WHAT IS AN ACCEPTABLE CAESAREAN SECTION RATE?

INTRODUCTION

Recently the print media has published several articles condemning the rate of caesarean sections as being “too high”. SASOG has been approached by interested bodies to give a ruling on this subject, and to suggest an “acceptable” caesarean section rate; assuming the rate is at present, “too high.” The subject prompts more heat than light, and this paper aims to show that there can never be a “correct” or acceptable caesarean section (c/s) rate to fit all circumstances – nor should there be. The question does not lend itself to an empirical answer. Many factors drive the caesarean section rate, and these will examined in some detail.

WHAT IS THE PROBLEM?

Over the past 2 decades, the caesarean section rate has increased dramatically. The causes are as follows.

- **Progress in obstetrics and neonatology**
  
  Nowadays smaller neonates with medical conditions or genetic syndromes, can survive. These premature infants, and their placentas, often have limited reserve and are invariably delivered by caesarean section. Breech presentation babies and twins are usually delivered – certainly in private practice – by caesar, with robust academic justification. After the work of Abdul Sultan and Richard Johansen, both eminent SA doctors the dangers of operative delivery to the pelvic floor have been appreciated, and a caesar is often less traumatic than difficult instrumental intervention. Vaginal delivery has certainly been shown to markedly increase the rate of prolapse, and perhaps incontinence and sexual dysfunction.

- **A rise in HIV infection rates**
  
  Over the past decade the rate of HIV infection has risen dramatically, and in South Africa the incidence approached 20% of pregnant women in some areas. The use of antiretroviral therapy (ARV’s) is patchy and inconsistent, and while ARV’s reduce mother – to – child infection rates if used consistently and correctly, work has shown that ARV’s with caesarean section offer the best protection against vertical transmission. In private practice, the use of ARV’s with an elective caesarean section at 38w gestation is common practice, with very low rates of vertical transmission.
• **The fear of litigation**

The incidence of medicolegal litigation against obstetricians over the past decade has risen exponentially, and the public have come to expect a good outcome of each pregnancy. Clearly this is unrealistic – an adverse end to the pregnancy often results in litigation, which is always expensive, whatever the outcome. No amount of care and attention can prevent the occasional obstetrical mishap, but patients perceptions of failure are such that lawyers are consulted under these circumstances, with expensive litigation driven by lawyers resulting. No obstetrical tool or intervention ensures a universally successful pregnancy, yet caesarean section is perceived to be the ultimate and preferred mode of delivery in any high – risk case. Claims against obstetricians are settled for huge sums, and a private obstetrician in 2011 pays R180,000 per annum as litigation insurance. There is no end in sight to this upward spiral, which may be checked when obstetricians pass on the cost of litigation insurance to patients, who in turn may need to deliver in state institutions. This would force government intervention as has happened in many areas around the world. In private institutions, labour wards are staffed by midwives who may or may not be competent. No residential obstetricians staff delivery rooms, leading to a reliance on nursing staff. Those obstetricians in state institutions were generally indemnified by their employers in the past, but this is also changing. Individuals may now be held personally accountable if circumstances are obvious that negligence occurred, and state medical institutions will not offer indemnity to employees under these circumstances. State employees are well advised to carry their own professional liability insurance, even if “private” work is not done.

• **The case for convenience**

A caesar is unquestionably more convenient that an unscheduled vaginal delivery in terms of time management, despite the fact that a normal delivery is often quick. Unscheduled deliveries may cause chaos in waiting rooms, and patients so inconvenienced have little insight into the routine of a busy obstetrician. If called to assess a patient in labour at a labour ward some distance from the doctor’s rooms or home, a caesar is often the easiest, if not the best plan of delivery. This may be especially true if the midwife’s obstetrical judgment is questionable, and a caesar is perceived to be the safest alternative to repeated fruitless trips to the labour ward. The number of midwives, especially those with proper training and experience, is steadily diminishing. Obstetricians may under these circumstances resort to pre – emptive caesar rather than trust the judgment of novice midwives in interpreting CTG’s.

