General Advice for Helping a Breech Baby Turn

**some of these can be used together, thereby increasing their effectiveness. Check with your care provider before using any of the suggestions*

1. Walk a lot. Creates movement in the pelvis, providing more room for baby to turn.
2. Soaking in water first will help relax everything, creating even more room.
3. Breech tilt – if done 10 minutes twice a day for 2 -3 weeks after the 30th week, the pelvic tilt had an 88.7 – 96% success rate in research done with 744 women. It is recommended this be done on an empty stomach and that the pelvis be raised 9 – 12 inches above the head. Gravity pushes the baby's head into the fundus, tucks it, and baby can then do a somersault into a vertex position.
4. Talk to the baby about turning. Partner can even speak to close to mom, low down on her belly, to encourage baby to move towards the sound.
5. Visualization of the baby turning, while practising deep relaxation. You can imagine a helium balloon attached to the baby's foot, imagine the baby turning somersaults.
6. Nice things (music, whale sounds) played through headphones placed near the pubic bone to encourage baby to move towards the sounds.
7. Place a bag of frozen peas/corn on top of mom's belly, most babies don't like this cold and will move away from it.
8. Place a lit flashlight close to the vagina, (babies gravitate towards the light).
9. Reportedly the most successful technique is going to a swimming pool and doing handstands underwater. Get into the pool and spend at least 15 minutes paddling around and having fun. This will help to relax your abdominal muscles to give baby more room to turn, and deep water immersion will increase your amniotic fluid, also helpful to the baby's turning. Move to an area where you can stand with just your head above the water, then do 5 handstands in a row.
10. Self-applied acupressure on pressure point Bladder 67, which is on the outside of the little toe on both feet, right next to the nail.
11. Increase the volume of your amniotic fluid to make sure there is enough fluid for the baby to move around in. Drinking plenty of water – about a gallon a day- will help. Frequently immersing yourself in water, like a bath or swimming pool, also helps.
12. Mugwort on the little toe is an ancient Chinese remedy used for moxibustion (moxibustion is the application of heat to a specific acupoint and is also used in Japan).
13. Webster chiropractic technique to turn a breech baby.

Turning a breech baby with homeopathic remedies

1. Pulsatilla 200C 1 x day; repeat one more day if baby hasn't turned yet.
2. Pulsatilla 30C (homeopathic dosage 3 -5 pellets/globules under the tongue twice daily until baby turns) which encourages position change.
3. Try using Pulsatilla 6X, one tablet under the tongue 4 times per day. Combine this with the breech tilt exercise at least twice a day for 10 minutes each time. Take one pulsatilla tab before beginning the breech tilt.

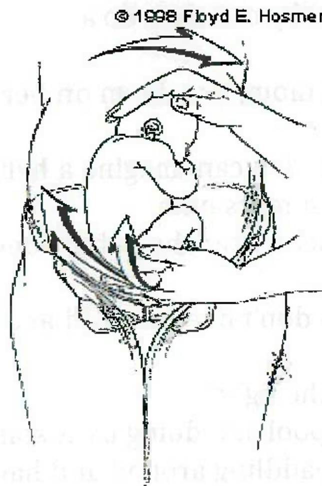
By 38 weeks gestation, 97% of babies turn head down by themselves

There are attached handouts detailing more of these techniques, please also see our website for more resources, www.renaissancemidwifery.ca/pages/resources.php

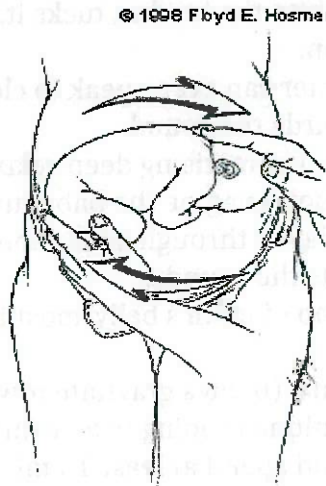
External Cephalic Version (ECV)

What is an External Cephalic Version?
External Cephalic Version (ECV) is a way to try to turn a baby from breech position to vertex (head-down) position while it's still in the mother's uterus. In other words, ECV means turning the baby from outside the abdomen so that it's in head-down position. Your midwife or doctor will use their hands on the outside of your abdomen (tummy) to try to turn the baby.

