Clinical Practice Procedures:
Obstetrics/Breech birth

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<td>Purpose</td>
<td>To ensure a consistent procedural approach for Breech birth.</td>
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<td>Applies to all QAS clinical staff.</td>
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A **breech birth** is the delivery of a baby from a breech presentation, where the foetus enters the birth canal with the buttocks or feet first, as opposed to the normal head first presentation.

**The main categories of breech delivery include:**

- **Frank breech**
  - The foetus's buttocks presents first, with the legs flexed at the hip and extended at the knees, placing the feet near the ears. Most breech babies, (65–70%) are in the Frank breech position.

- **Footling breech**
  - One or both feet presents first, with the buttocks at a higher position. This is rare at term, but relatively common with premature babies. Here the hips and knees are flexed so that the foetus is sitting cross-legged, with feet beside the buttocks. Increased risk of prolapsed cord with a footling breech.

- **Complete breech**
  - Here the hips and knees are flexed so that the foetus is sitting cross-legged, with feet beside the buttocks.

- **Kneeling breech**
  - The foetus is in a kneeling position, with one or both legs extended at the hips and flexed at the knees. This is extremely rare and often grouped with footling to form the category ‘incomplete breech’. Increased risk of prolapsed cord with a kneeling breech.
Indications
- To assist a labouring woman in the birth of her child when the child presents in a breech position

Contraindications
- Nil in this setting

Complications
- Foetal distress and hypoxia
- Failure to deliver
- Pain
- Prolapsed cord
- Shoulder dystocia
- Head entrapment
- Meconium aspiration
- Post-partum haemorrhage
- Inversion of the uterus

MANAGEMENT (Breech birth)
- Preparation for newborn resuscitation should be made at the earliest sign of breech presentation.[2]
- Consideration should be sought for early CCP/obstetric retrieval team backup.
- Ensure technique with appropriate infection control measures to be taken at all times.

NOTE: Perform all manoeuvres gently and without undue force.

The following procedure has been adapted from guidelines provided by the World Health Organisation.[3]
1. **Delivery of the buttocks and legs**

   a) Once the buttocks have entered the vagina tell the woman she can push with the contractions.

   b) Let the buttocks deliver until the lower back and then the shoulder blades are seen.

   c) Gently hold the buttocks in one hand, but do not pull.

   d) If the legs do not deliver spontaneously, deliver one leg at a time:
      - Push behind the knee to bend the leg;
      - Grasp the ankle and deliver the foot and leg;
      - Repeat for the other leg.
2. Delivery of the arms

e) Hold the baby by the hips with thumbs on the buttocks.

**NOTE:**
Do not hold the baby by the flanks or abdomen as this may cause kidney or liver damage.

**Unassisted**
(arms disengage spontaneously)

**Assisted**
(bend arm to bring hand over face)
**Arms stretched above the head or folded around the neck**

- **Use the Loveset’s manoeuvre:**
  
  a) Hold the baby by the hips and turn 180°, keeping the back uppermost and applying downward traction at the same time, so that the arm that was *posterior* becomes *anterior* and can be delivered under the pubic arch.
  
  b) Assist delivery of the arm by placing one or two fingers on the upper part of the arm. Draw the arm down over the chest as the elbow is flexed, with the hand sweeping over the face.
  
  c) To deliver the second arm, rotate the baby back 180°, keeping the back uppermost and applying downward traction, delivering the second arm in the same way under the pubic arch.
If the baby’s body cannot be turned to deliver the arm that is anterior first, deliver the shoulder that is posterior:

a) Hold and lift the baby up by the ankles.

b) Move the baby’s chest towards the woman’s inner leg. The shoulder that is posterior should deliver.

c) Free the arm and hand.

d) Lay the baby back down by the ankles. The shoulder that is anterior should now deliver.

**Lovesets manoeuvre 3**

**NOTE:** This procedure is different to the Burns Marshall Manoeuvre and once the arms are delivered the Adapted Mauriceau-Smellie-Veit is then undertaken.
3. **Delivery of the head**

Deliver the head by the Adapted Mauriceau-Smellie-Veit (MSV) manoeuvre as follows:

a) Lay the baby face down with the length of its body over your hand and arm.

b) Place the first and second fingers of this hand on the baby’s cheek bones and flex the head.

c) Use the other hand to hook the baby’s shoulders with the index and ring fingers with the middle finger on the baby’s occiput.

d) Gently flex the baby’s head towards the chest to bring the baby’s head down until the hairline is visible.

e) Pull gently to deliver the head.

f) Raise the baby, still astride the arm, until the mouth and nose are free.

g) Deliver the baby onto the mother’s abdomen for skin to skin contact.

