International Journal of Reproduction, Contraception, Obstetrics and Gynecology
Chaudhary V et al. Int J Reprod Contracept Obstet Gynecol. 2026 Jun;15(6):2299-2302
www.ijrcog.org
pISSN 2320-1770 | eISSN 2320-1789

DOI: https://dx.doi.org/10.18203/2320-1770.ijrcog20261653

Review Article

Current guidelines for management of breech presentation: a comparative review of Royal College of Obstetricians and Gynaecologists, American College of Obstetricians and Gynecologists and the Federation of Obstetric and Gynaecological Societies of India recommendations

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Received: 15 April 2026
Revised: 20 May 2026
Accepted: 22 May 2026

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ABSTRACT

Breech presentation remains a significant obstetric challenge, with variations in management strategies across different professional bodies. Clinical decisions are influenced by evolving evidence and institutional preferences. This review is aimed to compare and analyze current recommendations for the management of breech presentation from Royal College of Obstetricians and Gynaecologists (RCOG), the American College of Obstetricians and Gynecologists (ACOG), and the Federation of Obstetric and Gynaecological Societies of India (FOGSI). A narrative review of published guidelines and official recommendations from RCOG, ACOG, and FOGSI was conducted. Key domains analyzed included external cephalic version (ECV), criteria for vaginal breech delivery, intrapartum management, and indications for caesarean section. All three organizations support ECV as a first-line intervention in eligible women. While ACOG and RCOG permit planned vaginal breech delivery under strict selection criteria, FOGSI emphasizes institutional capability and clinician expertise. Differences exist in patient selection, intrapartum monitoring, and thresholds for caesarean delivery. Although core principles remain consistent, variations in recommendations reflect regional practices and medico-legal considerations. Standardization and skill-based training are essential to optimize outcomes in breech presentation.

Keywords: Breech presentation, ECV, Vaginal breech delivery, Guidelines, RCOG, ACOG, FOGSI

INTRODUCTION

Breech presentation complicates approximately 3-4% of term pregnancies and continues to pose a dilemma in obstetric management.[1-4] The publication of the Term Breech Trial significantly influenced global practice, leading to an increase in caesarean deliveries for breech fetuses.[4]

Despite advances in obstetric care, the optimal mode of delivery in breech presentation remains a subject of ongoing debate.[5,6]

However, concerns regarding long-term maternal morbidity and the declining expertise in vaginal breech delivery have reignited interest in selective vaginal birth.[7,8]

Various professional organizations, including RCOG, ACOG, and FOGSI, have issued guidelines reflecting evolving evidence and regional practice patterns.[2,3,9]

This review aims to compare these guidelines to highlight similarities, differences, and implications for clinical practice.

METHODOLOGY

A narrative review was conducted using official guideline documents and published recommendations from the RCOG, the ACOG, and FOGSI.[1-3] Key areas of comparison included ECV, mode of delivery, selection criteria for vaginal breech delivery, and intrapartum management.[10,11]

COMPARATIVE ANALYSIS

ECV

Summary: The recommendations regarding ECV are largely consistent across RCOG, ACOG, and FOGSI guidelines.[1-3] All three organizations advocate ECV as an effective first-line intervention for reducing the incidence of persistent breech presentation at term and lowering caesarean section rates.[10,15]

RCOG and ACOG strongly emphasize the use of tocolytic agents to improve the success rate of the procedure, whereas FOGSI recommendations are relatively less prescriptive and allow institutional discretion.[3]

The timing of ECV is also broadly similar, with most guidelines recommending the procedure after 36 weeks of gestation in nulliparous women and slightly later in multiparous women. Despite similarities in recommendations, differences exist in implementation due to variations in resource availability, clinician expertise, and patient acceptance.[12]

Table 1: Comparison of RCOG, ACOG, and FOGSI Recommendations for External Cephalic Version (ECV).

Aspect	RCOG	ACOG	FOGSI
Recommendation	Strongly recommended	Recommended	Recommended
Timing	≥36–37 weeks	≥36 weeks	≥36 weeks
Tocolysis	Recommended	Recommended	Variable
Contraindications	Standard	Standard	Standard

Planned mode of delivery

The comparison of planned mode of delivery highlights important differences in clinical approach among the three organizations.[1-3] RCOG and ACOG acknowledge that planned vaginal breech delivery may be considered in carefully selected patients when strict criteria are fulfilled and experienced obstetricians are available.[1,2,16] In contrast, FOGSI adopts a comparatively cautious stance because of inconsistent availability of skilled personnel and variability in institutional infrastructure across healthcare settings in India. Consequently, caesarean section remains the preferred mode of delivery in many centers, especially where adequate monitoring facilities and trained clinicians are lacking.[3,14] These differences underline the importance of adapting recommendations according to local healthcare resources and clinical expertise.[19]

Table 2: Comparison of recommendations for planned mode of delivery in breech presentation.

