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In Response

To the Editor:

I read with great interest Dr Matsubara's letter regarding our article "Planned Caesarean Hysterectomy Versus 'Conserving' Caesarean Section in Patients with Placenta Accreta." Dr Matsubara commented on two important topics and I would like to comment further on these issues:

1. The relatively high number of delayed hysterectomies, or, in other words, the high rate of "failed" conserving approaches reported in our series. The two other single centre series in the literature had a delayed hysterectomy rate of 20% and 15% respectively.[1,2] These rates, although lower than the rate we reported, are not statistically different because of the relatively small number of patients. Sentilhes et al. reported a multicentre questionnaire-based series of 167 "conservatively treated" patients with placenta accreta.[3] Their success rate in terms of uterine preservation was 75%. I believe that since our series was relatively "pure" it reflects the actual success rate following this surgical approach, although, as mentioned before, the results of all three series were comparable.

2. The other concern raised by Dr Matsubara was the fact that planned conserving surgery may force an inexperienced team to perform delayed postpartum hysterectomy in less than optimal urgent circumstances. I agree with Dr Matsubara that this surgical procedure should be undertaken only in centres where highly skilled surgeons are available and close follow-up is feasible. However, it is important to note that about one half of the patients with placenta accreta delivered in Mount Sinai Hospital during the period of our study were excluded from analysis because the delivery or the degree of invasion of the placenta could not be predicted. This relatively high rate of unexpected need to perform Caesarean hysterectomy (because of unsuspected invasive placentation or preterm labour) is not unique to our centre.[4] To my understanding, patients with an antenatal diagnosis of placenta accreta should be referred to a tertiary high-risk centre with the facility and proper staff to perform Caesarean hysterectomy 24 hours a day. This does not mandate the presence of such staff 24/7, but they should be available to perform the procedure if needed within a reasonable time.

Hagai Amsalem, MD
Department of Obstetrics and Gynaecology,
Division of Maternal Fetal Medicine, Mount Sinai Hospital,
Toronto ON

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Why Vaginal Breech Delivery Is an Acceptable Option

To the Editor:

One of my colleagues, who was a member of the Term Breech Trial Collaborative Group, sent me a copy of a recent article, "Consequences of the Term Breech Trial in Denmark."[1] At the top of the front page had been written the note "I think this paper vindicates the TBT."

I was a co-author of the 2009 SOGC Clinical Practice Guideline "Vaginal Delivery of Breech Presentation."[2] I have never believed that planned vaginal breech delivery is as safe for the baby as planned Caesarean section.[3] When I counsel women with a persistent breech presentation at term or in early labour, I tell them that "if you ask the baby how the baby would prefer to be delivered, the baby would answer, 'by Caesarean.'" I tell women that the risk

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of a singleton term cephalic baby dying or being damaged as a consequence of labour is about one in a thousand, and that if the baby is breech this risk is about two or three out of a thousand.[2,4] Even with strict selection criteria and intrapartum protocols, disasters can still happen. I am not naïve enough to believe that I will never have a stuck head or that, as some imply, vaginal breech delivery only goes wrong if the doctor has made a mistake.[5] There are too many counterexamples.[6–8] Nor do I believe that there is some irreducible perinatal mortality that we have to accept. Nor is there a nostalgic wish to preserve a skill, mastered with difficulty. I have no problem if an obstetrician prefers to perform a Caesarean section for all women with a breech presentation.

What I do believe is that the woman should receive a fair presentation of the pros and cons of vaginal breech delivery versus Caesarean section: namely, that with proper selection and good intrapartum progress and a skilled attendant, the chance of something permanently bad happening to the baby from attempted vaginal birth is about two or three per thousand, and that several hundred of those thousand women will need a Caesarean section to avoid one bad outcome for the baby.[2,4] The woman should not be driven by fear into having a Caesarean section. One has to discuss the risks of a Caesarean section for the mother in the current pregnancy[9,10]; the consequences of a uterine scar for future pregnancies, including uterine rupture, placenta previa, and placental abruption[11]; and the possible increased risks of perinatal morbidity and mortality in the next pregnancy.[12,13]

Most women will opt for a Caesarean section after being given this information. This is all right. I do not try to talk a woman into a vaginal breech delivery. I do not *recommend* it. But I will at least *offer* it if the circumstances are favourable. And I believe that an obstetrician who personally will not offer vaginal breech delivery to a woman should be willing to refer her to someone who will.

The last paragraph of the Danish paper reads as follows:

> When counseling women with breech presentation at term, they should be informed that it is well documented that elective CS is safer for the infant than planned vaginal delivery. However, they should also be informed that the risks of mortality and morbidity are very small in a setting with careful evaluation of cases and with good labor management and that having a vaginal delivery might benefit them in future pregnancies.[1]

That is my position as well. That is why I continue to support vaginal breech delivery.

Savas Menticoglou, MD
Division of Maternal-Fetal Medicine
Department of Obstetrics, Gynecology and Reproductive Sciences, Health Sciences Centre, Winnipeg MB

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