Beckenendlage (BEL) – sind Kaiserschnitte nicht doch vermeidbar?

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OBSTETRICS

Cesarean section delivery among primiparous women in rural China: an emerging epidemic

Reija Klemetti, PhD; Xuan Che, MS; Yan Gao, MS; Joanna Raven, MCommH; Zhuochun Wu, MD, MPH; Shenglan Tang, PhD; Elina Hemminki, DrPH

OBJECTIVE: The purpose of this study was to describe the trends and determinants of cesarean section (CS) delivery rates in rural China.

STUDY DESIGN: Data on rural primiparous women aged 15-49 years (n = 10,754) were obtained from 3 nationwide representative surveys in 1993, 1998, and 2003. The CS rate per 100 births and odds ratios by women's background characteristics were calculated with the use of logistic regression.

RESULTS: The CS rate increased from 1% in 1991 to 17% in 2002. After age adjustment, CS was most common among more educated women, who lived in Eastern China, who had high household income and health insurance, who used antenatal care, and who gave birth at a high-level hospital.

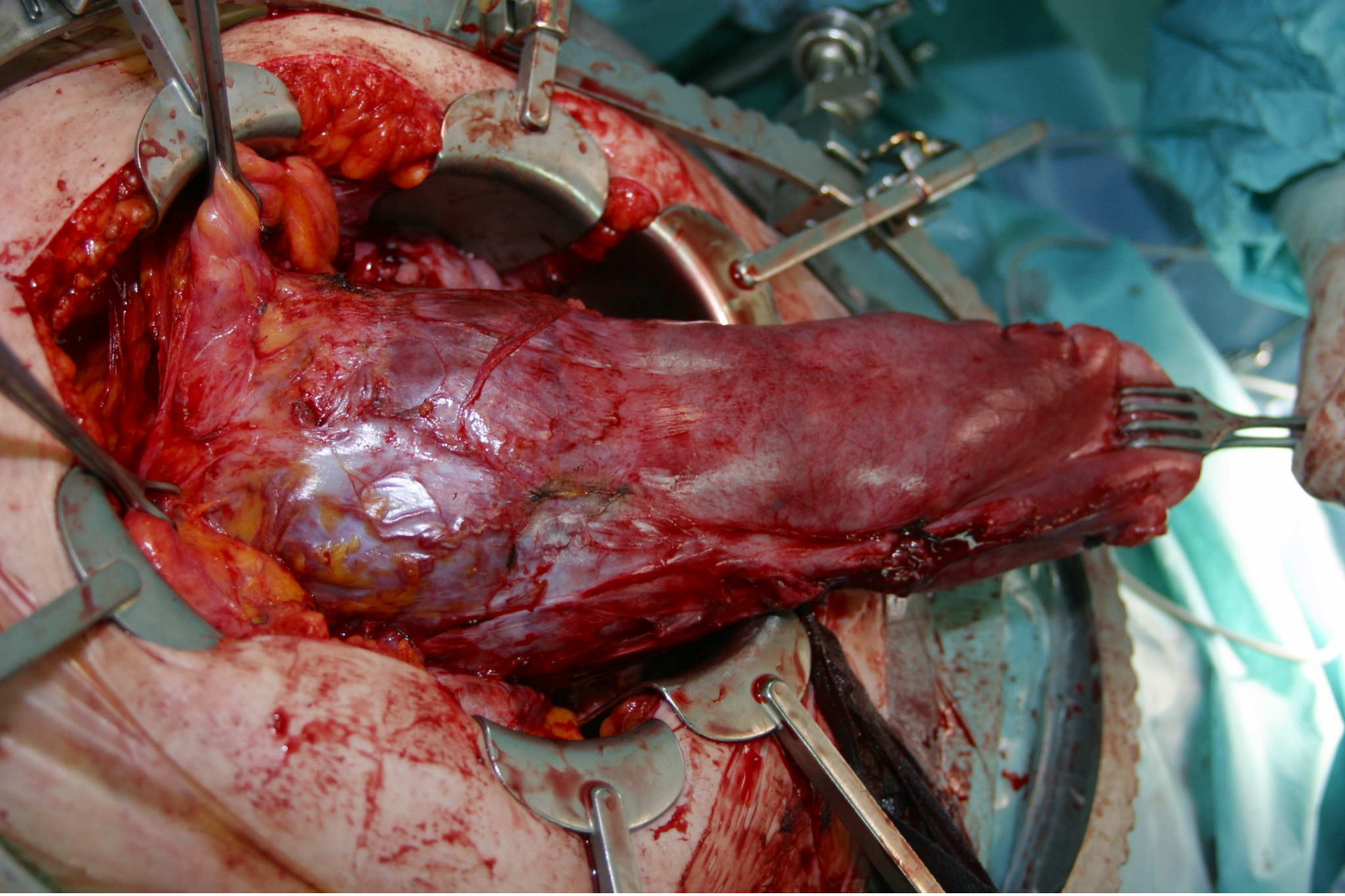
CONCLUSION: This development over the 10-year period may indicate very high CS rates in the near future; the epidemic of the use of CS that has been observed in urban China is likely to occur also in rural China. Further studies on the reasons and consequences of such excessive use of operative delivery are needed.

