

Management of breech presentation

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in [Appendix A](#).

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

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Objectives: To provide health professionals and women with information regarding the benefits and risks of their options when a breech presentation is diagnosed either at term or at planned or spontaneous preterm birth.

Target audience: Health professionals providing maternity care.

Values: The evidence was reviewed by the Women's Health Committee (RANZCOG) and applied to local factors relating to Australia and New Zealand.

Background: This statement was first developed by Women's Health Committee in February 2001 and reviewed in July 2021.

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1. Plain language summary

Babies lying bottom first or feet first in the mother's uterus (instead of in the head-first (cephalic) position) are called breech babies.

For babies with the breech presenting, labour and birth carry increased risk of harm (due to trauma or lack of oxygen) compared to the risk carried by those babies labouring with the head presenting. Caesarean section is often recommended as a safer method of birth for the breech baby but carries risks for the mother – both immediately and for future pregnancies.

Vaginal breech birth may be a safe option for carefully selected women who are counselled appropriately and who birth in facilities with access to skilled staff, operating theatre and neonatal care. Healthcare professionals should use the principles of shared decision making when counselling women.

External Cephalic Version (ECV), a procedure to turn the baby from a breech to a cephalic presentation, can reduce the incidence of breech presentation in labour and should be offered to mothers, if appropriate, late in the pregnancy.

The risks of vaginal breech birth and the conditions required for consideration of vaginal breech birth are discussed in this statement.

2. Summary of recommendations

Good Practice Point	Grade
All caregivers providing antenatal care should be experienced in palpation of the pregnant abdomen, including identification of the presenting part to diagnose breech presentation. The caregivers should have ready access to ultrasound by an experienced and appropriately qualified clinician to confirm presentation where they have any doubt regarding the presentation.	Good Practice Point
Recommendation 1	Grade
For women with suspected breech presentation in late third trimester, ultrasound imaging should be performed to confirm the examination findings. If breech presentation is confirmed, a detailed obstetric ultrasound should be performed to determine whether any fetal or maternal finding predisposing to malpresentation is present (such as a fetal anomaly, or undiagnosed placenta praevia). The ultrasound should include fetal biometry and assessment of amniotic fluid volume.	Consensus based recommendation
Recommendation 2	Grade
Women with a breech presentation at or near term should be informed about External Cephalic Version (ECV) and ECV should be offered, if clinically appropriate.	Evidence based recommendation (Grade A)
Recommendation 3	Grade
ECV should only be performed by suitably trained health professionals where there is facility for emergency caesarean section. Each institution should have its own documented protocol for offering and performing ECVs.	Consensus based recommendation

Recommendation 4	Grade
Where there is maternal preference for vaginal birth, the woman should be counselled about the risks and benefits of planned vaginal breech delivery in the intended location and clinical situation. The principles of shared decision making should be used during counselling.	Evidence based recommendation (Grade C)
Recommendation 5	Grade
Maternity units that offer vaginal breech birth should develop clear, strict and unambiguous protocols for case selection and management of vaginal breech birth to reduce neonatal morbidity and mortality.	Evidence based recommendation (Grade C)
Recommendation 6	Grade
Planned vaginal breech delivery must take place in a facility where appropriate experience and infrastructure are available, including: <ul style="list-style-type: none"> • Continuous electronic fetal heart monitoring in labour. • Immediate availability of caesarean facilities. • Availability of a suitably experienced obstetrician and midwife to manage the birth, with arrangements in place to manage shift changes and fatigue. 	Consensus based recommendation
Recommendation 7	Grade
When breech presentation is first recognised in labour, the obstetrician should discuss the options of emergency caesarean section or proceeding with attempted vaginal breech birth with the woman, explaining the respective risks and benefits of each option according to her individual circumstances. Wherever practicable, point-of-care ultrasound should be performed when breech presentation is first diagnosed in labour.	Evidence based recommendation (Grade C)
Recommendation 8	Grade
All maternity units should undertake regular training for all medical and midwifery staff using simulation to ensure that staff maintain adequate skills to be able to provide appropriate care when a woman is admitted in advanced labour with breech presentation.	Consensus based recommendation
Recommendation 9	Grade
When planned preterm delivery is required (i.e. when the mother is not in preterm labour) for maternal and/or fetal compromise with a viable fetus beyond 25 weeks gestation, in breech presentation, elective caesarean section is recommended. This should be performed by a clinician with appropriate experience. Head entrapment should be anticipated and preparations made to manage it, should this occur.	Consensus based recommendation
Recommendation 10	Grade
There is no clear neonatal benefit of birth by caesarean section for breech presentation at 22 ⁺⁰ to 24 ⁺⁶ weeks. The neonatal outcome at these gestations is likely to be determined by factors other than mode of birth. As a consequence, caesarean section at these gestations is not routinely recommended.	Evidence based recommendation (Grade C)
Recommendation 11	Grade
A planned Caesarean section is recommended for a twin pregnancy where the presenting twin is breech.	Evidence based recommendation (Grade C)

