In Elective Cesarean, Honor Patient Choice

A panel of experts says maternal requests should not be encouraged or discouraged.

BY KERRI WACHTER
Senior Writer

WASHINGTON — Any decision to choose between cesarean delivery by maternal request or trial of labor ultimately lies with the woman, once the potential risks and benefits associated with C-section have been discussed, concluded an independent panel of experts on cesarean section.

“Her decision should be honored,” Dr. Mary E. D’Alton, panel chairwoman, said at a conference on cesarean delivery sponsored by the National Institutes of Health. The panel, convened to assess the science regarding cesarean delivery on maternal request, concluded that available information on the risks and benefits of C-section on maternal request versus vaginal birth does not provide the basis for a recommendation in either direction.

The panel defined C-section on maternal request as a mother’s request for a cesarean delivery for a singleton pregnancy when she has no established medical indication for the procedure. This is distinct from emergency C-section or C-section performed after attempted vaginal delivery.

“We don’t believe [C-section on maternal request] should be discouraged or encouraged. We believe there should be a full discussion of the risks and benefits as we know them right now,” said Dr. D’Alton, chair of obstetrics and gynecology at Columbia University in New York.

Many believe that the rate of cesarean delivery by maternal request is increasing, with domestic and international estimates ranging from 4% to 18% of all cesarean deliveries. In 2004, almost one-third (29%) of all U.S. live births were by C-section, the highest rate ever reported.

Cesarean delivery on maternal request “may be a reasonable alternative to planned vaginal delivery, after thorough discussion with the patient, the panel of 18 experts said in a draft state-of-the-science report. “When a provider cannot support this request, it is appropriate to refer the woman to another provider.”

The panel advised against C-section for women desiring to have several children, but did not specify a number to use as a cutoff. Evidence seems to indicate that the risks of placenta previa and accreta rise with each C-section.

Planned vaginal delivery “provides an improved benefit/risk ratio for women who desire several children,” the panel concluded.

The panel also recommended that C-section on maternal request should not be performed prior to 39 weeks or without a diagnosis of lung maturity. Evidence suggests an increased risk of neonatal respiratory morbidity with C-section, compared with vaginal delivery.

The panel encouraged physicians to discuss with a woman her reasons for requesting a C-section, and to discuss pain management options if she is motivated by a fear of pain. “Efforts must be made to assure availability of pain management services for all women,” the panel said.

Good quality data on the benefits and risks of C-section on maternal request are limited. It is often difficult to retrospectively assess whether a C-section was genuinely requested by the mother. Frequently, emergency C-sections and/or C-sections following a trial of labor are lumped in with those performed after attempted vaginal delivery.

The findings support immediate administration of DMPA and suggest a potentially significant impact on continuation as well as avoidance of unintended pregnancies.

The immediate contraception protocol was designed to avoid this outcome, according to Dr. Rickert. While the earlier study looked specifically at the efficacy of the approach with respect to oral contraceptives, the current study sought to determine whether delivery of DMPA would lead to greater method continuation and thus pregnancy prevention—over a 6-month period, compared with delaying the injection and providing alternative contraceptive options for the interim period.

All subjects in both conditions underwent a history, physical, pregnancy test, and structured interview at the initial visit. All were instructed to return to the clinic in 21 days for a repeat urine pregnancy test and, for those assigned to the alternative condition, to receive their first DMPA injection. Dr. Rickert said. In addition, the women were followed through two subsequent appointments for DMPA injections and structured interviews.

As of February 2006, 278 of the women had completed the study; 14 were between the ages of 14 and 17 years, 118 were between the ages of 18 and 21, and 106 were between 22 and 26 years.

“Continuation rates were statistically higher at 6 months in the [immediate] DMPA group compared to the bridge group, meaning that more women in the DMPA group received their third injection,” he said. Other factors independently associated with 6-month DMPA continuation rates included partners’ awareness of DMPA use, returning for the pregnancy test visit, and history of emergency contraceptive pill use, “suggesting continuation is also affected by behaviors consistent with intentions not to become pregnant,” Dr. Rickert said.

The immediate DMPA group had significantly fewer pregnancies—2, compared with 23 in the bridge group—across the study period.

The findings support immediate administration of DMPA and suggest a potentially significant impact on continuation as well as avoidance of unintended pregnancies, Dr. Rickert concluded.

For Late-Pregnancy Choking Victim, Use Heimlich Maneuver on the Floor

BY BETSY BATES
Los Angeles Bureau

PASADENA, CALIF. — The Heimlich maneuver becomes unwieldy during the late stages of pregnancy, requiring adaptations, Dr. J. Gerald Quirk said at the annual meeting of the Obstetrical and Gynecological Assembly of Southern California.

Breast enlargement, diaphragm displacement, and the size and weight of a pregnant woman all contribute to difficulty in performing the traditional emergency maneuver to prevent choking during late pregnancy.

First described in 1974 by Dr. Henry Heimlich, a thoracic surgeon, the Heimlich maneuver involves standing behind a choking victim and placing a fist, thumb side in, underneath the diaphragm. With the other hand used to push against the fist, a series of abrupt upward thrusts are made; these motions can usually dislodge a piece of food from the airway.

Not only is it difficult to hold a woman in this position during late pregnancy, it is also hard to exert the force necessary to perform the maneuver correctly, said Dr. Quirk, professor and chair of obstetrics, gynecology, and reproductive medicine at Stony Brook (N.Y.) University.

“The best thing to do is an ice cube in a pillow case and press down on the lower part of the sternum,” he said.

The woman should be tilted slightly to one side to prevent airway compression.

Dr. Quirk said several case reports suggest that this adaptation is effective for use in late pregnancy.