

Caesarean section

National Collaborating Centre for Women's and Children's Health

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Evidence Tables

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Chapter 1 Introduction

Evidence tables 1.1 and 1.2 show the distribution of demographic and clinical characteristics for women giving birth using data from the NSCSA. The average age of women giving birth was 29 years, 16% were from ethnic minority groups. Forty one percent of all women were in their first pregnancy.

1.1 Demographic factors and CS rate for women giving birth in England & Wales (n = 147,087)

	All women (%)	CS before labour (%)	CS during labour (%)
<i>Maternal age (years)</i>			
12–19	7.4	4.4	9.3
20–24	17.4	6.2	9.9
25–29	28.1	8.8	12.1
30–34	29.9	11.9	13.1
35–39	14.0	15.0	14.3
40–50	2.4	20.1	15.8
Missing data	0.8	11.4	10.0
<i>Ethnicity</i>			
White	84.3	10.2	11.8
Black African	2.0	12.3	21.0
Black Caribbean	1.3	9.5	15.4
Black Other	0.9	10.2	14.3
Bangladeshi	0.7	7.8	11.7
Indian	2.5	9.4	13.9
Pakistani	3.1	8.4	10.4
Chinese	0.8	6.8	12.3
Asian Other	1.4	9.2	15.5
Other	2.1	8.7	13.2
Not known	0.2	7.0	9.4
Missing data	0.7	7.8	9.8

1.2 Clinical factors and CS rate for women giving birth in England & Wales (n = 147,087)

	% All women	% CS before labour	%CS during labour
<i>Number of previous vaginal deliveries</i>			
0	47.9	13.8	19.5
≥ 1	51.4	6.6	5.8
Missing data	0.7	10.3	8.9
<i>Number of previous CS</i>			
0	89.9	6.0	10.8
1	7.9	42.7	33.3
≥ 2	1.5	83.1	70.8
Missing data	0.7	11.0	8.3
<i>Gestation (weeks)</i>			
< 28	0.5	19.6	14.1
28–32	1.1	41.3	21.4
33–36	5.1	22.2	17.9
≥ 37	93.0	9.0	11.8
Missing data	0.3	10.3	10.4
<i>Onset of labour</i>			
Spontaneous	67.3	–	9.8
Induction	22.1	–	19.3
CS before labour	10.0	–	–
Missing data	0.6	–	–
<i>Presentation</i>			
Cephalic	95.9	7.9	11.0
Breech	3.6	60.8	71.2
Transverse	0.4	65.7	100
Missing data	0.1	39.0	57.3
<i>Birthweight</i>			
≤ 2500	5.8	23.5	18.1
2501–4000	81.2	9.3	11.0
> 4000	11.7	8.1	16.9
Missing data	1.3	19.1	15.7

Chapter 4 Planned CS

4.1 Breech presentation

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Nelson <i>et al.</i> 1986 ⁴⁸	189 children with cerebral palsy born in 12 university hospitals in the USA between 1959 and 1966 Follow up and analysis at age 7 years	Observational study	Prenatal and perinatal predictors of cerebral palsy	Important predictors before onset of labour Birth weight below 2001 g Major non-CNS congenital malformation Microcephaly at birth Breech presentation Overlap observed between breech presentation and characteristics determined before onset of labour Breech presentation With CP (n = 21): Birth weight < 2.0 kg: 9/21 (43%) Micro-cephaly at birth: 2/21 (9.5%) Congenital malformation: 7/21 (33.3%) Other: 1/21 (4.8%) Any: 13/21 (61.9%)		Case-control	2b
Kitchen <i>et al.</i> 1982 ²⁸	89 infants of gestational age from 24–28 weeks born in 1977 and 1988 in 2 Australian hospitals	Observational study Followed up after 2 years	Major handicap as defined as cerebral palsy, Mental Developmental Index < 69, deafness or blindness.	Handicap by presentation at birth (unadjusted figures): Presentation at birth: Vertex: Handicap: 16/36 (27.6%) No handicap: 42/53 (72.4%) Breech or transverse lie: Handicap: 20/36 (64.5%) No handicap: 1153 (35.5%) OR 4.77 (95% CI 1.71 to 13.62) A handicapped baby at 2 years in this population was 5 times as likely to have presented as a breech or transverse lie There was no adjustment for confounding factors for handicap		Case-control	2b

4.1 Breech presentation (external cephalic version)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Hofmeyr, Kulier Cochrane review Update 1999 ⁶³	6 RCTs 1 in South Africa 1 in Zimbabwe 2 in the Netherlands 1 in Denmark 1 in the US 612 women with a breech presentation. 3 trials: gestation 37 weeks or more 2 trials: gestation 36 weeks or more 1 trial: 33 to 40 weeks.	External cephalic version (ECV) (with or without the use of tocolysis) vs. No ECV	Non-cephalic births	ECV: 99/303 (32.7%) No ECV: 242/309 (78.3%) RR 0.42 (95% CI 0.35 to 0.50)	External cephalic version for breech presentation at 36 weeks compared with no external cephalic version reduces the incidence of non-cephalic births by 60%. Results were consistent from study to study	Systematic review of randomised controlled trials.	1a
Hofmeyr Cochrane review (Update 1994) ⁶⁴	3 RCTs and quasi-randomised trials. 1 in Sweden 1 in Zimbabwe 1 in the Netherlands 889 women with singleton breech presentation before term. ECV before 37 weeks of gestation. 1 trial ECV from 28 weeks 1 trial ECV from 33–36 weeks 1 trial ECV from 32 weeks	External cephalic version (ECV) before term vs. No ECV attempt	Non-cephalic births	ECV: 197/434 (38.5%) No ECV: 204/455 (44.8%) RR 1.02 (95% CI 0.89 to 1.17)	Performing ECV in breech babies before 37 weeks compared with no ECV does not make a difference to the incidence of non-cephalic births. Results were consistent from study to study	Systematic review of randomised and quasi randomised controlled trials.	1a
Hofmeyr Cochrane review update 2001 ⁶⁶	6 RCTs 617 women with breech presentation at term and no contraindication to ECV	Routine beta-mimetic tocolysis for ECV at term vs. no tocolysis	Failed ECV	Tocolysis: 136/317 (42.9%) No tocolysis: 176/300 (58.7%) RR 0.74 (95% CI 0.64 to 0.87)	The use of betamimetic tocolysis during ECV compared with no tocolysis reduces the incidence of failed ECV by 30%. Results were consistent from study to study	Systematic review of randomised and quasi randomised controlled trials.	1a

4.1 Breech presentation health economics (ECV)

Study	Population	Intervention details	Cost outcomes	Results	Comments	Study type	EL
Gifford 1995 ⁶⁹	Pregnant women with breech presentation of the baby at term.	1) ECV with TOL (for infants still in breech) 2) ECV with planned CS 3) Selected TOL for infants meeting specific criteria and CS for all others 4) planned CS for all breech infants	Literature review to identify cost and outcomes (probabilities of positive and negative consequences) of the four management options derived from RCTs California state charge data for 1993 as proxy for costs	Expected costs/case were: 1) US\$8071 for the ECV and TOL strategy; 2) US\$8276 for the ECV and CD strategy; 3) US\$8755 for the selected TOL strategy; 4) US\$9544 for the scheduled CD strategy	No incremental analysis was performed. Results highly sensitive to probabilities used.	Decision analysis model	
Adams 2000 ⁷³	695 women presenting with breech delivery	ECV	Mean Apgar scores Local hospital charges only. 1996 prices No synthesis of costs and benefits Resource use not analysed separately from costs	ECV attempted in 139 (20%) patients with breech presentation Unsuccessful ECV 56%, of which 7% proceeded to vaginal delivery Successful ECV 44% , of which 67% proceeded to vaginal delivery Estimated savings in charges, US\$648/delivery Savings from ECV versus ECV not attempted: around \$3000/delivery Potential savings from attempted ECV greater than for success/failure comparisons, based on the charges. This is due to reported higher rate of CS delivery for women not undergoing attempted ECV, and higher cost of CS for the non ECV group compared with the ECV group (US\$17476 vs. US\$14617)	Small, single institution sample size. Not randomised so groups may not be similar. Sensitivity analysis showed that savings may be as low as under US\$1000	Cost consequences	

4.1 Breech presentation health economics (ECV) (continued)

Study	Population	Intervention details	Cost outcomes	Results	Comments	Study type	EL
James 2001 ⁵³	176 women attending one hospital 1995–97	ECV and TOL	<p>Five outcomes recorded: ECV, uncomplicated cephalic delivery, assisted vaginal delivery (breech or cephalic), elective CS or emergency CS.</p> <p>Health service costs only reported. Used original costs from Clark <i>et al.</i> (bottom up costs), uplifted to 1997 prices. Prices validated by Regional Finance Directorate (top down costs). Setting: North Staffordshire</p> <p>Cost analysis only, no synthesis of costs and benefits</p>	<p>Vaginal delivery: £447 (baseline) External cephalic version – additional £187 (lower grade) – additional £193 (higher grade) Assisted delivery (ventouse): – additional £425 (lower grade) – additional £456 (higher grade) Emergency CS: – additional £1,955 (lower grade) – additional £1,992 (higher grade) Planned CS – (no vaginal delivery costs) – £2,403 (lower grade) – £2,439 (higher grade)</p> <p>Decision analysis: ECV yields expected cost of £1,452 vs. £1,828 for non ECV (low staff cost). Expected cost saving £376. With higher staff cost, saving of £384 is estimated.</p> <p>Sensitivity/threshold analysis: Cost of ECV would need to be around £718 for both ECV and non ECV approaches to yield the same overall cost (an increase of 285%) Cost of CS would need to fall to £857 for the non-ECV option to be the least cost option (a fall of 56%) Success rate of ECV would have to fall by 5% for ECV option to be the less favourable option in terms of costs</p>	High and low figures calculated depending on the grade of staff attending delivery	Costing study within decision analysis	

