Bedfordshire Hospitals
NHS Foundation Trust

CLINICAL PROCEDURAL DOCUMENT

Document Title: Guidelines for Elective Caesarean at Maternal Request (with no Additional Medical or Obstetric Indications)			
This document is relevant for staff at: (*please tick)*	**Luton Hospital site** √	**Bedford Hospital site**	**Both Hospital sites**
Policy			
Clinical Guideline X			
Standard Operating Procedure (SOP)			
Patient Group Direction (PGD)			
Integrated Care Pathway			

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Guidelines for Elective caesarean at maternal request (with no additional medical or obstetric indications)

Pathway for maternal request for caesarean birth (without medical or obstetric indication)

The Luton and Dunstable University Hospital promotes a practice of no unnecessary intervention. It is not the standard policy of the Luton and Dunstable Hospital maternity services to perform Caesarean Sections without any medical indication.

However, it is recognised for varying reasons such as previous birth experiences, fear of vaginal birth or vaginismus, some women will request to deliver their baby by caesarean section. It is important for these pregnant women expressing that they wish to have a Caesarean Section for Maternal Request with no medical need to be counselled and given support. It is important to consider the woman's emotional needs in such circumstances and support them through a decision-making process to enable them to make an informed choice.

The Luton and Dunstable University Hospital recognises that women need to be counselled in a supportive manner to ensure the reasons for their request are explored and that a comprehensive discussion of the risks and benefits of caesarean sections occurs.

Any woman who makes a request for an 'Elective Caesarean Section for maternal request' will be referred to the Birth Options Clinic in the first instance, so that her reason for requesting a Caesarean Section can be explored. It is the responsibility of the practitioner discussing the birth options with the woman to provide her with evidence based advice and reach the best possible plan for her needs (See Appendix 2). As part of the Birth Options appointment, the woman will be offered counselling, assessment and focused midwifery support where the rationale and reason for request is explored, and advice on risks and benefits and support offered. If the woman continues to request a caesarean section for maternal request she will then be referred to the Obstetric Led Clinic to have a decision made regarding the most appropriate mode of delivery.

Referral process

- At booking or at any time during the pregnancy, any woman requesting a caesarean birth without medical or obstetric indication must be referred to the Birth Options clinic led by the consultant midwife/ Professional Midwifery Advocate (PMA). A referral form is completed and appointment arranged electronically on IPM (see Appendix 1).
- At the appointment, the Consultant Midwife / PMA will offer counselling, psychological assessment and focused midwifery support, and will exploring the rationale and reason for the woman's request, provide advice on the risks and benefits, offer further referrals and support and detail this information in a care plan/the mothers hand held record.
- The Consultant Midwife / PMA will offer professional midwifery and where necessary arrange psychological care, exploring with the woman if any further support is needed and a holistic approach to health, synonymous with woman-centred care. Appropriate services can then be assessed and provided for women who have anxiety about birth, previous trauma or tocophobia, including psychological referral prior to decisions being made.
- Pregnant woman expressing that they wish to have a Caesarean Section for Maternal Request with no medical need will be offered counselling, psychological assessment and focused midwifery support exploring rationale and reason for request, offered advice on risks and benefits and support.
- Women who continue to request Caesarean Section with no medical need following the support/referrals will then be referred to a Consultant Obstetrician. Ultimately, if the request is deemed appropriate the Consultant Obstetrician will agree with it, however each case should be dealt on its individual merits, following consultation with the consultant.
- Where the woman reports fear of giving birth or previous traumatic birth the Birth Options Clinic will offer referral to the woman's GP for counselling and will also review the previous labour notes and debrief the experience if appropriate.
- A full discussion of overall benefits and risks of caesarean section will take place and be documented in the hand held notes
- All women seen in the Birth Options clinic will then be referred back to their named midwife and consultant team for antenatal care with a plan for follow up and review for final decision.

- If a Consultant Obstetrician cannot agree with a women's request of Caesarean Section she should be offered a second opinion by another Consultant.

Counselling women regarding benefits and risks

As well as exploring the reasons for the woman wanting a caesarean section a documented discussion of the risks and benefits of Caesarean section versus Vaginal Birth needs to occur. This can be facilitated during the Birth Options Clinic appointment.

This discussion needs to include:

- Summary of effects of CS V Vaginal Birth
- Maternal morbidity
- Effect on subsequent pregnancies
- Neonatal morbidity
- Anaesthetic complications

The charts below must be referred to in order to shape the discussion that takes place between the health professional and the woman. This can be completed at the Birth Options Clinic or at the Consultant Obstetricians appointment.