Key words: cesarean section delivery rate, primiparous women, rural China, trend

Cite this article as: Klemetti R, Che X, Gao Y, et al. Cesarean section delivery among primiparous women in rural China: an emerging epidemic. Am J Obstet Gynecol 2009;201:●●●●.

Sectioraten im Vergleich:

Sao Paulo	80%
China	40%
USA	30%
Deutschland	**27%**
Malawi	20%
Niederlande	11%
Russland	6%
Tansania	2%

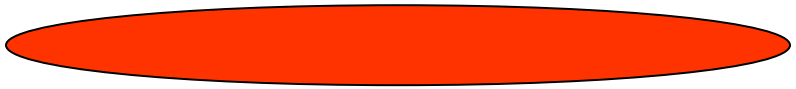


Beratungssituation spontan vs. Sectio

Sicherheit für das Kind ! perfekte Geburt !

Angst vor Schmerzen und Kontrollverlust

Furcht vor eigenen Spätschäden



Die Schwangere muss sich also zwischen der natürlichen Ungewissheit und der planbaren Gewissheit entscheiden.

einige Argumente

Die Spätfolgen einer traumatischen vaginalen Geburt werden mehr gewichtet.

Paradigmenwechsel:

vag.-op. Entbindung ⟷ Sectio

Sectiosterblichkeit

1983-1988	1 : 4363	0,23 %o	x 7
1989-1994	1 : 7700	0,13 %o	x 5,5
1995-2000	1 : 25903	0,04 %o	x 2,3

vaginale Entbindung	1 : 60062
primäre Sectio	1 : 60000

objektive Gründe für die ansteigende Sectio-Rate:

Zunahme der Mehrlingsschwangerschaften durch „Erfolge“ der Reproduktionsmedizin

Zunahme der Kindsgewichte (> 4000g)

Zunahme adipöser Schwangerer

chronisch kranke Frauen tragen heute Schwangerschaften aus (Mukoviszidose, operierte Herzfehler etc.)

Großzügigere Indikation zur sekundären Sectio

(Wunschsectio ??)

objektive Vorteile der Sectio:

bessere Planbarkeit

bessere Vorhersagbarkeit der Geburt

geringere neonatale Morbidität und Mortalität

objektive Nachteile der Sectio:

„Zustand nach Sectio“ (?)

Kosten

höhere pulmonale Morbidität der Neonaten

geburtsmedizinische Optionen werden nicht mehr erlernt

Articles

Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial

*Mary E Hannah, Walter J Hannah, Sheila A Hewson, Ellen D Hodnett, Saroj Saigal, Andrew R Willan, for the Term Breech Trial Collaborative Group**

Summary

Background For 3–4% of pregnancies, the fetus will be in the breech presentation at term. For most of these women, the approach to delivery is controversial. We did a randomised trial to compare a policy of planned caesarean section with a policy of planned vaginal birth for selected breech-presentation pregnancies.

Methods At 121 centres in 26 countries, 2088 women with a singleton fetus in a frank or complete breech presentation were randomly assigned planned caesarean section or planned vaginal birth. Women having a vaginal breech delivery had an experienced clinician at the birth. Mothers and infants were followed-up to 6 weeks post partum. The primary outcomes were perinatal mortality, neonatal mortality, or serious neonatal morbidity; and maternal mortality or serious maternal morbidity. Analysis was by intention to treat.