4.1 Breech presentation health economics (ECV) (continued)

Study	Population	Intervention details	Cost outcomes	Results	Comments	Study type	EL
Rozenberg 2000 ⁶⁸	68 women with breech presentation at 36 weeks of gestation	ECV under epidural anaesthesia after failure of first attempt with tocolysis alone	Effectiveness data: ECV Success rate CS rate for success/ failure Costs analysis covered obstetric procedures; cost data from local and national sources. No patient costs or downstream costs included	Caesarean rate successful ECV group 7.4% unsuccessful ECV group 46.3 % (p = 0.0007) Cost of delivery successful ECV £2,230 unsuccessful ECV £2,595 with no second ECV £2,118 (assuming CS delivery for 75% of breech births) Given probabilities of 57% success for initial ECV and 16% success for second ECV and 27% for ECV failure, the weighted mean cost for attempted ECV was £1,320, and for planned CV for breech without TOL £2,314	No sensitivity analysis No comparison with women who did not undergo ECV	Cost effectiveness	
Kilpatrick 1995 ⁷¹	36 women who underwent repeat ECV in one US hospital	Repeat ECV after initial failed ECV	Effectiveness data from a retrospective cohort study 1987–92 Outcome: successful achievement of vertex position in labour and consequent need for CS Hospital costs collected for sample of women retrospectively. Hospital costs only included. Costs and resources analysed together using hospital charge system, converted to 1992 prices	Cost of an ECV US\$300 Repeat ECV cost was US\$10,800 for 36 patients. Total delivery cost/successful ECV US\$5059 (± US\$2,656, p = 0.03) Total delivery cost/woman who failed repeat ECV US\$8,042 (± £3,439, p = 0.03) Successful repeat ECV on 6 women, cost US\$30,354 which would have been \$48,252 without repeat ECV (difference \$18,000). Subtraction of the cost of ECV leaves a saving of US\$7,200	No sensitivity analysis Does not include complications arising from mode of delivery Cohort study may be subject to bias		

4.1 Breech presentation health economics (ECV) (continued)

Study	Population	Intervention details	Cost outcomes	Results	Comments	Study type	EL
Mauldin 1996 ²	203 pregnant women with singleton gestation	ECV	<p>Primary effectiveness outcomes used in the model: successful ECV rate success rate impact on maternal and neonatal outcomes</p> <p>Health service costs only obtained from insurer</p> <p>Prices from year 1996</p>	<p>ECV initial success rate 48%</p> <p>Infants who remained vertex 83%</p> <p>Vaginal delivery after successful ECV 66%</p> <p>CS after successful ECV 34%</p> <p>Unsuccessful ECV remaining vertex 14% and of these 67% delivered vaginally 5% were transverse and 81% breech</p> <p>Higher parity, transverse oblique presentation, longer pregnancy and posterior placenta were all associated with significantly increased likelihood of successful version</p> <p>Cost estimates ECV US\$285 Cephalic CS US\$9967 Breech CS US\$10,783 Cephalic VD US\$5,583 Breech VD US\$ 5,996 All VD US\$5,585 All CS US\$9,883</p> <p>Mean savings/successful; ECV US\$2,462 compared with unsuccessful ECV at 48% success</p> <p>Higher success rate would yield higher savings</p>	<p>Resources not analysed separately from costs</p> <p>No synthesis of costs and benefits</p>	Cost effectiveness	

4.1 Breech presentation health economics (ECV) (continued)

Study	Population	Intervention details	Cost outcomes	Results	Comments	Study type	EL
Mauldin 1998 ⁶⁴⁹	84 twin gestations with vertex and non vertex twins: 41 selected for TOL 19 for ECV 24 for planned CS	Breech extraction ECV Planned CS	Clinical outcomes, maternal and neonatal morbidity rates Hospitalisation (not used in economic analysis) Charge data from one hospital (US) 1996 prices Costs and benefits not combined	Maternal morbidity rate: Breech extraction: ECV 42% CS group 37% n.s. Maternal LOS: Breech extraction 3.4 days ECV 6.3 days CS group 7.0 days (p < 0.0001) Neonatal pulmonary disease: Breech extraction 7% ECV 24% CS group 31% (p = 0.002) Neonatal infectious disease: Breech extraction 1% ECV 0% CS group 16% (p = 0.0005) Infants requiring ventilator: Breech extraction 5% ECV 12% CS group 14% (p = 0.01) Infants admitted to SCBU: Breech extraction 71% ECV 51% CS group 50% (p = 0.0001) Infant hospitalisation: Breech extraction 4.8 days ECV 12.4 days CS group 17.8 days (p = 0.0001) Charges: TOL group: US\$5890 ± US\$2,304 ECV group: US\$8,638 ± \$4,175 CS group: US\$7,814 ± 3294 ANOVA p = 0.001	Retrospective cohort study in a single centre, open to bias Resources not reported separately from costs No synthesis of costs and benefits		

4.1 Breech presentation

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Van Loon <i>et al.</i> 1997 ⁶⁵⁰	235 women with singleton breech presentation at term Term defined as duration 37 weeks gestation or more Randomised between January 1993 and April 1996 US hospital	Pelvimetry results revealed to obstetricians vs. pelvimetry results not disclosed to obstetricians (mode of delivery decided clinically)	Vaginal delivery Overall CS rate Emergency CS rate	CS percentage: VD: Pelvimetry results revealed: 68/118 (57.6%) Pelvimetry results not disclosed: 58/117 (49.6%) RR 1.16 (95% CI 0.91 to 1.48) Overall CS rate: Pelvimetry results revealed: 50/118 (42.2%) Pelvimetry results not disclosed: 59/117 (50.4%) RR 0.84 (95% CI 0.64 to 1.11) Emergency CS rate: Pelvimetry results revealed: 22/118 (18.6%) Pelvimetry results not disclosed: 41/117 (35.0%) RR 0.53 (95% CI 0.34 to 0.83) NNT: 6	Revealing pelvimetry results prior to making a decision about mode of delivery did not make a difference to the vaginal delivery rate or the CS rate but reduced the emergency CS rate by 50% Computer-generated randomisation No description of allocation concealment Women were analysed by intention to treat	RCT	1b

4.1 Breech presentation and CS

Mother outcomes

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Hofmeyr and Hannah Cochrane Systematic review updated 2000 ³⁶	3 RCTs involving 2396 women with a breech presentation at term suitable for vaginal delivery	Planned CS vs. planned vaginal delivery	Maternal morbidity (pooled) Maternal morbidity measures included: – Postpartum bleeding (including blood transfusion) – Genital tract injury – Wound infection, dehiscence or breakdown – Maternal systemic infection – Early postpartum depression – Time in hospital after delivery	Planned CS: 107/1169 (9.2%) Planned vaginal delivery: 106/1227 (8.6%) RR (95% CI): 1.29 (1.03 to 1.61)	Planned CS compared with planned vaginal delivery increases maternal morbidity by 30% Results generally consistent from study to study	Systematic review of randomised controlled trials	1b
Hannah <i>et al.</i> 2000 ⁴⁸	2088 women with a singleton fetus in a frank or complete breech presentation at term. Multicentre randomised trial at 121 centres in 26 countries (high and low perinatal mortality rates)	Planned CS vs. planned vaginal delivery	Maternal mortality	Planned CS: 0/1041 Planned vaginal delivery: 1/1041	Centrally controlled randomisation Analysis was by intention to treat	RCT	1b
Gimovsky <i>et al.</i> 1983 ⁴³	105 women with non frank breech presentations at term. US hospital	Trial of labour vs. elective CS	Maternal mortality	No report of maternal deaths	Method of randomisation not indicated.	RCT	1b
Collea <i>et al.</i> 1980 ⁴⁴	208 women with frank breech presentation at term. US hospital	Trial of labour vs. elective CS	Maternal mortality	No report of maternal deaths	Method of randomisation not indicated	RCT	1b

Baby outcomes

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Hofmeyr and Hannah Cochrane Systematic review updated 2000 ³⁶	3 RCTs involving 2396 women with a breech presentation at term suitable for vaginal delivery ³	Planned CS vs. planned vaginal delivery	Perinatal and neonatal death (excluding fatal anomalies)	Planned CS: 3/1166 (0.26%) Planned vaginal delivery: 14/1222 (1.15%) RR 0.29 (95% CI 0.10-0.86) Countries with low (20/1000 or less) perinatal mortality rate was 0.26 (95% CI 0.03 to 2.00)	Planned CS is associated with a 70% decrease in mortality compared with planned vaginal delivery for breech delivery at term.	Systematic review of randomised controlled trials	1a

4.1 Breech presentation and CS (continued)

Baby outcomes

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Hofmeyr and Hannah Cochrane Systematic review updated 2000 ³⁶	3 RCTs involving 2396 women with a breech presentation at term suitable for vaginal delivery	Planned CS vs. planned vaginal delivery	Perinatal death or neonatal morbidity Neonatal morbidity measures included: – Birth trauma – Seizures occurring at less than 24 hours of age or requiring two or more drugs to control them. – Apgar score of less than 4 at 5 min – Cord blood base deficit of at least 15 – Hypotonia for at least 2 hours – Stupor, decreased response to pain or coma. – Intubation and ventilation for at least 24 h – Tube feeding for 4 days or more – Admission to the neonatal intensive care unit for longer than 4 days.	Planned CS: 20/1132 (0.18%) Planned vaginal delivery: 66/1152 (5.73%) RR 0.31 (95% CI 0.19 to 0.52) Countries with low (20/1000 or less) perinatal mortality rate was 0.13 (95% CI 0.05 to –0.31)	Planned CS is associated with a 70% decrease in death or morbidity compared with planned vaginal delivery for breech delivery at term.	Systematic review of randomised controlled trials	1a
Hofmeyr and Hannah Cochrane Systematic review updated 2000 ³⁶	3 RCTs Involving 2396 women with a breech presentation at term suitable for vaginal delivery.	Planned CS vs. planned vaginal delivery	5-minute Apgar < 7	Planned CS: 11/1164 (0.94%) Planned vaginal delivery: 38/1211 (3.14%) Total: 3/1039 (0.3%) RR 0.32 (95% CI 0.17 to 0.61)	Planned CS compared with planned vaginal delivery reduced the incidence of 5min Apgar score < 7 by 70%	Systematic review of randomised controlled trials	1a
Hannah <i>et al.</i> ⁴⁸	Pregnant women with a singleton fetus in a frank or complete breech presentation Randomised multicentre trial	Planned CS 1041 Planned vaginal birth 1042	Perinatal mortality, neonatal mortality or serious neonatal morbidity Maternal mortality or serious maternal morbidity	Planned CS: Low national perinatal mortality rate: 0/514 High national perinatal mortality rate: 3/525 (0.6%) Planned vaginal birth: Low national perinatal mortality rate: 3/511 (0.6%) High national perinatal mortality rate: 10/528 (1.9%) Total: 13/1039 (1.3%) Relative risk 0.23 (95% CI 0.07 to 0.81) p = 0.01	Overall, a policy of planned CS one baby will avoid death or serious morbidity for every additional 14 CS done May be higher (up to 39) in Countries with a high PMR And as low as 7 in a country with a low PMR Babies with lethal congenital abnormalities Excluded from analysis	RCT	1b

