Breech Presentation Information

What is a Breech Baby?

We say that babies are “presenting breech” when baby’s head is up (you may feel it under your ribs!) and bottom is down. There are different types of breech presentations, depending on whether baby’s bottom, feet or sometimes even knees are lowest in your pelvis.

Many babies are breech during pregnancy, but most turn head-down at some point and only about 3-4% (3 to 4 in every 100) of babies remain breech. When babies are breech late in pregnancy, we give them extra attention because occasionally this positioning is the result of a problem, such as a very low placenta or rarely a problem with the baby. However, most of the time the breech positioning occurs by accident, for example if your particular pelvic type invites breech babies. They can run in families!

Additionally, in some cases, birth with a baby in the breech position is associated with some increased risks which should be considered. Therefore, we offer all women whose babies are breech from 36 weeks detailed information and further counselling.

What is the likelihood that my baby will turn on their own after 36 weeks?

If you have had a baby before, and that baby was head-down there is still about a 1 in 3 chance the baby will turn by his/herself, but we recommend you consider your options in case baby remains breech.

However, if you have had a breech baby before or this is your first pregnancy, it is much less likely that your baby will turn before birth. It is also less likely if baby’s legs are stretched straight up (extended breech).
What are my options?

For the majority of women we offer the following:

**External Cephalic Version** – This is a technique to turn the baby in the womb. If successful, you would return to your original birth plans. The chances of you getting a normal delivery are no different than if your baby had always been head down. More information is available in this booklet.

**Planned Caesarean Section at 39 weeks** – This timing is considered ideal to strike a balance between waiting for your baby to reach full maturity, while it is still likely the surgery will occur before you go in to labour, when it is safest.

**Planned Vaginal Breech Birth in the upright or all fours position** – If you wish to have a vaginal delivery this is the optimal position to labour and deliver in – just like for head down babies. It gives the baby the freedom to move through the pelvis and allows more room. Your labour needs to progress normally and there should be no concerns about baby. If you choose this option you will be advised not to have an epidural and not to deliver in the water. Your labour and delivery will be conducted by a midwife but we recommend that the oncall Obstetrician is present for the delivery in case manoeuvres are needed to help your baby deliver.

We would monitor your baby’s heart rate intermittently as we do with low dependency labours or you may choose to have continuous monitoring. Breech labours are usually faster than labours with a head first baby. You will deliver either kneeling or in all fours and will be free to move around during the delivery as you feel the need to do so. If labour was not proceeding in a completely normal fashion you would be offered a caesarean section. A paediatrician will be present at delivery to ensure that your baby is well.

**Planned Vaginal Breech Delivery with an epidural** – You may feel you would like an epidural to help with the labour pains. Your delivery will be managed by the on-call Obstetrician with a midwife. An epidural has the benefits of providing pain relief and should manoeuvres be needed to help with the delivery these will be easier with an epidural. However it has the disadvantage of reducing the likelihood of you achieving a vaginal delivery and also increasing the likelihood of you needing help with the delivery.
You will need a cannula in and baby’s heart rate will be monitored all the time using a CTG (heart rate monitor). Delivery will be on a delivery bed with your legs in stirrups and conventional well known techniques used to deliver the bottom, legs, arms and head (sometimes forceps are required to gently deliver the head). An episiotomy is usually recommended. If labour was not proceeding in a completely normal fashion you would be offered a caesarean section in labour. A paediatrician will be present at delivery to ensure that your baby is well.

**External Cephalic version (ECV)**

1. **What is ECV?**
   This is where the obstetrician turns the baby from a breech position into a head down (cephalic) position. The baby is turned through a forward or backward summersault in the womb by the obstetrician moving the baby through your tummy (abdominal wall).

2. **What are the chances it will work?**
   The success rate is about 30-50%, so for every 100 attempts at ECV 30-50 babies will be turned round into the head down (cephalic) position. Some babies who fail to turn will turn by themselves as your pregnancy continues. The chance of your baby turning back round to a breech is about 5%, if this happens the baby we can try to turn the baby back again if you wish.

