Cesarean Section

A troubling trend in women’s health issues is the inappropriate use of cesarean sections. This method of delivery grew significantly in recent decades, and a 1993 report in Soc Sci Med states that half of the C-sections performed in the United States are unnecessary. According to this study, the main reasons for performing a cesarean—including a previous C-section and slow or difficult labor, among others—have been least clearly connected to benefits. The studies below point to a host of potential complications associated with cesarean deliveries—starting with higher rates of maternal mortality than with vaginal deliveries.

Other problems include ruptured uterus and hemorrhage, fever, urinary tract infections, and wound infection.
This article indicates that in the U.S., almost 1 out of 4 deliveries are performed by cesarean section. These rates are among the highest recorded in the developed countries. From 1970 to 1993, overall rates of primary cesarean sections increased by 4-folds, from 5.5% to 22.8%. Since deliveries by cesarean section carry a significantly higher risk of complications for both the mother and the newborn, the national health goal for the year 2000 has been to lower its rate to 15% or below, a value that has not been observed since 1978.


The results of this study show that the rate of cesarean sections in Scotland increased by over 3-fold in the period from 1962 to 1992, with no apparent cause to justify this increase other than a lowered threshold of acceptance of the procedure in obstetric practice.


This article emphasizes that half of the cesarean sections performed in the U.S. are unnecessary. This surplus needlessly endangers women and their babies and adds over $1 billion to the annual health care costs. Cesarean section deliveries are associated with a 2- to 4-fold increased rate of maternal mortality and with a 5- to 10-fold increased rate of maternal morbidity, compared to vaginal deliveries. Newborns delivered via cesarean section are at increased risk of respiratory disease and of being delivered before proper time. The author highlights how decisions concerning the need for cesarean delivery seem to be influenced more by social, economic, and physicians’ personal reasons than by medical factors. This is well illustrated by the fact that those women who are at highest risk of pregnancy complications and who would benefit the most from a cesarean section are the least likely to receive it. On the other hand, indications such as previous cesarean, slow or difficult labor or delivery, presentation of the rear of the baby at the uterine cervix and fetal distress, are the main reasons for performing a C-section, even though these conditions have been least clearly associated
with benefits for the fetus and the mother.


The results of this study show that approximately 40% of cesarean sections performed in Ohio have no medical indication that justifies their use and are therefore unnecessary.


The results of this study show that 1 in 4 cesarean sections performed for lack of progression during labor are done in disagreement with professional guidelines, and are therefore inappropriate. Every year, 1 million women deliver by cesarean section in the U.S. In approximately 300,000 cases, the reason for the cesarean section is lack of progress in labor, meaning that the head of the baby is progressing slowly through the birth canal. According to the American College of Obstetricians and Gynecologists’ guidelines, “lack of progress” can be diagnosed only after the cervix is dilated by 3 centimeters in primiparous (first time mothers) and by 4 centimeters in women who had delivered in the past. This study, conducted on 733 women who had an unplanned cesarean section, showed that in 68% of them the reported reason for the C-section was lack of progress in labor. When the researchers reviewed their medical records they found that, counter to published guidelines, 24% of them had undergone C-section before their cervix was dilated enough to justify a diagnosis of slow progress. These findings suggest that every year in the U.S., approximately 75,000 cesarean sections may be performed too early during labor, for unnecessary reasons.

The results of this study show that 30% of cesarean sections performed in an English teaching hospital were unnecessary. There was significant disagreement between physicians as to whether or not to perform a cesarean section. Even more importantly, when physicians were presented at different times with the same information, their opinion as to whether or not to perform a cesarean section was inconsistent in 25% of cases. These data indicate that clinical decisions in obstetrics are often influenced by physicians’ personal reasons rather than by medical factors.


The results of this study show that maternal mortality rates in women delivering by cesarean section are 7 times higher than those of women delivering by vaginal route.


