ACOG Criticized for Restricting Rural VBACs

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New Orleans — Neonatal and maternal mortality in California did not significantly change after the American College of Obstetricians and Gynecologists recommended that vaginal births be attempted after cesarean delivery only in settings with "immediately available" emergency care, according to one study.

John Zweifler, M.D., and research fellow Susan Hughes compared neonatal and maternal deaths from 1996 to 2002, before and after the 1999 recommendations from the American College of Obstetricians and Gynecologists. They reviewed maternal demographics, birth data, and outcomes, noting previous cesarean sections and whether hospitals were in rural or urban areas.

Very low-birth-weight infants were the only group in the study to experience significantly higher mortality associated with vaginal births after cesarean (VBAC).

When ACOG was contacted for comment, a representative, Gary Hankins, M.D., criticized the study design and its implications.

In 1996, ACOG encouraged VBACs, Dr. Zweifler said at the annual conference of the Society of Teachers of Family Medicine. In 1998, the college changed its recommendations on VBACs and stated they should be attempted only where emergency care is "readily available."

The following year, ACOG further restricted the recommendations to settings where emergency care is "immediately available." The college retained the wording of these recommendations in its latest update (Obstet. Gynecol. 2004;104:203-12).

ACOG defines "immediately available" as having access to anesthesia services and a physician throughout active labor, as well as the resources to perform an emergency cesarean. "But for those of us in rural settings, this could impair our ability to do VBAC," Dr. Zweifler said. "We were concerned that a change in ACOG guidelines would have deleterious effects on our [residency] program."

California Birth Statistical Master files consider mortality to be associated with

MDs Need Brush Up on Parturient Resuscitation

Palm Desert, Calf. — Obstetricians, emergency physicians, and anesthesiologists may suffer significant knowledge gaps when it comes to resuscitation of women in labor, suggest survey results presented in poster form at the annual meeting of the Society for Obstetric Anesthesia and Perinatology.

Faculty and residents in all three groups of specialists at Stanford (Calif.) University responded to an 11-question anonymous survey covering four critical knowledge areas concerning resuscitation after catastrophic events in labor that lead to cardiorespiratory arrest:

- ► Awareness of the need for left uterine displacement.
- ► Recall of specific standard advanced cardiac life support (ACLS) algorithms.
- ► Knowledge of pertinent maternal physiology.
- ► Awareness of the recommendation to perform C-section in women at more than 20 weeks' gestation after 5 minutes of unsuccessful resuscitation for cardiac arrest.

Among 74 respondents, anesthesiologists answered the most questions correctly (average 76%). They were also better informed than other specialists about relevant maternal physiology.

Emergency physicians scored highest on questions regarding ACLS algorithms, averaging 93% correct responses.

All three groups earned similar scores on questions relating to left uterine displacement during resuscitation and the 5-minute cesarean rule. However, the rate of correct responses to those questions was low, at 60%-75%, said Leslie C. Andes, M.D., of the Stanford department of anesthesiology, and her associates.

They recommended that residents in all three specialties be required to complete ACLS certification, with an emphasis on the special resuscitation needs of women in labor. Labor and delivery suites are not the only places in a hospital where pregnant women may need to be resuscitated, the investigators noted in the poster.

—Betsy Bates

birth if it occurs within 72 hours of delivery, explained Dr. Zweifler, program director of the University of California, San Francisco, family medicine residency program, in Fresno.

There were more than 3.5 million single births in California from 1996 to 2002, including 2.7 million vaginal births, 456,000 primary cesarean sections, and 386,000 births by women with a history of cesarean section. Of the women with a history of cesarean delivery, 312,000 had a repeat cesarean, and 74,000 had an attempted VBAC. There were 61,000 successful VBACs and 13,000 failed ones.

VBAC rates decreased from 1996 to 2002, reflecting national trends, Ms. Hughes said. The biggest drop was in rural VBACs.

The study found that "there were very few maternal deaths, about 35. So statistically, there were no differences in maternal mortality between time periods or attempted VBAC, versus repeat cesareans," Ms. Hughes said. There was a statistically significant increase in mortality for infants weighing less than 1,500 g.

"Attempted VBACs in both time periods had higher death rates than repeat cesareans," Ms. Hughes added.

However, there were no significant differences in mortality for infants born heavier than 1,500 g, including those heavier than 4,000 g. "You might expect to see [VBAC] complications in the large birth weight group, but we did not see a higher rate," he said.

Reliability of birth certificate data was a possible limitation of the study, Ms. Hughes said. In addition, there was no information on morbidities, such as uterine rupture or newborn encephalopathy.

"The more restrictive ACOG guidelines have not improved VBAC-related neonatal or maternal mortality," Dr. Zweifler said. "We feel [that] with previous cesarean, we can expect similar outcomes with either a VBAC or C-section with a normal- or large-birth-weight baby."

"ACOG's recommendation is purely based on the fact there is no more catastrophic event that befalls women than uterine rupture," said Dr. Hankins, chair of the ACOG Committee on Obstetric Practice.

"Studies clearly show that if you are not really available to respond to this emergency in a very quick fashion—generally less than 30 minutes—you can expect, in a significant number of cases, either the death of the baby or permanent neurologic injury of the baby from birth asphyxia, said Dr. Hankins, professor in the ob.gyn. department at the University of Texas Medical Branch, Galveston. ■