

The Evidence-Based C-Section and the Risks Involved in the Exaggeration of its Use

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As most abdominal operations have endoscopic alternatives, caesarean section will remain the only abdominal operation in the future. Therefore, it's of utmost importance to constantly evaluate the various steps for his or her necessity and for his or her optimal way of performance. The modified Joel-Cohen method leads to a shorter incision to delivery time, lower rate of febrile morbidity compared to the normal Pfannenstiel incision. The use of sharp instruments for opening peritoneum as it will be proved to be safer, and exteriorization of the uterus makes stitching easier and avoids unnecessary bleeding. Suturing the uterus with one layer only leads to stronger scars and reduced pain. Leaving both peritoneum layers open reduces adhesions. The fascia being sutured continuously with first knot underneath the fascia prevents irritation in the sub-cutis and by a right-handed surgeon, from the right to the left, proved to be ergonomic. Since the introduction of this modified and simplified method, it's been evaluated in dozens of peer-reviewed publications from different countries. Without exception, all showed various advantages of this method: shorter operation time, shorter hospitalization, quicker mobilization, less blood loss, lower rate of febrile morbidity, lower costs, and less need for painkillers. Only 10 instruments and three sutures are needed, which simplifies the workload of nurses. In order to standardize this operation, it is important to use constantly the same needles and instruments. Big needle is important for the uterus, as fewer steps are done and thus less foreign body reaction. This operation is suggested as universal routine method for caesarean delivery and its principles should apply to all or any surgical disciplines. Unfortunately, the speed of caesarean delivery is rising constantly round the world. As evolution continues, it might be influenced by this high rate. In this presentation, the logic of the necessity to limit the numbers of caesarean delivery supported anthropological studies are going to be presented.

Rates of caesarean delivery still rise worldwide, with recent (2016) reported rates of 24.5% in Western Europe, 32% in North America, and 41% in South America. In the presence of maternal or fetal complications, caesarean delivery can effectively reduce maternal and perinatal mortality and morbidity; however, an increasing proportion of babies are delivered by caesarean when there is no medical or obstetric indication. The short-term adverse associations of caesarean delivery for the mother, like infection, haemorrhage, visceral injury, and venous thromboembolism, are minimized to the purpose that caesarean delivery is considered as safe as vaginal delivery in high-income countries, though in low- and middle-income countries, there is an increased risk of adverse short-term maternal outcomes even with caesarean delivery without medical indication. This notwithstanding, the long-term risks and benefits of caesarean delivery for mother, baby, and subsequent pregnancies are less frequently discussed with women, and there are few randomized controlled trials (RCTs) addressing the issue. Systematic reviews of observational studies investigating the longer-term associations of caesarean delivery provide conflicting results on risks and benefits for mother and baby.

Maternal preferences are an important influence on decisions about mode of delivery. At present, evidence of longer-term complications of caesarean delivery has not been adequately synthesized to permit fully informed

decisions about mode of delivery to be made. The aim of this systematic review and meta-analysis is to summarize the evidence about long-term risks and benefits of caesarean delivery for ladies, children, and therefore the associations with future pregnancies.

Prior to analysis, we made the subsequent changes to our methods from the published protocol. We clarified that the definition of 'prospective cohort study' included studies if data had been collected prospectively, albeit analysis was retrospective. We changed the threshold of heterogeneity that we would use random effects meta-analysis from chi-squared test p-value 40%. We added the RoBANS tool for the assessment of bias and study quality to the use of the SIGN checklist. In addition, at the info extraction stage, we made a choice to report both 'small for gestational age' and 'low birth weight' as secondary subsequent pregnancy outcomes in our analysis instead of 'fetal growth restriction' as laid out in our protocol.

Some caesarean deliveries are planned and scheduled, while others are performed as a result of complication that occurs during labour. There are several conditions in which caesarean delivery is more likely to occur. These include:

- Fetal distress, indicated by abnormal fetal heart rate
- Abnormal position of the fetus breech presentation (breech or transverse positioning)
- Labour that fails to progress
- Size of a baby is too large to be delivered vaginally

Previous history of caesarean delivery Initially, clinicians were concerned about the scar from the previous birth rupturing. However, growing evidence is supporting safe childbirth after caesarean (VBAC)

The same study mentioned previously by Karakaya and colleagues also included transcutaneous electrical nerve stimulation (TENS). The TENS pads were placed on either side of the incision and it was set to the following parameters: frequency of 120 Hz, pulse width of 60 us, and intensity evoking a strong tingling sensation for 30 minutes. The researchers found that pain and difficulty performing functional activities decreased significantly as measured by visual analogue scales at rest and through movement. This study supports other research that has indicated TENS to be effective in decreasing post-caesarean incisional pain. A meta-analysis calculated the mean formation rate of adhesions to be 41% amongst women undergoing caesarean delivery procedures. and postoperative adhesions have been found to be a culprit in chronic pain. Nonsurgical management has included various soft tissue interventions. In a pilot study, Comesana and colleagues performed myofascial induction therapy sessions on 10 women with caesarean section scars older than 1.5 years. Results were similar, therein they showed improved structure of the scar and improved function and quality of life as measured by ultrasound, Schober's Test, and therefore the 36-Item Short Form Survey A randomized controlled trial was done more recently by Wasserman and colleagues. Participants were split into 2 groups who received 4

treatments. Group 1 received superficial massage and scar rolling; Group 2 received the same treatment in formation.