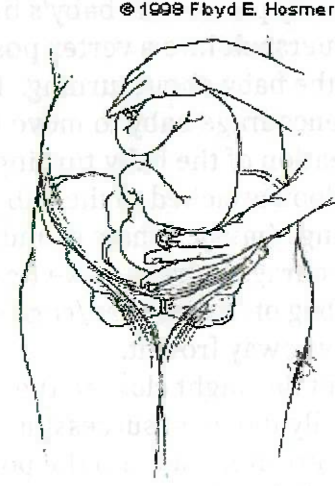
A view of the procedure:



Beginning the forward roll. The doctor places his or her hands on the abdomen, moving the baby up out of the pelvic bones.



The baby is turned either forward or backward ...



... until the baby is in the vertex (head-down) position.

(Am Family Physician 58(3), 1998. (permission to copy granted)

Who can have an ECV?
Many women with normal pregnancies may have an ECV. Women who should not are women with one of the following:

- Vaginal bleeding
- A placenta that is near or covering the opening of the uterus
- A nonreactive non-stress test
- An abnormally small baby
- A low level of amniotic fluid
- An abnormal fetal heart rate
- Premature rupture of membranes
- Twins or other more

What affects the success rate of an ECV?
The success rate of ECV depends on several factors, including the following:
How close you are to your due date
How much fluid is around the baby
How many babies you've delivered
How much your baby is estimated to weigh
How the placenta is positioned
How your baby is positioned

Excerpt from The Birth Report

by Valmai Howe Elkins (published 1983)

Nine years ago I devised the "Elkins Procedure" to encourage babies presenting breech to rotate to vertex (head first). I was lying awake one night thinking about a friend who had been told that she had a big baby in breech presentation, and if the baby didn't turn her doctor would prefer to deliver by Caesarean. I knew how much Sue had been looking forward to a normal birth so I started considering the problem.

Since about 96 or 97 percent of babies were programmed to seek that position, and that something had upset the programming for babies who were presenting buttocks (breech) first. Then I speculated that if we could give these babies a taste of a head down position they might tend to seek it – and it occurred to me that the knee-chest position, a standard position taught in childbirth education classes to relieve pressure in back and low abdomen in late pregnancy, might be the answer.

I decided that the baby needed a fair length of time head down, followed by a long period in which it would lose that orientation, followed by another period of head down and so on. One factor was the length of time a pregnant woman could comfortably stay in the knee-chest position. I came up with this procedure:

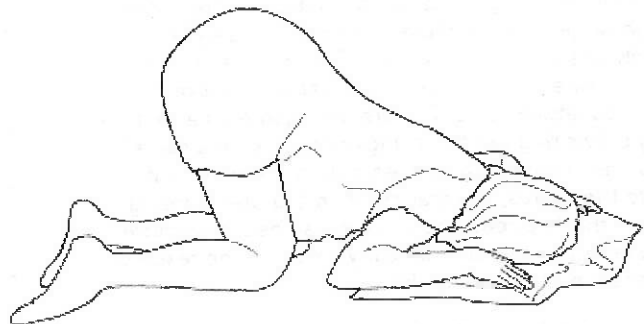
Fifteen minutes of knee-chest position, repeated every two hours of waking time, for 5 days.

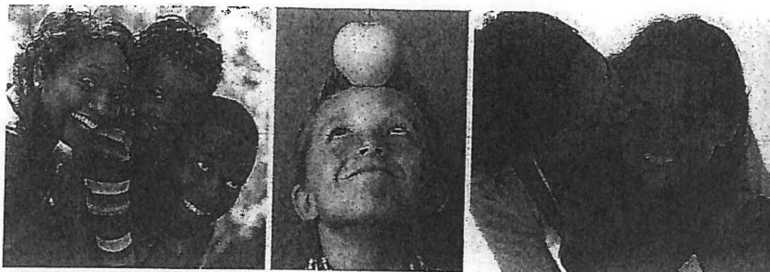
Somewhat unscientific and haphazard, I admit, but people are often haphazard. I suggested it to Sue and it appeared to work – at least her baby rotated to vertex position in 5 days.

Since then, 72 out of 80 babies all within three weeks of due date have turned within the time that their mothers were following the procedure although many of the mothers had been told they would need Caesareans. The biggest baby was 10 pounds 4 – the smallest 6 pounds 6, and there have been no complications. (Ofthose babies who did not turn, three were found to have short cords, one mother had a heart shaped uterus and two had low lying placentae.)

