

THE SOCIETY OF  
OBSTETRICIANS AND  
GYNAECOLOGISTS OF  
CANADA



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### SOGC STATEMENT ON VAGINAL BREECH

The Canadian Consensus on Breech Management at Term was presented as a Policy Statement (#31) by the SOGC in November 1994.

The workshop, which compiled these Consensus statements, used the best level of evidence that was then available, together with current expert opinion to aid practitioners in the safe management of the term vaginal breech delivery.

These guidelines have since been incorporated into a Canadian led International Randomized Controlled Trial designed to address the issues of whether the fetuses at term presenting as a frank or complete breech are best born vaginally, or by planned elective Low Segment Cesarean Section (LSCS).

The results of this study have been published in *The Lancet*, Volume 556, October 21, 2000 and members are encouraged to read this landmark study in its entirety.

As a result of the findings of this study the Executive and Council of the SOGC feel it necessary to advise its members, and the public, that the best method of delivering a term frank or complete breech singleton is by planned LSCS. This policy results in a significantly lower, although not absent, risk of infant mortality and/or morbidity than planned vaginal birth.

From this study, composite data from the participating countries demonstrated the overall risk of perinatal death for the term frank/complete breech fetus with planned cesarean birth was reduced by 75% (RR 0.23, CI 0.07-0.8). From the same study, in developed countries such as Canada, the chance of a term breech infant dying associated with a policy of planned vaginal birth is 1 in 170 (3/511) while no deaths (0/514) were reported in the planned cesarean section group. The chance of serious short-term neonatal morbidity was reported as one in 20 in the planned vaginal birth group versus one in 250 in the planned cesarean section group. A policy of planned LSCS will reduce these risks without a significant increase in immediate maternal complications.

Practitioners are encouraged to ensure that these data are conveyed to women who are contemplating breech vaginal birth and to obtain an informed and documented consent.

The risks of LSCS should also be discussed and documented. When scheduling a LSCS it is important to ensure that accurate dating and presentation of the fetus are confirmed just prior to undertaking the delivery.

This study should in no way be extrapolated to the vaginal breech delivery of the second twin. This topic is addressed in the SOGC Consensus Statement on the Management of Twin Pregnancies published in July and August 2000.

The study also does not address the issue of pre-term breech deliveries, breech with anomalies, or breeches presenting in the late stages of labour. This study has not addressed the long-term infant morbidity and mortality but a two year follow-up study is underway.

The long term implications of delivery by LSCS on subsequent reproductive performance such as the risk of placenta accreta and uterine rupture, was not addressed in this study.

A complete update of the SOGC Policy statement on the management of the term breech, is in progress.