COMMENTARY

Management of Breech Presentation in Areas with High Prevalence of HIV Infection

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Holmes and Hofmeyr[1] stated that in settings where caesarean section (CS) is safe and available, HIV positive women, or those who might be at risk of HIV with a fetus with a term breech presentation should be offered elective CS to reduce the risks of both vaginal breech delivery and mother to child HIV transmission. In settings where CS is unsafe or unavailable, or when women prefer vaginal delivery, they recommend external cephalic version (ECV) at term instead. The evidence for these recommendations, however, is not very convincing, as there is no evidence that ECV increases the risk of mother to child HIV transmission. ECV is an evidence-based intervention to reduce the number of breech births.[2] ECV should thus be recommended to all women with a term breech presentation, whether or not they are HIV positive and whether or not CS is safe and available.

Secondly, there is no evidence that a policy of planned CS is better for neonatal outcome than a policy of planned vaginal delivery in breech presentation at term. Although the Hannah term breech trial[3] suggested this in 2000, the long-term follow-up of a majority of the trial's infants at two years of age showed no difference between the two study arms[4].

Although Hannah et al suggested that the policy is safe for the mother, the trial did not have enough power to reach such a conclusion. From the confidential enquiries into maternal deaths in the UK and The Netherlands the hysterectomy and even maternal death.[7] Also, post-caesarean sepsis may lead to serious complications needing re-laparotomy, multi-organ failure and even maternal death. Late complications are infertility, extra-uterine pregnancy, repeat need for caesarean section, uterine scar rupture in a subsequent labour, as well as placenta praevia and accreta[8-9]. This last condition may lead to uncontrollable haemorrhage and hysterectomy. Especially in settings where women still prefer more children, this danger will increase exponentially with the number of previous operations.

In addition to this, the evidence that CS reduces the risk of mother to child HIV transmission stems for the period that only one antiretroviral agent was used during pregnancy[10]. At present, however, highly active antiretroviral therapy (HAART) is used and it includes three different drugs. Both The Netherlands and Canada nowadays have the policy of accepting vaginal birth when the viral load is not detectable in the blood of the woman[11-12].

This calls for every effort to make HAART available to all HIV positive pregnant women in this world, and not like now only to those few who live in those parts of the world where HIV is much less prevalent. Moodley rightly argued against routine caesarean section for HIV positive women, but with HAART available for such women it is also not indicated in the more privileged parts of the world[13].

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