Complete Summary

GUIDELINE TITLE

Care of women with breech presentation or previous caesarean birth.

BIBLIOGRAPHIC SOURCE(S)

New Zealand Guidelines Group (NZGG). Care of women with breech presentation or previous caesarean birth. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2004 Nov. 80 p. [168 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

- Pregnancy with breech presentation
- Pregnancy with previous cesarean section

GUIDELINE CATEGORY

Management

CLINICAL SPECIALTY

Family Practice
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Physicians

GUIDELINE OBJECTIVE(S)

To offer guidance on the risks and benefits of caesarean compared to planned vaginal delivery in those with breech presentation or who have undergone previous caesarean section

TARGET POPULATION

Pregnant women at term with breech presentation or who have undergone previous caesarean section

INTERVENTIONS AND PRACTICES CONSIDERED

Antenatal Management

1. Provision of evidence-based information on risks and benefits of caesarean and vaginal birth
2. Participation in cultural awareness programmes
3. External cephalic version (ECV) for women with uncomplicated breech presentation
4. Cardiotocography
5. Moxibustion for women with uncomplicated breech presentation
6. Use of tocolytic agents
    - Salbutamol
    - Ritodrine
    - Terbutaline
    - Nifedipine
    - Intravenous nitroglycerin
    - Sublingual glyceryl trinitrate spray

Care During Labour

Breech Presentation

1. Amniotomy
2. Foetal monitoring (intermittent auscultation or continuous electronic foetal monitoring [EFM])
3. Encouragement of active labour positions that facilitate birth of infant's body and head
4. Use of Lovsett manoeuvre for breech delivery
5. Use of Mauriceau-Smellie-Veit (MSV) grip or forceps for breech delivery
6. Immediate access to obstetricians/paediatricians and caesarean facilities

Vaginal Birth After Caesarean

1. Induction of labour, if indicated, using amniotomy, membrane stripping, prostaglandins, misoprostol, and oxytocin
2. Careful use of Syntocinon to augment uterine activity
3. Epidural analgesia
4. Continuous EFM
5. Caesarean delivery offered as an option after discussion of risks and benefits for women with previous vertical uterine incision or history of uterine rupture
6. Immediate access to obstetricians/paediatricians and caesarean facilities

Interventions Considered But Not Recommended

Ultrasound estimation of foetal weight, pelvimetry (including magnetic resonance imaging [MRI]), hard or vigorous massage of the baby in utero, antenatal positioning exercises

MAJOR OUTCOMES CONSIDERED

- Rate of caesarean birth
- Rate of vaginal birth
- Rate of cephalic presentation
- Maternal and foetal outcomes
- Maternal and foetal morbidity and mortality

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The searches concentrated on finding high grade evidence to answer the identified clinical questions, such as systematic reviews, randomised controlled trials, and, where these were not available, observational studies such as well-designed cohort and case control studies. Only these types of study design were graded. Where these types of studies were not available, less rigorous study designs such as cross-sectional studies and case studies were considered but were not formally graded.

Further details on the Search Strategy for the guideline are available online at www.nzgg.org.nz.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

+ Strong study where all or most of the validity criteria are met

~ Fair study where not all the validity criteria are met, but the results of the study are not likely to be influenced by bias

x Weak study where very few of the validity criteria are met and there is a high risk of bias

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Studies were graded using a two-tier system that is detailed in the *Handbook for the Preparation of Explicit Evidence-Based Clinical Practice Guidelines*, published in November 2001 by the New Zealand Guidelines Group (NZGG). This system has been adapted from other grading systems currently in use, in particular the Scottish Intercollegiate Guidelines Network (SIGN) system.

The searches concentrated on finding high grade evidence to answer the identified clinical questions, such as systematic reviews, randomised controlled trials and, where these were not available, observational studies such as well-designed cohort and case control studies. Only these types of study design were graded. Where these types of studies were not available, less rigorous study designs such as cross sectional studies and case studies were considered but were not formally graded.

The two-tier system follows this process:

- Critical appraisal of individual relevant studies (identified from the searching) and assigning of a **level of evidence** for the first section of the GATEFRAME checklist that is incorporated into the evidence tables. A random sample of appraisals in the guideline was performed independently by two assessors and the results compared.
- Joint consensus by the development team on the issues of volume, consistency, clinical relevance and applicability of the body of evidence in the evidence table (filling out the NZGG Considered Judgment form for each clinical question) and development of **graded recommendations** that attempt to answer the clinical questions posed.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

A multidisciplinary group of health practitioners and consumers was convened as the guideline development team in 2002 and two subgroups formed, one to prepare a guideline for the care of women with breech presentation and the other to prepare a guideline on the care of women who have had previous caesarean birth.