• **The question of pelvic floor damage**

Does vaginal delivery damage the pelvic floor sufficiently to cause urinary incontinence, anal incontinence, prolapse or sexual dysfunction? Conversely, does an elective caesarean section protect the women from the above? Given that vaginal birth is at least partly responsible for incontinence and sexual dysfunction, and certainly responsible for prolapse, is elective caesarean section justified under all circumstances? Many women may wish to deliver vaginally without unnecessary intervention. This is a laudable objective. But the natural birth lobby has appropriated vaginal birth (in the same
way many obstetricians advocate blanket caesarean sections) and suggest intervention during childbirth, except during extreme cases, is almost always unnecessary, unnatural and detrimental. Fanaticism, from whatever point of view, is unhelpful. One writer suggested “if you don’t want an episiotomy, a forceps, or a caesarean, you simply make certain that when you are in labour you have chosen a place where these procedures are unable to be performed. It’s as simple as that!” When addressing the problem of pelvic floor damage, data suggest that the effects of pregnancy and childbirth on lower urinary tract symptoms (LUTS) and anal incontinence are confusing, contradictory and counter intuitive. We know that 5% of all young nulliparous women have significant stress urinary incontinence (SUI) and 40% of all nulliparous women experience occasional SUI. Consider the evidence presented below.

VAGINAL DELIVERY DAMAGES THE PELVIC FLOOR

Dietz showed in 2005 that following delivery, 36% of women suffered avulsion injuries to the levator muscle complex, associated with markedly increased pelvic floor descent. His 3-dimensional pelvic floor ultrasound scans before, and 4 months after delivery, in primigravid women demonstrated the extent of levator trauma caused by vaginal and especially forceps delivery. More recently he showed that levator trauma is associated with pelvic organ prolapse. De Lancey and others prefer MRI to 3-D ultrasound to image the pelvic floor. He showed that 66% of forceps deliveries, 25% of vacuum deliveries and 10% of women after a spontaneous vaginal delivery showed levator ani muscle injury. While levator muscle avulsion is an obvious consequence of vaginal parity, the damage occurs also at the microscopic level, with ultrastructural damage to the sarcomeres.

In a study by Lukacz and others of 4,500 women, women after a vaginal delivery had a significantly higher chance of prolapse, SUI, overactive bladder and anal incontinence (42%) when compared to nulliparous women (27%) and women delivered by c/s (27%). Murphy showed that c/s was significantly protective against pelvic floor surgery in later life, when compared to normal vaginal or forceps delivery. The 3rd international consultation on incontinence showed unequivocally that vaginal parity significantly increases the relative risk (RR) of prolapse. After two vaginal deliveries the RR is 8.4, after 4 deliveries the RR is 10.9, yet after only c/s the RR of prolapse is 0.3. Rottveit showed similarly that the prevalence of prolapse increased after vaginal birth: the odds ratio (OR) of prolapse was 5.3 (2.3 – 12.3) following 3 or more vaginal deliveries, with a OR of 1.6 (.4 – 6.4) after c/s.

Swift reported that in a population of female subjects seen for routine health care, 67.8% of women who had more than 3 vaginal deliveries had stage 2 or greater pelvic floor organ prolapse. Recently Larson identified women with prolapse in Sweden, and compared mode of delivery with long term outcomes. A total of 1.4 million women were investigated, and c/s was associated with a significantly lower risk of pelvic organ prolapse vs vaginal delivery – OR 0.18 (0.16 – 0.20). Although no local SA data exist, US data suggest that African American women have less prolapse than white women – the odds ratio for uterine prolapse of African Americans is 0.6 (0.5 – 0.8), for rectocoele is 0.5(0.4 – 0.6) and for cystocele is 0.7 (0.6 – 0.7). It is important that the prevalence of pelvic organ prolapse (POP) and lower urinary tract symptoms (LUTS) in black women be investigated to provide robust data. The risk factors of POP are well known, and include pregnancy per se, vaginal birth, instrumental delivery, fetal
macrosomia, duration of the second stage of labour, and perhaps the use of epidural analgesia.\textsuperscript{8} Given the above data, it must seem tempting to suggest that it is possible to modify obstetric practice to prevent POP.

