Chapter 28

BREECH PRESENTATION

The SOGC Recommends

1. The best method of delivering a term frank or complete breech singleton is by planned LSCS. This policy results in a significantly lower, although not absent, risk of infant mortality and/or morbidity than planned vaginal birth.

2. Practitioners are encouraged to ensure that this information is conveyed to women who are contemplating breech vaginal birth and that they obtain an informed and documented consent.

3. The risks of LSCS should also be discussed and documented. When scheduling a LSCS it is important to ensure that accurate dating and presentation of the fetus are confirmed just prior to undertaking the Caesarean section.

Management of the Unplanned Vaginal Breech Birth

- Appropriate fetal health surveillance
- Anaesthetist should be notified and come to attend birth
- NRP provider with airway skills should be present at the birth
- Maternal bladder should be emptied just prior to birth, if possible
- Piper forceps should be available for the aftercoming head
- Ideally, a physician experienced with breech birth should be involved
- Experienced nursing staff should be available
- Deliver the breech as an assisted breech. Breech extraction must not be performed.

Technique

1. Empty bladder

2. Summon anaesthesia and have him/her attend

3. Ensure adequate analgesia, if possible.

4. Spontaneous descent and expulsion to the umbilicus should occur with maternal pushing only. **DO NOT PULL ON THE BREECH!**

5. Ensure that the sacrum is in an anterior position. May be facilitated if needed.

6. Episiotomy may be considered once the anterior buttock and anus are "stretching" the perineum. This is the best time to do an episiotomy.

7. Extract the legs when the popliteal fossae are visible (Pinard's manoeuvre).

8. With a warm towel, grasp the baby by the anterior and posterior iliac spines with gentle downward traction with mother pushing until the scapulae are visible. Do not pull on the breech or compress the abdomen. Maintain flexion of the foetal head by keeping the body below the horizontal. If necessary, flex the baby's head with a hand suprapubically.

9. Rotate the body to facilitate delivery of the arms by sweeping the anterior humerus across the chest of the fetus (Loveset manoeuvre). Rotate other arm anterior and repeat.

10. Support the baby to maintain the head in a flexed position. Suprapubic pressure may help. Maternal expulsive efforts should be encouraged.

11. The body should be supported in a horizontal position.

12. The Mauriceau-Smellie-Veit manoeuvre can be used to deliver the head in flexion. The fetal body is placed astride the operator's forearm. The middle finger is placed in the fetal mouth and the other fingers support the maxilla encouraging flexion. The other hand is placed on the fetal back with the middle fingers against the occiput. Gentle traction is exerted in a downward and outward direction to ensure a controlled release of the head.

13. Use Piper forceps for the aftercoming head if needed.

References

1. Society of Obstetricians and Gynecologists of Canada (SOGC), Alarm Course Syllabus, 13th ed., 2006.