The breech guideline development team met for the first time in April 2002 and the vaginal birth after caesarean (VBAC) guideline development team met for the first time in June 2002 to finalise the clinical questions that had previously been suggested by the feasibility group. Ground rules and terms of reference were discussed and conflicts of interest identified. The group considered draft evidence tables and developed recommendations based on each of the clinical questions by using a New Zealand Guideline Group (NZGG) Considered Judgment form (available at www.nzgg.org.nz).

The draft guideline was sent out for external peer review in October 2002. A second meeting of both subgroups was held in early December 2002, to discuss the draft guideline and comments made by external peer review, and to develop an algorithm and policy for implementation of the guideline.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendations

A - The recommendation is supported by good evidence (where there is a number of studies that are valid, consistent, applicable, and clinically relevant).

B - The recommendation is supported by fair evidence (based on studies that are valid, but there are some concerns about the volume, consistency, applicability, and clinical relevance of the evidence that may cause some uncertainty but are not likely to be overturned by other evidence).

C - The recommendation is supported by international expert opinion.

I - No recommendation can be made because the evidence is insufficient (either evidence is lacking, of poor quality, conflicting, or the balance of benefits and harms cannot be determined).

GPP - Where no evidence is available, best practice recommendations are made based on the experience of the Guideline Development Team.

COST ANALYSIS

Vaginal Birth After Caesarean

A literature search has identified several studies on this topic. The methodologies used varied between studies, and, as a result, the conclusions are conflicting. In particular, the assumptions used about successful outcome and rate of uterine

rupture differed. All the studies compared the cost of a planned vaginal birth with the cost of elective caesarean (see Table 6.1 in the original guideline document). The long-term outcomes included were usually cerebral palsy secondary to birth asphyxia resulting from uterine rupture.

Breech Presentation

Only one economic analysis was identified that considered the costs associated with breech presentation. The question that the analysis considered was whether or not external cephalic version (ECV) with epidural anaesthesia was a cost-effective procedure after the first attempt failed with tocolysis. The conclusions were that ECV under epidural reduces the rate of caesarean associated with breech presentation but its relative safety remains in question. The costs were increased in the group with ECV under epidural when compared with expectant management but no comparison was made with routine elective caesarean as this trial preceded the publication of the term breech trial.

The Cost of Elective Caesarean for No Medical Indication

No cost analysis of this scenario was found. In order to cost elective caesarean with no medical indications, it is necessary to estimate the costs involved in planned vaginal birth with all the possible outcomes (including spontaneous vaginal birth, operative vaginal birth, and emergency caesarean) and compare this with elective caesarean.

An economic analysis of alternative modes of birth during the first two months postpartum was identified. The costs of three modes of birth were compared. Spontaneous vaginal birth was costed as 1,698 pounds sterling, instrumental vaginal birth 2,262 pounds sterling, and caesarean 3,200 pounds sterling. The long-term outcomes were not included in this cost analysis. Elective caesarean was not specifically costed and, as some complications may be fewer in this group, it is not possible to extrapolate from caesarean as a whole.

A systematic review of economic aspects of alternative modes of birth identified 49 studies that reported costs. Data from the better quality studies demonstrated that caesarean costs a health service substantially more than other modes of birth. The range of costs of an uncomplicated vaginal birth was 629 to 1,298 pounds sterling compared with 1,238 to 3,551 pounds sterling for a caesarean. All of the papers only considered short-term health care costs.

New Zealand Costs

No published data are available on the costs of the options of elective caesarean, emergency caesarean, and vaginal delivery. However, information from the NZ Health Information Service using the National Minimum Dataset (NMDS) public hospital data on length of stay and cost of caesarean versus vaginal delivery was available (personal communication). In 2000 to 2001, the cost of caesarean was $3,701 while the cost of vaginal delivery was $1,731. The mean length of stay was 5.2 days for caesarean and 2.35 for vaginal births. These data are not very useful as they do not take into account the number of planned vaginal deliveries that require emergency caesarean. Furthermore, the neonatal costs are not taken into consideration.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A draft of this guideline was widely circulated to over 80 individuals/organisations for comment in October 2002 as part of the peer review process. A list of these individuals/organizations is provided in the original guideline document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the Levels of Evidence and Grades of Recommendation (**A-C, I, and Good Practice Points [GPP]**) are given at the end of the "Major Recommendations" field. Where no evidence is available, best practice recommendations are made based on the experience of the Guideline Development Team.

