It's a breech!

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"It's a Breech!"

by Mo Tabib

Author's note: Names have been changed to preserve anonymity.

Over the last decades, caesarean section has become the method of choice for breech presentation. This article is a reflection on my personal experience as a midwife and my thoughts in regard to questioning the justifications for performing routine caesarean for all breeches.

Gemma was a para 1 with a previous spontaneous vaginal delivery with no pregnancy complications who was admitted at 40.6 weeks gestation with an undiagnosed breech presentation. I was told Gemma was waiting for admission in the midwives' unit. I was also told she had been referred to the hospital by her community midwife.

When I entered the room, she was sitting on the bed looking terrified, though she was trying to put on a brave face.

"I had planned for a homebirth, but my community midwife said baby has passed meconium and I had to come to hospital. Can I stay in the midwives' unit? I really don't want to go to the labour ward."

I said, "Let me examine you first to see where we are and then we'll make a decision together."

On examination, the cervix was 4 cm dilated. What I could feel was definitely not the head—it was a breech presentation. I thought, *How can I tell her that not only she has to go to labour ward, but she also needs to be taken to theatre to have a caesarean?* (Caesarean is usually the method of choice for breech presentation in our hospital.)

I said, "Everything looks fine, baby is absolutely happy, you are fine and I think your baby might be breech. Of course this is not an abnormality, it is just different from the presentation of most babies at the time of birth." Then my mind flew back to years ago when I used to work in a very rural area of Iran. At the time I was a midwife working in a midwife-led unit, where the nearest consultant-led hospital was two hours away. I was trained to deal with undiagnosed breech deliveries, not because we were supporting vaginal breech deliveries but because we could not get them to the hospital and theatre in time.

There were several occasions in which I had no choice but to assist with vaginal breech births. Interestingly I had noticed that progress for these vaginal breech births was more rapid than a cephalic presentation. In my experience, the outcomes for all these women and neonates were good. What I had learned from the experience was that providing a calm, reassuring environment for these mothers was one of the most essential factors. This allowed the appropriate hormones to act and for the pelvic muscles to relax and open (Evans 2012). If moms felt reassured and safe, they would feel confident and would stay focused and in control of their labour.

In breech presentation, one of the main concerns is dealing with a trapped head. Anxiety and stress can distract the natural process of labour and cause this to happen.

"In nature, when a labouring animal feels threatened or disturbed, the stress hormone catecholamine shuts down labour. Similarly, when a labouring woman does not feel safe or protected or when the progress of her normal labour is altered, catecholamine levels rise and labour slows down or stops" (Lothian 2004).

As a result of my experience, I have always been wondering whether or not caesarean section is truly the best method of delivery for every mother with a breech presentation. Especially since the study of Hannah et al. in 2000, caesarean has become the method of choice around the world. However, the Royal College of Midwives made this statement about the Hannah et al. study:

> The study concluded that, for breech presentations, the results were clearly in favour of planned caesarean section over planned vaginal delivery. But after adjustment to exclude women who had had prolonged labour, induction or augmentation, epidural or no skilled/experienced clinician at the birth, the results were similar.
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> The follow-up study two years later by Hannah et al. 2004 did not show any difference in the long-term outcomes. Hopefully, these supportive findings will now challenge the practices put in place after the original study. (Royal College of Midwives)

There is evidence based on other studies that concludes, "In places where planned vaginal delivery is a common practice and when strict criteria are met before and during labour, planned vaginal delivery of singleton fetuses in breech presentation at term remains a safe option that can be offered to women" (Goffinet et al. 2006).

In the Goffinet et al. study, the population studied consisted of 8105 pregnant women delivering singleton fetuses in breech presentation at term in 138 French and 36 Belgian maternity units.

I thought, *How can I help Gemma to make an informed choice? Could my previous experience be an influential factor?*

Being a midwife for 20 years has given me the insight not to underestimate the effect of mind on body and, consequently, on the process of labour. How could I discuss the different aspects and the potential risks in a way that would empower Gemma to make an informed choice?

Gemma's voice pulled me out of my questioning mind, "I have an 18-month-old at home—I want to avoid a caesarean if at all possible."

Now I was ready to share anything I knew.

