Breech baby at the end of pregnancy

Who is this leaflet for?
This information is for you if your baby is breech towards the end of your pregnancy. It may also be helpful if you are a partner, relative or friend of someone whose baby is breech.

Key Points

- Breech is very common in early pregnancy and by 36-37 weeks, most babies will turn into the head first position. If your baby has not turned it does not usually mean that you or your baby have any problems.

- Turning your baby into the head first position so that you can have a normal vaginal delivery is the safest way to have your baby.

- The alternative to turning your baby into the head first position is to have a planned caesarean birth or a planned vaginal breech birth.

- Evidence suggests that planned caesarean birth is safer than vaginal breech birth. However, both can potentially cause more problems than delivering vaginally head first.

What is breech?

Babies lying bottom first or feet first in the uterus (womb) instead of in the usual head first position are called breech babies. In early pregnancy, breech is very common and by 36 to 37 weeks of pregnancy, most babies turn naturally into the head first position.

Three to four in every 100 (3% - 4%) babies are breech at the end of pregnancy.

A breech baby may be lying in one of the following positions:

**Extended or frank breech** – the baby is bottom first, with the thighs against the chest and feet up by the ears. Most breech babies are in this position.

**Flexed breech** – the baby is bottom first, with the thighs against the chest, and the knees bent.
Footling breech – when the baby’s foot or feet are below the bottom.

Why is my baby breech?

It may just be a matter of chance that your baby hasn’t turned into the head first position. However, there are certain factors that make it more difficult for a baby to turn during pregnancy and therefore, more likely to stay in the breech position.

These include:

- if your placenta is in a low-lying position. See RCOG Patient Information: Low lying placenta after 20 weeks (placenta praevia) information for you which can be found online here: https://www.rcog.org.uk/en/patients/patient-leaflets/a-low-lying-placenta-after-20-weeks-placenta-praevia/
- if you have too much or too little fluid (amniotic fluid) around your baby
- if you have more than one baby in the uterus (womb)
- if this is your first pregnancy

Very rarely, breech may be the sign of a problem with the baby. Many problems are picked up during the scan you are offered at around 20 weeks of pregnancy.

What if my baby is breech towards the end of my pregnancy?

If your baby is breech at 36 weeks pregnancy, your obstetrician or midwife will discuss the following with you:

- trying to turn your baby in the uterus into the head first position (by external cephalic version (ECV) – see below for more information)
- planned caesarean section
- vaginal breech delivery
External cephalic version (ECV) - turning a breech baby in the womb

Why turn my baby head first?
If your ECV is successful and your baby is turned into the head first position, you are more likely to have a normal vaginal birth. Successful ECV lowers your chances of a caesarean birth and its associated risks.

What does it involve?
External Cephalic Version (ECV) involves applying gentle pressure on your abdomen to help your baby turn in the uterus to lie head first.

Relaxing the muscles of the uterus with medication has been shown to improve the chance of turning your baby. This medication is given by injection before the ECV and is safe to give during pregnancy. It may make you feel flushed and aware of your heart beating faster than usual but this will only be for a short time.

ECV can be uncomfortable and occasionally painful but your obstetrician or midwife will stop if you are experiencing pain. The procedure only lasts for a few minutes. With your consent, the obstetrician or midwife may have more than one attempt at turning your baby.

Before the ECV, you will have an ultrasound scan to confirm the baby is breech and have your pulse and blood pressure checked. After the ECV an ultrasound scan is performed again to see whether your baby has turned. The baby’s heart rate will also be monitored before and after the procedure. You will be advised to contact the hospital if you have bleeding, abdominal pain, contractions or reduced fetal movements after ECV.

ECV is usually performed after 36 or 37 weeks of pregnancy. However, it can be done right up until the early stages of labour. You do not need to make any preparations for your ECV.

If your blood type is D negative, you will be advised to have an anti-D injection after the ECV and to have a blood test (Kleihauer) - see NICE Patient Information: Routine Antenatal anti-D prophylaxis for women who are rhesus D negative found here: https://www.nice.org.uk/guidance/ta156/resources/routine-antenatal-antid-prophylaxis-for-women-who-are-rhesus-d-negative-374979421

Is ECV safe for me and my baby?
ECV is generally safe with a very low complication rate. Overall, there doesn’t appear to be an increased risk to your baby from having ECV. After your baby is turned, you will normally go home and wait for labour to begin. When you do go into labour, your chances of needing delivery by caesarean section, forceps or suction cup (vacuum) is slightly higher than if your baby had always been head down.

Immediately after ECV there is 1 in 200 chance of your baby needing to be delivered by emergency caesarean section because of bleeding from the placenta and/or changes in your baby’s heartbeat.
An ECV should be carried out in a hospital where your baby can be delivered by emergency caesarean section if needed. It should be carried out by a doctor or midwife trained in ECV.

Most women can be offered an ECV, including women who have had one caesarean section before.

ECV should not be carried out if:

- you need a caesarean section for other reasons
- you have had vaginal bleeding during the previous seven days
- the baby’s heart rate tracing (also known as CTG) is abnormal
- your uterus (womb) is not the normal pear-shape (some women have a womb which resembles a heart-shape known as a bicornuate uterus).
- your waters have broken before you go into labour - see RCOG patient information When your waters break early: information for you, found here: https://www.rcog.org.uk/en/patients/patient-leaflets/when-your-waters-break-early/
- you are pregnant with more than one baby - see RCOG patient information Multiple Pregnancy - Having more than one baby: information for you, found here: https://www.rcog.org.uk/en/patients/patient-leaflets/multiple-pregnancy-having-more-than-one-baby/)

Is ECV always successful?

