

## Term Breech Trial conclusions challenged



I read with great interest “The term breech: vaginal or cesarean delivery?” [January], by Alex Vidaeff, MD, Edward Yeomans, MD, Ellen Mozurkewich, MD, and Martin Gimovsky, MD, regarding the Term Breech Trial (TBT) conducted by Mary E. Hannah. The study’s remarkable scientific design, along with the work of all those involved, undoubtedly gave significant weight to the conclusion that elective cesarean should be the preferred mode of delivery for term breech fetuses.

Our teaching hospital in Romania had the honor of participating in the TBT. In this country, term breech pregnancies with no other complications are allowed to undertake

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a well-supervised trial of labor, and approximately 60% of these fetuses are delivered vaginally. But in reviewing the TBT results from our institution, we observed that even in study conditions, only 60% of the patients randomized to planned vaginal birth actually delivered vaginally; the others delivered via cesarean due to complications during labor—findings consistent with the overall results reported by the TBT.

It should be noted, however, that none of the breech deliveries were counted in the significant perinatal morbidity and mortality cases for that year, unless other obstetric circumstances were present. Could this indicate that it is better to wait and see how a patient’s labor patterns develop before deciding to perform a cesarean? Our impression is that perinatal mortality and morbidity have more to do with the way a labor is conducted than the mode of delivery. We propose that further research is needed to establish a safe and standard way of supervising a breech labor, and to solve such debatable issues as the use of augmentation, epidural analgesia, or premature interference with the fetus during delivery.

—GABRIEL BANCEANU, PHD  
BUCHAREST, ROMANIA

### **Drs. Vidaeff and Yeomans respond:**

It appears as though Dr. Banceanu feels—as we do—that further research on term breech deliveries is still needed. Selection of appropriate candidates for vaginal breech delivery is the first step in the process, and undeniably a very important one. However, as Dr. Banceanu points out, the management of labor and delivery is often critical in determining outcomes. Unfortunately, this element could not be controlled or adequately accounted for in the TBT.

A recent challenge to the American College of Obstetricians and Gynecologists (ACOG) endorsement of planned cesarean delivery for breech presentation at term indicates to us that obstetricians can still agree to disagree on this subject.<sup>1</sup>

### **Dr. Mozurkewich responds:**

I appreciate Dr. Banceanu’s comments. It is interesting to note that at his hospital, a trial

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**TABLE 1** VBAC risk scoring system\*.<sup>†</sup>

SCORE 2 FOR EACH ITEM	SCORE 1 FOR EACH ITEM	SCORE 0 FOR EACH ITEM
<b>Past:</b>		
1 cesarean	2 cesareans	More than 2 cesareans
2-layer closure	2-layer closure, with postoperative fever	1-layer closure
Cesarean more than 2 years ago	Cesarean 1-2 years ago	Cesarean less than 1 year ago
Cesarean not due to CPD	Cesarean performed due to dystocia	Cesarean performed due to CPD
Term vaginal birth	Premature vaginal birth	No vaginal birth
<b>Present:</b>		
Singleton	Twins (both cephalic)	Twins (only first cephalic)
Cephalic	Breech	Other presentations
Fetal weight less than 3,500 g	Fetal weight 3,500-4,500 g	Fetal weight above 4,500 g
Expect spontaneous labor	Expect labor will need augmentation	Expect labor will need to be induced
Maternal weight less than 170 lbs	Maternal weight 171-250 lbs	Maternal weight above 250 lbs
<small>CPD = cephalopelvic disproportion; VBAC = vaginal birth after cesarean  *Low risk: 16-20 points; medium risk: 6-15 points; high risk: 0-5 points  <sup>†</sup>Score 0 for each item you cannot document from history.</small>		

of labor did not result in any perinatal deaths or cases of serious perinatal morbidity among TBT participants. He suggests that optimal management of the properly selected breech presentation at term may be to allow a trial of labor and to assign mode of delivery based on intrapartum progress. However, the “planned vaginal birth” group in the TBT essentially received the same management protocol that Dr. Banceanu describes.<sup>2</sup> The guidelines that formed the TBT’s protocol for intrapartum management stemmed from a Canadian consensus conference on breech presentation at term and established clear conditions necessary for the continuation of labor trials.<sup>3</sup> But even despite these relatively optimal

trial conditions, the investigators reported increases in perinatal morbidity and mortality in the planned vaginal birth group.<sup>2</sup>

In addition, the authors performed a sub-analysis in which subjects were excluded if they experienced vaginal breech delivery after prolonged labor, induction or augmentation of labor, footling or uncertain breech presentation at delivery, or if the clinician at delivery was not skilled or experienced. Despite these exclusions, planned cesarean section prevailed. For these reasons, I feel the overall conclusions and recommendations of the TBT are quite robust.

## REFERENCES

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## Scoring patients for VBAC

In “VBAC: Safer than you think” [August], Ellen Mozurkewich, MD, recommends carefully selecting patients for vaginal delivery after cesarean (VBAC). However, she does not offer clear guidelines for such a selection process. Here at Elmhurst Hospital Center-Mt. Sinai affiliation, we utilize a scoring system to identify candidates at low, medium, and high risk for VBAC (Table 1). While patients who score from 16 to 20 points are considered low-risk and, therefore, good candidates for VBAC, patients who score 0 to 5 points are considered high-risk and should never be offered a trial of labor. Medium-risk



patients, scoring from 6 to 15 points, require individualized consideration with extensive counseling.

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**Dr. Mozurkewich responds:**

Thank you, Dr. Hakim-Elahi, for your comments. To my knowledge, none of the scoring systems designed to predict failed trial of labor have proven reliable.

In an assessment of several models, Macones and colleagues reported a best-model sensitivity for prediction of failed trial of labor of 77%, with a specificity of 65%.<sup>1</sup> This means that 35% of women discouraged from undergoing a trial of labor under this system would have achieved vaginal delivery. Other investigators have reported on scoring systems with similar test characteristics.<sup>2,3</sup> In a decision analysis, Macones suggested that an ideal system should have both sensitivity and specificity in excess of 75% in order "to obtain a reasonable trade-off between reduction in morbidity and the total rate of cesarean sections."<sup>4</sup> In the absence of a validated scoring system meeting these requirements, our institution continues to select and counsel candidates for trial of labor according to published ACOG guidelines.<sup>5</sup> ■

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