assessment of the mode of delivery. Another group at potentially higher risk are primigravida patients, a subgroup not considered in the report but presumably identifiable from the database.

The critical question therefore remains: is a carefully planned and managed trial of vaginal delivery any less safe for the fetus than an elective caesarean section? The uncertainty is in itself an argument in favour of elective caesarean section for all breech presentations at term since this reduces the opportunity for errors of judgment.

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1 Thorpe-Beeston JG, Banfield PJ, Saunders NJStG. Outcome of breech delivery at term. *BMJ* 1992;305:746-7. (26 September.)

EDITOR,—J G Thorpe-Beeston and colleagues present data based on large numbers which lend support to a policy of elective caesarean section for breech presentation at term.¹ Their results, however, were not stratified for parity. Though arguing against a policy of elective caesarean section in a primigravida patient may be difficult, vaginal breech delivery in a parous woman is less likely to pose technical difficulties. There were 90 vaginal breech deliveries in the Rotunda Hospital in 1990; 68 of the patients were multiparous. Is vaginal breech delivery just as hazardous in parous women as in primigravida women? Given the few intrapartum and neonatal deaths in the study and possible bias in the way in which patients may have been selected for elective caesarean section, Thorpe-Beeston and colleagues' data are unlikely to provide a satisfactory answer to this question.

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1 Thorpe-Beeston JG, Banfield PJ, Saunders NJStG. Outcome of breech delivery at term. *BMJ* 1992;305:746-7. (26 September.)

EDITOR,—Before obstetricians begin telling women that the chance of a baby dying if delivered vaginally by the breech at term is 1% compared with 0.03% if delivered by elective caesarean section¹ they should ask two questions. Firstly, how many of the vaginal breech deliveries were supervised by a consultant? Secondly, how many consultants supervise new trainees (of all grades) when they are first appointed in order to ensure that they are competent to deliver fetuses presenting by the breech vaginally?

J G Thorpe-Beeston and colleagues' paper will be used to reduce the choices available to women, whereas we think it shows that an experienced consultant should be present in the labour ward for breech presentations.

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EDITOR,—Having recently been faced with the decision of whether to opt for vaginal delivery or caesarean section when my own baby presented by the breech, I was particularly interested in J G Thorpe-Beeston and colleagues' paper.¹ I agree with the authors that women and their obstetricians need good quality information on which to base

their choice of mode of delivery, but the paper raises several questions.

Firstly, inaccuracy is a problem in any retrospective analysis, particularly one based on routinely collected activity data, but the authors do not comment on the completeness of the data or attempts at validation. The quality of the data is especially important when rare events, such as neonatal deaths, are being looked at: a small error in the number of deaths can have a major effect on the relative risk.

Secondly, in assessing the risk faced by a baby whose mother chooses vaginal delivery it is appropriate to compare outcomes in those women who have a trial of labour, regardless of the eventual route of delivery, and those who have elective caesarean sections. The authors have done this when assessing the relative risk of their chosen indicators of morbidity but not when calculating the risk of death.

It thus seems premature to suggest a policy of caesarean section for all women with breech presentation at term.

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1 Thorpe-Beeston JG, Banfield PJ, Saunders NJStG. Outcome of breech delivery at term. *BMJ* 1992;305:746-7. (26 September.)

EDITOR,—J G Thorpe-Beeston and colleagues report the neonatal mortality and morbidity associated with breech deliveries, having studied nearly 3500 cases.¹ Though the Apgar score is a well proved numerical assessment, it is probably too crude to assess any long term and less severe neurological deficit. A cohort study of the infants in the authors' breech delivery group, assessing the academic performance at school age, would be useful to ascertain whether the rapid moulding and possible cerebral trauma have a long term effect.

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1 Thorpe-Beeston JG, Banfield PJ, Saunders NJStG. Outcome of breech delivery at term. *BMJ* 1992;305:746-7. (26 September.)