If you are faced with the possibility of a Caesarean because of a difficult presentation I'd suggest you discuss this procedure with your care provider.

About the author: Valmai Howe Elkins, while teaching childbirth education at McGill University, pioneered the hospital Birthing Room and introduced the concept and design across North America. The Rights of the Pregnant Parent, dubbed "the book that changed hospital birth," became an international bestseller, followed by The Birth Report.





The Wellness Family

Dr. Robson-McInnis Keeps You Informed

The Webster Technique

Many years ago, if a mother was told that her unborn baby was in the wrong position (i.e. breech, transverse, face/brow) it was assumed that the safest course of action was a C-section. While there were other options such as "External Cephalic Version" by an obstetrician, there were risks involved that a C-section could avoid. This has resulted in over 30% of births being by C-section, 20% of which are due to malpresentation. As the rate of C-sections has risen, so has the rate of pregnancy-associated deaths.[1,2]

In the 1970's, chiropractor, Dr. Larry Webster, found a connection between a sacral subluxation (pelvic misalignment) and fetal malposition. The presence of this subluxation pattern may cause ligament tension which could result in undue uterine tension making it more difficult for the fetus to move into optimal position for birth. He discovered a simple way to determine the presence of, and provide chiropractic care for, this misalignment and resultant ligament tautness or in-utero constraint. The result of the procedure was that many babies were naturally able to assume the normal vertex (head down) position.[3]

What is In-Utero Constraint?

In her article "The Webster Technique – A Chiropractic Analysis and Adjustment for Pregnant Women", Dr. Jeanne Ohm defines intrauterine constraint (or in-utero constraint) as a condition where fetal movement is restricted, resulting in potential adverse effects to its development throughout pregnancy. Furthermore, limited movement and space in the uterus can lead to malpresentation in various forms: breech, transverse, posterior as well as ascynclitic presentations."[4]

She goes on to discuss the labor difficulties that may result from in-utero constraint including increased pain or dystocia (slow or difficult labor), the need for medical interventions as well as a more traumatic birth experience for both mother and baby.

To truly understand this cause and effect, picture a basketball net hanging from a ring. If the net is twisted the basketball can't get through. The net must be hanging evenly for the ball to easily pass. The same is true of the mother's uterus. The sacrum is one of the bones in the pelvic ring, like the ring of the basketball hoop. The uterine ligaments attach to this boney pelvic ring like the strings of the net. If a sacral subluxation has caused an uneven pull in the ligaments attached to the uterus, this may result in the uterus being tense. When this happens, the uterine wall becomes more rigid and the fetus has more difficulty moving. The result of which is called in-utero constraint.

What is the Webster Technique?

A simple Google search provides the following definition which was provided to the website "Spinning Babies" by Dr. Jeanne Ohm: "A chiropractic adjustment called the Webster Technique is a specific sacral adjustment to help facilitate the mother's pelvic alignment and nerve system function. This in turn balances pelvic muscles and ligaments, reduces torsion to the uterus and offers a greater potential for optimal fetal positioning."[5]

The Webster Technique is performed by a trained Doctor of Chiropractic. The doctor will determine which side of the pelvis has the sacral rotation by checking muscle tension through the leg muscles that attach to the pelvis. Then an adjustment to the sacrum will be performed to realign it in the pelvic ring. Afterward, the doctor will make a contact with a few ounces of pressure on the mother's abdomen, over a pelvic ligament. Once the tension is released the uterine wall should relax allowing the fetus to more easily move into the optimum position for delivery.

More midwives and obstetricians are recognizing the value of the Webster Technique as a non-invasive approach to malpresentations.

Dr. Claudia Anrig, co-editor of the Pediatric Chiropractic textbook, was one of only two instructors to receive official endorsement by Dr. Webster to teach his technique. It was during this time that she developed the Advance Webster Technique – adapting the sacral adjustment and ligament contact to address breech, transverse, and face/brow presentation – which was used by Dr. Webster in his practice. The Advanced Webster Technique has been taught and used effectively by the chiropractic profession for over 30 years.[3]

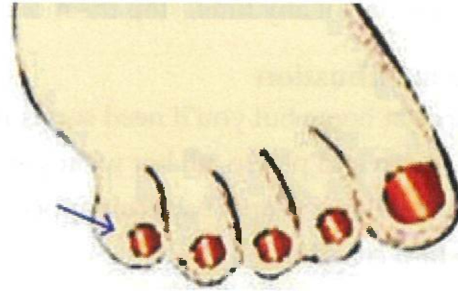
Who benefits from the Webster Technique?

