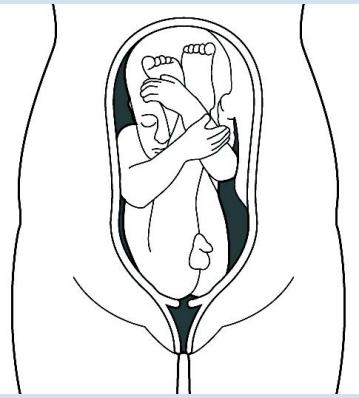
Breech babies

This factsheet explains what the term 'breech' means and the options available to you if your baby remains in the breech position after 36 weeks of pregnancy. We hope it will help to answer some of the questions you may have. If you have any further questions or concerns, please speak to your midwife or obstetrician.

What does 'breech' mean?

Breech is the term used to describe babies lying in a bottom or feet-first position in the womb (uterus) instead of in the usual head-down (also known as head-first or cephalic) position.

Breech is very common in early pregnancy, as babies often change their position in the womb. There are three main breech positions:



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.

Approximately 20% (20 in 100) of babies will be in the breech position at 28 weeks of pregnancy. However, most babies will naturally move into a head-down position and by 37 weeks, less than 4% (four in 100) of babies will still be in the breech position.

There are certain situations that may make it more difficult for your baby to turn during pregnancy and therefore they are more likely to remain in a breech position. These include:

- having too much or too little amniotic fluid around your baby
- having a low-lying placenta (also known as placenta praevia)
- having a multiple pregnancy (expecting more than one baby)

If your baby is breech at 36 weeks of pregnancy

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

- confirm the position of your baby
- assess your baby's growth
- measure the amount of amniotic fluid surrounding your baby
- measure the blood flow to your baby

We will also offer you an appointment in the maternity day assessment unit to discuss the following options with you:

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

External cephalic version (ECV)

ECV is a way of turning a breech baby around into a head-down position. It involves an obstetrician (a doctor who specialises in the care of women during pregnancy, labour and after birth) applying pressure on the outside of your abdomen. ECV is a safe procedure, but it can be uncomfortable.

A successful ECV will:

- greatly reduce your chances of needing a caesarean section
- allow your baby to be born vaginally head-first (this has the least risk of complications for you and your baby)

An ECV is not suitable for everyone. We will not recommend an ECV if:

- a caesarean section has been recommended for another reason
- you have a low-lying placenta (placenta praevia)
- you have had vaginal bleeding within the last seven days
- your baby's heart rate tracing (also known as CTG) indicates concerns about their wellbeing
- your waters have broken
- you are expecting more than one baby (unless it is used to help the vaginal birth of your second twin after the birth of your first twin)
- there are concerns about the shape of your womb

Your obstetrician will discuss your individual suitability for ECV with you if:

- you have previously had a caesarean section
- your baby is smaller than expected or the amniotic fluid around your baby is reduced
- you have raised blood pressure or protein in your urine
- you have previously had a fibroid removed or other uterine surgery
- there are concerns about your baby's development

If an ECV is appropriate for you, it will usually be performed from 36 weeks of pregnancy (if you are expecting your first baby) or from 37 weeks (if you have had a baby before).

Does an ECV always work?

Nationally, around 50% of breech babies can be turned using ECV. ECV is more likely to work if you have had a vaginal birth before. Please be aware that even if your ECV is successful, there is a small chance (less than 5%) that your baby will turn back into a breech position.

Are there any risks or complications?

Occasionally, an ECV can cause babies to become distressed (this is shown through changes in their heart rate). This can increase your risk of needing an emergency caesarean section immediately after the procedure. However, this is rare (one in 200 chance). For this reason, the ECV will be performed on Labour Ward at Princess Anne Hospital.

Complications associated with an ECV are rare (less than 1%), but they include:

- placental abruption (when the placenta starts to come away from the inner wall of the womb before the baby is born, and causes a decrease in the baby's oxygen supply and heavy bleeding for the mother)
- feto-maternal haemorrhage (when the baby's blood enters the mother's circulation)
- cord entanglement (when the umbilical cord gets tangled around the baby's body)
- fetal bradycardia (when the baby's heart rate is abnormally low)
- uterine rupture (when the muscular wall of the womb tears during pregnancy or during delivery)
- fetal injury (when the baby is injured)

If any of these complications occur, you may need an emergency caesarean section.

Even if the ECV is successful, your chances of needing an emergency caesarean section or assistance with your baby's birth (forceps or ventouse) are slightly higher than if your baby had always been in a head-down position.

Preparation for the ECV procedure

On the morning of the procedure, you can have an early breakfast (before 7am) and then water only after 7am. You will then need to arrive at Labour Ward for 9am. We recommend bringing someone with you to your appointment for support.

