Raiders of the Lost Art

Thoughts on Vaginal Breech Delivery

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Before I can make any comments about this topic it is only fair to disclose my bias. The members of the Birth Action Coalition and I believe that the right of patients and families to informed consent and exercise of their free will is of paramount importance. Along with this right comes the responsibility to accept the consequences of their decision. With this in mind I believe there is still a role for the option of a vaginal breech delivery.

About 3% of women near term will find themselves confronting the dilemma of their baby presenting in breech presentation. As the baby gets closer to term there is a decreasing chance the baby will spontaneously flip to a head first presentation. This is due simply to mechanics of the growing baby having less room. Occasionally, breech babies result from innate abnormalities of the uterus or with the fetus itself. Most of the time, however, there is no obvious explanation as to why the baby ends up in this position.

The current trend in obstetrics is to recommend a c/section for this condition. There is data in the literature to suggest that this may be the safest route overall. Sadly, most resident training institutions no longer teach the skills necessary for safe vaginal breech deliveries. Combined with economics and fears of liability, the availability of a trained specialist in breech delivery will continue to diminish. While this may be expedient for the current times is can pose a danger in that inevitably some women will arrive in labor ready to deliver a breech baby and there will be no one around who knows what to do.

When a woman finds herself at 36 weeks into her pregnancy with a breech baby what should she do? That decision depends on many factors but should start with gathering information. In my practice, I would generally recommend the following advice. An ultrasound should be performed to determine that there are no obvious abnormalities of the baby or the uterus. Ultrasound can give an estimate of fetal weight, head and feet position and general health of the fetal environment. If all appears normal then the option of acupuncture, chiropractic techniques, certain exercises and other noninvasive techniques can be attempted over the next week. Should this fail then I would offer an attempt at external version around 37 weeks. This is done at a hospital delivery unit and I try to turn the baby to a head first position using pressure on the outside. It can be uncomfortable and has a success rate of about 50-70%. Version is easier when the baby is in the complete breech presentation (sitting Indian style) than when in the frank breech presentation (diving pike position).

When version fails then some decisions have to be made. There are certain criteria which studies have shown that, when met, make a trial of vaginal birth in breech presentation a safe option. These include:
1) Estimated fetal weight between 2500 and 4000 grams
2) Frank or Complete Breech Presentation
3) An adequate maternal pelvis (formerly measured by x-ray but can be assessed by exam and is a subjective sizing of the opening of the bony structures of the pelvis)
4) Baby's head must be flexed and not extended
5) Spontaneous labor and a reassuring fetal heart rate pattern.

If all these criteria are not met then a c/section may well be the only safe option available. This conclusion is supported by the current literature and, although a woman cannot be forced to have surgery, it would be unwise to refuse in my opinion. However, if these criteria are met then you do have the option of asking to wait for labor and see how things progress. The biggest obstacle might be finding an able and willing practitioner as the skills and desire of doctors to conduct a vaginal breech delivery will slowly disappear in the next generation. The Birth Action Coalition believes strongly that consumer demand for these birth choices is the only thing that might reverse this trend and save these skills.

The American College of Ob/Gyn reaffirmed the following opinion in 2008:

Mode of Term Singleton Breech Delivery

ABSTRACT: In light of recent studies that further clarify the long-term risks of vaginal breech delivery, the American College of Obstetricians and Gynecologists recommends that the decision regarding mode of delivery should depend on the experience of the health care provider. Cesarean delivery will be the preferred mode for most physicians because of the diminishing expertise in vaginal breech delivery. Planned vaginal delivery of a term singleton breech fetus may be reasonable under hospital-specific protocol guidelines for both eligibility and labor management. Before a vaginal breech delivery is planned, women should be informed that the risk of perinatal or neonatal mortality or short-term serious neonatal morbidity may be higher than if a cesarean delivery is planned, and the patient's informed consent should be documented.

ACOG opinions may not accurately reflect all our beliefs but we know they have strong influence when it comes to forming national policy. While not for all, I believe the choice for a vaginal breech delivery should remain a viable option. As we have seen with other birth choices, however, there are economic and legal pressures being brought to bear that are severely limiting your birth choices. This trend may not be reversible in the reality of the world we live in here in the United States. It will most certainly disappear if we remain passive and silent. We urge you to continue to speak out for your rights.