The Webster Technique proves to be most beneficial when chiropractic care is sought early in the pregnancy, as this may decrease the need for medical intervention. If the fetus has unrestricted movement throughout the entire pregnancy then there is no need for external maneuvers or C-section deliveries.

External maneuvers, like External Cephalic Version or others, are risky with only about 58% success.[6] Interestingly, one of the signs of a failed version is "a uterus tense to palpation",[2] meaning that the uterus is tense or tight, which is exactly what the Webster Technique theoretically addresses.

The Breech Point & Moxibustion

The acupuncture point known as Zhiyin (or Bladder 67) is located on the little toe, on the outside corner of the nail. You should mark it gently, using a felt tip pen, on both feet.



Here is a quotation from "A Manual of Acupuncture" by Peter Deadman & Mazin Al-Khafaji with Kevin Baker:
the principle application of Zhiyin Bladder-67 .. is in the treatment for malposition of the foetus, for which it is renowned. For this purpose it is treated by stick moxibustion for fifteen – twenty minutes bilaterally ... The woman should loosen her clothes and sit in a comfortable semi reclining position. It is common practice in China to demonstrate this method to the pregnant woman who is then supplied moxa sticks for self treatment at home.

What is moxibustion?

Moxibustion is a traditional Chinese technique to turn a breech baby to head first, usually around 34–36 weeks of pregnancy. Moxa – sticks of dried herb – are used to heat specific energy points on your little toes. The heat is absorbed into the points and transferred via energy channels, triggering hormone changes which relax the muscles in your uterus to allow extra "give", and increasing your baby's activity, encouraging him to turn. Research suggests moxibustion is about 66% successful, which is better than ECV.

Is moxibustion safe in pregnancy?

Moxibustion is not appropriate for every mum with a breech baby. Whilst it is a gentle and generally safe technique, it should not be used if:

- Your midwife has said it is not appropriate for you to have ECV
- You have had a previous caesarean or other uterine surgery
- You are expecting more than one baby or your baby is very big or very small or known to have health problems
- You have had vaginal bleeding, have a low-lying placenta or placenta previa, or any other pregnancy complications
- You have high blood pressure, diabetes or any other medical condition, or if you're due to have a caesarean for a medical reason
- Your baby keeps changing position, especially if there is a lot of fluid.

Do not try any other way of turning your baby during the five days of the moxibustion treatment and do not continue the treatment beyond five days.

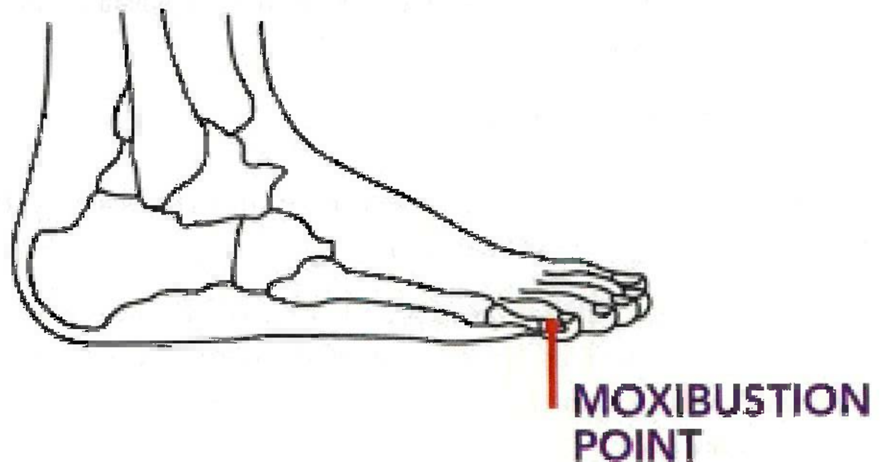
If you are concerned at any time, stop the moxibustion and consult your midwife.

