

Patient information factsheet

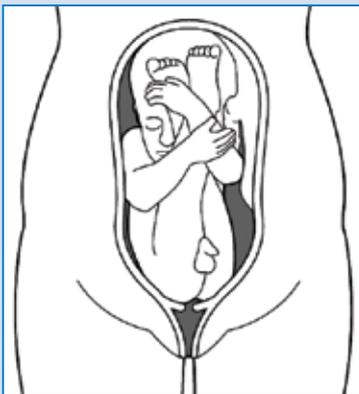
Breech babies

The purpose of this factsheet is to explain what is meant by the term 'breech' and the choices available to you if your baby remains in the breech position after 36 weeks of pregnancy.

This includes the procedures used to encourage your baby to turn into a head-down (cephalic) position, if this is appropriate and the options for giving birth to a baby in the breech position if turning your baby isn't possible.

The term 'breech'

Breech is the term used to describe your baby if he/she is lying in a bottom or feet first position. The exact position may vary, however it may be described as one of the following:



Extended or frank breech

The baby is bottom first, with the thighs against the chest and feet up by the ears. Most breech babies are in this position.



Flexed breech

The baby is bottom first, with the thighs against the chest and the knees bent.



Footling breech

The baby's foot or feet are below the bottom.

About 20% (20 in 100) of babies will be in the breech position at 28 weeks of pregnancy, but most will move into a head down (cephalic) position and by 37 weeks less than 3% (three in 100) are still breech.

At 36 weeks of pregnancy

If your baby is still in the breech position at 36 weeks of pregnancy you will be offered a scan to:

- confirm the position of your baby
- assess your baby's growth
- measure the amount of fluid surrounding your baby

You will also be offered an appointment in a consultant antenatal clinic or the day obstetric unit where the following options will be discussed with you:

- turning your baby (external cephalic version, or ECV for short)
- planned (elective) caesarean section when your baby is delivered via surgery to your abdomen
- vaginal breech birth

Turning your baby around (ECV)

ECV is a way of turning your baby around so he/she can be born in a head-down position. It involves applying pressure on the outside of your abdomen. If an ECV is appropriate for you, it is usually carried out from 36 weeks of pregnancy.

A successful ECV will:

- greatly reduce your chances of needing a caesarean section for breech alone
- allow your baby to be born head-first which has the least risk of complications for you and your baby

Local statistics produced for University Hospital Southampton NHS Foundation Trust show ECV is successful for about 35% of women. The baby will sometimes turn back into the breech position, but this is rare.

The rate of emergency caesarean sections as a complication of ECV is less than 1% (one in 100). This is because on rare occasions the baby may become distressed during the procedure (due to separation of the placenta or compression of the umbilical cord) which could lead to a caesarean section. However, as a precaution, the ECV procedure may be carried out in the operating theatre.

On the day of the ECV

On the day of the procedure you must not eat after midnight and only drink water after 7.30am. You will be asked to come to the labour ward at 9am and it is a good idea to have somebody with you for support.

Before the ECV takes place:

- Your baby's heartbeat will be monitored and you will be scanned to confirm your baby is still in a breech position.
- You will be given medication to help your womb relax, so your baby is easier to turn.
- You will be seen by an anaesthetist due to the small possibility of a caesarean section.
- You will be asked to sign a consent form for the ECV and also for the possibility of having a caesarean section.
- Your veins will be assessed and your anaesthetist may recommend you have a cannula inserted (this is a thin tube that is placed in the vein and is used to take blood and may also be used to give fluid and drugs if necessary).
- Even if a cannula is not needed initially, a blood sample to check your blood group and iron levels is recommended.

The ECV procedure itself

The obstetrician (doctor who specialises in the care of women during pregnancy, labour and after birth) will place his or her hands on your abdomen, putting one hand on your baby's head and the other on their bottom, and will try to turn the baby so that their head lies in the lower part of the womb.

This usually takes 15 to 20 minutes, but if you find it too uncomfortable or painful, you can choose to stop at any time.

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After the procedure:

- Your baby is monitored for about 30 minutes after the procedure, even if the ECV is not successful (your baby didn't turn).
- An injection of anti-D is recommended if your blood group is known to be Rhesus negative. Please discuss the reason for this with your midwife or obstetrician.
- If the ECV is successful (your baby has turned around), you are advised to make an appointment to see your midwife a week later to:
 - check your wellbeing and that of your baby
 - discuss your plans for vaginal birth.
- If the ECV is unsuccessful you will be given the opportunity to discuss your alternatives: elective caesarean section and planned vaginal breech birth

Delays to the procedure

On rare occasions it may be necessary to delay or postpone your ECV to another day. This may be due to other emergencies taking place within the labour ward and decisions will be undertaken to protect the wellbeing of you and your baby.

