**Antepartum External Cephalic Version of Breech Presentation**

**Confirmation of indication**
- Breech or transverse lie
- Pregnancy of 36 weeks or more
- Ultrasound examination

**Actions prior to procedure**
- Perform fetal assessment study
- Ensure capability for immediate cesarean delivery
- Determine Rh status
- Receive informed consent

*Existing evidence may not support routine use of a tocolytic agent in multiparous patients. A tocolytic could improve success in primiparous patients.*

**Actions during and/or following procedure**
- Monitor fetal heart rate
- Monitor procedure with ultrasound
- Administer Rh immunoglobulin if indicated

**Actions prior to discharge**
- Observe patient for at least one hour for pain, bleeding or labor
- Confirm normal fetal heart rate

**Contraindications**
- Compromised fetus
- Placenta previa
- Multiple gestation
- Uterine malformation
- Major fetal anomaly
- Uteroplacental insufficiency
- Significant third trimester bleed
- Suspected intrauterine growth restriction
- Amniotic fluid abnormalities
- Maternal cardiac disease
- Pregnancy-induced hypertension
- Uncontrolled hypertension
- Non-reassuring fetal heart rate pattern

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**Cesarean Delivery for Non-reassuring Fetal Status**

**Confirmation of indication**
- Presence of one or more of the following:
  - Recurrent late decelerations, or severe or prolonged variable decelerations
  - Sinusoidal pattern
  - Prolonged bradycardia

**Actions prior to procedure**
- All of the following actions must be performed:
  - Reposition patient
  - Administer oxygen to mother
  - Discontinue uterine stimulants and attempt to correct uterine hyperstimulation, if present
  - Perform vaginal examination
  - Check maternal vital signs
  - Correct maternal hypotension associated with regional anesthesia, if present
Cesarean Section

Confirmation of Indication:
- Absence of cervical dilatation after at least 2 hours of active phase of labor or no descent of presenting part for at least 1 hour during the second stage of labor with the patient in active labor
- Active labor is defined by the presence of all of the following:
  - Cervix dilated to at least 3 cm. in nullipara or 4 cm. in multipara
  - Adequate frequency and intensity of uterine activity

Actions performed prior to procedure:
- Determination of ruptured membranes
- Oxytocin infusion for inadequate contractions when progressive cervical dilatation or descent of presenting part fails to occur in the active phase of labor
- Anesthesia consultation and evaluation
- Fetal heart rate monitored before preparation of abdomen
- Qualified personnel in attendance for resuscitation and care of newborn
- Vaginal examination before surgery to confirm failure to progress

Confirmation of Indication:
- Lack of progress in labor
- Failure of descent of the presenting part
- Footling, complete or incomplete breech
- Premature pregnancy with the presenting part being a breech
- Pelvic size less than optimal for vaginal breech delivery
- Primiparous breech at term with unengaged presenting part and/or an unripe cervix

Vaginal birth may be considered when the following is present:
- Appropriate size fetus (optimal weight less than 4 kg) at term
- A frank breech presentation
- Adequate pelvis
- A physician experienced in vaginal breech delivery
- A progressive spontaneous labor with adequate progress in dilatation, effacement, and descent
- Exclusion of hyperextension of fetal head and macrocephaly
- Anesthesia personnel present for delivery
- Facility capable of emergency cesarean delivery

Repeat Cesarean Delivery

Confirmation of indication:
- Previous uterine scar and, after appropriate counseling, patient declines attempt at vaginal birth
- Contraindication to attempt at vaginal birth
  - Contracted pelvis
  - Previous classical or T-shaped incision or other transfundal uterine incision
  - Inability to perform emergency cesarean delivery because of unavailability of surgeon, anesthesia, sufficient staff, or facility
- Obstetrical or medical contraindication to vaginal delivery (i.e., central placental previa, active genital herpes, invasive cervical cancer, some cases of twin gestation and multiple gestations greater than twins)

Actions prior to procedure:
- Anesthesia consultation
- Documentation of fetal pulmonary maturity by:
  - Fetal heart tones for 20 weeks by nonelectric fetoscope or for 30 weeks by Doppler
  - Serum or urine hCG positive by reliable laboratory at least 36 weeks previously
  - Ultrasound measurement before 20 weeks confirming gestational age of greater than or equal to 39 weeks
  - Amniocentesis that demonstrates fetal lung maturity
  - Monitor fetal heart rate (by electronic fetal monitoring or auscultation) immediately prior to preparation of abdomen
- Request that qualified personnel be in attendance for resuscitation and care of newborn
- Documentation of indication for cesarean delivery

Actions prior to procedure:
- Anesthesia consultation
- Documentation of fetal pulmonary maturity by:
  - Fetal heart tones for 20 weeks by nonelectric fetoscope or for 30 weeks by Doppler
  - Serum or urine hCG positive by reliable laboratory at least 36 weeks previously
  - Ultrasound measurement before 20 weeks confirming gestational age of greater than or equal to 39 weeks
  - Amniocentesis that demonstrates fetal lung maturity
  - Monitor fetal heart rate (by electronic fetal monitoring or auscultation) immediately prior to preparation of abdomen
- Request that qualified personnel be in attendance for resuscitation and care of newborn
- Documentation of indication for cesarean delivery

Yes

Actions prior to procedure:
- Anesthesia consultation and evaluation
- Fetal heart rate monitored before preparation of abdomen
- Qualified personnel in attendance for resuscitation and care of newborn
- Vaginal examination before surgery to confirm failure to progress

No
Vaginal Birth After Cesarean Section (VBAC)

Obtain patient's obstetric history

Contraindications for VBAC?
- Contracted pelvis
- Previous classical or T-shaped incision or other transfundal uterine incision
- Inability to perform emergency cesarean delivery because of unavailability of surgeon, anesthesia, sufficient staff, or facility
- Obstetrical or medical contraindication to vaginal delivery (i.e. central placental previa, active genital herpes, invasive cervical cancer)

Yes

Prenatal care and repeat cesarean delivery

No

Counsel patient regarding benefits and risks of VBAC

Patient desires trial of labor?

Yes

Routine prenatal care

No

Prenatal care (Please refer to Oxford's Obstetrical Care Guideline)

Repeat cesarean delivery

Normal labor?

Yes

Vaginal birth appropriate?

No

Actions performed prior to procedure:
- Determination of type of previous uterine scar
- Continuous fetal monitoring
- Ability to perform an immediate C-Section (anesthesia available, C-Section room available, adequate fetal resuscitation equipment)

Vaginal birth

Based on The American College of Obstetricians & Gynecologists (ACOG) Guidelines

Oxford Approved: Q1 1995
Reviewed & Updated: Q2 1997, Q3 1998, Q4 2000, Q4 2002

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We value your input on our guidelines. If you have any questions or comments, please e-mail bminta@oxfordhealth.com or write to:

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