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Breech Presentation - Caesarean operation versus normal birth

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There are widespread fears surrounding vaginal delivery of the breech presentation and a lack of information generally available on safe vaginal delivery of a breech. There is also a lack of honesty about the risks of caesarean section and sparse knowledge of the post-caesarean difficulties many mothers encounter. These factors, together with the prevailing myths and beliefs that caesareans guarantee healthy babies, more often than not leave the woman with no option but to blindly accept the decisions made for her by her obstetrician.

Mothers may not be aware much earlier than 36-37 weeks that their baby remaining in a breech position is a problem. The prevalence of breech presentation decreases from about 15% at 29-32 weeks gestation to between 3-4% at term.(1)

Many hospitals have a policy of elective caesarean section at 38 weeks gestation for all breech presentations. For many mothers, particularly those who have made great efforts to maximise the chances of 'as natural a birth as possible', such a position is extremely confidence-shattering and desperately upsetting - loss of control of, or involvement in, the delivery of her baby is often total.

In fact, a mother in such a position does have three main choices although these are unlikely to be made known to her:

- Elective caesarean section
- Vaginal breech delivery or vaginal breech extraction using forceps
- Natural, active breech birth

Despite the widespread acceptance that breech babies should be delivered by caesarean section, it has not been proven to be safer for the baby than natural active breech birth. An international multi-centre Term Breech Trial is currently being undertaken to look at the question of which is the better approach for management of the breech baby at term: planned caesarean section or planned vaginal birth.

Estimates of the perinatal mortality attributable to vaginal delivery of breech presentation have varied, but it is generally accepted to be four times that for cephalic presentation when corrected for abnormalities. However, in a review of over 10,000 breech births in eighty-six hospitals world-wide, Fortney et al (1986)(2) found that the neonatal mortality rate in breech births was about twice the

overall neonatal mortality rate.

The sad fact is that babies in the breech position are at higher risk than cephalic babies. Unfortunately widespread use of caesarean delivery for breech babies has not demonstrated an improvement in the outcome statistics.

Caesarean operations do not guarantee delivery of healthy babies, breech or otherwise. Neither are all the 'hazards' of vaginal delivery always avoided. Breech presenting babies are still born bottom first even when delivered operatively.

"*It is incorrect to assume . . . that caesarean breech delivery is never traumatic for the fetus. Several retrospective studies have shown that brachial plexus injury, damage to soft tissues, fractures, lacerations, and entrapment of the fetal head behind the uterine incision followed by intracranial hemorrhage occur in caesarean breech deliveries as well.*"(3)

Some obstetricians prefer to use a low vertical, rather than a transverse, uterine incision when delivering a breech baby by caesarean since vertical incisions can be extended with less risk to the mother should the need arise. This, of course, has implications for future deliveries since it is widely believed that vertical scars are at slightly higher risk of rupture.

The main fears surrounding vaginal breech delivery are birth trauma and asphyxia. With a breech, the after-coming head does not have an opportunity to mould before passing through the birth canal. If the baby is small or premature there is a danger that the body may deliver easily leaving the head trapped behind an incompletely dilated cervix or an inadequate pelvis.

However, Collea et al (1978) point out that "*excessively slow delivery of the head may result in fetal asphyxia, although found no direct relationship between umbilicus-to-mouth delivery time and Apgar score.*"(4)

As the rate of caesarean delivery of breech babies rises, fewer and fewer midwives and doctors are learning the skills of vaginal breech delivery. In cases where the baby's head does get trapped the birth attendants may act inappropriately by forcefully extracting the baby which may cause severe brain and spinal cord injuries, bruising sufficient to cause hyperbilirubinemia, trauma to the liver, kidneys, spleen and adrenals.

In the ICEA review Delivery Alternatives in the Term Breech Pregnancy the views of Irwin Kaiser, an American ob/gyn are noted:

"*I have never in my life had trouble with a breech. And I rarely section for a breech. Now, of course there are some skills involved in delivering breeches. And, many doctors trained today aren't learning them. However, if doctors don't have the skills, maybe they ought to be doing something else - perhaps administrative medecine.*" (3)

Although in theory breech babies are not benefiting from caesarean delivery, they may well be doing so in practice, because the skills of vaginal breech delivery are being lost.