How to use moxibustion

You can do this at home but you'll need someone to help you. Check with your midwife that your baby is still breech and please tell her what you intend to do. Two types of moxa sticks are available from Chinese medicine shops (paper-wrapped or charcoal-impregnated) – *be sure to ask for moxa specifically to turn breech babies.*

- Remove a centimetre of paper from one end of a moxa stick, then light it with a match.
- Blow out the flame, leaving the stick smoking and hot.
- Sit comfortably, relaxed and loosen tight clothing. Make sure you've emptied your bladder before you start.
- The energy points are found on the outer corner at the base (cuticle) of your little (fifth) toe nails (see diagram).
- Ask your partner to direct heat from the stick over the energy points, about half a centimetre away from your skin. It should feel warm but not excessively hot.
- Move from one foot to the other, holding the stick for 15-30 seconds over the point on one foot, then to the point on the other foot. Alternate between your two feet for at least 20-30 minutes per session.

The treatment should be done twice a day, for five days (ten treatments). Complete the five days of treatment, even if you think your baby has turned.



Please DO NOT attempt moxibustion without informing your midwife or doctor. You must be sure that your baby is still breech before you start the procedure.

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.

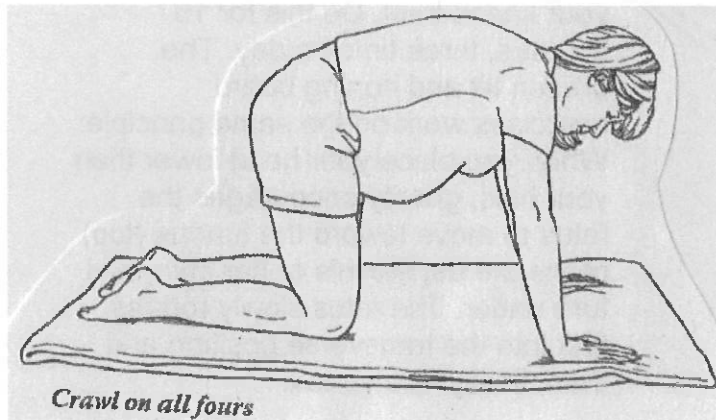
Any presentation other than vertex (headfirst) is considered breech. In a frank breech, the most common type, the buttocks are first, with the legs fully extended, straight up. A footling refers to one of both feet first, while in a complete breech the fetus is crossed-legged, bottom first. About 4 percent 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:

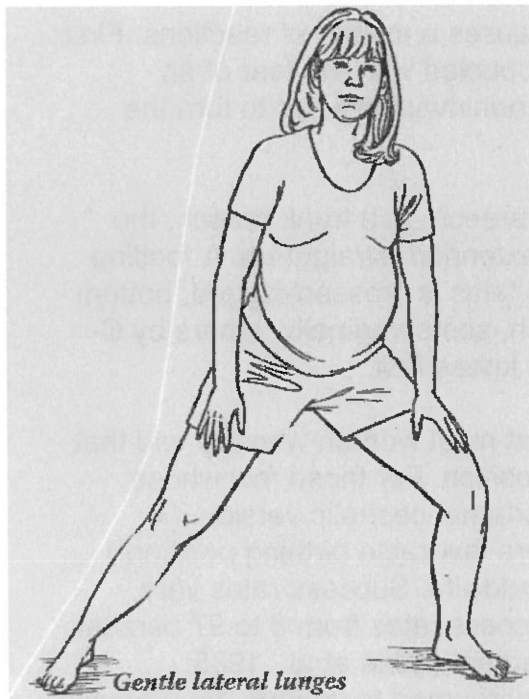
1. Crawl on all fours. This allows gravity to bring the baby's head down. It also provides room for an occiput-posterior baby to turn.


Crawl on all fours

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

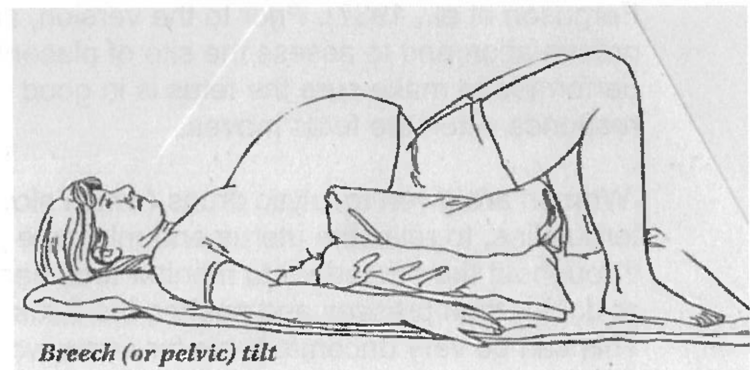
3. Rock your pelvis. This is particularly effective when used in conjunction with crawling. Get on your hands and knees, keeping your wrists and feet in neutral positions. In order to avoid wrist pain and/or calf cramps, make two fists and lean on your knuckles. with your weight mostly on your