3. Introduction

Between three and four per cent of singleton fetuses will present by the breech beyond 37 weeks of gestation, with the majority of these presentations being detected prior to labour.⁽¹⁾ The issue of how to manage and plan delivery in this situation has been controversial, with much of the debate centred around a study by Hannah and colleagues (2000), the 'Term Breech Trial'. This trial described below, has changed clinical practice with as many as 90 per cent of breech presentations at term now delivered by caesarean section.⁽²⁾

3.1 Evidence summary and basis for recommendations

The most widely quoted study regarding the management of breech presentation at term is the 'Term Breech Trial'. Published in 2000, this large, international multicenter randomised clinical trial compared a policy of planned vaginal delivery with planned caesarean section for selected breech presentations. It reported that perinatal mortality and serious neonatal morbidity were significantly lower in the planned caesarean section group (1.6 per cent) compared to the planned vaginal birth group (5 per cent) (RR 0.33, $p < 0.0001$). Perinatal death occurred in 0.3 per cent of planned caesarean births and 1.3 per cent of all planned vaginal births (RR 0.23, $p = 0.01$), while serious neonatal morbidity occurred in 1.4 per cent of planned caesarean births versus 3.8 per cent of planned vaginal births (RR 0.36, $p = 0.0003$). Serious maternal morbidity showed no difference between the two groups.

Subsequent follow-up data on a subset of survivors failed to show long-term differences in death and neurodevelopmental delay between the two groups at 2 years of age.⁽³⁾ However, because of the small number of patients involved, those long term outcomes are not suitable endpoints.⁽³⁾

At least one study published in the wake of the Term Breech Trial is consistent and has shown an association between the increased use of planned caesarean section for breech presentation at term and improvements in perinatal outcome (including halving perinatal mortality and even greater reductions in the incidence of birth trauma).⁽⁴⁾

Reitberg et al (2005) in their paper "The effect of the Term breech Trial on medical intervention behaviour and neonatal outcome in the Netherlands: an analysis of 35,453 term breech deliveries" calculated that 175 caesarean sections would be required to avoid one fetal death.⁽⁵⁾

The benefits of caesarean section reducing newborn morbidity must be balanced against the immediate and longer term risks of caesarean delivery. The downstream risks relating to future births include the potential for scar rupture in labour, the surgical risks of repeat caesarean section and placenta accreta. (See: **RANZCOG Statement C-Obs 38** Birth after previous caesarean section.)

A further consequence of the practice of performing caesarean section to deliver breech presenting babies is a limitation of the opportunities for training and experience of vaginal breech birth for obstetricians and midwives.

The Term Breech Trial has been criticised on methodological grounds⁽⁶⁻⁹⁾ thereby making its generalisability and applicability to appropriately staffed and resourced Australian and New Zealand hospitals uncertain.

