Editorial

After ten years of the Term Breech Trial[1] (TBT) aftermath which saw the virtual closing down of the vaginal breech birth option, there seems to be a glimmer of new reason on the horizon - the Clinical Practice Guideline 'Vaginal delivery of breech presentation'[2]. Coming from the Society of Obstetricians and Gynaecologists of Canada (SOGC), this recent guideline evidences much of the reasonable and experienced medical opinion of its predecessor, which set up the protocols for the TBT, though, the actual trial lacked experienced practitioners, had poor case selection, skewed randomisation and inaccurate analysis which gave rise to the inevitable conclusion and spurious recommendation that all women with breech-presenting babies should have elective caesearean sections – a recommendation which has been criticised by many commentators because of the study's flaws.[3] The 2006 observational prospective PREMODA study[4] in France and Belgium, four times larger than the TBT, showing no difference in perinatal mortality or serious neonatal morbidity between caesarean section delivery and vaginal birth, has been influential in the birth of this new guideline.

While still having the inevitable focus on obstetric practitioners being the primary birth attendants and an absence of some basic midwifery tenets of physiological breech birth, heartening foundations of the SOGC guideline are the premises that the best indicator of likely trouble-free vaginal breech birth is spontaneous labour onset and progress, and skilled birth attendants. The guideline is at pains to point out that women "should not be abandoned"[5] when they decline what has become in many Western countries, including New Zealand, tantamount to mandatory caesarean in that practitioners withdraw their services and become unavailable for vaginal birth.

Recognition of and support for a woman's right to decline surgery, but still being provided with 'best care', has been the basis on which midwives have provided services to women and their breech babies in, at least, the UK, USA, Netherlands, Australia and New Zealand. Internationally, midwives have stepped up their visibility in supporting vaginal breech birth and initiatives for the midwife to be the primary caregiver are being debated. New Zealand is no exception as has been previously reported in *Birthspirit Midwifery Journal*[6], and in this issue, Margaret Gardener and Jennie Crawshaw report on a multi-disciplinary meeting to discuss access to care in the Otago region. These and other Otago midwives need to be congratulated for driving (and supporting) initiatives which recognise women's informed decision-making. Such open debate augers well for women who choose to give birth to their breech babies rather than having them surgically removed against their wills, as numerous women have reported since the TBT.

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References

1. Hannah M.A, Hannah WJ, Hewson SA, Hodnett ED, Saigal S, et al. Planned caesarian section versus planned vaginal birth for breech presentation at term: a randomized multicentre trial. *The Lancet* 2000;356(9239):1375-1383.

2. Society of Obstetricians and Gynaecologists of Canada. Vaginal delivery of breech presentation. No. 226, June 2009. *Journal of Obstetrics and Gynaecology Canada* 2009;31(6):557–566. Available www.sogc.org/media/pdf/advisories/CpgBreechJune09_e.pdf. Accessed 2 September 2009.

3. For an example, see, Banks M. *Term Breech Trial – Commentary* 2000. Available at http://www.birthspirit.co.nz/Articles/index.php. Accessed 1 February 2010.

4. Goffinet F, Carayol M, Foidart JM, Alexander S, Uzan S, Subtil D, et al. Is planned vaginal delivery for breech presentation at term still an option? Results of an observational prospective survey in France and Belgium. *American Journal of Obstetrics & Gynecology* 2006;194:1002–1011.

5. Society of Obstetricians and Gynaecologists of Canada. *Op cit*; p. 559.

6. Banks M. Keep on singing when life's a breech. *Birthspirit Midwifery Journal* 2008;1:64-65.