Women are designed to deliver vaginally and not by Caesarean section.
Why are women born with such a strange pelvis?
Why are women born with such a strange pelvis?

1. to run faster
2. to sleep better
3. to deliver vaginally
The female & the male pelvis

- And why is the male pelvis so different?
The female & the male pelvis

• And why is the male pelvis so different?

1-to run faster
2-to sleep better
3-to be unable to deliver a child
4- all 3 options correct
The car of my wife and my garage door
What should be the conclusion from that slide......
What should be the conclusion from that slide......

- The incidence of CSs has nothing to do with evidence based medicine.
- It has more to do with the doctor’s salary, the lazy doctor who does not want to work at night, the doctor who has lost his/her skills to attend a (difficult) vaginal delivery.
- Medical legal issues.
Medico legal issues

• Depend on the court experts
• Which are your/our own colleagues

• Make agreements within your societies and with the legal governmental bodies to ask only experts who are still fully engaged in active clinical practice

• Create clear guidelines: ‘Shoulder dystocia is a complication not a mistake/fault’
Caesarean Sections in Asia, 2007-08

Lumbiganon et al, Lancet, 2010;375:440-442
Caesarean Sections in Asia, 2007-08

Lumbiganon et al, Lancet, 2010;375:440-442
Caesarean Sections in Asia, 2007-08

Mat. mort, ICU admission, blood transfusion, hysterectomy, int iliac art ligation

RR
Antepartum CS without indication 2.7 (1.4-5.5)

Intrapartum CS without indication 14.2 (9.8-20.7)

Lumbiganon et al, Lancet, 2010;375:440-442
# Placenta previa/accreta and previous CS’s

<table>
<thead>
<tr>
<th>Previous CS</th>
<th>Previa (%)</th>
<th>Previa/Accreta (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 0</td>
<td>0.3</td>
<td>3.3</td>
</tr>
<tr>
<td>• 1</td>
<td>0.8</td>
<td>11</td>
</tr>
<tr>
<td>• 2</td>
<td>2.0</td>
<td>40</td>
</tr>
<tr>
<td>• 3 or more</td>
<td>4.2</td>
<td>60</td>
</tr>
</tbody>
</table>

## Placenta accreta, increta and percreta (and hysterectomy)

<table>
<thead>
<tr>
<th>Number previous CS’s</th>
<th>Total</th>
<th>Placenta AIP</th>
<th>Per 1000</th>
<th>1:10000</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>3</td>
<td>0.04</td>
<td>1:25000</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>4141</td>
<td>1.9</td>
<td>1:526</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>378</td>
<td>2.6</td>
<td>1:385</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>39</td>
<td>51.3</td>
<td>1:19</td>
<td></td>
</tr>
<tr>
<td>≥ 4</td>
<td>11</td>
<td>90.9</td>
<td>1:11</td>
<td></td>
</tr>
</tbody>
</table>

And a uterine rupture in 0.4 to 4% of subsequent pregnancies, with a perinatal death in 10% of cases.
Very importantly

There is no evidence that the increasing CS rate is associated with improved perinatal outcome (lower perinatal mortality; lower rate of asphyxia; Eckerlund & Gerdtham Int J Techn Assess Health Care 1999),

With possibly as an only exception the breech population???
More CS, better outcome?? No, only in breech deliveries

Data ‘Stichting PRN’
CS for breech position at follow up; mother versus infant

2000 SC

11 infants

1000 subsequent pregnancies:
• 10 uterine ruptures
• 1 perinatal death

1 uterine rupture for each infant ‘saved’

(Kwee et al, 2005; Rietberg et al, 2005)
CS for breech position at follow up; mother versus infant

1000 subsequent pregnancies:
• 10 uterine ruptures
• 1 perinatal death

1 uterine rupture for each infant ‘saved’
• 3 hysterectomies (placenta increta, uterine rupture)
• 4 % risk of 1 maternal death / peripartum hysterectomy

And,
one maternal death for 80 infants that are “saved”

(Kwee et al, 2005; Rietberg et al, 2005)
This implies that counseling becomes more and more important.
Progress in obstetrics

is more difficult to achieve than many of us believe/think
CS in all women with diabetes

