*Original Article*

# The evaluation of maternal morbidity and perinatal morbidity & mortality in Breech Delivery and Its Comparison with Mode of Delivery

**Dr. Anupama Sharma [1] *, Dr. Himanshu Shah [2], Dr. Vandana Mourya [3]**

1. Department of Obstetrics and Gynecology, Nepalgunj Medical College, Teaching Hospital, Kohalpur, Nepal.
2. Department of Orthopedics, Nepalgunj Medical College, Teaching Hospital, Kohalpur, Nepal.
3. Department of Radiodiagnosis & Imaging, Nepalgunj Medical College, Teaching Hospital, Kohalpur, Nepal.

* Correspondence: Sharmaanupama125@gmail.com

**Abstract:** Breech presentation is a longitudinal lay with the buttocks or feet closest to the cervix that occurs in 3-4% of deliveries. The percentage of breech deliveries reduces from 22-25% before 28 weeks to 7-15% at 32 weeks to 3-4% at term. Before 32 weeks, 50% of pregnancies exhibit breech, two to four percent of pregnancies stay breech until delivery because most early breech presentations spontaneously change to cephalic position. This study is to evaluate maternal morbidity and perinatal morbidity and mortality in breech delivery. It compare the results by mode of delivery so that appropriate protocol for delivery can be devised without compromising fetomaternal well being. The research took place in the Obstetrics and Gynecology department of Nepalgunj Medical College Teaching Hospital in Kohalpur, and it adhered to the principles of a prospective hospital-based study design, N=60 cases make up the study. The study includes all cases of breech presentation that occur at or near term and do not involve any complications related to the mother's health or surgery. Regardless of gestational age, a clinically acceptable pelvis, an estimated foetal weight of 2.5-3 kg, a frank or full breech presentation, and the mother's agreement to vaginal delivery are all necessary criteria. The incidence of breech presentation is higher in patients who are multigravida (56.7% of the time) compared to patients who are primigravida (43.3%). There is a higher incidence of breech presentation among patients who are between the ages of 21 and 25 years old, with 38.3% of patients falling into this age range. The gestational age of 37-40 weeks is more common in both first-time mothers and women who have given birth more than once, with an incidence of 78.34%. Compared to complete breech, which occurs 11.54 percent of the time, frank breech is more common in first-time mothers (76.92 percent). Complete breech is more common in multigravida pregnancies (55.86%) compared to frank breech, which occurs in 38.24% of pregnancies. LSCS is the most common method of birth among first-time mothers (84.62%), whereas assisted breech delivery is the second most common method (15.38%). There should be a plan in place to educate the community on the significance of prenatal care, as well as the risks of breech delivery for both the mother and the unborn child. The first step in determining the fetal weight is to do a sonographic check upon entrance.

