REVIEW ARTICLE

# Caesarean section on maternal request: An obstetrician's dilemma

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**ABSTRACT**

Now a day's mother requesting caesarean delivery is very much common in obstetrical practice. They mostly belief that elective caesarean is safer than vaginal delivery. Fear and anxiety of labour pain, fear of pelvic floor damage and the belief that caesarean section can prevent prolapse and sexual dysfunction are some of the reasons that pregnant mothers approach the obstetrician for elective caesarean section. It should be considered keeping in view the mother's perspective and also by providing clear, unbiased information of evidence based guidelines.

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Cesarean delivery on maternal request (CDMR) is not a well recognized clinical entity and it is a debatable issue in recent times. It is defined as a cesarean delivery for a singleton pregnancy on maternal request at term in the absence of medical or obstetrical indication. This is a term adopted and endorsed by National Institutes of Health (NIH) state-of-the-science conference 2006 [1].

There is no randomized trial available on cesarean delivery for non medical reason. Currently available evidence is based on indirect analyses which compare elective cesarean section with a combination of vaginal deliveries and emergency caesarean deliveries. It is estimated that 2.5% of all deliveries in USA are due to maternal request. A recent national audit in the United Kingdom (UK) revealed that 7% of all elective caesarean sections were performed for this reason [2]. It is interesting to know that 31% of female obstetricians in London with an uncomplicated singleton pregnancy at term choose an elective caesarean section for themselves [3]. The controversy and debate surrounding CDMR reflects the changing attitude of both obstetrician and patients. When a woman comes with such a request it is seen that 69% of obstetrician comply with such a wish.

## Reasons for choosing caesarean section

Although the preference to elective cesarean section is experienced in both the developing and the developed world, the reasons may vary from society to society. The willingness of a planned delivery and psychological fear of labor pain is seems to be the main reason for women choosing caesarean section. Protection of the pelvic floor is a frequently cited reason for requesting a caesarean [3]. They invariably believe that childbirth inevitably damages the pelvic floor,

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and that caesarean sections can effectively prevent subsequent incontinence, prolapse and sexual dysfunction. Some women mistakenly believe that a C-section will better preserve their pre-baby figure.

Fear of childbirth is particularly common to nulliparous women who have had no prior experience. This intense psychological fear of childbirth is termed as tocophobia [4]. This fear expressed as fear of pelvic floor injury, of requiring emergency caesarean section, of losing the baby and of being left alone in labour. It is estimated that 6-10% of women suffer from tocophobia [5].

Secondary tocophobia is another condition that may arise as a result of a previous traumatic delivery. Most of the women who had previous unsuccessful vaginal delivery resulting in emergency caesarean section usually do not prefer vaginal delivery for the next time. Many women who have had instrumental delivery would prefer to have caesarean section if they needed a second instrumental delivery [6]. It is not uncommon that many women request to have caesarean section because they want bilateral tubectomy at the same time.

**Maternal risks of caesarean section**

Safety data on elective caesarean sections on request is not available and it is important to acknowledge that it is not entirely risk-free. Febrile morbidity and sepsis, wound infection, blood loss, operative injury to bladder and ureter, anesthesia-related complications are uncommon, but always remain a potential threat for mother and baby. Pulmonary embolism remains a leading cause of maternal mortality which is far more likely to occur following a caesarean section. In the developing world the incidences of morbidity is likely to be higher than the rest of the world, probably due to poor antisepsis as a result of lack of hospital supplies, quality control, and in some cases, lack of infection prevention guidelines.

A report on all maternal deaths in England, Scotland and Wales, suggest that the mortality from an elective caesarean section is three times higher than that in a vaginal birth [7]. The prevalence of hysterectomy after caesarean section is high and there is also evidence of decreased fecundity, increased risk of ectopic pregnancies and placenta praevia. Uterine scar always increases a chance of uterine rupture in subsequent pregnancies. In addition, blood loss for a healthy woman after a vaginal delivery is estimated to be 500 ml in comparison to 1,000 ml for a cesarean delivery, thus increasing the possible need for a blood transfusion during the postpartum period [8].