A recent meta-analysis conducted by Berhan and Haileamlak (2016) that included observational, non-randomized data calculated absolute risks of perinatal mortality in the planned vaginal and planned caesarean section groups of about 1 in 333 and 1 in 2,000 respectively.⁽¹⁰⁾ While this difference in perinatal outcomes was statistically significant, the authors of the meta-analysis argued that the absolute risks were very small (almost equivalent to a cephalic presentation at term) and the practice of individualised management of breech presentation could be substantiated by their study. However, the

accompanying editorial did not concur with this interpretation, and stated that "Informed parents may of course continue to choose vaginal delivery, but it is no longer justifiable for obstetricians to claim that in their hands there is no increased fetal risk from vaginal birth".⁽¹¹⁾

Some expert groups consider that with adherence to strict criteria before and during labour, planned vaginal delivery of the singleton breech at term may be an option to offer to appropriately counselled and selected women where appropriate personnel and infrastructure to support such a birth are in place.⁽⁶⁾

Where vaginal breech delivery is to be considered, the suggested minimum requirements for management are provided below, to ensure the safest possible conduct of vaginal breech delivery for appropriately experienced Fellows and trainees under direct supervision.

4. Discussion and recommendations

4.1 Diagnosis of a Breech Presentation in the late third trimester

Where the diagnosis of breech presentation has been made late in the third trimester, ultrasound should be performed by a suitably-experienced practitioner to determine whether any fetal or maternal findings predisposing to malpresentation are present (such as a fetal congenital anomaly, or undiagnosed placenta praevia, for example). Ultrasound is also used to locate the placenta, quantify the liquor volume, estimate the fetal weight by measuring the biparietal diameter, head circumference, abdominal circumference and femur length, and diagnose adverse fetal findings such as hyperextension of the fetal neck or cord or footling presentation.

Good Practice Point	Grade
All caregivers providing antenatal care should be experienced in palpation of the pregnant abdomen, including identification of the presenting part to diagnose breech presentation. The caregivers should have ready access to ultrasound by an experienced and appropriately qualified clinician to confirm presentation where they have any doubt regarding the presentation.	Good Practice Point
Recommendation 1	Grade
For women with suspected breech presentation in late third trimester, an ultrasound should be performed to confirm the examination findings. If breech presentation is confirmed, a detailed obstetric ultrasound should be performed to determine whether any fetal or maternal finding predisposing to malpresentation is present (such as a fetal anomaly, or undiagnosed placenta praevia). The ultrasound should include fetal biometry and assessment of amniotic fluid volume.	Consensus based recommendation

4.2 External Cephalic Version

External Cephalic Version (ECV) has an important role in the management of term breech presentation, and should be offered to all women in whom it is appropriate. ECV is inappropriate where a caesarean section is indicated on other grounds. ECV is associated with a reduction in caesarean section for non-cephalic presentation.

ECV should only be performed by suitably trained health professionals or by a trainee working under direct supervision.

It should only be performed in an institution where there is facility for emergency caesarean section if needed and according to appropriate institutional protocols that define the place of cardiotocography,

ultrasound, and tocolysis.

ECV should be offered at term from 37⁺⁰ weeks of gestation. In nulliparous women, a pragmatic approach may be to offer ECV from 36⁺⁰ weeks of gestation since they have a low chance of spontaneous version after 36 weeks. Spontaneous version is more common in multiparous women. There is no clear benefit to ECV prior to 36 weeks gestation. There is no upper gestation limit for when ECV can be offered, but contraindications may be more common at later gestation. There is a paucity of data on intrapartum ECV, but success has been reported. Intrapartum ECV may be considered if informed consent is possible, providing the membranes are intact and no contraindications exist. ^(12, 13)

There is limited evidence to guide the number of attempts at ECV. No more than four attempts are advised, for a maximum of 10 minutes overall. ⁽¹⁴⁾

Women undergoing ECV who are Rh negative should be offered additional Anti-D within 72 hours, whether the ECV is successful or not (**See: RANZCOG statement C-Obs 6** - Guidelines for use of Rh(D) Immunoglobulin(Anti-D) in obstetrics).

