



Cesarean Delivery on Maternal Request (CDMR): Do's and Don'ts

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Abstract

Cesarean section is the most common surgical procedure in the world. Cesarean Section on Maternal Request (CSMR) is one that is performed on pregnant woman without any medical or obstetrics indications and without contraindication to vaginal delivery. CSMR should never be performed before <39 weeks. There is increased incidence of CSMR worldwide, not only for perceived medical benefits but due to social, cultural and lifestyle changes. The validity of consent for CSMR is invalid and the ethical principles surrounding the use are complicated. It is of utmost importance that it does not dent resources of country and deprive care to woman requiring medically individualized care. It is necessary for obstetrician dealing with request for CSMR that they establish reasons for request provide clear unbiased opinions and seek second opinion from a colleague that may help patients to reconsider request and make a more informed decision.

Keywords: Cesarean Section on Maternal Request (CSMR), Obstetrician, Vaginal Delivery

Introduction

Cesarean Delivery on Maternal Request (CDMR) is defined as Cesarean delivery for a singleton pregnancy on maternal request at term in the absence of medical or obstetrical indication. The terminology received adoption by National institute of Health (NIH) state of the science conference 2006 [1]. The earliest literature available for Caesarean section rate was published in 1937 in USA and the rate was at 6%. There has been increase in the rate of Caesarean section. The currently published data suggests that nearly 1/3 rd of all births [2] are by caesarean section. CDMR rates in USA currently account for 11.2% [3] and that for UK 7% [4]. There is paucity of literature pertaining to CDMR as no randomized trials are available. In an interesting study by Al Mufti et al in UK, 31% of female obstetricians in London with an uncomplicated singleton pregnancy at term choose an elective Caesarean section themselves [5]. This reflect change in attitude of obstetricians and patients to extent that 69% of obstetricians comply with desire of CDMR. The American college of gynecology and obstetricians in 2013 published guidelines for Caesarean section on request according to which it should be performed after 39 weeks of gestation and should not be carried out as effective pain control mechanism. The Caesarean section was associated with longer hospital stay, greater chances of neonatal respiratory problems and higher incidence of

hysterectomies and placenta accreta in subsequent pregnancies. The British guidelines by National institute of clinical excellence elaborates on advantages of C Section like abdominal – perineal pain during childbirth, vaginal injury, early post partum hemorrhage and shock [6]. However, Caesarean section was associated with longer hospital stay in comparison to vaginal route. In a developing country with limited resources it is of utmost importance that the resources are used judiciously. In taking decision for CDMR the guiding principle for obstetricians are autonomy, justice, non-maleficance and beneficence. Autonomy is respect to patient's wishes and non maleficance means no harm. It is important for obstetricians that they weigh pros and cones with the patient before deciding to go ahead with Caesarean section. CSMR satisfies only single principle i.e. autonomy, in the absence of evidence that Caesarean is beneficial to patient. This might devaluate clinical judgement. In developing nations providing CSMR might devaluate clinical judgement in absence of beneficial effect of Caesarean [7]. In developing nations CSMR has to be assessed in terms of individual rights verse right of society. Each one of us owe a duty towards society so does the obstetricians. Medical professionals are bound by ethical duty towards society for allocation of health care resources to those procedures and treatment which have clear evidence of net benefit to health [8]. Providing CSMR violates these

principles of justice. Ideally the physician should assist patient by explaining the medical plans and linking them with patient's values i.e. interpretative relationship with repeated consultation helping the woman to take control of her decisions.

Why Caesarean section?

Mother's request for Caesarean section can be broadly classified into three categories:

Childbirth perception: Woman's role in society has changed over past few decades, with greater autonomy, career orientation; late marriage coupled with shared experience of suffering of labor makes many woman to decide in favor of cesarean over vaginal delivery. Antenatal education plays key role in eliminating unrealistic expectations and birth plans. The prospect of labor and subsequent delivery can be frightening to nulliparous woman. The morbid fear of labor and childbirth termed as tokophobia [9] may sometimes lead to CSMR. Such woman has low socialization score and higher levels of anxiety with more likelihood of depression, all these are risk factors for post-traumatic stress disorder (PTSD) [10]. Preventive measures for PTSD may be primary or secondary. Primary ones include informing pregnant woman in realistic way for labor and birth [11]. Secondary prevention is aimed at better postnatal care and developing family and friends as support mechanisms. It is essential that health care professionals adopt these preventive strategies for improving childbirth experience and minimize CSMR. Woman who have previous traumatic labor experience like forceps delivery with still birth, emergency cesarean section with prolonged labor also opt for CSMR.