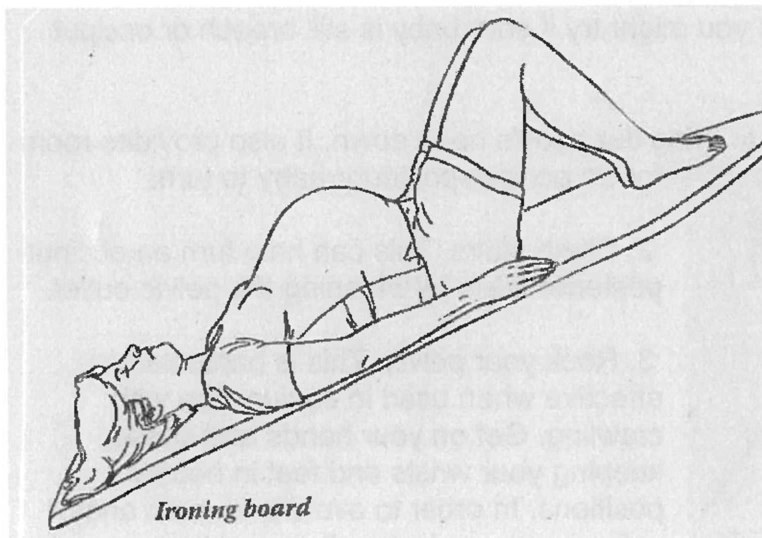
knees, flex your feet so you are gently resting on your toes. Pull your belly toward your spine. On an inhalation, arch your back. Your belly remains pulled in toward your spine. Exhale and slowly return to a relaxed spine. Do this three times a day, for a count of 10 each time.


Gentle lateral lunges

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

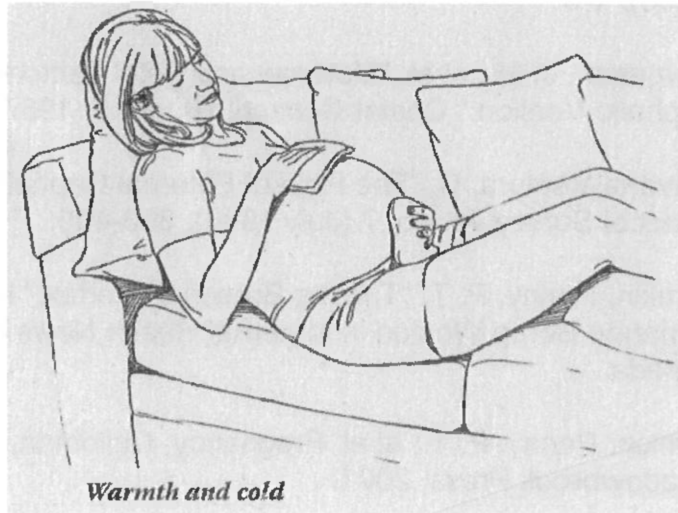
5. Breech tilt. Raise your hips about a foot above a firm surface and tuck pillows under your hips. Concentrate on relaxing all your muscles, particularly your abdomen. This should be done three times daily, for 10 to 15 minutes each time, on an empty stomach.

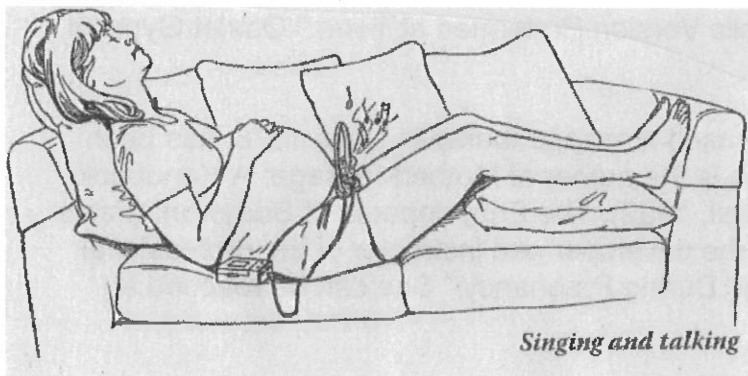

Breech (or pelvic) tilt


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.

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