When performed in appropriate clinical settings, ECV has a low rate of serious adverse outcomes. It is important to note ECV is not without potential hazards, and large series reveal that about one in 200 attempts will require emergency caesarean section for a serious adverse outcome such as placental abruption, cord prolapse, or acute fetal compromise. Minor complications (transient CTG abnormalities for less than 3 minutes, rupture of membranes and small antepartum haemorrhage) were reported to occur in 48 (4.3 per cent) of 1121 patients undergoing ECV at a tertiary centre in Sydney. ⁽⁹⁾ The need for emergency caesarean birth following ECV is less than for women in normal labour. Hence, fasting, administration of anaesthetic premedication or insertion of intravenous access (unless for tocolysis) are not recommended as a routine. However, each woman should be assessed for individual risk factors and the full clinical picture should be considered. Studies have not been sufficiently powered to estimate the frequency of uterine rupture, perinatal death or long term morbidity associated with ECV but case reports exist of these outcomes. ^(10, 11) Urgent delivery is advised following ECV if there is persistence of CTG abnormality, vaginal bleeding or unexplained abdominal pain.

Approximately 3 per cent of babies revert to breech after a successful ECV. Although a successful ECV reduces the chance of caesarean section, labour after ECV is associated with a slightly increased rate of caesarean section and instrumental birth when compared with spontaneous cephalic presentation.

ECV success can be predicted to some extent using predictive models. However, these models are of insufficient predictive value to alter practice and hence should not be used routinely to determine whether ECV can be attempted. The use of tocolysis improves the success rate of ECV. The success rate of ECV has been reported as 40 percent in nulliparous women and 60 per cent in multiparae, but these depend on case selection and experience of the clinical staff. ⁽¹²⁾

Recommendation 2	Grade
Women with a breech presentation at or near term should be informed about External Cephalic Version (ECV) and offered it, if clinically appropriate.	Evidence based recommendation (Grade A)

4.2.1 Contraindications to ECV

Absolute contraindications to ECV that are likely to be associated with increased mortality or morbidity:

- where caesarean delivery is required for e.g. placenta praevia
- antepartum haemorrhage within the last 7 days
- abnormal cardiotocography
- ruptured membranes

- where there is rhesus isoimmunisation
- multiple pregnancy (except delivery of second twin)

Relative contraindications where ECV might be more complicated:

- small-for-gestational-age fetus with abnormal Doppler parameters
- pre-eclampsia
- oligohydramnios
- major fetal anomalies
- uterine anomalies (ECV is less likely to be successful)

The role of ECV with one previous caesarean section has been controversial. However, the largest analysis has shown that ECV after one caesarean section appears to have no greater risk than with an unscarred uterus. There were insufficient numbers to determine the low risk of uterine rupture. ⁽¹⁵⁾

Recommendation 3	Grade
ECV should only be performed by suitably trained health professionals where there is facility for emergency caesarean section. Each institution should have its own documented protocol for offering and performing ECVs, including absolute and relative contraindications.	Consensus based recommendation

4.3 Non ECV methods of managing breech presentation

Women should be advised that there is no evidence that postural management alone promotes spontaneous version to cephalic presentation. ⁽¹⁶⁾

Women should be advised that there is no evidence, from recent trials, that moxibustion is effective for version of breech position. ⁽¹⁷⁻²⁰⁾

4.4 Planned caesarean section for breech

Almost 90 per cent of fetuses presenting by the breech at term are now delivered by caesarean section. ⁽²⁾

It is recommended that elective caesarean section for breech presentation should be performed at 39 weeks gestation in the absence of any additional risk factors (**See: RANZCOG statement C-Obs 23** - Timing of elective caesarean section at term)

A large scale epidemiological study reviewed 2 million births in non-anomalous babies and found that breech presentation was a significant marker of late term stillbirth. Based on this information, it may be preferable to perform elective caesarean section prior to 40 weeks.

Obstetricians should be aware that breech presentation is associated with increased risk of fetal injury at caesarean section. For recommendations to minimise risks associated with breech caesarean section, please refer to (**See RANZCOG statement: C-Obs 37** Delivery of the fetus at caesarean section).