Summary of the effects of CS compared with vaginal birth for women and their babies

The Cochrane review by Lavender et al (2012) evaluated the effects of planned Caesarean Section versus planned vaginal birth in women with no clear clinical indication for Caesarean Section. All randomised controlled trials (RCTs) containing pregnant women in their first pregnancy, with cephalic presentation at term, with no medical indication for CS were included. The primary outcomes were:

- serious maternal morbidity or death
- serious neonatal morbidity or perinatal death, excluding fatal malformations postnatal depression.

Summary of the effects of CS compared with vaginal birth for women and their babies

(Tick to confirm discussed)

Increased with CS	√	**No difference after CS**	√	**Reduced with CS**	√
Abdominal pain		Haemorrhage		Perineal pain	
Bladder injury		Infection		Urinary incontinence	
Ureteric injury		Genital tract injury		Uterovaginal prolapse	
Need for further surgery		Faecal incontinence			
Hysterectomy		Back pain			
Intensive therapy/high dependency unit admission		Dyspareunia			
Thromboembolic disease		Postnatal depression			
Length of hospital stay		Neonatal mortality (except breech)			
Readmission to hospital		Intracranial haemorrhage			
Maternal death		Brachial plexus injuries			
Antepartum stillbirth in future pregnancies		Cerebral palsy			
Placenta Praevia in future pregnancies					
Uterine rupture					
Not having more children					
Neonatal respiratory morbidity					

- ***This table shows the direction of the effect of C/S not the size of the effect****
- ***Risks may be different in individual women***

Document within the pregnancy record the reason/s why the mother has chosen this mode of delivery, detailing any significant history i.e. relatives with traumatic birth histories, what has been discussed and the plan that has been agreed with the woman.
Any referrals made to support the woman with tokophobia (such as referrals to Talking Therapies) to be documented with follow up appointments identified as part of the care plan.

Maternal morbidity

	Caesarean	Vaginal delivery
Abdominal pain around time of birth	9%	5%
Bladder injury	0.1%	0.003%
Ureteric injury	0.03%	0.001%
Need for further surgery	0.5%	0.03%
Hysterectomy	0.7-0.8%	0.01-0.02%
Admission to ITU	0.9%	0.1%

Subsequent fertility and pregnancies

Fertility, Miscarriage, Ectopic pregnancy and Placental abruption have all been associated with previous Caesarean. However, the studies do not distinguish between elective and emergency Caesarean and fail to control for confounding factors making it impossible to assess the effects of an elective procedure accurately.

Research suggests that the risk of uterine or tubal infertility is probably not substantially increased in women on whom uncomplicated Caesarean sections have been performed. Placenta praevia and placenta accreta are rare but serious complications. The risk of placenta praevia in a woman with an unscarred uterus is around 2.6/1000 births.

Table to show the risk of placenta praevia with respect to the number of previous Caesarean sections; data adapted from Ananth et al

Caesarean Section (n)	Odds ratio (95% confidence intervals)	
1	4.5	(3.6-5.5)
2	7.4	(7.1-7.7)
3	6.5	(3.6-11.6)
4 or more	44.9	(13.5-149.5)

The risk of placenta accreta in placenta praevia is higher in the presence of a uterine scar. Caesarean hysterectomy is required in up to 11% of cases of placenta praevia and 82% of cases of placenta accreta.

Complication of operation	**1**	**Number 2**	**Of 3**	**Previous 4**	**Caesareans 5**	**6**
Placenta accreta	0.24%	0.31%	0.57%	2.13%	2.33%	6.74%
Hysterectomy	0.65%	0.42%	0.9%	2.41%	3.49%	8.99%
In women with Placenta praevia, the risk of accreta	3%	11%	40%	61%	67%	
Bladder injury		0.3%	0.8%		2.4%	
Transfusion		7.2%	7.9%		14.1%	

Maternal bonding

Although mode of delivery may play a part in levels of postnatal depression/anxiety, other factors such as social support, marital problems, stressful life events and previous psychiatric history are more likely to be greater influencing factors.

No difference in breast-feeding problems between Caesarean and vaginal deliveries have been demonstrated.

