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Case Report

Enigma of Caesarean Birthing Trends

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Abstract:

Increasing worldwide rates of caesarean section are of global concern, especially on maternal request have become a hotly debated issue. A Caesarean delivery (C-section/CS) is used to deliver a baby through surgical incisions made in the abdomen and uterus. It is a lifesaving procedure for mothers and newborns in certain circumstances. While the need for a first-time C-section of a primigravida woman isn't' clear until after labour starts. Planning for a C-section might be necessary if women who have had a C-section earlier or had other systemic diseases like heart or brain diseases. When not strictly necessary, caesarean section cause unnecessary national expenditure and place a strain on scarce public health resources in lower- and middle-income countries. The consequences on adverse health outcomes, due to CS include i) babies born are more likely to develop transient tachypnoea & get accidental surgical injuries to the baby. Though the mother won't feel much pain during the surgery, recovering from a CS is more painful & takes a longer time than from a natural birth.

There is a payment wedge for C-sections relative to vaginal deliveries under fee-for-service and an information asymmetry between obstetricians and patients as most illiterate or Less-informed patients or their families cannot reduce the asymmetry by seeking an independent second opinion during labour and are possibly exploited.

Materials & Methods: This article is based on author's experience of two deliveries by caesarean section in September and November 2024. CS in September was of a poorly built young lady of 28 years, Primigravida, a precious pregnancy as it was successful after a long-term consultation, hormonal and other efforts (D&C) for 2 years after marriage. The woman was clearly influenced during ANC itself in Bengaluru and during labour in Raichur a district head quarter both private obstetric facilities. The delivery in November was second gravida of twin girls, diagnosed by scanning in Australia, previous delivery also CS, a justifiable cause for CS. Literature search adds value for argument for justifiable reasons of CS & unnecessary caesarean sections.

Outcomes: Both mothers are doing well now but the process of recovery from surgery has taken about 3 weeks. However, the baby of avoidable CS is suffering from frequent upper respiratory infections in the first 3 months of life. The cost involved was around INR 300,000 each and the young infants URIs costing another INR 100,000 so far. The twins of 2.2 kg and 1.8 kg are needing special care where two aunts have taken of for a month each to take care of them an indirect cost of INR 50,000each month.

Keywords: pregnancy, primigravida; gynaecologists

Abbreviations:

pregnancy, primigravida, cs= caesarean section delivery, ffs= free for service in public sector, obstetricians, conflict of interest, multigravida, too young (<18 years), too old pregnancies (>34 yrs), breech presentation, hand prolapse, labour second stage delay

Introduction

A Caesarean delivery (C-section) is used to deliver a baby through surgical incisions made in the abdomen and uterus. It is a lifesaving procedure for mothers and newborns in certain circumstances. While the need for a first-time C-section of a primigravida woman isn't' clear until after labour starts. Planning for a C-section might be necessary if women who have had a C-section earlier or had other systemic diseases like heart or brain diseases [1]. Increasing worldwide rates of caesarean section and those especially upon maternal request have become common and are of a global concern and a hotly debated public Health issue.

Data available (2010–2018) from 154 countries covering 94.5% of world live births shows that 21.1% of women gave birth by caesarean worldwide, averages ranging from 5% in sub-Saharan Africa to 42.8% in Latin America & Caribbean [2]. CS has risen in all regions since 1990 [3].

In India there is a rise in the number of Caesarean sections (C-section) despite a drop in medical complications during pregnancy and labour due to better antenatal care and early identification of complications between 2016 and 2021 in the country. Most women have more than one reason for opting caesarean birth. Across India the 'non-poor' were more likely to opt for C-sections. The chances of a delivery through C-section are greater if a woman gave birth in a private hospital, or if she is overweight and older (aged 35-49) were and most importantly if a woman gave birth in a private hospital. Other factors that could contribute to adverse birth outcomes and possibly justify C-sections are the mother's age being less than 18 years or greater than 34 years, the interval between births being less than 24 months or the child being the fourth or more born to the mother and therefore considered as high-risk fertility behaviour [4].

When not strictly necessary, CS can cause several adverse health outcomes, leading to unnecessary expenditure, and place a strain on scarce public health resources. The consequences of CS include i) babies born by scheduled C-section are more likely to develop a transient tachypnoea (to breathe too fast for a few days after birth), surgical injury- rare and accidental nicks to the baby's skin can occur. The mother won't feel much pain during the surgery, but recovering from a C-section may be more painful and take longer than recovering from a natural birth [5].