1790 SC to prevent one Erb’s palsy, with lasting consequences

900 subsequent pregnancies:
• 9 uterine ruptures → 1 perinatal death
• 3 hysterectomies (placenta increta, uterine rupture)
• 4 % risk of 1 maternal death / peripartum hysterectomy

In other words,
One perinatal death for one Erb’s palsy prevented

(Kwee et al, 2005; Rietberg et al, 2005)
Progress in obstetrics

.......is more difficult to achieve than many of us believe/think
And what about twins
The Canadian Twin Birth Study

- CS or planned vaginal birth in twins
- N= 2,800
CS or planned vaginal birth in Twins?

Adverse outcome: perinatal mortality or severe morbidity

<table>
<thead>
<tr>
<th>Planned CS</th>
<th>Planned VB</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>1398</td>
</tr>
<tr>
<td>CS</td>
<td>89.9%</td>
</tr>
<tr>
<td>Adverse outcome*</td>
<td>57 (2.05%)</td>
</tr>
</tbody>
</table>

32-39 wks; twin A cephalic; no effect parity, gest age at randomization, mat age, presentation twin B
So, ..............
So, ..............

There is no reason to do a CS in all cases of twins, breeches or mat. diabetes
Elective repeat CS and RDS, n=13,258

36 % performed before 39 weeks of gestation

<table>
<thead>
<tr>
<th>Weeks</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>37 wks</td>
<td>4.2 (2.7-6.6)</td>
</tr>
<tr>
<td>38 wks</td>
<td>2.1 (1.5-2.9)</td>
</tr>
<tr>
<td>39 wks (reference)</td>
<td></td>
</tr>
<tr>
<td>40 wks</td>
<td>1.1</td>
</tr>
<tr>
<td>41 wks</td>
<td>1.0</td>
</tr>
<tr>
<td>42 wks</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Admission to NICU, newborn sepsis, treated hypoglycemia

Tita et al, NEJM 2009; MFM units network USA
Elective CS and respiratory outcome, n=20,973

56% performed before 39 weeks of gestation

<table>
<thead>
<tr>
<th>Week</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>37 wks</td>
<td>3.2 (2.5-4.2)</td>
</tr>
<tr>
<td>38 wks</td>
<td>1.7 (1.4-2.1)</td>
</tr>
<tr>
<td>39 wks</td>
<td>(reference)</td>
</tr>
<tr>
<td>40 wks</td>
<td>0.9</td>
</tr>
<tr>
<td>41 wks</td>
<td>0.8</td>
</tr>
<tr>
<td>42 wks</td>
<td>0.3 (0.1-1.0)</td>
</tr>
</tbody>
</table>

Significantly higher incidence of sepsis (<38 wks), hypoglycemia (<39 wks), hyperbilirubinemia (<38 wks) and NICU admission (<38 wks)

Wilmink et al, AJOG March 2010; Dutch National Registry 2000-2006
So,

Never do an elective CS before 39 weeks of gestation, unless there is documentation of lung maturity

ACOG Committee Opinion no 394, December 2007, CS on maternal request
But,
But, ..................

• We have lost our skills to attend a vaginal breech or twin delivery .........
• And we will do the CS at around 37 weeks, to prevent
And, we will do the CS around 37 wks, to prevent...

a) an emergency CS with higher maternal risks

b) unexpected vaginal breech delivery
And, we will not do the CS after 37 wks, but around 37 wks, to prevent..

a) an emergency CS, with higher maternal risks

labour will start in 10-15% of cases before 39 wks. So the poor doctor may – indeed – have to work at night. However the risk for RDS is 30% lower after the start of spontaneous contractions (Gerten et al., AJOG, 2005)

Intrapartum CS is more risky for the mother than elective CS. However that holds for the real intrapartum period and not at the beginning of labour and patients should be instructed to come early

b) unexpected vaginal breech delivery
And, we will not do the CS after 39 wks, but around 37 wks, to prevent...

a) an emergency CS, with higher maternal risks

labour will start in 10-15% of cases before 39 wks. So the poor doctor may have to work at night. However the risk for RDS is 30% lower after the start of spontaneous contractions (Gerten et al, AJOG, 2005)

