Article for March 7, 2010 of Today's Health for the Empowered Woman

CESAREAN BIRTH

One can hardly read any article on women's health these days without coming across a reference to Cesarean Section: "not cost effective"; "too many done"; "done so doctor can go golfing"; "sue the doctor because it wasn't done soon enough and the baby is damaged", etc. etc. This article will outline the history of cesarean birth, detail why it may be needed, what it involves and what happens after your baby is born.

The great majority of people hold to the myth that the term Cesarean Section (CS from now on) was coined because Julius Caesar was born this way. Actually he wrote the "Lex Cesarea" meaning Caesar's Law which mandated that if a pregnant woman were to die before giving birth the baby would be removed from her in an attempt to save the baby's life. So by definition it was a universally fatal procedure. He could not have been born this way as there are historical accounts of his mother Portia. As history progressed, attempts to save babies by CS were done on live mothers but again, they were fatal to the mother as no one thought or knew how to close the wound. With advent of suture material such as flax and cotton, survival of this procedure began and when modern anesthesia and antibiotics came along it became a safe procedure when deemed necessary. It is still more risky than vaginal birth but more about that later.

So why perform a CS at all? There are times when it is not possible for a baby to be born through the mother's vagina. A CS is a surgical procedure that enables the birth of a baby through a surgical incision into the mother's abdomen and uterus done under general or spinal anesthesia. Today every attempt is made to make the experience as meaningful as a traditional birth. If the mother agrees to a spinal anesthetic and she is awake and pain free during the procedure, the father can be with her in the operating room. She can see and touch her baby before it is brought to the nursery and be reassured that everything is ok.

There are many reasons why a CS may be performed but doctor convenience is definitely not one of them. Our doctors sleep at the hospital every night so they will not be going home sooner if they deliver the baby sooner. There is also more time spent on rounds with a surgical patient, more risk, more paperwork, etc. Reimbursement is not an issue either as the cost of a vaginal or CS birth is roughly the same. Some CS's are scheduled in advance for known conditions such as a baby too large to pass through the birth canal, a very small or sick fetus that would be made sicker through a conventional birth; a mother with a known small pelvis or previous history of a very difficult birth; mother with certain medical conditions that would be made worse through the rigors of labor (for example, heart disease, vascular abnormalities of the brain, etc.), multiple pregnancy, and of course previous CS. It was always the dictum "once a cesarean, always a cesarean" because there was fear that a previously surgically opened uterus could rupture during a subsequent labor with the certain death of the fetus and possible death of the mother.

Patient groups clamored for attempt of labor if they had had a previous CS and a protocol for "Vaginal Birth After Cesarean" (VBAC) was developed. A very long and detailed informed consent is given for women who are candidates however; this is falling into disfavor as the very real risks become widely known.

70% of women with multiple pregnancies have CS because of positioning in the uterus that makes vaginal birth extremely difficult if not impossible and I know of no medical center that would entertain the thought of a vaginal birth for triplets or greater for the same reason. Today most breech presentations (baby coming out buttocks or feet first), are delivered by CS because the head is the largest part of the baby. If, during an attempt at vaginal birth for a breech, the baby's body is delivered but the head becomes stuck it would be an obstetrical disaster. The most common reason for CS is "failure to progress in labor". Roughly one third of CS are done for this reason. In general, the cervix has not opened enough for the baby to pass through despite sedation and labor enhancing medications. There are times when the baby's heart rate will indicate a problem caused by the umbilical cord being pinched causing reduced flow to the baby's heart. This usually requires an emergency CS. Toxemia of pregnancy characterized by high blood pressure, protein in the urine, swelling, and blood abnormalities frequently requires termination of the pregnancy expeditiously to treat the mom, so CS is performed. Lastly, placental problems might require CS. Placenta previa is a condition in which the placenta partially or entirely covers the cervical opening so that the baby cannot pass through and placental abruption is a condition in which the placenta separates before the delivery with the potential for life threatening bleeding. Both these conditions warrant CS.

When the decision is made for CS a medication to reduce stomach acid will given, antibiotics will be administrated, the abdomen washed with surgical prep soap and catheter inserted into the bladder so that the bladder will not be in the way during the operation with attendant risk. If the operation is an emergency for fetal distress or severe bleeding a general anesthetic will be used because of the faster prep time. If not, a spinal anesthetic or epidural block will be encouraged so that mom can be awake, father can attend, less risk of lung problems. At the time of operation when the patient is fully asleep or, in the case of a spinal, tested so that she is feeling no discomfort, a transverse (bikini cut) or midline incision is made and carried down to the uterus. The uterus is opened, the baby delivered and presented to the awaiting pediatric team for evaluation and support and then to the parents. The surgeon will then close all the layers that he had opened. Roughly three minutes to get the baby out and twenty to close. All stitches dissolve and the skin will be closed with either staples or stitches under the skin that cannot be seen.

There are many women who are afraid of labor and consider a CS the easy way out. It is not. It must be remembered that this is a major operation that carries risks that usually can be easily treated: the uterus, nearby pelvic organs or skin incision can get infected, blood loss that may require a transfusion, blood clots to lungs, bowel or bladder injury, anesthesia reactions.

After delivery most women can hold their baby in the operating room and as soon as they return from the recovery room. Breast feeding can be initiated once the mom is awake and ready. The catheter from the bladder is removed within twelve hours as well as the i.v. tubing. Pain medications will be prescribed. Usual hospital stay is 2-4 days depending upon how long it takes for the woman's body to recover. At home special care is needed to avoid strenuous activities, lifting, stair climbing, driving. As with a vaginal delivery sex should be avoided for six weeks to prevent infection.

In summary, there are many reasons why a CS may be needed for delivery. Some centers offer CS classes. Above all, information is empowerment and a thorough discussion with your provider about pros and cons and risks and benefits is the best course.