4.2 Multiple pregnancy

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Crowther, 2000 ³⁷	60 pairs of twins (see trial below for more details)	Vaginal delivery versus CS for second twin in a breech position	Maternal: Duration of hospitalisation, febrile morbidity, need for blood transfusion, operative morbidity Neonatal: Apgar scores, birth trauma, neonatal mortality and morbidity	Maternal febrile morbidity: RR 3.67 (95% CI 1.15 to 11.69)	Only one trial	Systematic review	1a
Rabinovici, 1987 ⁴⁵	60 women in spontaneous or induced labour with twin pregnancy-both twins alive-first twin vertex, 2nd twin breech/transverse lie Gestational age 35–42 weeks Exclusion criteria: Fetal anomaly Signs of abruption or acute placental insufficiency. Indication for CS or vaginal delivery Cervix > 7 cm dilated	As above	As above	Maternal febrile morbidity: Elective CS: 11/27 (40.7%) Vaginal delivery: 3/27 (11.1%) RR 3.67 (95 % CI 1.15 to 11.69) No difference in neonatal outcomes	Blinding of treatment allocation not possible Exclusion after randomisation 9% No pretrial sample size given	RCT	1b
Rhydstrom, 2001 ⁸⁷	18125 twins delivered in Sweden between 1991 and 1997 Breech vaginal delivery vs. CS all twins, all gestations	Observational study	Neonatal mortality by mode of delivery and presentation-breech vaginal delivery vs. CS	All gestations: OR 1.47 (95% CI 0.99 to 2.17) < 32 weeks: OR 2.50 (95% CI 1.58 to 3.99) 32–36 weeks: OR 0.40 (95% CI 0.13 to 1.24) > 37 weeks: OR 0.48 (95% CI 0.13 to 1.71)		Cohort	2b
Abu-Heija, 1997 ⁶⁵¹	58 sets of twin pregnancies with twin 1 breech 37 delivered by CS. 21 delivered vaginally	Observational study	Perinatal mortality and morbidity	No differences in perinatal mortality by mode of delivery No differences in perinatal morbidity as measured by Apgar scores at 1 and 5 minutes		Cohort	2b

4.2 Multiple pregnancy (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Essel, 1996 ⁶⁵²	68 women carrying twin gestations breech–breech and breech–transverse presentations delivered in a South African hospital between February 1989 27 delivered by CS 41 delivered vaginally Inclusion criteria for vaginal delivery Estimated fetal weight < 3500 g Well-flexed fetal head No footling breech presentation Clinically adequate maternal pelvis	Prospective observational study (CS vs. vaginal delivery)	Birth weights, 5-minute Apgar score ≤ 7 , neonatal mortality	Both twin 1 and twin 2 in the CS group had greater birth weights than their cohort delivered vaginally ($p < 0.02$ for twin 1 and $p < 0.01$ for twin 2) No difference in Apgar score or neonatal mortality	Underpowered for neonatal mortality	Cohort	2b
Blickstein, 1993 ⁶⁵³	69 sets of twins in breech-vertex presentation 35 delivered by CS 24 delivered vaginally	Retrospective observational study	Maternal outcomes: – Maternal mortality – Postpartum haemorrhage – Febrile morbidity Baby outcomes: – Perinatal death – Birth trauma	There was no difference any of the maternal or baby outcomes		Cohort	2b
Greig, 1999 ⁸⁸	457 sets of twins Second twin Breech and vertex presentation	Record review	1- and 5-minute Apgar scores, umbilical artery and vein pH, duration of neonatal hospitalisation, incidence and length of ventilation, IVH, birth trauma, mortality rates (Apgar score results presented by mean according to weight group)	Study did not show any difference in any of the outcomes other than mean 1-minute Apgar This was lower in breech, vaginal births at birth weight > 2500 g ($p = 0.02$) There was only one case of significant birth trauma among the 457 sets of twins which occurred in the vaginal delivery group		Cohort	2b

4.2 Multiple pregnancy (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Gocke, 1989 ⁶⁵⁴	136 twin gestations with non-vertex second twins Birth weights > 1500 g	Observational study (delivery by CS vs. vaginal delivery of second twin) Vaginal delivery group consists of attempted external version and primary breech extraction	Maternal outcomes: – Postpartum hospital stay – Need for blood transfusion – Endometritis Baby outcomes: – Neonatal death – Birth trauma – 5-minute Apgar score < 7 – Admission to SCBU	No difference in any outcomes other than length of maternal hospital stay. This was longer with CS (p < 0.05)	Length of hospital stay anticipated to be longer with CS	Cohort	2b
Petterson, 1993 ⁸⁰	Babies delivered in Western Australia 1980–1989 226,517 singletons 5132 twins 225 triplets	Observational study	Cases of cerebral palsy	Cerebral palsy/1000 live births: Singleton: 1.6 (95% CI 1.4 to 1.8) Twin: 7.4 (95% CI 5.3 to 10.0) Triplet: 95% CI 26.7 (11 to 60)		Longitudinal	3
Dommergues, 1995 ⁹³	55 sets of triplets CS 23, vaginal delivery 23	Observational study	Neonatal mortality	Neonatal mortality by mode of delivery: CS: 0/69 (0.0%) Vaginal delivery: 1/69 (1.5%) p value: NS		Cohort	2b
Ziadeh, 2000 ⁹⁴	41 sets of triplets at 28 weeks or more 20 delivered by CS, 21 delivered vaginally	Observational study	Baby outcomes: – Perinatal death – Apgar score of < 7 at 5 minutes	Perinatal death by mode of delivery: CS: 18/60 (30.0%) Vaginal delivery: 14/63 (22.2%) p < 0.05 Apgar score < 7 at 5 minutes: CS: 8/60 (3.3%) Vaginal delivery: 6/63 (9.5%) p < 0.05		Cohort	2b
Clarke, 1994 ⁶⁵⁵	19 triplet pregnancies delivered between 1981 and 1982 in a hospital in New Zealand: CS 12; vaginal delivery 7 Mean gestation at delivery 33 weeks (all) CS 31 weeks and 6 days Vaginal delivery 35 weeks and 2 days	Observational study	Perinatal death Apgar < 7 at 5 minutes	Perinatal death: CS: 6/18 (33.3%) Vaginal delivery: 0/21 (0.0%) Apgar score < 7 at 5 minutes CS: 18/36 (50.0%) Vaginal delivery: 3/21 (14.9%)		Cohort	2b

4.2 Multiple pregnancy (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Wildschut, 1995 ⁹²	31 triplet pregnancies for planned abdominal delivery versus 39 for planned vaginal birth	Retrospective cohort	Perinatal mortality and early neonatal complications	Perinatal mortality: Perinatal mortality*: Vaginal: 7.8% CS: 18.4% p = 0.02 Neonatal complications: Vaginal: 36% CS: 31% p = 0.03 *Fetuses < 500 g excluded		Cohort	2b

Timing of planned CS for twin pregnancy

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Chasen, 1999 ⁹⁶	79 sets of twins delivered by CS between 36 weeks and 37 weeks 6 days vs. 47 sets of twins delivered between 38 weeks and 40 weeks 2 days Delivered at a US hospital between 1993 and 1997 Inclusion criterion: gestational age \geq 36 weeks gestation	Observational study	Respiratory distress syndrome and transient tachypnoea of the newborn	Incidence of respiratory distress syndrome by mode of delivery: Neonates with respiratory disorders: Gestation at delivery < 38 weeks: 10/11 (90.9%) Neonates without respiratory disorders: Gestation at delivery < 38 weeks: 69/115 (60.6%) p = 0.04		Case-control 3 study	

4.3 Preterm birth and CS; 4.4 Small for gestational age and CS*

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Sachs, 1983 ¹⁰¹	376350 singleton deliveries, vertex and breech, all birth weights	Audit	Neonatal mortality rate (NMR) = number of live born infants dying within the first 28 days/1000 live births	All vertex births: NMR VD: 243 (1521) NMR CS: 246 (285) RR 1.0 Birth weights 1000–1500 g: NMR VD: 172 (99) NMR CS: 129 (70) RR 1.3 (95% CI 1.1 to 1.5) Neonatal MR for vaginal vs. caesarean births	The results for vertex presentations only are given here	Audit	3
Atrash, 1991 ¹⁰²	Retrospective collection of data on recorded neonatal deaths of single births (n = 7808)		RR and 95% confidence intervals of mortality among single caesarean births compared with vaginal births in different weight groups	500–1499 g: RR 0.72: (95% CI 0.69 to 0.76) 1500–2499 g: RR 1.46: (95% CI 1.31 to 1.63) 2500–3499 g: RR 2.06: (95% CI 1.85 to 2.30) 3500–8165 g: RR 2.08: (95% CI 1.78 to 2.44) Total: RR 1.57: (95% CI 1.49 to 1.65)	Actual data were not published, only calculated RR. Neonatal mortality risk also calculated in terms of race (results not given here as only locally relevant)	Audit	3
Grant, 2000 ³⁵	Systematic review of elective CS versus expectant management for delivery of the small baby. Six studies identified. Details of the 2 trials addressing preterm vertex births are shown here						
Lumley, 1984 ⁴⁰	Patients delivering from 26–31 weeks	Planned CS vs. expectant management with selective CS	Multiple maternal and neonatal mortality and morbidity indices	Nil published	Abandoned as > 40% of eligible patients were withdrawn pre randomisation on consultants discretion	RCT	1b
Wallace, 1984 ⁴¹	Established preterm labour, 26–33 weeks, cephalic	Planned CS vs. expectant management with selective CS	Apgar, neonatal death, neonatal complications		Abandoned as birth weights of babies entered into the study were in excess of VLBW.	RCT	1b
Rosen, 1984 ¹⁰⁰	17,260 vertex deliveries at all birth weights, collected retrospectively	Retrospective review of cases	Intra partum death, neonatal death, gross neonatal neurological morbidity	Neonatal deaths: 1000 g: VD–ND 25; CS–ND 13; p = 0.5 2000 g: VD–ND 5; CS–ND 4; p = 0.0002 3000 g: VD–ND 9; CS–ND 3; p = 0.014	Selection of results only (35 variables considered)	Survey	3

4.3 Preterm birth and CS; 4.4 Small for gestational age and CS* (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Topp, 1997 ⁹⁹	175 cases from the Danish Cerebral Palsy register, 687 controls (4/case) randomly selected preterm babies	Search of maternity birth records for details of pregnancy and birth	Complications in pregnancy and mode of delivery when comparing cases with CP and matched controls	Rate of CS higher in cases but not when breech and vertex considered separately: Cases (n = 175); controls (n = 687) V: 75 cases (59%); 266 controls (50%) OR 1.47 (95% CI 0.96 to 2.24); p: NS B: 43 cases (90%); 121 controls (79%) OR 1.81 (95% CI 0.6 to 5.47); p: NS Total: 118 cases (67%); 387 controls (56%); OR 1.67 (95% CI 1.16 to 2.41); p = 0.01		Case-control 2b	

