

C-Section

About Routine C-Sections Instead of Breech Delivery

Routine cesarean section for breech presentation has been recommended over the last forty years. As a consequence, the rate of vaginal breech delivery has decreased sharply. In the United States, the rate of cesarean section for breech presentation rose from just 10 percent to nearly 80 percent in 15 years (1970-1985). On closer examination, however, it is clear that the association between breech presentation and perinatal mortality is due principally to the confounding variables of prematurity and congenital malformation. Traumatic injury and complications giving rise to birth asphyxia in a vaginal breech delivery are uncommon. The recommendations for routine cesarean section have therefore been made on the basis of imperfect data. The issue of vaginal delivery compared with abdominal delivery of the term breech pregnancy is currently being addressed in a worldwide multicenter randomized controlled trial ("The Term Breech Trial"). -MIDIRS 9:1, March 1999

Reasons for present cesarean rate

1. Dystocia or failure of labor to progress (31% of cesareans): pelvic opening too small for the baby; birth canal too small for the baby; contractions irregular or not intense enough to dilate the cervix.
2. Breech presentation (12% of cesareans): baby emerging feet first.
3. Repeat cesarean (31% of cesareans): mother has previously given birth by cesarean.
4. Fetal distress (5% of cesareans): baby is shown to have abnormal heartbeat pattern with fetal monitoring, and diagnosis is confirmed by fetal scalp blood pH testing.
5. Other (21% of cesareans): maternal illness such as diabetes or heart disease, active herpes, or medical emergencies such as placenta previa or prolapsed cord.

Wrapped Cords

A study that looked at outcomes of pregnancies complicated by a multiple nuchal cord entanglement included 8,565 deliveries. A single loop of cord around the fetal neck at delivery was found in 2,191 deliveries, and more than one loop was found in 326 deliveries. Pregnancies with a multiple cord entanglement were more likely to have an abnormal cardiotocograph consisting of persistent variable deceleration in advanced labor. These infants were also more likely to have meconium, a low Apgar score at one minute, and a low umbilical artery pH of <7.10. There was no difference in the rate of cesarean sections, placental abruption and Apgar scores at five minutes between the two groups, and no stillbirths occurred in the cord entanglement group. The study concluded that with multiple nuchal cord entanglement there was no risk of adverse neonatal outcome, and that a multiple cord entanglement is not a contributing factor in intrapartum stillbirth, placental abruption or cesarean delivery.

-MIDIRS Dec. 1996

Prerequisites for a safe vaginal birth after a previous cesarean (VBAC)

Common management guidelines

1. Parents have discussed all the pros and cons of a VBAC with their doctor.
2. The present pregnancy has no indications for recommending a cesarean section.
3. A low transverse incision was used in the previous cesarean section.
4. The mother is admitted to the hospital early in labor, so that her progress can be carefully monitored.
5. Backup facilities for an immediate cesarean section are available.

Controversial Management Guidelines

1. Some doctors will not permit a trial labor if the mother has previously had a cesarean section because of too small a pelvis
2. Some doctors won't use drugs that stimulate labor if the mother has had a previous cesarean.
3. Some doctors don't recommend regional anesthesia during a vaginal delivery after a cesarean because they believe it could mask rupture problems.
4. Some doctors recommend the routine use of low forceps to shorten labor if the woman has previously had a cesarean.

Patient choices suggested by the cesarean support groups

- Allow the mother to forego any preoperative medication.
- Allow the mother to choose regional anesthesia so she can see the baby being born.
- Use epidural anesthesia if a qualified anesthesiologist is attending.
- Use a low transverse skin incision whenever possible for cosmetic reasons.
- Allow the father to remain with the mother in the delivery room.
- Allow the mother to have her arms free.
- Allow the mother to view the birth without a screen or with a mirror.
- Encourage the doctor to talk reassuringly with the parents during the operation.
- Allow the mother, if possible, or the father to hold the baby immediately after the birth.
- Have the initial routine pediatric exam done where the parents can watch.
- Delay weighing, measuring, and eye drops until after the initial bonding period.
- Allow for the mother, father and baby to remain together in the recovery room during first hour after birth.
- Allow the mother to nurse the baby as soon as the operation has been completed.
- Allow the mother to have full rooming in as soon as she wishes.
- Allow mother to have a helper such as the husband or a friend to assist her in caring for the baby.
- Allow siblings to visit the mother and baby daily.
- With repeat cesareans, have preliminary laboratory test done on an outpatient basis so the mother does not have to be admitted until the day of the surgery.

