CAM 2016 Annual Conference

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Presents

Real Breech Birth
Breech Birth vs Delivery

They are both a part of the breech learning experience.

Delivery
- Induced or augmented
- Epidural
- Hospital restrictions
- AROM
- Fetal monitoring
- Episiotomy
- Applied traction
- Legs delivered
- Arms delivered
- Body lifted
- Head by forceps

Birth
- Spontaneous >37 weeks
- No augmentation, C/S
- Labor positions of comfort
- Pinard or Doppler for FHR
- Intake encouraged
- No AROM
- Minimal Vaginal Exams
- Spontaneous push efforts
  – Guided by attendant
- Birth all fours
- Hands off the breech
- No episiotomy
Maternal Causes

Uterine anomalies - bicornate, fibroid, tumors
Contracted pelvis - restricting descent
Multipartity - reduced uterine tone
Primagravida - tight uterine tone
Fetal Causes

Placental location - previa, cornua
Cord - short/entangled
Multiple gestation
Preterm
Oligohydramnios
Polyhydramnios
Hydrocephaly
Anomalies (3 times higher)
Fetal death
Maternal Risks

*Vaginal breech delivery is no greater physical risk than a cephalic delivery*

Surgical delivery may have more immediate and long term effects
- Infection
- Hemorrhage
- Organ Injury
- Adhesions
- Additional Surgeries
  - (hysterectomy, bladder repair, repeat cesarean)
- ↑ Maternal Mortality.
Fetal Risks

○ Asphyxia and Death
  • Cord Prolapse (frank and/or occult)
  • Head entrapment

○ Perinatal morbidity/mortality
  • Delivery trauma
    - Brain
    - Spinal Cord Injuries
    - Organ and Gland damage or rupture
    - Fractures
    - Cervical and Brachial Plexus paralysis

○ Preterm
○ Anomalies
Examination
should be collaborative findings

- **History** - previous breech, discomfort below ribs, vaginal kicking
- **Abdominal Palpation**
  - Head - *may move independently of body, below ribs*
  - Difficulties - *abdominal tone, obesity, polyhydramnios*
- **Vaginal Assessment**
  - Soft butt, lumpy genitals/limbs, firm sacrum
  - Difficulties - *closed cervix, protruding sac*
- **Auscultation** - *should not be used for fetal position*
- **Ultrasound** - determine presentation, anomalies, size, fluid levels, localize placenta & cord
Early Diagnosis

*aids in the ability to work with the client to affect possible successful version and/or make decisions regarding all delivery options*

- **Fetal Size vs Maternal Space**
  - Too much space - may revert
  - Too little space - ↑ risks, unsuccessful version

- **Assessment begins at**
  - Primips - 30 to 32 weeks
  - Multips - 32 to 34

- **Preterm Versions 34 - 37 weeks**
  - May use ‘Slant Board’
  - External Cephalic Version ‘ECV’
  - Greater success
External Cephalic Version

defined as trans abdominal manual rotation of the fetus to a cephalic presentation

- Allopathic Approach - not universally accepted
  - At ‘term’ 37 week, hospital procedure
    - possible emergency c/s
  - Ultrasound evaluation and guidance
  - Fetal monitor assessment (post versions)
  - Sedative for relaxing the mother
    - may allow for too vigorous attempt
  - Ritodrine or similar uterine relaxants
  - Operating room ready
    - should adverse reaction occur
Risks of ECV
can be a safer alternative to breech or cesarean delivery

- Change in fetal heart rate (4.7%)
  - Cord compromise, entanglement, & knotting
- Placental abruption (0.18%)
- Rupture of membranes (0.22%)
- Cord prolapse (0.18%)
- Vaginal bleeding (0.34%)
- Maternal trauma
- Stillbirth (0.24%)
- Emergency C/S (1 in 286 versions)

