

## EDITORIAL

# External cephalic version: a terrible opportunity to waste

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Breech presentation complicates 3 to 4% of pregnancies at term. Since the Term Breech Trial was published,<sup>1</sup> the rate of breech vaginal birth has fallen precipitously. Breech vaginal birth is no longer considered the standard of care and the vast majority of singleton breech presentations lead to a cesarean delivery. Meanwhile, the cesarean delivery rate in the United States has reached an all-time high of 31.1%<sup>2</sup> and continues to increase annually. The primary cesarean delivery rate is similarly at an all-time high despite recommendations from Health People 2010 for a primary cesarean rate of 15%.<sup>3</sup> Of these, an increasing number of primary cesarean deliveries are performed for breech presentation.<sup>4</sup> The reasons fewer women today opt for attempted external cephalic version (ECV) are less clear. Patient request and physician ambivalence may be involved, driven by the concern that even if successful, ECV may result in a cesarean. In this issue, Clock *et al.* provide compelling evidence from a matched case–control study that women who have undergone a successful ECV are not at increased risk for cesarean delivery.

The authors matched 197 women who had undergone successful ECV with the next 2 women of similar parity, gestational age, delivery history and type of labor who presented for labor management. They found successful ECV did not increase the chance of a cesarean or operative vaginal delivery. Even patients with a prior cesarean who underwent ECV had a similar cesarean rate when compared with the matched control group. The discrepancy in this finding from prior studies is not entirely clear. However, the authors did take great care to match appropriately study patients to controls with similar obstetric characteristics.

Of great concern is the steady fall in ECV procedures seen during the study period, from 1998 to 2006. The reasons for this decline were not studied by the authors, but their postulates, that physician threshold for cesarean delivery is lower and patient request is more common, are plausible, and this topic deserves further study.

Since the peak of vaginal birth after cesarean delivery in 1996, the rate of trial of labor after cesarean has steadily fallen as well and is currently less than 10%.<sup>2</sup> Yet, complications from cesareans are well known. With each cesarean, a woman's risk increases for abnormal placentation, hysterectomy, adhesion-related complications such as bowel, ureteral, and bladder injury, prolonged operative time, and for the sequelae of such complications including postoperative ventilation, hospital days, transfusion of more than four units of blood<sup>5</sup> and maternal

mortality<sup>6</sup>. These risks are magnified when a woman undergoes multiple cesareans. Fetal and neonatal risks due to cesarean delivery are similarly significant. The risk of delivery-related perinatal death during a trial of labor is 11 times greater compared with a planned repeat cesarean delivery.<sup>7</sup> Thus, prevention of the first cesarean is critical for reducing maternal and neonatal cesarean-related morbidities down the road.

On the basis of data from their own institution, the authors estimate that if all eligible lower-risk women in the United States were offered ECV and just 46% accepted, 22 161 fewer cesarean deliveries would be performed each year. Although it may seem minor compared with more than 1 million cesareans per year, some among these women will incur future morbidities otherwise avoided by vaginal birth, such as trial-of-labor-related uterine rupture, difficult repeat cesarean delivery, adhesions, abnormal placentation, obstetric hemorrhage and pulmonary embolism, to name a few. However, while the authors' estimates were appropriately conservative, imagine the overall reduction in cesareans that might be seen if ECV for breech presentation was considered the standard of care and if more than 60% of ECVs were successful. More than 50 000 unnecessary cesarean deliveries each year would reduce the overall cesarean delivery rate by more than 1%, reduce perinatal and maternal morbidity, and reduce health-care costs in current and future pregnancies.

If the trends of avoiding ECV and not performing trial of labor after cesarean continue, skills and comfort levels will continue to diminish, cesarean rates will continue to increase, morbidities from repeat cesarean will continue to increase and the door may eventually close on something that was once preventable. Although cesarean delivery has become safer throughout the twentieth century, its ease and availability should not be confused with being safer, on average, than vaginal delivery. Many cesareans can, and probably should, be reasonably avoided. This study lends support to the routine use of ECV, a safe procedure,<sup>8</sup> as one component of an overall approach to reducing the cesarean rate. With trial of labor after cesarean rapidly disappearing, the opportunity to avoid a primary cesarean delivery is a terrible thing to waste.

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