PLACE OF CAESAREAN SECTION IN BREECH PRESENTATION

by

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It is well to recognize at the beginning that with the increased safety, caesarean sections are being frequently performed in breech presentation depending upon a wide range of indications.

An analysis was made of 712 cases of breech presentation out of total confinements of 28,600 cases in the Eden Hospital during the period from January, 1960 to December, 1961.

Table I shows incidence of caesarean section in breech presentation:—

TABLE I

Incidence of Caesarean Section in Breech Presentation (January, 1960 *to December,* 1961)

Total number of confinements	28,600	
Total breech deliveries	712	
Vaginal deliveries	651	(91.4%)
Caesarean sections	61	(8.6%)
Average incidence of caesarean section		2.5%

The indications for caesarean section in these 61 cases are shown in Table II.

TABLE II

Indications for Caesarean Section in Breech Presentation

	No. of cases
Foetopelvic disproportion	18
Previous Caesarean section ..	10
Elderly primigravida (age above 30 years)	8
Multipara with bad obstetric history ..	4
Ovarian tumour obstructing pelvis ..	1
Bicornuate uterus	1
Following pelvic floor repair ..	1
Uterine inertia	2
Severe Pre-eclampsia	2
Placenta Praevia	3
Post-maturity	3
Large baby (above 8 lbs.)	4
Foetal distress	2
Cord Prolapse	2
	61

When these indications are analysed, it is evident that any significant complication of pregnancy or labour which demands caesarean section in the usual cephalic presentation constitutes an equally or more important indication of section in breech presentation. Thus whether it is a breech or vertex presentation, caesarean section is obligatory in such indications as placenta praevia, prolapse of the cord, prolonged labour, foetal distress, elderly primigravida, especially following long-standing sterility, and bad obstetric history in

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a multipara. The presence of breech presentation in such complications merely favours abdominal delivery.

Contracted Pelvis

The commonest indication for caesarean section in this series is foetopelvic disproportion, mostly due to contracted pelvis, which constitutes 29.6 per cent of all sections done for breech presentation. The diagnosis of foetopelvic disproportion is more difficult in breech presentation than in cephalic presentation as in the latter case, capacity of the pelvis can be assessed by fitting of the foetal head. There is usually no problem in the diagnosis of grossly contracted pelvis which can be recognised by ordinary clinical methods. But the difficulty is with the border-line pelvis in which trial labour may be allowed if the presentation is vertex but not in breech. Since the after-coming head comes in relation to such a pelvis only at the terminal moments of delivery, if any disproportion exists whatever may be its degree, a forceful delivery of such a baby brings out either a still-born or a severely injured baby.

In this series caesarean section was done in 6 cases for grossly contracted pelvis and in 12 cases for border line contracted pelvis. Trial labour was not allowed whenever there was any suspicion regarding the capacity of the maternal pelvis.

Arnot (1952) is of the opinion that if section is to be done at all for foeto-pelvic disproportion it must be done at the beginning of labour. Mengert (1954) advocated section in primigravida if the breech is not engaged at the beginning of labour.

Elderly Primigravida

In the present series 8 cases of breech presentation were delivered by caesarean section in primigravidae above the age of 30 years. Foetal mortality in such age group is very high in breech presentation if vaginal delivery is allowed. We believe that section should be seriously considered in such cases as there is a great desire for a living baby by the elderly primipara.

Multipara with Bad Obstetric History

In multipara, commonest indication of section in breech presentation in this study was previous caesarean section. Out of 61 cases of caesarean section, 10 cases were due to repeated section. Caesarean section was done in 4 cases of breech presentation in multipara with history of loss of one or two previous infants due to difficult vaginal delivery.

Abnormality in the Passage

Caesarean section was done in one case of primigravida, aged 30 years, with fibromyoma arising from the body of the uterus and occupying the pelvis. In one case there was bicornuate uterus and in another, section was done due to stenosis of the cervix following Fothergill's operation.

Birth Weight of the Baby

In this series, caesarean section was done in 4 cases where the babies were over-sized (above 8 lbs. weight) and the foetopelvic disproportion existed as the babies were appreciably larger in size. It must be admitted that the estimation of accurate size of the baby in uterus is extreme-

ly difficult. For practical purpose, we classified the foetus as large, medium and small. Table III shows the difference in foetal mortality rate in different weight groups in our hospital.