4.5 Planned vaginal breech birth

Although the majority of breech births are by caesarean section, with careful case selection and appropriate intrapartum management, in an institution with adequate experience and infrastructure, it is possible to plan for attempted vaginal birth in some cases. This will depend upon the experience of the clinical team, and the infrastructure available.

Maternity units should develop a checklist to ensure comprehensive, evidence based counselling regarding planned mode of delivery for breech presenting babies. Women who request a trial of vaginal birth should be counselled about the potential risks and benefits of vaginal breech birth, giving due regard to the experience of the clinical team and the infrastructure available.

Maternity units that support planned vaginal breech birth should have clear, strict, unambiguous protocols for case selection and management of vaginal breech birth.

If a woman wishes to attempt vaginal breech birth, units with limited access to experienced birth attendants and/ infrastructure should offer antenatal referral to a unit where appropriate skill level, experience and expertise is available.

In the situation where vaginal breech birth is deemed inappropriate for an individual mother based on clinical assessment and risk factors, it may be reasonable to obtain a second opinion, if the mother requests this. All maternity units should develop a checklist to guide discussion and counselling as well as documentation of recommendations for birth.

The essential components of planned vaginal breech birth are:

- Appropriate case selection
- Management according to a strict protocol
- Availability of skilled birth attendants.

Where a vaginal delivery of a breech presentation is planned, appropriate infrastructure must include:

- Continuous electronic fetal heart monitoring in labour.
- Immediate availability of skilled anaesthetic staff, facilities for immediate caesarean section, and paediatric resuscitation.
- Availability of a suitably experienced midwife and obstetrician for all of labour with arrangements in place to manage shift changes and fatigue.

4.5.1 *Contraindications to vaginal breech delivery include:*

- Cord presentation
- Fetal growth restriction (estimated fetal weight < 10th%) or macrosomia (estimated fetal weight > 3.8kg)
- Any presentation other than frank (extended) or complete (flexed) breech
- Hyperextension of fetal neck on ultrasound
- Evidence of antenatal fetal compromise (e.g. abnormal CTG)
- Fetal anomaly incompatible with vaginal delivery.

The role of pelvimetry is unclear. One study has reported that the use of MRI pelvimetry reduced the emergency caesarean section rate.⁽²¹⁾ Further evidence is required to more clearly delineate the role of pelvimetry in breech presentation.⁽⁴⁾

Induction of labour is not recommended. Augmentation of labour should, similarly, be avoided as adequate progress may be the best evidence for adequate fetopelvic proportions. The effect of epidural analgesia on the success of vaginal breech birth is unclear, but it is likely to increase the risk of intervention.

The first stage of labour should be managed according to the same principles as with a cephalic presentation but with continuous electronic fetal monitoring. Where the progress is slow, caesarean section should be considered.

A passive second stage to allow descent of the breech to the perineum is recommended prior to active pushing. If the breech is not visible within 2 hours of the passive second stage, caesarean section should be recommended.⁽⁴⁾

There is limited data in relation to maternal position at delivery and outcome of vaginal breech birth. Comparison of an upright position with historical data with birth occurring in lithotomy position, is favourable with the rate of maternal perineal injuries being lower.⁽²²⁾ Women may choose an all-

fours position but this can present a difficulty when manoeuvres are required.

The choice of manoeuvres used, if required, to assist with delivery of the breech, should depend on the individual experience and preference of the appropriately skilled birth attendant.

Active pushing should not be encouraged until the breech is visible. Traction should be avoided; a 'hands-off' approach is required, but with appropriate and timely intervention if progress is not made once the umbilicus has delivered or if the arms are extended. Tactile stimulation of the fetus may result in reflex extension of the arms or neck and should be minimised. Care must be taken to avoid fetal trauma; the fetus should be grasped around the pelvic girdle (not soft tissues) and the neck should never be hyperextended. Selective rather than routine episiotomy is recommended.