Findings Data were received for 2083 women. Of the 1041 women assigned planned caesarean section, 941 (90·4%) were delivered by caesarean section. Of the 1042 women assigned planned vaginal birth, 591 (56·7%) delivered vaginally. Perinatal mortality, neonatal mortality, or serious neonatal morbidity was significantly lower for the planned caesarean section group than for the planned vaginal birth group (17 of 1039 [1·6%] *vs* 52 of 1039 [5·0%]; relative risk 0·33 [95% CI 0·19–0·56]; p<0·0001). There were no differences between groups in terms of maternal mortality or serious maternal morbidity (41 of 1041 [3·9%] *vs* 33 of 1042 [3·2%]; 1·24 [0·79–1·95]; p=0·35).

Interpretation Planned caesarean section is better than planned vaginal birth for the term fetus in the breech presentation; serious maternal complications are similar between the groups.

Lancet 2000; **356:** 1375–83
See Commentary page 1368

American Journal of Obstetrics and Gynecology (2004) 191, 864–71

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Outcomes of children at 2 years after planned cesarean birth versus planned vaginal birth for breech presentation at term: The International Randomized Term Breech Trial

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Objective: The purpose of this study was to determine whether planned cesarean delivery for the singleton fetus in breech presentation at term reduces the risk of death or neurodevelopmental delay at 2 years of age.

Study design: In selected centers in the Term Breech Trial, children were screened for abnormalities at ≥2 years of age with the Ages and Stages Questionnaire, followed by a neurodevelopmental assessment if the Ages and Stages Questionnaire score was abnormal.

Results: A total of 923 of 1159 children (79.6%) from 85 centers were followed to 2 years of age. The risk of death or neurodevelopmental delay was no different for the planned cesarean than for the planned vaginal birth groups (14 children [3.1%] vs 13 children [2.8%]; relative risk, 1.09; 95% CI, 0.52- 2.30; $P = .85$; risk difference, +0.3%; 95% CI, −1.9%, +2.4%).

Conclusion: Planned cesarean delivery is not associated with a reduction in risk of death or neurodevelopmental delay in children at 2 years of age.

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Expertenkommission der AGMFM und der DGGG

Geburt bei Beckenendlage

AWMF 015/051

Berger, R., J. Dudenhausen, A. Feige, W. Gonser, B.J. Hackelöer (federführend), H. Halle, M. Häusler, F. Kainer, M. Kühnert, KTM Schneider, K. Vetter, E. Weiss, J. Wisser.

absolute Bedingungen für eine vaginale BEL-Geburt:

Einverständnis und Motivation der Schwangeren

Beckendiagnostik (MRT) bei Erstgebärenden

Gestationsalter > 35. SSW

zeitgerechtes fetales Wachstum

fetales Schätzgewicht > 2500 g - < 4000 g

Prinzipien des geburtshilflichen Managements bei BEL:

Ruhe, Geduld und Erfahrung („operator skills“)

