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Bottom first!

What to expect if your baby is breech

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What is a breech baby?

A breech baby is one that is born bottom first rather than the usual head first. Most breech babies will have straight legs going up past their ears (a “complete breech”), or bent legs in the usual foetal position (a “flexed breech”). Some will have one bent and one straight leg. Others have their legs curled up beneath them, so that their feet are born first, and even more rarely can have their legs in a kneeling position and be born knee first. In most cases there is no obvious reason why a baby is breech.

Typically 3-4% of babies will be breech at full-term. This is an awkward statistic – not frequent enough for midwives and doctors to see them regularly, and frequent enough that most people know someone who has had a breech baby. Even more awkwardly, approximately 1 in 4 of all babies will be breech at 30 weeks, and most of those will turn into a head-down position by themselves with no intervention. However, the details matter. First-time babies are less likely to turn, as are babies in women who have already had a previous breech.

Undiagnosed breeches

Some breech babies always go undiagnosed until labour has commenced, either because the baby turns breech very late in pregnancy, or because it felt like a head-down baby to the midwife. It can be quite a difficult experience for women to be told in advanced labour that their baby is breech, and especially difficult at that stage to make a logical informed decision about the birth.

Ante-natal care

Usually a breech baby is first recognised by your community midwife at a regular antenatal appointment. Addenbrookes is currently running a major study of first time pregnancies, which includes regular ultrasound scans, and these will also show if a baby is breech. In my own limited experience, women with breech babies often describe a hard round “bum” digging into their ribs. Not all breeches are spotted in pregnancy, especially if the baby’s legs are straight so that the kicks are high up towards your ribs, just as they would be in a head-down baby.

A suspected breech pregnancy should be referred for an ultrasound “positional” scan at 36 weeks, and anyone planning a home birth should also be offered a scan at that time. If the scan shows that the baby is breech, then the hospital midwives will explain a procedure called ECV (external cephalic version) which aims to turn the baby, and book an appointment for you straightaway. There are some cases (for example low fluid levels) where an ECV will not be offered. However, ECVs can usually be offered to women who have had previous Caesareans. If the baby remains breech, then you will have a “clinic appointment” with a hospital consultant to discuss your birth options.

Turning methods

The first focus in a breech pregnancy is always to try to encourage the baby to turn head-down. A turned baby is no longer breech, and the pregnancy and birth can then proceed just like any other, allowing you to have your baby at home or in the Midwife-led Birthing Unit if you wish to.

There are several “alternative” turning methods, which can be started as early as 34 weeks, as well as the ECV offered by the NHS. If you try the alternative approaches it is worth checking whether or not your particular practitioner has successfully turned breech babies before.

Most of the turning methods are combined with positional exercises. The formal positions are the “knee/chest” position, where you kneel with your shoulders resting on the floor (or a cushion) and your bottom in the air, or a reclining position where you lie on your back with your legs up against the wall and cushions supporting you under your bottom. The aim is to have your pelvis higher than your shoulders to encourage the baby to move out of your hips. This gives the baby room to move into a head-down position, which usually happens after the exercises rather than during them. Lots of “floor-scrubbing” is also meant to help – one breech mum I spoke to bought gardening knee pads to make this more comfortable!

The alternative methods include an acupuncture technique called moxibustion, which involves burning moxa sticks over a certain acupressure point on your little toe every day for 10 days. If the first course of treatment is unsuccessful, then a second can be tried after a gap of 4-5 days. Success rates of 50-80% have been reported, although formal published studies show insufficient evidence of benefit to recommend the use of this method within the NHS.

Other methods include a chiropractic method called the Webster Technique, which ensures that the mother’s pelvis is straight and aligned, a cranial osteopathy method and homeopathy using pulsatilla.

ECV is offered in the NHS at 36 or 37 weeks. There is a formal study underway looking at using ECV at 33-35 weeks, but this will not become standard practice unless the study shows good results. An ECV is done by one of the Rosie consultants, several of whom regularly carry them out. The doctor uses their hands to push the baby around into a head-down position, following the same path that a baby would take if she turned by herself. Ultrasound scan is used to check the baby’s heart beat and position during the procedure. Although women often say that ECVs are “uncomfortable”, this means “uncomfortable but not so painful that I needed to ask the doctor to stop”. Roughly half of all ECVs are successful, meaning that from then on the pregnancy is treated as normal.

If the first ECV is unsuccessful, then a second one can be attempted. One aspect which always worries people is that you are asked to skip breakfast before an ECV and to bring a hospital bag. This is in case the ECV triggers a labour or upsets the baby and requires you to stay in for a Caesarean. However, in reality, this happens very rarely, less than once a year at Addenbrookes, so is an example of the hospital being highly cautious.

Many breech mums try several turning methods, to give themselves the greatest possible chance of turning their babies. You should always tell each practitioner if you are using other methods, to ensure that they don’t counteract each other.