**Keywords:** maternal morbidity, perinatal morbidity, breech delivery

## 1. INTRODUCTION

Breech presentation is a longitudinal lay with the buttocks or feet closest to the cervix that occurs in 3-4% of deliveries. The percentage of breech deliveries reduces from 22-25% before 28 weeks to 7-15% at 32 weeks to 3-4% at term [1]. Breech presentation care has been difficult since antiquity, the relationship between the lower extremities and buttock of breech presentation divides it into frank (50-70%), complete (5-10%), and footling or incomplete (10-30%). Before 32 weeks, 50% of pregnancies exhibit breech, two to four percent of pregnancies stay breech until delivery because most early breech presentations spontaneously change to cephalic position [2]. Prematurity, hydramnios, high parity with uterine relaxation, multiple fetuses, oligohydramnios, hydrocephaly, anencephaly, and other congenital malformations, previous breech delivery, uterine anomalies (septate, sub-septate, arcuate, and caudate), placenta previa, and pelvic tumors predispose Breech presentation is associated with higher maternal, perinatal, and mortality than cephalic presentation due to preterm, congenital abnormalities, and mechanical and hypoxic birth injury [3]. Genital tract laceration, trouble delivering the after-coming head, cervical tear, episiotomy extension, and significant perineal tear may occur during delivery [4]. Relaxation anesthesia can cause uterine atony and postpartum hemorrhage, manual birth canal procedures risk infection. Fetal traumas include soft tissue injuries, clavicle and humerus fractures, sternocleidomastoid hematomas, brachial plexus paralysis, and birth hypoxia [5]. Separations of the scapula, humerus, and femur epiphysis may be more significant. Prenatal breech presentation diagnostic helps the obstetrician assess and deliver the baby [6]. Diagnostically, a hard, round, ballotable fundus head with FHS heard loudest slightly above the umbilicus and more on vaginal examination of the soft breech suggests diagnosis. USG confirms diagnosis by identifying fetus attitude, placental localization, EFW, liquor, congenital anomalies, uterine anomalies, fetal growth, and hyper extended neck, which recommends delivery mode [7]. Retrospective studies reveal that vaginal breech delivery increases perinatal morbidity and mortality 4-10 times more than vertex delivery [8]. After trial of labor, injury or mortality was 1%, 0.09% after elective cesarean section, and greater after emergency. An experienced obstetrician is more likely to perform a safe vaginal breech delivery trial, reducing the need for cesarean section [9]. All-breech elective cesarean section did not reduce perinatal death and morbidity, according to previous studies. For patients who meet vaginal breech delivery criteria, a trial of vaginal birth can lower the emergency cesarean section threshold [10]. Some hospitals have a cesarean section rate above 100% to prevent fetal hazards from vaginal breech delivery. CS substantially reduces breech delivery-related perinatal death but not fetal or mother morbidity. Thus, any breech birth method or technique improvement should improve perinatal outcomes and mother mortality [11]. Breech delivery increases maternal and perinatal mortality regardless of method. Choosing and planning the birth route during antenatal care or early labor is critical since unplanned vaginal delivery increases morbidity and death [12]. Many of our parturients prefer vaginal breech delivery and severely oppose cesarean section, making this crucial. A big global randomized trial found elective cesarean delivery beneficial, many studies have found no difference in short- and long-term morbidity and mortality rates between vaginally and abdominally delivered children.20-25 Cesarean delivery may increase maternal morbidity and costs [13]. Breech presentation management is popular worldwide, obstetricians worldwide have researched breech birth management. Perinatal mortality and morbidity of nulliparous mothers' singleton term breech babies delivered vaginally and by cesarean section, it allowed 96 (85.7%) of 112 singleton term breech presentations to labor [14]. Mortality and morbidity were similar across vaginally delivered and cesarean section groups in three birth weight categories for most criteria. In low and very low birth weight vaginal and cesarean section patients, delivery modality affected death. Term pregnant women with breech

 

presentation find the best delivery strategy, it examined how mode of delivery, parity, gestational age, maternal age, maternal medical illness, and birth weight affected perinatal outcome in each delivery. Factors did not cause poor perinatal outcomes. Mode of delivery most affected perinatal outcome. A study indicated that elective cesarean section is the safest way to deliver term breech babies [15]. The aim of this study is to evaluate maternal morbidity and perinatal morbidity and mortality in breech delivery. It compare the results by mode of delivery so that appropriate protocol for delivery can be devised without compromising fetomaternal wellbeing.

