Tidsskriftet Tidsskrift for Den norske legeforening

Breech deliveries at units other than women's clinics

INVITERT KOMMENTAR

INGVILD VISTAD

ingvild.vistad@sshf.no

Ingvild Vistad, specialist in obstetrics and gynaecology, senior consultant at the Women's Clinic, Sørlandet Hospital Kristiansand, and professor at South Campus, Institute of Clinical Medicine, University of Oslo

The author has completed the ICMJE form and declares no conflicts of interest.

Many people have strong opinions about where women should give birth. Hammerfest Hospital does not have a women's clinic, but nevertheless handles breech deliveries, thus deviating from national guidelines on high-risk deliveries.

This edition of the Journal of the Norwegian Medical Association includes a retrospective review of pregnant women with a singleton breach presentation delivered from gestational week 35 at Hammerfest Hospital over a 20-year period (1). Breech presentation is rare, occurring in only 3–4 % of pregnancies at term. Vaginal breech delivery is considered high risk because of the greater risk of complications, illness and injury to both mother and child (2). Obstetricians therefore need to be skilled in evaluating the indications for vaginal delivery, monitoring labour progress and, not least, performing the necessary techniques to ensure a safe delivery. However, it is also important to avoid unnecessary caesarean sections, which can have negative consequences for both mother and child (3).

In addition to maintaining a sufficient case volume to preserve expertise in managing breech presentations, high-risk births require access to a neonatal intensive care unit (4). Norway has chosen to maintain the tradition of vaginal breech delivery in departments with a high level of obstetric expertise. In practice, this refers to women's clinics (5). Norway thus differs from many other countries where, since publication of the large multi-centre Term Breech Trial in The Lancet in 2000, most breech presentations are delivered by planned caesarean section (6, 7). The Term Breech Trial

concluded that planned caesarean section provided the best outcome for breech presentations (6), but the study has since been criticised for methodological weaknesses, and its generalisability to the Norwegian context is limited (8).

Maternity care in Norway is designed to be decentralised and differentiated to accommodate patient preferences and ensure care is provided based on defined selective criteria (4). Maternity care is divided into three levels: women's clinics, maternity wards and midwifery-led units. The level of care is assessed based on risk factors described in the clinical guidelines on quality in intrapartum care (*Et trygt fødetilbud – kvalitetskrav til fødselsomsorgen*) (4). The fact that Hammerfest Hospital handles breech deliveries despite not having a women's clinic is due to geographic and climatic challenges and the considerable distance to the nearest women's clinic at the University Hospital of North Norway in Tromsø. In addition, Hammerfest Hospital is the only hospital in the Finnmark region with a neonatal intensive care unit and paediatric department. The advisory board for obstetrics and gynaecology in Northern Norway Regional Health Authority therefore considers it medically justifiable for the maternity ward in Hammerfest to carry out some tasks that would normally be handled by a women's clinic, including breech deliveries (1).

> ***«It is important to investigate and present the data as it enhances transparency and strengthens trust among patients and healthcare personnel. The study also shows that the doctors at the Hammerfest maternity ward focus on safe breech deliveries»***

When national recommendations on quality standards for maternity care are not followed, it is particularly important to evaluate one's own practice, as Dalgård and Darell et al. have done (1). Focussing on one's own practice can help improve the standard of care and identify areas where work is needed to ensure safer and more effective patient care pathways. In the period 2004–23, 57 of 272 (21 %) breech presentations ended with vaginal deliveries at the maternity ward in Hammerfest (1). This is lower than the proportion (31 %) recorded in Norway's Medical Birth Registry (9). A key reason for this difference is likely the perception that performing a caesarean section is safer than vaginal delivery in a department with a limited number of breech deliveries. However, in line with changes in the criteria, the figures from Hammerfest show a trend towards more vaginal breech deliveries in recent years. The data presented show no serious complications or neonatal mortality during the study period.

A sufficiently high number of cases is needed to ensure statistical power when assessing the risk and safety associated with rare outcomes. Data from Norway's Medical Birth Registry for 1999–2009 indicate a prevalence of severe outcomes in breech presentations (defined as intrapartum death, neonatal death and cerebral palsy) of 3.1 per 1000 live vaginal births (10). In the study by Dalgård and Darell et al., there were 57 vaginal breech deliveries over a 20-year period; an extremely low number considering the low risk of severe birth outcomes. No definitive conclusions about the safety of vaginal breech delivery can therefore be drawn from the Hammerfest study. Nevertheless, it is important to investigate and present the data as it improves transparency and strengthens trust among patients and healthcare personnel. The study also shows that the doctors at the Hammerfest maternity ward focus on safe breech deliveries. One of the various measures implemented to enhance competence in the

department is to have an additional specialist in obstetrics and gynaecology present during vaginal breech deliveries (1). Overall, this may help improve safety for patients with breech deliveries in Finnmark.

REFERENCES

1. Dalgård E, Darell A, Nakling OJ et al. Forløsning ved seteleie ved fødeavdelingen i hammerfest i 2004–23 – en retrospektiv studie. Tidsskr Nor Legeforen 2025; 145. doi: 10.4045/tidsskr.24.0527. [CrossRef]

2. Toijonen AE, Heinonen ST, Gissler MVM et al. A comparison of risk factors for breech presentation in preterm and term labor: a nationwide, population-based case-control study. Arch Gynecol Obstet 2020; 301: 393–403. [PubMed][CrossRef]

3. Keag OE, Norman JE, Stock SJ. Long-term risks and benefits associated with cesarean delivery for mother, baby, and subsequent pregnancies: Systematic review and meta-analysis. PLoS Med 2018; 15. doi: 10.1371/journal.pmed.1002494. [PubMed][CrossRef]

4. Helsedirektoratet. Et trygt fødetilbud. Forslag til kvalitetskrav til fødeselsomsorgen. https://www.legeforeningen.no/contentassets/94db4a6ffaa44b729af3674968d3c7c5/hoeringsvedlegg-helsedirektoratet-fodetilbud-3.pdf Accessed 30.4.2025.

5. Håheim LL, Albrechtsen S, Berge LN et al. Breech birth at term: vaginal delivery or elective cesarean section? A systematic review of the literature by a Norwegian review team. Acta Obstet Gynecol Scand 2004; 83: 126–30. [PubMed]

6. Term Breech Trial Collaborative Group. Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. Lancet 2000; 356: 1375–83. [PubMed][CrossRef]

7. Hartnack Tharin JE, Rasmussen S, Krebs L. Consequences of the Term Breech Trial in Denmark. Acta Obstet Gynecol Scand 2011; 90: 767–71. [PubMed][CrossRef]

8. Glezerman M. Five years to the term breech trial: the rise and fall of a randomized controlled trial. Am J Obstet Gynecol 2006; 194: 20–5. [PubMed][CrossRef]

9. Vistad I, Klungsøyr K, Albrechtsen S et al. Neonatal outcome of singleton term breech deliveries in Norway from 1991 to 2011. Acta Obstet Gynecol Scand 2015; 94: 997–1004. [PubMed][CrossRef]

10. Bjellmo S, Andersen GL, Martinussen MP et al. Is vaginal breech delivery associated with higher risk for perinatal death and cerebral palsy compared with vaginal cephalic birth? Registry-based cohort study in Norway. BMJ Open 2017; 7. doi: 10.1136/bmjopen-2016-014979. [PubMed][CrossRef]

Publisert: 22 May 2025. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.25.0206