AIMS For a better birth...

Keep Your Hands off the Breech

By Mary Cronk, MBE

AIMS Journal Autumn 1998, Vol 10 No 3

Mary Cronk, MBE is a well known and well respected independent midwife. During her many years of practice she has acquired a vast experience of birthing breech babies vaginally. In this article, which is an edited version of a talk which she gives to accompany her unique and revealing set of breech birth slides, she explains how babies can be born presenting by the breech.

Approximately 3-4% of babies will present by the breech at term. The first question a midwife will ask is "Why is this baby presenting this way?" It could be due simply to prematurity, many babies present by the breech until 30 weeks or so, and if labour starts before then, we will have a baby presenting by the breech. For these babies, there is some evidence that they do better if delivered by caesarean section. The 28 week baby who arrives on the labour ward with its buttocks visible at the vulva (entrance to the birth canal) sometimes doesn't do too well, and this, of course, is one of the factors that skews the morbidity figures for vaginal breech birth.

If the pregnancy has reached term we still need to consider whether there is any reason why this baby is presenting by the breech. Placenta praevia is a possibility. Women with this condition do not always bleed antenatally, and this possibility is an occasion where selective ultrasound is of considerable value, as it can identify a placenta praevia, or other objects in the pelvis, such as fibroids or ovarian cysts which would make caesarean section advisable. There may be a bi-cornuate uterus - a uterus which is divided. This condition does not necessarily exclude a vaginal birth, it will depend on the degree.

A midwife will also be considering whether the baby has a problem. Fetal anomalies such as hydrocephaly and conditions involving generalised laxity, for example, brittle bone disease, can lead to a breech presentation and these conditions should be excluded if possible.

A normal breech birth

Having excluded the above complications, the "normal" woman who at term has a baby in a breech position which shows no inclination to turn can, I believe be born easily and spontaneously, if the labour proceeds spontaneously and easily. Just like a cephalic presentation (head down), if the labour progresses and all is well, the woman is supported and cared for, the baby will be born. There is one major difference. Where in a cephalic presentation, labour is incoordinate, or lacks progress, augmentation is occasionally justified. I do not believe that there is any place for induction or augmentation in a breech labour. If a breech labour does not progress, this woman's body is telling us something, and we should

listen. There is no emergency, there is no rush, this labour just isn't progressing, and this baby should be delivered by caesarean operation.

I do not feel that there is any place for either trying to push breeches through pelvises with oxytocic drugs or pulling them through with actively managed breech extractions. I feel that this management is what has contributed to giving vaginal breech delivery poor outcomes and such a bad name. In my experience, if the labour does not progress well and spontaneously, the baby needs to be delivered by caesarean operation.

Some years ago, I looked after a woman whose baby, at term, was presenting by the breech. It was her second baby, her first weighed 8lbs and was delivered by forceps. She had very mixed feelings about how that labour had been "managed" and desperately wanted this second baby to be born at home. Labour commenced at term + 10 days. It started, it stopped, then there would be another few hours of good strong contractions, then it all stopped again, the fetal heart remained good, and the mother remained in a good condition. She was well rested, she was able to eat and drink as she wished, but over a period of two days, her labour just did not progress.

There was no emergency, the cervix, though effaced and thin, was not dilating beyond 2-3cms, the presenting part was not descending, this labour was not effective. When Caroline was ready, and had started to come to terms with the fact that this second birth would need help, we transferred to hospital where Jack was born by caesarean operation. He weighed 10lbs 8ozs and was in excellent condition. It was now perfectly obvious why the labour had not progressed spontaneously. If we had tried to do clever things with oxytocic drugs, I believe Jack would very soon have become distressed.

This woman's experience demonstrates the necessary and proper use of surgery to deliver babies but many women consider that they have had unnecessary surgery electively performed simply because of breech presentation. Many are performed because while we have good surgeons who can do a good caesarean operation they, and many midwives, have forgotten that many breeches can safely been born vaginally. Many midwives have lost or never been enabled to learn the skills of how to assist women to give birth when the diagnosis is made that its a breech.

It is my view that a breech presentation is a normal presentation, though not the usual presentation. A normal labour and a spontaneous birth are not to be excluded just because the presenting part is breech, but I emphasise that I am not saying that all breeches can or should be born vaginally.

Having attended many breech births it is my experience that if labour progresses well and spontaneously, and by that I mean, spontaneous onset at or around term, contractions that come oftener, last longer, get stronger, a cervix that effaces, and dilates and a presenting part that descends through the pelvis, *this baby will be born.*

Labour

Many women during their labour will adopt a hands and knees position. I find that this is the best position

for the mother, the baby and the midwife. Some practitioners ask the mother to stand in an upright position. I am concerned that the placenta may separate too quickly in this position. When the mother is on her hands and knees the uterus appears horizontal and tipped forward. It seems to me that if the woman is vertical there may be some traction on the cord/placenta from gravity just after the birth and in the absence of a contraction. I do not have any evidence to support this theory but I feel that until I have evidence to refute it, I should not encourage women to give birth to breeches in a vertical position. It also seems that women will bend forward and assume the all fours position if not directed by us. We need research to help us in this area.