## 2. MATERIALS AND METHODS

The research took place in the Obstetrics and Gynecology department of Nepalgunj Medical College Teaching Hospital in Kohalpur, and it adhered to the principles of a prospective hospital-based study design, N=60 cases make up this study. This study includes all cases of breech presentation that occur at or near term and do not involve any complications related to the mother's health or surgery. Regardless of gestational age, a clinically acceptable pelvis, an estimated foetal weight of 2.5-3 kg, a frank or full breech presentation, and the mother's agreement to vaginal delivery are all necessary criteria. With the patient's and caregiver's signed agreement after thorough explanation, the study included patients who met the inclusion criteria. The patient's obstetric history, antenatal care history, number of visits, and other pertinent details were all meticulously documented upon admission. On a pre-made Proforma, we also noted the patient's history of breech and abdominal deliveries, along with any complications that may have occurred during those deliveries. Every patient had their height and weight taken as part of a comprehensive systemic and general assessment. Measurements of fundal height, abdominal girth, pregnancy status, fetal heart sound location, presenting part engagement, and uterine contractions were all part of the abdominal examination. The presence of a bag of membranes, the presenting component, and its station were among the variables assessed during the per vaginal examination, along with the cervix's consistency, location, effacement, and dilation. Experienced obstetricians confirmed that the pelvis was adequate. All patients had routine examinations such as hemoglobin and urine testing for albumin, glucose, and microscopy. All of the cases that were part of the study had ultrasound to confirm the following: the presence of a single fetus, the kind of breech presentation, the volume of amniotic fluid, the placement of the placenta, the estimated weight of the fetus, and the absence of any apparent congenital anomalies. Additional investigations were conducted as needed after that, taking into account the patient's condition and any related consequences. They kept a careful eye on the fetal heart rate and the uterine contractions. We confirmed the results of the pelvic examination and evaluated the labor progress with a vaginal examination after the membranes ruptured. The vaginal breech delivery trial was brief. Any indication of fetal distress or a failure to progress during labor led to the decision to perform a cesarean section on the patient. The delivery could go on as planned because no problems had arisen. More frequent monitoring of the foetal heart rate—every fifteen minutes—began following membrane rupture. We moved the patient to the edge of the table and performed the delivery in the lithotomy position once the progress was good and the breech position was visible at the vulval outlet. There was careful documentation of the delivery procedure and any complications that occurred with vaginal deliveries. Nobody tried to turn the breech to the vertex. Any uterine abnormalities were carefully examined during the cesarean section if one was performed, and the reason for the procedure was documented. The visiting pediatrician promptly attended to all newborns. We looked for signs of damage or birth defects in the infants. We recorded the Apgar score at 0, 1, and 5 minutes. In a patient whose first day of last menstrual period was uncertain or unknown, we searched for signs of premature birth in

 

kids with low birth weight. We found out what killed the neonate in each case. Cervical and perineal tears, postpartum bleeding, uterine rupture, infection of the postpartum wound, and urinary tract infections were among the maternal symptoms examined. There was daily monitoring of the mother and infant in the ward until they were discharged. We used SPSS, or the statistical tool for the social sciences, to examine, process, and analyze all of the data. Tables and bar graphs display the results of descriptive statistics calculations, such as the mean and standard deviation.

## 3. RESULTS AND DISCUSSION

### 3.1 Interpretation of Results

In this study, total number of cases studied is N=60 which were selected on randomized basis. Maternal morbidity and perinatal morbidity and mortality were studied in both groups of females who delivered breech either vaginally or by LSCS. The mean age of participant in the study is 28 ± 5.77. The youngest participant's age is 15 years and the oldest is 35 years. According to the study, most of the patients fall in the age group 21-25 years with an incidence of 38.3% as the reproductive age group fall in this group.

**Table 01:** Incidence of Breech Presentation According to Age

| Age ( in years) | No of cases | Percent |
|---|---|---|
| 15-20 | 17 | 28.3 |
| 21-25 | 23 | 38.3 |
| 26-30 | 12 | 20.0 |
| 31-35 | 8 | 13.3 |
| Total | 60 | 100.0 |

Out of 60 cases studied, 26 were primigravida with breech presentation giving an incidence of 43.3% and 34 were multigravida giving an incidence of 56.7%.

