

## Active Breech Birth: The Point of Least Resistance

In March 2006 I attended the first international Breech Birth Conference in Vancouver, Canada which gathered together midwives, medical practitioners and researchers to discuss such issues as research, safety and techniques used during vaginal breech birth. Presenters came from eight different countries - Canada, Germany, Norway, Belgium, United Kingdom, Netherlands, Australia and New Zealand. It was a valuable time of exchanging ideas and heartening to meet other supporters of vaginal breech birth equally committed to growing and maintaining the skills necessary to support women during the experience. The multi-disciplinary programme meant accessibility to different approaches as well as an international flavour.

One workshop I attended was on symphysiotomy – the surgical division of the fibrocartilaginous symphysis pubis and its reinforcing ligaments by way of a scalpel blade through the mons pubis. This technique is an obstetric strategy to allow birth of the often dreaded - but rarely occurring - head entrapment of the breech baby, which the presenter noted occurs probably once in every five hundred breech births when cephalo-pelvic disproportion has been excluded (Menticoglou, 2006). Gruesome you may say - but it was actually very affirming for me as it re-emphasised the importance of the woman's position for giving birth to her breech baby to avoid, what I term, 'bed dystocia'.

Bed dystocia occurs when the baby's progress is halted, due to, firstly, reduction of the woman's lumbar spine curvature (lordosis), secondly, the backward tilting of the pelvis and, thirdly, entrapment of the sacrum by maternal weight, all of which can occur with lying on a firm bed. These changes mean the brim of the woman's pelvis is less accessible to the baby's after-coming head (or shoulders in cephalic presentation), most particularly, if the woman is in the stranded beetle position (lithotomy). Equally, the antero-posterior diameter of the woman's pelvic outlet is reduced as her sacrum is hampered in moving outwards.

The iatrogenic cause of and corrective strategies for bed dystocia have clearly been demonstrated by Gherman and others. Their radiological examination of pelvic diameters of women at least 37 weeks pregnant, studied the dorsal lithotomy position as well as during the McRoberts' manoeuvre (hyperflexion of the woman's legs onto her chest). The authors note "McRoberts' maneuver does not change the actual dimensions of the maternal pelvis, it straightens the sacrum relative to the lumbar spine, with a cephalic rotation of the symphysis pubis sliding over the fetal shoulder" (Gherman, Tramont, Muffley & Goodley, 2000). Thus the manoeuvre is a correctional technique used to release the entrapped sacrum held by the woman's weight on the obstetric bed.

Russell's 1969 study of pelvic x-rays of 96 women in the last trimester of pregnancy in both the dorsal and sitting positions identified the gains that can be made to increase all pelvic diameters by positional changes (Russell, 1969). Further, the 'primitive' birthing positions such as upright positions with the hips abducted – as in a supported squat – "considerably increases the outlet measurement of the pelvis" (Russell, 1982). Equally, the forward tilting of the pelvis slides the innominate bones forward and down to

increase the anterior-posterior diameter of the inlet. This tilting forward of the pelvis is a movement an active breech birthing woman intuitively takes as she pokes out her buttocks. Depending on when she does it, this can effectively help the baby's head into the pelvic brim, roll the baby's head down into the posterior space or precipitates the action of the face sweeping over the perineum as the pubic arch acts as a fulcrum for the baby's head (Banks, 1998).

The 28 percent increase in the pelvic outlet – 1cm in the transverse diameter and 2cm in the antero-posterior diameter (Russell, 1982) of active birthing is greater than that which is normally achieved by symphysiotomy, which, primarily, increases the transverse diameters by 1cm (Menticoglou, 1990). While medicine describes symphysiotomy as part of "the obstetric arsenal" (Bjorklund, 2002), women giving birth to their breech babies can feel comforted that the midwifery approach of utilising active birthing positions will not wage war on their bodies and incapacitate their babies' descent. Instead it facilitates breech birth with both woman and baby as active participants to optimise maternal pelvic diameters and the birth of the baby's after-coming head.

### References

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