



The National Childbirth Trust

The voice of parents

This sheet is for women who have a baby lying in a bottom down (breech) position towards the end of their pregnancy. It provides information on possible ways to turn the baby and planning for the birth.

Why does it matter if my baby is in the breech position?

The largest part of an unborn baby is its head. Most babies are usually lying head down by the end of pregnancy, so the largest part is born first. This makes birth more straightforward. Between 3–4% of babies though are in the breech position at the end of pregnancy. When a baby is born 'bottom first' there is a greater chance of complications. This is partly because babies who are premature, or have some types of physical problem, are more likely to be born bottom first. But it is also because a breech birth doesn't always go as smoothly as a headfirst birth.

Ways to turn the baby

Most babies who are in the breech position at 32–34 weeks turn themselves into a headfirst position. If your baby is still breech at 37 weeks there are a few things that you can do to try to turn the baby.

It may be possible for an obstetrician to turn your baby using a technique called 'external cephalic version' or ECV. This involves the obstetrician pushing on your tummy to move the baby around – like doing a forward roll. (Cephalic means head, so ECV means turning the baby's head around from the outside.) ECV is done in hospital. You may be offered a drug (tocolysis) to help your uterus to stay relaxed. Having an ECV should not be painful for you – although it can be uncomfortable. In order for the baby to be turned, first its bottom needs to be pushed up out of your pelvis so that there is space for the baby to move around. Then the doctor has to push quite firmly,

holding the baby to prevent him or her returning to the breech position. Some babies resist being moved and some spontaneously move back to lying bottom first. Usually, just over half of all breech babies can be turned this way.

Research has shown that the success rate of ECV depends partly on the experience of the obstetrician. Success is greater in women who have had a baby before.

All hospitals should now offer women the chance to have an ECV if their baby is breech at 37 weeks. If your hospital doesn't, you can ask to be referred to one that does. Women may not be offered this procedure if their waters have broken, they are already in labour, have previously had a caesarean, or have bleeding or a small or sick baby.

There are some other techniques you could try to encourage your baby to turn, but there is limited evidence to show whether they make a difference. One of these is regular use of the knee–chest position. To adopt this position, kneel on your bed and with your knees comfortably apart and your hip joints over your knees, rest your shoulders down on the pillow. Some midwives recommend that this position is adopted regularly towards the end of pregnancy, say for 15 minutes, two to three times a day. So far, studies have not clearly demonstrated that 'postural techniques' work and further research is needed. Acupressure is another possibility. In China burning moxibustion (a traditional Chinese herbal medicine) has increased the number of babies that turn. To find out more visit a registered acupuncturist or shiatsu practitioner or find a good book on the subject.

Planning the birth

If your baby stays breech, then you will need to decide which kind of birth you will opt for – vaginal birth or caesarean section. In recent years, breech babies have been increasingly delivered by planned caesarean section, as many doctors believe that this is safest for the baby. In 2000 an international trial was carried out to try to get some clear answers about whether a caesarean or a managed vaginal delivery was better for breech babies. However, despite the trial, there is still debate about the short-term versus long-term benefits and risks, and how the trial results should be interpreted. In this trial, more babies died in the group allocated to planned vaginal birth. However, most vaginal births went well. The trial methodology has been criticized. Furthermore in the long-term the apparent advantages for planned caesarean section may be reduced. There are, for example, more obstetric complications in future pregnancies following surgery, and a small increased risk of reduced fertility and stillbirth. Since this research, most doctors have recommended that breech babies should be born by caesarean section.

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But there are a few hospitals that continue to believe in the value of vaginal breech birth and offer this option so it is worth asking for your hospital's policy. There is no clear-cut answer about which mode of birth is safest overall. On balance a caesarean may be beneficial if the pregnancy is more complex, but if there are no significant additional risk factors, a vaginal birth may be a good option.

What is a vaginal breech birth like?

For the mother, a vaginal breech birth need not be more difficult or painful than a headfirst birth. However, like headfirst births, breech births vary. Vaginal breech births are managed in different ways by healthcare professionals depending on their training and experience. Some births are 'managed' or 'assisted' with epidural anaesthesia, episiotomy (a cut to enlarge the vagina) and forceps. Others are 'natural' or 'physiological' in which the woman is free to move about and change position; monitoring of the baby's heartbeat allows the mother to be upright and mobile; neither an epidural or opiates are used; the midwife or doctor does not touch the baby's body as it is being born unless there is a clear reason to do so; the baby is born entirely through the unaided, expulsive efforts of the mother. Providing all goes well, the midwife avoids touching the mother or baby during the birth and holds her hands ready to receive the baby once it has completely emerged.

Almost everyone agrees that if labour does not go smoothly, it is safer to deliver the baby by caesarean. In the UK about half of the women who start off labour with a breech baby will end up having a caesarean.

Things to consider when planning

Some breech positions allow for an easier vaginal birth. The safest positions are when the baby has its legs straight up, with its feet by its ears (the 'frank breech') or legs crossed with its feet higher than its bottom (the 'complete breech'). If the baby's foot or knee are coming first, labour is less likely to go smoothly and you may be advised to opt for a caesarean.

If the baby is particularly big, you will probably be advised to have a caesarean birth, but bear in mind that judgements about the size of the baby before birth can be inaccurate. So if you have a clear preference for a vaginal birth you may want to discuss just how big the baby is expected to be and what additional risks the doctor thinks this poses, to help you decide what is right for you and your baby.

The safety of a vaginal breech birth depends partly on the approach and experience of the midwife or doctor at the birth. As a caesarean has become usual for breech babies, trainee midwives and doctors have fewer opportunities to gain experience in vaginal breech births, and many will only be familiar with the managed approach. Your hospital may say that they don't have any staff experienced in natural breech birth. If you want a natural breech birth there are no easy answers to this dilemma. If you decide to persuade the hospital to support your preference, it may help to emphasise the value of having midwives and doctors with experience of natural vaginal breech birth. Some women labour too fast for a caesarean and occasionally breech presentation is not diagnosed, so bottom-first births continue, despite hospital policies. You might want to consider enquiring about care from an independent midwife; they usually have experience of natural breech births, but you would have to pay for their services. To contact the Independent Midwives Association phone 01483 821104 or go to www.independentmidwives.org.uk.

Special circumstances

Your choices may be affected if you have had a caesarean section for a previous baby. For example, NICE (National Institute for Clinical Excellence) recommend that ECV is not offered to women who have previously had a caesarean, although some experienced obstetricians may be prepared to offer ECV. However, a breech birth may be an option. To find out more about VBAC, ask for the NCT sheet on *Vaginal birth after a caesarean* (VBAC).

Some doctors believe that caesarean section is safer for preterm babies and twins in the breech position; however, the research on single, full-term babies cannot be applied directly to twins or to premature babies. Discuss the options with your caregivers.

To sum up

If there are not specific contraindications and your baby is breech at 37 weeks of pregnancy you should be offered ECV. If the baby cannot be turned you are likely to be advised to have a caesarean section.

A vaginal breech birth may be the right choice if:

- you want to avoid a caesarean section
- your baby is in a good position and not expected to be too big
- you can find a midwife or doctor willing and experienced in natural breech birth.

In some areas you will need to be very clear, persuasive and determined to arrange a vaginal birth for your baby; in other areas you will get lots of support. Discuss the options with your caregivers.

For further information or references contact the NCT Information Officer, Lynn Balmforth, at l_balmforth@nct.org.uk or phone 0870 444 8707.

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