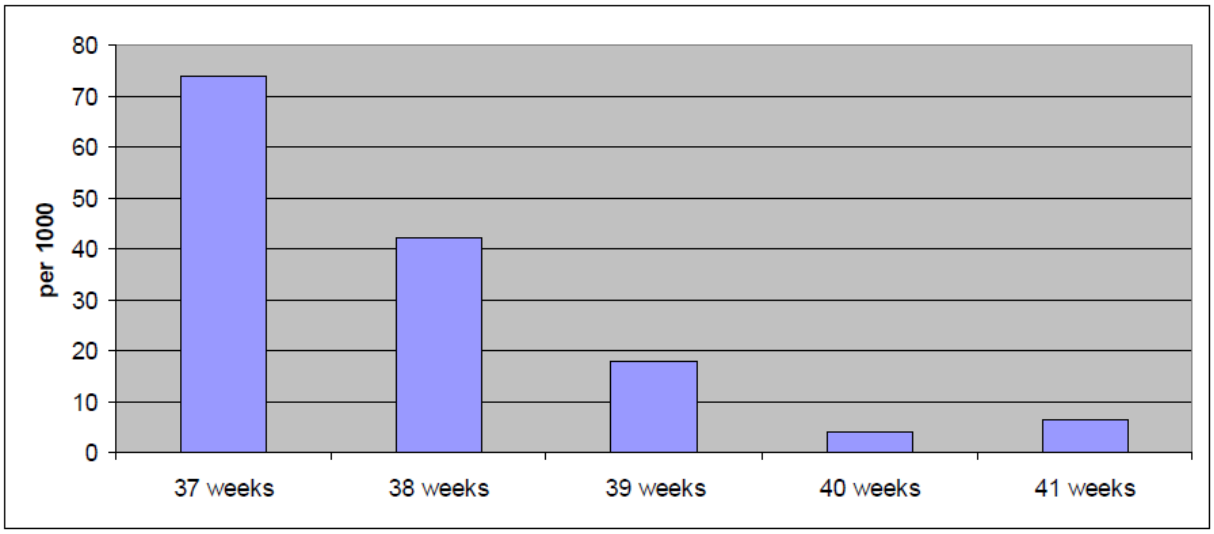
Neonatal effects of Caesarean versus vaginal delivery

- **Neonatal morbidity**

The incidence of neonatal respiratory morbidity rate is higher in Caesarean delivery than vaginal delivery (3.5% versus 0.5%).

NICE CG 132 (full version) shows the risk of respiratory morbidity:

Figure 7.1 Respiratory morbidity per 1000 for CS before labour[282] [evidence level 3]



There is a risk of fetal laceration at Caesarean (up to 2% cases including emergency and elective Caesarean). Appropriate precautions and technique though will largely remove this risk.

There is no difference in the rates of the following

	Caesarean	Vaginal
Neonatal mortality (excluding breech)	0.1%	0.1%
Intracranial haemorrhage	0.008-0.04%	0.01-0.03%
Brachial plexus injury	Overall risk 0.05%	

Cerebral palsy Overall risk 0.2%

There are some studies that suggest increased risks of chronic diseases (inflammatory bowel disease, asthma, diabetes, obesity) in babies born by CS compared to vaginal delivery. The current view of NICE and other authorities is that the evidence on this issue is unconvincing, the impact if present often disappears in childhood and numerically the impact is small. It would be appropriate to make passing mention of this issue and be willing to respond to questions.

Anaesthetic Complications

Regional Anaesthesia

- Post dural puncture headache 1 in 200 women
- Temporary nerve damage (numbness, weakness or nerve pain) 1:1000
- Permanent nerve damage (numbness, weakness or nerve pain) 1:23,500
- Severe injury including paralysis and death 1:250,000

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- NICE Caesarean Section Quality Standard (2013) National Collaborating Centre for Women's and Children's Health. NICE. London. RCOG Press. Available from: https://www.nice.org.uk/guidance/qs32

Audit

Standards to be audited	Lead for the audit	Frequency, audit Tool and Methodology	Reporting arrangements	Acting on recommendations and Lead (s)	Change in practice and lessons to be shared Dissemination of results/action plans.
1. Evidence of discussion of choice of mode of delivery 2. Documented discussion with two lead professionals for decision for LSCS 3. Outcome of mother and baby 4. Monitoring of access/referral to further support	Will be nominated by the maternity audit leads (Consultant or Midwife) according to the Maternity Governance Audit plan.	This will be performed according to audit plan. Data will be collected using an audit proforma (designed by the auditors and approved by the maternity audit leads. The auditors will analyse the data and develop recommendations and action plans from the audit results.	The audit results, recommendations and action plans will be presented either at an audit meeting, a Clinical Governance day or at a Risk and Audit meeting.	The O & G Risk and Governance Committee will approve recommendations and action plans to be implemented within a specific time frame. The auditors will implement and monitor action plans with support from the clinical leads, senior midwives and pertinent groups. There will be six-monthly update of action plans. The O & G Risk and Governance Committee will oversee the implementation and monitoring of the action plans.	The audit results and approved action plans will be disseminated by the maternity audit team to all relevant staff groups, pertinent meetings and through the Delivery Suite newsletter, Risk and Governance newsletter, the Senior Staff meetings, the Delivery Suite Forum and by email. The Trust Audit and Clinical Effectiveness Group will be updated regularly by the maternity audit team.

