No place like home

Breech home birth is unusual enough – especially if the woman cannot progress during labour while being watched by her chosen midwife! **Valerie Gommon** reports

The aim of this article is to share my observations on the progress of an unusual and yet "normal" labour and birth. The labour was unusual for two reasons: firstly, the baby was in a breech position; and secondly, the client was unable to labour while being observed. Had the birth been within a hospital environment the outcome may well have been very different.

My client, whom I shall call Esther, booked her maternity care with me when she was 34 weeks pregnant, having recently moved into my practice area. Esther had not felt confident with her previous NHS care; this, alongside the uncertainty of moving to a new area, led her and her partner to decide that they wanted a known midwife at their planned homebirth and to book my services as an independent midwife.

Breech detected

At 38 weeks' gestation, it was detected that the baby was in fact in a breech position. Esther was obviously concerned by this but was keen to proceed with her plans for a homebirth. As her midwife I gave her information to facilitate her decision making. I provided the couple with a selection of articles and web references regarding breech birth and lent them copies of *Breech Birth Womanwise* (Banks 2004), *Breech Birth* (Waites 2003) and *Breech Birth: What are my Options?* (Evans 2005). I suggested that the usual course of advice would be referral to an obstetrician who would probably suggest external cephalic version (ECV) and, if this were unsuccessful, encourage an elective caesarean in view of the RCOG guidelines (RCOG 2001).

We explored "natural" options of trying to turn a breech baby – for example lying with the bottom raised, acupuncture, reflexology, handstands in the swimming pool and ECV. Esther tried some of these, but felt strongly that her baby was unable to turn.

After consideration she decided to try an ECV. However, despite the RCOG and NICE guidelines stating that "all women with an uncomplicated breech pregnancy at term should be offered ECV" (NICE 2004, RCOG 1993), I found it very difficult to arrange an ECV (I tried five hospitals). Eventually I found a willing obstetrician, and this was arranged for the following day at 38+2 weeks' gestation.

The obstetrician was very sympathetic and kind, and attempted a gentle, but usuccessful, ECV. The baby had one leg flexed and the other extended; the obstetrician suggested that the extended leg made ECV more difficult and concurred with Esther's feeling that her baby could not turn. At this stage Esther said that she would either continue with an attempted home breech birth or have an elective caesarean. The obstetrician was extremely non-judgemental and explained again the RCOG guidelines – which suggested caesarean to be the preferred mode of delivery – but also conceded that he had considerable experience of breech birth and that most babies will be born successfully if the labour progresses well.

Careful planning

The couple were left to consider their options. I put in place a plan of care to have midwives experienced in breech birth to attend with me should Esther decide to labour at home. I also discussed the case with my named supervisor of midwives (SOM) and also an SOM at the local hospital to forewarn them that I might need an urgent transfer to hospital.

I visited as planned at 39+1 and Esther was feeling relaxed about her decision to labour and birth at home. We discussed the fact that breech babies are more likely to need resuscitation, and the possibility of having an ambulance on standby if there were any concerns. We also discussed that I would recommend transfer to hospital if there were any concerns that labour was not progressing well. I indicated that I would be likely to recommend transfer earlier than I would with a cephalic baby. We also discussed when she should call me and what to do if there should be a cord prolapse early in labour (although the bottom appeared well engaged into the pelvis at this time, reassuring me that this was unlikely).

> When I was not present, the couple informed me, Esther would contract regularly and strongly. When I was with her, however, the contractions stopped

I arranged a joint visit with my second midwife who is very experienced in breech birth. Together we went through the mechanisms of breech birth with the aid of a doll, pelvis and slides. Clinically all was well with the pregnancy and we all agreed that we were happy to await labour.

Labour begins

At T+12 I had a call from the couple informing me that labour had started, and at 0515 I arrived at their home. During the first stage of labour Esther had an acute reaction to having anyone other than her partner present or "watching" her. When I was not present, they informed me, that she would contract regularly and strongly; when I was with her, however, the contractions stopped. Initially I thought that she was in the latent phase of labour and I dealt with this by going upstairs to sleep; every hour or so, I performed maternal and fetal observations and found no deviation from normal. Membranes ruptured at 0700 and liquor was mostly clear, with just small "blobs" of meconium (as would be expected with a breech baby). Esther continued to contract well in my absence, but not at all when I was present. I spent the morning going for a walk, having lunch at a nearby pub and intermittently checking back on progress. Esther appeared calm and well,

showing few signs of being in labour. Her inability to labour while "being watched" strongly corresponds with Michel Odent's (and others) observation that we need to give priority to the woman's need for privacy in order to enable her labour (Odent 2003).