*Studies included consider all small babies: preterm and SGA

4.6 Mother-to-child transmission of maternal infections

HIV

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
European Mode of Delivery Collaboration, 1999 ⁴⁷	n = 436 women between 34 and 38 weeks of pregnancy with confirmed HIV-1 diagnosis without indication (or contraindication)	Caesarean section delivery vs. vaginal delivery	HIV infection status of child by 18 months (n = 370)	Intention-to-treat by infection status: CS: negative 167 (98.2%); positive 3 (1.8%); OR 0.2 (95% CI 0.1 to 0.6) VD: negative 179 (89.5%); positive 21 (10.5%); OR 1.0	No woman breastfed Randomisation through computer generated lists and analysis by intention to treat and by actual mode of delivery	RCT	1b
	For CS delivery in various European countries, including the UK			Actual mode of delivery by infection status: CS (all) : negative 196 (96.5%); positive 7 (3.5%); OR 0.4 (95% CI 0.2 to 0.9) Elective CS: negative 165 (97.6%); positive 4 (2.4%); OR 0.4 0.3 (95% CI 0.1 to 0.8) Emergency CS: negative 31 (91.2%); positive 3 (8.8%); OR 0.4 1.0 (0.3 to 3.7) VD: negative 179 (89.5%); positive 21 (10.5%); OR 0.4 (1.0)			
Urbani, 2001 ¹²⁴	307 women who delivered by CS	59 HIV positive women, 248 HIV negative women. Cross-sectional study	Demographic comparisons, indications for CS, mean maternal haemoglobin, endometritis, duration of hospital stay	Endometritis: HIV+ 24%; HIV- 7%; p = 0.0003 Hospital stay (mean days): HIV+ 4.2; HIV- 4.3; p: NS Mean duration of antibiotic use: no data given No other differences between the HIV+ and HIV- groups	5 HIV positive women had a CD4 count < 200.	Cross-sectional	3
Rodrigues, 2001 ¹²²	86 HIV+ women undergoing a CS	Case-control study Comparison with 86 HIV negative women having CS	Minor and major postoperative complications	Minor complications: HIV+ 66.3%; HIV- 41.8%; OR 2.73 (95% CI 1.4 to 6.1) Major complications: HIV+ 9.3; HIV- 3.4; OR 2.84 (95% CI 0.65 to 14.06)		Case control	2b

4.6 Mother-to-child transmission of maternal infections (continued)

HIV

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Maiques-Montesinos, 1999 ¹²³	45 HIV+ women having CS	Comparison with 90 matched controls	Baseline compared with post-operative characteristics, duration of hospital stay, need for postoperative antibiotics, incidence of minor and major puerperal complications	Days of hospital stay; HIV+ 8.0; HIV- 7.0; p < 0.0005 Need for post operative antibiotics; HIV+ 29; HIV- 18; p < 0.00001 Mild temperature (37.5-380) ; HIV+ 15; HIV- 9; p < 0.002 Fever (> 380 C) ; HIV+ 17; HIV- 10;p < 0.0005 Wound infection; HIV+ 12; HIV- 6; p < 0.003	HIV positive women with CD4 within normal limits did not differ in terms of hospital stay with control women	Retrospective case-control	2b
Grubert, 1999 ¹²¹	62 HIV+ women undergoing CS	Compared with 62 HIV negative women	Major complications (fever > 48 hours requiring antibiotics, further surgery needed, blood transfusion) Minor complications (transient fever, impaired wound healing, lochiostasis, endometritis)	Minor complications: HIV+ 5; HIV- 4; OR 1.3 (95% CI 0.3 to 4.9) Major complications: HIV+ 20; HIV- 77; OR 3.7 (95% CI 1.4 to 9.6) No difference between women on antiretrovirals and those who were not		Retrospective case-control	2b

HIV health economics

Note: level of evidence is not relevant to economic models and therefore not been included here

Study	Population	Intervention details	Cost Outcomes	Results	Comments	Study type
Halpern 2000 ¹²⁷	4958 HIV positive women who did not breastfeed	Planned CS versus VD	<p>Cases of mother-to-child transmission of HIV avoided</p> <p>Child's life-years saved based on average US life expectancy of 75.8 years and the estimated life expectancy of 9.4 years for an HIV-infected child</p> <p>Costs estimated from published data, inflated to 1998 prices, reported at population level only</p> <p>Discounting at 5%</p>	<p>68% women received ART</p> <p>Seroprevalence rate 1.7/1000</p> <p>Planned CS vs. VD led to a reduction of:</p> <ul style="list-style-type: none"> - 466 vases with no ART - 198 cases with ZDV - 120 cases with combination ART <p>Planned CS resulted in saving of US\$4,359,377</p> <p>Incremental cost effectiveness of planned CS over VD:</p> <p>ECS was the dominant strategy (more effective, less costly) when no ART used</p> <p>Incremental cost-effectiveness of planned CS over VD</p> <p>with ZDV:</p> <p>US\$1,131/case avoided and US\$112,693/life year saved</p> <p>With combination ART:</p> <p>US\$1,697/case avoided and US\$112,693/life year saved</p>	<p>Resources and costs not reported separately</p> <p>Results were sensitive to vertical transmission rates and costs of treating paediatric HIV disease</p>	Cost-effectiveness with modelling
Mrus 2000 ¹²⁶	Hypothetical cohort of expectant mothers with HIV	Planned CS versus VD	<p>Total life time costs</p> <p>Quality adjusted life expectancy</p> <p>Maternal death rate, HIV transmission rate</p> <p>Data from literature review (RCTs) including complication rates</p> <p>Future medical costs discounted</p>	<p>Base line results:</p> <p>Caesarean section 34.9 infected infants/1000 deliveries</p> <p>Vaginal delivery 62.3 infected infants</p> <p>Compared with vaginal delivery, CS results in US\$3900 savings/birth and 24.7 fewer HIV infected infants/100,000 deliveries (dominant strategy)</p> <p>This result did not change over a wide range of assumptions</p> <p>Threshold analysis</p> <p>Only when transmission rate fell to 1.3% and the RR of transmission exceeded 89% did the elective CS cost more than VD</p>	Extensive sensitivity analysis undertaken on all parameters	Cost-effectiveness with modelling

HIV health economics (continued)

Note: level of evidence is not relevant to economic models and therefore not been included here

Study	Population	Intervention details	Cost Outcomes	Results	Comments	Study type
Chen 2001 ¹²⁸	7000 HIV infected women	Planned CS versus VD	Effectiveness data from published RCTs (1996–99) Outcome: Proportion refusing CS delivery Proportion undergoing vaginal and CS delivery Transmission rates Complication rates (from prospective studies not RCT data) Third party payer costs, derived from review of the evidence, converted into 1998 US\$ prices Lifetime costs discounted at 5% Resource use data from completed studies (1995–99) Price years 1998	Cost data used in the model: VD without complications: US\$2,269 VD with complications: US\$3,230 CS without complications: US\$4,316 CS with complications: US\$5,576 Lifetime costs of medical care for paediatric HIV: US\$86,130 Synthesis costs and benefits Cost saving of US\$37,284/case of perinatal HIV infection prevented after elective CS was recommended (range US\$7,742 when cost of CS was US\$5,577, to US\$286,963 when life time costs of medical care for paediatric HIV infection was £335,809) Threshold analysis: CS is no longer a cost-saving option under the following conditions: If perinatal transmission rate were decreased by 43.3% for all methods If the cost of uncomplicated vaginal delivery was less than US\$556 If the cost of uncomplicated CS delivery was less than US\$5,907 If the discounted lifetime costs for paediatric HIV infection was less than US\$49,000		Cost-effectiveness analysis
Ratcliffe 1998 ¹²⁵	Hypothetical cohort of women with confirmed HIV status	Strategies to prevent transmission of HIV Planned CS vs. other mode of delivery Bottle feeding Bottle feeding plus CS Bottle feeding plus CS plus ZDV	Health service costs from data published in 1991 and 1996 And from one London maternity unit; adjusted to 1996 prices Evidence data from published studies 1992–97	Cost: No intervention £502.50 Bottle feeding £503.80 Bottle feeding plus CS £726.20 Bottle feeding plus ZDV £1,189.30 All three £1,411.70 Incremental cost effectiveness ratios (cost/transmission avoided compared with next best option) Bottle feeding £15 Bottle feeding plus CS £9,248 Bottle feeding plus ZDV £7,594 All three £18,546	Reported ICER from clinical and public health perspective (different estimates of transmission risk). Public health perspective reported here	

Hepatitis B virus

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Lee <i>et al.</i> 1988 ¹³⁵	447 infants born to mothers positive for Hepatitis B e antigen and hepatitis B surface antigen who received hepatitis B immunisation antenatally 62 delivered by CS 385 delivered by vaginal delivery	After birth infants were given differing schedules of hepatitis vaccine and immunoglobulin at 2 weeks and 1 and 2 months: Schedule: 1 = vaccine alone 2 = vaccine +HBIG x 1 3 = vaccine + HBIG x 2	Hepatitis B infection in neonates	HBV infected/total infants: Vaccine alone: CS: 3/9 (33%) VD: 39/99 (39%) Vaccine +HBIG x 1: CS: 3/43 (7%) VD: 45/221 (20%) Vaccine + HBIG x 2: CS: 6/62 (< 10%) VD: 96/385 (24.9%) p < 0.02		Non-randomised controlled study	2a

Hepatitis C virus

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Pembrey, 2001 ¹³⁸	1474 hepatitis C virus infected women from 36 centres in eight Western European countries	Observational study	Effect of mode of delivery on risk of mother-to-child transmission of HCV	Risk of vertical transmission for women with HIV co-infection: CS:13/159 (8.2%); crude OR 0.43 (95% CI 0.23 to 0.80) VD: 57/329 (17.3%) Risk of vertical transmission for women without HIV co-infection: CS: 15/218 (6.9); crude OR 1.19 (95% CI 0.64 to 2.20) VD: 39/666 (5.9)	Adjustment for breastfeeding status, centre category and maternal age at delivery	Retrospective analysis of audit data	3
Papaevangelou, 1998 ⁶⁵⁶	62 offspring born to 54 HCV and HIV co-infected women in a New York hospital between March 1987 and October 1994	Observational study	Infant HCV infection as assessed by nested RNA PCR	Risk of vertical transmission by mode of delivery: CS: 3/16 (18.8%); RR 1.09 (95% CI 0.31 to 3.83) VD: 6/35 (17.1%)		Cohort	2b