Myths: Childbirth damaging pelvic floor is commonly cited as reason for CSMR [12], however the literature studies are controversial as it is the pregnancy rather than labor or delivery been responsible for it [13]. The most important factor is individual variability [14,15]. CSMR provides woman luxury to schedule their childbirth and plan the maternity leaves as per convenience. Religious beliefs, astrology dictates the timing of cesarean section and mothers electively adopting CSMR [16]. These are widespread in woman of higher socioeconomic class who are not willing to accept hours of uncertainty about vaginal delivery. Woman who are desirous of bilateral tubal ligation or those who conceive with artificial insemination techniques also go for cesarean section and is generally accepted by obstetrician.

Complications of vaginal delivery: Anal incontinence affects 8-19% of woman after vaginal delivery [17]. Similarly, 4-7% with fecal incontinence and 1% with incontinence of flatus after operative vaginal delivery. Anal incontinence after cesarean section has mixed reviews in literature 18 varying between 1-3% 20. The current knowledge is insufficient to suggest that cesarean offers advantage over vaginal delivery for preventing anal incontinence. Urinary incontinence varies from 21-32% from 9 weeks to 3 months after vaginal delivery [18]. If cesarean section was performed after onset of labor the incidence of urinary incontinence was high. Prospective randomized trial (The term breech trial) showed that there was no difference of symptoms after 2 years of post cesarean or vaginal delivery [19]. The national institute of health consensus

statement [20] concluded that there was weak quality evidence that cesarean section prevented urinary incontinence. There was insufficient evidence to recommend cesarean section for prevention of urinary incontinence. In terms of pelvic organ prolapsed, vaginal birth increased incidence of prolapse [21]. The breech trial did not find any significant difference in sexual function 6 months after delivery. The possible mechanisms for sexual dysfunction after delivery include dyspareunia due to perineal lacerations, pudendal neuropathy and general health of mother.

Cesarean Ill Effects

Vaginal delivery is the safest mode of delivery in an uncomplicated low risk patient [22]. Cesarean section is associated with febrile morbidity, sepsis, wound infection, operative injury, blood loss, predisposition to placenta previa and uterine rupture in subsequent pregnancies. Many times hysterectomies are done to prevent hemorrhage after cesarean section, more so in developing countries [23].

Another serious ill effect of cesarean section is use of blood transfusion as blood loss following normal cesarean delivery is approximately 1000 ml in comparison to vaginal delivery which is 500 ml [24]. The figures are of significance in population where there is high prevalence of anemia where maternal iron supplementation is rampant.

Fetal considerations

Respiratory distress syndrome and transient tachypnoea in the new born are most common side effects after cesarean section [25]. Another problem is that elective cesarean section are based on EDD (Expected date of delivery) and when EDD is uncertain, the cesarean section may lead to increased neonatal respiratory complications. Elective cesarean section before 39 weeks should be given steroids to prevent respiratory complications.

Ethical issue

The core foundation of ethical relationship between the obstetrician and patient requires exchange of accurate, scientific, unbiased information through effective communication thereby making a balance between patient's autonomy and duty of physician together with simultaneously upholding principles of beneficence, non-maleficence and justice [26]. The patient counseling should incorporate woman values, cultural context concerns, reproductive plans, risk factors and psychological concerns [22]. The obstetrician has autonomy and beneficence-based obligation towards mother and mother & obstetrician both have responsibility towards fetus. Therefore, obstetrician is duty bound to ensure that his/ her actions are ethical [27]. Just as no surgeon would perform total appendectomy in a patient with no appendix pathology in spite of appendix being vestigial organ, similarly obstetrician would not opt for hysterectomy in a young female with completed family size as uterine cervical cancer prophylaxis.

Conclusion

The best form of delivery is the safe one. Every pregnant woman should be given choice for the child's mode of delivery as per the

principle of autonomy granting her respect. The obstetrician should listen to patient, her concerns and elaborate on the reasons that prompted woman to seek CSMR. Thereafter obstetrician should provide clear, scientific and unbiased information to the patient emphasizing on risk and benefits of elective cesarean section. Pros and cons should be discussed with patient and those who still want it should be referred to a second obstetrician for making a better-informed consent. Cases where obstetrician feels that cesarean is justified on moral, ethical and medical grounds should go ahead.

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