EvidenceBasedBirth.com/Rebecca-Dekker
Persistent Breech

Greater than 37 weeks, begin frank discussion of delivery options

- Delivery options
  - Referral to physician (C/S or vaginal)
  - Referral to other qualified provider
- Informed consent (form)
  - Client breech education
  - Local rules and regulations (varies)
  - Standard of care
  - Experience levels
  - Risks
  - Written informed consent (signed)
Breech Score Index

is designed for use at the onset of labor for determining the feasibility of attempting a vaginal breech delivery (a helpful thought process), however but it remains paramount the midwife use her own judgement

<table>
<thead>
<tr>
<th>Score</th>
<th>0 points</th>
<th>1 point</th>
<th>2 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parity</td>
<td>Primip</td>
<td>Multip</td>
<td></td>
</tr>
<tr>
<td>Gestational Age</td>
<td>&gt;= 39 weeks</td>
<td>37 - 38 weeks</td>
<td>36 - 37 weeks</td>
</tr>
<tr>
<td>Estimated Fetal Weight</td>
<td>8 lbs</td>
<td>7 - 8 lbs</td>
<td>5 - 7 lbs</td>
</tr>
<tr>
<td>Cervical Dilation at Admission</td>
<td>2 cm</td>
<td>3 cm</td>
<td>&gt;= 4 cm</td>
</tr>
<tr>
<td>Station at Admission</td>
<td>-3 or higher</td>
<td>-2</td>
<td>&lt;= -1</td>
</tr>
<tr>
<td>Previous Breech</td>
<td>0</td>
<td>1</td>
<td>&gt;= 2</td>
</tr>
</tbody>
</table>

Score of 3 or less is indication for cesarean section, score 4 to 5 indicates careful review made suggests one should proceed with caution, score of 5 or more would indicate a reasonable chance of successful vaginal delivery, subtract 1 for footing breeches - somewhat more difficult to manage.

By Valerie El Hatta, "Normalizing the Breech Delivery," Midwifery Today Issue 38
Unplanned Breech Delivery

*birth not imminent, > 1 - 2 hours before time of delivery*

- **Verbally inform client of the situation**
  - All risks
  - Encourage hospital transfer *(skill level/regulations)*
  - Car vs ambulance *(depends on progress of labor)*
  - Midwife provider in direct attendance
    - may have more experience than EMS
  - Advise receiving hospital and doctor of arrival
  - Client record must reflect
    - all care, informed consent and transfer information
Birth Imminent

no time for safe transfer to hospital < 1 hr

- **Multitask the following**
  - verbally advise the client
    - of the need to not push, blowing
    - your skill levels
    - need for possible EMS back up
  - monitor FHT’s q 15 or less
  - set up for delivery and resuscitation
  - take charge of the birth room!
    - MAINTAIN a calm safe atmosphere

*Mentally review your steps of breech delivery!*
The Optimal Birth Team

Not including client participants

○ Primary Midwife
  • Experienced in progress & mechanisms of breech
  • Skilled in vaginal/cervical assessments
  • Recognizes & responds to abnormal FHR
  • Skilled in neonatal resuscitation
  • Knows personal limitations

○ Assistant Midwife
  • Basic knowledge of breech
  • Can perform supra pubic pressure

○ Other Assistants
  • Can chart events
  • Time keeper
  • Help with positional assists
Progress of the Breech Labor

○ Labor is ‘Quieter’
  • easier until transition

○ Dilation vs Contraction (does not match Vertex)
  • often more dilation progress than ‘appears’
  • sac and breech soft, easy dilation
    – *wedges and pulls up to dilate*
  • easy to mistake for BH contractions
    – how you can find yourself easily surprised!

○ Labor in Transition is difficult to control
  • *STRONG URGE* to Push

○ Second Stage
  • may need expedited delivery
The Breech Client in Labor

- **Normal activity** (unless descent, strong urge w/o full dilation)
  - Strong urge, encourage side lie, en face ‘blowing’
- **Vitals** (same as vertex)
- **Fetal heart rate**
  - q 30 minutes - early, active labor w/o ROM
  - q 15 minutes - active, ROM
    - *higher risk of cord prolapse/compromise*
  - q 5 minutes - transition with descent
  - after every ctx second stage
  - continuous with any drop in FHT
    - *vaginal assessment for cord prolapse* (lift/replace, EMS)
    - *change maternal position*
    - *possible expedited delivery*
Vaginal Assessments

