Head over heels: what you can do when your baby's breech?
Mothering Magazine
Elaine Stillerman

When a pregnant woman is told that her baby is breech, it causes a myriad of reactions. First are feelings of concern and stress over this upsetting news, coupled with the fear of an inevitable cesarean section. Fret not. There are a number of noninvasive ways to turn the baby.

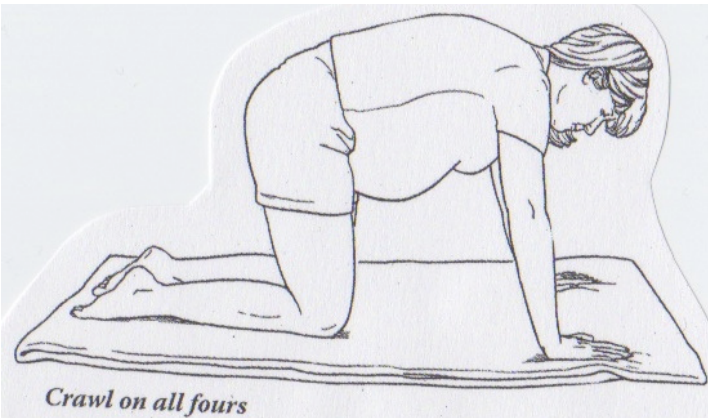
Any presentation other than vertex (headfirst) is considered breech. In a frank breech, the most common type, the buttocks are first, with the legs fully extended, straight up. A footling refers to one of both feet first, while in a complete breech the fetus is crossed-legged, bottom first. About 4 percent of fetuses are born in a complete breech, some vaginally, others by C-section (Bolane 1999). Another type of breech is kneeling, or knees first.

A reexamination of the statistics shows that it's fair to say that most women who are told that their fetuses are breech will have babies born in the vertex position. For those few whose babies are still breech, there is manual version, also called external cephalic version. (A version is a turning of a breech presentation by hand to a more favorable birthing position.) This viable alternative to breech is performed by a doctor or midwife. Success rates vary, according to the reports. Savona-Ventura (1986) reported success rates from 8 to 97 percent, while other studies showed an average success rate of 70 percent (Stine et al., 1985; Ferguson et al., 1987). Prior to the version, an ultrasound is performed to confirm the breech presentation and to assess the site of placental attachment. A non-stress test may also be performed to make sure the fetus is in good health. This test indicates how the fetal heart rate responds when the fetus moves.

Women are given tocolytic drugs (which slow or prevent the onset of labor), such as terbutaline, to relax the uterus and minimize preterm labor contractions. The ultrasound is used throughout the procedure to monitor fetal heart rate and to confirm fetal position. The midwife or doctor then presses and pushes the fetus, trying to turn the baby into the vertex position. This can be very uncomfortable for some women. The procedure is stopped immediately if there are any signs of fetal distress.

Here are some noninvasive suggestions you might try if your baby is still breech or occiput posterior at 36 or 37 weeks:

1. Crawl on all fours. This allows gravity to bring the baby's head down. It also provides room for an occiput-posterior baby to turn.


Crawl on all fours

2. Climb stairs. This can help turn an occiput-posterior fetus by widening the pelvic outlet.

3. Rock your pelvis. This is particularly effective when used in conjunction with crawling. Get on your hands and knees, keeping your wrists and feet in neutral positions. In order to avoid wrist pain and/or calf cramps, make two fists and lean on your knuckles. with your weight mostly on your

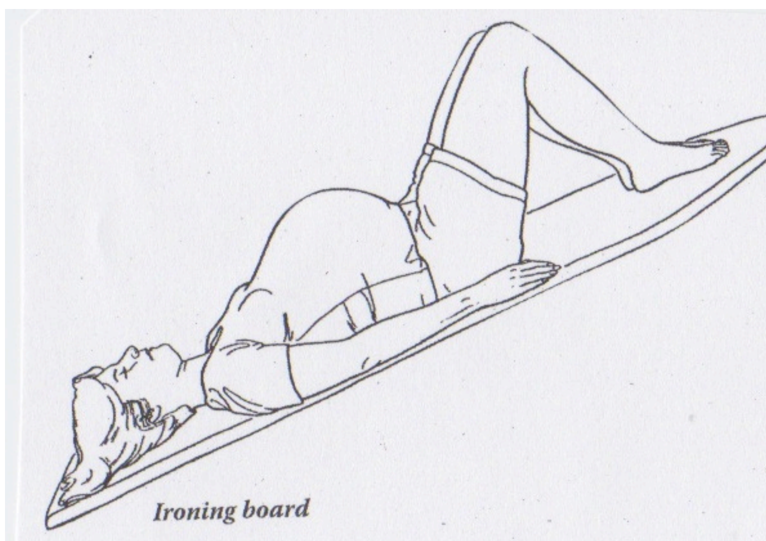
knees, flex your feet so you are gently resting on your toes. Pull your belly toward your spine. On an inhalation, arch your back. Your belly remains pulled in toward your spine. Exhale and slowly return to a relaxed spine. Do this three times a day, for a count of 10 each time.