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

Consultant Midwife Led Clinic Referral Form

Name: ……

Hospital Number :……..

EDD: ……/……/…… G P

Mobile Number :……..

Referred by: (PRINT NAME)…….

Reason for referral: please circle

BIRTH OPTIONS **JOINT VBAC**

- **Tocophobia**
- **Previous Traumatic Delivery**
- **Complex Social Concerns**
- **Maternal Request CS**
- **Birth Plan Review:**

Amber Criteria: Please state condition/risks……..…….……

……

Red Criteria: Please state condition/risks…….……

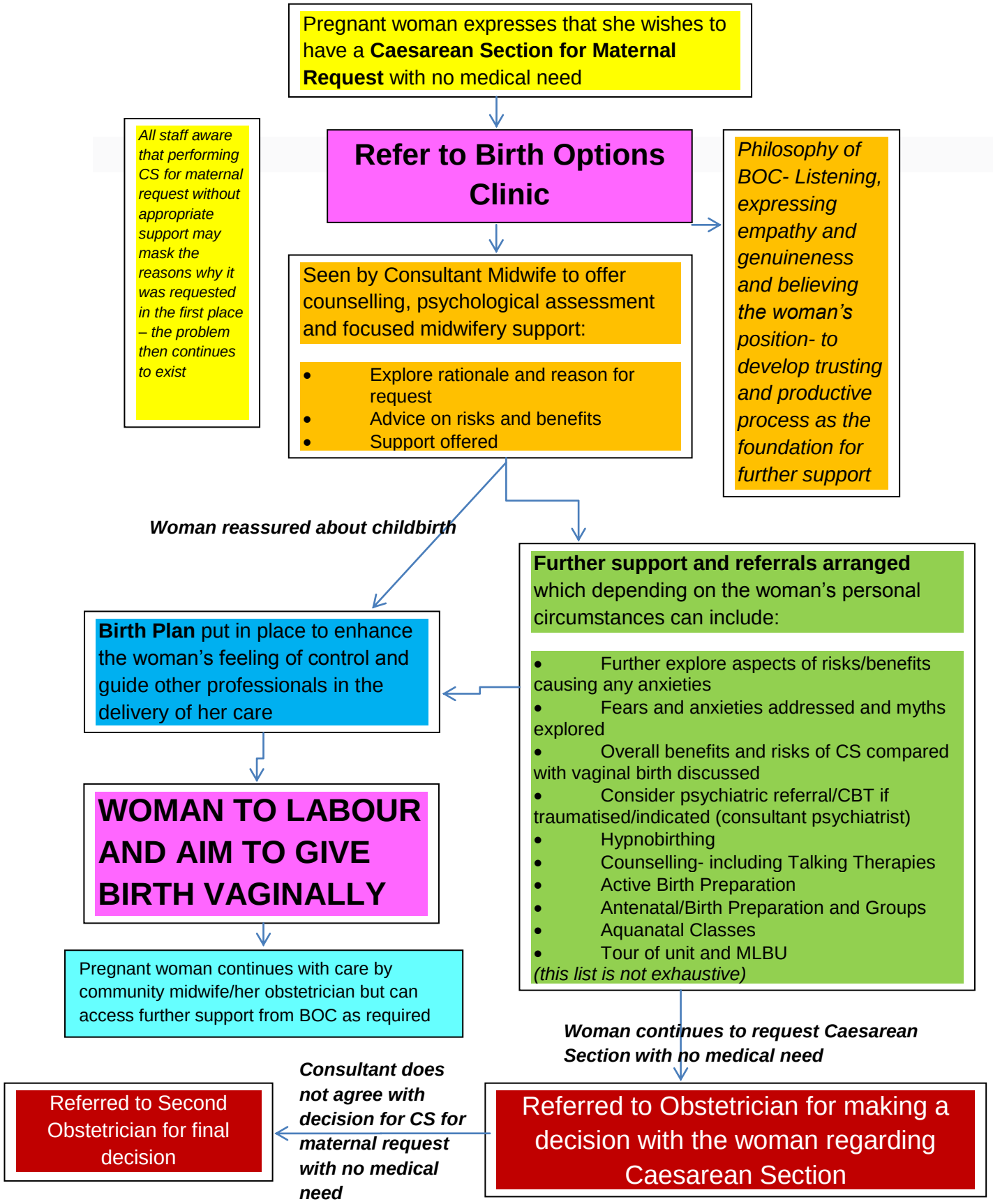
……

Other: Please State……..

……

Date received: ____/____/_____ Appointment date:____/____/_____

Appendix 2
Management of Women Requesting Caesarean Section for Maternal Request



Appendix 3

Patient Information Leaflet available here:

www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-choosing-to-have-a-c-section.pdf