Informed Decision Making

GPP - Evidence-based information on the risks and benefits of caesarean and vaginal birth should be provided to women prior to birth so that they can make informed decisions and choices about their care.

Mäori Perspectives

GPP - A cultural care plan for the whänau should be offered to Mäori women.

GPP - Cultural awareness training programmes should be made available in each District Health Board (DHB) to ensure that Mäori women are able to access culturally appropriate birthing services.

Pacific Perspectives

GPP - Hard or vigorous traditional massage of the baby *in utero* is not recommended.

GPP - Cultural awareness training programmes should be made available in DHBs to ensure Pacific women are able to access culturally appropriate birthing services.

Antenatal Management

B - Women with uncomplicated (extended or flexed leg) breech presentation at term should be offered a caesarean after full discussion of the risks and benefits. (*The evidence for this recommendation may not be applicable to all women with breech presentation. The study population was highly selected and not all the study clinicians had optimal experience with vaginal breech birth.*)

A - Women with uncomplicated breech at 37 to 40 weeks should be offered external cephalic version (ECV) to increase the likelihood of cephalic presentation and vaginal birth.

I - There is currently insufficient information to adequately assess the risks of ECV. Low complication rates have been reported.

I - There is currently insufficient information to recommend ECV prior to 37 weeks.

B - Women with uncomplicated breech at 37 to 40 weeks may be offered tocolysis (with betamimetic drugs) to increase the success of ECV.

I - There is insufficient evidence to make specific recommendations about type of tocolytic treatment or dose.

I - There is insufficient evidence to recommend the use of spinal or epidural analgesia to facilitate ECV with the goal of increasing the likelihood of cephalic presentation or reducing the caesarean rate.

I - There is insufficient evidence to recommend routine and/or specific antenatal positioning exercises.

B - Moxibustion may be offered to women with breech presentation from 33 weeks of pregnancy to facilitate the change from breech to cephalic presentation.

I - There is insufficient evidence to recommend ultrasound estimation of foetal weight in women with breech presentation planning vaginal birth.

B - Pelvimetry, including magnetic resonance imaging (MRI), for women with breech presentation is not recommended.

I - There is insufficient evidence to recommend routine caesarean for women with the second twin presenting as breech.

I - There is insufficient evidence to recommend caesarean or vaginal breech birth for pre-term breech.

GPP - Breech presentation should be identified antenatally and arrangements made for the woman to give birth in an appropriate facility, where possible.

GPP - Before and after ECV, electronic foetal monitoring (EFM) is recommended.

A Practical Guide for Caring for Women in Labour with Breech Presentation

GPP - When a breech presentation is identified, the informed choice and consent process should be clearly documented.

GPP - Continuity of care should be maintained wherever possible.

GPP - Women who elect to have vaginal birth should have immediate access to obstetricians/paediatricians and caesarean facilities.

GPP - In active labour with uncomplicated flexed or extended legs breech presentation at term, it is recommended that:

- Amniotomy may be performed, with caution, when clinically indicated
- The infant's heart rate monitoring is done by either intermittent auscultation every 15 to 30 minutes in active labour 1st stage and after each contraction in 2nd stage or by continuous EFM
- The essential elements of vaginal breech birth are to prevent trauma and delay (with associated hypoxia/asphyxia). Therefore:
    - Total breech extraction should not be performed.
    - Active labour positions that facilitate the birth of the infant's body and head should be encouraged.
    - Spontaneous birth of the infant's body including the thorax should occur by maternal effort where possible.
    - No traction (which may extend arms and cause trauma) should be applied to the infant's body.
    - During the delivery of the buttocks and thorax, the birth attendant is recommended to keep the infant's back in the anterior position.
    - The Lovsett manoeuvre, using gentle traction, should be used to deliver extended or nuchal arms or may be used during assisted birth.
    - Controlled birth of the after-coming infant's head is achieved by:
        - Mauriceau-Smellie-Veit (MSV) grip or forceps in a prone position
        - Adapted MSV grip, maternal effort, and/or support of the baby in active birth positions

There should be immediate access to obstetricians/paediatricians and caesarean facilities.

Care of Women Having Vaginal Birth After Caesarean (VBAC)

B - Women with a previous caesarean with no additional risk factors should be offered VBAC. The risks and benefits of VBAC for individual women should be discussed and an informed decision made.