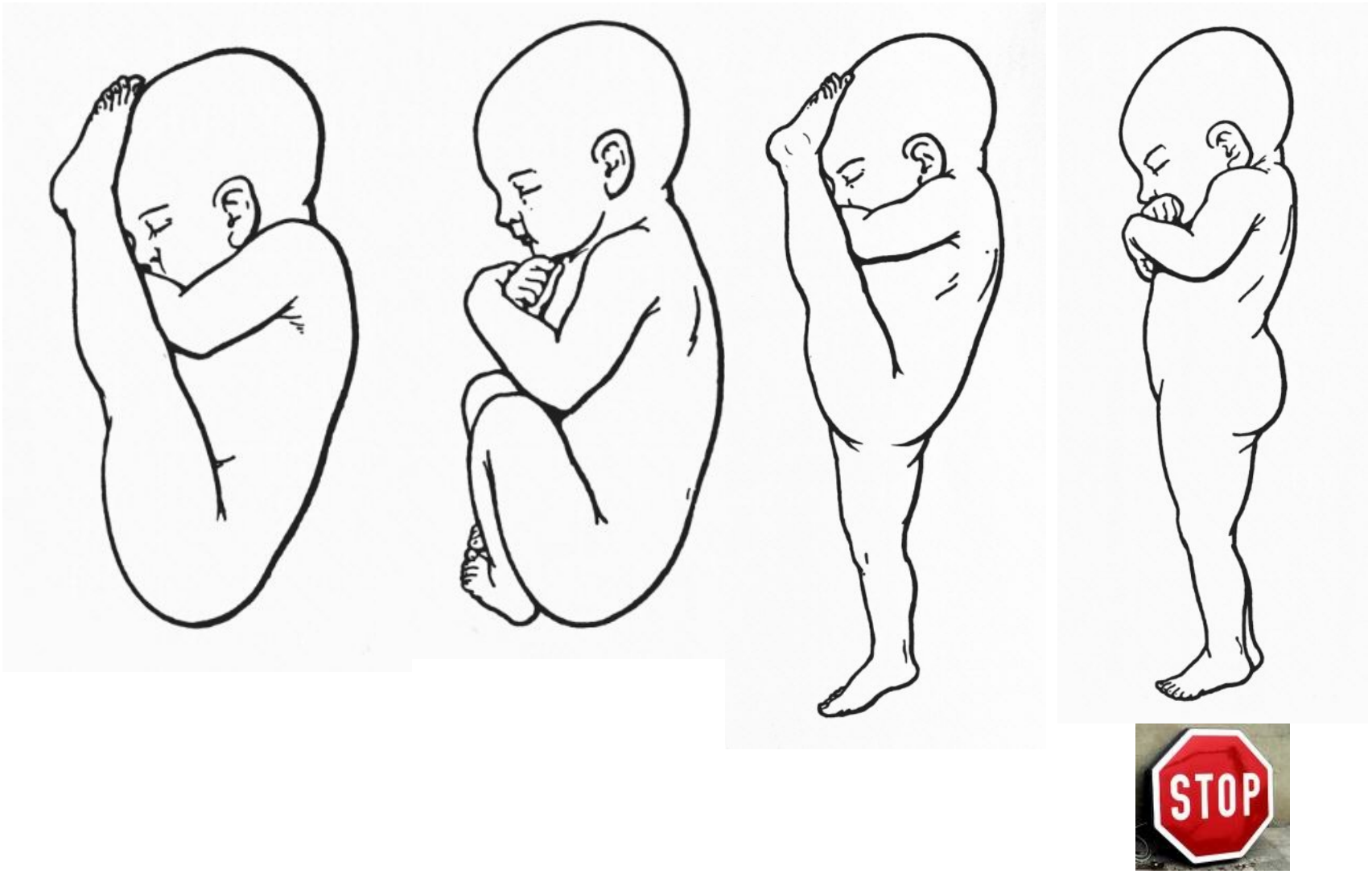
kein „Beschleunigen“ der Geburt !