Intervention to expedite breech birth is required if there is evidence of poor fetal condition (lack of fetal tone) or if there is a delay of more than 5 minutes from delivery of the buttocks to the head, or of more than 3 minutes from the umbilicus to the head.

There is little comparative evidence regarding techniques of assisted breech birth. If the back starts to rotate posteriorly, gentle rotation without traction should be used to ensure that it remains anterior. Once the scapula is visible, the arms can be hooked down by inserting a finger in the elbow and flexing the arms across the chest or, if nuchal, Lovset's manoeuvre is advised. Delivery is achieved either with the Mauriceau-Smellie-Veit manoeuvre or with forceps. Suprapubic pressure will aid flexion.

Recommendation 4	Grade
Where there is maternal preference for vaginal birth, the woman should be counselled about the risks and benefits of planned vaginal breech birth in the intended location and clinical situation. The principles of shared decision making should be used during counselling.	Evidence based recommendation (Grade C)
Recommendation 5	Grade
Maternity units that offer vaginal breech birth should develop clear, strict and unambiguous protocols for case selection and management of vaginal breech birth to reduce neonatal morbidity and mortality.	Evidence based recommendation (Grade C)
Recommendation 6	Grade
Planned vaginal breech delivery must take place in a facility where appropriate experience and infrastructure are available, including: <ul style="list-style-type: none"> • Continuous electronic fetal heart monitoring in labour. • Immediate availability of caesarean facilities. • Availability of a suitably experienced obstetrician and midwife to manage the birth, with arrangements in place to manage shift changes and fatigue. 	Consensus based recommendation

4.6 Management of the Breech Presentation that is first diagnosed in labour

Breech presentation may be first diagnosed in labour, without the recommended assessment and counselling having been undertaken. In determining the preferred mode of delivery in this circumstance, the accoucheur should still consider the full clinical picture including contraindications to vaginal breech birth and ideally, intrapartum ultrasound should be performed at diagnosis.

In some cases, the diagnosis of breech presentation will be made near to delivery, especially when a labour is progressing rapidly. This will allow only a very small window for decision-making regarding the mode of delivery. Increased fetal risks of vaginal breech delivery exist where there is a possibility of undiagnosed

congenital abnormalities or undiagnosed hyperextension of the fetal head.

In the situation of first diagnosis of breech in labour, the obstetrician should discuss the options for mode of birth with the woman, explaining the balance of the fetal and maternal risks and benefits for that woman's individual circumstances. The fundamental principles of informed consent and shared decision making should be observed.

All maternity units should undertake regular training for all medical and midwifery staff, including simulation based training, to ensure that staff maintain adequate skills in vaginal breech birth to be able to provide appropriate care when a woman is admitted in advanced labour with breech presentation.

Recommendation 7	Grade
<p>When breech presentation is first recognised in labour, the obstetrician should discuss the options of emergency caesarean section or proceeding with attempted vaginal breech birth with the woman, explaining the respective risks and benefits of each option according to her individual circumstances.</p> <p>Wherever practicable, point-of-care ultrasound should be performed when breech presentation is first diagnosed in labour.</p>	Evidence based recommendation (Grade C)
Recommendation 8	Grade
<p>All maternity units should undertake regular training for all medical and midwifery staff using simulation to ensure that staff maintain adequate skills to be able to provide appropriate care when a woman is admitted in advanced labour with breech presentation.</p>	Consensus based recommendation

4.7 Management of preterm breech

Breech presentation is more common preterm and most preterm deliveries are unplanned (as a result of spontaneous preterm labour). Adequate high-quality evidence for management of preterm breech birth is lacking. ⁽²³⁾ A Cochrane systematic review assessed the effects of planned immediate caesarean section versus planned vaginal breech birth for women presenting in preterm labour with a singleton pregnancy. There were no significant differences between the two groups with respect to immediate outcomes or follow-up in childhood. ⁽²⁴⁾ The mode of delivery should be individualised based on the stage of labour, type of breech presentation, fetal wellbeing and the availability of skilled and experienced staff. The principles of shared decision making should be used when making a decision about mode of delivery.