Advantages and disadvantages of vaginal birth versus planned caesarean section

If an ECV has been considered inappropriate or proved to be unsuccessful, it is important for you to consider the advantages and disadvantages of both planned (elective) caesarean section and planned vaginal breech birth. The table below will help you understand what these are:

	Advantages	Disadvantages
Caesarean section	<ul style="list-style-type: none">• A planned caesarean section is considered to be safer for your baby than a vaginal breech birth.• A planned caesarean section is safer than an emergency caesarean section, in the event of a planned vaginal breech birth being unsuccessful.	<ul style="list-style-type: none">• Having a caesarean section creates a scar on your uterus (womb) and as a consequence there are greater risks associated with future pregnancies. These are due to:<ul style="list-style-type: none">- a small risk of scar separation (please discuss this with your obstetrician)- the risk of developing problems with your placenta which can cause bleeding:<ul style="list-style-type: none">- placenta praevia (when your placenta is low down in the uterus) or- placenta accreta (when the placenta grows into the scar tissue)
Vaginal Birth	<ul style="list-style-type: none">• A shorter stay in hospital.• You are more likely to successfully begin and continue breastfeeding (however the research available compares vaginal birth with all caesareans and does not address elective caesarean or breech birth specifically).• You have a smaller chance of complications such as:<ul style="list-style-type: none">- infection- heavy bleeding- bladder injury (10 times less common)- blood clots (5 times less common)• You are less likely to need to be readmitted to hospital.	<ul style="list-style-type: none">• Your baby is more likely to develop an infection and experience birth-related bruising, nerve damage or an inadequate supply of oxygen to the brain.• It is not possible to guarantee midwives and obstetricians experienced in vaginal breech birth are available at all times. A more experienced member of staff will be called in if necessary.

It is important that you discuss the implications of these advantages and disadvantages with your obstetrician and consider your future pregnancy plans.

Reasons you might be advised to choose a planned caesarean instead of a vaginal breech birth

You may be advised against a vaginal breech birth if:

- your baby's feet are below its bottom (known as a footling breech)
- your baby is large (more than 3.8kg or 8.4lb)
- your baby is small (less than 2.5kg or 5.5lb)
- a scan of your baby's position suggests their neck is tilted back
- you have had a caesarean before
- you have a narrow pelvis (there is less room for your baby to pass safely through the birth canal)
- you have a low-lying placenta
- you have medical problems that complicate your pregnancy

Planned caesarean section

Research shows that a planned (elective) caesarean section at 37-42 weeks (term) carries less risk of complications for breech babies than a planned vaginal birth.

A planned caesarean due to breech is usually carried out around the 39 weeks of pregnancy and the procedure is fully explained in the additional information sheet 'Elective (planned) caesarean section'. Please ask for a copy if you haven't been given one yet.

Going into labour before the date of your caesarean section

Approximately 5% (five in 100) of women will go into labour before the date of their planned caesarean section. This may result in a vaginal birth if things progress too quickly, but if time allows a caesarean section will be carried out as planned.

Vaginal breech birth

Just over half of women for whom a vaginal breech birth is considered appropriate give birth without the need for a caesarean section.

However, a caesarean may be necessary if:

- your baby shows signs of becoming distressed in labour
- your cervix (neck of the womb) does not fully dilate or
- your baby does not pass through your pelvis

Therefore you are advised to consider the following recommendations when established labour has been confirmed:

Monitoring your baby's heartbeat

- Continuous monitoring of your baby's heartbeat until birth is recommended as this enables any changes in heart rate to be detected. Many women are concerned that this monitoring will be intrusive and have an effect on their mobility. However, you are encouraged to remain active and mobile, standing or kneeling, using birth aids such as the birthing ball. Please discuss use of the telemetry (wireless) machine with your midwife.

Information about pain relief

- All of the usual choices of pain relief during labour are available to you, however you are advised to discuss the advantages and disadvantages of each with your midwife or obstetrician.
- You are advised to consider the influence pain relief such as pethidine, remifentanyl or epidural anaesthesia has on your ability to remain active and mobile. However, an epidural may be considered beneficial as it prepares you for a possible caesarean. Again, your midwife or obstetrician can advise you further.

Place of birth

- You will be advised to labour on labour ward and transfer to an operating theatre before your baby is born, in case you do need a caesarean. An obstetrician and paediatrician (doctor who looks after babies) will be present for your baby's birth.
- It is recommended that you have a cannula inserted. This is a thin tube that is placed in the vein and is used to take blood and may also be used to give fluid and drugs if necessary.

Additional care after your baby is born

When babies have been in a breech position after 36 weeks of pregnancy there is a slightly increased risk of unstable hips. Your baby will be offered a hip assessment as part of their 'first medical examination' to assess the stability of their hip joints. An ultrasound scan at around six weeks of age will also be arranged. If you have any questions about this please ask your midwife or paediatrician.

This information leaflet is intended to give you information and answer any of your immediate questions. Please feel free to discuss any further questions and concerns with your midwife or doctor.

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