**LOWER URINARY TRACT SYMPTOMS (LUTS) AND THE MODE OF DELIVERY**

As we have seen, there is good evidence that vaginal delivery causes POP. But evidence for incontinence is not so clear cut. The International randomized term breech trial looked at outcomes after planned c/s vs vaginal delivery for breech presentations at term.\textsuperscript{13} At 3 months, there was more urinary incontinence following vaginal delivery than after c/s. Yet when patients were followed up 2 years after delivery, the difference in LUTS appeared to disappear. In a prospective study\textsuperscript{14} of 3,887 women reviewed 6 months after delivery, urinary incontinence and SUI was significantly less after c/s, but c/s was (surprisingly) not protective of anal incontinence. Unsurprisingly, the biggest predictor of anal incontinence was birthmass >4kg. In the famous EPINCONT study\textsuperscript{15} of over 15,000 women, the prevalence of SUI was 21% in women following vaginal delivery, 15% after c/s, and 10% in nulliparous subjects. The attributable risk – that is the proportion of any incontinence among women who delivered vaginally that would be prevented by c/s – was 35%. Ekström and workers compared LUTS after elective c/s vs vaginal delivery, and found SUI had a RR of 8.9, urgency incontinence a RR of 4.1, and urinary urgency a RR of 7.3 when compared to c/s.\textsuperscript{16} After 9 months all symptoms of LUTS were increased in the vaginal delivery group. In a study of identical twins to evaluate environmental determinants causing SUI, Goldberg found that vaginal delivery mode represented a powerful determinant of SUI: women having vaginal birth had twice the risk of SUI when compared with their twin sisters who had a c/s.\textsuperscript{17} Recently Hilton\textsuperscript{18} examined obstetric risk factors and pelvic floor dysfunction 20 years after delivery: this showed that both urinary incontinence (OR .47) and faecal incontinence (OR 0.32) were significantly lower after first delivery by c/s. However, 25% of women had urinary incontinence and 12% had faecal incontinence after c/s, suggesting that other additional factors causing incontinence are also at play. In fact the incidence of faecal incontinence in the elderly is quite similar in men and women. Altman\textsuperscript{19} reported that stress incontinence symptoms are more common following vaginal delivery when compared to c/s, 10 years after delivery.\textsuperscript{19} However, the incidence of anal incontinence is similar in both groups.

A systematic review by Press\textsuperscript{20} suggests that mild and moderate SUI is reduced by c/s, but severe symptoms are equivalent regardless of mode of delivery. A French postal survey\textsuperscript{23} showed the incidence of severe SUI was 7% in nulliparous women, and similar in parous women regardless of delivery mode.

In summary, from the evidence presented it seems that c/s is somewhat protective against SUI - certainly in mild to moderate degrees of stress incontinence.
ANAL INCONTINENCE DATA

The epidemiology of anal incontinence suggest that in women, 77% - 83% of anal incontinence (AI) in vaginally parous women is due to obstetric sphincter dysfunction. But avoidance of sphincter damage by c/s does not necessarily prevent AI, proving that other important aetiological factors are also involved. As noted above, the incidence of AI in elderly men is rather similar to that of women. Rottveit in 2005 showed that in 15,000 women younger than 65 year of age, the risk of AI following caesarean delivery was OR 1.5 vs OR 2.5 after vaginal birth. Instrumental delivery doubled the odds of incontinence, as did a fetal mass >4kg. The Cochrane review of 2004 confirmed that the most common cause of sphincter damage and faecal incontinence is obstetrical trauma. The first vaginal delivery causes the most damage due to neurological damage to the pudendal nerve, the pelvic fascia, and the levator plate. Sultan has published extensively on the subject over many years – his work shows that 35% of primiparous women and 44% of multiparous subjects develop sphincter defects during vaginal birth, but clearly not all suffer AI as a consequence.

Forceps delivery is most damaging to the anal sphincter, and according to Sultan, fully 80% of women suffer anal sphincter damage on ultrasound scan following forceps delivery and up to 37% will develop anal incontinence. Women having a c/s show no anal sphincter damage, but some will nevertheless develop AI. In a large meta – analysis of over 14,000 cases, Nelson and others reviewed the efficacy of caesarean section in the prevention of anal incontinence. 15 Studies were analised, and the authors suggested that 167 c/s were necessary to prevent 1 case of anal incontinence. A similar systematic review in 2007 by Pretlove showed no real evidence that c/s prevents AI. A paper by Fritel showed that no obstetric variable (parity, mode of delivery, fetal mass, episiotomy, 3rd degree tear or perineal damage) made any difference: the prevalence of faecal incontinence at midlife was similar for all women, regardless of parity or mode of delivery.

Another study found no evidence that exclusive caesarean section delivery protects against subsequent faecal incontinence. But a first birth by forceps delivery incurs a two fold increase in the risk of persistent faecal incontinence. Finally, a recent Cochrane review of 21 studies examines caesarean delivery for the prevention of anal incontinence, in 31,698 women. The review concludes that elective caesarean does not confer benefit for the preservation of anal continence – but calls for a randomized trial of c/s vs vaginal birth to bolster their conclusion!