There is also some evidence that when the woman is standing, the birth can be too swift and the placenta can separate too quickly; assisted too much by gravity, it can arrive almost on top of the baby's head. So, I prefer the all fours position.

Old midwifery text books show that when a woman is on her back for the delivery the attendants lift the baby up by the heels, over the mother's pubis; when she is on her hands and knees this movement happens by gravity.

Keep your hands off

For a normal breech birth the time-honoured advice, hands off the breech, is still the safest advice. Keep your hands to yourself; sit on them if necessary. When the buttocks reach the perineum the decision will need to be made as to whether an episiotomy is necessary . If the perineum is tight and rigid and substantially hindering progress, despite good contractions and expulsive efforts an episiotomy is justifiable. This decision really needs to be left to the attendant at that time.

Extended legs may look as if they are going on forever, but do not touch, they will flop out, shortly followed by the arms. Now one can touch the baby, giving gentle support but allowing the body to take some of its own weight which will bring the chin onto the perineum. Untouched, the head will usually emerge but I believe it is permissible for the attendant to flex the head (chin onto chest) by placing the right index finger in the baby's mouth and the left index finger behind the baby's occiput (back of the baby's head) and thereby assisting the flexion of the head.

The baby's condition

While many breech babies will be born with satisfactory Apgar scores, some babies, in my experience, are slow to breathe spontaneously. They are pink, the heart rate is good, but they often only score one on reflexes, one on muscle tone and are not breathing spontaneously. It is important to have a bag and mask at hand, or in the hospital to have the resuscitaire ready. In my experience, a minute or so of bag and mask is all that is necessary, and respiration follows. It is important to have discussed this with the parents beforehand, and that they know that the baby may need some help "to get going".

If labour does not progress spontaneously, there is no hurry, no panic. This baby is fine, the labour is just going nowhere fast, and needs help. The woman and baby are in good condition, transfer when the

woman is ready, in the hospital consult when the woman is ready, and strongly advise that she have the baby by caesarean operation.

Mary Cronk

Things to Remember

These are the points which midwives should bear in mind when facilitating a vaginal breech birth:

- Don't push a breech through a pelvis with oxytocic drugs
- No inductions, no augmentations
- If the labour does not progress - caesarean operation
- Don't pull a breech down through the pelvis - no breech extractions
- Breech by propulsion, **not** traction
- If it isn't coming down - caesarean operation
- Keep your hands off - sit on them if necessary
- Be ready to bag and mask.

Breech Delivery Versus Breech Birth?

The lists below dramatically illustrates the difference between breech delivery (sometimes referred to as breech extraction) and normal physiological breech birth.

Breech delivery

- Could be induced.
- If slow or poor progress, may be augmented.
- Epidural commonly strongly advised.
- Food and fluid restricted, therefore IV drip in situ.
- Membranes commonly ruptured artificially to enable an electrode to be applied to the buttocks to enable continuous electronic fetal monitoring. The scrotum is to be avoided...
- ..therefore, first stage immobility.
- When second stage reached, patient put in lithotomy position (on her back).
- Contractions enhanced/controlled by oxytocic drip.
- When buttocks on perineum, routine episiotomy.
- Attending practitioner applies traction to the buttocks gripping the hips.
- Legs, if extended are brought down with pressure from the attendants fingers behind the knee. Further traction is applied to the trunk, the arms are pushed up over the baby's head by this manoeuvre.
- The arms now are required to be delivered by Loveset's manoeuvre. The baby is then lifted up by its feet, by a second attendant and forceps are applied to deliver the head.
- Third stage managed actively by oxytocic injection and controlled cord traction.

Breech birth

- Spontaneous onset anytime after about the 37th week.
- No augmentation if labour is slow or there is poor progress - caesarean section.
- Mother encouraged to assume positions of choice during the first stage.
- Fetal heart listened to frequently with a Pinard stethoscope or a hand held Doppler Sonic aid using ultrasound.
- Food and drink encouraged, but remembering that women in strong progressing labour rarely want to eat.
- Membranes not ruptured artificially.
- Vaginal examinations restricted to avoid accidental rupturing of the membranes.
- If, and when spontaneous rupture occurs conduct a vaginal examination as soon as possible.
- Second stage by maternal propulsion and spontaneous expulsive efforts guided by the attendant if judged appropriate.
- Mother encouraged to be in an all-fours position.
- No routine episiotomy.
- Third stage without chemical or mechanical assistance, usually managed according to woman's wishes.

Editor's Note:

Mary Cronk is available to give talks to AIMS or any other interested groups on this subject. Tel: (01243) 670382.