

Vaginal Breech Delivery Guideline: The Time Has Come

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Pre-emptive Caesarean section has been promoted since the publication of the Term Breech Trial in 2000.¹ The published trial indicated that there were serious differences in short-term neonatal morbidity, from 0.4 for deliveries via Caesarean section to 5.1 for vaginal deliveries. The publication has had widespread influence throughout the world, including in low-resource countries, where many obstetricians are opting for breech deliveries.

By 2003–2004, a number of countries had started to question the results of the Term Breech Trial. Further re-analysis and follow-up indicated that at five years, there was very little difference in neonatal outcome. Maternal outcome was not significantly changed, as there was no increase in maternal mortality for either vaginal or Caesarean section delivery.

The Collège National des Gynécologues et Obstétriciens Français was the first, at a 2001 symposium, to call into question this systematic approach to breech delivery. A large group of physicians in France addressed the issue and decided to continue promoting the breech vaginal delivery option.

In 2006, Goffinet et al. published the PROMEDA Study,² which showed no difference in perinatal mortality or serious neonatal morbidity between labour and planned Caesarean section.

In Canada, the province of Quebec was an exception, with a significant number of physicians still electing to offer breech vaginal delivery. The University of Sherbrooke continued to teach its residents the method; many of these former residents are now in practice in Quebec and are offering women this option.

The SOGC Clinical Practice Guideline, “Vaginal Delivery of Breech Presentation,” in this issue of the *Journal* offers health care providers an option for safe vaginal breech

delivery.³ Many of the recommendations are taken from “Attendance at Labour: Guidelines for Obstetrical Care”⁴ (an update to this 2000 SOGC Policy Statement is in press), which offered recommendations for the selection of patients for labour and vaginal delivery.

Some women’s groups advocate for the right to choose a vaginal delivery for a breech presentation. There are, therefore, women who present at term, requesting breech vaginal delivery, causing concern for themselves, their families, and the physicians who take care of them. Since many of the university centres have stopped training their physicians in breech vaginal delivery, there is a serious shortage of qualified physicians to supervise, and/or perform breech vaginal deliveries.

Given that the recommendations of the new SOGC guideline, “Vaginal Delivery of Breech Presentation,” state that spontaneous or assisted breech vaginal delivery is acceptable when certain criteria are met, it will require a coordinated effort from doctors and midwives to undergo training, or to refresh their training, in breech vaginal delivery. Fortunately, the Canadian ALARM program and the International ALARM program have continued to promote breech vaginal delivery. The SOGC will call upon APOG to put together a small working group that, in conjunction with SOGC, will address the training issues. The new SOGC guideline, “Vaginal Delivery of Breech Presentation,” will be presented by Dr Robert Gagnon, Chair of the Maternal Fetal Medicine Committee, as part of an international symposium at the 2009 SOGC Annual Clinical Meeting, and Dr Frank A. Louwen, Professor of Obstetrics and Gynaecology, University of Frankfurt, has been invited to present a new option for the positioning of women during the second stage of breech vaginal delivery.

The elective Caesarean section approach for breech presentation has many problems in both developed and developing countries. In developed countries, the timing of the Caesarean section is an issue as are overcrowded schedules

and competing demands for operating room time. The Caesarean section rate in Canada, which is close to 27%, is at the upper limit for medically indicated procedures. Although it is widely believed that many women do ask for elective Caesarean section, we should be careful that we do not inadvertently promote it when women do not ask.

In developing countries, the situation is even more problematic. These countries have very low resources and certainly cannot afford a Caesarean section rate of 25%. However, because elective Caesarean section for breech presentation is promoted at international meetings and in the developed world, many physicians in low-resource countries are reluctant not to offer elective Caesarean section for breech delivery.

In both low- and high-resource countries, this situation has stretched resources to the limit without proof of long-term benefits. More and more, this is reminiscent of the introduction of continuous fetal monitoring, which seemed to have great promise to reduce neonatal morbidity and mortality, but in the end did not, actually increasing the Caesarean section rate instead.

Women in Canada and abroad are requesting the option of breech vaginal delivery. Will it be obstetricians and gynaecologists offering this, or, since many hospitals are not offering breech vaginal delivery, will women rely on midwives to do so? Some women with a breech presentation elect to deliver at home because they believe they will be refused a breech vaginal delivery at the hospital. It is urgent

that we take on this responsibility and that every hospital in Canada offer safe breech vaginal delivery. We need to meet with our colleagues in midwifery to support their request for breech vaginal delivery in hospital and access to consultation with their obstetrician colleagues.

We cannot condone home breech vaginal delivery; thus, we must offer breech vaginal delivery as a safe alternative in our maternity hospitals. There will be a difficult transition period when some of our experienced members will most probably have to be on call to help their colleagues train and feel more comfortable with breech vaginal delivery. Fortunately, there are still many obstetrician-gynaecologists in this country who have had extensive experience with vaginal breech delivery and who are positive about it. The SOGC calls on all colleagues to work together to offer the option of breech vaginal delivery to Canadian women.

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ERRATUM

Johnson N, Medd L, Shah PS, Shannon P, Campisi P, Windrim R, Ryan G. A challenging delivery by EXIT procedure of a fetus with a giant cervical teratoma. *J Obstet Gynaecol Can* 2009;31(3):267–71.

Greg Ryan, MB, FRCS, and Laura Medd, RDMS, were inadvertently omitted from the list of authors for this case report. The authors and the *Journal of Obstetrics and Gynaecology Canada* regret the error and any inconvenience it may have caused.

Johnson N, Medd L, Shah PS, Shannon P, Campisi P, Windrim R, Ryan G. « A challenging delivery by EXIT procedure of a fetus with a giant cervical teratoma », *J Obstet Gynaecol Can*, vol. 31, n° 3, 2009, p. 267-71.

Les noms de M. Greg Ryan, MB, FRCS, et de Mme Laura Medd, RDMS, ont été omis par inadvertance de la liste des auteurs de cet exposé de cas. Les auteurs et le *Journal d'obstétrique et gynécologie du Canada* regrettent cette erreur et tout inconvéniént qu'elle a pu causer.