Gentle lateral lunges

4. Gentle lateral lunges can widen the pelvic outlet and help an occiput-posterior fetus to turn.

5. Breech tilt. Raise your hips about a foot above a firm surface and tuck pillows under your hips. Concentrate on relaxing all your muscles, particularly your abdomen. This should be done three times daily, for 10 to 15 minutes each time, on an empty stomach.

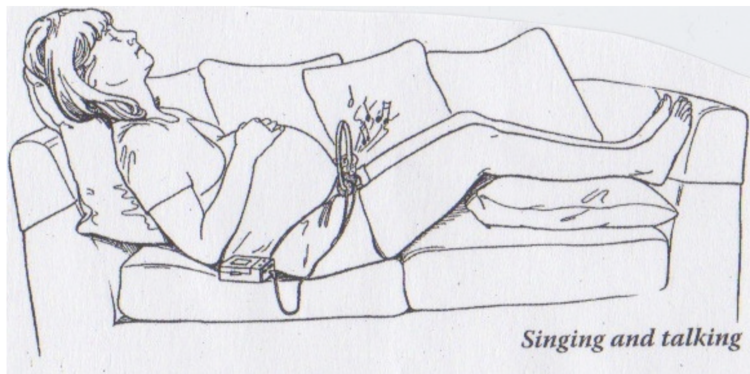
Breech (or pelvic) tilt


Ironing board

6. Ironing board. Place an ironing board of wide, slanted plank on a secure surface at a 45-degree angle. Lie on the board head-down, with your knees bent. Do this for 15 minutes, three times a day. The breech tilt and ironing board exercises work on the same principle: When you place your head lower than your hips, gravity encourages the fetus to move toward the fundus (top) of the uterus, flex his or her chin, and turn under. The fetus slowly rotates, first into the transverse position and then, finally, the vertex.

7. Warmth and cold. Place an ice pack on the top of your uterus and a warm pack at the bottom of your uterus. The fetus will move toward the heat.

Warmth and cold


Singing and talking

8. Singing and talking. Make a tape of your own voice talking or singing to the baby. Play this tape back through earphones and place the earphones near your pubic bone so the baby can hear your voice. The principle is that fetuses hear well and will gradually move toward the pleasant sounds.

9. Visualizations. To add mental power to the mix while performing any of the above procedures, visualize the fetus turning in your uterus.

10. Moxibustion. Stimulating with moxibustion (mugwort, or Artemisia vulguris) the acupuncture point Bladder 67, found on the outside of the nails of both little toes, has proven very effective in turning a fetus. If you don't have access to an acupuncturist who does moxibustion, you can have your partner press on both Bladder 67 points, hold for a count of 6 to l0, and repeat 6 to 10 times. Warning: These points must not be stimulated before 37 weeks, and then only if the baby is still breech. (See sidebar, page 63.)

11. Bodywork. Some bodywork techniques have been very effective in turning breech presentation. Find a practitioner who does myofascial release or cranio-sacral therapy. Sacral-occipital blocking is done by a chiropractor or osteopath and helps realign and balance the pelvis. The theory behind these gentle techniques is that certain myofascial restrictions make it difficult of impossible for a fetus to turn far enough to get into vertex position. By removing these restrictions and aligning the pelvis, the fetus has room to turn.

BIBLIOGRAPHY

Bilodeau. R., and R. Marier. "Breech Presentation at Term." Am Journal Obstet Gynecol 130, no. 5 (1 March 1978): 555-557.

Bolane, Jamie Eloise, BFA. With Child. Waco, TX: Childbirth Graphics, 1995

Cox, Janice P. "Delivery Alternatives in the Term Breech Pregnancy." ICEA Review 12, no. 4 (1988): 1-9

Ferguson, J. M., et al. "Maternal and Fetal Factors Affecting Success of Antepartum External Cephalic Version." Obstet Gynecol 70, no. 5 (1987): 722-725.

Savona-Ventura, C. "The Role of External Cephalic Version in Modern Obstetrics." Obstet Gynecol Survey 41. no. 7 (July 1986): 393-400.

Simkin, Penny, P. T. "Turning Breech to Vertex," ICEA tear sheet, 1987. From article by Marianne Borup Weston in Maternal Health News 8, no. 3 (October 1983), Vancouver, BC, Canada.

Simkin, Penny, P. T., et al. Pregnancy, Childbirth, and the Newborn, revised ed. New York: Meadowbrook Press, 2001.

Stine, L. E., et al, "Update on External Cephalic Version Performed at Term." Obstet Gynecol 65, no. 5 (1985): 642-646.

Elaine Stillerman, LMT, a New York State licensed massage therapist since 1978, has been working with pregnant women since 1980. She is the author of MotherMassage: A Handbook for Relieving the Discomforts of Pregnancy (Dell, 1992), The Encyclopedia of Bodywork (Facts on File, 1996), and numerous articles. She is the developer and instructor of the professional certification course "MotherMassage: Massage During Pregnancy." She can be reached at www.MotherMassage.net.