Genital herpes simplex virus

Study	Population	Intervention	Outcomes	Results	Comments	Study type	Evidence level
Nahmias, 1971 ¹⁴²	238 women with genital herpes during pregnancy or at their first postpartum visit	Observational study	Neonatal infection with HSV	Number of infections: Vaginal delivery: 4/9 Abdominal delivery: 0/2	Very small numbers	Observational study	3
Scott, 1996 ¹⁵²	46 pregnant women with first episode of HSV during pregnancy	Acyclovir 400 mg tds versus placebo from 36 weeks gestation	Delivery by CS for recurrent infection	OR = 0.04 (95% CI 0.002 to 0.745) for delivery by CS in women taking acyclovir compared with placebo		RCT	1b
Brocklehurst, 1998 ¹⁵¹	63 pregnant women with recurrent genital herpes infection < 36 weeks	Acyclovir orally from 36 weeks till term. Control group received placebo	Delivery by CS for recurrent infection	OR = 0.44 (95% CI 0.09 to 1.59) for delivery by CS in women taking acyclovir compared with placebo		RCT	1b
Braig, 2001 ¹⁵³	288 pregnant women with at least one episode of HSV during pregnancy, 201 women with a history of genital herpes but no recurrence in the index pregnancy	Group 1: 167 women received oral acyclovir from 36 weeks till term Group 2: 121 women given placebo Group 3: 201 women (history only) received placebo	Viral shedding in pregnancy and CS for HSV	CS: Group 1: 8.4% Group 2: 16.5% Group 3: 9.9% p < 0.001 Viral shedding: Group 1: 0% Group 2: 5% Group 3: 0.5% p < 0.05		RCT	1b

Genital herpes simplex virus health economics

Note: level of evidence is not relevant to economic models and therefore not been included here

Study	Population	Intervention details	Cost Outcomes	Results	Comments	Study type
Randolph 1993 ¹⁵⁴	Hypothetical cohort of 1 million women with and without herpes lesions at delivery, and women with and without a history of HSV and herpes lesions at delivery	Universal CS	Efficacy of CS Neonatal deaths Neonatal severe disability Neonatal moderate disability Neonatal normal outcome Incremental maternal mortality following CS (in excess of vaginal delivery mortality) QALY analysis assumed death = 0 severe disability 0.1 weighting Moderate disability 0.5 weighting. Future costs and benefits (QALYs) discounted at 4% Hospital care and lifetime disability costs included. Price date not given Costs over 30 years Calculated as incremental cost of CS over standard delivery.	Efficacy of CS 80% Neonatal deaths 0.183 Neonatal severe disability 0.154 Neonatal moderate disability 0.101 Neonatal normal outcome 0.562 Incremental maternal mortality following CS (in excess of vaginal delivery mortality) 0.00015 9 neonatal cases averted/million births for women with a history of HSV/lesions at delivery 18 neonatal cases prevented/million births for women with no history. Universal CS delivery represents US\$2.5 million/case of neonatal HSV averted from women with recurrent herpes For women with no history of genital HSV before delivery, the cost/case of is a saving of over US\$38,000	Costs and resources not reported separately, but estimates based on non-systematic review of the literature Extensive sensitivity analysis around rates of transmission validity findings, but no sensitivity analysis of cost data	Cost-effectiveness analysis, with decision analysis
Randolph 1996 ¹⁵⁵	10,000 women with at least one documented outbreak of genital herpes	Four strategies: A: CS B: acyclovir prophylaxis and CS C: acyclovir prophylaxis in late pregnancy and vaginal delivery, with screening and follow up of infants D: Do nothing	Case of vertically transmitted herpes prevented Resource use and cost reported separately Price year not reported	Strategy A: US\$4,056,203/case prevented (2.8 cases) Strategy B: US\$3,076,749/case prevented (5.5 cases) Strategy C: US\$2,363,634/case prevented (5.0 cases) Strategy D: US\$361,724/case prevented (nil) Incremental cost/case prevented (compared with doing nothing, strategy D): A: US\$1,319,457 B: US\$493,641 C: US\$ 400,382	Effectiveness data from RCTs One hospital setting. Sensitivity analysis not thoroughly investigated, which weakens the conclusions	

Genital herpes simplex virus health economics (continued)

Note: level of evidence is not relevant to economic models and therefore not been included here

Study	Population	Intervention details	Cost Outcomes	Results	Comments	Study type
Scott 1998 ¹⁵⁶	46 pregnant women with their first case of HSV during pregnancy (group 1) a history of HSV (group 2) or a diagnosis of HSV before pregnancy but no frequent recurrence (group 3)	Acyclovir suppression versus no therapy	Risk of HSV recurrence at delivery and CS rates in treated and untreated groups Recurrence without therapy 30% Costs based on clinical charges during 1995	Mean cost/patient US\$7,225 treated and US\$7,625 not treated Highest cost savings US\$455/patient produced by women whose first episode occurred during pregnancy Rate of CS was the most sensitive variable for groups 1 and 2 Results also sensitive to compliance rates	Effectiveness data from RCT Costs/resources not reported separately Given the lack of details of costs, difficult to apply to other settings	Cost analysis (prevention and treatment)

4.7 Maternal request for CS

Rates of maternal request for CS

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Gamble ¹⁵⁷	12 observational studies including total of 13285 women in Australia, Ireland, Sweden and UK In 11 studies the women were surveyed just after delivery In one study women were surveyed ante natally (n = 33)	Observational study	Rates of maternal request for CS	All CS: 1.5% to 28% Elective CS: 5% to 48% In absence of known current or previous obstetric complications: 0% to 1%	Variety if methods used: structured questionnaires/ interviews and review of case notes Data collection was primarily done by clinicians Post hoc rationalisation Studies did not address quality or amount of information women were given about CS Limited investigation of reasons for requesting CS such as previous negative birth experiences or sexual abuse	Review	3
Gamble ¹⁵⁷	310 women in Australia recruited from antenatal clinics, between 36 to 40 weeks of gestation	Observational study	Rates of maternal request for CS	Nulliparae: 2.9% Multiparae: 9.2% All women: 6.4%	Data collected using questionnaires	Cross-sectional	3
Johanson ¹⁵⁸	117 women attending a UK antenatal clinic	Observational study	Rates of maternal request for CS	Nulliparae: 9% Multiparae: 5% All women: 8%	Data collected using questionnaires	Cross-sectional	3

4.7 Maternal request for CS (continued)

Rates of maternal request for CS

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Hildingsson ¹⁶⁰	3061 women attending 593 antenatal clinics in Sweden	Observational study	Rates of maternal request for CS	<p>Preference for CS: All women: 8.2%</p> <p>Parity: Primiparae: 7.0%; RR 1.00 Multiparae: 9.0%; RR 1.2 (95% CI 1.0 to 1.6)</p> <p>Age: < 25 years: 8.0%; RR 1.0 (95% CI 0.7 to 1.4) 25–35 years: 8.0%; RR 1.0 > 35 years: 11.0%; 1.5 (95% CI 1.0 to 2.1)</p> <p>Previous mode of delivery: VD: 5.0%; RR 1.0 Elective CS: 49.0%; RR 9.4 (95% CI 6.9 to 12.8) Emergency CS: 32.0%; 6.2 (95% CI 4.6 to 8.3)</p>	Data collected using questionnaires	Cross-sectional	3
NSCSA ⁴	2475 women booked to deliver in 40 maternity units in England, Wales and Northern Ireland, surveyed antenatally (average gestation 35 weeks)	Observational study	Maternal preference for delivery	<p>Preference for CS: All women: 5.3% Primigravida: 3.3% All multiparae: 7.0% Multiparae, previous SVD only: 3.2% Multiparae with previous CS: 19.9% Multiparae with previous operative vaginal delivery: 7.0% Multiparae with previous stillbirth or neonatal death: 9.4% No problems reported in current pregnancy: 4.7%</p>	Data collected using questionnaire	Cross-sectional	3
Potter ¹⁶¹	1612 pregnant women in Brazil Interviewed twice antenatally and once postpartum	Observational study	Maternal preference for delivery	<p>80–90% of all women declared preference for vaginal delivery</p> <p>Over 80% of multiparae with no previous CS and 42% of multiparae with previous CS had a preference for vaginal delivery</p>	CS rates in Brazil: 70% in private sector, 30% in public sector	Cross-sectional	3

4.7 Maternal request for CS (continued)

Rates of maternal request for CS

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Osis ¹⁶²	656 women who had given birth in Brazil, interviewed postnatally	Observational study	Maternal preference for delivery	Preference for vaginal delivery was expressed by 90% of women who had had a previous vaginal delivery compared with 75% of women who had had previous CS only		Cross-sectional	3
Edwards ¹⁵⁹	All women attending an antenatal clinic in Wales July–November 1999	Observational study	Maternal preference for delivery	Preferred mode of delivery (n = 344): Await spontaneous labour/ IOL at term +12 days: 79% IOL at 39 weeks: 6% Elective CS at 39 weeks: 14% Reasons given for elective CS preference: To avoid vaginal trauma: 28% Safer for baby: 25% To avoid a long labour: 21% Timed delivery: 18% Existing medical problems: 7% To prevent an emergency CS: 2%	Response rate to survey not reported	Cross-sectional	3

Fear of childbirth

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Melender ¹⁶⁵	481 women 16–40 weeks gestation, Finland 2000–2001	Observational study Use of a structured questionnaire about objects, causes and manifestation of fear	Factor analysis of the structured questionnaire	<p>Of 329 respondents, 78% expressed fears relating to pregnancy, childbirth or both.</p> <p>Fears concerning childbirth, health care staff, family life and CS were more common among primiparous than multiparous women ($p < 0.001$)</p> <p>Childbirth fear occurred more often in primiparous women who had not attended antenatal classes compared with those who had attended them ($p = 0.009$)</p> <p>Fear of healthcare workers was more common among women who had problems in the current pregnancy compared with those who had not and among those who were planning an elective CS</p> <p>The causes of fear were reported to be alarming information, negative stories told by others and diseases</p> <p>Manifestations of fears included stress symptoms, influence on everyday life, wish to have CS, and wish to avoid current pregnancy and childbirth</p>	Response rate 69%	Cross-sectional	3