Birth options

If your baby refuses to turn then you should be given an appointment with a hospital consultant to discuss the birth. You should take advantage of this to ask all the questions you want, which people are often nervous to do!

Although many pregnancy books will list “breech” as one of the conditions that “requires” an elective Caesarean, this is not actually the case, and breech babies have been born safely throughout history. Addenbrookes are supportive of women who ask for a vaginal breech birth, though will ask you to labour in the delivery unit, rather than in the Midwife-led Birthing Unit or at home. As with many aspects of pregnancy and birth, their approach is to give you information about the risks of the different options, and allow you to make your own choice.

If you decide to have an elective Caesarean, then this will be scheduled for approximately 39 weeks. The doctors should go through all the risks of a Caesarean with you, which are the same as the risks for a head-down Caesarean. If you go into labour before 39 weeks then your Caesarean will be classed as an “emergency Caesarean” even if you are only in early labour when it is carried out.

If you choose a vaginal birth, then you will be recommended to use the hospital delivery unit, and have constant monitoring of your baby’s heartbeat. The delivery will be supervised by the most senior doctor on duty, ie a consultant during the day or a senior registrar at night, all of whom have delivered vaginal breech babies as part of their required training. First time mums will be encouraged to have an epidural and intravenous access in case labour does not progress and a Caesarean becomes necessary.

The key criteria for proceeding with a vaginal breech birth will be that the labour progresses steadily. If labour slows for any reason then that is taken as a sign that a Caesarean is needed. For this reason they will not induce a breech baby, which means that if you develop a condition which would usually be a reason for an induction (for example, gestational diabetes, low fluid levels or slow growth of your baby), the doctors will recommend that you have a Caesarean instead. In fact breech labours will often progress more quickly and intensely than a head-first labour (although for me my bottom-first labour took exactly the same time as my head-first one).

Different practitioners have different approaches to breech birth. All doctors and midwives in the UK have annual training on how to deal with a breech baby, though very few have the opportunity to deliver breech babies in practice. One key rule is “hands off the breech”, which is Addenbrookes standard practice. Doctors in Addenbrookes will deliver the baby with the mother in the lithotomy position, ie lying on your back, since this is how they are trained to help the baby out if needed. In Germany and at The Farm in Tennessee, breeches are generally delivered in a standing position, while midwives trained by Mary Cronk and Jane Evans (the UK breech experts) encourage women to use an all fours position, leaning further and further forward as the baby emerges.

In cases of undiagnosed breeches, the staff will move you to the delivery unit and turn you onto your back for delivery, if it is safe to do so. In practice some breech labours progress so quickly that all they can do is catch the baby from whatever position the mother happens to be in, whether that is upright, or on all fours, or leaning on a table.

Concerns are usually around babies “getting stuck”, though everyone is trained in simple manoeuvres to help a breech baby out. Jane Evans always says that in a normally-developed baby there is not much difference between the size of the hips and the head, so if the hips can come out then so can the head. The other practical concern is that an individual doctor

does not deliver many breech babies, so some are more confident than others. Typically Addenbrookes has between 2 and 5 vaginal breech births each month.

The alternative is to use an independent midwife with breech experience, which will ensure that the person delivering your baby is confident of their own breech skills. The most experienced breech midwife local to Cambridge is Valerie Gommon, now that Jane Evans has moved to the west country. This would mean that you have a home birth, since independent midwives cannot practise in the hospital.

If you go ahead with a vaginal breech birth, then it can take up to 5 minutes from the baby first being visible (which is called “rumping” rather than “crowning”), to her being born. This amusingly means that your doctor or midwife will know the sex of the baby long before you do. Usually the bottom comes out first (except for in a footling breech when the feet come out first), then the legs come out and unfold, then the arms, and finally the head. The umbilical cord is visible once the hips have been born, which means you can see it pulsing throughout the birth. Breech babies have a higher chance of needing help to take their first breath than head-first babies, so you may not get to hold your baby straight away, until she has good APGAR scores.

Post-natal care

Breech babies may suffer bruising of their genitals, regardless of whether they are born vaginally or by Caesarean. This can be quite severe, and for boys may require an immediate ultrasound, but usually clears up within a few days. Otherwise a post-natal breech baby is the same as any other baby, except that she will automatically have a hip scan at 6 weeks, since breech babies are more likely to have “clicky hips”.

Cranial osteopathy can also be very helpful for breech babies, since their bodies have not been subjected to the usual pressures of a head-down pregnancy and birth.

For more information:

Breech birth: What are my options? – Jane Evans, published by AIMS

Breech birth – Benna Waites, available from Amazon and other booksellers

The Breech Babies Club - www.breechbabiesclub.org

To find your nearest independent midwife - www.independentmidwives.org.uk

The full text of this article is available at www.breechbabiesclub.org and at www.birthlight.com