SCENARIO

Premature Vaginal Breech Delivery

LEARNING OBJECTIVES

Identification of breech presentation
Counsel mother on options for delivery of breech presentation
Be aware of unfavourable features that increase the risk of vaginal delivery
Appropriate communication with team – SBAR
Knowledge and use of manoeuvres to deliver vaginal breech
Avoidance of inappropriate manipulation of baby
Management of complications;
- -fetal distress
- -slow progress
- -head entrapment

EQUIPMENT LIST

Mannequin Noelle/SimMom/PROMPT Pelvis	Delivery Pack
Suturing Pack	Forceps (NBF/Keillands)
Baby	CTG/Monitoring

PERSONNEL	FACULTY
MINIMUM: 2	MINIMUM: 1
Trainee	Facilitator
Midwife	
Paediatrician	
Partner	

TIME REQUIRMENTS
TOTAL 40 minutes

Set up:	5 mins	Simulation:	15mins
Pre Brief:	5 mins	Debrief:	15mins

INFORMATION TO CANDIDATE

PATIENT DETAILS

Name: Anne Jinbes
Age: 25
Weight/BMI: 29
Gestation: 30 weeks

Phx: Asthma PRN Salbutamol
Allergies: Nil
G2P1 Prev SVD

SCENARIO BACKGROUND

Location: Triage/Labour Ward

Situation:
Anne presents to triage with history of threatened preterm labour. She has experienced regular painful contractions and watery discharge from 0500hrs. Midwife could see copious clear liquor and as the patient was very distressed she performed a vaginal examination. Anne is 8cm dilated and a possible breech presentation.

CTG: cont 4:10, 125 bpm, variability 8, no decelerations no accelerations

Task: Please review and mange Mrs Jinbes

RCOG CURRICULUM MAPPING

Module 10: Management of Labour
Management of the breech in labour
Module 11: Management of Delivery
Recognise undiagnosed breech
Vaginal breech delivery

INFORMATION FOR ROLEPLAYERS

BACKGROUND

Your name is Anne Jinbes. You are 25 years old this is your second pregnancy. Your first pregnancy was very straightforward with no problems. You had a normal delivery. This pregnancy has been uncomplicated. You are usually well with mild asthma that only requires occasional inhaler use. You smoke 5 cigarettes a day. Your BMI is 29.

You have attended labour ward today at 30 weeks, you think you might be in labour as you started to have regular painful contractions and leaking water from 0500hrs.
The midwife examines you and finds that you are 9cm dilated- you are shocked and very concerned. The midwife then says she thinks the baby might be breech. You aren't really sure what that means. She leaves quickly to get the doctor.

QUESTIONS

Can this be dangerous for my baby?
Can we stop the labour it's too early?
I am very scared is it safe to have a normal delivery?
Can I have a section?

FACILITATOR- SCENARIO DIRECTION

Candidate introduces self to patient/partner
Takes brief history- focus to elicit any unfavourable features for vaginal breech
Assessment-
Abdominal: Longitudinal, engaged breech
Vaginal: Anterior Rim, palpable, fetal anus, sacrum anterior and presenting part at spines.
Communicates findings with patient/midwife, coordinator, anaesthetics, consultant and Special Care baby unit.
USS: Findings breech
CTG: Contractions 4:10 130bpm variability 10, reassuring variable decelerations <50% contractions
Counsel patient on mode of delivery- difficult: premature traumatic section at this advanced stage vs vaginal breech- consultant involvement
Position patient – depends on experience of clinician and preference of patient (*RCOG 2017*)
IVC/FBC/G&S- Discuss Epidural
Request presence of paediatricians, consultant oncall, coordinator, neonatal special care team

FACILITATOR- SCENARIO DIRECTION
(cont.)

30mins later breech visible on perineum

Remain hands off breech unless rotating sacro-posterior
CTG Contractions 4:10 135bpm variability 7 variable decelerations <50% contractions
Next contraction umbilicus visible – legs not spontaneously delivered, place finger in popliteal fossa to flex knee and deliver legs
Scapula visible –Arms not delivering – diagnose Nuchal Arm- loveset manoeuvre, ensuring any manipulation of baby is with hands on bony prominences of pelvis not soft tissue of abdomen.
Attempt to deliver head with Mauriceau Smellie Veit/ Burns-Marshall- not delivered
Attempt to deliver with forceps- head not delivering
Recognise head entrapment- communicate this to team and declare emergency
Catheterise bladder
McRoberts Position
Consider/discuss:
GTN Inhaler /terbutaline SC
Cervical (Duhrssen) incisions (2/10 O'Clock) => Massive PPH
(*Fetal survival unlikely with following)*
Symphysiotomy => insert metal urethral catheter, scalpel to dissect anterior fibres of pubic symphisis, support pelvis, orthopaedic advice
Caesarean Section with Zavanelli Manoeuvre => high risk of severe infant hypoxia and mortality

Complete 3rd stage

Patient/Team Debrief

SCENARIO DEBRIEF

TOPICS TO DISCUSS

Evidence used to counsel women with breech presentation
Premature breech mode of delivery
Advantages/disadvantages of epidural Anaesthesia
Optimal position for women Supine/ All Fours
Recognising features of delay or obstructed labour
Management of the after coming head
Management of head entrapment

REFERENCES

Green Top Guideline Management of Breech Presentation No. 20b RCOG 2017

Health Education England

Health Education England

Developing people for health and healthcare