C- Women with a previous caesarean where the uterine incision is vertical should be advised there is an increased risk of uterine rupture and offered caesarean.

C - Women with a history of previous uterine rupture should be advised there is an increased risk of further uterine rupture and offered caesarean.

B - In pregnant women with previous caesarean requiring delivery, induction of labour may be offered if indicated. Women need to be advised of the potential risks and benefits of this procedure.

C - In women with previous caesarean in labour with poor uterine activity, the careful use of Syntocinon may be considered.

C - All women who have had a previous caesarean must be referred for consultation with an obstetrician during the antenatal period, preferably prior to 36 weeks.

C - Pregnant women with previous caesarean may be offered an epidural although there is no evidence that this will improve the chance of successful vaginal birth.

C - The possible benefits and risks of continuous EFM should be discussed with women with previous caesarean. Abnormalities in the foetal heart rate may precede uterine rupture and specialist consultation should be sought immediately.

B - X-ray pelvimetry in women with previous caesarean is not recommended.

C - Pregnant women with two previous caesarean births and no additional risk factors for vaginal birth may be offered planned vaginal birth after discussing the risks and benefits.

GPP - Women with previous caesarean should be offered continuity of midwifery care during pregnancy, labour, and birth.

GPP - Full and unbiased information on choosing VBAC should be discussed on a case-by-case basis with the pregnant woman with previous caesarean to enable her to make an informed decision about her birth choices.

GPP - There should be immediate access to obstetricians/paediatricians and caesarean facilities.

Definitions:

Levels of Evidence

+ Strong study where all or most of the validity criteria are met

~ Fair study where not all the validity criteria are met, but the results of the study are not likely to be influenced by bias

x Weak study where very few of the validity criteria are met and there is a high risk of bias

Grades of Recommendations

A - The recommendation is supported by good evidence (where there is a number of studies that are valid, consistent, applicable, and clinically relevant).

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C - The recommendation is supported by international expert opinion.

I - No recommendation can be made because the evidence is insufficient (either evidence is lacking, of poor quality, conflicting, or the balance of benefits and harms cannot be determined).

GPP - Where no evidence is available, best practice recommendations are made based on the experience of the Guideline Development Team.

CLINICAL ALGORITHM(S)

Clinical algorithms are provided for:

- Antenatal Care of Women With Breech Presentation
- Breech Labour and Birth
- Vaginal Birth After Caesarean (VBAC)

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

The literature searches concentrated on finding high grade evidence to answer the identified clinical questions, such as systematic reviews, randomised controlled trials and, where these were not available, observational studies such as well-designed cohort and case control studies. Only these types of study design were graded (see "Major Recommendations").Where these types of studies were not available, less rigorous study designs such as cross sectional studies and case studies were considered but were not formally graded.

The advice on caesarean section given in the guideline is based on epidemiological and other research evidence, supplemented where necessary by the consensus opinion of the expert development team based on their own experience.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

General

Provision of appropriate care and minimization of complications for breech delivery and vaginal delivery in women who have undergone previous caesarean section

Specific

- Caesarean section may result in a decreased risk of perineal pain, urinary incontinence, and uterine rupture compared to vaginal birth.

- Vaginal birth may result in a decrease in blood loss, reduce transfusion rate, infection rate, reduce the need for medical intervention and enable earlier mobilization compared to caesarean section.
- Use of routine continuous electronic foetal monitoring (EFM) may produce a reduction in neonatal seizures.

POTENTIAL HARMS

- Caesarean section may result in increased risk of thromboembolic complications, febrile morbidity, transfusion, and hysterectomy compared to vaginal birth.
- Caesarean section may result in increased risk of placenta previa, placenta accreta, placental abruption, infertility, ectopic pregnancy, and miscarriage in future pregnancies.
- Vaginal birth after caesarean may result in uterine rupture, foetal distress, and need for emergency caesarean section.
- Induction of labour with prostaglandins may result in a small risk of uterine rupture.
- Low complication rates have been reported with external cephalic version (ECV), including foetal bradycardia and transient cardiotocograph (CTG) changes.
- An increase in the rate of admission of newborns to the neonatal intensive care unit, and increased rate of respiratory problems in newborns is associated with caesarean section.

