suite/MAU] by a [midwife/obstetric consultant/obstetric registrar]. You will have the opportunity to discuss any concerns or questions you have with the staff present and you are able to change your mind about having the procedure at any time.

Before the procedure we will offer you an injection [of ...] to help relax the womb. While you are lying in a flat or semi-recumbent position on the bed, the [midwife/doctor] will place their hands on your abdomen to move the baby up and out of the pelvis. They will attempt to turn the baby through a forward or backward somersault to a head down position. They will then check the baby's new position with an ultrasound. You may find the ECV procedure uncomfortable.

If your blood group is Rhesus negative you will be given an injection of anti-D. This is because some of the baby's blood cells can transfer to the mother, which can sensitise you for future pregnancies.

ECV is a very safe procedure for you and for your baby, however, as with all procedures there are potential risks involved.

- Your baby may turn back to breech presentation in 1 per 40 (2.5%) cases.
- Rarely, there can occur bleeding behind the placenta or fetal compromise, which can require delivery by caesarean section. This occurs only 1 per 200 (0.5%) cases or less.
- Your waters may break.

Please phone [number] if you have any concerns after your ECV procedure, including a change in fetal movements.

Other options can be used in conjunction with or separately from an ECV, such as:

**Moxibustion** – a traditional Chinese therapy which involves heating/burning dried mugwort on the outside of the little toe.

**Acupuncture** – another traditional Chinese therapy which involves the use of sterile needles being applied to pressure points on the body to turn the baby.

**Active birthing techniques** –adopting positions to encourage the baby to rotate to a head down position.

As with all these alternative therapies it is important to seek advice from trained practitioners. Speak to your midwife or doctor for further information.

**Further information and reading, available on-line from the Royal College of Obstetricians and Gynaecologists:**

RCOG Green-top Guideline 20a: *External cephalic version and reducing the incidence of breech presentation*

RCOG Green-top Guideline 20b: *Management of Breech Presentation*

RCOG leaflet: *Choosing to have a caesarean section*

## What are my birth options if my baby remains breech?

**Elective CS** – planned surgery at about 39 weeks gestation. It is planned for this gestation because you are unlikely to go into labour before the surgery, but it is safer for your baby to be born after 39 weeks.

**Vaginal breech birth** – Your labour would start spontaneously and when you attend in labour you would be cared for by a midwife. We would offer to continually monitor your baby's heartbeat, especially in second stage. You would have bloods taken and offered pain relief if needed. This includes an epidural if you wish, but this may increase the chance of having intervention such as a CS or instrumental delivery. We can also offer you use of a pool for hydrotherapy, with telemetry monitoring, for the first stage of your labour, although we recommend birthing outside the water.

You would be encouraged to mobilise during your labour. During the birth you may be in either a kneeling/hands & knees position or a semi-recumbent position, depending on your preference and the skill of the practitioner. An obstetric doctor and a neonatal doctor will be present for the birth as well in case of any complications. As with all births, if your labour does not progress normally or if there are any concerns with the fetal heart beat, we may recommend a CS in labour.