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Editorial



Breech presentation at term: Is it the time to revisit the mode



An introduction to the Mini-Symposium commissioned by the European Board and College of Obstetrics and Gynaecology (EBCOG)

The incidence of Caesarean sections (CS) is globally rising. In some European countries, the CS incidence is approaching almost 50 % [1]. Up to 3–4 % of babies at term are born with breech presentation and almost all are delivered by planned CS. It is well recognised that each CS virtually generates a repeat CS.

Until the end of last millennium, the standard practice was to allow carefully selected patients with breech presentation at term to attempt vaginal delivery [2,3]. However following the publication of “the term breech trial [4]”, it all changed globally and a planned elective CS delivery for breech became a norm. This trial provided evidence of lower short term perinatal mortality and morbidity for the planned elective CS group compared with the planned vaginal delivery group. The trial did not report on the long term outcome of the babies and the impact of primary CS on the subsequent obstetric performance of the women with a scarred uterus in future pregnancies [5,6].

This changed clinical practice of offering a planned elective CS for breech at term in many countries, including the UK has led to reduction in the training and experience in dealing with a breech in labour. The current generation of obstetricians have lost the “the fine art of delivering breech vaginally”, therefore even parous women who have delivered virginally previously, are quite often denied an attempt at vaginal birth.

The follow up reviews [7] and PREMODA Study [8] have questioned the robustness of the methodology and the safety data of the “Term Breech Trial”, and have questioned whether this trial results have led to a premature change in clinical practice.

The standards of care working group of the European board and college of obstetrics and gynaecology (EBCOG) has commissioned this mini symposium on the management of term breech from a

large referral centre in Germany, where trial of vaginal birth is allowed even for women with a previous CS scar. This symposium comprises of four papers from the centre. As this is a controversial area of clinical practice, two experts have been invited to write commentaries expressing opposing views on the mode of delivery to stimulate intellectual discussion.

For those readers, who are keen to consider “Trial of Vaginal delivery for Breech”, newly written Clinical Practice Guidelines from the French College of Gynaecologists and Obstetricians (CNGOF) have also been included in this mini-symposium [9].

The first paper in the symposium by, Bruggmann et al. reports analysis of all the publications on this topic from 1900 to 2014 and has identified 1438 original studies. It has been pointed out that the highest number of most cited publications came from the industrialized world and there is lack of robust data from the developing and emerging countries. The authors therefore justifiably call for further collaborative research to collect accurate and reliable data from these countries about the short and long term outcomes of mothers and babies.

In the second paper, Paul et al. has reported on the outcome of trial of vaginal birth in a carefully selected group of women with a previous CS who were allowed a trial of vaginal birth. Although the number of women in this study group are small but do provide reassuring outcome data, both for the newborn and the mother.

In the third paper, Kaisen et al. have provided comparative data on maternal and neonatal outcome after attempted vaginal breech delivery among nulliparous and multiparous women with breech presentation at term. The rate of emergency CS in nulliparous women was 40 % compared to 17 % in multiparous women. Reassuringly, perinatal morbidity data were comparable in both parities.

In the fourth paper, Mollmann et al. have reported the short term maternal and foetal outcome in intended vaginal breech deliveries according to the gestational age (at term and post term). Although there was no difference in short term neonatal morbidity and mortality but the rate of CS was increased in post term delivery cohort (36% Vs 26%).

Asma Khalil and her colleagues from the United Kingdom argues that planned elective CS for term breech has reduced perinatal and neonatal morbidity and mortality when compared with planned vaginal birth and this is supported by a Cochrane review. Furthermore, over the past twenty years, the obstetric practice within the UK has changed to such an extent that almost all women with term breech are delivered by a CS. Arguably, this lack of experience in delivering vaginal breech can potentially compromise foetal outcomes and it will be safer to opt for CS even in labour. These improved outcomes for the newborn needs to be balanced against maternal risks associated with multiple Caesareans in future pregnancies.

Gerard Visser from the Netherlands strongly argues that it is the time to revisit the findings of “The term breech trial”. Within the Netherland, the rate of CS for term breech increased from 50% to 80%, resulting in 2000 extra CS. He argues that the long term adverse impact of primary CS during the subsequent pregnancies such as risks of pre-term birth, placenta accreta, emergency hysterectomy and maternal deaths have been overlooked. French and Belgium data did not show any adverse longterm perinatal outcomes in the vaginal delivery groups from those obstetric units where planned vaginal delivery is offered by using a strict selection criterion.

Lastly, “Breech Presentation Clinical Practice Guidelines” by the French College of Gynaecologists and Obstetricians will be of interest to those clinicians who may wish to offer a trial of vaginal birth to carefully selected women with breech presentation. It is stated that that the risks of severe short and long term complications appear similar after a trial of labour and a planned caesarean delivery, as long as subsequent pregnancies are not considered. The guidelines recommend external cephalic version in suitable patients. It is of interest to note that this guideline has recommended radiological pelvimetry for assessment of pelvic dimensions rather than MRI Imaging which has been used by the Frankfurt group.

It is important that the informed decision making about the planned route of delivery should be made between the women and the obstetrician, taking account of women’s autonomy and obstetrician’s skills in a particular mode of delivery. Safe delivery of the baby and the mother should remain a priority.

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