EDITOR,—The data given by J G Thorpe-Beeston and colleagues are insufficient to substantiate the implication that elective caesarean section should be the mode of delivery for infants presenting by the breech at term.¹ The authors gathered data from all maternity units in the North West Thames region, and thus outcome cannot be related to management in different units. In particular, policies of selection for vaginal breech delivery may differ from one unit to another.² There is also no mention of the influence on outcome of induction of labour and augmentation in breech presentation. It would be interesting to know the incidence of undiagnosed breech presentation in labour and how management of this problem influenced the results.

The fact that "the fetus presenting by the breech may already be damaged"³ should surely be considered before caesarean section is advocated for all mature breech presentations. This damage will not be reflected by the neonatal death rate alone: subtle physical or mental handicap may take months or even years to manifest itself. Delivery by caesarean section has not been shown to reduce this morbidity.¹

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1 Thorpe-Beeston JG, Banfield PJ, Saunders NJStG. Outcome of breech delivery at term. *BMJ* 1992;305:746-7. (26 September.)

2 Bingham P, Hird V, Lilford RJ. Management of the mature selected breech presentation: an analysis based on the intended method of delivery. *Br J Obstet Gynaecol* 1987;94:746-52.

3 Hytten FE. Breech presentation: is it a bad omen? *Br J Obstet Gynaecol* 1982;89:879-80.

4 Westgren LM, Ingemarsson I. Breech delivery and mental handicap. *Baillieres Clin Obstet Gynaecol* 1988;2:187-94.

AUTHORS' REPLY,—It is a common misconception that the higher rates of vaginal breech delivery achieved by multiparous women are accompanied by correspondingly lower perinatal mortality.¹ Though selection policies for attempts at vaginal birth will vary between units, the actual rate of vaginal breech delivery in North West Thames region is fairly consistent at around 20-30% and in no unit exceeds 40%.²

We agree that, although a low Apgar score is not in itself a good predictor of long term outcome, it may indicate the possibility of an acute asphyxial episode. The estimated increase in the incidence of major handicap after vaginal breech delivery (4/1000) would, however, not necessarily be reflected by statistics for special care baby units. Knowledge of the statistical association between breech presentation and pre-existing neurological damage is of no value in the management of an individual case, when one has to assume that each baby has the potential for normal development.

None of the correspondents has addressed the two main issues raised in our paper. Exactly how does one counsel a pregnant woman whose fetus is presenting by the breech at term? And how is the next generation of specialists supposed to gain skill in vaginal breech delivery given their current exposure to it? Instead the correspondents focused attention on the apparent increase in perinatal loss associated with vaginal delivery. Various opinions are expressed—that data were entered inaccurately, the deaths were unavoidable or unrelated to the mode of delivery, the risks were overstated, or the figures even if accurate were related to violations of protocol or inexperience. The paradox is, of course, that a database system practical and robust enough to determine the actual incidence of perinatal loss in a large population cannot provide the fine detail necessary to resolve which of these opinions, if any, is correct.

Nevertheless, though the risks may have been overstated, they will not have been underestimated. Therefore it should be entirely reasonable to inform women that though the risk of perinatal loss could be close to 1%, it is certainly no more than this. Having tested this approach in the past few months, we have found that most women seem to prefer this clear statement to the vague concepts of fetal and maternal risk that are usually invoked during these discussions. Furthermore, several women have viewed a greater than 99% chance of a live birth as sufficiently reassuring for them to attempt vaginal delivery, so our original assumption as to how women would react to these data may have been incorrect. We must emphasise that at no stage did we advocate a policy of universal caesarean section; we merely attempted to highlight some of the problems associated with a trial of labour.

Finally, full (and documented) discussion of this degree of potential risk would surely be more likely to reduce rather than increase the likelihood of litigation in the event of subsequent complications.

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1 Myerscough PR, ed. *Munro Kerr's obstetrics*. 9th ed. London: Bailliere Tindall, 1977:103.

2 Banfield PJ, O'Hanlon M, Chapple J, Mugford M. *Second report of the North-West Thames region maternity statistics, 1990*. London: North West Thames Regional Health Authority, 1992.

3 Bingham P, Lilford RJ. Management of the selected term breech: assessment of the risks of selective vaginal delivery versus caesarean section for all cases. *Obstet Gynaecol* 1987;69:965-78.