Fear of childbirth (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Saisto ¹⁶⁶	100 pregnant women (about 33 weeks), in their second pregnancy requesting elective CS due to fear of childbirth that was not present in their first pregnancy 200 women with at least 1 previous birth and no history of fear of childbirth	Observational study	Spontaneous miscarriage before first delivery Spontaneous miscarriage between deliveries Previous infertility Time between deliveries Epidural analgesia in first delivery Duration of second stage of delivery Vacuum extraction in first delivery Emergency CS in first delivery Induction of labour in first delivery Duration and intervention during third stage of labour in first delivery	Spontaneous miscarriage before first delivery: OR 1.73, 95% CI 1.05 to 2.85 Spontaneous miscarriage between deliveries: OR 3.11, 95% CI 1.16 to 8.34 Time between deliveries: OR 1.44, 95% CI 1.19 to 1.75 Vacuum extraction in first delivery: OR 4.50, 95% CI 2.18 to 9.31 Emergency CS in first delivery: OR 26.91, 95% CI 11.86 to 61.07 Duration of second stage of labour was longer in the group of cases (62 minutes, SD 35) compared with controls (47 minutes, SD 30) No difference between the groups for previous infertility, epidural analgesia in first delivery, induction of labour in first delivery and duration and intervention during third stage of labour in first delivery	Odds ratios are reported to be adjusted odds ratios although it is not clear what had been adjusted for	Case-control	3
Johnson ²⁶	Pregnant women at least 16 years of age in Sheffield, England, surveyed at 32 weeks gestation	Observational study Questionnaire to measure: 1. W-DEQ scores: Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ) (a validated 33 item questionnaire measurement of fear of childbirth based on women's cognitive appraisals regarding the delivery during pregnancy) 2. measure of state/trait anxiety (STAI) (validated, based on 40 item questionnaire separated into scales of state anxiety and trait anxiety)	Emergency CS Spontaneous vertex delivery Assisted vaginal delivery Elective CS	Mean W-DEQ score for all women: 65.41 (SD 17.49) No difference in fear of childbirth levels between women who were aware of complications that may lead to a CS and those who were not No difference in scores according to mode of delivery. OR (95% CI) of emergency CS vs. spontaneous vertex delivery: Medical risk: 2.48 (1.12 to 5.52) Nulliparity: 9.11 (3.78 to 21.96) Previous CS: 9.94 (2.83 to 34.93) Reason to expect CS: 1.95 (0.84 to 4.52) Age: 1.09 (1.02 to 1.17) Fear of childbirth (W-DEQ) scores: 1.00 (0.98 to 1.01)	Questionnaire sent out to 1200 women, response rate 35% Compared with the population, a higher proportion of women in the study group were aged between 30-39 years. The elective CS rate was 11% in the study group compared with 6% in the hospital population	Cross-sectional	3

Fear of childbirth (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Ryding ¹⁶⁷	<p>Pregnant women at least 32 weeks gestation in Sweden 1992–1993</p> <p>Excluded women planning an elective CS and those that received treatment for their fear of childbirth</p>	<p>Observational study</p> <p>Cases: those delivered by emergency CS (n = 97)</p> <p>Controls: women from the same population that delivered vaginally, matched for age and parity (n = 194)</p>	<p>Fear of childbirth measured by a questionnaire at 32 weeks gestation, using</p> <p>1. W-DEQ scores. Score of 84 or above considered to be serious fear of childbirth (upper 10th centile of distribution of scores)</p> <p>2. STAI - state and trait anxiety index</p> <p>3. Stress coping inventory (SCI)</p>	<p>Mean W-DEQ score for all women: 54.1 (s.d.21.1):</p> <p>Mean difference in score (cases–controls):</p> <p>W-DEQ: 10.3 (95% CI 5.3 to 15.3)</p> <p>STAI: 2.7 (95% CI 0.1 to 5.3)</p> <p>SCI: SCI (95% CI –0.3 to 10.3)</p>	<p>Emergency CS rate in Sweden 6.3%, overall CS rate 9.1%</p> <p>84% response rate to questionnaire</p>	Nested case–control	3

Fear of childbirth (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Saisto ¹⁶⁸	176 low-risk and physically healthy pregnant women referred to the antenatal clinic because of fear of vaginal delivery	<p>Provision of information and conversation regarding previous obstetric experiences, feelings and misconceptions and psychotherapy with a trained obstetrician at 24, 28, 32, 36 and 38 weeks gestation vs. usual care—standard information distribution and routine obstetric appointments at 24 and 36 weeks</p> <p>All participants were given 3 questionnaires (before randomisation, 4 weeks before due date, 3 months after delivery)</p> <p>Refusal to answer the questionnaire was used as an indication of the woman's motivation for treatment and confrontation of fears</p>	<p>Primary outcome measure: CS rate</p> <p>Other outcome measures: Duration of labour, pregnancy related anxiety, satisfaction with childbirth</p>	<p>176 women randomised</p> <p>112 women (64%) completed all 3 questionnaires</p> <p>Women who did not complete questionnaires had fewer appointments (OR 2.03 95% CI 1.30, 3.21).</p> <p>Non response to questionnaires was equal between the two groups</p> <p>Overall, 62% of all randomised women who initially chose to deliver by CS chose to have a vaginal birth</p> <p>Women choosing to deliver by CS: Intervention group n = 85: 20 (23%) Control group (n = 91): 26 (28%) RR 0.82 (95% CI 0.50 to 1.36); 1.00</p> <p>No difference in mean score for anxiety during pregnancy between the two groups (p > 0.05)</p> <p>Significantly lower mean scores for fear of pain in labour in intervention group (p = 0.04)</p> <p>No difference in mean score for fear of obstetricians unfriendly behaviour between the two groups (p = 0.05)</p> <p>Duration of labour was shorter in the intervention group (6.8 (SD 3.8) hours) compared with 8.5 (SD 4.8) hours in the control group (p = 0.04)</p> <p>No difference in use of epidural analgesia between the groups (85% to 82%)</p>	<p>Women identified by either request for CS or a screening questionnaire</p> <p>Randomisation in blocks of 20 using sealed opaque envelopes</p> <p>Intention to treat analysis</p> <p>Women in the intervention group mentioned birth related concerns more frequently in the pre-randomisation questionnaire than those in the control group</p>	RCT	1b

Chapter 5 Factors affecting likelihood of CS during intrapartum care

5.1. Place of birth

Home birth

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Olsen, 2003 ¹⁷¹	11 low-risk multiparous women	Planned home vs. planned hospital birth	Operative delivery, perineal sutures, nitrous oxide and oxygen, pethidine, baby not breastfed, mother disappointed about allocation, father did not state that he was relieved	No actual data provided Statistical analysis: all no difference	Systematic review including one RCT Underpowered due to small numbers	RCT	1b
Olsen, 1997 ¹⁷²	Six trials included. 24092 low-risk pregnant women	Home vs. hospital births	Perinatal and maternal mortality and morbidity outcome measures of low Apgar scores, maternal lacerations and intervention rates (induction, augmentation, episiotomy, operative vaginal birth and CS)	Perinatal mortality: OR 0.87 (95% CI 0.54 to 1.41) Apgar: OR 0.55 (95% CI 0.41 to 0.74) Lacerations: OR 0.67 (95% CI 0.54 to 0.83) *Inductions: (95% CI 0.06 to 0.39) *Augmentation: (95% CI 0.26 to 0.69) *Episiotomy: (95% CI 0.02 to 0.39) *Operative vaginal birth: (95% CI 0.03 to 0.42) *CS (95% CI 0.05 to 0.31) *Range of ORs given	Individual data not given	Meta analysis of comparative and cohort studies	2b
Janssen, 2002	862 planned home births and 571 hospital births with midwives and 743 physician led hospital births	Home vs. hospital care	Epidural use, induced, augmentation, episiotomy, CS, 3-degree tear, PPH, infection, Apgar < 7 at 5 minutes, transfer to another hospital, use of oxygen > 4hours	Home vs. physician hospital birth: Epidural: OR 0.20 (95% CI 0.14 to 0.27) Induction: OR 0.16 (95% CI 0.11 to 0.24) Augmentation: OR 0.33 (95% CI 0.23 to 0.47) Episiotomy: OR 0.22 (95% CI 0.13 to 0.33) CS: OR 0.30 (95% CI 0.22 to 0.43) 3-degree tear: OR 0.85 (95% CI 0.43 to 1.66) PPH: OR 0.90 (95% CI 0.58 to 1.45) Infection: OR 0.24 (95% CI 0.1 to 0.59) Apgar: OR 0.84 (95% CI 0.32 to 2.19) Transfer: OR 1.4 (95% CI 0.39 to 5.04) Oxygen > 4hours: OR 0.54 (95% CI 0.27 to 1.07) Home vs. midwife hospital birth: Epidural: OR 0.25 (95% CI 0.17 to 0.35) Induction: OR 0.30 (95% CI 0.20 to 0.46) Augmentation: OR 0.34 (95% CI 0.24 to 0.51) Episiotomy: OR 0.43 (95% CI 0.27 to 0.69) CS: OR 0.66 (95% CI 0.44 to 0.99) 3-degree tear: OR 0.53 (95% CI 0.28 to 1.00) PPH: OR 0.90 0.83 (95% CI 0.50 to 1.38) Infection: OR 0.26 (95% CI 0.10 to 0.68) Apgar: OR 2.28 (95% CI 0.59 to 8.8) Transfer: OR 1.00 (95% CI 0.30 to 3.40) Oxygen > 4 hours: OR 0.65 (95% CI 0.30 to 1.41)	OR was adjusted for maternal age, lone parent status, income quintile, substance use and parity	Cohort	2b

Childbirth care in a midwifery-led unit

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Hodnett, 2003 ¹⁸¹	Six trials (see below)	Birth centre ('home like' care) vs. usual care	CS rate (38 other outcomes)	Reported in all six trials (meta analysis) OR 0.85 (95% CI 0.72 to 1.00)	Individual trials described below	Systematic review	1a
*Byrne ¹⁸³	200 women with normal uncomplicated pregnancies attending and antenatal clinic in Australia Exclusion criteria: Any pregnancy risk factors or presentation to antenatal clinic after 30 weeks gestation	Birthing centre care, described as home-like surroundings to encourage women to feel relaxed and to use their own resources to cope with labour v usual care (Cont)	Primary outcomes: maternal satisfaction Intervention rates: CS Episiotomy Method of feeding at 6 weeks postpartum Costs	Intact perineum: Intervention group (n = 100): 20 Control group (n = 100): 27 RR 0.74 (95% CI 0.45 to 1.23) Episiotomy: Intervention group (n = 100): 35 Control group (n = 100):27 RR 1.30 (95% CI 0.85 to 1.97) 1st/2nd degree tear Intervention group (n = 100): 37 Control group (n = 100):32 RR 1.16 (95% CI 0.79 to 1.70) CS: Intervention group (n = 100): 9 Control group (n = 100): 14 RR 0.64 (95% CI 0.29 to 1.42)	No differences in mothers perception of control, satisfaction, anxiety and bonding or method of feeding at 6 weeks postpartum between the two groups	RCT	1b
*Waldernstorm ¹⁸²	1860 women giving birth in Stockholm between 1989–93 Exclusion criteria: Women with a complicating general condition e.g. diabetes or hypertension, drug users and smokers	Birthing centre care described as home like, no further details (Int) vs. usual care (Cont)	CS Instrumental vaginal delivery Episiotomy	CS: Intervention group (n = 928): 7.1% Control group (n = 932): 8.9% p > 0.05 Instrumental vaginal delivery: Intervention group (n = 928): 3.9% Control group (n = 932): 4.5% p > 0.05 Episiotomy: Intervention group (n = 928): 7.8% Control group (n = 932): 8.3% p > 0.05		RCT	1b

