

## PLACE OF CAESAREAN SECTION IN IMPROVING FOETAL SALVAGE IN BREECH PRESENTATION

by

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The present review was undertaken to ascertain the best method of management for breech at term with a view to improve the foetal outcome and bring it at par with that of vertex deliveries.

In 1973 we planned our new approach towards the management of breech cases to bring down perinatal mortality and morbidity. Every known and diagnosed case of breech was to be delivered by elective caesarean section, however an attempt on version without anaesthesia was attempted between 34 to 36 weeks. Patient who were admitted in labour with good progress, especially multiparas with history of easy labours were allowed to deliver vaginally. Forceps was always kept ready in case there was any difficulty in the delivery of after-coming head.

The present series includes single breech at term delivered in the Department of Obstetrics and Gynaecology, Patna Medical College Hospital during 1973 to 1976 managed in one unit of the Hospital. A comparison has been made with the earlier series of 1971 to 1973.

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TABLE I  
Incidence of Breech

Year	Total No. of deliveries	Breech delivery	Incidence in %
1971-73	34022	832	2.44
1973-76	24284	731	3.01

Out of total 731 cases of breech, only 164 were managed by our unit alone. These include booked as well as emergency cases. Premature breech deliveries were not considered for analysis. The incidence of breech delivery shows slight increase from 2.44% of the previous series to 3.01% in the present series, and this is mainly due to the gravitation of all abnormal cases to this premier institution of the State.

Number of primi and multipara in our group as shown in Table II does not show any statistically significant difference in the two series.

An analysis of the various modes of delivery (Table III) in these cases of breech at term showed that precipitous labour occurred in about 19.6% of the cases and this did not show any difference in both the series. The number of breech extraction and assisted breech

TABLE II  
Number of Primigravida and Multigravida

	Total No. of cases	Primi-gravida	Multi-gravida
Present series	164	93 (56.7%)	71 (43.3%)
Previous series	832	434 (52.2%)	398 (47.8%)

TABLE III  
Mode of Delivery

Mode of delivery	Present series	Previous series
Precipitous delivery	32 (19.6%)	216 (25.9%)
Assisted breech	40 (24.4%)	432 (52.3%)
Breech extraction	8 (4.8%)	105 (12.2%)
Caesarean section	84 (51.2%)	79 (9.6%)

delivery showed considerable lowering of the figures in the present series because of more active management. The caesarean section rate was increased five times giving an incidence of 51.2% as compared to 9.8% of the earlier series. Breech extraction was done in 2 multipar where labour otherwise was progressing well but foetal distress developed. The other 6 cases were admitted in emergency with labour in progress but breech arrested at the outlet only due to inertia and extended legs.

An analysis was made for the various indications for caesarean section (Table IV). In 74 cases the indication was breech only and majority of them were

elective cases. Few cases however, came as emergency in early labour with or without rupture of membranes. In 88.1% of the caesarean section cases the only indication was breech presentation as compared to 6.3% of the earlier series. Cases of elderly primi and bad obstetric history which was the main deciding factor in earlier series, are included in the same group. Since elective caesarean section was planned in breech cases the problem of postmaturity did not arise except in unbooked cases.

Remarkable improvement in perinatal mortality and morbidity has been seen in our present series (Table V). The 3 babies that were lost in the present series

TABLE IV  
Indication for Caesarean Section

Indications	Present series	Previous series
Elective C.S. for breech	74 (88.1%)	5 (6.3%)
Cord prolapse	1 (1.2%)	10 (12.7%)
Postmaturity	1 (1.2%)	9 (11.5%)
Foetal distress	2 (2.4%)	14 (17.6%)
Uterine inertia	1 (1.2%)	23 (29.2%)
Antepartum haemorrhage	2 (2.4%)	7 (8.9%)
Disproportion	3 (3.5%)	11 (13.9%)



TABLE V  
Perinatal Mortality

	No. of Cases	Perinatal Mortality	
		No.	%
Present series	164	3	1.8
Previous series	832	67	8.05

were delivered vaginally (Table V). Two babies died due to asphyxia following prolonged labour and third baby showed signs of intracranial haemorrhage. None of the babies delivered abdominally showed any birth trauma. Congenital abnormalities were seen in one case of spina-bifida and meningocele.