Intrapartum CS is more risky than elective CS. However that holds for real intrapartum and not at the beginning of labour and patients should be instructed to come early

b) unexpected vaginal breech delivery

“Sorry Mrs So-and-so I have to do the CS at 37 wks, putting your baby at a 4fold increased risk for respiratory disorders, because I am too stupid, or forgot to practice how to do an unexpected breech delivery”

If that is the case, than we really have to.......
pray seriously for a better future
CS is associated with a 23% increase in childhood-onset type-1-diabetes

Cardwell et al, Diabetologia 2008;51:726-735; meta-analysis of observational studies
CS is associated with a 20% increase in childhood asthma

<table>
<thead>
<tr>
<th>First author</th>
<th>Asthma C-sect/tot (%)</th>
<th>Controls C-sect/tot (%)</th>
<th>Odds ratio (95%CI)</th>
<th>OR (95% CI)</th>
<th>Relative weight (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oliveti</td>
<td>33/131 (25)</td>
<td>31/131 (24)</td>
<td></td>
<td>1.09 (0.62,1.91)</td>
<td>1.1</td>
</tr>
<tr>
<td>Xu</td>
<td>49/282 (17)</td>
<td>1098/7804 (14)</td>
<td></td>
<td>1.28 (0.94,1.76)</td>
<td>2.9</td>
</tr>
<tr>
<td>Nafstad</td>
<td>20/160 (13)</td>
<td>259/2312 (11)</td>
<td></td>
<td>1.13 (0.70,1.84)</td>
<td>1.4</td>
</tr>
<tr>
<td>Xu</td>
<td>14/98 (14)</td>
<td>89/1855 (5)</td>
<td></td>
<td>3.31 (1.81,6.05)</td>
<td>0.9</td>
</tr>
<tr>
<td>Annesi-Maesano</td>
<td>39/406 (10)</td>
<td>249/3659 (7)</td>
<td></td>
<td>1.46 (1.02,2.07)</td>
<td>2.4</td>
</tr>
<tr>
<td>McKeever</td>
<td>873/5082 (17)</td>
<td>3200/19 608 (16)</td>
<td></td>
<td>1.06 (0.98,1.15)</td>
<td>11.5</td>
</tr>
<tr>
<td>Kero</td>
<td>366/2050 (18)</td>
<td>840/57 815 (15)</td>
<td></td>
<td>1.27 (1.13,1.42)</td>
<td>9.5</td>
</tr>
<tr>
<td>Kero</td>
<td>8/12 (67)</td>
<td>58/119 (49)</td>
<td></td>
<td>2.10 (0.60,7.36)</td>
<td>0.2</td>
</tr>
<tr>
<td>Bager</td>
<td>69/1116 (6)</td>
<td>424/8696 (5)</td>
<td></td>
<td>1.27 (0.98,1.65)</td>
<td>3.9</td>
</tr>
<tr>
<td>Hakansson</td>
<td>1120/13 058 (9)</td>
<td>60 110/850 175 (7)</td>
<td></td>
<td>1.23 (1.16,1.31)</td>
<td>12.6</td>
</tr>
<tr>
<td>Negele</td>
<td>1/11 (9)</td>
<td>424/1432 (30)</td>
<td></td>
<td>0.24 (0.03,1.86)</td>
<td>0.1</td>
</tr>
<tr>
<td>Vonk</td>
<td>14/133 (11)</td>
<td>25/401 (6)</td>
<td></td>
<td>1.77 (0.89,3.51)</td>
<td>0.7</td>
</tr>
<tr>
<td>Maitra</td>
<td>175/1461 (12)</td>
<td>602/5725 (10)</td>
<td></td>
<td>1.16 (0.97,1.39)</td>
<td>6.4</td>
</tr>
<tr>
<td>Smith</td>
<td>641/3856 (17)</td>
<td>24 728/169 283 (15)</td>
<td></td>
<td>1.17 (1.07,1.27)</td>
<td>11.3</td>
</tr>
<tr>
<td>Kunukulaaratchy</td>
<td>16/107 (15)</td>
<td>65/737 (9)</td>
<td></td>
<td>1.82 (1.01,3.28)</td>
<td>1.0</td>
</tr>
<tr>
<td>Debley</td>
<td>385/2028 (19)</td>
<td>1239/8292 (15)</td>
<td></td>
<td>1.33 (1.18,1.51)</td>
<td>8.9</td>
</tr>
<tr>
<td>Al-Kurbaisy</td>
<td>41/644 (6)</td>
<td>111/1618 (7)</td>
<td></td>
<td>0.92 (0.64,1.34)</td>
<td>2.2</td>
</tr>
<tr>
<td>Hagendorrens</td>
<td>26/196 (13)</td>
<td>62/592 (10)</td>
<td></td>
<td>1.31 (0.80,2.13)</td>
<td>1.4</td>
</tr>
<tr>
<td>Bernsen</td>
<td>10/144 (7)</td>
<td>71/1507 (5)</td>
<td></td>
<td>1.51 (0.76,3.00)</td>
<td>0.7</td>
</tr>
<tr>
<td>Juhn</td>
<td>41/469 (9)</td>
<td>673/6637 (10)</td>
<td></td>
<td>0.85 (0.61,1.18)</td>
<td>2.7</td>
</tr>
<tr>
<td>Renz-Polster</td>
<td>132/698 (19)</td>
<td>1154/7174 (16)</td>
<td></td>
<td>1.22 (1.00,1.49)</td>
<td>5.6</td>
</tr>
<tr>
<td>Salam</td>
<td>129/508 (25)</td>
<td>584/2928 (20)</td>
<td></td>
<td>1.37 (1.10,1.70)</td>
<td>5.0</td>
</tr>
<tr>
<td>Rusconi</td>
<td>247/844 (29)</td>
<td>3916/14 765 (27)</td>
<td></td>
<td>1.15 (0.98,1.34)</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Overall