Childbirth care in a midwifery-led unit (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
*Hundley ¹⁸⁵	2844 low risk women, as defined by existing booking criteria for general practitioner units in Grampian, Scotland Exclusion criteria: pre-existing maternal disease, infertility, complicated obstetric history and multiple pregnancy	Care and delivery of low-risk women in a midwife-managed birth unit, described as 'homely', in which women retain a sense of control (Int) vs. care and delivery in a consultant-led labour ward	Maternal and perinatal morbidity	No difference in percentage of women who had normal deliveries between the groups Difference in % was 2.9% (-0.5% to 6%)	1900 women randomised to midwifery managed units and 944 to labour ward 34% transferred to labour ward antepartum, 16% transferred intrapartum Significant differences in monitoring, fetal distress, analgesia, mobility and use of episiotomy No differences in fetal outcome	RCT	1b
*Klein ¹⁸⁷	114 low-risk women	Birth centre care described as an attractive room with a double bed. No routine enema, shaving, IV infusion or EFM vs. routine hospital care in a labour ward	Mode of delivery, oxytocin use, epidural use, episiotomy, Apgar, morbidity of neonate	No difference in any outcome measured		RCT	1b
*MacVicar, 1993 ¹⁸⁴	3510 women with no obvious risk factors	Midwife-led care in a birth centre which was furnished to resemble a normal household bedroom with no equipment in view vs. obstetrician-led care	Complications in antenatal, intrapartum and postnatal period. Maternal and fetal morbidity and mortality. Women's satisfaction	CS: Experimental: 144 (7%) Control: 78 (7%) p: NS		RCT	1b
*Chapman, 1986 ¹⁸⁶	148 parous women	Randomised to standard care or 'home-like' care	Length of labour, mode of delivery, complications	Only 3 CSs occurred, all in the control group. This was not statistically significant		RCT	1b

* denotes trials included in systematic review by Hodnett, 2003¹⁸¹

Delayed admission to labour ward

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Lauzon, 2001 ¹⁹⁰	209 low-risk nulliparous women, 37 weeks of gestation, singleton pregnancy, spontaneous onset of labour	Intervention group received 'labour assessment' which included FHR determination, maternal BP and urine tests, frequency and duration of contractions, status of amniotic membranes and cervical dilatation assessment. If all of these were normal and < 3 cm dilated with intact membranes the woman was allowed to go home or remain in a 'home-like' area to walk around. Control group admitted direct to labour ward	CS, amniotomy, anaesthesia, episiotomy, forceps, vacuum, length of labour, time in labour ward postpartum stay, satisfaction (sense of control), oxytocin administration, Apgar	CS: OR 0.7; (95% CI 0.27 to 1.79) Time in labour ward: WMD -5.2 hours (95% CI -7.06 to 3.34) Oxytocics: OR0.45 (95% CI 0.25 to 0.80) Analgesia: OR0.36; (95% CI 0.16 to 0.78) Sense of control: WMD 16.00; (95% CI 7.52 to 24.48) No difference with other outcomes	Only one study included in the review. Insufficient power to detect a difference in CS due to small size	Systematic review (1 RCT)	1b

5.2 Reducing the likelihood of CS

One-to-one support in labour

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Hodnett, 2001 ¹⁹⁴	5000 women in 14 trials	Continuous support during labour (intervention) versus routine care (control)	Medication for pain relief Operative vaginal delivery CS 5-minute Apgar scores < 7	Outcome OR Medication for pain relief: OR 0.71 (95% CI 0.20 to 0.81) Operative VD: OR 0.77 (95% CI 0.65 to 0.90) CS: OR 0.77 (95% CI 0.64 to 0.91) 5-minute Apgar scores < 7: OR 0.5 (95% CI 0.28 to 0.87)	Support differed between trials in terms of person, timing and duration	Systematic review	1a
Hodnett, 2002 ¹⁹⁵	6915 women at thirteen hospitals, with a live, singleton fetus, 34 weeks gestation or more and were in established labour	Usual care (control, n = 3461) or continuous emotional support by a specially trained nurse (intervention, n = 3454)	Primary: CS rate Secondary: other intrapartum events and indicators of maternal and neonatal morbidity	CS rate: Intervention: 432 (12.5%) Control: 437 (12.6%) RR 0.99 (95% CI 0.87 to 1.12) p =0.44 No difference in secondary outcomes	Comparison of patients evaluation of future preferences for labour favoured the continuous support group	Multi-centred RCT	1b

Pregnancy after 41 weeks

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Crowley , 2003 ¹⁹⁶	Women included in RCT that compared induction of labour with expectant management for pregnancies continuing beyond 41 weeks	Induction of labour	Perinatal mortality CS	Perinatal mortality: 19 trials; n = 7925; Peto OR 0.20; 95% CI 0.06 to 0.70 CS: 9 RCTs; n = 5954;Peto OR 0.87; 95% CI 0.77 to 0.99		Systematic review	1a

Partogram

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Philpott, 1972 ²⁰¹	624 primigravid women, malpresentations and multiple pregnancies excluded compared with 738 similar women	Use of partogram	1. Oxytocin given 2. Labour 12–24 hours 3. Labour > 24 hours 4. Vacuum extraction 5. CS 6. Perinatal deaths	Outcome 1966 Study p 1 12.3% 9.7% < 0.01 2 29.5% 4.6% < 0.001 3 13.0% 0.6% < 0.001 4 9.1% 13.4% < 0.001 5 9.9% 2.6% < 0.001 6 5.8% 0.6% < 0.001 1966 series (n = 738) Study series (n = 624)	Retrospective comparison Results given only as percentages or proportions of n	Descriptive	3
WHO, 1994 ²⁰²	4 pairs of hospitals in South East Asia. All hospitals were already practicing active management of labour	One of each pair was randomly selected to receive the partogram (4 hour action line)	Duration of labour (hours) median Labour > 18 hours Labour augmented Postpartum sepsis Mode of delivery (singleton, cephalic CS)	Duration of labour: Before (n = 18,254): median 3.25 hours After (n = 17,230): median 3.13 hours p = 0.819 Labour > 18 hours: Before (n = 18,254): 1147 (6.4%) After (n = 17,230): 589 (3.4%) p = 0.002 Labour augmented: Before (n = 18,254): 3785 (20.7%) After (n = 17,230): 1573 (9.1%) p = 0.023 Postpartum sepsis: Before (n = 18,254): 127 After (n = 17,230): 37 p = 0.028 Mode of delivery: Before (n = 18,254): 2278 (12.5%) After (n = 17,230): 1926 (11.2%) p = 0.841 n = number of deliveries	Active management only Results given for all women, multiparous and nulliparous together. Patterns were similar for both	Cluster RCT	1b

Partogram (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Lavender, 1998 ²⁰³	928 primigravid women with uncomplicated pregnancies in spontaneous labour at term	Partograms with the action line 2, 3 or 4 hours to the right of the alert line	Primary: CS rate, maternal satisfaction	<p>Satisfaction score:</p> <p>2 hours (n = 315): 23.5 (5.9%)</p> <p>3 hours (n = 302): 21.4 (6.1%)</p> <p>4 hours (n = 311): 19.3 (5.6%)</p> <p>2 hours vs. 3 hours: RR 3.5 (95% CI 1.7 to 5.3)</p> <p>CS:</p> <p>2 hours (n = 315): 35 (11.1%)</p> <p>3 hours (n = 302): 43 (14.2%)</p> <p>4 hours (n = 311): 26 (8.4%)</p> <p>2 hours vs. 3 hours: RR 0.8 (95% CI 0.5 to 1.2)</p> <p>Results are expressed as n (%). Differences between groups are given as odds ratio (95% CI).</p> <p>No difference in the secondary outcomes so not reflected here</p>		RCT	1b
Pattinson R C, 2003 ²⁰⁴	694 health nulliparous women in active labour, at term with a health singleton pregnancy and cephalic presentatio South Africa	Aggressive management protocol. Single line partogram, a vaginal examination every two hours and use of oxytocin infusion if the line was crossed (n = 344) vs. expectant management protocol. Two-line partogram, with the alert line and a parallel action line four hours to the right, with a vaginal examination every four hours. If the action line was reached, oxytocin was started. The women were reassessed every two hours thereafter. Analgesia was prescribed on request (n = 350)	Mode of birth	<p>Caesarean section: 16.0% vs. 23.4%. RR 0.68, 95% CI 0.50 to 0.93</p> <p>Operative deliveries: 20.3% vs. 27.9%. RR 0.73, 95% CI 0.56 to 0.96</p>	<p>Multicentre</p> <p>Randomisation through sealed opaque envelope form box in labour ward and randomisation was based on a computer generated list of random numbers (perinatal death includes one protocol violation, patients enrolled into the trial with a known intrauterine death)</p>	RCT	1b

