Breech Basics

With Gail Tully, CPM

Review upright vaginal breech birth, view video footage, and explore what “Hands off the Breech” may mean to your practice. When to be *hands-off* and when to be *hands-on*. Could a new approach to protecting the breech cardinal movements mean a coming revolution in vaginal breech birth?

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Breech Basics Handouts

For a Surprise Vaginal Breech

Time—is there enough time to get to the hospital?

Should EMT be called? Record conversation about informed consent, parent choice in place of birth.

Does the Midwife have the support *she* needs, such as an assistant skilled in resuscitation?

Is the family favorable for home breech by support attributes?

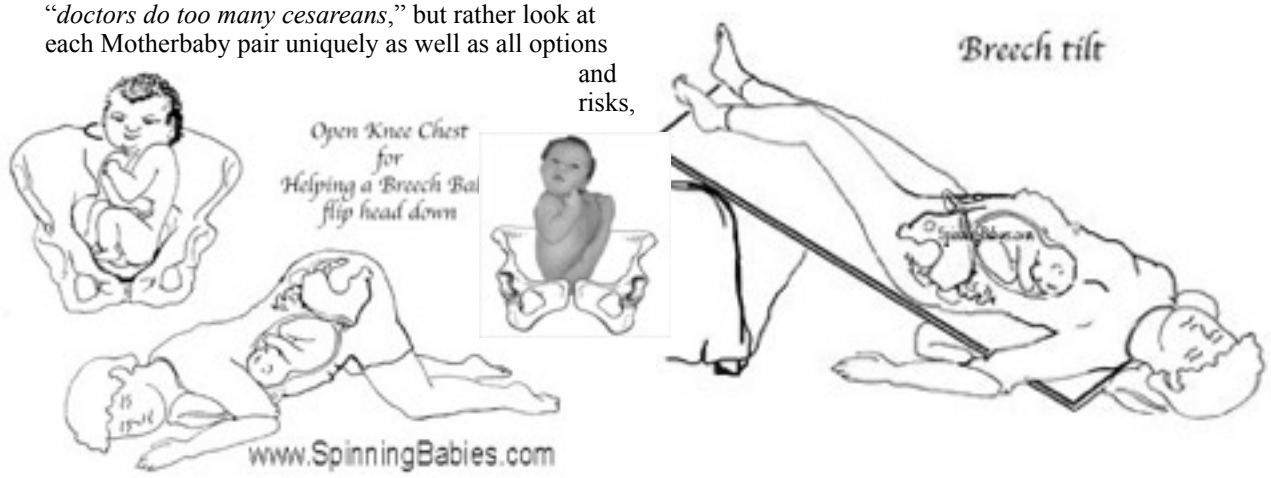
Planning ahead for a vaginal breech birth at home:

The physical attributes of the mother and child are not the only things to consider in planning to stay at home for a breech birth. We include social and emotional attributes. These are added to the screening assessment:

Social and Emotional Considerations for birthing a breech presenting baby at home	
Favorable attributes	Unfavorable attributes
Point of Faith Preparation for breech, internal "locus of control" Discussion, informed consent Physiological breech approach (knee-elbow, hands off) Has watched a video Ultrasound or MRI, a reassuring effect for long labors Time for couple to discuss, alone, breech home birth Support in immediate & extended family	Lack of strong Point of Faith Not prepared for breech No time for informed consent Surprise breech More than a little anxiety in mother Anxiety in father Hostility in family or community Midwife not comfortable, not experienced; Hands on

Gail Tully, CPM with guidance by Janet Hofer, Traditional Midwife (late).

The *Safest* approach to vaginal breech birth, besides ongoing assessment, is honest, open communication. Neither the parents nor the midwife should have an ideological basis for this choice. That means, we don't attempt a vaginal birth because "*natural birth is better*," or "*doctors do too many cesareans*," but rather look at each Motherbaby pair uniquely as well as all options and risks,



including risk of injury or death of the baby and the mother. While honoring the mother –and father's- intuition, we take a very practical approach.

To flip, ***Balance*** 1st w/FLInversion
Then pick one of these:

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Breech Birth Protocols

Breech birth can be a lovely variation on a natural process. Dilation may be less painful and, for some, faster than the typical head-down presentation. Mothers know the importance of being both relaxed and active during a breech birth. So, rather than drugged, women can respond instinctively to labor and their baby. Risk reduction is a holistic approach. Breech vaginal birth can be a very conscious choice. Protocols protect our decisions when fatigue, emotion, birth plans, or inexperience might confuse issues. These breech protocols reflect, in my opinion, the best practice for a homebirth in my area:

