

key points

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Caesarean section (CS) rates have steadily risen from 10% of all deliveries in the 1980s to a current figure of around 23.8%. Approximately 75% of CS are emergency procedures and only 25% are elective planned deliveries. When deciding whether to offer CS, it is important to consider the psychological implications for the patient as well as the physical and mental sequelae in future pregnancies.

Clinicians should provide pregnant women with evidence-based information and support. Information should include details about the true indication(s) for the CS and what it implies, including its risks and benefits.

The updated NICE guideline does not advocate CS in uncomplicated pregnancies. However, it supports CS on maternal request when attempts to empower the mother to have a vaginal birth have not been successful. CS on maternal request only represented 1.4% of all CS in 2001.

A vaginal birth costs £700 less than a CS but if we incorporate the cost of postpartum and lifelong urinary incontinence into the adverse outcomes and the quality adjusted life years (QALY), then CS becomes a cost-effective alternative to vaginal birth.

CS may reduce perineal and abdominal pain during birth and 3 days postpartum. It may also reduce injury to the vagina, early postpartum haemorrhage and obstetric shock. The following patients should be offered a planned elective CS: singleton breech presentation at term, after external cephalic version has failed, has been declined or is contraindicated; multiple pregnancies when the first twin is not cephalic; placenta praevia minor or major, (close to or covering the os); HIV-positive women who are not on any antiretroviral therapy, have a high viral load or co-infection with hepatitis C irrespective of viral load; and women with primary genital herpes simplex virus infection occurring in the third trimester.

After one CS the risk of uterine rupture increases if labour is induced or augmented. In women with up to four CS, the risk of fever, bladder injuries and surgical injuries is not affected by the planned mode of delivery. Uterine rupture is higher in vaginal birth after caesarean section (VBAC), but is rare. Planned VBAC also has a risk of emergency CS. Women who have had a successful previous VBAC have an increased probability of vaginal birth.