

NATIONAL POST

Wednesday, July 15, 2009

Breech birth gets a reboot by research

C-section debate

Presented by



Dr . Yoel Abells, National Post

A single study can sometimes have a profound impact on medical practice. Research can influence approaches to prevention, diagnosis and treatment, with the goal being better care. But sometimes, the effect is not entirely what we expected. The management of breech deliveries is a case in point.

At delivery, most babies come out head first. When a fetus is lying in a breech position, the baby's head is facing up and the presenting parts are the buttocks, legs or both. About 3% to 4% of babies remain in this position at birth. There are three primary types of breech presentations: frank (legs point straight up, with feet near face), complete (knees bent and feet near the buttocks) and footling (one or both feet are down).

Before 2000, it was common to deliver many of these babies vaginally. The concern is that the largest part of the baby -- the head -- comes out last. Rarely, the head can get caught and is either difficult or impossible to deliver. Additionally, there is an increased risk of the cord getting compressed, compromising oxygen flow to the baby. All these are obstetrical emergencies, and the consequences can be profound. The question that had never been formally addressed was whether it was better to avoid a vaginal delivery in favour of an elective Caesarian section (CS).

To this end, a major study was conducted and its results were published in the *Lancet* in October 2000. Its goal was to determine the safest approach to breech deliveries. The short-term neonatal morbidity was found to be significantly higher in babies born vaginally. While the authors never argued their analyses supported an absolute ban on vaginal breech delivery (VBD), almost overnight, the standard of care became elective CS for all breech presentations. The option was essentially taken out of the hands of both patients and physicians.

But the winds of change in attitude appeared in last month's *Journal of the Society of Obstetricians and Gynecologists of Canada*. While acknowledging the strengths of the initial trial, the Maternal Fetal Medicine Committee also point to some limitations. Reference is made to a 2006 article published in the *American Journal of Obstetrics and Gynecology* in which the same question is addressed. This study concluded that in the proper environment, with trained personnel, VBD is a viable option because no significant differences in morbidity and mortality were noted.

As a result, the society has adopted a less restrictive approach. New guidelines provide a clear template on which to base the decision to attempt a VBD. Criteria include perilabour ultrasound assessment of the breech, the baby's size and the position of the baby's head. The adequacy of the mother's pelvis should be determined. And electronic fetal heart-rate monitoring is essential, as is good labour progress.

What does all this mean? In his guest editorial, professor Andre Lalonde states: "Women in Canada and abroad are requesting the option of breech vaginal delivery ..." Wide pendulum swings in the approach to care always worry me. Almost invariably, the pendulum shifts back toward the middle. It appears that this has been the case with VBD. Because of the new guidelines, the opportunity for choice has returned.

-Submit your health questions to Dr. Yoel Abells by sending an email to the address below.

familyhealth@nationalpost.com

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