Labour with a preterm breech should be managed as with a term breech. Birth attendants should be aware of the risk of head entrapment (9.3 per cent of vaginal breech births at 24-27 weeks) and be prepared to manage this complication. Incisions in the cervix (at 2, 6 and 10 o'clock) may be used, with or without tocolysis.

Up to 25 per cent of all preterm births are iatrogenic due to antenatal complications (such as pre-eclampsia or fetal growth restriction). When planned preterm delivery (i.e. when the mother is not in preterm labour) is required for maternal and/or fetal compromise with a viable fetus beyond 25 weeks gestation, in breech presentation, elective caesarean section is recommended.

Caesarean section for preterm breech presentation should be performed by a clinician with appropriate experience and with preparation to manage head entrapment at caesarean section. Extension of the uterine incision to a J shape or inverted T may be utilised.

There is no clear neonatal benefit of birth by caesarean section for breech presentation at 22⁺⁰ to 24⁺⁶ weeks. The evidence that does exist is of limited quality. Neonatal outcome is likely to be determined by factors other than mode of birth at this gestation. As a consequence, caesarean section at these gestations should be an exceptional event that is rarely undertaken.

Recommendation 9	Grade
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When planned preterm delivery is required (i.e. when the mother is not in preterm labour) for maternal and/or fetal compromise with a viable fetus beyond 25 weeks gestation, in breech presentation, elective caesarean section is recommended. This should be performed by a clinician with appropriate experience. Head entrapment should be anticipated and preparations made to manage it, should this occur.	Consensus based recommendation
Recommendation 10	Grade
There is no clear neonatal benefit of birth by caesarean section for breech presentation at 22 ⁺⁰ to 24 ⁺⁶ weeks. The neonatal outcome at these gestations is likely to be determined by factors other than mode of birth. As a consequence, caesarean section at these gestations is not routinely recommended.	Evidence based recommendation (Grade C)

4.8 Management of twin pregnancy with breech presentation

A planned caesarean section is recommended for a twin pregnancy where the presenting twin is breech. ^(25, 26) The mode of delivery for a first breech twin in spontaneous labour should be individualised based on cervical dilatation, station of the presenting part, type of breech presentation, fetal wellbeing and availability of appropriately skilled staff.

Routine caesarean section for breech presentation of the second twin is not recommended in either term or preterm births.

Recommendation 11	Grade
A planned caesarean section is recommended for a twin pregnancy where the presenting twin is breech	Evidence based recommendation- Grade C

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6. Other suggested reading

The Society of Obstetricians and Gynaecologists of Canada (SOGC) Clinical Practice Guideline: Vaginal Delivery of Breech Presentation. June 2009; No. 226: 557-566. Available at: [https://www.jogc.com/article/S1701-2163\(16\)34221-9/pdf](https://www.jogc.com/article/S1701-2163(16)34221-9/pdf)

Updated: The Society of Obstetricians and Gynaecologists of Canada (SOGC) Clinical Practice Guideline: No. 384 Management of Breech Presentation at Term. August 2019;No. 41: 8: 1193-1205. Available at: [https://www.jogc.com/article/S1701-2163\(18\)31040-5/fulltext](https://www.jogc.com/article/S1701-2163(18)31040-5/fulltext)

7. Links to other College statements

Guidelines for use of Rh(D) Immunoglobulin(Anti-D) in obstetrics (C-Obs 6)

[https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Use-of-Rh\(D\)-Isoimmunisation-\(C-Obs-6\).pdf?ext=.pdf](https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Use-of-Rh(D)-Isoimmunisation-(C-Obs-6).pdf?ext=.pdf)

Placenta Accreta (C-Obs 20)

[https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Placenta-Accreta-\(C-Obs-20\)-Review-March-2014,-Amended-November-2015_1.pdf?ext=.pdf](https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Placenta-Accreta-(C-Obs-20)-Review-March-2014,-Amended-November-2015_1.pdf?ext=.pdf)

Timing of elective caesarean section at term (C-Obs 23)

