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Avoid an Unnecesarean

Healthy throughout pregnancy and anxiously anticipating the birth of her child, a first-time mother-to-be is informed by the hospital that her baby is measuring too big for her to birth. Her pregnancy is now considered "high risk" and she is told she'll need to schedule a cesarean to prevent injury or death to her and her baby.

Relax. Breathe deeply. If you have been visualizing a normal birth for the duration of your pregnancy, being told that you are physically incapable of delivering this baby and that vaginal birth is somehow reckless is a large blow to be dealt. Weighing risks, talking to experts and researching information on vaginal birth is probably not how you want to spend your last week or two of pregnancy.

You may or may not have something of a fight ahead of you, depending on the hospital's culture and your doctor's attitudes.

Get a second opinion! It is always prudent to seek a second opinion for any elective medical procedure, especially a **major abdominal surgery** with a long list of possible adverse outcomes for mother and child.

Seeking out another doctor in the same institution will most likely not result in an objective opinion due to stringent hospital protocol and politics. If you have not already seen one for **concurrent care**, a midwife that does not work for a hospital can be an excellent source of information about prenatal care and preparing for your birth.

Get more information about your current care provider. Ask what their C-section, episiotomy and induction rates are. Would you trust a doctor with a 50% C-section rate to make sound recommendations regarding your birth?

It's rarely too late to find a new care provider (doctor or midwife) or birth location (new hospital, birth center or home). According to Childbirth Connection, a national not-for-profit organization whose mission is to improve the quality of maternity care through research, education, advocacy and policy, you may have to change your place of birth and/or caregiver to get what you want**.**

Ask for evidence. Is this "recommendation" of a C-section based on evidence or is it merely the practice of defensive medicine? The burden of proof is on the doctor wanting to schedule a primary C-section for a non-diabetic woman.

At this juncture, doctors are known to share a personal anecdote about shoulder dystocia in which the baby died or suffered nerve damage during birth to support their recommendation and scare the pregnant woman into compliance. This is also referred to as "playing the dead baby card." Such events are tragic for all parties involved, including the labor and delivery staff. They are also EXTREMELY rare and unpredictable.

The American College of Obstetrics and Gynecology does not support prophylactic cesarean delivery for suspected fetal macrosomia with estimated weights of less than 5,000 g, stating that "…it is safe to allow a trial of labor for estimated fetal weight of more than 4,000 g."

A few of the many studies indicating vaginal birth when a large baby is suspected are:

Most of the traditional risk factors for shoulder dystocia have no predictive value, shoulder dystocia itself is an unpredictable event, and infants at risk for permanent injury are virtually impossible to predict.

Nocon, James J.; McKenzie, Debra K.; Thomas, Lisa J.; Hansell, Richard S. Shoulder Dystocia: An Analysis of Risks and Obstetric Maneuvers. Am J Obstet Gynecol 1993;168:1732-9.

Evidence is lacking to support labor induction or elective cesarean delivery in women without diabetes who are at term when a fetus is suspected of having macrosomia.

Benacerraf BR, Gelman R, Frigoletto FD Jr. Sonographically estimated fetal weights: accuracy and limitation. Am J Obstet Gynecol 1998;159:1118-21.

Vaginal delivery is a reasonable alternative to elective cesarean for infants with estimated birth weights of at least 4500 g, and a trial of labor can be offered.

Lipscomb KR, Gregory K, Shaw K. The outcome of macrosomic infants weighing at least 4500 grams: Los Angeles County + University of Southern California experience. Obstet Gynecol. 1995 Apr;85(4):558-64.

Nearly 3,700 elective C-sections must be performed on women with an estimated fetal weight of 4500g (9 lbs., 15 oz.) to prevent ONE case of permanent brachial plexus injury to a child.

Rouse DJ, Owen J, Goldenberg RL, Cliver SP. The effectiveness and costs of elective cesarean delivery for fetal macrosomia diagnosed by ultrasound. JAMA 1996;276:1480-6.

The inaccuracy of estimating fetal weight is a severe limitation in attempting to establish guidelines designed to prevent shoulder dystocia.

Nesbitt, Thomas S. MD, MPH; Gilbert, William M. MD; Herrchen, Beate PhD. Shoulder dystocia and associated risk factors with macrosomic infants born in California. Am J Obstet Gynecol 1998;179:476-80.

One half of all cases of shoulder dystocia occur at birth weights of less than 4,000 g (8 lbs., 13 oz.).

Acker DB, Sachs BP, Friedman EA. Risk factors for shoulder dystocia in the average-weight infant. Obstet Gynecol 1986;67:614-8.

Nearly one half of all cases of permanent brachial plexus injuries occur in infants weighing less than 4,500 g (9 lbs., 15 oz.).

Ouzounian JG, Korst LM, Phelan JP. Permanent Erb's palsy: a lack of a relationship with obstetrical risk factors. Am J Perinatol 1998;15:221-3.

Not convinced by their reasons? Say no. Many mothers do not realize that they have the right to refuse ANY intervention, including tests, induction, heparin locks (IV's), fetal monitoring, epidurals, pain medication and cesareans. It is your choice to deliver your baby in a hospital. It is your choice to consent to each and every step along the way.