We all know that medical decision-making during childbirth is well-suited to testing for inducement. There is a well-documented payment wedge for C-sections relative to vaginal deliveries under fee-for-service [FFS] and an information asymmetry between obstetricians and patients. Illiterate or Less-informed patients and their families cannot reduce the asymmetry by seeking an independent second opinion during labour [1].

This article is based on author's experience of two deliveries by caesarean section in September and November 2024. CS in September was clearly unjustifiable as she was influenced during ANC itself and during labour both private obstetric facilities. The delivery in November was second gravida of twin girls, previous delivery also by CS, a justifiable cause for repeat CS.

Case Reports:

1 Vanshi Patil: Vaani aged 28 years, now married for 3 years, had conception problem since mid-2022. A D&C followed by hormone therapy was done for 6 months in 2022. Her husband's sperm count, and quality was proved normal in March 2022.In September 2022 Hormone (TSH 3rd generation), a follicular study and scanning of KUB & Pelvis and basic investigations of Blood were done on 20th September and repeated on 22 November 2022, reported: i) Retroverted uterus, normal in size ii) Both ovaries Normal. iii) No abnormality.

Date	Day of Cycle	Endometrial Thickness	Right Ovarian Follicle mms	Left Ovarian follicle mm	Scanning date
22/20/22	11th	6	1.4x1.4x1.4	Small	24/10/22
25/10/22	14th	8	23x9	Small	27/10/22
27/10/22	16th	10	27x20	Small	29/10/22

Table 1: Key markers of Follicular Study

In Starting 27th October 2023, another course of hormone and supportive therapy was done but had a miscarriage of 10 weeks pregnancy. On 23 February 2024 scanning confirmed pregnancy and another scan rule out genetic abnormalities. In May 2024 I had an opportunity of examining physically. As a norm she went to her mother home Raichur in August 2024 for delivery. In September the local obstetrician suggests normal delivery and asked if she would go for Pudendal block to minimize the labour pain with a warning that if she fails to deliver normally, a CS may have to be done. Fearing the unavoidable CS, family opted for CS in early September and post operatively no untoward things happened. This caesarean section was totally influenced by the attending Gynaecologists. However, the newborn had common cold (Rhinovirus infection) in the first month itself and repeatedly every month. The October 2024 episode was severe with wheeze, needing hospitalization for 4 days, Oxygen support and ICU care, managed with standard protocol of URI in young infants. A 2 D echo report read mild congenital Peri-membranous VSD, LR shunt, No PDA, Normal Biventricular function (62%). The parents have been alerted her sensitivity common cold and repeated URI & counselled for proper care. Vanshi named a week ago now had her recent episode of Common cold on 15/11/2024.

2 Adithi's Second Gravida:

Aditi my niece married in 2017 had her fist baby girl in 2019. The couple live in Sydney Australia as her husband is a software, Engineer. Thou herself an Engineering graduate, hasn't been working since 2019 after her first childbirth. Her second pregnancy was diagnosed as twin girls' pregnancy (Australia doesn't have restriction in revealing gender of the babies unlike in

India where sex cannot be intimated even to parents fearing female foeticide) She came to Mysuru for delivery and a private obstetrician who had attended her first CS, chose to schedule a CS in 38th week and did so on 3 November 2024. This one is a justifiable Caesarean delivery and extracted both babies in a gap of 1.5 minute. Both kids weighing 2.3kg and 1.8 kg are doing well as seen on 8th November.

Discussions:

A Caesarean delivery (C-section /CS) is a lifesaving procedure for mothers and newborns used to deliver a baby through surgical incisions made on the mother's abdomen & uterus. While the need for a first-time C-section of a primigravida woman isn't' clear until after labour starts. Planning for a C-section might be necessary if women who have had a C-section earlier or have systemic health concerns like heart or brain diseases, therefore have a risk to deliver through vaginal birthing [1]. The reasons for a CS can be of three categories:

1. Common technical reasons for caesarean section (CS): i) Labour dystocia: A CS is recommended for women only if Labor isn't progressing normally (labour dystocia). Prolonged first stage (due to prolonged dilation or opening of the cervix) or prolonged second stage (prolonged time of pushing after complete cervical dilation) are key reasons. ii) The baby is in distress: Changes in a baby's heartbeat (very fast or slow) might make a C-section the safest option iii) The baby in an unusual position: A C-section is the safest way to deliver babies whose feet or buttocks enter the birth canal first (breech) or babies whose sides or shoulders come first (transverse). iv) Multiple pregnancies: A woman carrying more than one baby, twins, triplets or more especially when labour starts too early, or the babies are not in a head-down position v) Placental Problems: Placenta previa a condition in which the placenta covers the opening of the cervix, a CS is recommended vi) Prolapsed umbilical cord: If a loop of umbilical cord slips through the

cervix in front of the baby, CS is resorted to vii) Other health concerns: A C-section might be recommended for women with a heart or brain condition viii) Cervical canal blockage: A large fibroid blocking the birth canal, ix) Disproportionate head size of the baby: If the baby has severe hydrocephalus (a condition that causes the head to be unusually large) might be reasons for a C-section. x) A pelvic fracture or other condition restricting pelvic expansion or contraction.