PDA empfohlen

Episiotomie nicht obligar

keine frühzeitige Amniotomie

Druck von oben (suprasymphysär)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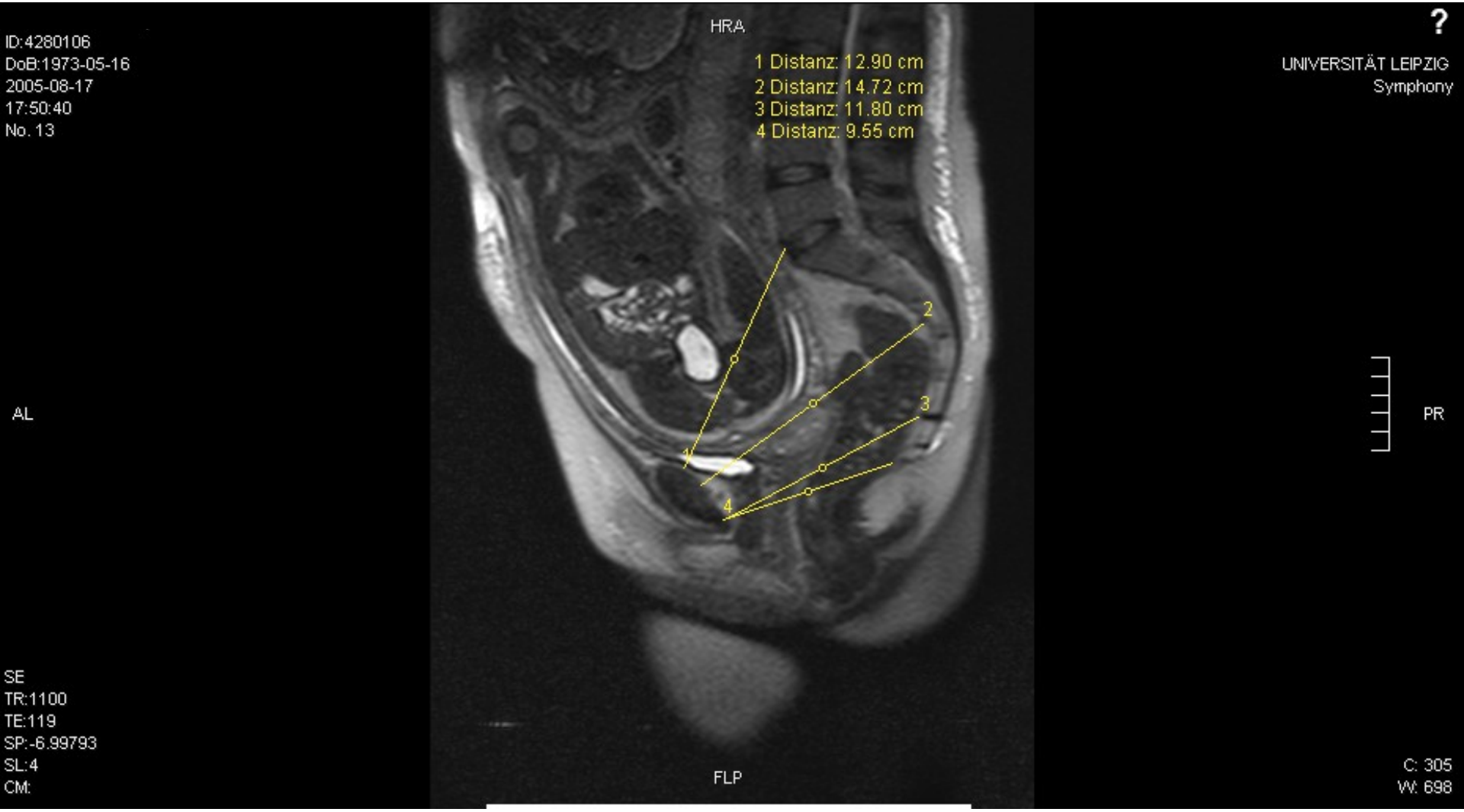
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3 Distanz: 11.80 cm
4 Distanz: 9.55 cm
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AL
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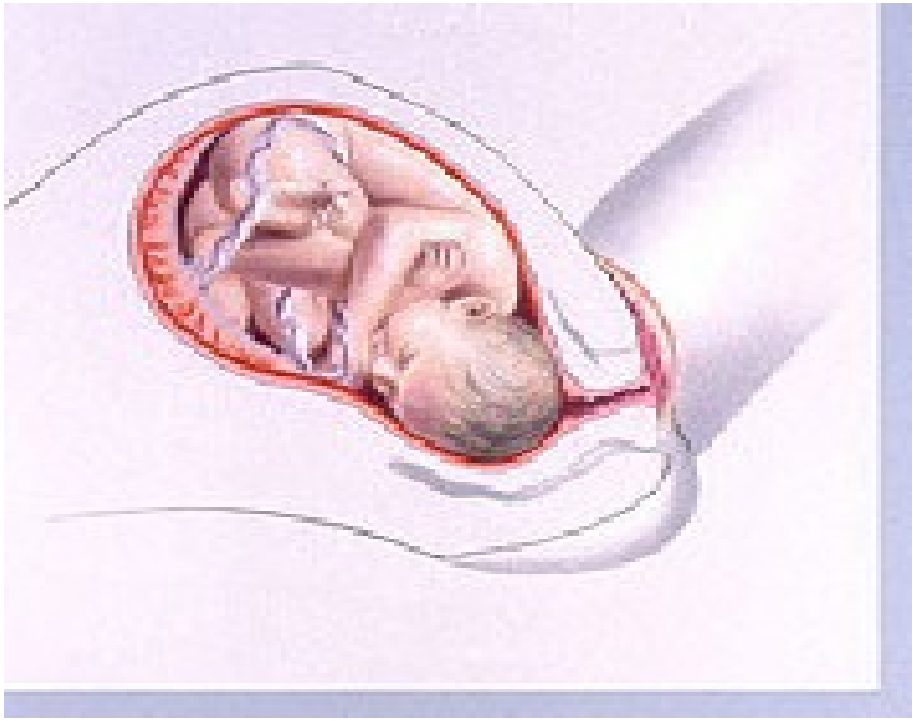
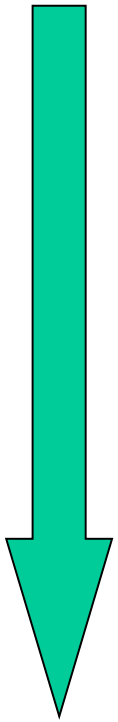
SP:-6.99793
SL:4
CM:
FLP
C: 305
W: 698

