In 2009, the most recent year for which final data is available, a record 32.9 percent of women gave birth by C-section, according to the National Vital Statistics System, part of the Centers for Disease Control. Preliminary data shows that in 2010 the rate declined only slightly, to 32.8 percent.

C-section is an inevitable part of the way modern obstetrics operates. According to the International Cesarean Awareness Network, several factors play into reasons for a surgical delivery: an active herpes outbreak, which could expose the baby to serious illness; a previous C-section with a vertical scar on the uterus, which may pose a danger of uterine rupture during labor; breech presentation; twins in which one of the babies is breech; fetal distress; serious bleeding from an abnormally placed or separating placenta; and maternal disease (such as heart disease) that, when coupled with labor, may put the mother in danger.
Most of these conditions are rare. However, induction plays a larger role in the numerous surgical deliveries that are performed each year. According to the American College of Obstetricians and Gynecologists (ACOG), the rate of this common medical intervention has more than doubled in the U.S. since 1990. In 2006, 22 percent (roughly one out of every five) of all pregnant women had their labor induced. Two years later, 44 percent of women who attempted to give birth vaginally were induced. The goal of labor induction is to artificially stimulate uterine contractions so women can deliver vaginally. But women who are induced are twice as likely to deliver by C-section as women who go into labor on their own.

The first component to labor induction is cervical ripening. If the cervix is not yet ready to dilate, then drugs are used to ripen the cervix. Once the cervix is ripened, labor can be induced with synthetic oxytocin (Pitocin), membrane stripping, rupture of the amniotic membrane or nipple stimulation. Misoprostol, a medication for peptic ulcers, is a commonly used off-label drug that both ripens the cervix and induces labor. ACOG guidelines indicate that inducing labor with misoprostol should be avoided in women who have had even one prior cesarean delivery, due to the possibility of uterine rupture (which can be catastrophic, resulting in hysterectomy or death).

As a midwife, I have seen many women remain pregnant past their due dates—due in large part to an awkward fetal position that can be remedied with skill, or simply because the baby is not ready to be born yet. We wait patiently, and eventually labor initiates. Most times women give birth before 42 weeks' gestation—and giving birth vaginally should be what we are striving for.

Looking at the obstetrical trend of overusing C-sections and seeing no relief in sight, we need to shift our focus to C-section recovery. There is a great need for manual work to be done in the pelvis to assist in successful healing. Uterine manipulation can relieve the procedure’s common long-term iatrogenic outcomes of bladder injury, sexual dissatisfaction, secondary infertility, endometriosis and nerve damage at the incision site.

It can also help the uterus become independent again. During a C-section, a low vertical incision is made into the lower segment of the uterus. The posterior bladder often adheres to the anterior side of the uterus, conjoining them so that they no longer behave like two
independent organs. The body’s way of healing post-surgically is to make scar tissue, which essentially glues everything together. An old osteopathic technique called visceral manipulation can be useful in regaining the optimal function of an independent uterus.

Ultimately, if needed, a C-section can save a life. In these cases, and for other women who give birth via C-section, manual work can be a tremendous aid to physical healing.

Cesarean Fact Cards

- When a cesarean is necessary, it can be a lifesaving technique for both mother and infant.
- The risk to your infant from the very low incidence of uterine rupture (less than 1 percent) is much less than the risk to your infant from respiratory distress as a result of a scheduled cesarean.
- Vaginal Birth After Cesarean (VBAC) is safer for both mother and infant, in most cases, than a routine repeat cesarean, which is major surgery.
- Many indications for cesarean can and should be questioned, including cephalopelvic disproportion (CPD, or baby too big, pelvis too small), dystocia, failure to progress, breech, etc.
- One in four births is a cesarean, with some hospitals reporting as high as one in two. This represents a 400 percent increase in less than 15 years. This cesarean rate increase has not led to an improvement in the infant mortality and morbidity rates, but instead has put mothers and babies at greater risk. Rates began to fall in the mid-1990s, but are rising again in the new millennium.
Expanding Our Focus: C-Section Recovery

Written by Jennifer Mercier, PhD
Thursday, 01 March 2012 00:00 - Last Updated Monday, 19 August 2013 09:13

Half of all cesarean women suffer complications, and the maternal mortality rate is at least two to four times that of women with vaginal births. Approximately 180 women die annually in the United States from elective repeat cesareans.

According to the World Health Organization, “Countries with some of the lowest perinatal mortality rates in the world have cesarean rates of less than 10 percent. There is no justification for any region to have a rate higher than 10–15 percent.”

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