By 1530, when Esther decided that she wanted to get into the pool, I took this as a good sign that labour was progressing. She still appeared very calm and did not really look as if she were in labour.

At 1810 I had asked for permission to perform a vaginal examination – the first and only one – because I was unsure what was happening. (I very often do not need to perform vaginal examinations as there are so many other cues as to what is happening, such as the purple line, vulval bulging, anal dilation, breathing and vocalisation.) Esther was happy to be examined, and I found that her cervix was 9cm dilated, baby in LSA (left sacro anterior) position, at the spines – all was well and progressing.

At 1930 Esther decided to call both her mother and mother-in-law. She had very relaxed conversations with both, informing them that we expected that the baby would be born soon! She showed no signs of moving into the second stage; however, I felt that it was time to call my second midwife.

Birth

By 2030 Esther was actively pushing. At 2115 the breech was just visible, fetal heart was within normal limits and Esther was in good condition, contractions were good and expulsive. At 2125 the buttocks were advancing well, appeared well perfused and the baby was passing meconium and urine.

The buttocks advanced quickly at 2130 and "rumped" in LSA position. The baby's right leg was flexed and birthed first, followed by the left extended leg. The baby girl was descending easily and the arms spontaneously birthed; we observed a full and pulsating cord and the heartbeat was visible at the chest, >100 beats per minute. We noticed that the baby did not flex its arms or legs as we anticipated (a sign of a healthy baby with good tone); however, as all other observations were within normal limits, we were not unduly concerned.

At 2132 the chin spontaneously came down and the baby was born without recourse to any manoeuvres.

> I feel sure that, since Esther was unable to labour in the presence of a midwife whom she knew, she almost certainly would not have been able to labour and birth in a hospital environment

Apgars were 6/1, 10/5, and no resuscitation was required.

Postnatal challenges

There is another interesting twist to this story. The baby was extremely reluctant to breastfeed; indeed, I would go as far as to say that she *did not* make attempts to breastfeed. She was quite unsettled and agitated and it was really difficult to work out what was going on as she showed no signs of being unwell.

I suggested that the parents take their baby daughter to a cranio-sacral therapist. This they did –three times) After the first visit, the baby was uncurled, a completely different shape and more settled. However, she continued to refuse the breast for two difficult weeks, during which time the mother gave expressed breast milk via a cup. Eventually, after two days skin-to-skin in bed, taking all pressure off the baby (ie, not attempting to feed her) and a final visit to the cranio-sacral osteopath, the baby began to breastfeed.

It was a stressful time. Anecdotally I have heard that breech babies can sometimes find it difficult to feed; I can only conclude that she was in some way uncomfortable and that the cranio-sacral therapy released something. Esther, however, feels that her baby simply wasn't ready to feed straight after birth, but needed time to settle first – that her daughter became stressed and thus rejected the breast. When the pressure of feeding was removed, her baby chose to feed.

At a month postnatally, I discharged mother and baby, successfully breastfeeding and feeling very pleased with themselves.

Conclusion

This was a positive and joyous, yet unusual, labour and birth. I feel sure that, since Esther was unable to labour in the presence of a midwife whom she knew, she almost certainly would not have been able to labour and birth in a hospital environment. A lesson for us all, perhaps? **TPM**

Valerie Gommon is an independent midwife in Milton Keynes.
www.3shiresmidwife.co.uk

Acknowledgements

Thanks to Jane Evans, second midwife, for much support, help and guidance, and Ann Davison, La Leche League breastfeeding counsellor.

REFERENCES

Banks M (1998). *Breech Birth Woman-Wise*, New Zealand: Birthspirit Books.

Evans J (2005). *Breech Birth: What are my Options?* AIMS.

NICE (2004). *Caesarean Section: Clinical Guideline 13*, London: NICE.

Odent M (2003). *Birth and Breastfeeding: Rediscovering the Needs of Women During Pregnancy and Childbirth*, London: Clairview Books.

RCOG (1993). *The Effective Procedures in Obstetrics Suitable for Audit*, Manchester: RCOG Audit Unit.

RCOG (2001). *The Management of Breech Presentation*, London: RCOG.

Waites B (2003). *Breech Birth*, London: Free Association Books.

USEFUL WEBSITES

Campaign for Normal Birth (Royal College of Midwives) Normal breech birth: www.rcmnormalbirth.net/default.asp?sID=1099658440484

Association of Radical Midwives
Midwifery skills needed for breech birth: www.radmid.demon.co.uk/skills.htm
Commentary on the term breech trial: http://www.radmid.demon.co.uk/breechbanks.htm