I discussed the available evidence and the options and explained that if she decided to try a vaginal birth, there would be a low threshold for a caesarean if labour did not progress satisfactorily or if baby became distressed.

In the end, I added that I would support her either way. If she chose a caesarean I would be by her side, and if she chose a vaginal birth I would be quite confident to look after her and deliver her baby.

"What if your shift is finished and I am still in labour?"

"Gemma, I promise I will see your baby in your arms before I go home."

Following this, medical staff were informed and the obstetric registrar performed a scan and discussed the options and potential risks with Gemma.

"I would like to try a vaginal birth, but if baby gets distressed or my labour doesn't progress, then I will give consent for a caesarean," Gemma said.

Gemma's decision was respected by the medical team. Continuous fetal monitoring commenced and fetal heart tones remained reassuring during labour. After six hours of swaying on the ball, being on all-fours or standing up rocking her hips, Gemma gave birth gently and quietly to her healthy son Leo in the hands-and-knees position. Leo was 3740 grams (8.25 lb) and had Apgar's of 8 and 9. Gemma had an intact perineum and only 100 ml of blood loss. The satisfaction seen in Gemma's eyes was immeasurable, something that was not considered in the Hannah et al. study.

In fact the only vaginal breech deliveries I have seen in my current work place were undiagnosed breeches. The breech presentation for these women was discovered when baby's bottom was out. This is always dealt with as an emergency situation: the scary sounds of an emergency buzzer goes on, dozens of medical and midwifery staff who are complete strangers to the woman enter the room and usually the medical staff takes over and starts with a hands-on technique. These women are not given the slightest chance to trust their inherent ability and deliver their babies in peace or have a positive experience of birth. In fact, it is highly likely that they are traumatised by the experience.

Gemma's story was an exception in our hospital, as the usual practice is caesarean for breech presentation. Even if the mother chooses a trial of vaginal birth, it is usually an obstetric birth in the lithotomy position in theatre. However, Gemma's labour progressed quickly and before I knew it, the cervix was fully dilated and baby was on its way out with no time for a transfer to theatre. We did take every necessary precaution: a paediatrician was present in the resuscitation room, theatre was ready, and two obstetric registrars were standing behind me in case any problems arose during birth. While Gemma was on all-fours facing the wall, she could only hear my calm, reassuring voice, encouraging her that she was doing amazing and that the birth was going well. Gravity was the best aid for Gemma and her baby; legs flopped out followed shortly after by arms. There was about a two-minute gap between the delivery of the body and the next contraction, but it felt like hours. I assume this is the time that inexperienced practitioners might panic and be tempted to start using their hands when there is no contraction present, whereas with little or no input from the practitioner, the baby will flex his head and birth alone as Gemma's baby did.

> For a normal breech birth, the time-honoured advice, hands off the breech, is still the safest advice. Keep your hands to yourself; sit on them if necessary. Old midwifery textbooks show that when a woman is on her back for the delivery, the attendants lift the baby up by the heels, over the mother's pubis; when she is on her hands and knees this movement happens by gravity (Cronk 2007).
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> The majority of injuries in cases of vaginal breech delivery are those caused by pulling or jerking on the baby's body in an effort to hasten delivery (Barrett 2008).

The aim of this article is not to suggest that all women with a breech baby should be given the option of vaginal birth or to undermine the value of surgery for some of these women. However, I am questioning the necessity of elective surgery performed simply because of breech presentation. We have forgotten that many of these women would be able to give birth safely via the vaginal route. It should be questioned whether calling for routine caesarean for all breeches is the best choice, no matter what this means for the women involved, like Gemma, who may have an 18-month-old at home with little support for child care.

Routine caesarean for all breech presentations also has caused the skills necessary for assisting a vaginal breech birth to be lost.

"Many midwives have lost, or never been enabled to learn, the skills necessary to assist a woman to give birth when the diagnosis has been made. This lack of skills and confidence continues to drive the caesarean rate for breech presentations even higher and contributes to accidental injury of the baby during caesarean delivery" (Gaskin 2004).

Gemma had a positive and empowering birth experience, a natural birth in a safe place and a well-equipped hospital with medical support. Would it not be ideal to give the same option to other women, too?

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