PIPADOR REVISION

MRCOG Part 1 Revision Notes

Breech Presentation

CLINICAL MANAGEMENT • LECTURE 473

VISUAL EXAMINATION REVISION NOTES

2026 Edition

473

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Breech Presentation

Definitions, ECV and mode of birth for breech presentation (RCOG GTG 20a and 20b)

≈ 3–4%	ECV	≈ 50%	1 in 200
Breech at term	From 36/37 weeks	ECV success	Emergency CS after ECV

■ KEY FACTS: Learning objectives

- Define breech presentation and its types.
- Describe external cephalic version (ECV) — indications, contraindications, success and risks (RCOG GTG 20a).
- Describe counselling on mode of birth, vaginal breech birth and preterm/undiagnosed breech (RCOG GTG 20b).

473.1 Key definitions

Term	Definition
Breech presentation	Fetus presenting buttocks or feet first — ≈ 20% at 28 weeks, ≈ 3–4% at term
Frank (extended) breech	• Hips flexed, knees extended (feet near head) — most common at term • Most favourable for vaginal birth
Complete (flexed) breech	Hips and knees flexed
Footling / incomplete breech	• One or both feet below the buttocks — ↑ cord prolapse • Unfavourable for vaginal birth
External cephalic version (ECV)	Turning the fetus to cephalic by abdominal manipulation
Planned vaginal breech birth	Supported vaginal birth of a selected breech baby by a skilled attendant

■ IN PLAIN ENGLISH: Breech presentation

Most breech babies turn by themselves before 36 weeks. If not, **ECV** turns about half; if the baby stays breech, women choose between **planned caesarean** (slightly safer for the baby) and **planned vaginal breech birth** (safer for the mother's future pregnancies) after balanced counselling.

473.2 Causes

- Prematurity (commonest)
  - Uterine anomalies/fibroids, placenta praevia
  - Polyhydramnios/oligohydramnios
  - Multiple pregnancy
  - Fetal anomaly (neuromuscular, anencephaly, hydrocephalus), multiparity, previous breech.
- Breech at term warrants ultrasound for placental site, liquor, fetal growth and anomalies.

