Cesarean Birth by Maternal Request

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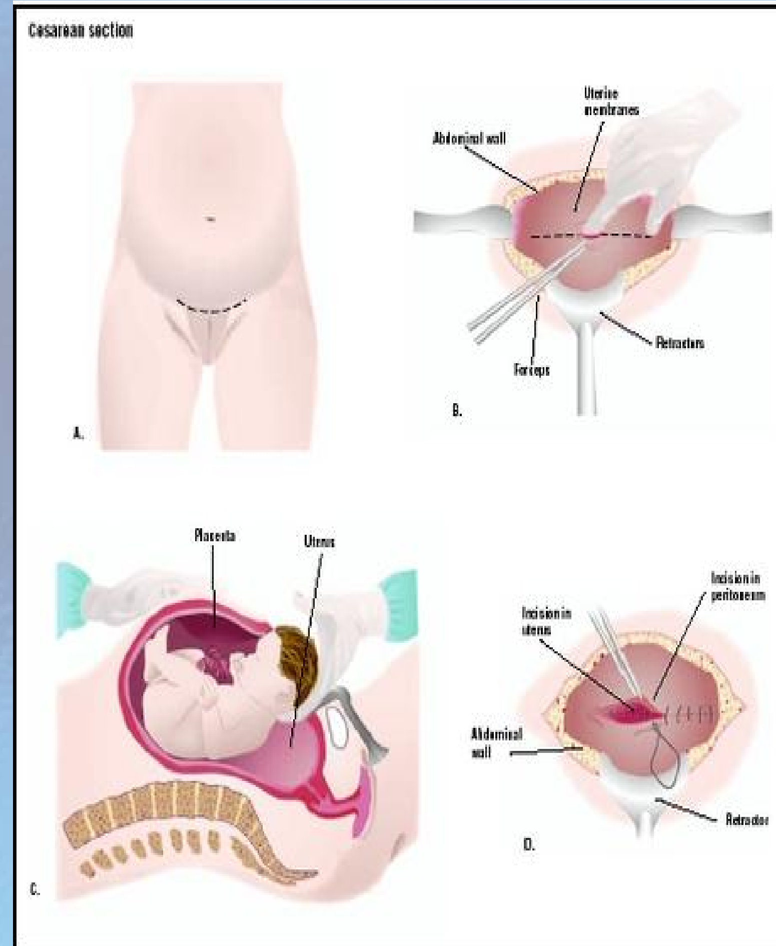
What?

- Cesarean delivery
- Term singleton
- Maternal request
- Absence of medical or obstetric indication



http://content.answers.com

Terms

- Patient choice cesarean at term
- Cesarean delivery on maternal request
- Elective prophylactic cesarean delivery
- Cesarean on demand

blog.modernmechanix.com

Controversial to say the least…

- Media
- Consensus conferences
- Journal articles
- Professional associations statements
- Wikipedia
- Websites
- Law

- www.**cesareansection**on demand.com/
- en.**wikipedia**.org/wiki/Caesarean_delivery_on_maternal_request
- *"For the baby, the risks are far higher for vaginal delivery than for an elective c-section at term."*
- *Dr. Ben Harer, FACOG, past President of the American College of Obstetricians and Gynecologists*

History of the Cesarean

- In present day, women may be afraid of the pain of childbirth, but they do not expect it to kill them.
- They also expect their babies to survive.
- The same could not be said of many women as late as the 19th century.
- An operation once performed to save a baby when its mother was dying, now changes the outcome favourably for most women and babies its performed on.
- Yes, there is sound reason to believe its performed too frequently, but it has transformed childbirth.

Prevalence

http://www.healthgrades.com/media/DMS/pdf/PatientChoiceCSectionsRiseJune2004.pdf

- 1-18% of all cesareans worldwide
- 1-3% in the United States
- Difficult to know true prevalence in Canada but probably at best 1-2%.
- Difficulty lies in how it's coded so difficult to identify in a retrospective fashion.