[https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Timing-of-elective-caesarean-section-\(C-Obs-23\)-March18.pdf?ext=.pdf](https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Timing-of-elective-caesarean-section-(C-Obs-23)-March18.pdf?ext=.pdf)

Delivery of the fetus at caesarean section (C-Obs 37)

[https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Workforce%20and%20Practice%20Issues/Delivery-of-fetus-at-caesarean-section-\(C-Obs-37\).pdf?ext=.pdf](https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Workforce%20and%20Practice%20Issues/Delivery-of-fetus-at-caesarean-section-(C-Obs-37).pdf?ext=.pdf)

Birth after previous caesarean section (C-Obs 38)

[https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Birth-after-previous-Caesarean-Section-\(C-Obs-38\)Review-March-2019.pdf?ext=.pdf](https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Birth-after-previous-Caesarean-Section-(C-Obs-38)Review-March-2019.pdf?ext=.pdf)

Consent and the Provision of Information to Patients in Australia regarding Proposed Treatment (C-Gen 02a)

[https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Consent-and-provision-of-information-to-patients-in-Australia-\(C-Gen-2a\).pdf?ext=.pdf](https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20General/Consent-and-provision-of-information-to-patients-in-Australia-(C-Gen-2a).pdf?ext=.pdf)

Evidence-based Medicine, Obstetrics and Gynaecology (C-Gen 15)

https://ranzcof.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-

[%20General/Evidence-based_Medicine_Obstetrics_and_Gynaecology_\(C-Gen-15\)-March-2021.pdf?ext=.pdf](#)

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair and Board Member
Dr Gillian Gibson	Deputy Chair, Gynaecology
Dr Scott White	Deputy Chair, Obstetrics and Subspecialties Representative
Dr Jared Watts	Member and EAC Representative
Dr Kristy Milward	Member and Councillor
Dr Will Milford	Member and Councillor
Dr Frank O'Keeffe	Member and Councillor
Professor Sue Walker	Member
Dr Roy Watson	Member and Councillor
Dr Susan Fleming	Member and Councillor
Dr Sue Belgrave	Member and Councillor
Dr Marilyn Clarke	ATSI Representative
Associate Professor Kirsten Black	Member
Dr Thangeswaran Rudra	Member
Dr Nisha Khot	Member and SIMG Representative
Dr Judith Gardiner	Diplomate Representative
Dr Angela Brown	Midwifery Representative, Australia
Ms Adrienne Priday	Midwifery Representative, New Zealand
Ms Ann Jorgensen	Community Representative
Dr Ashleigh Seiler	Trainee Representative
Dr Leigh Duncan	Maori Representative
Prof Caroline De Costa	Co-opted member (ANZJOG member)
Dr Christine Sammartino	Observer

Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was developed in July 2016 and updated in July 2021. The Women's Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the July 2021 committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii).
- The updated statement was circulated for consultation among Members and recommended to the RANZCOG Board. The Board approved the statement with a recommendation to update consensus-based recommendations where supporting evidence was identified. Three recommendations were updated (Grade C).

ii. *Declaration of interest process and management*

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. *Grading of recommendations*

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women's Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

Recommendation category		Description
Evidence-based	A	Body of evidence can be trusted to guide practice
	B	Body of evidence can be trusted to guide practice in most situations
	C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
	D	The body of evidence is weak and the recommendation must be applied with caution
Consensus-based		Recommendation based on clinical opinion and expertise as insufficient evidence available
Good Practice Note		Practical advice and information based on clinical opinion and expertise

Appendix C Full Disclaimer

Purpose

This Statement has been developed to provide general advice to practitioners about women's health issues concerning Management of breech presentation at term and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any person with a breech presentation. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual person with a breech presentation at term and the particular circumstances of each case.

Quality of information

The information available in management of breech presentation at term is intended as a guide and provided for information purposes only. The information is based on the Australian/New Zealand context using the best available evidence and information at the time of preparation. While the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) had endeavoured to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available. The use of this information is entirely at your own risk and responsibility.

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