**NOTE:** Ask an assistant to push above the mother’s pubic bone (suprapubic pressure) as the head delivers. This helps to keep the baby’s head flexed.

![Adapted Mauriceau-Smellie-Veit (MSV) manoeuvre](image)
4. **Care of the newly born (postnatal cares)**

a) Thoroughly dry the newborn, wipe the eyes and assess the newborn’s breathing.

b) If the newborn is crying or breathing effectively (chest rising at least 30 times per minute) leave the newborn with the mother. If the newborn is not breathing effectively, immediately refer to CPG: Resuscitation – Newly born.

c) Ensure the newborn is kept warm and heat loss is minimised – if required utilise baby blanket and beanie from the QAS ‘Maternity Pack’.

d) Assess neonatal and maternal observations:
   - **Neonatal observations:** APGAR (at 1 and 5 minutes), HR, RR, Temp and muscle tone – every 15 mins
   - **Maternal:** HR, BP, Temp, PV loss and fundal check – every 15 mins

e) Cord clamping and cutting:
   - Late cord clamping and cutting (3–5 minutes following birth) is recommended for all births whilst initiating simultaneous essential neonatal care. Immediate cord clamping (< 1 minute following birth) should only be performed if the newly born is asphyxiated and needs to be moved immediately for resuscitation.[4,5,6,7]
   - Some mothers may request the cord remain intact with placenta attached (not clamped or cut). This request should be respected unless the newborn is required to be moved for resuscitation.

f) If the mother consents, clamp the cord at 10, 15 and 20 centimetres from the newborn and cut between 15 and 20 centimetres.

g) Provide a safe warm environment with uninterrupted skin to skin contact. Encourage breast feeding to promote the production of maternal oxytocin.
5. **Active management of the third stage of labour (oxytocin administration)**

a) Promote maternal production of oxytocin by providing a safe, warm environment with uninterrupted skin to skin contact between mother and baby, and encourage breastfeeding.

b) Administer oxytocin (refer to DTP: Oxytocin).

c) Observe for and confirm signs of placental separation:
   - The uterus rises in the abdomen
   - The uterus becomes firmer and globular (ballotable)
   - Fresh show/trickle of blood
   - Lengthening of the umbilical cord.

d) Delivery of the placenta.
   - Assist the mother to birth the placenta by her own efforts. Encourage her to adopt an upright position, bearing down to expel the placenta; **OR**
   - Guard the uterus by placing one hand suprapubically and applying steady controlled cord traction until the placenta is visible. Support the birth of the placenta and membranes by gently twisting to strengthen the placenta and limit the chance of retained products – do **not** apply increased traction if resistance is felt.

e) Retain the placenta for visual inspection by the midwife and/or doctor.

f) Complete a fundal assessment:

   - If the uterus is soft – massage the fundus until it is firm and central, consider asking the mother to pass urine, as a full bladder can inhibit the contraction of the uterus. Fundal massage is only to be performed **following** delivery of the placenta.

   - If the uterus is firm – do **not** massage the fundus as this may cause further bleeding and pain for the mother.

g) Assess and estimate blood loss (normally around 200–300 mLs).
6. **Physiological management of the third stage of labour**  
   *(refusal of oxytocin)*[8]

   a) Promote maternal production of oxytocin by providing a safe, warm environment with uninterrupted skin to skin contact between mother and baby, and encourage breastfeeding.

   b) Assist the mother to birth the placenta naturally by her own efforts. Encourage her to adopt an upright position, bearing down to expel the placenta.

   c) **Do not** apply cord traction.

   d) Once the placenta has been delivered, retain for visual inspection by the midwife and/or doctor.

   e) Complete a fundal assessment:
      - If the uterus is soft – massage the fundus until it is firm and central, consider asking the mother to pass urine, as a full bladder can inhibit the contraction of the uterus. Fundal massage is only to be performed **following** delivery of the placenta.
      - If the uterus is firm – **do not** massage the fundus as this may cause further bleeding and pain for the mother.

   f) Assess and estimate blood loss (normally around 200–300 mLs).

   **NOTE:** If blood loss exceeds 500 mL, refer to *CPG: Primary postpartum haemorrhage*.