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The number of Cesarean sections performed in the United States has more than quadrupled since 1970, making C-sections the most frequently performed surgical procedure. We investigate why it's on the rise and offer strategies for minimizing the associated risks.

# C-Sections

BY ▶ JEANNE FAULKNER

Today most moms can say they either know someone who has had a C-section or have had one themselves. It's no wonder, because C-section rates are higher than ever—the procedure is performed in nearly 30 percent of all deliveries, according to the National Center for Health Statistics. More than one million babies are born by C-section annually. At the same time, C-sections have become a topic of increasing controversy. Experts debate whether women should choose C-sections when no health risks apply, whether women can deliver vaginally after a previous C-section, and whether vaginal delivery is even a reasonable option in an industry struggling with insurance and litigation.

Most recently, a pair of studies raised some unsettling questions about this common procedure. While C-sections have been favored by ob/gyns who want to minimize childbirth risks, the surgery may pose some unexpected dangers. Read on to learn the facts about C-section rates, the causes, and the consequences.

### The Trouble with C-Sections

Although most C-sections result in healthy mothers and babies, there is always the risk of complications. A study published in *Obstetrics & Gynecology* last fall found an association between C-sections and a three-fold higher risk of maternal death from blood clots, complications from anesthesia, and infection, as compared with vaginal deliveries. Another study, recently published in *Birth: Issues in Perinatal Care*, reported almost three times

the risk of neonatal death (babies less than 28 days old) in low-risk C-sections compared with vaginal births.

"Even with no complications in pregnancy, labor, or delivery, we found greater incidence of mortality," says Michael Malloy, MD, a neonatologist at The University of Texas Medical Branch, who co-authored the latter study. "We're concerned and need further clarifying research to determine if infants are truly at higher risk for mortality if born by C-section."

While many women have perfectly healthy deliveries, C-sections can result in other less-than-ideal postpartum outcomes. In the 39th week of her first pregnancy, Jessica Volechok, 32 of Lomita, CA, was tired and uncomfortable, so she was delighted when her doctor suggested induction. But after two days on Pitocin (a labor-inducing drug) and epidural

anesthesia, her labor stalled at five centimeters and she agreed to a C-section. "I was disappointed but I just wanted to meet my son."

Although baby Jackson arrived safely, when the nurses finally brought him to her hours later, she felt too "doped up" to hold him, let alone breastfeed. Worse yet, Jessica developed chills and fever from a surgical infection initially treated with the wrong antibiotics. "I was so busy fighting infection I never produced milk. We spent \$1,000 that first year on formula."

### Why Rates Are Up

The reasons for the rise are multiple and include complex medical, legal, and social issues. Women are waiting longer to have their first child, and mothers older than 35 have greater medical risks that

can lead to C-sections. Infertility treatments result in more multiples (twins, triplets, and so on), which are also more commonly delivered surgically. Increasing rates of obesity and diabetes have led to bigger babies and more difficult deliveries. And vaginal births after C-section, known as VBAC, are controversial and less common, resulting in yet more C-sections (see "The VBAC Quandary," p 85). Other contributing factors include:

**Cultural Changes** As a society we've moved further away from "natural" labor. Much of early labor can safely take place at home, but many first-time moms rush to the hospital at the first signs of labor, creating an artificial timeline. Once a woman checks in, the clock starts ticking. If labor isn't progressing, an ob/gyn may insist on interventions—such as rupturing membranes and Pitocin—to move the



As a society, we've moved further away from 'natural' labor.

birth along. "Once you start intervening it's a snowball rolling down the hill," says Lisa Betina Uncles, a certified nurse midwife at Family Health and Birth Center in Washington, DC. "One intervention begets another, and eventually a C-section is just one more."

**Technology** Another factor is the now-standard practice of using fetal heart monitors in labor/delivery rooms. Heart monitors attached to the mother's abdomen are used to interpret baby's wellbeing, and if the monitor raises any red flags, there will be pressure to deliver via C-section. "People look at monitor strips as videos of what's going on inside, but babies' heart rates fluctuate in normal deliveries," Uncles says. "We rush women to C-section because the heart tones are crashing, [yet] most [babies] come out with excellent APGAR scores." Studies suggest that fetal heart monitoring is actually an inaccurate indicator of hypoxia (decreased oxygen to the brain and tissues) most of the time. That means most babies delivered by C-section because of "scary fetal heart tones" are born healthy.