473.3 External cephalic version

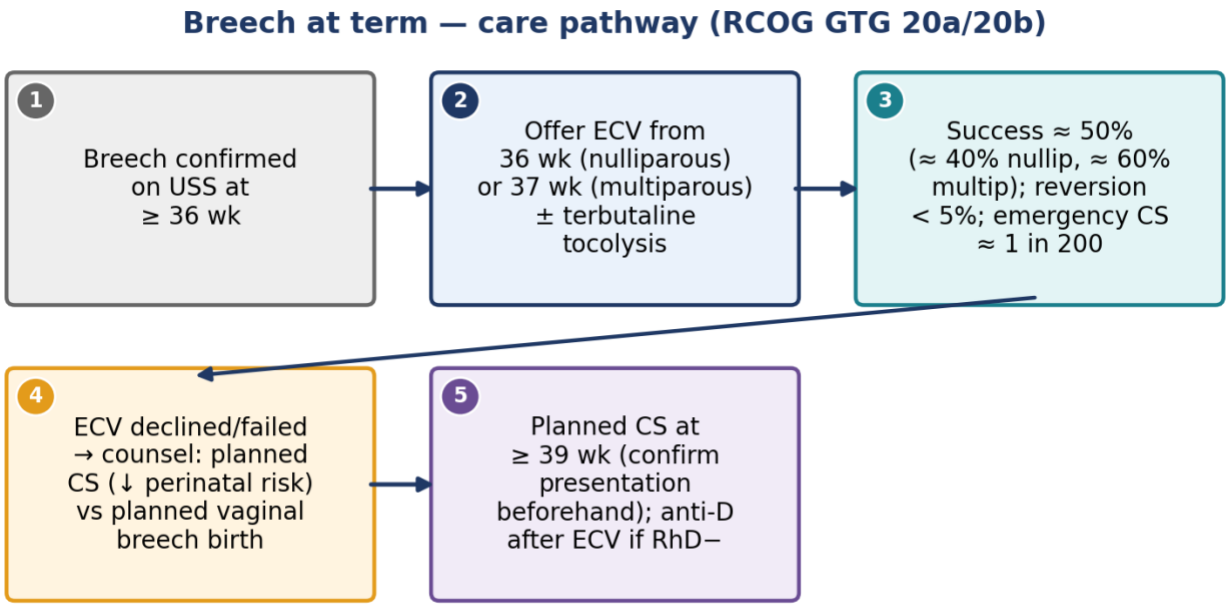


Figure 473.1 — Breech at term care pathway

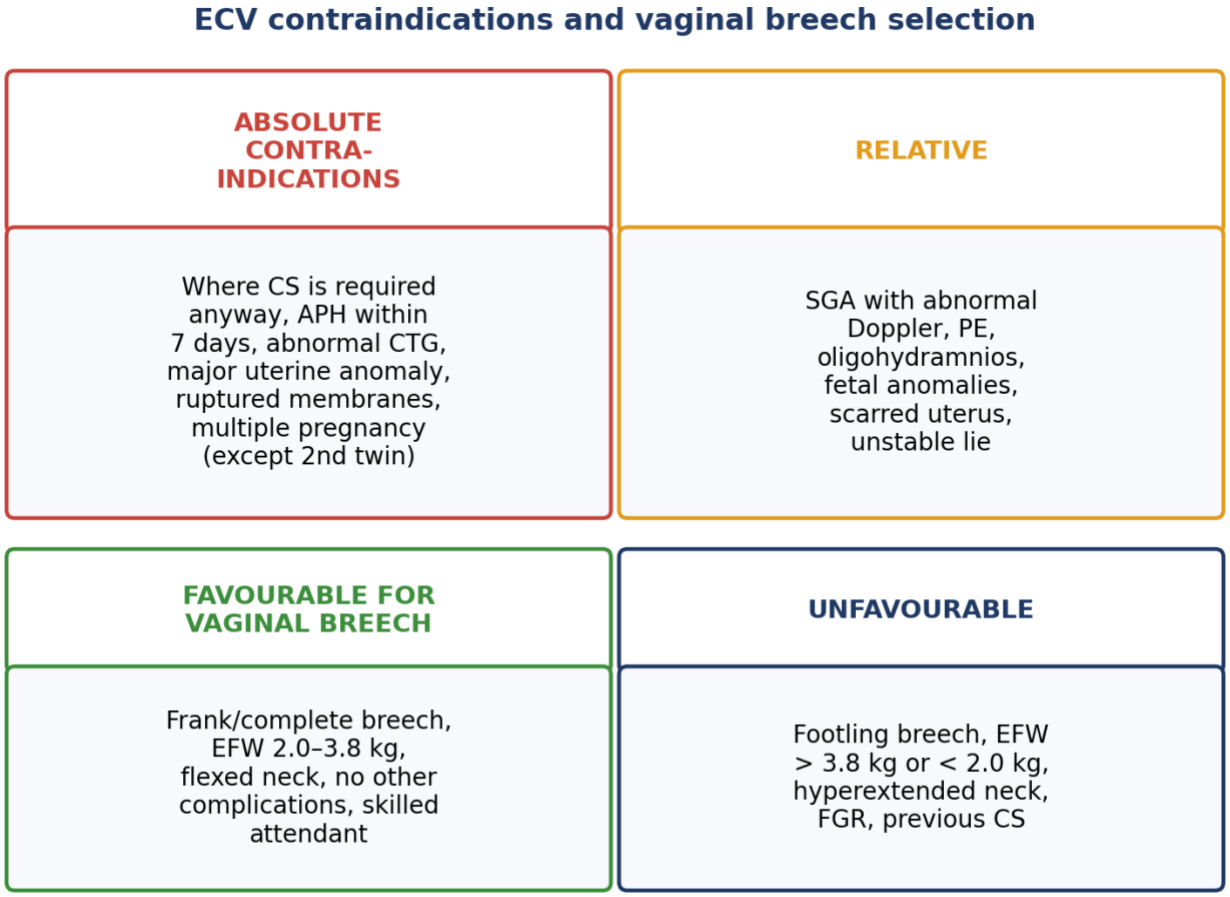


Figure 473.2 — ECV contraindications and vaginal breech selection

Topic	RCOG GTG 20a
Timing	From 36 weeks (nulliparous), 37 weeks (multiparous) — can be performed in early labour if membranes intact

Topic	RCOG GTG 20a
Tocolysis	Terbutaline 250 µg SC improves success
Success factors	Multiparity, unengaged breech, palpable head, relaxed uterus, non-anterior placenta, normal liquor
Risks	• Transient FHR abnormalities • Emergency CS ≈ 1 in 200 • Placental abruption, cord accident rare • Spontaneous reversion < 5%
Aftercare	• CTG before and after • Anti-D (≥ 500 IU + Kleihauer) for RhD-negative women
Previous CS	ECV is not contraindicated (success similar, small uterine rupture risk)
Alternatives	Moxibustion — limited evidence; postural techniques — no evidence

473.4 Mode of birth (RCOG GTG 20b)

- **Term Breech Trial**: planned CS reduces perinatal mortality and early neonatal morbidity (perinatal death ≈ 0.5/1,000 with planned CS vs ≈ 2/1,000 with planned vaginal birth, beyond 39 weeks)
  - No difference in long-term (2-year) neurodevelopmental outcome.
- Planned CS: small ↑ maternal risk and future pregnancy risks (placenta praevia/accreta, uterine rupture).
- Planned vaginal breech birth: appropriate with careful selection, informed consent, continuous CTG
  - Experienced attendant
  - Upright or semi-recumbent positions
  - 'hands off the breech'
  - IOL may be considered
  - Augmentation only for weak contractions with epidural.
- Planned CS at ≥ 39 weeks (confirm presentation on the day).

473.5 Special situations

Situation	Management
Preterm breech in labour	• Mode individualised • Routine CS not recommended in spontaneous preterm labour (consider CS 26–36 wk if appropriate) • Risk of head entrapment
Undiagnosed breech in labour	• Assess suitability • Vaginal birth not contraindicated if progressing well and no other concerns
Breech second twin	Vaginal breech/internal podalic version acceptable by skilled operator
Head entrapment	Lovset/Mauriceau–Smellie–Veit manoeuvres, cervical incisions (Dührssen), symphysiotomy, CS

■ COMMON PITFALLS

Not offering ECV to eligible women.

Forgetting anti-D after ECV.

Pulling on the breech (traction) during vaginal breech birth — risks head extension and entrapment.

473.6 Must-know summary

■ EXAM TIP

- Breech ≈ 3–4% at term; scan for cause; offer ECV from 36 (nullip) / 37 (multip) wk.
- ECV success ≈ 50%; terbutaline helps; emergency CS ≈ 1 in 200; anti-D if RhD−.
- Planned CS slightly safer for baby (Term Breech Trial); vaginal breech possible with selection and skilled attendant.
- Unfavourable: footling, EFW > 3.8 kg or < 2.0 kg, hyperextended neck, FGR.

■ MNEMONIC / MEMORY AID

Vaginal breech — 'Hands off the breech' (only assist once the umbilicus is born).