BREECH PRESENTATION AT TERM

Week 66

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Reading Assignment:
ACOG Committee Opinion # 745
Mode of Term Singleton Breech Delivery

Watch ECV Video
https://youtu.be/0y1MrMjtWKo
LEARNING OBJECTIVES

• To review risk factors for fetal malpresentation

• To be able to diagnose breech presentation

• To feel comfortable counseling patients on management options for the breech fetus at term
CASE VIGNETTE

• Ms. F.M. is a 28 y.o. G3 P2002 woman at 36 weeks EGA who presents to your office for routine PNC.

  • She reports her last pregnancy resulted in a cesarean delivery due to fetal malpresentation.

  • She would like to know if the same thing will happen during this pregnancy?
FOCUSED HISTORY

What elements of this patient’s history are most relevant?

- **OBHx:** FT NSVD x 1, FT C/S x 1 for fetal malpresentation
- **GYNHx:** Reports history of fibroids. Denies ovarian cysts, abnormal paps.
- **PMHx:** Denies
- **PSHx:** Cesarean delivery 3 years ago
- **MEDS:** PNV
- **ALL:** NKDA
- **SocHx:** Denies use of tobacco, ETOH, illicit drugs
What elements of the patient’s physical exam are most important?

- **Vitals:** T37°C, BP 128/84, HR 82, RR 18
- **Abdominal exam:** Gravid, soft, nontender
- **Leopold maneuvers:** Palpation of a hard, round, mobile structure at the abdomen superior to the pubic bone
- **Cervical exam:** L/C/P, unable to palpate a presenting part
- **Fetal assessment:** FH 36cm, FHR 140bpm
BACKGROUND

- Breech presentation refers to the fetus in the longitudinal lie with the buttocks or lower extremities entering the pelvis first

- **What are the 3 types of breech presentation?**
  - Frank breech
  - Complete breech
  - Incomplete breech
ETIOLOGY/PATHOPHYSIOLOGY

• What clinical conditions are associated with breech presentation?
  • Prematurity
  • Multiple gestations
  • Aneuploidies
  • Congenital anomalies
  • Mullerian anomalies
  • Uterine leiomyoma
  • Placentation (placenta previa, etc.)
  • Hydramnios
  • Laxity of the maternal abdominal wall

Clinical conditions associated with breech presentation include:
  • Those that may increase or decrease fetal motility
  • Those that may affect the vertical polarity of the uterine cavity
EPIDEMIOLOGY

• The percentage of breech presentations increases with decreasing gestational age:
  • Term pregnancies: 3 – 4 %
  • 32 weeks: 7%
  • ≤ 28 weeks: 25%

• What is the recurrence rate for the second pregnancy following one breech delivery?
  • ~ 10%

• What is the recurrence rate for the third pregnancy following two breech deliveries?
  • 27%

Prior cesarean delivery can increase the incidence of breech presentation two-fold!
EVALUATION

• **Physical exam:**
  • Leopold maneuvers
  • Cervical exam

• **Ultrasonography**
  • Fetal lie and presenting part should be visualized and documented
  • If breech presentation is diagnosed additional information is needed:
    • Specific type of breech
    • Degree of flexion of the fetal head
    • EFW
    • AFI
    • Placental location
    • Fetal anatomy review (if not done previously)

Fetal presentation should be assessed and documented at 36 0/7 weeks of gestation to allow for external cephalic version to be offered.
You determine that Ms. F.M.’s fetus is in a complete breech presentation. How will you counsel her regarding her options for labor and delivery?

- The decision regarding the mode of delivery should be based on a shared decision making model, including the patient’s wishes and the experience of the obstetrician.
- External cephalic version is an alternative to planned cesarean delivery in the women with a term, singleton breech fetus, desiring a planned vaginal delivery of a vertex-presenting fetus and has no contraindications.
- Planned vaginal delivery of a term singleton may be reasonable under hospital-specific protocol guidelines.
• The trend in the US is to perform cesarean delivery for term, singleton fetuses in a breech presentation
  • In 2002, the rate of cesarean deliveries for women in labor with breech presentation was 86.9%

• The number of practitioners with the skills and experience to perform vaginal breech delivery has decreased.

• In 2000, a large, international, multicenter randomized clinical trial comparing a policy of planned cesarean delivery with planned vaginal delivery was conducted (Term Breech Trial).
  • Perinatal mortality, neonatal mortality and serious neonatal morbidity were significantly lower among the planned C/D group compared with the planned vaginal delivery group.
  • There was no difference in maternal morbidity or mortality observed.
MANAGEMENT – VAGINAL BREECH DELIVERY

• After the Term Breech Trial, in 2001, ACOG recommended that planned vaginal delivery of a term singleton breech was no longer appropriate.

• However, after additional publications, ACOG now states that “Planned vaginal delivery may be reasonable under hospital-specific protocol guidelines for both eligibility and labor management.”

• If a vaginal breech delivery is planned, a detailed informed consent should be documented, including risk that perinatal or neonatal mortality or short-term serious neonatal morbidity may be higher than if a cesarean delivery is planned.
MANAGEMENT – EXTERNAL CEPHALIC VERSION

• ECV should be offered as an alternative to planned cesarean for a woman who has a term, singleton breech fetus, desires a planned vaginal delivery of a vertex-presenting fetus, and has no contraindications.
  • ECV has been shown to decrease C/D rates by 43% with no difference in maternal or fetal complications.