- All mothers are assessed for pelvic alignment and myofascial issues. Repeated bodywork increases safety.
- Labor begins spontaneously, without induction or augmentation, between 36-42 weeks. Mother doesn't have hypertension; diabetes or diabetic symptoms. Metabolic stagnation or imbalance? Be more cautious.
- The baby's head is normal size, and tucked (chin to chest, flexed) or neutral before labor, as noted by palpation (feeling the woman's abdomen) or by ultrasound, or MRI.
- The baby is frank; or, if complete or footling is of no more than average size and the mother is having body work to help her pelvis and womb be symmetrical for birth. Myofascial release is good for all mothers.
- Mother's pelvis size is fine as determined by the previous vaginal birth of an average sized or larger baby, or, by pelvimetry which includes an internal exam of the pelvis. (An MRI may be useful for some mothers.)
- Labor progresses readily without a stall in active labor. Absence of start-and-stop pattern in presence of strong contractions. No breaking the water (AROM). Vaginal exams are avoided; possibly one done early to assess Primip, VBAC, or transport.
- The mother's physiological birthing position; When the presenting part is visible mother moves to Hands and Knees (knee - elbow) which protects flexion and rotation to sacrum anterior. After midwives have resolved several stuck breech babies, they will be safer at resolving obstruction in other maternal positions. Clear the area in front of mother after hips are born.
- The person catching keeps hands off unless the arms or head need help to come out. No perineal massage or support, no pushing on/touching the mother to stop her sitting on her baby (mom will feel baby and stop herself). Episiotomy is not routine. No wiping the mother's bottom during birth. No towel around baby. All this avoids a mother clenching. Quiet patience is key. Positive words tell mother of signs of progress or that you are about to intervene to help baby.
- 2nd stage can last 4 hrs. After a latent phase early on, the pushing urge takes over and there is descent. If there is no progress after an hour of good pushing we transport for surgery. With slow descent, - the baby *is* coming down - pushing at home is given 3 hrs. If the hips aren't then being born, meaning birth time isn't imminent, we transport. No discussion. No extraction. No debate. A cesarean is strongly protective of the baby in this case.
- The attendant has experience and practices regular simulation of breech birth, hopefully with each birth team; knows the maneuvers; newborn resuscitation; delayed cord clamping; and how to flex the head and open the pelvic outlet.

About 20% of Jane Evan's planned home breech births finish with cesarean surgery. About 20% of Dr. Louwen's planned spontaneous breech births finish with cesarean in his Frankfort University hospital.

The "hands-off" approach protects baby. "Helping" might startle or restrict the baby and increases risk of complications. Touching the mother might cause her to clench her muscles. Let gravity be the midwife. All parents must accept responsibility for their births. Midwives must be transparent with the limits of their experience. Physiological breech home birth may not be safer than physiologic breech in hospital. Physiologic breech birth is seldom available in hospital. Cesarean breech birth may be safer for the baby, especially when physiological breech birth is not practiced and/or there is not a person with gentle and abundant experience present. Though breech home birth isn't supported by society, parents do have the right to choose. Breech birth *can* happen at home.

Breech Basics Handouts

Quotes from the Breech Conference

Coalition for Breech Birth Ottawa, Ontario, Canada October 15-16, 2009 and Pre-conference, A day at the Breech, October 14, 2009

Jane Evans, Midwife (UK, Independent) 30 years as a midwife, and independent of the British medical system since 1991. Wrote **Breech Birth, What are my options?**
She quotes Mary Cronk, her previous midwifery partner as saying that labor progress is when
"contractions are close, long and strong, and they get closer and closer, longer and longer, and stronger and stronger and from the Mum's view, they are too close, too long and too strong. " (It's cuter with an English accent.)
"The optimal position for the breech is frank and on the right hand side."
"Don't say 'Push,' say, 'Allow your body.'"
"The baby magically rotates to the Left Sacrum Transverse to allow shoulders to come into the pelvic brim."
"When you see the "Valley of the Cord" (crease in chest) you know the arms will come spontaneously afterwards."
"If you have somebody ferreting about, feeling where the cervix is, you tend to clench up a bit don't you?"
"Whatever you do, you're interfering and you're likely to have to help out later."
"Upright breech is a much more sensible position."
"Cord prolapse…why are we in such a frath about it?"
When the head flexes the occiput rolls on the anterior surface of the symphysis and "Women convert religions; Women go from the Christian prayer position to a Muslim prayer position."

Dr. Robert Gagnon, co-author on Canada's breech guidelines and a prominent research physician. The guidelines do not discuss home breech, mind you but I think he said,
"I think there is a place for home breech delivery outside of all health systems."
I quickly cleaned my ears after that but I think he really said that!
"Nothing has a risk of zero."
"For me, having an experienced midwife like Jane Evans would be great in our center."
"Effective maternal pushing is essential and should be encouraged…and now I think pushing on all fours is the best."

Betty-Anne Daviss, midwife, Ottawa, Ontario, Canada
"She can't get through her labor if she doesn't have hope."
"Midwives have to take back breech skills. ..the mothers have never been deskilled."
"We're not on the fringe, we're on the frontier."

