AIMS For a better birth...

Hands off that breech!

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Independent Midwife Mary Cronk MBE makes a plea for more research, and suggests ways to help women birth their breech babies normally.

I have been a member of AIMS for over forty years, having joined at a time when one of the major problems was the lack of maternity beds for women who needed or wanted them.

I have in my archives a Social Report on a woman expecting her first baby. The notes say the following: "Home circumstances: one room and kitchen, inside lavatory, coal range running cold water-suitable for home confinement."

When her baby presented by the breech at term, I thought it the perfect reason to get the hospital bed that she wanted, but my referral letter came back stating that she would do very well in the hands of her known district midwife! While this article is not about maternity beds, but about breech birth, my notes from the start of AIMS remind me that breech-presenting babies were not only under the care of district midwives, but were also considered unusual-not abnormal. I still consider a breech to be a normal (but unusual) presentation for a baby to assume.

Why Breech?

Recently, together with the independent midwife Jane Evans, I have stomped the country giving study days to midwives about pregnancies where the baby presents by the breech. The questions we ask ourselves when the diagnosis comes back may be the same questions that a woman with a breech baby needs to consider when she is deciding on her birth plan. Most breech presenting babies are that way round purely by chance, but there can be other reasons. For example, it may be due to prematurity: many babies present by the breech until 30 weeks or so, and if labour starts before then, this explains the position. (There is some evidence that very premature breech babies do better if delivered by Caesarean section. Despite this, there is always a 28-weeker who arrives on the labour ward with the buttocks at the vulva, and this is one of the factors that skews the morbidity figures for vaginal breech delivery).

If the pregnancy is at term we need to ask if there is another reason for this breech presentation? Placenta Praevia? They don't always bleed antenatally. If the woman has chosen not to have a routine ultrasound scan (and this is a situation where the advantages of selective ultrasound should be explained, because it can be helpful in excluding placenta praevia, or other objects in the pelvis such as fibroids and

ovarian cysts) we need to keep in mind the possibility of a bi-cornuate uterus. This does not necessarily exclude vaginal birth, it depends on the degree, but it is something to check.

Another question to ask is does this baby have a problem? There are serious but rare anomalies that the baby may have such as hydrocephaly (water on the brain) that can lead to breech presentation that can be excluded, again by ultrasound scan. Conditions which involve lack of muscle tone can also contribute to a breech presentation and do not always show on scan. I think of ostogenesis imperfecta (brittle bone disease) or severe Downs Syndrome. While emphasising the normality of the vast majority of bum-first babies, I think a good midwife should explore with the woman that there might be a problem. Last year I attended a home breech birth of a gorgeous little girl who has Downs Syndrome and an associated heart problem. The parents had made a fully informed choice not to have antenatal screening, and little Emma found the breech position much more to her liking.

The 'Normal' Breech

But let's consider the "normal" woman at term with her normal baby in the breech position, showing no inclination to turn. I believe that this baby can be born easily and spontaneously, if the labour proceeds spontaneously and easily-just like a cephalic presentation. There is one major difference. In a cephalic presentation, if the labour is inco-ordinate, or lacks progress, augmentation is occasionally justified. I do not believe that there is any place for induction or augmentation in a breech labour. If the labour does not progress, this woman's body is telling us something, and we should listen. There is no emergency, there is no rush, this labour just isn't progressing, and this baby is likely to benefit from being delivered by Caesarean section.

What do I mean by a "normally progressing" labour? A labour that starts spontaneously around term (any time between the 37th and the 42nd week of pregnancy-or later if the woman has delivered late before) with contractions that come oftener, last longer, get stronger; come even oftener, last even longer, get even stronger; and then, as far as the woman is concerned, come too b---y often, lasting too b----y long, and are too b---y strong. This accompanies a cervix that effaces and dilates and a presenting part that descends in the birth canal.

I do not feel that there is any place for either trying to push breeches through pelvises with oxytocic drugs, or pulling them through with actively managed medical breech extractions with the woman immobilised by epidural anaesthesia and strung up in the lithotomy [lying on her back] position. I feel that that is what has contributed to giving vaginal breech delivery poor outcomes and such a bad name. If the Hannah trial has told us anything, it is that medically-managed vaginal breech delivery-particularly in inexperienced hands-is less safe than Caesarean section. In my experience if the labour does not progress well spontaneously, the baby needs to be delivered by Caesarean section.

Breech by Caesarean

I looked after a woman some years ago. At term the baby was presenting by the breech. It was her second

baby, her first, weighing 8lbs, had been delivered by forceps. She had very mixed feelings about how that labour had been "managed" and desperately wanted to birth this second baby at home. Labour commenced at term +10. It started, it stopped, then there was another few hours of good strong contractions, and then it all stopped again. The fetal heart was good, the mother was in good condition: well rested, well hydrated, and well nourished. But over the period of two days, her labour just did not progress. There was no emergency, the cervix was not dilating beyond 3-4 cms, though effaced and thin. The presenting part was not descending, this labour was not effective.