CONTRAINDICATIONS

CONTRAINDICATIONS

Contraindications for External Cephalic Version (ECV)

Absolute:

- Multiple pregnancy
- Antepartum haemorrhage
- Placenta praevia
- Established labour
- Premature rupture of membranes
- Severe pregnancy-induced hypertension
- Maternal cardiac disease
- Previous uterine surgery (apart from caesarean)
- Cases in which caesarean is necessary
- Lack of maternal consent

Relative:

- Previous caesarean
- Diabetes
- Hypertension
- Impaired foetal growth
- Obesity

- Foetal and uterine anomalies

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Evidence-based best practice guidelines are produced to help health practitioners and consumers make decisions about health care in specific clinical circumstances. Research has shown that if properly developed, communicated, and implemented, guidelines can improve care. The advice on caesarean section given in this guideline is based on epidemiological and other research evidence, supplemented where necessary by the consensus opinion of the expert development team based on their own experience.
- While guidelines represent a statement of best practice based on the latest available evidence (at the time of publishing), they are not intended to replace the health practitioner's judgement in each individual case.
- There is a lack of well-designed studies in the area of management of breech presentation and the management of vaginal birth after caesarean.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Performance Indicators for Caesarean

Performance indicators can be used to monitor the success of the guideline and the implementation phase. District Health Boards, hospitals, and individual's practice could be monitored this way. The performance indicators were developed after a literature search. Two documents, *The National Sentinel Caesarean Section Audit* and *Guide to Inpatient Quality Indicators*, were identified. The group undertook an internal process incorporating the information above and developed the list of performance indicators as listed in Chapter 7 of the original guideline document. They will require piloting and evaluation prior to being incorporated into a national process.

Dissemination

- Speakers from the guideline team to address conferences and meetings of obstetricians/midwives and general practitioners
- Promotion of the guideline recommendations to District Health Board (DHB) managers to promote establishment of breech and vaginal birth after caesarean (VBAC) clinics
- Promotion of the information on risks/benefits and alternatives to caesarean in women's and family-focused magazines and newspapers
- Inclusion of information in the booklets that pregnant women are given by the Ministry of Health

The role of implementation in guideline development cannot be over emphasised. The following implementation strategies are suggested:

Breech Presentation

1. The information contained in the guideline needs to be presented to maternity care providers and pregnant women who are involved in decision-making about management. In addition to the dissemination of the guideline, training in external cephalic version and vaginal breech birth will be necessary.
2. Hospitals that provide maternity care should establish dedicated breech clinics where women with breech presentation from 36 weeks can be seen for external cephalic version (ECV).

Vaginal Birth after Caesarean

1. The information contained in the guideline needs to be presented to maternity care providers and pregnant women who are involved in decision-making about management of labour following caesarean.
2. Hospitals that provide maternity care should consider establishing a clinic staffed by midwives and obstetricians who are committed to the recommendations in the Guideline for women who have had a previous caesarean. The Lead Maternity Carer could potentially attend the specialist consultation in order to maintain continuity. The aim of the clinic would be to provide information on the benefits and risks of the options available to them of repeat caesarean and planned vaginal birth.

Evaluation

To assess whether guidelines improve practice, evaluation of the effectiveness of the implementation strategy is important. It is recommended that an appropriate strategy be designed to thoroughly evaluate the impact of the guideline at a reasonable interval after publication. Evaluation ensures that the process of care reflects the evidence-based guideline recommendations that are designed to improve birth outcomes for all women.

Issues to be considered as part of the audit process are:

- Identification of the number of health care practitioners (midwives, general practitioners and obstetricians) that are aware of the guideline recommendations
- Identification of the coverage of the consumer information and whether it is routinely made available to pregnant women considering a caesarean
- Comparative measurement of health outcomes for mothers and infants, in particular:
    - Caesarean rates
    - Maternal/foetal morbidity and mortality
    - Women's satisfaction.

In addition to measuring the impact of the guideline on health outcomes, evaluation processes need to be designed to assess the effects on changing attitudes or behaviour and reducing practice variation throughout New Zealand.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Clinical Algorithm
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New Zealand Guidelines Group (NZGG). Care of women with breech presentation or previous caesarean birth. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2004 Nov. 80 p. [168 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Nov

GUIDELINE DEVELOPER(S)

New Zealand Guidelines Group - Private Nonprofit Organization

SOURCE(S) OF FUNDING

New Zealand Guidelines Group

GUIDELINE COMMITTEE

Caesarean Birth Guideline Development Team

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Team Members: Cindy Farquhar (Chair) Professor and Postgraduate Chair of Obstetrics and Gynaecology, NWH, Auckland; Anne Lethaby (Project Manager) NZGG, EPIQ, Department of Community Health, University of Auckland, Auckland; Karen Guilliland, Midwife, CEO, NZ College of Midwives, Christchurch, Nominated by the NZ College of Midwives; Sharron Cole, Consumer representative, National President of Parents Centres New Zealand, Nominated by the Parents Centre National Organisation

