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CESAREAN SECTION RATE

To the Editor:

An unfortunate typographical error occurred in the first sentence of Dr. McClain's article on cesarean section (*McClain CS: Why women choose trial of labor or repeat cesarean section. J Fam Pract 1985; 21:210-216*). A 27 percent increase in the American cesarean section rate over eight years would have indeed been startling, but the correct number is not 27 percent; it is 270 percent! The threefold increase from about 5 percent in 1970 to 15 percent in 1978 was well documented in a widely publicized NIH task force report. But what has happened since 1978? A review of the most recently released national statistics reveal that there were about 3.7 million births in 1984 of which 813,000 were by the cesarean operation. Hence, six years after the NIH report, the American cesarean section rate had increased another 47 percent to an amazing 22 percent. At some hospitals the cesarean rate is now passing 30 percent. With hundreds of thousands of these operations being unnecessary repeat procedures, it is indeed time to reevaluate the situation.

I applaud Dr. McClain for her work on the decision-making process in mothers with prior cesarean sections. However, while a myriad of complex variables undoubtedly enter into each woman's decision, the most important factor was not fully evaluated. The physician's

attitude can clearly overwhelm all other variables and tip the scales in favor of surgery. It is common knowledge that how a physician presents an option will have a profound effect on the patient's decision. It is unfortunate, but true, that the American obstetrician has little incentive to allow vaginal birth after cesarean section. In fact, there are financial, temporal, and medicolegal pressures that push the obstetrician to opt for repeat operation in spite of data that strongly suggest this may not be in the patient's best interest. Hence, if the option for vaginal birth is presented at all, it is often done with bias. For example, a woman might be told that she is welcome to attempt a trial of labor as long as she understands that after hours of excruciating pain her womb might explode resulting in her death or at least in the death of her baby. While such a one-sided presentation ignores the reassuring findings of some 50 studies published over the past 30 years, it would clearly overwhelm the scripts, scenarios, and other complex variables discussed in Dr. McClain's publication. Obviously the patient would choose a repeat operation.

Although antibiotics and transfusions have decreased the dangers of cesarean section, all recent data indicate that the risk of maternal death is still at least two to four times greater than with vaginal birth. In our institution, this fact and many others are presented in an unbiased fashion during a

monthly VBAC (vaginal birth after cesarean section) class. Only when the presentation is made in such a manner will the variables discussed in Dr. McClain's study have a chance to interact.

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The preceding letter was referred to Dr. McClain, who responds as follows:

I wish to thank Dr. Flamm for pointing out the error at the beginning of my article on women's choice of repeat cesarean section or trial of labor. The correct figure for the percentage increase in cesarean sections from 1970 to 1978 is 162 percent (from 195,000 births by cesarean section in 1970 to 510,000 in 1978).

I agree wholeheartedly with Dr. Flamm's observations that the majority of US obstetricians wield great influence over the choices made by their patients and that most still favor elective repeat cesarean section despite the demonstrated medical and economic advantages of vaginal birth after cesarean section.

However, women in my study were recruited from hospitals with "liberal trial of labor protocols" (my article, page 212). What this means is that trial of labor was ideally offered to all women who met the basic eligibility criteria—

previous cesarean section by low transverse incision, and no recurring or new indications for repeat cesarean section. In reality, differences existed of course among individual obstetricians with respect to how (or indeed whether) the trial of labor option was presented and how much encouragement was provided to the reluctant or fearful patient.

Despite differences among obstetricians, women in the study knew of their eligibility for trial of labor. They felt that they were making the decision, not their obstetrician; indeed, if a potential study respondent felt she had no choice but to undergo repeat cesarean section, she was not accepted into the study. It was in this decision-making climate that the scripts and scenarios described in my analysis so clearly led some women to choose trial of labor and others to prefer elective repeat cesarean section.

Most women given the choice want to deliver vaginally after a prior cesarean section. In hospitals that offer trial of labor to medically eligible women, about three fourths attempt vaginal birth and most succeed. Unfortunately, however, about one fourth of eligible women still opt for elective repeat cesarean section.¹ Of my completed sample 28 of 100 respondents did so. I have described elsewhere how both cultural and physician-patient communication factors contributed to these women's decision strategies.² Regardless of the complex interplay of social and medical influences on women's delivery choices, that one fourth turn down the opportunity to give birth vaginally is disturbing and points to a new problem in the elective repeat cesarean dilemma—allowing patients to effectively demand surgery for childbirth in the ab-

sence of medical indications.

Dr. Flamm's main point remains true. The majority of obstetricians in the United States still subscribe, for a variety of reasons, to "once a cesarean, always a cesarean," despite the findings of increasing numbers of clinical studies that vaginal birth after cesarean section is safer and cheaper. However, the dictum by now has been internalized by large numbers of women as well. That women subscribe wholesale to obstetrical fashions in the attempt to gain control over their reproductive experiences has been amply demonstrated in other research. Two examples are American women's demands for "twilight sleep" in earlier decades of this century,³ and women's acquiescence to skyrocketing rates of cesarean section deliveries in other countries.⁴ The challenge before us is clearly twofold, that is, to educate both obstetricians and child-bearing women about the objective risks and benefits of elective repeat cesarean section versus vaginal birth after cesarean.