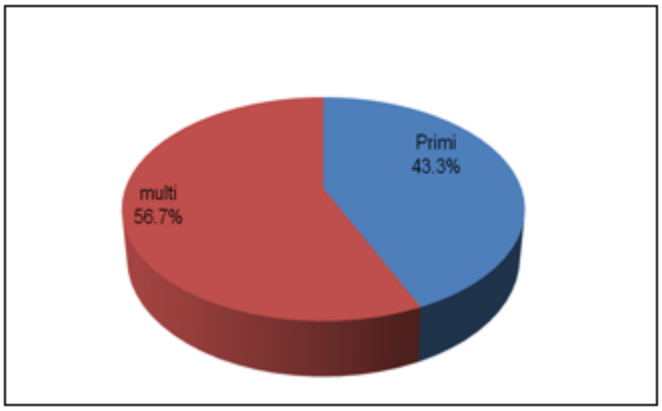


**Figure 01:** Incidence of breech presenation according to parity

According to the study, frank breech was more common among the primigravida women with an overall incidence of 76.92% whereas among the multi gravida patients complete breech was more common with an overall incidence of 55.88%. There were 3 cases of incomplete (footling) breech among primigravida with an incidence of 11.54% and 2 in multigravida patients with an incidence of 5.88%. There was no case of breech with knee presentation in this study.

**Table 02:** Distribution of type of breech according to parity

| Type of breech | Primi | | Multi | | Total | p value |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | | |
| Complete | 3 | 11.54 | 19 | 55.88 | 22 | 0.002 |
| Frank | 20 | 76.92 | 13 | 38.24 | 33 | |
| Incomplete (footling) | 3 | 11.54 | 2 | 5.88 | 5 | |
| **Total** | 26 | 100 | 34 | 100 | 60 | |

According to the table below, majority of the patients were admitted to this hospital at the gestational age of 37-40 weeks of gestation in both primigravida and multigravida with an incidence of 84.62% and 73.53% respectively. 2 cases of multigravida were of gestational age less than 36 weeks with an incidence of 5.88% and there were no primigravida patients with gestational age less than 36. 11 cases of multigravida patient were post dated with an incidence of 20.59% and 4 cases of primigravida patient were postdated with an incidence of 15.38%.

**Table 03:** Gestational Age in relation to Parity

| Gestational Age in weeks | Primi | | Multi | | Total | | p value |
|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | |
| 28-36 | 0 | 0 | 2 | 5.88 | 2 | 3.33 | 0.372 |
| 37-40 | 22 | 84.62 | 25 | 73.53 | 47 | 78.34 | |
| >40 | 4 | 15.38 | 7 | 20.59 | 11 | 18.33 | |

According to the table below, among 26 cases of primi, majority of cases (22) had LSCS with an incidence of 84.62% and 4 cases had assisted breech delivery with an incidence of 15.38%. Among the multigravida patients, majority (18) had assisted breech delivery with an incidence of 52.94% and 16 had undergone LSCS with an incidence of 47.06%.

**Table 04:** Distribution of Mode of Delivery in relation to parity

| Mode of delivery | Primi | | Multi | | Total | p value |
|---|---|---|---|---|---|---|
| | No. | % | No. | % | | |
| Assisted breech delivery | 4 | 15.38 | 18 | 52.94 | 22 | 0.003 |
| LSCS | 22 | 84.62 | 16 | 47.06 | 38 | |
| **Total** | 26 | 100 | 34 | 100 | 60 | |

 

According to the table below emergency LSCS was more common than elective LSCS with an incidence of 68.42% and 31.58% respectively, as most of the cases were undiagnosed and were referred late to our hospital from peripheral centers.

**Table 05:** Incidence of Elective cesarean section and Emergency cesarean section

| Type of LSCS | No. of cases | Percentage |
|---|---|---|
| Emergency LSCS | 26 | 68.42 |
| Elective LSCS | 12 | 31.58 |
| Total | 38 | 100 |

According to the table below, most common indication for LSCS among primigravida is breech presentation in 10 cases with an incidence of 45.45%. 7 cases had fetal distress with an incidence of 31.81%. Fetal distress was diagnosed on the basis of fetal bradycardia. 3 cases were operated for footling breech with an incidence of 13.64%. 1 case was operated for cord prolapsed with an incidence of 4.55% and 1 case was of elderly primi with breech presentation with an incidence of 4.55%.

