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Cephalic version by moxibustion for breech presentation

Meaghan E Coyle, Caroline Smith, Brian Peat

Background

Breech presentation at term can cause complications during birth and increase the chance of caesarean section. Moxibustion (a type of Chinese medicine which involves burning a herb close to the skin) at the acupuncture point Bladder 67 (BL67) (Chinese name *Zhiyin*), located at the tip of the fifth toe, has been proposed as a way of changing breech presentation to cephalic presentation. This is an update of a review first published in 2005 and last published in 2012.

Objectives

To examine the effectiveness and safety of moxibustion on changing the presentation of an unborn baby in the breech position, the need for external cephalic version (ECV), mode of birth, and perinatal morbidity and mortality.

Search methods

For this update, we searched Cochrane Pregnancy and Childbirth's Trials Register (which includes trials from CENTRAL, MEDLINE, Embase, CINAHL, and conference proceedings), ClinicalTrials.gov, and the WHO International Clinical Trials Registry Platform (ICTRP) (4 November 2021). We also searched MEDLINE, CINAHL, AMED, Embase and MIDIRS (inception to 3 November 2021), and the reference lists of retrieved studies.

Selection criteria

The inclusion criteria were published and unpublished randomised or quasi-randomised controlled trials comparing moxibustion either alone or in combination with other techniques (e.g. acupuncture or postural techniques) with a control group (no moxibustion) or other methods (e.g. acupuncture, postural techniques) in women with a singleton breech presentation.

Data collection and analysis

Two review authors independently determined trial eligibility, assessed trial quality, and extracted data. Outcome measures were baby's presentation at birth, need for ECV, mode of birth, perinatal morbidity and

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mortality, maternal complications and maternal satisfaction, and adverse events. We assessed the certainty of the evidence using the GRADE approach.

Main results

This updated review includes 13 studies (2181 women), of which six trials are new. Most studies used adequate methods for random sequence generation and allocation concealment. Blinding of participants and personnel is challenging with a manual therapy intervention; however, the use of objective outcomes meant that the lack of blinding was unlikely to affect the results. Most studies reported little or no loss to follow-up, and few trial protocols were available. One study that was terminated early was judged as high risk for other sources of bias.

Meta-analysis showed that compared to usual care alone, the combination of moxibustion plus usual care probably reduces the chance of non-cephalic presentation at birth (7 trials, 1152 women; risk ratio (RR) 0.87, 95% confidence interval (CI) 0.78 to 0.99, I^2 = 38%; moderate-certainty evidence), but the evidence is very uncertain about the effect of moxibustion plus usual care on the need for ECV (4 trials, 692 women; RR 0.62, 95% CI 0.32 to 1.21, I^2 = 78%; low-certainty evidence) because the CIs included both appreciable benefit and moderate harm. Adding moxibustion to usual care probably has little to no effect on the chance of caesarean section (6 trials, 1030 women; RR 0.94, 95% CI 0.83 to 1.05, I^2 = 0%; moderate-certainty evidence). The evidence is very uncertain about the effect of moxibustion plus usual care on the the chance of premature rupture of membranes (3 trials, 402 women; RR 1.31, 95% CI 0.17 to 10.21, I^2 = 59%; low-certainty evidence) because there were very few data. Moxibustion plus usual care probably reduces the use of oxytocin (1 trial, 260 women; RR 0.28, 95% CI 0.13 to 0.60; moderate-certainty evidence). The evidence is very uncertain about the chance of cord blood pH less than 7.1 (1 trial, 212 women; RR 3.00, 95% CI 0.32 to 28.38; low-certainty evidence) because there were very few data. We are very uncertain whether the combination of moxibustion plus usual care increases the chance of adverse events (including nausea, unpleasant odour, abdominal pain and uterine contractions; intervention: 27/65, control: 0/57), as only one study presented data in a way that could be reanalysed (122 women; RR 48.33, 95% CI 3.01 to 774.86; very low–certainty evidence).

When moxibustion plus usual care was compared with sham moxibustion plus usual care, we found that moxibustion probably reduces the chance of non-cephalic presentation at birth (1 trial, 272 women; RR 0.74, 95% CI 0.58 to 0.95; moderate-certainty evidence) and probably results in little to no effect on the rate of caesarean section (1 trial, 272 women; RR 0.84, 95% CI 0.68 to 1.04; moderate-certainty evidence). No study that compared moxibustion plus usual care with sham moxibustion plus usual care reported on the clinically important outcomes of need for ECV, premature rupture of membranes, use of oxytocin, and cord blood pH less than 7.1, and one trial that reported adverse events reported data for the whole sample.

When moxibustion was combined with acupuncture and usual care, there was very little evidence about the effect of the combination on non-cephalic presentation at birth (1 trial, 226 women; RR 0.73, 95% CI 0.57 to 0.94) and at the end of treatment (2 trials, 254 women; RR 0.73, 95% CI 0.57 to 0.93), and on the need for ECV (1 trial, 14 women; RR 0.45, 95% CI 0.07 to 3.01). There was very little evidence about whether moxibustion plus acupuncture plus usual care reduced the chance of caesarean section (2 trials, 240 women; RR 0.80, 95% CI 0.65 to 0.99) or pre-eclampsia (1 trial, 14 women; RR 5.00, 95% CI 0.24 to 104.15). The certainty of the evidence for this comparison was not assessed.

Authors' conclusions

We found moderate-certainty evidence that moxibustion plus usual care probably reduces the chance of non-cephalic presentation at birth, but uncertain evidence about the need for ECV. Moderate-certainty evidence

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from one study shows that moxibustion plus usual care probably reduces the use of oxytocin before or during labour. However, moxibustion plus usual care probably results in little to no difference in the rate of caesarean section, and we are uncertain about its effects on the chance of premature rupture of membranes and cord blood pH less than 7.1.