TABLE III

Foetal Mortality Rate in Different Weight Groups in Vaginal Delivery of Breech Presentation

Parity	5½ lbs. to 5 lbs. 15 ozs.	6 lbs. to 6 lbs. 15 ozs.	7 lbs. to 7 lbs. 15 ozs.	8 lbs. to 8 lbs. 15 ozs.	9 lbs. & above
Primipara	16.5%	9%	4%	18.4%	40%
Multipara	8.2%	5.5%	5.6%	9.7%	20%
All cases	14.0%	6.2%	4.5%	13.3%	26%

Whenever the estimated size of the unborn child was considered as more than 8 lbs. caesarean section was performed. With the liberal use of caesarean section in this group of cases, the foetal mortality rate was reduced to 3.2 per cent. It is difficult, no doubt, to deliver a large baby as vertex; but it is far more difficult to deliver such a baby as a breech, vaginal manipulations being affected by the large body.

Miscellaneous Indications

The other conditions in which caesarean section was done, e.g. placenta praevia, severe pre-eclampsia, post-maturity, foetal distress and prolapse of the cord could have been the indications for section regardless of the presentation.

Maternal and Foetal Results

Table IV shows the maternal and foetal mortality rate in vaginal delivery and in caesarean section.

TABLE IV

Maternal and Foetal Results in Breech Presentation

Nature of delivery	No. of Cases	Maternal mortality		Foetal mortality	
		No.	Percent	No.	Percent
Vaginal delivery	651	2	0.3%	59	9.06%
Caesarean section	61	1	1.6%	2	3.2%

One maternal death that occurred in the caesarean section group was due to development of fulminating infection by cl. Welchi in the post-operative period.

Two foetal deaths in the same group were due to prematurity — one in a case of severe pre-eclampsia and the other in a case of placenta praevia.

In foetal mortality correction was made for congenital deformities incompatible with life e.g. hydrocephalus, meningocele etc. and for antepartum and intrapartum deaths due to undetermined causes.

Table V shows the foetal mortality rate in breech presentation in primiparae and in multiparae depending upon various methods of delivery.

TABLE V

Corrected Foetal Mortality Rate in Primiparae and in Multiparae Depending upon Various Methods of Delivery of Breech Presentation

	Primipara	Multipara
Vaginal:		
Spontaneous	3.5%	1.2%
Assisted delivery	8.4%	6.3%
Breech extraction	11.2%	7.4%
Forceps for aftercoming head	7.5%	4.8%
Caesarean section	3.2%	1.5%

From the review of 61 cases of caesarean section done for breech presentation, the fact which stands out prominently is that the foetal mortality rate has been considerably reduced by section (from 9.06 per cent in vaginal delivery to 3.2 per cent in section). But there was one maternal death in 61 cases of caesarean section (1.6 per cent) whereas there were only 2 maternal deaths in 651 cases of vaginal delivery (0.3 per cent) of breech presentation.

Conclusion

There can be few, however, who will doubt the need for caesarean section for breech presentation in an elderly primigravida or in a patient with foetopelvic disproportion even though of mild degree, and primigravida with large baby (above 8 lbs.). Any other significant complication of pregnancy or labour which would be a good indication for section even in the usual cephalic type of presentation is an equally or more valid indication for section in breech presentation. By caesarean section foetal mortality rate has been considerably decreased but with increased risk to maternal life. We do not believe that one balances the other by any means, and would therefore suggest that the decision for caesarean section, to be done for a breech presentation, should be given very serious consideration. The lowered foetal mortality should by no means be bought at a price of increased maternal mortality.

Summary

1. Sixty-one cases of caesarean section done in 712 cases of breech presentation are reported with their indications.

2. A critical analysis has been made of different indications for section with special emphasis on foetopelvic relationship.

3. Maternal and foetal results have been compared in various types of vaginal and abdominal deliveries.

4. A plea has been made for serious consideration before resorting to caesarean section for breech presentation keeping in mind that although foetal mortality is reduced by caesarean section (vaginal 9.06 per cent; caesarean section 3.2 per cent), maternal mortality is quite high in caesarean section (vaginal 0.3 per cent; caesarean section 1.6 per cent).

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References

1. Arnot, P. H. and Nelson, D. R.: Am. J. Obst. & Gynec., **64**: 591, 1952.
2. Grieg, D. S.: J. Obst. & Gynec. Brit. Emp., **52**: 122, 1945.
3. Knight, R. Vand and O'Connel, C. P.: Am. J. Obst. & Gynec., **64**: 1049, 1952.
4. Mengert, W. F.: Am. J. Obst. & Gynec., **68**: 250, 1954.
5. Meyer, H.: Am. J. Obst. & Gynec. **56**: 375, 1948.
6. Tompkins, Pendleton: Am. J. Obst. Gynec., **51**: 595, 1945.
7. Varton, Keith C.: J. Obst. & Gynec. Brit. Emp. **52**: 417, 1945.
8. Warwick, H. P. and Lipsett, H. L.: Am. J. Obst. & Gynec., **61**: 1306, 1951.