Turn Turn Turn: Options for Turning and Birthing Breech Babies

Labels: Chiropractic for Life, Issue #28, Author Heather Yost, D.C.

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Wednesday, 01 December 2010 00:00

A breech presentation refers to the position of the baby in the uterus. It is normal, up to the seventh month of pregnancy, for the baby to be in a head-up, or breech, position. After the seventh month, any position other than vertex (head-down) may not only challenge the possibility of a vaginal birth, but put abnormal stressors on the developing baby.

The risk is small; research shows that approximately 4 percent of full-term (38-42 week) pregnancies are breech presentations. There are several causes of a breech presentation. A structurally altered pelvis is a likely possibility; this can be caused by rickets (severe vitamin D deficiency), poor bone and joint development, or structural or functional pelvic compromise. Additional causes of a breech presentation are uterine abnormalities, placenta previa, multiple births, excessive amniotic fluid, or fetal anomalies such as hydrocephaly and anencephaly.

There are three main types of breech presentations: frank, complete and footling. With a frank presentation, the baby's legs are extended upward with feet near the head. This is the most common breech presentation, occurring 65 to 70 percent of the time. Complete presentation means the baby is "sitting" upright in the uterus, with legs crossed and feet near the buttocks. A footling presentation is when one or both of the baby's feet are extended downward toward the cervix.

Throughout the 1990s, some breech babies were still delivered normally. However, beginning in 2003, nearly all hospitals declared a halt on delivering breech babies vaginally. Caesarian section became the protocol, and is now performed nearly 100 percent of the time for breech-positioned babies due to a recommendation by the American College of Obstetricians and Gynecologists (ACOG). Options on breech vaginal delivery have quickly become a thing of the past. Not only that, but in the medical field, the need to train an obstetrician on vaginal breech births no longer exists! Some midwives, however, are still trained in breech presentations, and may be willing to assist in vaginal breech births.

The virtual elimination of vaginal breech births has now raised a generation of obstetricians who are inexperienced and unprepared to handle a breech case. But what about the woman who knows she is carrying a breech baby and doesn't want a cesarean section? Few doctors remain who offer alternative techniques or choices for breech delivery. Most obstetricians simply suggest the woman go in for an external cephalic version (ECV; see below) at around 37 weeks, and if that fails, will encourage the woman to schedule a caesarian.

Women need to be educated and empowered to know that many options exist, ranging from prevention to treatment, both invasive and non-invasive. There are a variety of alternative techniques that gently help the baby move head-down, including those listed below.

Chiropractic Care

Use of the Webster technique may help with baby positioning. The Webster technique, as defined by the International Chiropractic Pediatric Association (ICPA), is "a specific chiropractic analysis and adjustment that reduces interference to the nerve system and balances maternal pelvic muscles and ligaments. This in turn reduces torsion in the uterus, a cause of intra-uterine constraint of the baby and allows for optimal fetal positioning in preparation for birth." Optimal fetal positioning leads to a safer, easier birth.

There have been a few studies indicating success in regards to optimal fetal positioning and the Webster technique. The Journal of Manipulative and Physiological Therapeutics (JMPT) reported an 82 percent success rate of babies turning head-down when doctors of chiropractic utilized the Webster technique. The conclusion of this retrospective study declared that chiropractic care may be a valuable adjunct to prenatal care. Truly, the Webster technique needs further investigation in fetal positioning and its role in the overall care of pregnant patients.

The ICPA is conducting a major practice-based research project to determine the effectiveness of the Webster technique. The authors discussed their preliminary results: "There is a long tradition in chiropractic on the care of the pregnant patient. The results of our study demonstrate some measure of effectiveness and safety of the Webster technique in relieving the consequences of intrauterine constraint (i.e., malposition/malpresentation) in pregnancy. Higher-level research designs are needed to make cause and effect inferences." The ICPA is currently proceeding with their conclusions: "This presentation contributes to the knowledge base that pregnant patients may derive benefits from the Webster technique. We advocate for continued research in this field."

Currently, the ICPA recommends that women receive chiropractic care throughout pregnancy to create pelvic neuro-biomechanical function. Even when the baby's position is appropriately head-down, chiropractic care with the Webster technique optimizes neuro-biomechanical function of the pelvis. Found to be safe, the implications of the Webster technique throughout pregnancy may have a huge impact in supporting natural childbirth.