Breech Sub-Group: Joanne Rama, Mäori Midwife, Auckland, Nominated by Nga Maia Midwives Collective; Bridget-Mary McGown, Consumer, Invercargill, Nominated by the Invercargill Parents Centre; Maggie Banks, Midwife, NZ College of Midwives, Waikato, Nominated by the NZ College of Midwives; Nimisha Waller, Midwife, Auckland University of Technology, Auckland, Nominated by the NZ College of Midwives; Don Simmers, General Practitioner, Queenstown Medical Centre, Queenstown, Nominated by The Royal New Zealand College of General Practitioners; Colin Conaghan, Consultant in Obstetrics and Gynaecology, Hyatt Chambers, Christchurch, Representing The Royal Australian and New Zealand College of Obstetricians and Gynaecologists; Mahesh Harillal, Consultant in Obstetrics and Gynaecology, NWH, Auckland, Nominated by The Royal Australian and New Zealand College of Obstetricians and Gynaecologists; Marion Heeney, General Manager of Womens Health, Counties-Manukau Health, Auckland, Nominated by the Health Funds Association of New Zealand Inc.

VBAC Sub-Group: Lynda Croft, Consultant in Obstetrics and Gynaecology, Hyatt Chambers, Christchurch; Rob Buist, Consultant in Obstetrics and Gynaecology, NWH, Auckland, Nominated by The Royal Australian and New Zealand College of Obstetricians and Gynaecologists; Maralyn Foureur, Professor of Midwifery and Women's Health, Wellington Women's Hospital, Wellington; Celia Butler, Maternity Manager, Nelson Hospital, Nelson, Nominated by DHB and Health Service Managers; Joanne Rama, Mäori Midwife, Auckland, Nominated by Nga Maia Midwives Collective; Brenda Hinton, Consumer, Maternity Services Consumer Council, Auckland; Philippa Peck, Consumer, Palmerston North; Ann Yates, Clinical Leader of Midwifery, Auckland DHB, Auckland, Nominated by NZ College of Midwives; Tim Cookson, General Practitioner, Wellington; Alec Ekeroma, Consultant in Obstetrics and Gynaecology, Middlemore Hospital, Auckland and Vice President, Pacifika Medical Association. Nominated by Pacifika Medical Association

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Declarations of competing interests within the guideline development team:

Cindy Farquhar

- Reimbursement for conference travel and fees for speaking, examining and consulting from the New Zealand Guideline Group (NZGG), Royal Australian and New Zealand College of Obstetrics and Gynaecology, and conference organizers

Karen Guilliland

- Director, PHARMAC
- Reimbursement for conference travel and fees for speaking and consulting from a number of professional bodies

Sharron Cole

- Hutt Valley District Health Board member
- Reimbursement for travel from the Chinese University of Hong Kong

There were no other conflicts of interest.

ENDORSER(S)

New Zealand College of Midwives Inc. - Medical Specialty Society
Paediatric Society of New Zealand - Medical Specialty Society
Parents Centres of New Zealand - Professional Association
Pasifika Medical Association - Professional Association
Perinatal Society of New Zealand Inc. - Medical Specialty Society

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.

Print copies: Available from the New Zealand Guidelines Group Inc., Level 10, 40 Mercer Street, PO Box 10 665, The Terrace, Wellington, New Zealand; Tel: 64 4 471 4180; Fax: 64 4 471 4185; e-mail: info@nzgg.org.nz

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- New Zealand Guidelines Group (NZGG). General summary. Care of women with breech presentation or previous caesarean birth. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2004 Nov. 8 p.

Electronic copies: Available from in Portable Document Format (PDF) from the New Zealand Guidelines Group Web site.

Print copies: Available from the New Zealand Guidelines Group Inc., Level 10, 40 Mercer Street, PO Box 10 665, The Terrace, Wellington, New Zealand; Tel: 64 4 471 4180; Fax: 64 4 471 4185; e-mail: info@nzgg.org.nz

Additionally, Audit Criteria/Indicators can be found in Chapter 7 of the original guideline document.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on February 8, 2005. The information was verified by the guideline developer on March 16, 2005.

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Date Modified: 9/29/2008