Childhood studies

Reduced risk of asthma after Caesarean | Increased risk of asthma after Caesarean

Thavagnanam et al Clin Exp Allergy 2007;38:629-633; meta-analysis of observational studies
CS is associated with a 20% increase in childhood asthma

Limitations:
Observational studies!
However, no clear effects of:
- low birth weight
- breastfeeding
- passive smoking
No publication bias:
(funnel plot:)

Thavagnanam et al Clin Exp Allergy 2007;38:629-633; meta-analysis of observational studies
Effects of CS on Immune response

- Lower duration of pregnancy
- Absence of stress of labour
- 'Hygiene Hypothesis': N, Type and Diversity of gut microbiota reduced (delayed developmental balance between TH-1 and TH-2-like immune response (Stachan, BMJ, 1989))

S.Koletzko, 2011; Cho & Norman, AJOG, 2012
Colonization with Bacteroides fragilis

M.M. Gronlund et al. JPGN, 1999
Low bacterial richness and diversity, especially after elective CS

Azad et al, CMAJ, Febr 11, 2013
Effects CS on Immune response

- Later risks for allergy
- Celiac disease
- Aseptic necrosis of femoral head
- Cancer in the young

Cho & Norman, AJOG, 2012
Cesarean Delivery and Childhood obesity

Huh et al Arch Dis Child, 2012; USA; adjusted for mat BMI and birth weight
Cesarean Delivery and Childhood obesity

Meta-analysis, 2 case control and 7 cohort studies

<table>
<thead>
<tr>
<th>Group</th>
<th>OR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>1.32</td>
<td>(1.15-1.51)</td>
</tr>
<tr>
<td>Adolescents</td>
<td>1.24</td>
<td>(1.00-1.54)</td>
</tr>
<tr>
<td>Adults</td>
<td>1.50</td>
<td>(1.02-2.20)</td>
</tr>
<tr>
<td>Overall</td>
<td>1.33</td>
<td>(1.19-1.47)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality of trials</th>
<th>OR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>High quality</td>
<td>1.18</td>
<td>(1.09-1.27)</td>
</tr>
<tr>
<td>Median quality</td>
<td>1.78</td>
<td>(1.43-2.22)</td>
</tr>
</tbody>
</table>

H-t Li et al, Int J Obesity 2013
Caesarean section and Childhood immunity and obesity