**Table 06:** Indications of LSCS among Primi

| Indications | No. of cases | percentage |
|---|---|---|
| Primi with Breech | 10 | 45.45 |
| Fetal distress | 7 | 31.81 |
| Footling Breech | 3 | 13.64 |
| Cord prolapsed | 1 | 4.55 |
| Elderly primi | 1 | 4.55 |
| Total | 22 | 100 |

According to the table below, most common cause of LSCS among multigravida was previous LSCS with an incidence of 43.75%. Precious baby, footling breech, fetal distress and big baby were other indications for LSCS with an incidence of 12.5% each. Fetal distress was diagnosed on the basis of fetal bradycardia and precious baby was on the basis of bad obstetric history. 1 case was of low lying placenta with an incidence of 6.25%.

**Table 07:** Indications of LSCS among Multi

| Indications | No. of cases | Percentage |
|---|---|---|
| Previous LSCS | 7 | 43.75 |
| Precious baby | 2 | 12.5 |
| Footling breech | 2 | 12.5 |
| Fetal distress | 2 | 12.5 |
| Big baby | 2 | 12.5 |
| Low lying Placenta | 1 | 6.25 |
| Total | 16 | 100 |

According to the table below, 1 patient had uterine anomaly i.e. sub septate uterus with an incidence of 2.63%.

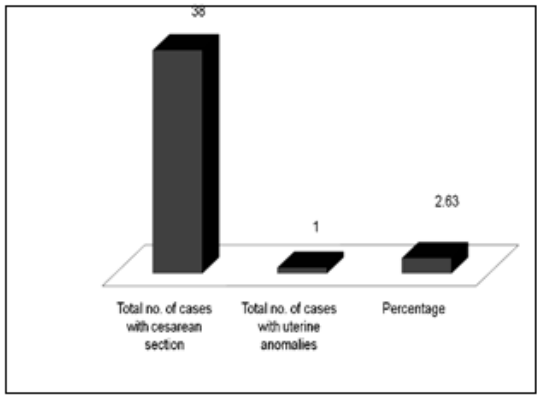


**Figure 02:** Incidence of uterine anomalies among cesarean section patients

According to the table below, in 2 cases out of 22 vaginal deliveries, difficulty in delivery of after coming head was experienced with an incidence of 9.09%.

**Table 08:** Incidence of difficulty in delivery of after coming head in vaginal delivery

| Total no. of vaginal delivery | No. of cases with difficulty in delivering head | Percentage |
|---|---|---|
| 22 | 2 | 9.09 |

According to the table below, assisted breech delivery was associated with higher incidence of fetal injuries i.e. 22.73% as compared to LSCS with an incidence of 0%. Out of 22 cases delivered vaginally 3 babies had soft tissue injury with good recovery, 1 case of intra-partum asphyxia required prolonged NICU care and 1 case of cephalhematoma died after 3 days of life.

**Table 09**: Incidence of fetal morbidity in relation to mode of delivery

| Fetal morbidities | Mode of delivery | | | | Total | p value |
|---|---|---|---|---|---|---|
| | Assisted breech delivery | | LSCS | | | |
| | No. | % | No. | % | | |
| Soft tissue injury | 3 | 13.63 | 0 | 0 | 3 | 0.024 |
| Cephalhematoma | 1 | 4.55 | 0 | 0 | 1 | |
| Intra-partum asphyxia | 1 | 4.55 | 0 | 0 | 1 | |
| None | 17 | 77.27 | 38 | 100 | 55 | |

According to the table below, Apgar score at 5 minutes after birth was good (>7) among the babies who were delivered by LSCS with an incidence of 92.11% whereas Apgar score was satisfactory (5 to7) in most of the babies born by assisted breech delivery with an incidence of 50%. 13.6% of babies delivered vaginally had poor Apgar (<5) at 5 minutes compared to babies who were delivered by LSCS with an incidence of 2.6%.