You have the right to informed consent for vaginal birth. Ask what, if any, forms you need to sign in advance to indicate that you understand the risks involved and that you intend to deliver your child vaginally.

Hire a doula or monitrice. If you have already been set up by the hospital's staff to labor on the defensive, consider an extra helper or two to join you. An experienced, professional doula can physically and emotionally support you and your partner during labor. Be aware, however, that a doula cannot intervene in your birth and cannot provide medical advice. If a doula is not financially feasible, consider utilizing a friend or family member with whom you are comfortable who can help speak on your behalf or prompt you or your partner to request things.

http://www.dona.org/

Think twice about getting an epidural. Epidurals, known for slowing labor, inhibit and often prohibit your ability to use gravity to your advantage by getting off your back to push. Squatting, standing or sitting in labor helps to open your pelvis. Going with your body's natural urge to push can prevent coached or "purple" pushing and consequent tearing or generous episiotomies.

If the institution in which you have chosen to birth adamantly insists upon heparin locks (IV's), electronic fetal monitoring, laboring and/or delivering flat on your back and other limiting policies, you might want to consider the choice you have made to deliver your baby there. **You have options**.

"OK, I've thought twice and I want an epidural." Talk with your care provider about minimizing any negative effects of epidural anesthesia, including administering the epidural in late labor, administering a light dose of epidural anesthesia, choosing a labor

position that facilitates the use of gravity, reducing the epidural dose during pushing and allowing the baby to ‘“labor down.”

Stay mobile. Use gravity to your advantage! Walk, squat, move, kneel and stand if it makes you comfortable. While more research is needed on vertical labor positions and outcomes, it is generally believed that lying flat on your back does not allow your pelvis to widen to accommodate as much baby as possible.

Talk to everyone you can at the hospital about getting into an upright position in labor (squatting, standing, on knees). Inform them that you will need them to set up a birthing (squat) bar. Many doctors have very little experience catching a baby in any other position than the lithotomy position (in which a woman is lying flat on her back). This is the easiest position for doctors, but many women find it extremely uncomfortable and ineffective.

Here are a few studies that suggest tendencies toward benefits of squatting in labor:

Length of the expulsion phase may be shortened in squatting versus supine position. Research suggests tendency toward reduced use of forceps in squatting labors.

Racinet C, Eymery P, Philibert L, Lucas C, Labor in the squatting position. [A randomized trial comparing the squatting position with the classical position for the expulsion phase], J Gynecol Obstet Biol Reprod (Paris). 1999 Jun;28(3):263-70.

Second and third degree tears, forceps deliveries lower in squatting deliveries.

Nasir A, Korejo R, Noorani KJ., Child birth in squatting position, J Pak Med Assoc . 2007 Jan;57(1):19-22. Randomised, controlled trial of squatting in the second stage of labour.

Second stage of labor shorter in squatting women, less labor augmentation required and fewer mechanical deliveries and episiotomies.

Golay J, Vedam S, Sorger L, The squatting position for the second stage of labor: Effects on labor and on maternal and fetal well-being, Birth: Issues in Perinatal Care. 2007 Apr; 20(2):73-8.

Don’t rush it! In this induction aggressive culture, it might seem counterintuitive to “let baby bake any longer” for fear that he or she will grow too large for birth. There is no evidence that supports induction prior for suspected fetal macrosomia as beneficial to mother and child.

From ACOG’s Guidelines on Fetal Macrosomia:

> “In cases of term patients with suspected fetal macrosomia, **current evidence does not support early induction of labor.** Results from recent reports indicate that induction of labor at least **doubles the risk of cesarean delivery without reducing the risk of shoulder dystocia or newborn morbidity.**”

In a 1993 study to test the hypothesis that elective induction of labor, compared to spontaneous labor, reduces the cesarean rate in women with a sonographic diagnosis of fetal macrosomia, researchers concluded that because **elective induction of labor increased the cesarean rate** and did not prevent shoulder dystocia, mothers with macrosomic fetuses can safely labor spontaneously. [Combs CA, Singh NB, Khoury JC. Elective induction versus spontaneous labor after sonographic diagnosis of fetal macrosomia. Obstet Gynecol. 1993 Apr;81(4):492-6.]

To help avoid a rushed labor, **stay at home as long as possible**. You can labor at home with a partner, doula or monitrice. Whenever you leave your home to birth in an institution, *even a free-standing birth center*, you are on their timetable and will be expected to submit to their protocols. "Failure to progress" is often "failure to be patient" on the part of doctors.

Talk to other women who have had big babies vaginally. Yes, babies weighing more than 4000g (8 lbs., 13 oz.) are born vaginally. Often. So are ten-plus pound babies. Babies rarely grow too big for their mothers' pelvises to accommodate. Interventions such as labor-inducing drugs (such as synthetic oxytocin, also known as Pitocin), epidurals, continuous fetal monitoring and IVs that leave the woman bed-bound and laboring supine (on one's back) decrease a woman's chances of safely birthing her child and increase her chances of having an unnecesarean.

Talk to other women who have delivered big babies vaginally. Read their birth stories. Ask them what they would recommend.

If after weighing risk and benefits, a cesarean feels like the best option for you, consider preparing a birth plan for a family centered cesarean section.