CATEGORY:

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1. Plain language summary

Recommendation 4	Grade
Where there is maternal preference for vaginal birth, the woman should be counselled about the risks and benefits of planned vaginal breech delivery in the intended location and clinical situation. The principles of shared decision making should be used during counselling.	Evidence based recommendation (Grade C)

Recommendation 5	Grade
Maternity units that offer vaginal breech birth should develop clear, strict and unambiguous protocols for case selection and management of vaginal breech birth to	

3.

ultrasound, and tocolysis.

ECV should be offered at term from 37^{+0} weeks of gestation. In nulliparous women, a pragmatic approach may be to offer ECV from 36^{+0}

Maternity units that support planned vaginal breech birth should have clear, strict, unambiguous protocols for case selection and management of vaginal breech birth.

If a woman wishes to attempt vaginal breech birth, units with limited access to experienced birth attendants and/ infrastructure should offer antenatal referral to a unit where appropriate skill level, experience and expertise is available.

In the situation where vaginal breech birth is deemed inappropriate for an individual mother based on clinical assessment and risk factors, it may be reasonable to obtain

fours position but this can present a difficulty when manoeuvres are required.

The choice of manoeuvres used, if required, to assist with delivery of the breech, should depend on the individual experience and preference of the appropriately skilled birth attendant.

Active pushing should not be encouraged until the breech is visible. Traction should be avoided; a 'hands-off' approach is required, but with appropriate and timely intervention if progress is not made once the umbilicus has delivered or if the arms are extended. Tactile stimulation of the fetus may result in reflex extension of the arms or neck and should be minimised. Care must be taken to avoid fetal trauma; the fetus should be grasped around the pelvic girdle (not soft tissues) and the neck should never be hyperextended. Selective rather than routine episiotomy is recommended.

Intervention to expedite breech birth is required if there is evidence of poor fetal condition (lack of fetal tone) or if there is a delay of more than 5 minutes from delivery of the buttocks to the head, or of more than 3 minutes from the umbilicus to the head.

There is little comparative evidence regarding techniques of assisted breech birth. If the back starts to rotate posteriorly, gentle rotation without traction should be used to ensure that it remains anterior. Once the scapula is visible, the arms can be hooked down by inserting a finger in the elbow and flexing the arms across the chest or, if nuchal, Lovset's manoeuvre is advised. Delivery is achieved either with the Mauriceau-Smellie-Veit manoeuvre or with forceps. Suprapubic pressure will aid flexion.

Recommendation 4	Grade
Where there is maternal preference for vaginal birth, the woman should be counselled about the risks and benefits of planned vaginal breech birth in the intended location and clinical situation. The principles of shared decision making should be used during counselling.	Evidence based recommendation (Grade C)

Recommendation 5	Grade
Maternity units that offer vaginal breech birth should develop clear, strict and unambiguous protocols for case selection and management of vaginal breech birth to reduce neonatal morbidity and mortality.	Evidence based recommendation (Grade C)

Recommendation 6	Grade
Planned vaginal breech delivery must take place in a facility where appropriate experience and infrastructure are available, including: • Continuous electronic fetal heart monitoring in labour. • Immediate availability of caesarean facilities. • Availability of a suitably experienced obstetrician and midwife to manage the birth, with arrangements in place to manage shift changes and fat -222.23 59840.0.80n23	

congenital abnormalities or undiagnosed hyperextension of the fetal head.

In the situation of first diagnosis of breech in labour, the obstetrician should discuss the options for mode of birth with the woman, explaining the balance of the fetal and maternal risks and benefits for that woman's individual circumstances. The fundamental principles of informed consent and shared decision making should be observed.

All maternity units should undertake regular training for all medical and midwifery staff, including simulation

Recommendation 7	Grade
When breech presentation is first recognised in labour, the obstetrician should discuss the options of emergency caesarean section or proceeding with attempted vaginal breech is	

When planned preterm delivery is required (i.e. when the mother is not in preterm labour) for maternal and/or fetal compromise with a viable fetus beyond 25 weeks gestation, in breech presentation, elective caesarean section is recommended. This should be performed by a clinician with appropriate experience. Head entrapment should be anticipated and preparations made to manage it, should this occur.	Consensus based recommendation
Recommendation 10	**Grade**
There is no clear neonatal benefit of birth by caesarean section for breech presentation at 22^{+0} to 24^{+6} weeks. The neonatal outcome at these	

5. References

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3. Whyte H, Hannah ME, Saigal S, Hannah WJ, Hewson S, Amankwah K, et al. Outcomes of children at 2 years after planned cesarean birth versus planned vaginal birth for breech presentation at term: the International Randomized Term Breech Trial. American journal of obstetrics and gynecology. 2004;191(3):864-71.
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Appendices

Appendix A Women's Health Committee Membership

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women's Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

Appendix C Full Disclaimer

Purpose

This Statement has been developed to provide general advice to practitioners about women's health issues concerning Management of breech presentation at term and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any person with a breech presentation. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual.

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