Before the procedure

We will:

- monitor your baby's heart rate and perform an ultrasound scan to confirm your baby is still in a breech position.
- give you an injection of medication (known as terbutaline) to help your womb relax, so your baby is easier to turn.
- ask an anaesthetist to come and see you due to the rare possibility that you may need a caesarean section.
- assess the veins in your arms and may recommend inserting a cannula (a thin tube that is placed in a vein and is used to take blood and/or give fluid and medication if necessary). Inserting a cannula and taking blood before your ECV may be appropriate if inserting a cannula is likely to take longer than usual in the event of an emergency or if you have antibodies in your blood. Your midwife or obstetrician will discuss this with you.
- ask you to sign a consent form for the ECV and also for the possibility of having a caesarean section.

During the procedure

Your obstetrician will place their hands on your abdomen, putting one hand on your baby's head and the other on their bottom. They will then try to turn your baby so that their head lies in the lower part of your womb. Throughout the procedure, we will regularly check your baby's heart rate and position. An ECV usually takes 15 to 20 minutes. Please let us know if you experience any discomfort or pain during the procedure and we can stop, or we can offer you gas and air to help relieve your pain.

After the procedure

We will monitor your baby's heart rate for about 30 minutes after the procedure, even if the ECV is not successful (your baby didn't turn around).

We may recommend you have an injection of anti-D if your blood group is known to be rhesus negative (unless your baby's blood group is also known to be rhesus negative). For more information about this, please speak to your midwife or obstetrician.

If the ECV is successful (your baby turned around), we will advise you to make an appointment to see your midwife a week later to:

- check your wellbeing, and the position and wellbeing of your baby
- discuss your plans for vaginal birth

If the ECV is unsuccessful (your baby didn't turn around), we will discuss your alternative options, such as:

- having a second attempt at ECV
- having a planned caesarean section
- having a planned vaginal breech birth

You will usually be able to go home after the ECV.

Contact the maternity day assessment unit on **023 8120 4463** (between 9am and 2.30am) if you experience any of the following symptoms:

- bleeding
- abdominal pain
- a reduction in your baby's movements

For urgent enquiries outside of this time, please call the Labour Ward on **023 8120 6002**. If you think you might be in labour or your waters have broken, please call the 24-hour Labour Line on **0300 123 9001**.

Delays to the procedure

Occasionally, we may need to delay or postpone your ECV. This may be due to other emergencies taking place on the Labour Ward. We will take the wellbeing of both you and your baby into consideration before making this decision.

Is there anything else I can do to help my baby turn around?

There is no scientific evidence that lying down or sitting in a particular position can help your baby to turn around. However, there is some evidence that the use of moxibustion (burning a Chinese herb called mugwort) at 33 to 35 weeks of pregnancy may help your baby to turn into the head-first position. This should be performed under the direction of a registered healthcare practitioner. Please speak to your midwife or obstetrician for more information.

Advantages and disadvantages of vaginal birth versus planned caesarean section

If you are not suitable for an ECV or an ECV is not successful, it is important that you consider the advantages and disadvantages of both planned caesarean section and planned vaginal breech birth (please see table on the next page).

	Advantages	Disadvantages
Caesarean section	• 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. • You have a lower risk of urinary incontinence (4% compared to 7% with a vaginal birth). • You are less likely to require a blood transfusion.	• You are more likely to need pain relief after your baby is born and a longer stay in hospital. • Your risk of venous thromboembolism (blood clots) is increased. Statistics suggest that women who have a caesarean section are twice as likely to have a blood clot compared to women having a vaginal birth. However, there are a number of steps you can take to prevent blood clots from occurring. For more information, please speak to your midwife or read the 'Understanding blood clots or venous thromboembolism (VTE) in pregnancy and after birth' booklet, which is available to download from **www.uhs.nhs.uk/maternity** • Having a caesarean section creates a scar on your womb and as a result you will have: - a small risk of scar separation in future pregnancies. Please discuss this with your obstetrician and download the 'Birth after caesarean section' factsheet from **www.uhs.nhs.uk/maternity** for more information. - a higher risk of developing problems with your placenta in future pregnancies, such as placenta praevia (when your placenta is low down in your womb) or placenta accreta (when your placenta grows into the scar tissue which can cause severe bleeding). This risk will increase every time you have a caesarean section. • 5% of babies born by caesarean section will be affected by transient tachypnoea of the newborn (a condition that causes breathing problems in newborn babies). This condition is usually only temporary and the likelihood can be reduced if you have an elective caesarean section after 39 weeks.
Vaginal birth	• You are more likely to have an easier recovery, less pain after birth and 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 planned caesarean or breech birth specifically). • You have a smaller chance of complications, such as: - heavy bleeding - bladder injury (ten times less common) - blood clots (five times less common) • You are less likely to be re-admitted to hospital.	• Your baby has an increased risk of birth-related complications such as bruising, nerve damage and a lack of oxygen to the brain. • Your chance of having a successful breech birth is much higher in the presence of a skilled birth attendant. If you are planning a vaginal breech birth, your birth will be attended by a senior obstetrician and a midwife. • 40% of women (40 out of every 100 women) who plan a vaginal breech birth have an emergency caesarean section during labour. • Research shows that breech babies born vaginally have a slightly higher chance of death around the time of their birth (two out of every 1000) compared to breech babies born by caesarean section (0.5 out of every 1000).