So in summary, there is evidence to suggest that vaginal birth damages the anal sphincter especially if forceps are used for delivery – but conversely, c/s does not confer protection of anal continence in the long term.

SEXUAL DYSFUNCTION: THE DATA

There is very little data on the subject of mode of delivery and subsequent sexual function. Dean and others considered sexual function and delivery mode, six years after parturition. Their study shows that a c/s results in significantly better vaginal tone than that following vaginal birth, which translates to better...
sexual satisfaction scores. In this study, there was no difference in the rates of dyspareunia, or urinary incontinence during coitus.

A study by Conelly\textsuperscript{31} showed that delivery mode and episiotomy were not associated with differences in the resumption of intercourse, anorgasmia, or dyspareunia. Most women resumed painless intercourse by 6 weeks, and experienced orgasm by 12 weeks. These data suggest that sexual function post partum is perhaps somewhat improved if the subject was delivered by caesarean section.

**ECONOMICS: THE TRUE COST OF C/S**

There have been remarkably few credible studies addressing the problem of the cost of an elective caesarean compared to a planned vaginal birth, using an “intention – to – treat” analysis. The cost of caesarean section is generally calculated by taking the total cost all caesarean sections performed and dividing this by the number of caesarean sections performed, thus obtaining a cost per caesarean section. This figure is misleading as the most expensive mode of delivery occurs in the patient who desires vaginal birth, has a prolonged labour, epidural, augmentation and then finally an emergency caesarean section. This birth would be recorded in the caesarean section group. However, the expense incurred is the consequence of the patient requesting a vaginal birth and should thus be included in the vaginal birth group for cost comparative purposes (intention to treat analysis).

The cost of caesarean section is further distorted by obstetric and medical complications that require caesarean section. For example, if a caesarean section is performed on a woman with a 28 week pregnancy for HELLP syndrome and the mother spends a long time in intensive care unit post operatively, the costs incurred in this situation are astronomical and are included in the caesarean section statistics. The expense is the consequence of a severe, life threatening obstetric complication and not the result of the chosen mode of delivery. When emergency caesarean sections and c/s for medical complications are excluded, it becomes evident that the cost incurred when a patient requests and elective caesarean section could well be lower than a vaginal birth.

One study addressing this cost issue was published in 2003, authored by an accountant and qualified doctor.\textsuperscript{33} Conventional wisdom is that a caesar costs more than a vaginal delivery and that programs to decrease the rate of caesarean delivery will offer the economic benefit. However, hospital charges in no way accurately reflect the true global costs of delivery – for example, the cost of supporting a 24hr labour ward staff that may or may not be working. In the study mentioned, the actual costs are as follows:
Table 1: costs of delivery

<table>
<thead>
<tr>
<th>Nulliparous women</th>
<th>(U/S dollars) 2003 costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total costs</td>
<td></td>
</tr>
<tr>
<td>Spontaneous labour</td>
<td>779</td>
</tr>
<tr>
<td>Induction / augmentation</td>
<td>917</td>
</tr>
<tr>
<td>Induction with epidural</td>
<td>1,005</td>
</tr>
<tr>
<td>Multiparous women</td>
<td></td>
</tr>
<tr>
<td>Spontaneous labour</td>
<td>734</td>
</tr>
<tr>
<td>Induction / augmentation</td>
<td>828</td>
</tr>
<tr>
<td>Induction with epidural</td>
<td>916</td>
</tr>
<tr>
<td>Elective c/s</td>
<td>918</td>
</tr>
<tr>
<td>Emergency c/s after labour</td>
<td>1,377</td>
</tr>
</tbody>
</table>

This particular hospital is a non - profit community – based facility, and the figures quoted are not estimates but actual factual numbers calculated in 2400 deliveries over one year.

HOW SAFE IS CAESAREAN SECTION?

Fortunately death following intra – or post partum mishap is rare, and data must be observational, with the potential for confounding variables and prenatal maternal morbidity causing inaccuracy. One study examining postpartum maternal mortality and caesarean delivery was published in 2006. The authors conclude that death following c/s was 3.3 times more likely than mortality after vaginal birth. This was due to complications of anaesthesia, puerperal sepsis and venous thrombo – embolism. However in a Canadian paper, a large population – based cohort of 2.2 million women were examined for adverse outcomes following delivery. The database gave delivery and outcome data over a 14 year period. The absolute differences in severe morbidity were very small, being 27 per 1000 deliveries for the c/s group vs 9 per 1000 for the normal delivery group. However the in – hospital mortality rate between the 2 groups was not significantly different.

