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Considerations about the Problem of Decrease the Rate of Caesarean Section

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In this trial of a retrospective cohort, we showed that in a group of 184 twin pregnancies, there were 12 cases of second fetus in transverse lie situation that were delivered by internal version and great breech extraction (VIGEP) without any damage of this fetuses [1].

Of course that to perform these maneuvers, the obstetrician has to be very well trained to deliver the fetus without causing damage of neither the fetus nor the mother. Also, he should know which is the best anesthetic procedure to ask the anesthetist to implement it and relax the uterus.

But, is not impossible to learn this techniques. Is easier to learn it first trying to perform the VIGEP in a second fetus during a c section. To learn to recognize the fetus feet, when and how to pull out and the right maneuvers to deliver the fetus (Rojas to shoulders, Pajot for the arms, Moriceau for the head) and not to commit the mistake of pulling a fetus hand. All of this could be learned during c sections for twin pregnancies before to try to perform it by vagina to deliver a second fetus in transverse lie situation.

It is not weird to suspect that it could be some problem with the second fetus and forecast that the extraction could be dangerous, but there are resources like ultrasound to verify what happens [2]. It is possible to estimate the fetal weight, the size of the head, and the presence of some obstacle and up to perform an external version to put the fetus in cephalad or breech position to facilitate the extraction [3].

These resources are part of the obstetrical resources to assist a difficult delivery without going immediately for performing a C-section. I mean: this is not theoretical, is 100% practical and possible.

But, regrettably, sometimes we receive some suggestions from the theorists (with all my respect) about some obstetrical resources that are not without serious risks for the practical physicians but do not imply any risk for them.

For example, the practical community cannot understand how the theorists have approved and moved to the assistance medicine the fake conclusions of the trial about breech delivery done by Hanna et al. [4]. Thirty years ago, we accepted because it was very well documented, the risks associated with the delivery of breeches in nulliparous women. It is clear and very understandable. But, accept the conclusions of the Hanna trial when any fetal death happens during delivery and all the fetal deaths happened in the neonatal period and not for causes related with delivery are very difficult to accept.

But, is more difficult to accept the global message to try to decrease the rate of c sections and at the same time proposes that all fetuses in breech should be delivered by c section. It is out of the scope of this editorial to analyze in detail the Hanna´s trial, but I mean only two things: first, according with what I have said previously about breech delivery in nulliparas is there are not enough obstetricians qualified as specialists in assisting breech´s and second as happens in some countries, who is going to accept to participate in a trial if there are not neonatal intensive care unit in the place of the breech delivery?

Another serious contradiction from the theorists is the trial of delivery after a c section, because it is not without risks for them but there are plenty of risks for practical obstetricians. For some reason in USA the trial have decreased in the last years from 70% to 30%, I mean, patients are delivered by vaginal means only if the patients come to the hospital with advanced labor. The rest go through a c section, which is very clear.

The rate of uterine rupture is not more than 1% if the uterine scar is transverse, but for those that suffer the rupture it is 100% and besides that with catastrophic outcomes for the fetus and sometimes for the mother too, without forgetting the legal problems for the physician [5].

So, I believe that is time to speak clearly. Theorists should think about the consequences of their recommendations

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and not only in their conclusions and statistical resources to show how much they know about statistics, because the problems are suffered by patients and physicians who assisted them. Include their conclusions about the costs of the delivery procedures which should be counterbalanced against the costs produced to keep a new born with brain damage because of a uterine rupture. These conclusions are said without recognizing that the epidemiological and sanitarist analysis are of upmost importance to unify the concepts and exert or try to exert the best medicine, in spite of there is not always evidence for all medical problems.

So and finally, I believe that obstetrical assistance is very difficult and we have to analyse very deeply every decision to assist a complicated delivery. The long term target is to get a healthy new born enough to be incorporated under the best conditions for the society. This target sometimes has nothing to do with what the theorists say.

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