Upon arrival
Suspected change
At ROM
With urge to push

*** HINT ***
Often easier to measure what is left
Regardless of what you see

CHECK FOR CERVIX!
Second Stage Management
‘Time of Patience’

- Once complete, attempt waiting
  - ONE hour, primipara
  - HALF hour, multipara
- Allows for any missed cervix
- Lessens likelihood of head entrapment
- Monitor FHT after every ctx
  - Drop with no recovery
    - possible expedited delivery
- Urge to push controlled by
  - Lessening gravity, recumbent side lie
  - En face, ‘blowing’ support & encouragement
  - Soft ‘grunting’ efforts at top of ctx
Delivery Positions

Second Stage

- Secure bed, firm mattress
- A clear area for birth team to work
- Upright positions
  - May be useful once pushing effort begins
  - As long as FHT can be heard (without exception)
  - May be moved easily into supine (for emergency)
- Water birth (may delay emergency measures)
Mechanism of Breech

- Descent occurs with compaction of the limbs
- Interior rotation of bitrochanteric diameter to AP diameter of pelvis
- Lateral flexion of the body as it comes under the symphysis pubis
- Restitution of the buttocks to sacrum anterior
- Internal rotation of the shoulders to oblique
- Internal rotation of the head with the sagittal suture transverse, rotates to OA
- Birth of the head by the chin, face and sinciput sweeping the perineum

Simplified

- Compaction occurs
- Hips to AP
- Body side bend (AP)
- Rotates SA (lifts)
- Shoulders oblique
- Head transverse to OA
- Face sweep perineum
Breech Delivery

Co-operation of the mother to instructions very is important!

- FHT is monitored after each contraction
  - observe color, tone of baby & cord
- Best is hands off but hands ready!
  - other than perineal support
  - preventing posterior rotation
- Be prepared for expedited delivery
  - Lithotomy may aid in emergency techniques

*Hips AP, body bends lateral*
Breech Delivery continued...

- Buttocks rotates to SA (and lifts)
- Legs often spontaneously deliver
- Umbilicus delivers ‘time count’ begins
  - cord compression often occurs
    - 3 - 5 minutes to prevent hypoxia, asphyxia & death
    - ‘loop of cord’ may be pulled but is not necessary
Gentle downward, side to side traction for assistance
- small towel for gripping
- using only the hips/pelvis

As the scapulas appear, arms may be ‘swept’ out
- sweeping motion (normally anterior then posterior)
  - up the spine,
  - over the shoulder,
  - down to the anticubital space,
  - push elbow to body
  - & sweep arm out
- followed by second arm

_Shoulders slightly oblique_
Encourage downward motion on baby, allowing the body ‘hang’

Observe for the hair line
- head/chin is tucked by the pubic arch
- supra pubic pressure may be needed
- a tucked chin head aids in delivery

Grasp feet with a towel

Lift baby to 90 degree angle
- face follows pelvic curve of caress

Chin is found on perineum

Ease head though perineum
- client stops pushing, is blowing
- prevention of ‘head popping out’
  - intra cranial bleeding
- aids in preventing vaginal tears

Burns Marshall Maneuver
Management of the Newborn

Risk is to the newborn

*Hypoxia, Asphyxia & Death*

- Be prepared for
  - Low Apgar scores
    - Resuscitation
    - EMS transfer
- Newborn Examination observe for
  - Birth trauma
    - Fracture
  - Respiratory distress
  - Poor reflex response
Advise parents of breech differences
  • Head shape, brow prominent (24 - 72 hrs)
  • Leg positions (24 - 36 hours)
  • Swelling and bruising of presenting part
    - May increase jaundice
  • Hemorrhoids
In Summary

- Breech is a normal variation of presentation with a higher risk to the fetus
- Safe vaginal breech depends on expertise, judgement and skill of the practitioner
- Early diagnosis of breech can effect the possibility of successful version
- ECV may be considered an option for some clients with full informed consent
- Breech should never be undertaken lightly due to the real risks to the fetus
- Referral of care should be encouraged