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THE GENOGRAM AND ELDERLY PATIENTS

To the Editor:

Dr. Christie-Seely ably demonstrated the therapeutic and diagnostic benefits of constructing a family genogram.¹ I have found that it serves an additional and important role in the assessment of the elderly, particularly those with mild to moderate intellectual impairment.

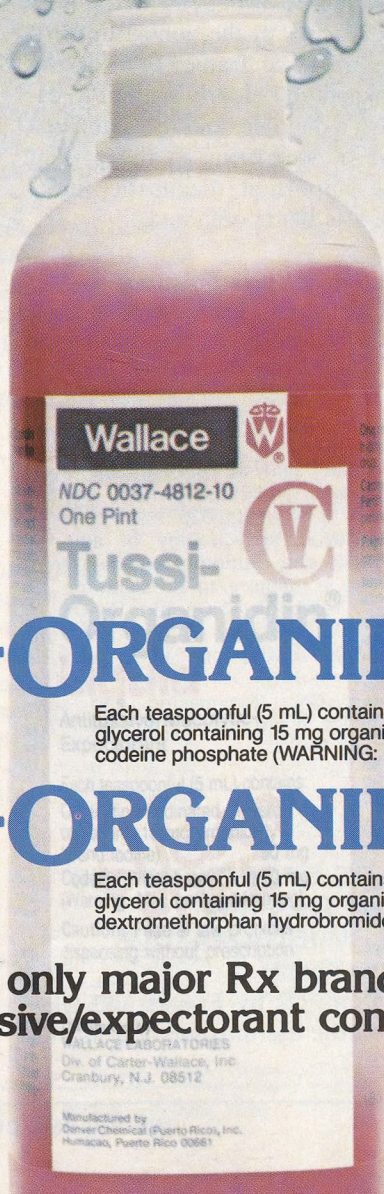
The mental status examination, essential in evaluating elderly patients, measures both short-term and long-term memory. In cases of mild or early dementia, there is usually a short-term memory deficit, whereas remote memory is less likely to be impaired.² Such patients may be very aware of their inability to "perform" well on the mental status examination, becoming self-conscious and upset. As a result, even the most experienced and sensitive physician may become uncomfortable. This jeopardizes a therapeutic physician-patient relationship and may further impair the patient's performance on the rest of the examination.

Family practice residents often find the mental status examination a difficult part of assessing the elderly. They may even avoid doing a formal evaluation, particularly on a patient whom they already know, for fear of offending them. In this situation it is useful for the resident to construct a genogram with the patient. This serves several purposes. First, it provides something to talk about. Some physicians are less proficient than others at talking with elderly patients. The genogram provides a ready framework for nonthreatening conversation, dissipating any awkwardness that may have arisen during the mental status examination.

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Second, patients who do poorly on immediate recall items may remember significant details about their childhood and family. Discussing their family history demonstrates this function of remote memory and bolsters their self-esteem. In addition, reminiscence may be therapeutic for the elderly.³

Third, important information about patterns of such illnesses as depression in the family may be obtained. Finally, the social support system, which is of paramount importance for the elderly, may be revealed. This includes relatives and friends who may be caretakers, companions, or dependents.

In summary, the genogram provides an ideal framework for the physician and elderly patient to establish a dialogue and re-establish a sense of well-being in the patient while important diagnostic information is being obtained.

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ACUTE BRONCHITIS AND TRIMETHOPRIM-SULFAMETHOXAZOLE

To the Editor:

The article by Franks and Gleiner on the use of trimethoprim-sul-

famethoxazole in acute bronchitis illustrates the difference between statistical significance and clinical relevance.

In this clinical trial, the authors examined a number of self-reported outcomes during a seven-day treatment period. They claimed a statistically significant improvement in the treatment group in several outcomes. However, I question whether the reduction in patients reporting cough, from 99 percent in the placebo group to 93 percent in the treatment group, has any real clinical significance. The same criticism applies to the difference in mean temperatures between 37.3°C and 36.9°C. The authors tried to show a difference in the number of patients who had returned to work after seven days, after stratifying on the basis of Gram stain results. The ambiguity of the analysis presented in Table 3, however, obscured this point. Furthermore, even upon entry into the study, a greater percentage of patients in the treatment group (55 percent) had been able to continue working compared with the control group (38 percent).

Despite the statistically significant differences, many clinicians would have doubts about the efficacy of trimethoprim-sulfamethoxazole for acute bronchitis based on the results of this study.

The severity and total length of cough, disability, and work loss during and after treatment would be more meaningful clinical outcomes.

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