• Which patients are candidates for ECV?
  • EGA of 37+0
  • Prior uterine scar ok
  • No contraindications to vaginal delivery
MANAGEMENT – EXTERNAL CEPHALIC VERSION

• What are the benefits of ECV?
  • Increased probability the fetus will be in a vertex presentation for delivery
  • Fewer cesarean births among women with a successful ECV vs not attempted ECV
  • Women with a successful ECV: lower hospital charges, reduced total LOS, lower odds of developing endometritis, sepsis and LOS > 7 days.

• What are the risks of ECV?
  • Placental abruption, umbilical cord prolapse, ROM, stillbirth, fetomaternal hemorrhage
    • All above stated risk ≤ 1%

• What are the success rates for ECV and what factors are predictive of success or failure?
  • Success rates vary widely: 16% - 100% with a pooled success rate of 58% and pooled complication rate of 6.1%.
  • Factors associated with success: unengaged breech, parity, increased AF, nonfrank breech presentation, EGA < 38 weeks, posterior placenta
  • Factors associated with failure: nulliparity, advanced dilatation, EFW < 2.5kg, anterior placenta, low station
ECV should be attempted only in settings in which cesarean delivery services are readily available!
MANAGEMENT – CESAREAN DELIVERY

• If a patient declines ECV, a cesarean delivery should be scheduled for 39 weeks EGA.
• R/B/A of cesarean delivery should be explained in detail during the counseling.
SOCIAL DETERMINANTS OF HEALTH

Disparities in the Success Rates of ECV Among Different Maternal Racial/Ethnic Groups

- Non-Hispanic White women have the lowest ECV success rate at 50%
- Non-Hispanic Black women have the highest ECV success rate at 66%
- An estimated 20 – 30% of eligible women are not being offered ECV, however the race/ethnicity breakdown of women who are offered or accept ECV has not been studied

Further investigation is needed to understand the underlying causes for this disparity!

**EPIC .PHRASE**

**.BBonBreechAtTerm**

Description: Counseling for mode of delivery for patients with breech at term

The patient was counseled on the position of the fetus. The fetus was noted to be in ***complete/incomplete/frank breech presentation. It was explained to the patient that the decision regarding the mode of delivery should be based on a shared decision making model, including the patient’s wishes and the experience of the obstetrician. External cephalic version is an alternative to planned cesarean delivery in women with a term, singleton breech fetus, desiring a planned vaginal delivery of a vertex-presenting fetus with no contraindications. The R/B/A of ECV were explained to the patient in detail. A planned vaginal delivery of a term singleton may be reasonable under hospital-specific protocol guidelines.

The patient opted for ***ECV vs planned cesarean delivery. Instructions were given to the patient regarding timing of the procedure, preop testing and what to expect after.
CODING AND BILLING

• Diagnostic Codes (ICD-10)
  • 032.1 Maternal care for breech presentation (complete or frank)
  • 032.8 Footling presentation or incomplete breech presentation
## CODING AND BILLING – NEW PATIENT

<table>
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<tr>
<th>HISTORY</th>
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<th>MEDICAL DIAGNOSIS MAKING</th>
<th>CODE</th>
<th>APPLICABLE GUIDELINES</th>
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| Problem focused:  
  - Chief complaint  
  - HPI (1-3)  
  - ROS (1-3) | Problem focused:  
  - 1 body system | Straight forward:  
  - Diagnosis: minimal  
  - Data: minimal  
  - Risk: minimal | 99201 | - Personally provided  
- Primary care exception  
- Physicians at teaching hospitals |
| Expanded problem focused:  
  - Chief complaint  
  - HPI (1-3)  
  - ROS (1-3) | Expanded problem focused:  
  - Affected areas and others | Straight forward:  
  - Diagnosis: minimal  
  - Data: minimal  
  - Risk: minimal | 99202 | - Personally provided  
- Primary care exception  
- Physicians at teaching hospitals |
| Comprehensive  
  - Chief complaint  
  - HPI (4)  
  - ROS (2-9)  
  - Past, family, social history (1) | Detailed:  
  - 7 systems | Low:  
  - Diagnosis: limited  
  - Data: limited  
  - Risk: low | 99203 | - Personally provided  
- Primary care exception  
- Physicians at teaching hospitals |
| Comprehensive  
  - Chief complaint  
  - HPI (4+)  
  - ROS (10+)  
  - Past, family, social history (3) | Comprehensive:  
  - 8 or more systems | Moderate:  
  - Diagnosis: multiple  
  - Data: moderate  
  - Risk: moderate | 99204 | - Personally provided  
- Physicians at teaching hospitals |
| Comprehensive  
  - Chief complaint  
  - HPI (4+)  
  - ROS (10+)  
  - Past, family, social history (3) | Comprehensive:  
  - 8 or more systems | High:  
  - Diagnosis: extended  
  - Data: extended  
  - Risk: high | 99205 | - Personally provided  
- Physicians at teaching hospitals |
# CODING AND BILLING – ESTABLISHED PATIENT

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EVIDENCE

• References