The ideal time to be evaluated and begin chiropractic care is before pregnancy, or in its early stages. A restriction in the pelvis may not be enough to adversely affect the baby's position, but may affect the mother's comfort, the progress and duration of labor, and the proper development of the child. One study indicates that first-time mothers receiving chiropractic care deliver 22 percent faster than those without adjustments, and deliver 37 percent faster on subsequent births. Again, further research is necessary, and the ICPA is proactive in accomplishing this.

"Breech Tilt" Positioning

Several exercises can easily be done at home to encourage repositioning of the baby. This particular one is simple, and can be very effective when implemented early in the pregnancy. In a "breech tilt" position, the mother lays on her back with her knees bent and feet flat on the floor. Slowly she raises her buttocks while a partner places firm cushions underneath, in order to elevate her hips 10 to 15 inches above her head. She then holds the position and relaxes, visualizing the baby moving head-down. This is repeated three to five times per day, for 10 to 15 minutes each time. This is most effective when the baby is active, and when the mother has an empty bladder and stomach. The partner should help the mother get into and out of this position.

Moxibustion

Chinese-medicine practitioners have been turning breech babies with acupuncture or moxibustion for hundreds of years. Moxibustion should be done at 37 weeks or later, as it may trigger labor. This treatment involves placing a lit moxa stick near the outer edge of the pinky toenail. This increases fetal activity and often corrects breech presentation.

A trial in which researchers randomly assigned women to moxibustion treatment indicated higher success rates with moxa than with external cephalic versions (ECV). An additional study in 1998 published in The Journal of the American Medical Association (JAMA) found that moxa corrected about 25 percent more breech presentations than a control group.

Homeopathic Remedies

Pulsatilla, a homeopathic remedy made from a fuzzy herb called wind flower, has long been used to change breech presentations prior to the onset of labor. The herbal remedy is most effective when given before the baby is deeply engaged in the pelvis.

External Cephalic Version

External cephalic version is an outpatient procedure used to turn the baby head-down in late pregnancy. The procedure can be used during labor, but must be done before the water ruptures. Generally ECVs are performed at around 36 or 37 weeks, and in fact are not safe before 36 weeks.

Initially, an ultrasound is performed to assess amniotic fluid and the position of the baby and placenta. A tocolytic medication (most commonly terbutaline) is given to relax the uterus and prevent contractions. The doctor attempts to turn the baby by placing her hands on the baby's head and buttocks and manually manipulating the baby to a vertex position. The procedure may be uncomfortable, but it rarely takes more than five minutes, whether it is effective or not.

Mothers are monitored for a short period afterward to watch the baby's response to the procedure. Although complications are rare during an ECV, they can occur. The major risks include: rupture of the amniotic sac, placental abruption, rupturing the uterus, damaging the umbilical cord, fetal distress, twisting or squeezing the umbilical cord (thereby reducing blood and oxygen to the baby), fetal injury, and opening a scar from a previous cesarean section. External cephalic version has an average success rate of 58 percent.

Breech Vaginal Birth

Cesarean sections do not eliminate the risks of birth injury; on the contrary, they add new risk to both mother and baby. The National Institutes of Health Taskforce on Cesarean Childbirth states that every woman with a breech presentation does not require a cesarean. It considers vaginal delivery a reasonable option under certain conditions, and when the midwife or doctor is experienced with this type of birth.

Vaginal birth does, however, carry some added risk of injury, and therefore certain conditions must be assessed. The type of presentation is perhaps the most important consideration. Frank breech positioning is the safest. The midwife or doctor must evaluate the fetal size in relation to the pelvis, whether or not there is hyperextension of the head, the maturity of the baby, and how labor is progressing. Most important, the obstetrician or midwife must have training in breech vaginal births. The Society of Obstetricians and Gynecologists of Canada has even launched a new program to teach physicians breech vaginal delivery techniques. New evidence shows that there is no difference in complication rates between vaginal and C-section deliveries in the case of breech births.

Education and knowledge will empower you to challenge the status quo and seek birth options that are more in line with your personal paradigm. Read, become informed, ask questions. Find providers supportive of your choices. Finally, be still and trust those decisions in line with your inner knowing. This is where you will find your true strength and power. So, what are the risks of a vaginal breech birth?

Until about 40 years ago, U.S. obstetricians treated breech birth as something relatively normal. Their training included how to deliver breech babies. But in the 1970s, obstetricians decided that cesarean sections were the solution to all pregnancy and labor complications. They were mistaken. Numerous studies have revealed that the trend from vaginal breech birthing to predominantly cesarean births has not improved breech outcomes, and in fact the majority of breech babies born vaginally result in uncomplicated births.