 

Table 10: Apgar score at 5 minutes after birth in relation to mode of delivery

| Apgar score at 5 minutes after birth | Mode of delivery | | Total |
|---|---|---|---|
| | Assisted breech delivery | LSCS | |
| > 7 | 8 (36.36%) | 35 (92.11%) | 43 |
| 5-7 | 11 (50%) | 2 (5.26%) | 13 |
| <5 | 3 (13.64%) | 1 (2.63%) | 4 |
| Total | 22 (100%) | 38 (100%) | 60 |

In this study perinatal outcome was good in LSCS with an incidence of 92.11%. 2 babies delivered vaginally died in their early neonatal period with a incidence of 9.09% and 1 baby delivered by LSCS died in its early neonatal period with an incidence of 2.63%.Out of these 3 neonatal deaths, 2 were because of IUGR and 1 baby died because of respiratory distress syndrome. Perinatal outcome was unsatisfactory in 5 cases with assisted breech delivery and single case with LSCS with Apgar score less than 7 at 5 minutes .All the six babies needed NICU admission and care which were shifted back to mother side after good recovery.

Table 11: Perinatal Outcomes In Relation to Mode of Delivery

| Mode of delivery | Perinatal Outcome | | | | | | | | p value |
|---|---|---|---|---|---|---|---|---|---|
| | Good | | Satisfactory | | Unsatisfactory | | Neonatal Death | | |
| | No. | % | No. | % | No. | % | No. | % | |
| Assisted Breech delivery | 10 | 45.45 | 5 | 22.73 | 5 | 22.73 | 2 | 9.09 | 0.001 |
| LSCS | 35 | 92.11 | 1 | 2.63 | 1 | 2.63 | 1 | 2.63 | |

According to the table below perinatal mortality was more in assisted breech delivery in primigravida with an incidence of 50%. There was no perinatal mortality among the multigravida patients who delivered either vaginally or by LSCS.

Table 12: Incidence of Perinatal mortality in relation to Parity and mode of delivery

| Mode of delivery | Perinatal Mortality | | | | | |
|---|---|---|---|---|---|---|
| | Primi | | | Multi | | |
| Assisted breech delivery | Total | Neonatal death | % | Total | Neonatal death | % |
| | 4 | 2 | 50 | 18 | 0 | 0 |
| LSCS | 22 | 1 | 4.55 | 16 | 0 | 0 |

In this study, it was observed that the mean weight of baby was 2756.67 ± 384.825 grams. Perinatal outcome was more unsatisfactory when the birth weight was in the range of 1500-2500 grams with an incidence of 66.67%. Also,

 

the incidence of perinatal mortality was more in the group with birth weight 1500-2500 grams with an incidence of 66.67%.

**Table 13:** Perinatal Outcome in relation to Birth weight

| Fetal Outcome | Baby Weight (gm) | | | Total | p value |
|---|---|---|---|---|---|
| | 1500-2500 | 2600-3000 | 3100-4000 | | |
| Good | 11 | 25 | 9 | 45 | 0.032 |
| Satisfactory | 0 | 6 | 0 | 6 | |
| Unsatisfactory | 4 | 2 | 0 | 6 | |
| Neonatal death | 2 | 0 | 1 | 3 | |
| Total | 17 | 33 | 10 | 60 | |

According to the table below, Incidence of maternal morbidity was lower among LSCS group (13.15%) as compared to vaginal delivery (31.83%). In 4 cases, who delivered vaginally had genital tract injury (18.18%). Post partum hemorrhage, urinary tract infection and episiotomy wound infection was seen in 3 cases with an incidence of 4.55% each. 3 cases that underwent LSCS developed UTI (7.89%), one case was complicated with PPH (2.63%) and 1 case had post LSCS wound infection (2.63%).

**Table 14:** Maternal Morbidity in relation to Mode of delivery

| SN | Maternal Complications | Mode of Delivery | | Total |
|---|---|---|---|---|
| | | Assisted breech delivery | LSCS | |
| 1 | Cervical tear | 2 (9.09%) | 0 | 2 |
| 2 | Third degree perineal tear | 2 (9.09%) | 0 | 2 |
| 3 | Post partum hemorrhage | 1 (4.55%) | 1(2.63%) | 2 |
| 4 | Post LSCS wound infection | 0 | 1 (2.63%) | 1 |
| 5 | Urinary tract infection | 1 (4.55%) | 3 (7.89%) | 4 |
| 6 | Episiotomy wound infection | 1 (4.55%) | 0 | 1 |
| 7 | None | 15 (68.17%) | 33 (86.85%) | 48 |
| **Total** | | **22 (100%)** | **38 (100%)** | **60** |