Another much voiced fear in association with vaginal breech birth is cord prolapse. Since the baby's bottom or legs do not fit the pelvis as closely as the head there is more chance that the cord may slip through. However, for the same reasons the pressure on the cord may not be as great, therefore a cord prolapse with a breech may not be the immediately life-threatening event that often presents with a head down baby. Although Confino, et al found that umbilical cord prolapse was much more common in breech presentations (3.7%) than in vertex presentations (0.3%)(5), cord prolapse may not necessarily be as devastating in breech presentations as it is in vertex presentations, because the fetal legs may shield the prolapsed cord from compression. There is literature which cites numerous instances of cord prolapse in breech deliveries without any apparent untoward effect on the fetus(3)

To those who express the doubt that the high rate of caesarean section for breech presentations has improved outcome statistics, quickly comes the response "but they don't do follow-up studies!". In fact, there have been two widely quoted studies which found no difference between breech infants delivered vaginally and breech infants delivered by caesarean.(6,7)

It would appear that in the case of a healthy mother with a healthy baby of normal size in a breech presentation, vaginal delivery at full term ought to be an option to be given serious consideration 'Informed choice' is very much the 'in' thing at present, but how often does this happen with a woman whose baby is in a breech presentation?

It is rarely acknowledged, for instance, that there are two very different 'types' of vaginal delivery. Generally speaking 'vaginal breech extraction' would better describe what the majority of British hospitals have to offer as a 'vaginal breech delivery' option. This often involves some or all of the following:

- Getting to the hospital early in labour (in case of cord prolapse)
- Continuous fetal monitoring
- Epidural (to avoid the mother pushing too early and of course it can be topped up if a caesarean becomes necessary)
- Mother in lithotomy position (flat on back, legs in stirrups - so the doctor has 'good' access)
- Large episiotomy (to accommodate the forceps)
- Complex manipulation with forceps

'Natural, active' breech birth is rarely the norm, although there are some midwives and the occasional obstetrician who consider breech as simply a variation of normal.

Michel Odent's natural protocol for breech birth involves no intervention whatsoever in the first stage of labour, leaving the woman free and 'naturally active'. In his book 'Birth Reborn' he writes that his only intervention is to:

"insist on the supported squatting position for delivery, since it is the most mechanically efficient. It reduces the likelihood of our having to pull the baby out, and is the best way to minimise the delay between the delivery of the baby's umbilicus and the baby's head . . . would never risk a breech delivery with the mother in a dorsal or semi-seated position."

"*If, on the other hand, contractions in the first stage labour are painful and inefficient and dilation does not progress, we must quickly dispense with the idea of vaginal delivery. Otherwise we face the danger of a last minute 'point of no return' when, after emergence of the baby's buttocks, it is too late to switch strategies and decide on a caesarean. However, although we always perform caesareans when first stage labour is difficult and the situation is not improving, most breech births in our clinic do end up as vaginal deliveries.*"(8)

Whether to opt for a caesarean, a trial of labour ending in a vaginal breech extraction, or a natural active breech birth is a very difficult decision for an individual mother, particularly if she is a first time mother.

Even if she has full information she has to weigh the risks of caesarean section to herself and her baby against the possible risks to the baby of vaginal delivery. The mortality rates for breech babies are at least two-to-four times higher than that for cephalic presentations. High rates of caesarean section for breech presenting babies have not been proved to improve outcome statistics, but the risks involved in operative delivery remain largely unacknowledged, summarily dismissed and are presented on the whole as being generally more acceptable.

Many women may well be content to go along with the medical advice being presented to them and opt for an elective caesarean at 38 weeks. They may consider the risks of an elective section more acceptable, especially if their confidence that the medical profession 'know best' is strong. The thought of a possibly long and difficult labour which could still end in an emergency caesarean, perhaps under general anaesthetic, may appear more frightening and seem pointless when they could arrange to schedule an epidural section at a possibly more 'convenient' time. Although the current availability of spinal anaesthetic should make use of a general anaesthetic unlikely.

Elective caesarean is also the option which encounters least resistance and most support since few obstetricians today would refuse a caesarean to a woman with a breech presenting baby. Other mothers too, are much more likely to understand such a decision since many have heard vague horror stories of breech births resulting in dead or brain-damaged babies.