The results of this study show that cesarean section delivery is associated with a 7-fold increased risk of maternal death, compared to vaginal delivery. After the exclusion of women who experienced medical complications before delivery, the risk of maternal death associated with cesarean section was estimated to be 5 times higher than that associated with vaginal delivery.

The results of this study show that cesarean section delivery carries an overall 15% risk of intra-operative maternal complications and a 36% risk of postoperative maternal morbidity. In particular, the risk of intraoperative complications is 7.4% in women who undergo elective cesarean section, and 23% in women who deliver by cesarean section after failure of attempted vaginal delivery. The most common intra-operative complications are ruptured uterus and hemorrhage. The most frequent postoperative complications are fever, hemorrhage, haematoma and urinary tract infections.


The results of this study, conducted on a cohort of 1,335 women who underwent Caesarean section in a Canadian teaching hospital, show that the rate of hospital-acquired infections in women delivered by primary and secondary caesarean section is 42.1% and 46.1%, respectively. Women delivered by primary section had significantly higher incidence of deep wound infections, endometritis and bacteraemia, compared to those delivered by secondary section. Hospital-acquired infections significantly prolonged length of hospital stay and costs of care.


The results of this study show that over 90% of women who deliver by cesarean section develop post-operative morbidity such as wound infection, intrauterine infection, urinary tract infection, urinary catheterization, chest infection, fever, and hemorrhage.


This study investigated some of the possible long-term effects associated with cesarean section
delivery, and focused on the rate of occurrence of ectopic pregnancy and placental complication in a cohort of almost 17,000 women who underwent cesarean section and a similar number of women who delivered by the vaginal route. Women with a history of cesarean section were found to have a 30% increased risk of subsequent ectopic pregnancy (gestation occurring elsewhere than in the uterus, for example in a fallopian tube or in the peritoneal cavity) and a 4-fold increased risk of placental complications (placenta previa and abruptio placentae), compared to those with a history of vaginal delivery.


Episiotomy

The effectiveness of this delivery practice is called into question by two reports, both published in 2000. A report in Obstetrics & Gynecology challenges the very reasons that physicians perform episiotomies. The authors say the practice has no scientific foundation —its assumed benefits have not been confirmed by studies—and that episiotomies should no longer be performed routinely. The second study indicates that episiotomies are associated with a significant increase, rather than decrease, in the risk of anal incontinence in women in the months following delivery.

This review emphasizes that the common obstetrical practice of cutting the tissue between the vagina and the anus (episiotomy) in women at stage 2 of delivery, has no scientific foundation and may, in fact, result in more trauma and suffering for the mother. Doctors perform episiotomy with the belief that this practice reduces the occurrence of pelvic prolapse and urinary incontinency in the mother, and the risk of brain damage in the baby. However, none of these assumptions have been confirmed by scientific studies. On the contrary, research has shown that leaving enough time for the muscles of the pelvic floor to stretch naturally results in lower rates of maternal incontinence. Among the reasons cited in the article for this practice to still be in use are: shorter time of delivery (which is advantageous for the physician), lack of experience with natural slow stretching of the pelvic floor muscles, and an interventionist attitude of the physician. The authors conclude that, based on available evidence, episiotomy should no longer
be routinely performed during delivery.


The results of this study show that episiotomy, the surgical incision of the perineum and vagina performed during delivery to reduce the risk of injury to the pelvic floor, is associated with a 3- to 5.5-fold increased risk of anal incontinence, compared to vaginal delivery. The study, conducted on 626 women followed-up for 6 months after delivery, found that the rate of fecal incontinence was 5.5-fold higher in those who underwent episiotomy, compared to those who did not have such procedure. In addition, 6 months after delivery, women who underwent episiotomy had a 3-fold increased rate of fecal incontinence and a 2-fold increased rate of gas incontinence, compared to women who had spontaneous laceration. These findings demonstrate that episiotomy is associated with a significant increase, rather than reduction, in risk of anal incontinence.


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Women’s Health Risks Associated with Orthodox Medicine - Part III

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