The type of birth you choose will not affect your chance of:
- having faecal incontinence (less control when opening your bowels)
- experiencing pain on sexual intercourse at three months after birth
- developing a birth-related infection

However, it is important to be aware that your risk of infection increases with your BMI, irrespective of whether you give birth vaginally or by caesarean section. For more information, please read the 'Pregnancy and body mass index' booklet. This is available to download from **www.uhs.nhs.uk/maternity**

It is important that you discuss the implications of these advantages and disadvantages with your obstetrician. Your complication risk is highest if you need to have an emergency caesarean section during labour (this is the case for 40% of women who plan a vaginal breech birth).

Reasons why we may advise you to choose a planned caesarean section instead of a vaginal breech birth

We may advise you not to have 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 (hyperextended)
- you have had a caesarean section before
- you have a low-lying placenta
- there are concerns about your health and wellbeing

Planned caesarean section

Research shows that a planned caesarean section at 37 to 42 weeks (sometimes known as 'term') carries a lower risk of complications for breech babies than a planned vaginal birth.

A planned caesarean section is usually carried out when you are 39 weeks pregnant. The procedure is fully explained in the 'Enhanced recovery after caesarean section' booklet which is available to download from **www.uhs.nhs.uk/maternity**

Going into labour before the date of your planned 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

Your chance of having a successful breech birth is much higher if there is a skilled birth attendant present. If you are planning a vaginal breech birth, your obstetrician will discuss this with you in advance and make a plan for when you are in labour. A senior obstetrician, a midwife and a paediatrician (a doctor who looks after babies) will be present at your baby's birth.

Just over half (60%) of women for whom a vaginal breech birth is considered appropriate give birth without the need for a caesarean section. However, a caesarean section may be necessary if:
- your baby shows signs of becoming distressed in labour
- your cervix (neck of your womb) does not fully dilate
- your baby does not pass through your pelvis

For this reason, we advise you to consider the following recommendations when you go into labour:

Continuous monitoring of your baby's heart rate
To help us detect any alterations in your baby's heart rate which may suggest there are changes in your baby's wellbeing, we will recommend continuous monitoring of your baby's heart rate throughout labour. Research has shown that continuous monitoring improves a baby's chance of a good outcome. However, it is also associated with an increased likelihood of caesarean section during labour and may affect your ability to remain upright and mobile.

We will encourage you to remain active (standing or kneeling) using birth aids, such as a birthing ball, to minimise the effect of continuous monitoring on your mobility. Please discuss continuous monitoring and the use of a telemetry (wireless) machine with your midwife or obstetrician.

Pain relief
As long as we can measure your baby's heart rate, all of the usual choices of pain relief during labour will be available to you. However, we advise you to discuss the advantages and disadvantages of each type with your midwife or obstetrician.

Certain types of pain relief, such as pethidine, remifentanil or epidural anaesthesia, may affect your ability to remain active and mobile during labour.

The effect of an epidural on the success of a breech birth is unclear. However, there is some evidence to suggest that it may increase your chance of needing intervention, such as an emergency caesarean section.

Place of birth
We recommend that you labour on Labour Ward. As a precaution, a senior obstetrician, a midwife and a paediatrician (a doctor who looks after babies) will be present for your baby's birth. When you are ready to push, we will transfer you to our theatre in case an emergency caesarean section becomes necessary.

We will recommend that you have a cannula (a thin plastic tube) inserted into a vein to allow us to take blood, and give you 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. We will offer your baby a hip assessment as part of their 'newborn and infant physical examination (NIPE)' to assess the stability of their hip joints. The NIPE will be performed within 72 hours of your baby's birth by a paediatric doctor, an advanced neonatal nurse practitioner or a specialist midwife. There is more information about the NIPE in the 'Screening tests for you and your baby' booklet, which is available to download from **www.gov.uk/phe/pregnancy-newborn-screening**

We will also arrange an ultrasound scan of your baby's hips for when they are around six weeks of age. If you have any questions about this, please speak to your midwife or paediatrician.

Contact us

If you have any further questions or concerns, please speak to your midwife or obstetrician.

If you have any urgent concerns about the wellbeing of you or your baby, please call the maternity day assessment unit on **023 8120 4463** (between 9am and 2.30am).

For urgent enquiries outside of this time, please call the Labour Ward on **023 8120 6002**.

If you think you might be in labour or your waters have broken, please call the 24-hour Labour Line on **0300 123 9001**.

Useful links

www.nhs.uk/pregnancy/labour-and-birth/what-happens/if-your-baby-is-breech

www.nct.org.uk/labour-birth/different-types-birth/assisted-or-complicated-birth/breech-babies-what-you-need-know

www.rcog.org.uk/en/patients/patient-leaflets/breech-baby-at-the-end-of-pregnancy

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