Moxibustion for breech presentation: significant new evidence

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Vas and colleagues\(^1\) report on a clinical efficacy trial evaluating the role of a single acupuncture point, Bladder 67 (BL67), compared with sham acupuncture (Spleen 1 (SP1)), and usual care only in cephalic version at birth for babies in a breech presentation. This well-designed randomised controlled trial demonstrated a higher rate of cephalic version at birth for women receiving moxibustion compared with sham moxibustion and the usual care group. No adverse effects were reported. Studies of sham moxibustion are few, and, in the context of breech presentation, the findings from this trial are significant, addressing the question does moxibustion at BL67 have a specific effect resulting in cephalic version of the fetus.

Evaluation of interventions to promote cephalic version at birth have international relevance. Babies born in a breech position have an increased risk of birth complications. To minimise these risks, rates of caesarean section (C/S) delivery have steadily increased internationally over time to 31.5% in 2009.\(^2\) This increasing C/S rate has resulted in health risks to the mother and infant and increased costs to health services arising from the treatment of morbidity associated with increased length of stay and re-admission after an operative delivery.\(^3\) \(^4\) Perhaps in response to this rising C/S rate, and concerns about increasing medical interventions in childbirth more generally, there is an increasing focus on strategies to promote normal birth.

Vas and colleagues contribute to a growing body of research evaluating the role of moxibustion to assist with the management of breech presentation.\(^1\) A recently updated Cochrane systematic review evaluated the use of moxibustion to promote cephalic version for babies in a breech presentation.\(^5\) Eight trials involving 1346 women were included in this review. Five meta-analyses were performed for comparison of moxibustion with no treatment, and one meta-analysis performed for comparison of moxibustion plus postural technique with postural technique. There were no comparisons of moxibustion with a sham control. Moxibustion was not found to reduce the number of non-cephalic presentations at birth compared with no treatment (\(p=0.45\)). It resulted in decreased use of oxytocin before or during labour for women who had vaginal deliveries compared with no treatment (risk ratio (RR) 0.28, 95% CI 0.13 to 0.60). It was found to result in fewer non-cephalic presentations at birth compared with acupuncture (RR 0.25, 95% CI 0.09 to 0.72). When combined with acupuncture, moxibustion resulted in fewer non-cephalic presentations at birth (RR 0.73, 95% CI 0.57 to 0.94), and fewer births by caesarean section (RR 0.79, 95% CI 0.64 to 0.98) compared with no treatment. When combined with a postural technique, it was found to result in fewer non-cephalic presentations at birth compared with the postural technique alone (RR 0.26, 95% CI 0.12 to 0.56).

The trials included in the review varied significantly in their application of moxibustion. Treatment duration ranged from 10 min to 60 min, with most studies applying moxibustion for 20 min. Treatment frequency was reported as daily in four trials, twice daily in one trial, and biweekly in two trials. The duration of moxibustion also ranged from 4 days to 2 weeks, although one trial continued until version was attained or the baby was delivered. An assessment of methodological bias found the majority of trials were of moderate methodological quality; however, the sample sizes in some studies were small (range 14–260), differences existed in interventions, and reporting was limited. For higher-quality trials, differences in study design were noted, and results of
meta-analyses should be interpreted with caution. The review concluded that there remains a need for robust, methodologically sound, randomised controlled trials of adequate statistical power to evaluate this intervention. A recommendation was made to include a range of clinically relevant outcome measures relating to birthing outcomes, maternal satisfaction, and adverse events, and for consideration of the timing and duration of treatment.

Vas and colleagues¹ provide new data contributing to the evidence on moxibustion. Determining the efficacy of moxibustion remains difficult because of the unavailability of a validated sham moxibustion device.⁶ However, the authors of the new study have demonstrated clinical efficacy of moxibustion when comparing point BL67 with SP1. BL67, an acupuncture point located on the dorsal aspect of the little toe, has traditionally been used to turn a baby and facilitate labour. The control point SP1, located on the dorsal aspect of the big toe, is traditionally associated with bleeding and fertility. The clinical reasoning for using SP1 is not presented, although traditional knowledge does not suggest that acupuncture is likely to have been influential on version of the fetus. Point specificity is an important underlying principle used in traditional Chinese medicine. Acupuncturists trained in traditional Chinese medicine believe in the therapeutic effect of acupuncture point stimulation, and use this principle in guiding treatment. However, the existence of point specificity remains controversial, since many acupuncture studies using control points in studies of sham acupuncture find similar effects to true acupuncture points.

The strength of this new study includes the design of an appropriately powered randomised controlled trial, with three arms to examine the efficacy and safety of moxibustion study. However, it is unclear whether women in the sham group remained blind to their group allocation. In other Western settings, demonstrations of moxibustion for breech presentation are easily accessed on the internet by pregnant women, compromising blinding.

Despite this promising new evidence, the role of moxibustion in promoting cephalic version remains elusive.

Competing interests CAS is the author of a Cochrane review of moxibustion for cephalic version.

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