LONG TERM COMPLICATIONS OF CAESAREAN SECTION

Regarding long – term complications for caesarean delivery, data from Lyden – Rochelle and Hemminki and Merilainen, from Finland calculate the increased risk of placenta praevia for women with a previous caesarean delivery at 0.5%. The incidence of placenta accreta in these women is 1 in 2500 patients or 0.04%, the increased risk of abruption is 1.15%, and the increased risk of ectopic gestation is 1.1%, in patients who have had a previous caesarean delivery.
This is taken together to give an 2.8% increased risk. The placental abruption risk for a patient who has had a previous caesarean delivery is 30% higher than a patient who is in labour and who has never had a caesarean delivery. Remember the difference between absolute risk and relative risk: it is important to separate these two concepts especially in rare and unusual occurrences. Because something is statistically significant does not mean that it is clinically relevant.

THE PROBLEM WITH DATA

It is unrealistic to expect women to have equipoise on the subject of elective c/s vs vaginal birth so data examining the incidence of rare differences in morbidity and mortality are retrospective and observational in character. But population groups are not homogenous, outcomes and definitions vary, interventions and differing methodology abound. The effects of bias are profound, since authors commonly hold views and opinions in line with their beliefs. For all these reasons it is difficult to easily interpret data, and draw valid conclusions that stand up to rigorous scrutiny. All to often the authors conclusions seem at variance with the data, and express opinions quite unjustified by the facts presented.

DO WOMEN DESERVE THE RIGHT TO CHOOSE?

It seems self – evident that the principle of informed consent is paramount, and all women deserve an impartial presentation of facts unclouded by personal bias or prejudice. However the facts may be aligned to suggest a preferred plan of action, more inline with the obstetrician’s convenience that patient’s preference. It may be impractical to allow patients an elective c/s if that be their wish, given the restraints of limited resources. For example, there is good evidence that c/s reduces vertical transmission of HIV, but the large numbers of HIV positive women in the public sector make c/s in this impossible. Transparency and honesty are the hallmarks of informed consent in ethical practice. So although the patient has the theoretical right to choose her treatment options, in practice the constraints of limited resources subjugates the patients right to choose, to what is practical under the circumstances.

More and more women are choosing caesarean section as their preferred method of birth. The most common reasons given by patients who request caesarean section are:

- To avoid the possibility of birth asphyxia and birth trauma in their babies
- To avoid the pelvic damage that can occur as a consequence of vaginal birth
- To take advantage of the convenience of a scheduled birth in a busy lifestyle
- Fear of pain of labour

WHAT IS THE “CORRECT” C/S RATE?

It is impossible to establish the “correct” c/s rate, since the huge number of patient and obstetrical variables makes a homogenous blanket rate impossible to establish. Comparing our c/s rate (which again
varies from place to place) to that of other countries is nonsensical, given the vastly different resources, circumstances and conditions between countries. We have noted the main factors driving high c/s rates: but an “optimal rate” can never be argued. The 15% c/s rate proposed by the WHO cannot remotely stand up to any quasi scientific scrutiny, and is more politically than medically justified.

**WHY IS THE C/S RATE SO HIGH?**

Must the rate be brought lower? There are many arguments advanced as to why the c/s rate should be reduced.

- **The academic argument**

  Academics have argued that the c/s needs to be reduced.\(^{35}\) Resources in most public hospitals are stretched to the limit, and the number of hospital beds in these institutions have not kept pace with billowing patient numbers. Patients are often ill due to associated HIV / AIDS morbidity, requiring more specialised personnel and longer hospital admissions, further exacerbating the problem. “Patient choice” under these circumstances is not possible, and is replaced by medical expediency. Academics suggest the c/s rate is unacceptably inflated – but there is no agreed “correct” c/s rate. Rates have increased particularly in the private sector, due to the pressure germain to practice under these circumstances, mainly of a medicolegal nature. Another argument is that doctors doing deliveries in private practice should be replaced by midwives.\(^{35}\) At present there is a critical shortage of well trained midwives, and the loss of experienced midwives is certainly not being addressed. This point alone, increases the c/s rate. Training of midwives is an issue that needs urgent attention. If an adverse event occurred under the care of a midwife, the hospital group would need to bear financial responsibility for litigation. It is simplistic and facile to suggest that the high c/s rate is the result of private obstetrician’s poor obstetric decisions and an unwillingness to perform normal deliveries. It has been shown that they alone should not shoulder all the blame for the high c/s rate since the causes are complex and multifactorial.