Timing and acquisition of gut microflora during early life events appears to play significant role in health and disease (Flint et al, 2012)
Dutch boy born by Caesarean Section
Another perspective

God, Allah and Buddha have designed the woman to be able to deliver vaginally
Another perspective

• God, Allah and Buddha have designed the woman to be able to deliver vaginally

• And later they designed the doctor to correct errors they might have made
Another perspective

- God, Allah and Buddha have designed the woman to deliver vaginally
- And later they designed the doctor to correct errors they might have made
- But, it seems unrealistic to assume that they made errors in 30-50% of the normal population or in 80% of the diabetic population
How to bring the CS rate down?

- Increase the doctor’s fee of a vaginal delivery and bring the CS fee down to half of that
- Have a companion present during the whole process of labour (care versus cure; ’Doula’)
- Re-establish the practical skills of the doctors*
- Confidence to the women
- Medico-legal

* Training shoulder dystocia results in a 3-fold decrease in brachial nerve injury; Inglis et al, AJOG 2011
conçu par plaisir, construit pour la vie
And delivered vaginally

At least in the vast majority of cases
How the Portugese bring their CS rate down? (D.Ayres-de-Campo)

- Dissimination of knowledge
- Uniform CS classification system
- Annual CS rate/hospital
- Payment of CS = vaginal delivery **
- Financement of hospitals based on CS rate
- Implementation of STAN technology

**(initially) not accepted by private sector**
Corruption in Europe

Corruption Watchdog Transparancy International, 2011
Risks of Uterine rupture, Placenta previa/accreta, Hysterectomy after previous CS, will be presented by

Corinne Hubinont
# Placenta previa/accreta and previous CS’s

<table>
<thead>
<tr>
<th>Previous CS</th>
<th>Previa (%)</th>
<th>Previa/Accreta (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0.3</td>
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<tr>
<td>1</td>
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<td>11</td>
</tr>
<tr>
<td>2</td>
<td>2.0</td>
<td>40</td>
</tr>
<tr>
<td>3 or more</td>
<td>4.2</td>
<td>60</td>
</tr>
</tbody>
</table>

OR for elective C delivery: 3 !!

Kamara et al BJOG 2013
Pregnancy after CS is also a problem in China

<table>
<thead>
<tr>
<th>Population pyramid</th>
<th>N children/woman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men 1970 Women</td>
<td>Men 2011 Women</td>
</tr>
</tbody>
</table>

china-europe-usa.com, Stanford University

United Nations
Another perspective

Man delivers abdominally,
God delivers vaginally
Meta-analysis is like a sausage: Only God and the butcher know what it contains. And both are not going to eat it.
Pasgeboorene onderdrukt eigen afweer voor gezonde darmflora

Immuunsysteem

Pasgeboren baby’s dempen actief hun afweersysteem. Daardoor zijn ze in hun eerste levensweken vaak ziek.

Door onze redactie wetenschap

AMSTERDAM. Baby’s lopen kort na hun geboorte snel een infectieziekte op doordat hun afweersysteem zichzelf op een laag pitje zet. Dat gebeurt om een gevaarlijke afweerreactie tegen zich vestigende darm- en huidbacteriën te voorkomen. Dat is wat anders dan wat de medische leerboeken nu zeggen. Daarin staat dat jonge baby’s zo bevattelijk zijn doordat hun afweercellen nog moeten rijpen.

Die eerste infectieziekten tijdens de opbouw van de darmflora zijn „een ongelukkig bijproduct van het grotere nut van actieve afweeronderdrukking“, schrijven onderzoekers van het Cincinnati Children’s Hospital Medical Center vandaag in *Nature*.

En baby’s komen inderdaad op de wereld met een onrijp afweersysteem. Ze krijgen daarom hulp, van afweerstoffen in de moedermelk. Ondertussen moet hun afweersysteem het verschil leren tussen lichaamseigen en lichaamsvreem, zodat de afweer voortaan weet wat het moet opruimen en wat het met rust moet laten. Maar dat is dus niet de hele verklaring voor hun vatbaarheid voor infectieziekten.

