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 chairperson, 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 planned vaginal birth does not provide the basis for a recommendation in either direction.

The panel urged physicians to discuss with a woman her reasons for requesting a C-section, and to discuss pain management options.

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 verification of lung maturity. Evidence suggests an increased risk of neonate 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 the ones by maternal request.

The interpretation of many outcome variables was confounded by a lack of appropriate comparison groups, inconsistency in outcome definitions, and the frequent use of composite outcomes. The panel identified two maternal outcome variables—both short term—with moderate-quality evidence.

One suggests a lower risk of blood loss associated with planned C-section than with the combination of planned vaginal delivery and unplanned C-section. The second indicates that C-section was associated with longer hospital stays than was vaginal delivery. The panel also identified one neonatal outcome with moderate-quality evidence—increased respiratory morbidity associated with planned C-section.

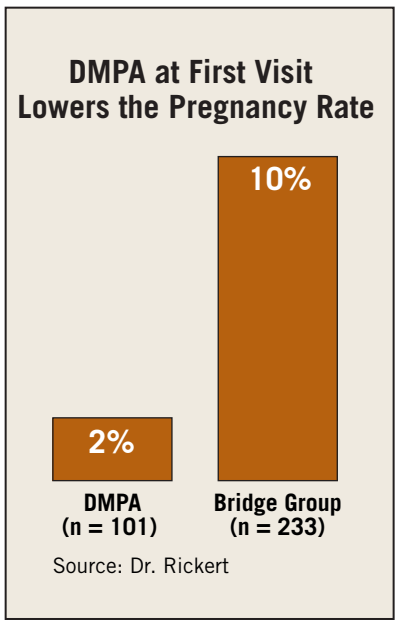
The final statement is available at http://consensus.nih.gov. ■

Initiating DMPA Without Delay Reduces Unintended Pregnancies

BY DIANA MAHONEY
New England Bureau

BOSTON — Immediate initiation of depot medroxyprogesterone acetate to adolescent and young adult women seeking the contraceptive injection resulted in higher continuation rates and substantially diminished unintended pregnancy rates at 6 months, compared with the use of alternative, short-term hormonal methods meant to bridge the period between initial request and injection at a later date, Vaughn I. Rickert, Psy.D., said at the annual meeting of the Society for Adolescent Medicine.

In a study of 334 young women aged 14-26 years who asked for depot medroxyprogesterone acetate (DMPA) during a reproductive health visit at an urban family planning clinic, 101 women were randomized to receive their first DMPA (Depo-Provera) injection at the conclusion of the visit, and 233 were randomized to an alternative "quick start" bridge condition whereby they were offered their choice of either oral contraceptive pills, the transdermal patch, or the vaginal ring, said Dr. Rickert of the Mailman School of Public Health at Columbia University in New York.



Historically, the rationale for waiting to initiate hormonal contraception "was to be sure the patient was not pregnant and to keep from altering the bleeding pattern," Dr. Rickert said. "Unfortunately, with the delayed initiation, many women don't take their first pill, and their motivation wanes." Similarly, asking women to return to the clinic at a later date for a DMPA injection means that some won't come back for it, thus increasing the likelihood for 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 immediate access to 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; 54 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] Depo group compared to the bridge group, meaning that more women in the Depo 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 lay her on the floor and press down on the lower part of the sternum," he said.

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

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