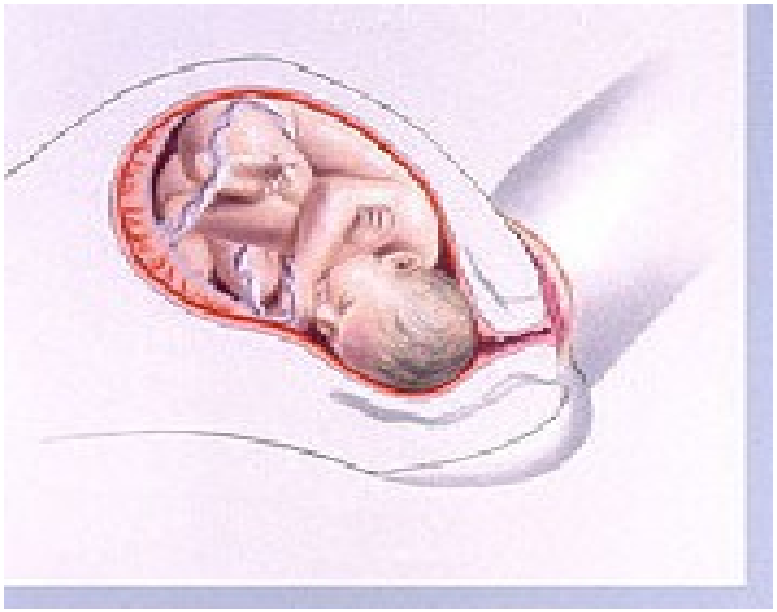
„umgekehrter Bracht“

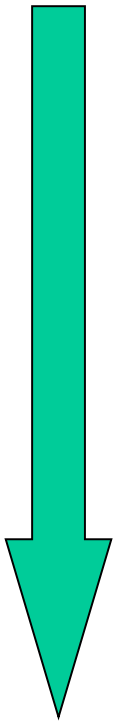
Schwerkraft

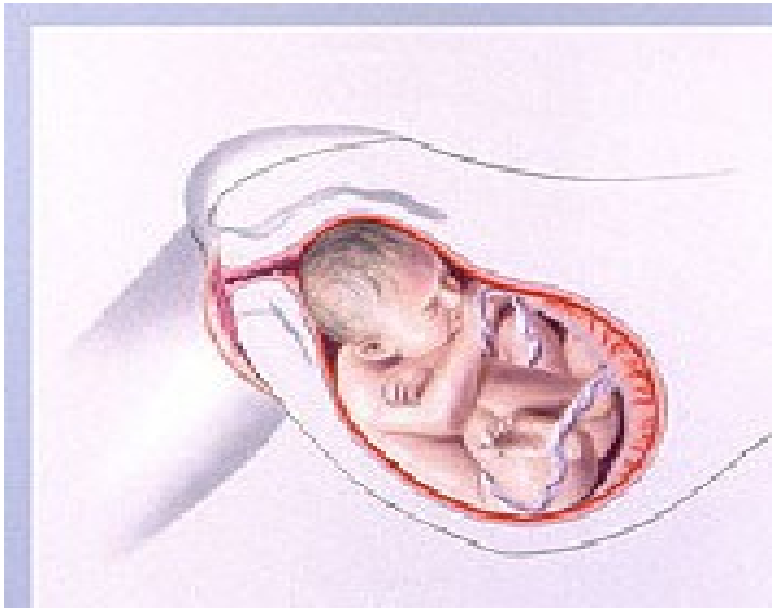


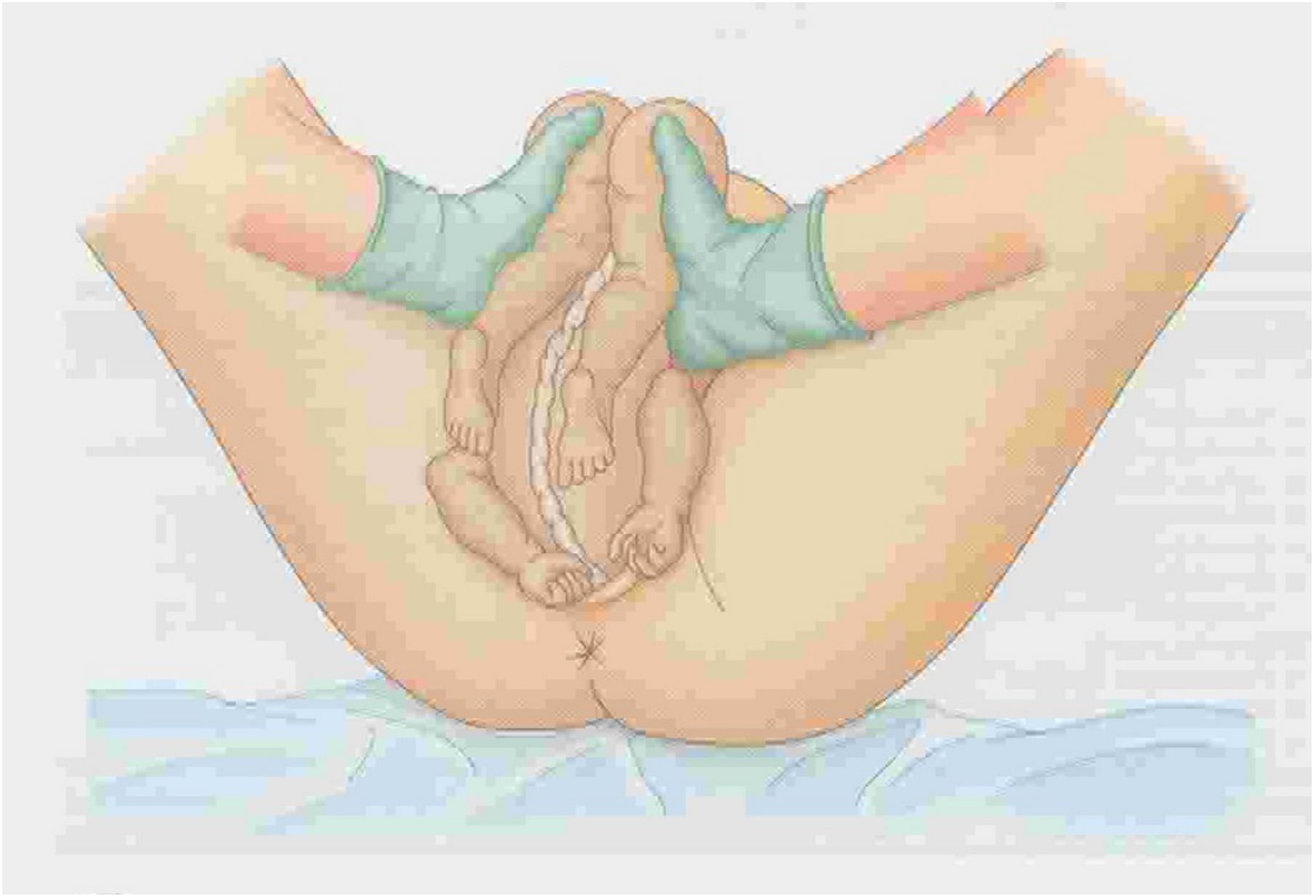


Schwerkraft









Vorteil der BEL-Entbindung im Vierfüßlerstand:

natürliche Geburtsmechanik

hohe Akzeptanz bei den Schwangeren

verbesserte Frühmorbidität (?)

Leipziger Ergebnisse 2008:

54 BEL mit Option der vaginalen Entbindung

21 Wunsch auf primäre Sectio

33 Wunsch auf vaginale Entbindung

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10 sekundäre Sectiones