„De afgelopen tien jaar zijn al eerder mechanismen van actieve afweeronderdrukking gevonden“, zegt kinderarts/infectioloog/immunoloog Louis Bont van het Wilhelmina Kinderziekenhuis, onderdeel van het UMC Utrecht. Bont doet ook onderzoek naar die vroege afweeronderdrukking, maar is niet bij deze publicatie betrokken. „In de baarmoeder is de afweer al onderdrukt, zodat de foetus de moeder niet als lichaamsvreemdt geeft afstoten. Meteen na de geboorte staat de baby massaal bloot aan stoffen die een afweerreactie kunnen opwekken. Die actieve onderdrukking is dus erg slim, want de zuigeling beschermt zich daarmee bijvoorbeeld tegen het krijgen van koelmelkallergie. En tegen een massale afweerreactie in de darmen, waar zich direct na de geboorte de darmbacteriën vestigen. De baby die ze ervoor betalen is een grotere vatbaarheid voor ernstiger infectieziekten.”

Te hevige afweerreacties kunnen zo uit de hand lopen dat ze dodelijk zijn. Allergische reacties en astma-anvallen zijn soms fataal. Iemand die aan bloedvergiftiging overlijdt, sterft in feite aan een massale afweerreactie.

„Dit onderzoek“, zegt Bont, „is vooral bijzonder omdat voor het eerst heel duidelijk een bepaald celttype is geïdentificeerd.” De onderzoekers vonden dat een bepaald type voorlopers van rode bloedcellen (CD71+ erythroïden) de demping verzorgen, maar alleen als die een bepaald enzym (arginase-2) produceren. Bont: „Daar zou je medicatie tegen kunnen ontwikkelen. Je zou die cellen kunnen stilleggen bij zuigelingen met een levensbedreigende infectie.”

NRC November 8, 2013
Active suppression of immune response in newborns to allow development of a healthy intestinal microflora and to tolerate food, through CD71 erythroid cells
Man delivers abdominally,
God delivers vaginally
Cesarean Delivery and Childhood obesity; most recent studies

No relation

• Lin et al, Hongkong, Ann Epidemiol 2013
• Flemming et al, Canada, Arch Dis Child 2013

Positive relation

• Wang et al, USA NICH study, Eur J Pediat 2013
• Children aged 12  adj. OR overweight  1.86 (1.27-2.73)
  adj. OR obesity  1.87 (1.19-2.95)
• Strongest relationship for boys
Caesarean section and Childhood obesity

Gut microflora may stimulate fat deposition and promote obesity through several mechanisms:

• It promotes obesity by improving energy yield from food
• It regulates gut permeability, low grade inflammation and immune balance
• It modulates metabolism/genes directly in the liver

J.E.Friedman, Diabetes in Pregnancy Study Group of North America, Washington November 1-2, 2013
The “Doula”
Continuous support compared to no-doula support: meta analysis 11 trials

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Odds ratio</th>
<th>(CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>need for oxytocin</td>
<td>0.29</td>
<td>(0.20 - 0.40)</td>
</tr>
<tr>
<td>need for analgesia</td>
<td>0.64</td>
<td>(0.49 - 0.85)</td>
</tr>
<tr>
<td>forceps</td>
<td>0.43</td>
<td>(0.28 - 0.65)</td>
</tr>
<tr>
<td>Caes. section</td>
<td>0.49</td>
<td>(0.37 - 0.65)</td>
</tr>
</tbody>
</table>

difference in duration of labour -1.6 h (-0.96 – -2.3)

(Scott et al, Am J O & G, 1999)
Care is more important than Cure
Main indication for CS in some countries: the doctor’s salary?

CS prevalence in Brasil 2006-2007:

- Public Health System 33.2%
- Private Services 72.2%

Rebelo et al, Acta O & G, 2010;89:903-908
Another problem regarding CSs……..

They are seem so easy to perform
Ines Ramirez Peres did her own CS
Discussions on CSs……..

For instance ‘why do you do a CS in all cases of twins and maternal diabetes…?’
Italian gynaecologist (GCDiR):

....... If you do so many Caesarean sections without a reason, than why not in case of maternal diabetes, twins etc.....