**Lawsuits** One of the reasons ob/gyns resort to fetal heart monitoring, however, is to avoid adverse birth outcomes that can lead to malpractice suits, which are particularly costly in obstetrics. "Hardly anybody sues for a C-section with a good outcome," says James Stempel, M.D., a Portland, OR, ob/gyn who has delivered babies for 26 years. "The lawsuit comes when you didn't do a C-section. Doctors can't afford not to do one if they think there's a problem."

**Postpartum Concerns** Some obstetricians do C-sections to save potential damage to the perineum (the area between the vagina and rectum). There's conflicting information about a vaginal delivery's affect on the pelvic floor, which are the muscles that support the bladder and rectum. Some studies suggest postpartum urinary and fecal incontinence are caused by prolonged pushing and severe vaginal lacerations. "In complicated situations when it's a choice of forceps causing a huge laceration or the operating room, I'll do the C-section every time," Stempel admits. "Nobody wants to wear Depends or need surgical repair later."

But doctors' opinions on this matter differ. "We don't know if C-sections truly protect the pelvic floor," says Mary D'Alton, M.D., chair of the ob/gyn department at Columbia University's College of Physicians and Surgeons in New York



City. "Incontinence rates appear somewhat greater the first few years following a serious vaginal laceration, but after that there's no difference from women who've never had babies."

### Scheduled Childbirths

For medical necessity and convenience, labor is frequently induced. Failed inductions, however, account for a big chunk of first-time C-sections. To activate labor, cervical ripening agents, Pitocin, and artificially rupturing membranes may be very effective, but they may not ultimately work if mom and baby aren't physiologically ready. A cervix that is not ripe and ready might not dilate. Rupturing membranes when baby's head isn't properly aligned in the pelvis can lead to a difficult trip down the birth canal.

News accounts have recently focused attention on scheduled C-sections, aka Cesarean Deliveries on Maternal Request (CDMR). Women who opt for CDMRs may be motivated by such factors as convenience—set the date, buy grandma the plane ticket, and so on—as well as fear of pain or complications. "Women are afraid of childbirth," says Kimberly Gregory, M.D., ob/gyn and vice chair of Women's Healthcare Quality and Performance Improvement at Cedars-Sinai Health Center in Los Angeles. "Our culture doesn't support birth being a natural experience, but education, support, and pain management can overcome that. C-section is usually safe but there are physiologic benefits mom and baby miss. We've become more lenient with our criteria for doing C-sections and getting away from the physiologic advantages of labor."

CDMRs represent less than four percent of all C-sections and the jury is out on their safety. A National Institutes of Health (NIH) panel announced in March 2006 they were unable to determine if the risks of CDMR outweigh the benefits, leaving the decision to the discretion of obstetricians and their patients.

### What's Best for Mom and Baby

In uncomplicated pregnancies, there's good reason to deliver vaginally. As babies are pushed through the birth canal, amniotic fluid is squeezed out of their lungs and airways. C-section babies don't have that advantage. "Babies breathe better, have better immune systems, and less infections and colic when they go through the birth canal and are colonized with normal flora," Dr. Gregory explains.

Yet oftentimes a C-section is the only way to go, and there's no argument that they save lives. Dr. D'Alton says, "We've made extraordinary advances in anesthesia, antibiotics, and surgical techniques and can minimize the negative impact of surgery."

Michelle Anderson, 32, of Park City, UT, had a C-section after developing preeclampsia, a hypertensive disorder that can occur during pregnancy. Her son Tyler was breech, tangled in his umbilical cord, and not getting enough blood through the placenta. A scheduled C-section averted the possibility of Tyler getting stuck and stressed during a vaginal birth.

So what's a pregnant woman to do?

- Take good care of yourself to reduce the risk of complications or interventions. Healthy women tend to have healthy babies. To stay healthy throughout pregnancy,

cy, get early and consistent prenatal care, watch your weight, and don't smoke or use drugs. Exercise will help keep excess weight off and get you ready for labor, which for many women (especially first-timers) is a marathon, not a sprint.