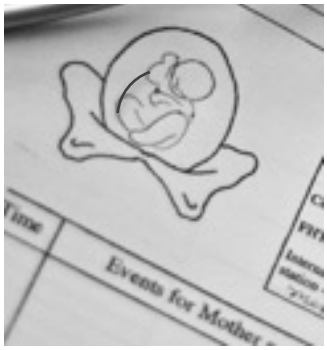
Robin Guy, Founder of CBB, mother of breech baby, cesarean against her will
"I'd always wondered what would have happened if I'd started sooner."

Dr. Andre Lalonde, Society of Obstetrics Gynecological of Canada
"Young people today are risk-adverse."
"The future of vaginal breech birth is training….every 2-years, retrain."

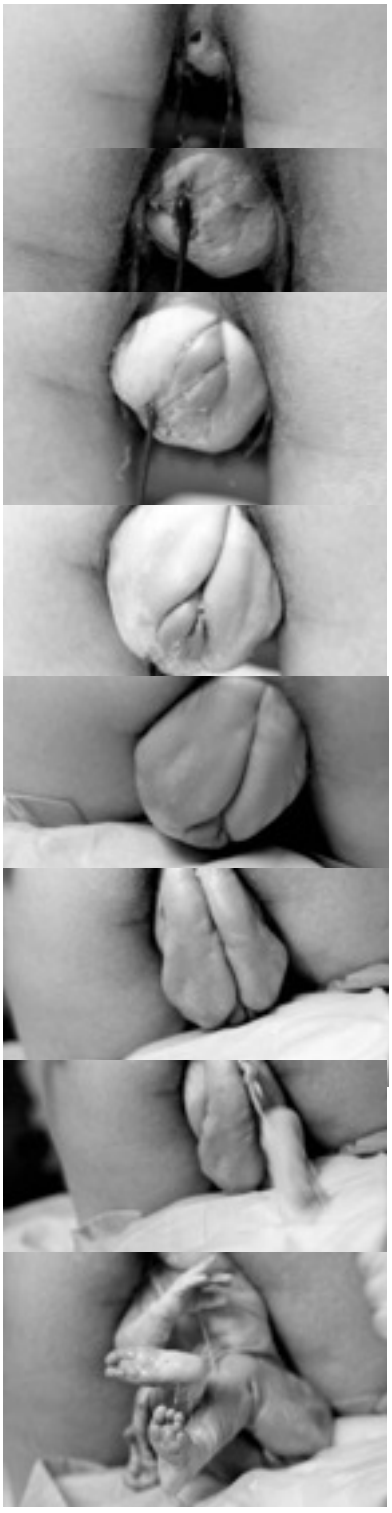
Dr. Frank Louwen, OB, Frankfort University Hospital, Frankfort, Germany,
"With hands and knees – no NICU."
"If woman on her back, and baby is posterior, then you have to move baby; if hands and knees, then baby does it themselves!"
"If you touch a child, complications are rising."
"The umbilical cord is never the reason not to have vaginal breech."
"If baby shows you the complete front, then arms will come down."
"Footling (position) is not decided by sonogram, but when the rupture of membranes and pushing starts."
"Prolonged 2nd stage is the main risk factor. With regular good contractions for 4 hours – we deliver immediately. This is explained at 36 weeks."
"You can not pull the baby out. That is not allowed and that is very important. No discussion."
"Don't break the water. …that's the best situation you can have for breech delivery."
"When you see the presentation, then the woman turns to the knee elbow position."
Tells that 5 years after the Guttenberg bible was printed, the first western book printing, another German book was printed. Author Henckel, title: We Have to Talk about the footling in breech.
Louwen maneuver – Head inside and shoulders are out. Now to help head out, push on shoulders with thumbs. Push directly to symphysis, not up or down, away from yourself.
2015: "Pelvimetry, as currently performed, adds little value to the effective management of breech presentation at term. -Bisits Andrew BISITS, Medical Co Director of Maternity Royal Hospital for Women, Randwick, NSW, Australia

Breech Basics Handouts

Spontaneous Breech Birth



What you see at the perineum tells a story of what is going on inside at at the brim of the pelvis.



This baby did not follow the classic rotations as described by Jane Evans.
Baby started out RSP.
Baby rotated at brim and pelvic floor until back was coming down from the left.

Rotation to Left was before this baby was in view.