Adverse events were inadequately reported in most trials.

Interventions from pregnancy to two years after birth for parents experiencing complex post-traumatic stress disorder and/or with childhood experience of maltreatment

Kimberley A Jones, Isabella Freijah, Sue E Brennan, Joanne E McKenzie, Tess M Bright, Renee Fiolet, Ilias Kamitsis, Carol Reid, Elise Davis, Shawana Andrews, Maria Muzik, Leonie Segal, Helen Herrman, Catherine Chamberlain

Background

Acceptable, effective and feasible support strategies (interventions) for parents experiencing complex post-traumatic stress disorder (CPTSD) symptoms or with a history of childhood maltreatment may offer an opportunity to support parental recovery, reduce the risk of intergenerational transmission of trauma and improve life-course trajectories for children and future generations. However, evidence relating to the effect of interventions has not been synthesised to provide a comprehensive review of available support strategies. This evidence synthesis is critical to inform further research, practice and policy approaches in this emerging area.

Objectives

To assess the effects of interventions provided to support parents who were experiencing CPTSD symptoms or who had experienced childhood maltreatment (or both), on parenting capacity and parental psychological or socio-emotional wellbeing.

Search methods

In October 2021 we searched CENTRAL, MEDLINE, Embase, six other databases and two trials registers, together with checking references and contacting experts to identify additional studies.

Selection criteria

All variants of randomised controlled trials (RCTs) comparing any intervention delivered in the perinatal period designed to support parents experiencing CPTSD symptoms or with a history of childhood maltreatment (or both), to any active or inactive control. Primary outcomes were parental psychological or socio-emotional wellbeing and parenting capacity between pregnancy and up to two years postpartum.

Data collection and analysis

Two review authors independently assessed the eligibility of trials for inclusion, extracted data using a pre-designed data extraction form, and assessed risk of bias and certainty of evidence. We contacted study authors for additional information as required. We analysed continuous data using mean difference (MD) for outcomes using a single measure, and standardised mean difference (SMD) for outcomes using multiple measures, and risk ratios (RR) for dichotomous data. All data are presented with 95% confidence intervals (CIs). We undertook meta-analyses using random-effects models.

Main results

We included evidence from 1925 participants in 15 RCTs that investigated the effect of 17 interventions. All included studies were published after 2005. Interventions included seven parenting interventions, eight

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psychological interventions and two service system approaches. The studies were funded by major research councils, government departments and philanthropic/charitable organisations. All evidence was of low or very low certainty.

Parenting interventions

Evidence was very uncertain from a study (33 participants) assessing the effects of a parenting intervention compared to attention control on trauma-related symptoms, and psychological wellbeing symptoms (postpartum depression), in mothers who had experienced childhood maltreatment and were experiencing current parenting risk factors. Evidence suggested that parenting interventions may improve parent-child relationships slightly compared to usual service provision (SMD 0.45, 95% CI -0.06 to 0.96; I^2 = 60%; 2 studies, 153 participants; low-certainty evidence). There may be little or no difference between parenting interventions and usual perinatal service in parenting skills including nurturance, supportive presence and reciprocity (SMD 0.25, 95% CI -0.07 to 0.58; I^2 = 0%; 4 studies, 149 participants; low-certainty evidence). No studies assessed the effects of parenting interventions on parents' substance use, relationship quality or self-harm.

Psychological interventions

Psychological interventions may result in little or no difference in trauma-related symptoms compared to usual care (SMD -0.05, 95% CI -0.40 to 0.31; I^2 = 39%; 4 studies, 247 participants; low-certainty evidence). Psychological interventions may make little or no difference compared to usual care to depression symptom severity (8 studies, 507 participants, low-certainty evidence, SMD -0.34, 95% CI -0.66 to -0.03; I^2 = 63%). An interpersonally focused cognitive behavioural analysis system of psychotherapy may slightly increase the number of pregnant women who quit smoking compared to usual smoking cessation therapy and prenatal care (189 participants, low-certainty evidence). A psychological intervention may slightly improve parents' relationship quality compared to usual care (1 study, 67 participants, low-certainty evidence). Benefits for parent-child relationships were very uncertain (26 participants, very low-certainty evidence), while there may be a slight improvement in parenting skills compared to usual care (66 participants, low-certainty evidence). No studies assessed the effects of psychological interventions on parents' self-harm.

Service system approaches

One service system approach assessed the effect of a financial empowerment education programme, with and without trauma-informed peer support, compared to usual care for parents with low incomes. The interventions increased depression slightly (52 participants, low-certainty evidence). No studies assessed the effects of service system interventions on parents' trauma-related symptoms, substance use, relationship quality, self-harm, parent-child relationships or parenting skills.

Authors' conclusions

There is currently a lack of high-quality evidence regarding the effectiveness of interventions to improve parenting capacity or parental psychological or socio-emotional wellbeing in parents experiencing CPTSD symptoms or who have experienced childhood maltreatment (or both). This lack of methodological rigour and high risk of bias made it difficult to interpret the findings of this review. Overall, results suggest that parenting interventions may slightly improve parent-child relationships but have a small, unimportant effect on parenting skills. Psychological interventions may help some women stop smoking in pregnancy, and may have small benefits on parents' relationships and parenting skills. A financial empowerment programme may slightly worsen depression symptoms. While potential beneficial effects were small, the importance of a

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positive effect in a small number of parents must be considered when making treatment and care decisions. There is a need for further high-quality research into effective strategies for this population.

If you have any questions or comments with regard to the above document please feel free to contact me.

Kind regards

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