**Neonatal consideration**

Cesarean delivery without labor is associated with an increased risk of neonatal respiratory complications including transient tachypnoea of the newborn which in turn increases admission, oxygen therapy and ventilatory support [9]. The incidence of respiratory distress is much higher than in vaginal delivery (0.036 Vs 0.0053) [10]. The complications are higher if caesarean sections are performed before 39 weeks of gestation. Babies born by elective Cesarean section before the 39th week of pregnancy have a three- to fourfold higher risk of breathing trouble than babies whose mothers have a normal vaginal delivery.

In addition, elective caesarean sections are scheduled based on the expected date of delivery (EDD).When the EDD is uncertain, a proportion of caesarean sections may inadvertently be performed prematurely, resulting in a further increase in neonatal respiratory complications. Planned vaginal delivery has again fewer incidences of Neonatal Intensive Care Unit admissions, oxygen resuscitation and jaundice.

With the evidence that antenatal steroids reduce the incidence of respiratory distress in the preterm <34 weeks gestation by 50%, literatures suggests that antenatal corticosteroids, in the dose recommended for preterm deliveries could improve the outcome of term babies delivered by elective caesarean section. [11,12]. Five studies lasting between three and 20 years, with more than 1500 patients, have shown no adverse effects of a single course of antenatal corticosteroids [13].

In the Western countries with the increase in caesarean section rate there has been a concurrent increase in the prevalence of asthma

and atopic disease. The prevalence of asthma in childhood in the UK has increased from 6% in 1973 to 27% in 2003 [14].

**Obstetrician's decision**

A cesarean can be a life-saving operation, and some babies would not be born vaginally under any circumstances; however, it is still a major surgery. Women have a legal right to know the risks associated with their treatment and the right to accept or refuse it. The physician should do proper counseling of the patient, to give her an opportunity to have an informed consent. Patients have the right to decline care but not to demand treatment that the physician holds to be unnecessarily risky. The FIGO Committee for the Ethical Aspects of Human Reproduction has argued that it is unethical to perform a caesarean section without a medical indication because of inadequate evidence to support a net benefit [15].

For most of the developing world, access to life-saving emergency cesarean section is not readily available to save the lives of women and those of their babies. It can be argued that the lack of adequate health care resources in the developing world which make even life saving emergency cesarean section not available to the majority of women, the safety issues surrounding the procedures, would favor that elective cesarean section on demand a potentially risky procedure.

The first step for the obstetrician is to listen to the patient and why and what source of information made her to request for the caesarean section. Once the reasons for the request have been established, the obstetrician should give clear and unbiased information about the validity of the reasons provided by the woman to support her request and the established benefits and disadvantages of an elective caesarean section. Every effort should be made to provide only information that has been scientifically proven to be true.

Ideally, discussions about the possible modes of delivery ought to be discussed much earlier in the pregnancy. Every pregnant woman wants to have a vaginal delivery with a very short labour, no or little requirement for pain relief and an intact perineum. If antenatal education is not complete then women can have unrealistic expectations and birth plans. It is very important that antenatal education emphasises the lack of control over events and that although vaginal delivery is most likely to happen, interventions can be necessary for medical reasons. Information about labour analgesia and its benefits should be discussed with the antenatal mothers.

**Conclusion**

There has been an increase in the number of women requesting caesarean section for no medical reason. The reasons for this are not only for perceived medical benefit, but also due to social, cultural and psychological factors. Despite dramatic improvements in the safety of anesthesia and surgery, mortality and morbidity are greater for elective caesarean sections compared to vaginal deliveries. The legal and ethical issues of request caesarean sections are complex. In dealing with requests for caesarean sections, obstetricians should establish the reasons for the request and provide clear, unbiased information based on the best available evidence. Individualized modifications to the management of labour may allow some women to have vaginal deliveries.

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