Year	CDMR 16 states	% deliveries
1999	29,257	1.56%
2000	32,950	1.77%
2001	34,792	1.88%
2002	40,693	2.21%

Factors to be considered

- Patient autonomy
- Accepted indications for cesarean birth
- Public perception
- Advantages of cesarean birth
- Disadvantages of cesarean birth

Cultural and Societal Issues

- Rituals and customs associated with vaginal birth
- Active participation in the process of labour and birth important to many women
- For some mode of delivery less important than control of the process.
- Trend away from vaginal breech deliveries and less women choosing VBAC may contribute to societal acceptance of cesarean births, possibly even perceived as a norm.

http://www.unt.edu/lpw/images/changingbest.jpg

Reasons for request

- Fear of pain
- Anxiety for the health of their unborn child
- Anxiety for the health of their own life
- Complicated birth of female relatives and concern of hereditary effects.
- Convenience
- Fear of pelvic floor damage
- Anxiety for lack of support from the staff
- Loss of control
- Worries for the pelvic examinations

http://www.emuseumstore.com/images/uploads/ro01b.jpg

Wiklund et al.
Acta Obst Gynecol 2007;86:451-6

Acta 82 4
Obstetricia et Gynecologica
SCANDINAVICA

- Differences
  - Planning to have only one child
  - Higher confidence in the obstetrician
  - Better birth experience (Day 0 and 3 mos. PP)
  - Less breast feeding at 3 mos. PP
- No Differences
  - Postnatal depression
  - Initiation of breastfeeding
  - Sexuality

Media

- www.electivecesarean.com

- Celebrities with CSOD:
  - Celine Dion, Catherine Zeta-Jones, Kate Hudson, Victoria Beckham, Britney Spears, Christina Aguilera

- Celebrities with planned vaginal birth:
  - Melania Trump, Jennifer Garner, Liv Tyler, Kate Moss

Media cont'd

- "Celeb mums Blamed as Caesarean Births Soar" (LIfeStyleExtra UK News)
  - James Walker, spokesman for the (RCOG), said celebrity mums have popularised caesarean births
  - "Celebrities are seen as having them so it's seen as acceptable and reasonable thing to do"
  - He also defend the operation against it's critics by saying that all medical developments in childbirth had been criticised at some point.
  - "If you go back in history, forceps were designed by obstetricians of the time so that rich people didn't have to push during labour. In the 1800's when Queen Victoria was first given chloroform for pain relief during birth that was seen as unnatural"

http://www.telegraph.co.uk/news/graphics/2004/07/15/mums/celebmums/VictoriaBeckham.jpg

Advantages

- Known endpoint
- Avoiding post-term
- Possible reduction in risk of pelvic floor injury and its sequelae
- Hard to measure benefits such as choosing the physician and controlled relaxed atmosphere.
- Possible lower PPH
- Avoiding emergency GA
- Prevention of stillbirth
- Reducing fetal morbidity related to the process of birth (e.g. brachial plexus injury)

Disadvantages

- Higher rates of surgical, infectious and thromboembolic complications.
- Maternal mortality
- Interference in maternal-infant interaction
- Increased risk placental problems next pregnancy
- Complications with multiple cesareans or VBAC
- Increased risk neonatal respiratory issues

NIH:Maternal Short-term & long-term benefits

- Moderate quality evidence favouring CDMR:
  - Less PPH
- Moderate quality evidence favouring Pl Vag Del
  - Shorter hospital stay
- Weak quality Evidence favor Pl Vag Del
  - Lower infection rates
  - Lower rate of anesthetic complications
  - Decreased future risk of placenta previa
  - More likely to breast feed

NIH:Benefits cont'd

- Weak quality evidence favoring CDMR
  - Less stress urinary incontinence
  - Less surgical complications
- Weak quality evidence sensitive to parity and planned family size
  - Subsequent uterine rupture
  - Subsequent need for hysterectomy
  - Subsequent fertility

NIH:Benefits cont'd

- Weak evidence that favor neither route
  - Anorectal function
  - Sexual function
  - Pelvic organ prolapse
  - Subsequent stillbirth
  - Maternal mortality

NIH: Neonatal Short-term & Long-term Benefits

- Moderate quality evidence favors pl vag
  - Less risk respiratory morbidity
- Weak quality evidence favors pl vag del
  - Less risk iatrogenic prematurity
  - Decreased length of hospital stay
- Weak quality evidence favors CDMR
  - Fewer stillbirths
  - Lower risk of ICH, asphyxia & encephalopathy
  - Lower risk of birth injury and laceration
  - Lower risk of infection

