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| [**Table of**](http://docs.google.com/scripts/om.dll/serveefb6.html?action=searchDB&searchDBfor=iss&id=jqo0103615)[**Contents**](http://docs.google.com/scripts/om.dll/serveefb6.html?action=searchDB&searchDBfor=iss&id=jqo0103615) | [**Drug**](http://docs.google.com/scripts/om.dll/serve07d7.html?action=searchDB&searchDBfor=art&artType=full&id=aqo010361504&special=genrx&target=body)[**Links**](http://docs.google.com/scripts/om.dll/serve07d7.html?action=searchDB&searchDBfor=art&artType=full&id=aqo010361504&special=genrx&target=body) | [**<<**](http://www.eobgynnews.com/scripts/om.dll/serve?action=searchDB&searchDBfor=art&artType=full&id=aqo010361503&nav=full)[**Article**](http://www.eobgynnews.com/scripts/om.dll/serve?action=searchDB&searchDBfor=art&artType=full&id=aqo010361503&nav=full) | [**>>**](http://www.eobgynnews.com/scripts/om.dll/serve?action=searchDB&searchDBfor=art&artType=full&id=aqo010361504b&nav=full)[**Article**](http://www.eobgynnews.com/scripts/om.dll/serve?action=searchDB&searchDBfor=art&artType=full&id=aqo010361504b&nav=full) |

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| Opinion |

*Guest Editorial*

 **Elective C-Section Revisited**

**Dr. L. Elaine Waetjen**

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The  **prophylactic use of elective cesarean section to prevent pelvic organ prolapse and urinary incontinence is gaining increased attention.** Dr. W. Benson Harer Jr., past president of the American College of Obstetricians and Gynecologists,  **stated publicly** last year that  **women should have the right to choose a cesarean delivery.**

With some evidence from clinical experience, epidemiology, and pathophysiology to blame vaginal delivery for pelvic floor dysfunction, why shouldn't we offer prophylactic C-sections to prevent this problem later in life?

**The answer is that the evidence does not support this approach. Preventive strategies should cause no more harm than the disease or problem that they are trying to prevent. Ideally, they should incorporate some kind of screening to identify people at risk. They should be cost effective and based on very good evidence of benefit. Elective C-section to preserve pelvic floor function fails on all these measures.**

We don't know that elective cesarean is protective.  **The idea that this strategy just makes sense is hazardous, especially with invasive management. We also should keep in mind that most women who have vaginal deliveries don't develop incontinence or prolapse later in life.**

The limited pathophysiologic evidence that elective C-section might decrease the risk of pelvic floor dysfunction rests on very small studies with very short follow-up times. Epidemiologic data suggest that a first vaginal delivery increases prolapse risk by about three- or fourfold and the risk of urinary incontinence by up to fivefold. The risk goes up with each additional vaginal delivery.

**An elective C-section does not appear to eliminate this risk. Data suggest that women undergoing elective C-section have a two- or threefold higher risk for pelvic organ prolapse and incontinence compared with nulliparous patients.**

Other factors could be promoting pelvic floor dysfunction besides delivery route. Consider that a  **recent study in Brazil, where many elective cesareans are performed, showed a 3.5-fold increased risk for urinary incontinence later in life after elective C-section, roughly equivalent to the rate after one vaginal delivery. In a study of more than 3,000 patients conducted in Australia, pelvic floor dysfunction was significantly associated with all modes of delivery.**

Epidemiologic studies on this topic vary in the populations studied and how outcomes were measured. Population-based studies estimate the prevalence of severe urinary incontinence to be about 7% and prolapse to be less than 1%. One study found the lifetime risk for prolapse or incontinence surgery to be about 11%. We must ask: Did all those women need prolapse surgery?

Data from a study at the University of California, San Francisco, showed that 30-year-old women in the southern United States had the same rate of prolapse surgery as older women in other areas of the country. This suggests large variation in physician practice and patient choice of surgery, and raises the question of whether we can use surgery as an outcome measure for studies of disease prevalence.

The studies on childbirth and pelvic floor dysfunction are observational studies, and at this point we can't use them to draw conclusions about causation. We can only suggest associations. Most studies do not include multivariable analyses, so we do not know how to interpret these results in the context of various other risk factors.

Perhaps vaginal delivery is actually a marker for women who will go on to develop pelvic organ prolapse or urinary incontinence because their tissues are more distensible. It's unlikely, but nevertheless must be considered.

**C-section causes more maternal morbidity and mortality than does vaginal delivery. In the short term, C-section doubles or triples the risk of maternal death; triples the risks for infection, hemorrhage, and hysterectomy; increases the risk of thromboembolism two- to fivefold, and causes surgical injury in about 1% of cases.**

**In the long term, cesarean section increases the maternal risk of future previa, accreta, uterine rupture, surgical injury, spontaneous abortions, and ectopic pregnancy while decreasing fecundity.**

**Babies delivered by cesarean have a higher risk of lung disorders and operative lacerations.**

**In addition, if we assume that vaginal delivery is responsible for 85% of all cases of prolapse or incontinence and that women truly have an 11% lifetime risk of undergoing surgery to treat these conditions, we would have to do 23 C-sections to prevent one such surgery later in life. We would also have to assume that C-section is completely protective, which we don't know to be true.**

**So instead of offering elective cesarean in an attempt to prevent future prolapse or incontinence, we should be examining what we can do in our management of vaginal deliveries to protect pelvic floor function.**

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