## 3.2 Discussion

The study examined 60 randomly selected pregnant women with breech presentation who attended Nepalgunj Medical College Teaching Hospital Kohalpur. Breech presentation poses many risks that require competent intervention. The best way to deliver breech-presented fetuses has been debated. These 60 cases met the criteria for the study, a study [16] 21 found 2.84% incidence. The breech delivery rate of 3.24% in this study is little high but within the stated 2-4% range. The 21-25 age group has the highest breech presentation rate (38.3%) [17]. Breech presentation was 26.6% in 21-15-year-olds, study found a 37.2% frequency in 26-30-year-olds. Women may marry sooner and conceive at 21-25 years [18]. In this study, 56.7% of multigravida patients had breech presentation, while 43.3% of primigravida did. According [19], multigravida patients had 75.9% breech presentation and primigravida patients 24.1%. Breech presentation was 87% in multigravida patients and 13% in primigravida. Breech presentation was 61.5% in multigravida and 38.5% in primigravida [20].The current study supports prior findings that

 

multigravida women have a higher rate of breech presentation than primigravida women. Complete breech occurred 65.3% in multigravida women and 34.7% in primigravida women [21]. In this study, multigravida women have a 55.88% full breech rate, while primigravida women have 76.92% frank breech. A study [22] found 67.3% frank breech in multigravida, which contradicts this study. It may be because his study included more multigravida women (85.33%). Today, 84.62% of primigravida women are delivered via LSCS and 15.38% vaginally. 47.06% of multigravida women had LSCS and 52.94% vaginally delivered. It found LSCS in 67.7% of primigravida women and vaginal delivery in 32.3%. Multigravida women delivered vaginally 76.88% of the time and LSCS 23.12%. LSCS delivered 73.5% of primigravida women and vaginal delivery 21.6% [23]. Thus, the present study matches most workers' because primigravida women had a higher rate of LSCS and multigravida women deliver vaginally [24]. According to this study, 36.36% of vaginally delivered babies have an Apgar score of 7 or above at 5 minutes after delivery, while 92.11% of LSCS babies do. According to [25], 1.3% of vaginally delivered babies had Apgar scores below 7 at 5 minutes following birth, while LSCS babies did not, it found 41, 64.6% of vaginal deliveries had Apgar scores above 7 at 5 minutes after birth, while 84.5% of LSCS deliveries did [26]. It found that 10.3% of vaginally delivered babies and 1.8% of LSCS babies had Apgar scores below 7 at 5 minutes after birth. All the studies above suggest that babies delivered by LSCS had a better Apgar score at 5 minutes after birth than those delivered vaginally since the head of the breech endures significant stress during vaginal delivery [27]. A study found 1.6% fetal morbidity in vaginal delivery and 0.6% with LSCS, 4.1% fetal morbidity in vaginally delivered groups and 2% in LSCS groups. In vaginal deliveries, it found 6.2% fetal morbidity compared to 0.9% in LSCS [28]. This study found that vaginal birth had 22.73% fetal morbidity and LSCS had none. This percentage variation may be due to health center facilities and vaginal breech birth skills [29]. In vaginal birth, [30] found 5% perinatal mortality and 1.6% in LSCS, vaginal birth with breech presentation had 14% perinatal mortality compared to 3.1% for LSCS. Vaginal breech had 17.3% perinatal mortality compared to 11.5% in LSCS [31]. In this study, vaginal birth has 9.09% perinatal mortality while LSCS has 2.63%. Since vaginal birth in breech presentation has a greater perinatal mortality rate than LSCS, this study agrees with the others. Primigravida had a 21.4% perinatal mortality rate, while multigravida had 18.7% [32]. Similarly, [33] showed that primigravida had 21.4% perinatal mortality and multigravida 18.7%. This study confirms the above studies with an 11.54% perinatal mortality rate in primigravida women and none in multigravida women. It observed that LSCS had 11.6% maternal mortality compared to 6.4% for vaginal delivery, LSCS increased maternal morbidity by 18.75% while vaginal delivery increased it by 12.5% [34]. A study found maternal morbidity in 11.18% of vaginal deliveries and 27.74% of LSCS deliveries, maternal morbidity to be 11.39% in vaginal deliveries and 16.66% in LSCS deliveries. Maternal morbidity was 31.83% for vaginal deliveries and 13.15% for LSCS deliveries in this study [35]. This study differs from others. Vaginal delivery favors maternal morbidity over LSCS. Early caesarean section, generous antibiotic usage, and good post-operative care may be factors, as may anesthesia. Maternity services differ by country. In industrialized countries, most pregnant women receive free prenatal, intrapartum, and postnatal care.