2. The individual psychological reasons: Psychological reasons, mostly influenced by peers and attending doctor during antenatal care include i) fear of pain, ii) previous caesarean birth, or negative birth experiences (self or any other known woman), higher education with misinformation iii) safety concerns related to health risk perceptions, iv) Promoting Positive attitudes towards CS during ANC, v) Superstitious beliefs in auspicious birth dates.

3. Institutional or Gynaecologist's Bias or Conflict of Interest: Most Gynaecologists of younger generation brain wash the Primigravida woman during routine antenatal care with possibilities of unbearable pain, perineal tear, fistulas etc due to straining and ease of delivery through caesarean. Doctors have several reasons to prefer C-sections to natural childbirth most common being conflict of interest of making Quick Bucks - more income, more convenience in planning and scheduling, and fear of malpractice lawsuits.

Global Standards of CS: According to The World Health Organization (WHO) no more than 10–15% of deliveries can be C-sections. Increased C sections give no advantage in terms of reducing infant or maternal mortality beyond 10%. According to WHO the factors that could contribute to adverse birth outcomes and possibly justify C-sections are the mother's age being less than 18 years or greater than 34 years, multiparty, the interval between births being less than 24 months, which are considered as high-risk fertility behaviour [3].

The proportion of C-sections in India increased from 17.2% in 2015–2016 to 21.5% in 2019–2021. This increase was seen in all but four states and union territories. According to the National Family Health Survey (NFHS-5) of 2019–2021, the proportion of caesarean section (C-section) deliveries in India was 21.5%. However, desegregation of the data based on the delivery place, private sector contributes more than three time of that in public sector [4]. In the private sector, these numbers stand at 43.1% (2016) and 49.7% (2021), meaning that nearly one in two deliveries in the private sector is a C-section in the years of 2019-2021 [4].

Type of delivery	Proportion of CS %
All India	21.5
Public facility	14.3
Private facility	45.4

Table 1: Proportion of CS in NFHS 5

A study by the Indian Institute of Technology Madras (Department of Humanities and Social Sciences) conducted the research in Tamil Nadu and Chhattisgarh and reported that there was a rise in the number of Caesarean sections (C-section) despite a drop in medical complications between 2016 and 2021 in the country. This, despite a drop in medical complications during pregnancy. The chances of a delivery through C-section were greater if a woman gave birth in a private hospital, the study revealed. Also, overweight and older women (aged 35-49) were more likely to have C-section deliveries. The chances of a delivery through C-section were greater if a woman gave birth in a private hospital [3].

Another descriptive qualitative study s conducted, using in-depth interviews with 27 pregnant women who preferred caesarean birth, attending antenatal care in Thailand Songklanagarind Hospital, from September 2018 to June 2019 inferred that Maternal reasons for caesarean preference were of six categories. They included i) fear of childbirth, ii) safety concerns related to health risk perceptions, iii) negative previous birth experiences, iv) positive attitudes toward caesarean birth, v) access to biased information and vi) superstitious beliefs in auspicious birth dates. Most women had more than one reason for opting caesarean birth. One striking reason was superstitious beliefs in auspicious birth dates, which are difficult for obstetricians to deal with.

Conclusion:

A Caesarean Section delivery (C-section /CS) is a lifesaving procedure used to deliver a baby through surgical incisions made on the mother's abdomen & uterus. The need for a first-time C-section of a primigravida woman isn't' clear until after labour starts.

Causes of high caesarean section usage vary widely between and within countries. Drivers include health sector policies and financing, cultural norms, perceptions and practices, private health sector influence for conflict of interest, and quality of healthcare.

However, when not strictly necessary, a C- section delivery can cause several adverse health outcomes on mothers and newborns, leads to unnecessary expenditure to the family and the nation, and places a strain on scarce public health resources in developing countries.

Therefore, the community Obstetricians must explore the exact reasons for the requests for caesarean birthing to prevent or diminish unnecessary caesarean sections.

Rather than recommending specific target rates, WHO underscores the importance of focusing on each woman's unique needs in pregnancy and childbirth.

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