   There is a small chance (<0.5%, less than one baby in 200) that your baby will require immediate caesarean delivery because of concern with the heart rate tracing or because the placenta has become separated.

3. **When will it be performed?**
   ECV is performed after 37 weeks gestation and before the onset of labour.

4. **Can everyone have ECV?**
   ECV cannot be performed in the following situations:
   - Multiple pregnancy (twins and above)
   - If you have already ruptured your membranes
   - If there is another reason to perform a caesarean section, for example the placenta is low lying
   - If the CTG (heart rate trace of baby) is not normal
There are also certain situations where it may not be possible to perform ECV:
- If you have significantly raised blood pressure
- If your baby is very small or there is not enough fluid around the baby
- If you have had a bleed in the last 7 days
- If there is an abnormality with the baby

5. **What happens if it works?**
You will be seen by your community midwife the following week to ensure your baby has stayed in the correct position. Labour is then awaited, you have the same chance of a normal delivery once the baby is turned as if the baby had always been head down.

6. **What will happen when I attend for ECV?**
ECV is performed in the morning on labour ward. The ECV will be performed by an experienced obstetrician.

Prior to starting the ECV it will be checked that labour ward is not busy, sometimes there may be a delay until labour ward is quieter. Before the procedure you will have a 20 minute CTG (heart rate trace of baby).

The ECV usually takes less than 15 minutes. Following the ECV you will have a further 20 minute CTG trace. Expect to be on labour ward for about two hours.

You will not require an anaesthetic, although some women find using gas and air helpful as the procedure can be uncomfortable, with pressure from the doctor’s hands. You will be given an injection of terbutaline to help relax the muscle wall of the womb.

Ultrasound is used to check the way the baby is lying and the amount of fluid around the baby before starting the ECV. Ultrasound will also be used during the procedure to look at the baby’s heartbeat.

You will lie on a bed possibly with a pillow under one of your hips. The bed may be tilted so your head is below your feet.

7. **What happens if it fails?**
If the first attempt fails a second attempt can be made after one week if you wish. If your baby stays breech the options of vaginal delivery or caesarean section will be discussed with you.
Breech Choices in summary, what are the risks?

One large research trial found that planned caesarean section appears to reduce the risks of early mortality and morbidity (death, injury or illness) for baby compared to a planned vaginal birth. Other research indicates we can lower this risk by being selective, and monitoring your baby closely during labour. Other studies from Europe show the risk of your baby dying in labour to be 1.3 – 1.6 per 1000 for a breech baby, compared with 0.9 per 1000 for a head down baby.

The most common adverse outcome is that your baby may need to spend time in the special care baby unit after birth and may need help with tube feeding in the days after birth. Your baby may need a little help with their breathing at delivery and therefore we will have a paediatrician present for the delivery.

While the increased risks must be considered, it is uncommon for healthy babies to die even in breech births and when babies are ill in the newborn period, the vast majority go on to become healthy children. In follow-up studies in the same research, there was no long-term difference in the outcomes (death or brain development at two years of age) between those who originally planned a caesarean delivery and those who planned a vaginal birth.

In addition, caesarean deliveries also carry risks, mostly for the mother but also for any babies you may plan to have in the future. Serious outcomes (such as hysterectomy or death) are very rare but are increased following surgical delivery. More commonly, 1 in 10 women will experience a wound infection and delayed recovery in the postnatal period, but a planned caesarean section should not affect your long-term health.

Current research shows that babies born by elective caesarean section are more likely to be obese and have a higher chance of developing asthma, eczema, infections and other problems. This is because they do not get exposed to the normal vaginal environment during birth. It is known that this normally helps the baby develop its immune system (how s/he fights infections).

Your obstetrician and midwife can give you more detailed information individual to your situation.
How do women make decisions?
Your birth choices are personal to you. Women often consider whether they intend to have more children, or if this is likely to be their only or last baby. The postnatal recovery period, for baby and themselves, is also often an important factor. Some women are immediately drawn to one option, others may want further information.

Other sources of information


*Breech Birth*, by Benna Waites

*Breech Birth: What are my options?* by Jane Evans