

MUCH Better Ways to Reduce the Primary Cesarean Rate Than Routine Induction at 39 Weeks

With the publication of the abstract for the ARRIVE Trial in February 2018, some news reports are touting the idea that inducing all pregnant woman at 39 weeks may be a beneficial strategy to reduce the rate of primary cesareans. According to the ARRIVE trial, routine induction at 39 weeks does not improve a composite score of perineal and neonatal outcomes, and is associated with only a small (3.6%) decrease in cesarean rates.

See the charts below for current evidence-based recommendations of particular importance for childbirth educators for reducing the primary cesaran rate.

National Partnership for Maternal Safety

Consensus Bundle on the Safe Reduction of Primary Cesarean Births⁶
Recommendations for Providers (March 2018)

Promote spontaneous onset and progress of labor.

Promote continuous labor support.

Delay admission to L & D until the onset of active labor at about 6 cm.

Encourage free movement as a pain management strategy.

Offer intermittent auscultation. If continuous monitoring is required for a medical reason, provide telemetry.

If epidural analgesia is used, preserve as much motor function as is possible, encourage frequent changing of position, and allow passive descent when there is no urge to push.

Adopt the “6 is the new 4” recommendation and allow more time for both stage I and stage II labor, based on Zhang’s work.

Promote the addition of in-house maternity care providers and the development of collaborative care models [CNMs & certified midwives].

Promote external cephalic version for breech babies.

Promote vaginal delivery for twin births when the first twin is vertex.

Increase instrumental births [when appropriate].

Rebecca Dekker Podcast²: ARRIVE Study (Feb. 5, 2018)

Cited Studies Which Successfully Reduced Cesarean Rates
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Javernick⁵. (2017). A quality improvement project, one NTSV study group, reduced primary c/sec rate from 28.9% to 12.3% in 12 months by

- Increasing reporting of c/sec rates to providers,
- Reducing elective inductions prior to 41 weeks,
- Increasing number of women admitted to labor at 4 or more cm dilation,
- Increasing the use of intermittent auscultation.

Bell¹. (2017). Another quality improvement project, three NTSV study groups, reduced primary c/sec rate from 27.9% to 19.7% by

- Physicians following new ACOG guidelines (Zhang) on diagnosing arrest in labor (allowing more time),
- Training nurses in labor support strategies including movement and positioning and the use of round birth balls and peanut balls.

Gimovsky⁴. (2016). Small RCT comparing cesarean rates of nulliparous women with epidural analgesia who were given 3 hours to push versus women who were given 4 hours to push. C/sec rate in usual (3 hour) pushing group was more than twice (43.2%) that of extended pushing (4 hour) group (19.5%).

Ghasemi³. (2013). Per Dr. Dekker (article in Persian). RCT comparing 100 women birthing in water to 100 women birthing on land. C/sec rate 5% in water group compared to 16% in land group.

Regaya⁸. (2010). Per Dr. Dekker (article in French). RCT of 200 women with 100 women authorized to ambulate until 6 cm and 100 women confined to bed in dorsal or lateral recumbent position. C/sec rate in ambulation group 5% versus 16% in group confined to bed.

McGrath & Kennell⁷. (2008). RCT comparing c/sec rates of nulliparous, middle class women with a labor partner who were provided a doula at the hospital with a similar group of women who did not have a doula. Doula group had a c/sec rate of 13.4% versus 25% in the group who did not have doula support.

References

1. Bell, A.D., Joy, S., Gullo, S., Higgins, R. & Stevenson, E. (2017). Implementing a systematic approach to reduce cesarean birth rates in nulliparous women. *Obstetrics & Gynecology*, 130(5), 1082-1089.
2. Dekker, R. (Feb. 5, 2018). ARRIVE trial (podcast). <https://itunes.apple.com/us/podcast/evidence-based-birth/id1334808138?mt=2>
3. Ghasemi, M., Tara, F. & Ashraf, H. (2013). Maternal-fetal and neonatal complications of water-birth compared with conventional delivery. *Iranian Journal of Obstetrics, Gynecology, and Infertility*, 16(70), 9-15.
4. Gimovsky, A.C. & Berghella, V. (2016). Randomized controlled trial of prolonged second stage: extending the time limit vs usual guidelines. *American Journal of Obstetrics & Gynecology*, 214(3), 361.e1-6.
5. Javernick, J.J. & Dempsey, A. (2017). Reducing the primary cesarean birth rate: a quality improvement project. *Journal of Midwifery & Women's Health*, 62(4), 477-483.
6. Lagrew, D.C, et al. (2018). National Partnership for Maternal Safety. Consensus bundle on safe reduction of primary cesarean births – supporting intended vaginal births. *Obstetrics & Gynecology*, 131(3), 503-513.
7. Mcgrath, S.K. & Kennell, J.H. (2008). A randomized controlled trial of continuous labor support for middle-class couples: effect on cesarean delivery rates. *Birth*, 35(2), 92-97.
8. Regaya, B., et al. (2010). Role of deambulation during labour: a prospective randomized study. *J Gynecol Obstet Biol Reprod (Paris)*, 30(8), 656-62. (In French).

For Additional Reports of Success Stories in Reducing Cesarean Rates, see

Smith, H., Peteson, N., Lagrew, D., & Main, E. (2016). *Toolkit to support vaginal birth and reduce primary cesareans: a quality improvement toolkit*. Stanford, VA: California Maternal Quality Care Collaborative.



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