## 4. CONCLUSIONS

The purpose of this study is to analyze maternal morbidity as well as perinatal morbidity and mortality in breech birth, and to compare these outcomes with those of other modes of delivery. This will allow for the development of an acceptable protocol for delivery that does not compromise the well-being of the mother and the baby. The incidence of breech presentation is higher in patients who are multigravida (56.7% of the time) compared to patients who are primigravida (43.3%). There is a higher incidence of

 

breech presentation among patients who are between the ages of 21 and 25 years old, with 38.3% of patients falling into this age range. The gestational age of 37-40 weeks is more common in both first-time mothers and women who have given birth more than once, with an incidence of 78.34%. Compared to complete breech, which occurs 11.54 percent of the time, frank breech is more common in first-time mothers (76.92 percent). Complete breech is more common in multigravida pregnancies (55.86%) compared to frank breech, which occurs in 38.24% of pregnancies. LSCS is the most common method of birth among first-time mothers (84.62%), whereas assisted breech delivery is the second most common method (15.38%). When compared to low-slung surgical delivery (LSCS), assisted breech delivery is more likely in multigravida patients (52.94%). The most common indication for LSCS among first-time mothers is breech presentation alone, which accounts for 45.45% total cases. A history of past LSCS is the most common indication for LSCS in multigravida, accounting for 43.75 percent of all cases. At a rate of 2.63 percent, the subseptate uterus is the most prevalent type of uterine abnormality that comes to light. The incidence of prenatal morbidity is higher in assisted breech birth, which has a rate of 22.73%, whereas there is no perinatal morbidity in low standard caesarean section (LSCS). The overall perinatal death rate is higher among first-time mothers who have a breech presentation and who deliver their babies vaginally (50%) as opposed to those who deliver their babies via LSCS (4.55%). There is no perinatal mortality in women who are multigravida, regardless of the technique of delivery. The overall perinatal mortality rate is higher in assisted breech delivery (9.09%) compared to low-slung surgical delivery (2.63%). When compared to low-slung surgical delivery (LSCS), assisted breech birth (31.81%) is associated with a greater rate of maternal morbidity. The results of this study make it abundantly evident that a cesarean section, in comparison to vaginal birth, is associated with a lower risk of unfavorable perinatal outcomes for a singleton fetus of breech presentation. The perinatal result of vaginal breech deliveries in multigravida women is better than that of vaginal breech deliveries in primigravida women, according to another piece of information. This study comes to the conclusion that, with the active participation of experienced obstetricians and the implementation of appropriate management, there is still a place for vaginal breech delivery in certain cases of breech presentation in multigravida women. On the other hand, cesarean section is the safest mode of delivery for patients who are having their first child. Cesarean section for the term breech has been a routine care in many hospitals, and this study also noticed that it is a standard care in institutions where appropriate facilities are available.

## 5. RECOMMENDATIONS

There should be a plan in place to educate the community on the significance of prenatal care, as well as the risks of breech delivery for both the mother and the unborn child. The first step in determining the fetal weight is to do a sonographic check upon entrance. Therefore, a choice can be made regarding the mode of delivery at that point. In addition to this, a superior neonatal care unit should be made available in order to lessen the risk of perinatal morbidity and mortality in cases of breech delivery. Additionally, a high-quality intrapartum care should be offered to the mother in the event that she wants to have a planned vaginal delivery or a cesarean section.

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