ECV is successful for about 50% of women. It is more successful if you have had a vaginal birth before. Your healthcare team should give you information about your own individual chance of success.

If the baby does not turn, it is possible to have another attempt on a different day. If the baby does not turn then, your obstetrician or midwife will discuss your options for birth (see below).

If ECV is successful, there is still a small chance that your baby will turn back to the breech position. However, this happens to less than 5 in 100 (5%) of women who have had a successful ECV.

Is there anything else I can do to help my baby turn?

There is no scientific evidence that lying down or sitting in a particular position can help your baby to turn. There is some evidence that use of moxibustion (burning a Chinese herb, called Mugwort) at 33-35 weeks of pregnancy when done under the direction of a registered health care practitioner, may help your baby to turn to from breech to head first, possibly by encouraging fetal movement.

What are my options for birth if my baby remains breech?

Depending on your situation, your choices are:

- planned caesarean birth
- planned vaginal breech birth
There are benefits and risks associated with both caesarean section and vaginal breech birth and these should be discussed between you and your obstetrician and/or midwife, so that you can choose the best plan for you and your baby.

**Caesarean birth**

If your baby is breech at the end of pregnancy and you are not in labour, you should be given the option of a caesarean section. Research has shown that planned caesarean birth is safer for your baby than a vaginal breech birth. However, there is no evidence that your baby’s long term health is affected by how he/she is born. There is a small increased chance that you may suffer complications from the caesarean section.

Caesarean section increases your chance of problems in future pregnancies whether you choose a vaginal delivery or a caesarean section in the pregnancy that follows your breech pregnancy. These problems include difficulties with your placenta, difficulty with caesarean surgery and a small increase in still birth in subsequent pregnancies.

If you choose a Caesarean section, and then go into labour before the operation, your healthcare professional will examine you to assess whether it is safe to proceed with the Caesarean section. If the baby is close to being born, it may be safer for you to have a vaginal breech birth.

**Vaginal breech birth**

After careful discussion with your obstetrician and midwife about your and your baby’s suitability for a breech delivery you may choose to have a vaginal breech birth. If you choose a vaginal breech birth, you will need to be cared for by a team trained and experienced in delivering breech babies vaginally. You should plan a hospital delivery where there are facilities for an emergency caesarean section as 40% of women planning a vaginal breech birth do need a caesarean section. Induction of labour is not usually recommended.

A successful vaginal birth carries the least risk of problems for you. In some cases, breech birth may cause serious short term complications for the baby. These complications do not seem to have a long-term effect on the baby.

Before choosing a vaginal breech birth, it is advised that you and your baby are assessed (see below).

Your obstetrician may advise you against a vaginal birth if:

- your baby is a footling breech
- your baby is large (estimated weight over 3800g)
- your baby is small (estimated weight less than 2000g)
- your baby is in a certain position for example, if the neck is very tilted back (hyper extended)
- you have a low-lying placenta (placenta praevia) – see **RCOG patient information Placenta praevia: information for you** found here: https://www.rcog.org.uk/en/patients/patient-leaflets/a-low-lying-placenta-after-20-weeks-placenta-praevia/
What can I expect in labour with a breech baby?

With a breech baby, you have the same choices for pain relief as with a baby who is head first. If you choose to have an epidural there is an increased chance of intervention for delivery. Whatever you choose, a calm atmosphere with continuous support should be provided.

If you have a vaginal breech birth, your baby’s heart rate will usually be monitored continuously as this has been shown to improve your baby’s chance of a good outcome.

In some circumstances, for example, if there are concerns about your baby’s heart rate or if your labour is not progressing, you may need an emergency Caesarean section during labour. A paediatrician (a doctor who specialises in the care of babies, children and teenagers) will attend the birth to check the baby.

What if I go into labour early?

If you go into labour before 37 weeks, the balance of benefits and risks of having a caesarean birth or vaginal birth changes and will be discussed with you.

What if I’m having more than one baby and one of them is breech?

If you are having twins and the first baby is breech, your obstetrician will usually recommend a planned caesarean birth.

If however, the first baby is head down, the position of the second twin before labour is less important because this baby can change position as soon as the first twin is born. The second baby then has lots more room to move, and so may turn naturally into a head down position or a doctor may be able to help the baby to turn - see RCOG patient information, Multiple Pregnancy - Having more than one baby: information for you found here [https://www.rcog.org.uk/en/patients/patient-leaflets/multiple-pregnancy-having-more-than-one-baby/](https://www.rcog.org.uk/en/patients/patient-leaflets/multiple-pregnancy-having-more-than-one-baby/) )

If you would like any further information on any aspects of breech babies and breech birth, you should speak with your obstetrician or midwife.
Making a choice

Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

*Ask 3 Questions is based on Shapland HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options. A cross-over trial. Patient Education and Counseling. 2011;84:379-85

Further information


Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG Green-top Clinical Guidelines External Cephalic Version and Reducing Incidence of Term Breech Presentation GTG 20 found here: and Management of Breech Presentation GTG 20b which contain a full list of the sources of evidence we have used.

You can find these online at the following links:

https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg20a/
https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg20b/

This leaflet was reviewed before publication by women attending clinics at XXXXXXX by the RCOG Women’s Network and by the RCOG Women’s Voices Involvement Panel.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.
A glossary of all medical terms is available on the RCOG website at: www.rcog.org.uk/en/patients/medical-terms

A final note
The Royal College of Obstetricians and Gynaecologists produces patient information for the public. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient’s case notes at the time the relevant decision is taken.

All RCOG guidelines are subject to review and both minor and major amendments on an ongoing basis. Please always visit www.rcog.org.uk for the most up-to-date version of this guideline.

© Royal College of Obstetricians and Gynaecologists 2016