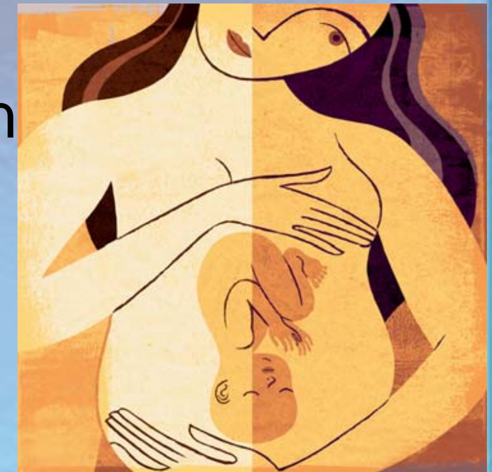
NIH State-of-the-Science Conference Mar 2006

NIH:What factors influence benefits and harms?

- Patient-specific
  - Age, childbearing plans, obesity
  - Accuracy of gestational age
  - Psychological factors
- Cultural and Societal Issues
  - Rituals and customs associated with birth
  - Media coverage

NIH:Factors cont'd

- Health care provider type/resources
  - Training, practice environment, personal philosophy, medico-legal experiences
  - OR/anesthesiologist availability, time of day, staff, economic considerations
- Ethical Issues
  - Nondirective counseling
  - Incorporate culture and cultural con
  - Individualized approach
  - Referral to another HCP



NIH:Conclusions

- Incidence of CDMR is increasing
- Insufficient evidence to evaluate fully the benefits and risks.
- Until available, CDMR carefully individualized and consistent with ethical principles
- Not recommended for women desiring several children

NIH State-of-the-Science Conference Mar 2006

NIH:Conclusions cont’d

- Not recommended prior to 39 weeks GA
- Should not be motivated by unavailability of effective pain management
- NIH should establish and maintain a web site to provide up-to-date information

NIH website

- For the complete consensus:
- http://consensus.nih.gov/2006/2006CesareanSOS027html.htm

My own research

- BC Perinatal Database Registry
- Term c-section for Breech (1,046)
- Term planned elective c-sections (38,021)
  - SVD = 24,089 (63.3%)
  - Assisted = 8352 (22%)
  - Emergency CS = 5580 (14.7%)
- Healthy moms and babies

Conclusions

- No difference in maternal morbidity between CS and PI VD.
- Subgroup analysis shows higher maternal morbidity for CS when compared to normal SVD.
- Neonatal morbidity lower in CS group (RR 0.34).
- Subgroup analysis shows no difference between CS and normal SVD but CS lower morbidity when compared to Assisted vaginal delivery or emergency intrapartum caesarean section.

ACOG Committee Opinion

AMERICAN COLLEGE OF
OBSTETRICIANS AND
GYNECOLOGISTS

- If the physician believe that (C/S) promotes the overall health and welfare of the woman and her fetus more than a vaginal birth, he or she is ethically justified in performing a cesarean delivery.
- Not ethically necessary to initiate a discussion of risks and benefits with every pregnant patient.
- Should not be performed before 39 wks
- Should not be motivated by unavailability of effective pain management
- Not recommended for women desiring several children.

U.K. NICE

National Institute for Clinical Excellence

- Maternal request on its own is not an indication for (C/S) and specific reasons for the request should be explored, discussed and recorded.
- In the absence of an identifiable reason, the overall benefits and risks of (C/S) compared with vaginal birth should be discussed and recorded.

SOGC

- Does not promote C/S on demand but promotes natural childbirth. The decision to perform a C/S during labour and delivery should be based on medical indications.
- Endorses and promotes evidence-based medicine. At this time, there is no evidence that a C/S carries less risk than a vaginal delivery for mother and baby.
- Each individual woman should receive the best information available on her options for labour and birth. The final decision rests between the woman and her health care provider as to the safest route for the birth of the baby.

Conclusions

- Find out why she's requesting a C/S.
- Review advantages and disadvantages as best known today
- Individualize the risk estimate:
  - E.g. Maternal age, future childbearing etc.
- Discuss this at more than one visit.
- Attempt to remain unbiased at all times.
- Can we deny?…….

http://webhost.bridgew.edu/mfichera/j0353679.gif