  The data presented above shows a clear evidence – based academic justification for c/s on the grounds of preventing pelvic organ prolapse. As our population ages, the burden of disease will increase, making prevention of POP ever more important, especially since changing practice may reduce the incidence of prolapse. It is important for academics to examine the evidence and form an impartial opinion based in the data. If selected elective c/s is impractical for logistical reasons, this must be stated. Clearly it is as incumbent on obstetricians in private practice to examine their conscience and provide care to the highest ethical standards. Epidemiological population based medical interventions are easy to justify on the academic wardround, but not so easy to justify before a magistrate faced with litigants being the parents of a compromised baby. This is particularly true if a vaginal delivery was attempted - a c/s is always considered the acceptable standard of care under these circumstances. For better or for worse a c/s is often considered the benchmark for best obstetrical practice.
• The medical aid’s argument

Medical aid schemes have justifiably and vociferously objected to the high c/s rate on the basis of c/s being drivers of the high cost of medical claims. The issue of patient’s choice is of low priority – it is moot whether a medical aid scheme would accept justification of an elective c/s on the (admittedly valid) ground of preventing prolapse 3 decades hence. Whatever the argument advanced, it is all about money and the reduction of costs. How the rate should be reduced is not made clear, and other causes of the high rate of c/s are of no consequence to medical insurers. The hidden surgical costs of genital prolapse are only apparent decades after childbirth: 400,000 prolapse operations are performed annually in the USA, and up to one third will fail, requiring surgical revision. At present there is no identified marker that accurately predicts which women are likely to suffer prolapse, as a consequence of obstetrical experience. The quality of life costs of prolapse are considerable, but remain unaddressed, and difficult to quantify.

THE PHYSICIANS RESPONSIBILITY

Does the obstetrician bear responsibility to the fiscus in reducing the c/s rate? The duty of the physician is to prevent an unnecessary squandering of scarce resources by preventing c/s for inappropriate indications. Once labour is established, a c/s solely to prevent pelvic floor damage is inappropriate. Once a woman has delivered vaginally, a c/s “to prevent prolapse” is facile. But the obstetrician is beholden not only to fiscal issues – as is the medical insurer – but to patient’s advocacy. The relationship to the patient is one of mutual trust and respect, understanding and explaining the issues involved, ensuring best outcomes for mother and child, and proper informed consent. The envisaged National Health Insurance Scheme aims to devolve many duties previously delegated to doctors, to highly trained nurses. This may include midwives doing normal deliveries – but the critical shortage of trained, skilled midwives will seriously impede implementation of the NHI model with questionable reduction of the c/s rate.

THE COST OF LITIGATION

There is no question that aggressive litigation has increased the costs of liability insurance directly driving up the c/s rate. The medical defense union (MDU) provides conditional litigation costing R187,830 per annum to private obstetricians, in 2011. The exponential increase in these litigation payments is unsustainable and requires government intervention. The era of unethical lawyer’s touting has arrived, with public advertising suggesting that adverse outcomes implies doctor’s negligence. Lawyers fuelled the public perception that science has overcome reproduction mishap, and perfect outcomes are the norm and should be expected. If impossibly raised outcome expectations are not met, a lawyer would be able to arrange compensation on a contingency basis.

THE FETUS AND CAESAREAN SECTIONS

Whilst a healthy term fetus can withstand the rigours of labour, in our country there are still significant numbers of babies that suffer intrapartum asphyxia due to fetal hypoxia, meconium aspiration and hypoxic encephalopathy. Fetal monitoring is not universally available, and is in itself, an imperfect
science. Inappropriate elective c/s may result in transient neonatal tachypnoea, representing the biggest disadvantage of c/s. However this must be weighed against the damage to babies caused by instrumental deliveries or prolonged labour. It is estimated that intrapartum asphyxia and birth trauma is the primary cause of death in 7.65/1000 births in SA. Many of these cases are associated with the unsafe use of intrapartum oxytocin, especially in multiparous women.

CONCLUSION

It is only justifiable to perform an elective c/s for an accepted medical indication, with formal informed consent, where the patient is impartially enlightened as to the risks and benefits of the procedure. Emergency c/s are justified for medical or fetal reasons, but do not afford any pelvic floor protection. The Health Professional Council of SA has made patient’s choice of medical intervention a desirable reality, provided informed consent is adhered to. Just as we have specific indications for a c/s, we ought to have specific indications for a vaginal delivery.
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