AIMS For a better birth...

# Turning Point for the Breech?

AIMS Journal, 1998, Vol 10, No 3

By Pat Thomas

There can't be a breech mother alive who has not tried to turn her baby. AIMS receives a great many calls each month from women whose babies are in a breech position and who, when they aren't being told that they must have caesareans, are being advised to go for long walks, spend long hours with their bottoms in the air or simply to spend time crawling around on the floor.

I did all of these things when my son was in the breech position. I also underwent ECV four times from around 37 weeks before term with an experienced practitioner (and can agree with Benna Waits [Into the Breech? Page 14, AIMS Journal Autumn 1998 p14], it was painful and ultimately not very helpful). My placenta was not in the way and although I had a big baby, there was still plenty of room for him to turn. Although my doctor did manage to turn the baby once, he reverted to the breech almost immediately. I took homeopathic remedies and burnt Chinese moxa sticks close to that crucial acupuncture point on my little toe - and considering how big I was this was no mean feat!

What nobody ever told me was whether was any of these things have any track record, any proof of their efficacy. Indeed, depending on how you look at it, the evidence was thin and is still somewhat inconclusive. Much of what we know about ECV comes from a medical point of view and is focused on how we can avoid performing expensive caesareans for breeches (ironic considering how enthusiastic our doctors are to perform this operation in the first place for this and other reasons). From this point of view ECV is a success story.

However, there appears to be no research at all into women's views about ECV, whether they want it, whether they feel it is helpful, whether it provoked anxiety and fear, or whether they would simply like for doctors and midwives to stop treating them as if they were carrying an infectious disease instead of a baby. There are many unknowns about breech babies, why some persist and why some don't and what part if any the baby and the emotional and psychological state of the mother plays in persistent breeches (see page 8).

Additionally, we don't really know what proportion of breech babies can be birthed successfully vaginally because so few are given the opportunity. The general rule of thumb is, if the first stage goes well, then the baby can be birthed vaginally. But how many women are "allowed" to get to that stage? By intervening, whether it be with ECV or caesareans, we have decreased our own knowledge of this part of the birth process.

Nevertheless, there is emerging medical enthusiasm for turning breeches at or shortly before term and it is backed by good quality research. If a doctor is enlightened and doesn't immediately recommend a caesarean, he or she may recommend that the mother try to have the baby turned. This is the external cephalic version. With ECV pressure is applied through the mother's abdomen to the baby (occasionally aided by the use of a tocolytic, or muscle relaxant) in order to try and alter the baby's position. On the whole ECV is more successful when performed at term (37 weeks plus) or in early labour.[1,2]

There have been, according to the Cochran Database, six randomised controlled trials on ECV (involving around 600 women) and the results appear to be consistent.[3] Women with uncomplicated breech presentations at term should be offered ECV. The Royal College of Obstetricians and Gynaecologists concurs with this view.[4]

Versions performed on a woman who has gone into labour spontaneously have been shown to reduce the caesarean operation rates considerably. In studies from the US two out of three babies presenting breech who underwent ECV at term proceeded to a cephalic birth (67%)[5].

This compares to information from the Cochrane review, which suggests that only around one in five (22%) who do not undergo ECV will turn spontaneously before delivery and that the caesarean section rate is halved for those mothers who have ECV from 30% to 15%. Babies who have undergone ECV do not appear to be at any increased risk, there was no difference in Apgar score, cord pH values, admission to the neonatal unit or postnatal death.[3]

One study showed that at the most conservative estimate, ECV performed on all breech babies in labour would prevent 34 per cent of all breech deliveries and 14 percent of all caesareans for breech[6]. We must remember, however, that, the success of ECV varies considerably depending on the skill and experience of the person carrying out the manoeuvre.

Two trials have reported on the use of ECV after a previous caesarean - ECV was successful in about 80 per cent of cases [7, 8].

But information contained in smaller studies should also not be ignored. For instance one prospective unblinded study, over 12 months which looked at the factors affecting ECV success, determined that while ECV does reduce the risk of a vaginal breech delivery and caesarean section, and it provides women and their caregivers with a third management option, to avoid one caesarean would take 5.9 attempted ECVs and the procedure may prove to be expensive (though probably not as expensive as a caesarean operation) in terms it operator time [9]. Perhaps more importantly, it can be emotionally

expensive for mothers, who may be enthusiastically told by their doctors and midwives that this procedure will make the difference between a safe birth and one which is risky.

ECV appears to be safe for mother and baby, though transient bradycardia (slow heartbeat) in the baby is a common reaction. This appears to resolve itself within an hour or so after the procedure. Before term there is generally thought to be around a one per cent chance that the baby could die during the procedure. In unskilled hands there is a chance of detaching the placenta during the procedure. A practitioner should use ultrasound to check both the baby's and the placenta's position.

Some babies revert to their breech position after an apparently successful version so women will need to weigh up the pros and cons of the procedure which can be painful and emotionally difficult to go through. Also we need to question whether ECV is or will soon become just another routine intervention. The directive to have ECV will be just as unpalatable to some women as the directive to have a caesarean. Certainly the use of ECV assumes that breech is an abnormality which needs to be fixed - no one has yet asked women how they feel about this assumption. If breech mothers are at greater risk of a caesarean operation (and the risks which this poses for future pregnancies) it may not be because breeches are more dangerous or more risky *per se*, but that our doctors and midwives have lost the skills necessary to facilitate a vaginal breech birth.

As for whether it is better for the baby in both the short term and the long term the question remains open. Certainly in one survey which looked at the outcome for both diagnosed breeches and undiagnosed breeches, those who were undiagnosed and delivered vaginally actually fared as well, and in some cases better, than those who had been diagnosed early and thus received the benefit of obstetric management [10].

By all means, let's revive the skill of turning breech babies and give women who want it another care option, but let's not do it at the expense of reviving the skill facilitating the vaginal birth of babies in this unusual, but not particularly dangerous, position.

**References**

1. Fortunato, SJ et al, *External cephalic version with tocolysis: factors associated with success,* Ob Gyn 1988; 72:59-62
2. Ferguson, JE, *Intrapartum external cephalic version,* Am J Ob Gyn 1985; 152:297-8
3. Hoffmeyer, GJ, *Cephalic version by postural management* In:Keirse, MJNC, et al eds, *Pregnancy and Childbirth Module of the Cochrane Database of Systematic Reviews, 1996 (updated 29 Feb 1996).* Available in the Cochrane Library from BMJ Publishing Group: London
4. RCOG, Effective procedures in obstetrics suitable for audit Manchester RCOG Medical Audit Unit, July 1993, p2
5. Zhang, J, et al. *Efficacy of external cephalic version: a view,* Ob Gyn 1993; 82: 306-12
6. Hoffmeyer,GJ, *External cephalic version at term: how high are the stakes?* Br J Ob Gyn, 1991; 98:1-3
7. Flamm, BL et al, *External cephalic version after previous caesarean section,* Am J Ob Gyn, 1991;

165:370-2

8. Shalev, E, et al, *External cephalic version at term, using tocolysis* Acta Ob Gyn Scand, 1991; 72:455-7
9. Healey, M et al, *Introducing external cephalic version at 36 weeks or more in a district general hospital: a review and an audit*, Br J Ob Gyn, 1993; 104: 1073-9
10. Nwosu, EC et al, *Undiagnosed breech*, Br J Ob Gyn, 1993; 98:1-3