- Don't be quick to jump into an induction—if you and your baby are healthy, hang in there and let Mother Nature set the birth date. A recently published study of 41,000 births to first-time mothers found that more than half of the C-sections studied were due to inducing labor when it wasn't medically necessary and admitting women to hospitals too early.
- Consider delaying an epidural until your labor is well established and progressing. Although studies don't indicate a link between epidurals and C-sections, an epidural given too early may slow labor progress and lead to further intervention.
- If your doctor or midwife suggests interventions, ask about all of the pros and cons. And bring an experienced advocate, such as doula or your mom, to support you during labor.
- Most importantly, talk with your doctor or midwife throughout pregnancy about your hopes and expectations. Labor is a vulnerable time—you don't want a struggle of wills at that stage. Whether you are opposed to C-section or not, you need to know your care provider & your advocate and will make decisions in the best interest of you and your child. ▶

*Jeanne Faulkner is a freelance writer, and a labor and delivery nurse in Portland, OR.*

## The VBAC Quandary

Another point of debate with C-sections is whether they prevent women from delivering future babies vaginally. A C-section can adversely affect subsequent pregnancies if there are complications with the placenta and incisional scar. Placental complications are infrequent but potentially serious. Another rare but severe complication is a uterine rupture during a VBAC labor. In those instances—less than one percent of VBAC—the previous incisional scar breaks, causing massive hemorrhage and risk of maternal and neonatal death. Ob/gyns believe the risks are minimized with repeat C-sections.

Despite these concerns, 60 to 80 percent of women are good candidates for safe VBAC, according to the American College of Obstetricians and Gynecologists (ACOG). Yet ACOG mandates that VBAC only take place in hospitals with immediate, 24-hour access to anesthesia and obstetricians ready to perform emergency C-section. That's no problem for large teaching hospitals filled with qualified staff, but many smaller hospitals can't meet those standards. Worse still, some insurance providers won't cover hospitals that perform VBAC. These obstacles effectively restrict access to VBAC for the vast majority of pregnant women.

Midwives may provide a better chance for VBAC because they typically spend more time with their patients, employ fewer interventions, and have lower C-section rates. That

is, if the hospital and back-up obstetrician is able to meet ACOG standards. Melissa Avery, vice president of the American College of Nurse-Midwives, says it takes a collaborative effort. "Obstetricians are in a difficult position. My patients are normally healthy and have no trouble delivering vaginally, but when something goes wrong I refer to my OB colleagues."

The current national VBAC rate is 11 to 15 percent. However, the ACOG has the goal of achieving a 65 percent VBAC rate by 2010, which puts doctors between a rock and a hard place. Dr. Gregory says, "We'll have to get creative as an industry to make VBACs attainable—maybe change how maternity units are staffed."

Sara Dunton, 32 of Alexandria, VA, had her first baby by C-section when she developed HELLP syndrome, a severe complication of preeclampsia. But with her second pregnancy, she was frustrated when planning for VBAC became a struggle. "I thought my doctor supported VBAC, but at 35 weeks [he] totally changed his tune, strongly discouraging VBAC with exaggerated statistics, though this pregnancy didn't put me at high risk." Dunton switched physicians and successfully delivered her second daughter vaginally. "It was a hassle, but worth it. I want three or four children, but not that many C-sections. I resent feeling coerced into unnecessary surgery."

## C-Sections Then and Now

The United States' C-section rate has steadily climbed since 1970, with an accompanying reduction in neonatal (less than 28 days) deaths, until recently.

Year	Total C-sections	C-sections as percentage of all births	Vaginal births as percentage of all births	VBAC rate per 100	Neonatal deaths (per 1,000 live births)
1970	205,000	5.5%	94.5%	2.2%	15.1
1980	596,000	16.5%	83.5%	3.4%	8.5
1990	914,096	22.7%	77.3%	19.9%	5.8
1995	806,722	20.8%	79.2%	27.5%	4.9
2000	923,991	22.9%	77.1%	20.6%	4.6
2001	978,411	24.4%	75.6%	16.4%	4.5
2002	1,043,846	26.1%	73.9%	12.6%	4.6
2003	1,119,388	27.5%	72.5%	10.6%	4.6
2004	1,190,210	29.1%	70.9%	9.2%	4.7

Sources: C-section rates: American College of Obstetricians and Gynecologists. Neonatal mortality rates: Centers for Disease Control and Prevention, Department of Health & Human Services