11/17/17njm

Breech Birth Information sheet

The Alaska Native Medical Center and Southcentral Foundation want to give you the best care possible. Taking part in choices about your delivery is an important part of this care. You have the added decision about how to give birth with this pregnancy because your baby is currently in breech position. We will give you information so that you can make the choice that is best for you and your family. Our goal is a healthy mother and baby, whether the birth is vaginal or cesarean delivery.

Feel free to contact your provider with questions and for additional information.

Breech delivery: baby is coming with the bottom first instead of the head first. The following discussion revolves around singleton births. Discussion of the second twin delivery is elsewhere.

Cephalic delivery: baby is coming with the head first.

Why is a breech delivery different from a cephalic delivery?
With a baby in breech position the forces of the contractions are different toward the cervix, making the first part of labor, opening of the cervix, in some instances less effective. When the baby is ready to be pushed out, there are additional maneuvers an obstetrician needs to be trained in and comfortable with to deliver the baby safely.

Can all women with a baby in breech position deliver vaginally?
No, we have specific guidelines on which women and their baby would be good candidates for a vaginal breech delivery.

What is the Alaska Native Medical Center's experience with breech delivery?
We have some providers who have extensive experience with breech deliveries and if we can align their schedule to your due date we would be happy to accommodate your breech delivery.

What are the criteria for a vaginal breech delivery?

-Estimated fetal weight at least 2500 grams (5 lb 8 oz) and not more than 4000 grams (8 lb 13 oz)
-Gestational age 36 weeks or more
-No hyperextension of the fetal head (chin and neck are farther away)
-Frank or complete breech presentation, meaning the fetal bottom is coming before the legs
-Adequate maternal pelvis; no suspicion of a small maternal pelvis
-No physical problems with the baby that may cause problems with a vaginal delivery
-Staff skilled in breech delivery and immediate availability of facilities for safe emergency Cesarean delivery
-No other reasons you should not have a vaginal birth (see also 'when is a cesarean delivery advised for a breech baby')

What are the risks of a vaginal breech delivery?

At two years of life:

-no difference in an infant's brain / nerve development or rate of death between vaginal vs. cesarean deliveries, even if the infant had the prior illnesses / injuries listed below

Short term risks:

Risks of cephalic vaginal deliveries are the same for breech vaginal deliveries including:

-bleeding
-pain
-fetal injury
-fetal distress: Low 5 minute Apgar score, early signs of brain, and nerve injury
-fetal death

More common to breech

-the following are often a result what caused the fetus to be breech to begin with
    -unsuccessful expulsion of the fetus
    -need for a forceps delivery or a cesarean delivery
    -head gets stuck: rare in the gestational ages allowed in ANMC guideline
    -cord comes out first giving fetal distress in need for an immediate cesarean birth

When is a cesarean delivery advised for a breech baby?

-When there is no obstetrician available for the delivery that has experience with breech vaginal delivery
-When labor doesn't progress normally
-Cord presentation
-Fetal growth restriction or fetal growth more than 4000 grams (8 lb 13 oz)
-Fetal feet first, instead of fetal bottom first
-Suspicion of small maternal pelvis
-Fetal anomaly incompatible with vaginal delivery
-Other conditions present precluding vaginal delivery even in the case of a cephalic baby like placenta previa, large uterine fibroids (growths in the uterus).

What are the risks of a cesarean birth?

<u>Maternal</u>

-Blood loss
-Infection
-Less maternal satisfaction with birth process
-Increased hospital stay and re-admissions
-Wound complications
    -numbness or pain
    -scar with poor cosmetic outcome (worse with infection / fluid causing wound breakdown)
    -endometriosis in scar
-Blood clots in legs, lungs, or blood vessels in the pelvis
-Maternal problems with anesthesia
-Injury to organs inside the body
-Intestinal obstruction
-Hysterectomy (Uterus or womb has to be removed - most often due to bleeding or scar tissue)
-Post menopausal bleeding
-Future pregnancy problems
    -scars developing on the uterus, bladder, abdominal wall, placenta and inside the abdomen
    -placenta growing into wall of womb – may require future hysterectomy
    -uterus or womb can rupture in future pregnancy
    -future stillbirth
    -future preterm birth
    -future infertility
    -many patients go on the have repeated cesareans –> increases risk of all the above
-Maternal death

<u>Fetal</u>

-At two years there are more medical problems in the infants delivered by cesarean delivery
-Fetal injury
-Fetal breathing problems initially and asthma in offspring later in life
-Decreased breast feeding
-Delayed and impaired interaction with infant after birth

Breech Birth planning sheet

GA 35-36 weeks: fetus is identified in breech presentation

Plan for External Cephalic Version (ECV) in L&D around 37 weeks

If ECV is unsuccessful – the provider will give the Breech Birth information sheet to the customer and plan a visit in the clinic with a provider who is able to assist with further questions regarding a vaginal breech delivery versus a planned cesarean delivery. An official growth ultrasound will be scheduled before meeting with the provider.

If a customer plans for a Cesarean delivery, this will be arranged.

If customer plans for a vaginal delivery and is an appropriate candidate as indicated by the provider with experience with vaginal breech birth, a coverage schedule will be arranged.

At the time of admission for labor, the customer will have an ultrasound by the L&D doctor on call if still breech and to confirm that the breech is not footling and does not have an extended head. If still vaginal breech candidate based on this the back-up vaginal breech provider will be called.

The breech provider will do their assessment and be available for the delivery; the breech back-up person needs to be in house from 6 cm dilatation onwards. Customer is offered an epidural for pain control.

If labor is not progressing in a normal pattern, augmentation may be initiated; however, this should be done with close observation of progression once active labor has commenced. Artificial rupture of membranes is not advised since this decreases the dilating effect of the bulging membranes on the cervix. As soon as membranes rupture, a vaginal check is performed to exclude cord prolapse.

The best indication of adequate fetal pelvic proportions is good progress in labor. Failure to progress for two hours despite adequate uterine contractions is an indication for CD. A passive second stage (i. e., delayed pushing) for up to 90 minutes is acceptable. However, once the woman starts bearing down, failure of the breech to descend and deliver within 60 minutes should be managed by cesarean delivery rather than breech extraction.

The delivery will be done in the operating room.