An additional disadvantage to an elective caesarean section is that the baby does not benefit from experiencing contractions. It is believed that the contractions of labour, together with the passage down the birth canal, help prepare the baby's lungs for breathing air and generally 'wake up' various systems in the body.(9) Babies born by caesarean before the onset of labour have a higher incidence of lung

disorders.

Some mothers may find themselves being advised by medical professionals at one of the small and ever diminishing number of hospitals that do still offer a 'trial of labour' culminating in a 'vaginal breech extraction'. Such an option at least enables the mother to go into labour spontaneously, enabling the baby's lungs to benefit from contractions. It also gives the baby a longer opportunity to turn.

Major abdominal surgery can be avoided. What is more, provided the woman manages to push the baby out - despite being in the most mechanically unfavourable position for childbirth possible (bar being hung upside down) - she will, at least, have had a 'normal' birth.

Amazingly some women do actually manage to give birth in such circumstances, some so rapidly that there is no time for epidurals or forceps. Women who have no deep-seated fear or dread of the lithotomy position and good levels of confidence in both themselves and their birth attendants can even have positive birth experiences, despite the breech presentation.

One mother who managed to give birth under just such conditions before her attendants were ready, commented to me that she found the stirrups useful because they gave her something to push against and that it would have been better if they'd been padded because they'd hurt her feet.

Apart from the obvious advantages of avoiding surgery it is unlikely that a woman planning to deliver a breech via the 'vaginal route' will be attended by an inexperienced midwife - she should be cared for by someone who is skilled in breech deliveries and who is conversant with the problems and risks involved. Since breech presentations are relatively rare such a person is likely to be one of the more experienced midwives or doctors at the hospital. There is support too for this option since it has medical sanction.

The disadvantages are that labour may be long and difficult and may end, after all, in a caesarean. Women who have prepared during pregnancy for a natural active birth may not be able to cope emotionally with the prospect of epidural, lithotomy, and forceps. Even if delivery is achieved under such circumstances some women may still suffer emotionally due to 'loss of control' and feelings that they have not 'given birth' as they had hoped to do.

So, what of the woman who is fortunate enough to be well informed and who takes the very unusual decision to remain 'naturally active' and give birth to her breech presenting baby in a supported standing squat? How much respect is such an 'informed choice' likely to engender? How much genuinely interested co- operation is she likely to encounter?

The general reaction from the vast majority of our maternity health professionals is very sadly likely to be at best unhelpful and at worst downright threatening. It is an indictment of our maternity services that if she steadfastly refuses to make the 'right' choice she is likely to find herself trying to give birth alone, unassisted, unsupported, surrounded by birth attendants oozing fear, with a ready-and-waiting operating theatre down the hall, complete with surgeon, knife at the ready, waiting for the errant patient to come to her senses.

Despite all the evidence pointing to the relative safety of natural active breech birth a mother can't possibly be properly 'informed' if she makes such a choice, can she?

References

1. Enkin Murray, Keirse Marc J N, Renfrew Mary, and Neilson James, A Guide to Effective Care in Pregnancy and Childbirth, Second Edition, Oxford University Press (1995)
2. Fortney, JA et al, Delivery type and neonatal mortality among 10,749 breeches, Am J Pub Health, 1986; 76(8): 980-5.
3. Cox Janice P, ICEA Review -Delivery alternatives in the term breech pregnancy, November 1988
4. Collea, JV et al, The randomized management of frank breech presentation: vaginal delivery vs. caesarean section, Am J Ob Gyn, 1978; 131:186-93
5. Confino, E et al, Vaginal versus caesarean section oriented approach in the management of breech delivery, Int J Ob Gyn, 1985; 23: 1-6.
6. Hughcroft, SA et al, Late results of caesarean and vaginal delivery in cases of breech presentation, Can Med Assoc J, 1981; 125: 726
7. Rosen, MG et al, Long term neurological morbidity in breech and vertex birth, Am J Ob Gyn, 1985; 151: 718-20.
8. Odent, M, Birth Reborn, Souvenir Press, 1984 see also Richards, Lynn Baptisti, The Vaginal Birth After Cesarean Experience, Bergin and Garvey, 1987.
9. Lagercrantz, H et al, The "stress" of being born, Scientific Arena, 1986; April: 92-102.