When Caroline was ready, and had started to come to terms with the fact that this second birth would also need help, we transferred to hospital where baby Jack was born by Caesarean operation. He weighed 10 lbs and was in excellent condition. It was now perfectly obvious why the labour had not progressed spontaneously. He was too big to pass easily through his mother's pelvis. If we had tried to do clever things with oxytocic drugs, I believe Jack would very soon have become distressed. The CS was a positive experience for his mother, she had remained in control and had made the decisions.

Unnecessary Caesarean Breech

But what I want to discuss is not the necessary and proper use of surgery to deliver babies, but what I and many others consider unnecessary surgery, electively performed simply because of breech presentation. Performed because while we have good surgeons who can do a good CS, they, and we, have forgotten, that most breeches can safely be born vaginally. Many midwives have lost, or never been able to learn, the skills of how to assist a woman to give birth when the diagnosis is made "It's a breech". Though we know all about mechanisms and we have sat with enough women through enough labours to know when a labour is progressing well and one which is not.

It always strikes me as totally inappropriate that the woman who says she wants a natural breech birth is referred to a Consultant Obstetrician. While I have the greatest respect for my Obstetrician colleagues, the fact is that they do not do normal. It's not their field of expertise, so why ask their opinion on a matter of which they have little or no experience? Very few, if any, obstetricians have ever sat with women throughout their labours and learned how normal labour in all its diversity progresses and how birth happens. A normal labour and a spontaneous birth are not to be excluded just because the presenting part is the breech.

I emphasise that I am not saying that all breeches can or should be born vaginally but then again, neither can all head-down babies. I have attended many breech births, and in my experience if the labour progresses well and spontaneously and by that I mean-spontaneous onset at or around term, contractions that come oftener, last longer, get stronger, a cervix that effaces and dilates, and a presenting part that descends through the pelvis, this baby will be born.

Many of the women that I help to birth their breech babies give birth at home, but this is not always the right place to be, and it is sometimes downright inconvenient for the family. But unfortunately not all hospitals seem able to facilitate women birthing their babies in peace, but that can be the subject of

another article.

Adopting the Best Position

When caring for a woman with a breech presentation, I encourage the woman in the early stages of labour to be in whatever position she finds comfortable. Most will want to be in some sort of forward leaning position. When the second (the expulsive) stage approaches, I ask the woman to be on her hands and knees, or in a sort of Christian prayer position. I find that this is the best position for mother, baby and midwife. I expect that the second stage will progress quite quickly. As the body emerges, I do not touch but observe, and only intervene if there is a reason to assist the normal mechanisms that the baby makes as it journeys through the pelvis. As the head emerges I may ask the woman to go forward from the Christian Prayer position into the Second Moslem prayer position. A conversion from Christianity to Islam assists the head to flex and be born. If this progress in the second stage does not take place, there will be no appearance of the bum. There is no rush, no panic, but this labour is not progressing and we transfer for a Caesarean.

I am aware that some practitioners ask the mother to stand in an upright position for the second stage, and the birth of the breech.

I am concerned that the placenta may separate too quickly if the woman is upright. It seems to me that if the woman is vertical, there may be some traction on the cord/placenta from gravity just after the birth (and in the absence of a contraction). While I do not have any hard evidence to support this theory, I feel that until I have evidence to refute it, I should not encourage women to give birth to breeches in the vertical position. It also seems that women will bend forward and assume the "all fours" position if not directed by us. We need more research to help us in this area.

After the Breech Birth

While many breech babies will be born with satisfactory Apgar scores, some, in my experience, are slow to breathe spontaneously. They are pink, the heart rate is good, but they often only score one on reflexes, and one on muscle tone, and are not breathing spontaneously. It is important to have bag and mask at hand, or in the hospital situation where bags and masks aren't available to have the resuscitaire ready (and in the room not the corridor). In my experience, a minute or so of bag and mask is all that is necessary, and respiration ensues. It is important to have discussed this with the parents beforehand, and that they know that baby may need some help "to get going".

Summary

- Don't push a breech through a pelvis with Oxytocic drugs: no inductions; no augmentations.
- If labour isn't progressing, suggest a CS.
- Don't pull a breech down through the pelvis, no breech extractions. Breech by propulsion not traction.
- If it isn't coming down, move to a CS.

- Keep your hands off, sit on them if necessary.
- Trust the woman's body.
- Be ready to bag and mask.