# The occasional breech

Peter Hutten-Czapski, MD
Alistair Anderson, MD

abridged from CJRM 2005;10(1):47-50

---

## Delivering a breech

The good news is that the vast majority of breech babies will deliver themselves. Thus, after calling for help, the first step in vaginal breech delivery is to encourage the mother's efforts.

As the breech crowns, consider a generous episiotomy to ease application of hands or forcepts. Do not apply traction on the baby because this may deflex and trap the head and cause injury (Fig. 1).

When the umbilicus delivers you may pull out a length of cord to ensure slack and to monitor fetal pulse. If the baby is facing up (sacrum posterior), rotate the baby gently by two hands on its pelvis so it assumes the more favourable face down position. Allow the baby's leg's to deliver by "popping out."

At this point the baby can be either left to hang or supported at 45 degrees to the floor or on a horizontal angle. Do not elevate the body beyond the horizontal (Fig. 2). The baby's back can be rotated from one anterior oblique to the other, which is helpful in flexing the arms across the chest. The shoulders can be delivered with the trunk in the oblique. When the scapulae deliver, the arms can be optionally swept across the chest and out of the birth canal (Fig. 3, Fig. 4).

A modified Mauriceau-Smellie-Veit (MSV) manoeuvre is used to flex the head. To deliver the head, set yourself below the baby. One hand goes on the baby's back with a finger pushing down on the occiput. Place the other hand under the baby with the forearm supporting it and with two fingers pushing up on the maxillae. Your assistant will follow with transabdominal pressure flexing the occiput. Some traction on the shoulders by your upper hand may be required. As the head delivers keep the baby's body in neutral position in respect to the head by raising it gently in a large arc (Fig. 5).

The vast majority of babies presenting in the breech position will be delivered by this method.

## Complications: Piper forceps

Failure to manually deliver the head in 2 or 3 minutes is an emergency and warrants an attempt at forceps, by an informed, even if inexperienced, operator.

An assistant holds the baby up to ease application. The operator starts by test assembling the forceps (Pipers are preferred, but any will do) and visualizing the application as if the presentation was occiput anterior. The handle of the left blade is held by the operator's left hand and inserted almost horizontally into the mother's left side. The operator's right hand may be used against the patient's left vaginal wall to direct the blade and reduce chances of injury from the insertion (Fig. 6). The blade may be left there or supported by the assistant while the right blade is applied.

The handle of the right blade is held by the operator's right hand and inserted in a manner similar to the first blade, between the mother's right side and the baby's head. The operator's left hand may be used against the patient's right vaginal wall to direct the blade and reduce chances of injury from the insertion.

The handles of the forceps should come together and lock easily without undue force. If not, they should be removed and reapplied. There is no other check on the application. When the operator is satisfied, the baby is laid down on the handle of the forceps and traction is applied. At first, traction is applied downward and then, as the head descends, the forceps can be progressively lifted in an arc reflecting the pelvic curve (Fig. 7).