

Breech Birth Can Be Safe, But Is it Worth the Effort?

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Whether term vaginal breech birth is safe is no longer a question. The PREMODA study has clearly shown that with careful selection and management by average maternity units, breech birth can be safe.¹ We are now left with two tasks. The first is to define, as clearly as possible, what parameters make vaginal breech birth safe. The second is to decide, individually and collectively as a profession, whether to make the effort required to offer vaginal breech birth.

Even with the quality of care limitations of the Term Breech Trial, the newborn outcomes at two years of age suggest safety.² Most feel, however, that the short-term morbidity was unacceptably high, especially given the much safer PREMODA results. What, then, did PREMODA do to ensure safety that the Term Breech Trial did not? What are the important selection criteria, intrapartum management parameters, and resource requirements needed to make breech birth acceptably safe? The Guidelines for Vaginal Breech Delivery in this issue of the Journal of Obstetrics and Gynaecology of Canada take on the first task by endeavouring to answer those questions.³

The second task, for individual clinicians and the obstetrical profession, is to re-establish systems to provide safe breech birth. For almost a decade, the pool of expertise in breech birth has been shrinking, and it will take effort and flexibility to re-expand it. Offering breech birth again will require systems of on-call coverage that pair more experienced practitioners with various learners, including practising obstetricians. Initially, centres able to establish such systems will need to serve as referral centres for women wishing a vaginal breech birth and as training centres for clinicians wishing to learn or refresh skills. Financial support for dual specialist attendance at breech births would be instrumental in helping re-establish breech delivery skills.

In the PREMODA study, the overall vaginal birth rate was only 23%. Is it important to mount the significant effort required to offer women breech birth if only one quarter

will thereby avoid Caesarean section? In the PREMODA study, 23% percent represented 1800 women who delivered their breech baby vaginally. Without any increase in perinatal morbidity or mortality, these 1800 women avoided the immediate risks and longer recovery associated with primary Caesarean section as well as the increased downstream risks of abnormal placentation, stillbirth, and uterine rupture in subsequent pregnancies. In North America, over 100 000 women have pregnancies that remain breech at term annually. With a success rate similar to that of the PREMODA study, some 25 000 could safely avoid Caesarean section.

The principles of patient autonomy and informed consent suggest that women with persistent breech presentation at term should have information about and access to an alternative to pre-emptive Caesarean section. Even using the Term Breech Trial alone as a basis for a consent discussion, the current practice of “not offering” women a trial of labour while providing ready access to Caesarean section is coercive, especially given the equivalency of long-term neonatal outcome. Now, with a more comprehensive understanding of the components required to make short-term outcomes of vaginal breech birth equivalent as well, it would be unethical not to provide this information to women. Although it may be difficult in some settings to offer vaginal breech birth routinely, its availability elsewhere should be disclosed and assistance offered to obtain it if requested. To offer only Caesarean section is ethically and legally difficult to justify if a reasonable alternative is available.

In 1972, Archie Cochrane awarded the obstetrical profession a wooden spoon as the least evidence-based medical specialty. This spurred a discipline-wide effort to establish an evidence-base for our practice: to throw out interventions based on dogma rather than science and to subject innovations to rigorous scrutiny. The profession rose to the challenge, and in many arenas we have succeeded. Yet

obstetrics is a complex and dynamic business: managing a breech in labour is not like treating high blood pressure. Our difficulty defining safe breech birth has historically, and perhaps rightly, hindered us from offering it widely. Now that we have a much better idea of what is required to offer safe breech birth, that is no longer the case. If we are not willing to put in the effort to help 25 000 women in North America every year avoid an unnecessary Caesarean section, we bear the responsibility for the increased maternal morbidity and mortality, as well as the excess abnormal placentation, uterine ruptures, stillbirths, and neonatal morbidity that will occur in subsequent pregnancies.

Incorporating complex skills and detailed consent discussions into obstetrical practice requires effort; but the practitioners working in the 174 centres in the PREMODA study were not all experts. In France, Belgium, and other parts of

the world, careful everyday practice achieves safe vaginal breech birth for thousands of women and their newborns. The challenge to obstetricians and the obstetrical profession around the world is to learn from these settings and provide similar choice of delivery mode to as many women as possible. Woman-centred care demands no less.

REFERENCES

1. Goffinet F, Carayol M, Foidart JM, Alexander S, Uzan S, Subtil D, et al.; PREMODA Study Group. Is planned vaginal delivery for breech presentation at term still an option? Results of an observational prospective survey in France and Belgium. *Am J Obstet Gynecol* 2006;194:1002–11.
2. Whyte H, Hannah ME, Saigal S, Hannah W, Hewson S, Amankwah K, et al. Outcomes of children at 2 years after planned cesarean birth versus planned vaginal birth for breech presentation at term: the International Randomized Term Breech Trial. *Am J Obstet Gynecol* 2004;191:864–71.
3. Kotaska A, Menticoglou S, Gagnon R. Vaginal delivery of breech presentation. SOGC Clinical Practice Guideline No. 226, June 2009. *J Obstet Gynaecol Can* 2009;31(6):557–66.