1. We see anterior bun first.
2. We see baby rotate to sacrum anterior as buttocks emerges
3. We see continuation of rotation as legs swing out.
4. We see from the angle of the legs that the shoulders are coming into the brim in oblique.
5. The baby's left shoulder comes into the pelvis first, we see the hips aim towards mother's left leg as this happens.
6. The baby's right shoulder comes into the pelvis second, we see the hips come back to the center.
7. The legs release spontaneously.
8. The baby's left arm came first, then the right. Which is to say, the baby's

To help the rest of the head out the mother spontaneously moves her chest to bed/floor. If you need to help, help the mother put her chest, not to her elbows, but touching chest to bed. Turn baby's face under tailbone to "OA." Flex head. Apply Fundal pressure (Kristeller's).

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Breech Chart Supplement Mother's Name _____
(In addition to regular labor flow charting.)

Baby's Name Baby's size Date:_____/_____/_____

Time/Date	Event
	Time that the breech was discovered
	Beginning of labor *cm. dil. _____ station_____
	Time of urge to push * dilation rechecked? Y N cm. dil _____ station_____ *The presence of this dilation question doesn't not assume an exam was done.
	Pushing becomes active pushing
	Appearance of breech at: Sacrum is SA LSA RSA SP LSP RSP LST RST Type of breech: frank complete single footling double footling knee(s) Remember, don't touch the baby or the perineum or push the mother up
	Mother' position
	Hips both out at: Sacrum is SA LSA RSA SP LSP RSP LST RST Remember, don't touch the baby. Baby's position after both hips out _____
	Umbilicus appeared Appears to be pulsing? Y N Cord ___full or ____flat? Cord touched? Y N Rate _____ If cord is white, and fetal position SA use fundal pressure. If ST, initiate partial extraction by rotating chest to bring down the arms. Reassess tone and cord.
First appeared at R L	Arms born spontaneously____ Assisted R _____ w rotation, & ___manually? Assisted L ____ w rot., &___manually Post. Arm was L R ? Time of Posterior arm _____, and Anterior Arm _____
	"Double Chin," or nape of neck visible? Y N Head manually flexed? Y N If yes, what technique?
	Airway made? Yes No, no need or if other reason, why?:
	Mother's position is same, ____ Mother changed now to
	Maneuvers for birth of head were: _____Spontaneous, no need for maneuvers _____Frank Louwen's nudge in subclavical space, towards pubic arch Y N _____Cheek bones brought down, occiput up (Mauriceau-Cronk) Y N _____Reposition chin from oblique diameter to center on the perineum in AP diameter _____Other:
	Birth of head Fast decompression? Y N
	Cord clamped at , or placenta delivered before cord clamped at

Apgar ____ 1 min _____ 5 mins _____10 mins Transport for baby? Y N Time:
Resuscitation ___cord resusc. ___mouth to mouth___delee ___PPV ___O2 __homeopathy __other:
See regular immediate postpartum chart for details.

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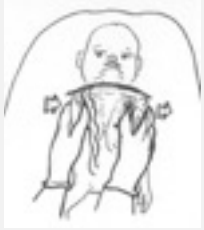
When Provider Will Touch or Not Touch Baby During Birth Process

Breech Basics Handouts

	Normal, Hands Off	Watch closely	Intervention Hands-On	Cesarean Recommended
Inlet	RST/RSP/RSA	LSA/LST		Hips can't enter inlet, Active labor stall
Midpelvis			Baby's spine remains to the Transverse diameter (thigh)	>=4 hour 2nd stage
Outlet	LST/ LSA to SA (OA)	RST		Once arms are born you Must flex

	Normal, Hands Off	Watch closely	Intervention Hands-On	Alternative method
Inlet	RST/RSP/RSA	 LSA/LST	Not coming? Avoid total breech extraction, except 2nd Twin. Do not do AROM. Go to Cesarean.	2nd twin may be extract'd
Rotating off the brim at the inlet or stuck on the inlet. Which is it?	 Shoulders in oblique indicate baby is rotating shoulders free of the inlet, then baby is SA 	 Baby's spine remains along mother's thigh in the transverse diameter. This baby is stuck and needs provider to rotate anterior arm off the brim. Pics by Louwen. Normal, arms will come next	The anterior arm is stuck on the brim so the provider carefully holds chest (not abdomen) to rotate the baby so that the face will end up facing mother's perineum (OA, essentially now).	 Rarely baby faces mother's back in "SA" when arms are stuck… these elbows are are against the sacrum Note, we are now seeing mother's anterior view.
Comments	If tone is low, use fundal pressure now	Rotate arms before birth is possible	180 then 90 degrees, or bring posterior arm out and then SA	Unusual complication, compound arms over head

Breech Basics Handouts

Outlet	Is baby vigorous? Is tone good? Cord ?	Shadow under perineum, No flaring of anus, do Nudge	Is head at the outlet? It must be OA to be at the outlet, not oblique!
 "From 'Christian Prayer pose' to 'Muslim'" for head (Mary Cronk).	If baby is limp, turn face to perineum (OA), flex chin and do fundal pressure.		Flex head to see chin (On back? See nape of the neck before lifting face out.)

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