Aspects	RCOG	ACOG	FOGSI
Vaginal breech	Allowed (strict criteria)	Allowed (select cases)	Limited recommendation
Cesarean section	Common	Common	Preferred in many centers

Selection criteria for vaginal breech delivery

All guidelines emphasize the importance of meticulous patient selection before attempting vaginal breech delivery.[1,2,9] Appropriate selection significantly reduces maternal and neonatal complications and improves the likelihood of successful vaginal birth.[5,7] Commonly accepted criteria include frank or complete breech presentation, estimated fetal weight between 2.5 and 3.5 kg, flexed fetal head, absence of fetopelvic disproportion, and availability of continuous intrapartum monitoring.[1,9,11] The presence of an experienced obstetrician skilled in breech delivery techniques is considered essential by all organizations.[11,17] Although the criteria are broadly similar, the degree of flexibility in interpretation varies between guidelines.

Common criteria across all guidelines include frank or complete breech presentation, estimated fetal weight between 2.5 and 3.5 kg, flexed fetal head, absence of fetopelvic disproportion, adequate maternal pelvis, and availability of a skilled obstetrician experienced in vaginal breech delivery.[1,2,9] Minor variations exist among guidelines regarding strictness of interpretation and institutional prerequisites.[3]

Intrapartum management

Intrapartum management protocols demonstrate both similarities and subtle differences among the reviewed guidelines. Continuous fetal heart rate monitoring is universally recommended because breech labor is associated with a higher risk of intrapartum fetal compromise.[11,19] RCOG and ACOG recommend cautious use of labor augmentation and advocate a low threshold for conversion to caesarean section in case of abnormal labor progression or fetal distress.[1,2,16] FOGSI recommendations are relatively variable and often depend on institutional practices and resource availability. Episiotomy is advised

selectively by RCOG and ACOG, whereas a more liberal approach may still be followed in certain centers in India. These variations reflect differing clinical environments and training patterns.[17,18]

Table 3: Comparison of intrapartum management recommendations for breech delivery.

Aspects	RCOG	ACOG	FOGSI
Continuous FHR monitoring	Yes	Yes	Yes
Labor augmentation	Cautious	Limited	Variable
Episiotomy	Selective	Selective	More liberal
Cesarean threshold	Low	Low	Lower

DISCUSSION

The management of breech presentation continues to evolve in response to emerging evidence, medico-legal considerations, and the availability of skilled obstetric care.[11,19] The publication of the term breech trial marked a major turning point, resulting in a global increase in caesarean section rates for breech presentation. However, subsequent criticism regarding study design, selection bias, and long-term maternal implications has led to a more balanced re-evaluation of vaginal breech delivery.

This review demonstrates that while RCOG and ACOG support planned vaginal breech delivery under stringent selection criteria, FOGSI adopts a relatively conservative approach. This divergence likely reflects differences in healthcare infrastructure, training opportunities, and medico-legal environments across regions.[14,19]

A consistent finding across all guidelines is the strong recommendation for ECV as a first-line intervention in eligible women. Increasing the uptake of ECV has the potential to significantly reduce the incidence of breech presentation at term and consequently decrease caesarean delivery rates.[10,15]

One of the most important challenges identified is the progressive decline in clinician expertise in vaginal breech delivery, largely attributed to the rising preference for caesarean section. This creates a self-perpetuating cycle where reduced training exposure further limits the safe practice of vaginal breech delivery. Addressing this gap requires structured training programs, simulation-based learning, and institutional protocols.[17,18]

Furthermore, individualized decision-making based on patient preference, clinical scenario, and available expertise is essential rather than adopting a universal approach.[16] Shared decision-making, particularly emphasized by ACOG, plays a crucial role in optimizing maternal and neonatal outcomes.

Future directions should focus on strengthening evidence through well-designed prospective studies and promoting skill retention among obstetricians.[13,20] In low-resource settings, context-specific adaptations of guidelines are essential to ensure safe and feasible implementation. Another important issue identified during comparison of the guidelines is the decline in training opportunities for vaginal breech delivery. Increasing caesarean section rates have reduced hands-on exposure of residents and young obstetricians to assisted breech birth techniques.[19] This decline in practical expertise may further contribute to the preference for caesarean section even in appropriately selected cases. Strengthening simulation-based training, supervised clinical exposure, and institutional protocols may help preserve essential obstetric skills and improve confidence in managing breech presentation safely.

Strengths and limitations

The strengths of this review include a comparative analysis of major international and national guidelines, clinically relevant synthesis applicable to real-world obstetric practice, and emphasis on both evidence-based recommendations and practical implementation.

However, the review has certain limitations, including its narrative design without systematic meta-analysis, potential selection bias in included literature, and lack of quantitative outcome comparison.[19,20]

CONCLUSION

Overall, this comparative review highlights that contemporary breech management guidelines share common evidence-based principles while differing in implementation according to institutional resources, training opportunities, and medico-legal environments. All major guidelines endorse external cephalic version as first-line management in eligible women and support selective vaginal breech delivery under carefully defined criteria with experienced supervision. The study advances current understanding by emphasizing the importance of standardized protocols, structured training in vaginal breech delivery, and individualized decision-making to optimize maternal and neonatal outcomes. Bridging the gap between guideline recommendations and real-world clinical practice, particularly in resource-limited settings, remains essential for improving outcomes in breech presentation.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

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Cite this article as: Chaudhary V, Agrawal S, Samaiya S. Current guidelines for management of breech presentation: a comparative review of Royal College of Obstetricians and Gynaecologists, American College of Obstetricians and Gynecologists and the Federation of Obstetric and Gynaecological Societies of India recommendations. Int J Reprod Contracept Obstet Gynecol 2026;15:2299-302.