TABLE VI  
Perinatal Morbidity

	Present Series	Previous Series
Brachial plexus injuries	2	25
Brain injury	3	35
Bony fractures	2	30
Asphyxiated but revived	5	38
Cerebral palsy.	1	15
Total	13 (7.79%)	243 (29.2%)

Thirteen babies showed various types of birth injuries, all of these have delivered vaginally. None of the babies delivered abdominally showed any damage at all. These babies could not be followed up for late effects on their personalities or mental capacity. High perinatal morbidity in earlier series has been evident because of the trauma. None of the cases delivered by C.S. showed any birth trauma. Only 1 case developed R.D.S. where an emergency caesarean section was done late in labour.

#### Discussion

The outstanding problem of breech

delivery are excess perinatal mortality and morbidity rate and thereby excess medicolegal liability. With best methods of breech delivery, after all the breech scoring system, use of ultra-sonar, x-ray pelvimetry, foetal blood sampling, the foetus still remains at a greater disadvantage than when presenting by the vertex. The mechanism of breech delivery as such causes increased birth trauma and foetal hypoxia.

Perinatal mortality and morbidity in term breech delivery has been reported to be 2 to 10 times higher than vertex deliveries in comparable cases. Kaplan *et al* (1973) and Ohlesen (1975) reported an excess foetal loss of 17/1000 and 16/1000 respectively, where as Minognie (1974) reported a figure as high as 103 and 130 per thousand in primipara and multipara respectively. They found incidence of foetal distress 8 times higher in breech cases than in vertex. Still higher foetal mortality rates have been reported by Kohiyar and Masani (1964) 8.6%, Rajani and Pathak (1964) 6.3%, Mukherjee and Barua (1964) 11.1%, Kapur and Kaur (1969) 8.6%, Kohiyar and Masani (1964) reported no foetal deaths in babies delivered by caesarean section. Kapur and Kaur (1969) reporting on 303 cases of breech concluded that caesarean section gave the best results as far as foetal salvage was concerned, but recommended its use only in selected cases.

Wright (1959) was the first to advocate the routine use of caesarean section and ever since the balance is gradually tilting in its favour. This observation has been made by many and evoked the recommendation that caesarean section would be routinely used for term breech cases, especially in primi.

Out of our 164 cases, we had no foetal

loss or injuries in caesarean section cases, whereas during vaginal delivery babies had birth trauma which resulted in foetal death within a week. Taking all 164 cases our foetal loss still remains at 1.8% although much better than 8.05% of the previous series, but still higher than the vertex cases.

Many obstetricians notably Greenhill (1974) while agreeing that every breech is a high risk baby and that there are no known birth trauma with abdominal delivery, advocate liberalisation of caesarean section on the plea that breech delivery through the vagina is a work of art and this art is being lost by doing mechanically more caesarean sections. Internal version and breech extraction as a management of transverse lie was also considered a work of art in the past but it was so only at the risk of the foetus and sometimes mothers also. Now transverse lie is always managed by caesarean section in any stage of labour. There is universal agreement that no matter what method we use or with any scoring system breech delivery causes damage to the foetus in one way or the other which may be immediate or delayed and also that abdominal delivery is the safest method of delivery.

Several factors in recent years are responsible for this changed attitude of the obstetrician towards adopting a most reliable method of delivering an undamaged infant into a small family.

The professional and medico-legal liability of the attending physician has increased as the society is becoming more demanding on us and method of delivery adopted should have no immediate or late effect on the newborn directly or indirectly.

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