

1: [Acta Med Croatica](#). 2007 Apr;61(2):177-84.

**[Dillema about the method of delivery for the fetus in breech presentation]**

[Article in Croatian]

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The management of preterm and term delivery of fetus in breech presentation is one of the most disputable issues in modern obstetric practice. Several years ago, one of the biggest randomized controlled studies in obstetrics, Term Breech Trial (TBT), tried to set up guidelines and resolve the question of the best method to deliver the fetus at term in breech presentation. The results of this study have shown that the policy of planned cesarean section reduces the risk of short-term adverse perinatal outcome, compared with the policy of planned vaginal birth. Many perinatal centers have accepted the recommendations from this study and different obstetric associations have implemented these results in their guidelines. On the other hand, TBT had some limitations, especially those connected with the impossibility of regular and objective comparison of these two methods of delivery. In addition, the same group of authors did not find differences in long-term outcomes between the planned cesarean section and vaginal delivery. Although the rate of planned cesarean section has increased following the publication of TBT, selective vaginal breech delivery is still very successfully used in the centers where doctors have the possibility to obtain experience in vaginal breech deliveries. The most common method of reduce the noncephalic presentation is external cephalic version at term. It reduces the incidence of noncephalic presentations at labor, thus reducing the number of cesarean sections as well. At this moment, there is not enough evidence to support cesarean section as the method of choice for delivery of preterm and term breech, having in mind obstetric indications and criteria. The decision whether to deliver vaginally or by cesarean section should be individual for each pregnant woman.

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[http://www.ncbi.nlm.nih.gov/pubmed/17585474?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed\\_ResultsPanel.Pubmed\\_DiscoveryPanel.Pubmed\\_Discovery\\_RA&linkpos=4&log\\$=relatedreviews&logdbfrom=pubmed](http://www.ncbi.nlm.nih.gov/pubmed/17585474?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DiscoveryPanel.Pubmed_Discovery_RA&linkpos=4&log$=relatedreviews&logdbfrom=pubmed)

1: [Clin Obstet Gynecol](#). 2007 Jun;50(2):526-36.  
[Links](#)

## **Trial of vaginal breech delivery: current role.**

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Breech presentation occurs at term in approximately 3% to 4% of singleton gestations. This presentation is associated with a variety of maternal and fetal conditions including preterm labor, abnormal amniotic fluid volume, hydrocephaly, anencephaly, mullerian anomalies, abnormal placentation, and multifetal gestation. Cesarean delivery has been associated with increased risk of subsequent accreta, placenta previa, hemorrhage, and hysterectomy. The Term Breech Trial initially suggested that planned vaginal breech delivery is associated with increased neonatal morbidity and mortality compared with planned cesarean delivery. Long-term follow-up of these vaginally delivered infants contradict the initial findings. Current debate surrounds the dilemma of whether the untoward complications of cesarean delivery are warranted given uncertain minimal increases in neonatal survival and improvement in neurologic outcome with planned cesarean.

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[http://www.ncbi.nlm.nih.gov/pubmed/17513938?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed\\_ResultsPanel.Pubmed\\_DiscoveryPanel.Pubmed\\_Discovery\\_RA&linkpos=5&log\\$=relatedreviews&logdbfrom=pubmed](http://www.ncbi.nlm.nih.gov/pubmed/17513938?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DiscoveryPanel.Pubmed_Discovery_RA&linkpos=5&log$=relatedreviews&logdbfrom=pubmed)

**1:** [Am J Obstet Gynecol.](#) 2006 Jan;194(1):20-5.

**Comment in:**

[Am J Obstet Gynecol.](#) 2006 Dec;195(6):1873; author reply 1873-4.

[Am J Obstet Gynecol.](#) 2006 Dec;195(6):e22; author reply e23.

**Five years to the term breech trial: the rise and fall of a randomized controlled trial.**

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**OBJECTIVE:** On the basis of the end points of neonatal morbidity and death, the authors of the term breech trial concluded unequivocally that cesarean delivery was safer for breech babies. **STUDY DESIGN:** Analysis of the original and new data gives rise to serious concerns as far as study design, methods, and conclusions are concerned. In a substantial number of cases, there was a lack of adherence to the inclusion criteria. There was a large interinstitutional variation of standard of care; inadequate methods of antepartum and intrapartum fetal assessment were used, and a large proportion of women were recruited during active labor. In many instances of planned vaginal delivery, there was no attendance of a clinician with adequate expertise. **RESULTS:** Most cases of neonatal death and morbidity in the term breech trial cannot be attributed to the mode of delivery. Moreover, analysis of outcome after 2 years has shown no difference between vaginal and abdominal deliveries of breech babies. **CONCLUSION:** The original term breech trial recommendations should be withdrawn.

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## **Mode of delivery for breech presentation in grandmultiparous women.**

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**OBJECTIVES:** To compare maternal and neonatal outcomes of planned vaginal delivery vs. elective cesarean delivery for breech presentation at term. **METHODS:** Retrospective study of term breech deliveries from January 1997 through December 2000. A group of 128 women for whom vaginal delivery was planned was compared with a group of 122 women who had an elective cesarean delivery with regard to neonatal mortality and morbidity (birth trauma, birth asphyxia, hyperbilirubinemia, and duration of stay in the neonatal intensive care unit) and maternal morbidity (infections, hemorrhage, hysterectomy, deep venous thrombosis, and pulmonary embolism). **RESULTS:** There was no difference in neonatal mortality and morbidity between the two groups (13.0% vs. 9.4%). There were fewer maternal complications in the planned vaginal group than in the elective cesarean group (5.5% vs. 18%;  $P < 0.01$ ). In the planned vaginal delivery group 70% of multiparas and 85% of grandmultiparas were delivered vaginally compared with 50% of nulliparas. **CONCLUSIONS:** In breech presentations at term vaginal delivery can be achieved in 85% of grandmultiparas without significant neonatal morbidity. Elective cesarean section is associated with increased maternal morbidity compared with planned vaginal delivery.

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[http://www.ncbi.nlm.nih.gov/pubmed/15145257?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed\\_ResultsPanel.Pubmed\\_DiscoveryPanel.Pubmed\\_Discovery\\_RA&linkpos=3&log\\$=relatedarticles&logdbfrom=pubmed](http://www.ncbi.nlm.nih.gov/pubmed/15145257?ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DiscoveryPanel.Pubmed_Discovery_RA&linkpos=3&log$=relatedarticles&logdbfrom=pubmed)