Short Commentary: How We Could Reverse the Ascending Cesarean Section Rate

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Cesarean section (CS) in its beginning years was associated with a high maternal mortality risk from hemorrhage, infection or both. With the discovery of antibiotics and the improvement in surgical and anesthetic techniques, CS has become safer and, therefore, well accepted and sometimes requested by women. CS rate has increased in many parts of the world [1], reaching alarming rate in some countries [2]. Despite the improvement in the quality of management, CSs still carry risks, albeit small, of morbidity and sometimes mortality [3]. Moreover, it is not always affordable by all women, especially in countries where there exists no health insurance policy. Finally, performing a CS may limit the family size, because it is associated with a risk of uterine rupture during future deliveries as well as a high risk of repeat CS [4], given that multiple CSs are associated with high morbidities that may necessitate irreversible contraception such as tubal ligation. Hence, CS rate should be reduced. Some strategies are discussed below.

Many CS are being carried out among nulliparous women for various reasons which include breech presentation and prolonged second stage of labor [5]. We should reconsider these indications since some authors observed that more patience during nulliparous second stage of labor can be associated with a safe vaginal delivery [1]. Moreover, other researchers noticed that some well selected nulliparous women with a fetus in breech presentation can deliver a healthy neonate vaginally [6]. Reducing CS rate in nulliparous women is important in the reduction of the global CS rate.

Furthermore, a multiparous woman who has delivered healthy babies weighing 4000 g or more vaginally could be allowed to also deliver babies in breech presentation vaginally when the estimated fetal weight is between 3500 and 3800g.

Another point of intervention is the refusal of trial of scar by many obstetricians when the fetal weight is ≥3500g. This is being practiced by many obstetricians, despite the lack of clear scientific evidences. If the maternal pelvis is adequate with the pelvic diameters largely above the normal values and if the lower segment uterine scar is well healed, a safe vaginal delivery of a fetus weighing 4000g is possible. According to the Society of Obstetricians and Gynaecologists of Canada, suspected fetal macrosomia is no more a contraindication to trial of scar after cesarean section [7]. Preconditions for a trial of CS scar should be reviewed. Since repeat CS is associated with future elective CS, avoiding a 2nd CS when it is possible can contribute to the reduction of the global CS rate.

Finally, electronic fetal monitoring has been associated with an increased rate of CS for suspected but clinically unproven fetal distress [8], essentially from poor interpretation of the cardiotocogram. Correct interpretation of the cardiotocogram is important to avoid unnecessary CSs.

Nevertheless, when trying to reduce CS rate, we should not expose the woman and/or her newborn to risk of morbidity or mortality. Consequently, we should reach the point where CSs are conducted neither too much, nor too less.

References

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