5.3 No influence on likelihood of CS

Walking in labour

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Bloom, 1998 ²⁰⁸	1067 pregnant women presenting in spontaneous labour between 36 to 41 weeks of gestation Inclusion criteria: Regular uterine contractions with cervical dilatation of 3–5 cm, cephalic presentation Exclusion criteria: Women with any known complication of pregnancy including breech presentation	Walking as desired during the first stage of labour (intervention) vs. usual care (control) Usual care: women in this group assumed their choice of supine, lateral or sitting positions during labour	Episiotomy SVD Forceps Shoulder dystocia CS	Episiotomy: Intervention (n = 536): 122 (23%) Control (n = 531): 124 (23%) RR 0.97 (95% CI 0.78 to 1.21) SVD: Intervention (n = 536): 490 (91%) Control (n = 531): 483 (91%) RR 1.00 (95% CI 0.97 to 1.04) Forceps: Intervention (n = 536): 23 (4%) Control (n = 531): 17 (3%) RR 1.34 (95% CI 0.72 to 2.48) Shoulder dystocia: Intervention (n = 536): 1 (0.2%) Control (n = 531): 2 (0.4%) RR 0.49 (95% CI 0.04 to 5.45) CS: Intervention (n = 536): 23 (4%) Control (n = 531): 31 (6%) RR 0.73 (95% CI 0.43 to 1.24)	78% of mothers in the walking group actually walked Results analysed by intention to treat Results were similar for nulliparous and parous mothers	RCT	1b
Flynn, 1978 ²⁰⁷	68 women in spontaneous labour 34 in each group, of whom 17 were primigravidae and 17 multigravidae	Walking as desired (intervention) versus confined to bed in left lateral position (control)	1. Uterine action 2. Mode of delivery 3. Analgesia required 4. Fetal heart rate and Apgar scores	VD: Intervention (n = 34): 31 Control (n = 34): 22 p < 0.01 Forceps: Intervention (n = 34): 2 Control (n = 34): 10 CS: Intervention (n = 34): 0 Control (n = 34): 1	Women were randomised only after they had expressed a desire to walk around during labour, potential selection bias. Very small numbers; little statistical weight	RCT	1b

Position in the second stage of labour

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Gupta, 2003 ²⁰⁹	RCTs which compared various positions used by pregnant women during the second stage of labour			Any upright or lateral position vs.supine position/lithotomy: 1. Duration of second stage of labour (minutes) all women: 12 studies; 3971 participants; WMD (fixed) -5.42 (95% CI -6.95 to 3.90) 2. Mode of delivery: 29 studies; 9536 participants; Peto OR 0.82 (95% CI 0.69 to 0.97) 3. Second degree perineal tears: 10 studies; 4257 participants; Peto OR 1.30 (95% CI 1.09 to 1.54) 4. Episiotomy: 11 studies; 3846 participants; Peto OR 0.73 (95% CI 0.64 to 0.84) 5 Blood loss > 500ml: 10 studies; 4303 participants; Peto OR 1.76 (95% CI 1.34 to 2.32) 6. Experienced severe pain at birth: 1 study; 517 participants; Peto OR 0.59 (95% CI 0.41 to 0.83) 7. Abnormal fetal heart rate patterns: 1 study; 517 participants; Peto OR 0.31 (95% CI 0.11 to 0.91)		Systematic review	1a

Immersion in water during labour

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Nikodem, 1999 ²¹¹	988 women in three trials	Immersion vs. no immersion during labour	Maternal outcomes including mode of delivery, fetal outcomes, neonatal outcomes, caregiver outcomes	No significant difference in any of the outcomes Mode of delivery was reported in one trial but not mentioned in the review.		Systematic review	1a
Rush, 1996 ²¹³	785 women at term in spontaneous labour with no risk factor for need for EFM or epidural	Immersion vs. no immersion during labour	Narcotic requirements, forceps and assisted deliveries, CS	SVD: Intervention: 293 (74.5%) Control: 275 (70%) p = 0.168 Forceps: Intervention: 65 (16.5%) Control: 86 (22.0%) p = 0.055 CS: Intervention: 35 (8.9%) Control: 0.615 p = 0.615		RCT	1b

Epidural analgesia during labour

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Halpern, 1998 ²²⁸	1614 nulliparous and 755 multiparous women with uncomplicated pregnancies	Epidural vs. parenteral analgesia during labour	All trials reported on CS rates as well as other maternal and neonatal outcomes	Pooled data (CS): Epidural: 97/1183 Opioid: 67/1186 OR 1.5 (95% CI 0.81 to 2.76)		Meta analysis of RCTs	1a
Howell, 1999 ²³⁵	11 studies, 3157 women	Epidural vs. other forms of analgesia	29 outcomes measured including CS	CS overall: 9 studies; Peto OR 1.30 (95% CI 0.93 to 1.83) CS dystocia: 5 studies; Peto OR 1.15 (95% CI 0.71 to 1.85) CS fetal distress: 5 studies; Peto OR 1.62 (95% CI 0.74 to 3.53)		Systematic review	1a

Complementary therapies during labour and CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Smith, 2003 ²³⁸	366 women using different modalities of pain management during labour	Acupuncture, aromatherapy, audio analgesia, hypnosis	Pain relief during labour. Some of the trials looked at CS. Only these results are given	Acupuncture vs. control CS: 1 study (90 participants); RR 0.96 (95% CI 0.06 to 14.83) Aromatherapy vs. control CS: 1 study (22 participants); RR 2.54 (95% CI 0.11 to 56.25) Hypnosis vs. control VD: 2 studies (125 participants); RR 1.38 (95% CI 1.10 to 1.74)	CS rates were not the primary outcome in any of the trials in this review	Systematic review	1a
Simpson, 2001 ²³⁶	192 low risk nulliparous women	Raspberry leaf herb consumed in tablet form from 32 weeks of gestation	Safety; side effects; length of labour; mode of birth	No difference shown in any of the outcomes measured		RCT	1b

5.4 Failure to progress

Active management of labour

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Lopez-Zeno, 1992 ⁶⁵⁷	705 women, nulliparous, term, spontaneous labour, cephalic presentation	<p>Active versus routine management of labour</p> <p>Active management of labour defined as: amniotomy within 1 hour of diagnosis of labour. If rate of cervical dilatation < 1 cm/hour then oxytocin infusion of 6mu/minute (to maximum of 36mu)</p> <p>Control: usual care as determined by individual woman's physician</p>	CS rate, length of labour, maternal and neonatal morbidity	<p>CS rate: Active (n = 351): 37 (10.5%) Control (n = 354): 50 (14.1) p < 0.05</p> <p>Length of first stage: Active (n = 351): 5.05 hours Control (n = 354): 6.72 hours p < 0.0001</p> <p>Length of second stage: Active (n = 351): 1.44 hours Control (n = 354): 1.43 hours p: NS</p> <p>Admission to delivery: Active (n = 351): 6.49 Control (n = 354): 8.15 p < 0.0001</p>		RCT	1b
Rigoletto, 1995 ⁶⁵⁸	1934 nulliparous women, term cephalic, spontaneous labour	<p>Active versus routine care</p> <p>Active management described as: childbirth classes, strict criteria for diagnosis of labour, standardised management of labour including early amniotomy and high dose oxytocin infusion, one to one nursing</p> <p>Control: usual care as determined by individual woman's physician</p>	CS rate, median duration of labour, maternal fever, proportion of women whose labour lasted longer than 12 hours	<p>CS rate: Active (n = 1009): 197 (19.5%) Control (n = 906): 176 (19.4%) RR 1.0 (95% CI 0.8 to 1.2)</p> <p>Median duration of labour: Active (n = 1009): 6.2 Control (n = 906): 8.9 RR (no data given)</p> <p>Maternal fever: Active (n = 1009): no data given Control (n = 906): no data given RR 0.6 (95% CI 0.4 to 0.9)</p> <p>Proportion > 12 hours: Active (n = 1009): 9% Control (n = 906): 26% p < 0.001</p>		RCT	1b

5.4 Failure to progress (continued)

Active management of labour

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Cammu, 1996 ⁶⁵⁹	306 nulliparous women, term cephalic, spontaneous labour, clear amniotic fluid, >150cm in height and at least one ANC visit	Active management vs.control Active management described as : early amniotomy and early use of oxytocin Control – usual care as determined by individual woman's physician	Use of oxytocin and amniotomy, labour duration, mode of delivery	Amniotomy: Active (n = 152): 86 (91%) Control (n = 154): 56 (57%) p < 0.01 Oxytocin use: Active (n = 152): 80 (53%) Control (n = 154): 41 (27%) p < 0.01 Length of labour: Active (n = 152): 254 minutes Control (n = 154): 283 minutes p 0.087 CS rate: Active (n = 152): 6 (3.9%) Control (n = 154): 4 (2.6%) p: NS		RCT	1b

Use of oxytocin to augment labour

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Bidgood, 1987 ²⁵²	Sixty nulliparous women, spontaneous labour, cephalic presentation	Three groups: Group 1 – observations Group 2 – low-dose oxytocin Group 3 – high-dose oxytocin	CS rate, cervical dilatation rate, 'delay to delivery' interval, duration of second stage Condition of newborn	No difference in CS rate Cervical dilatation rate increased after oxytocin given 'Delay to delivery' and second stage shorter in high-dose group No difference in condition of newborn	'Delay to delivery' not defined Small trial	RCT	1b

Early amniotomy

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Fraser, 1999 ²⁵⁶	9 studies	Early routine amniotomy vs. selective amniotomy	24 outcomes related to contractions, length of labour, neonatal and maternal morbidity	<p>Duration of labour: 3 trials (156 women); Peto OR -53.71 (WMD) (95% CI -66.457 to -40.965)</p> <p>CS: 8 trials (4008 women); Peto OR 1.26 (95% CI 0.96 to 1.66)</p> <p>5-minute Apgar < 7: 8 trials (3076 women); Peto OR 0.54 (95% CI 0.30 to 0.96)</p> <p>Use of oxytocin: 8 trials (3908 women); Peto OR 0.79 (95% CI 0.67 to 0.92)</p> <p>Only outcomes with a difference shown</p>	Good quality trials included Large numbers	Systematic review	1a

5.5 Eating during labour: low residue diet

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Scrutton, 1998 ²⁷⁴	94 women in labour, > 37 weeks, singleton, cephalic presentation	Randomised to eating (low residue diet) group or control (water only) group	1. Metabolic assessment 2. Gastric volumes 3. Labour outcomes	VD: Eating (n = 45): 20 Control (n = 43): 18 AVD: Eating (n = 45): 16 Control (n = 43): 13 CS: Eating (n = 45): 9 Control (n = 43): 12	Epidural rate higher than usual which may influence women's decision to eat or not in active labour	RCT	1b

6.1 Timing of CS: optimal gestational age for a planned CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Morrison, 1995 ²⁸²	All cases of respiratory distress syndrome (RDS) or transient tachypnoea of the newborn (TTN) at term requiring NICU	Prospective survey over 9 years	RR of respiratory morbidity for RDS and TTN in relation to mode of delivery and onset of parturition for each week of gestation at term	CS prelabour: Births (n): 2341 Respiratory morbidity: RR 83 RR: 35.5/1000 (95% CI 28.4 to 43.8) OR: 6.8 (95% CI 5.2 to 8.9) CS labour: Births (n): 2370 Respiratory morbidity: RR 29 RR rate/1000: 12.2 (95% CI 8.2 to 17.5) OR: 2.3 (95% CI 1.6 to 3.5) VD: Births (n): 28,578 Respiratory morbidity: RR 150 RR rate/1000: 5.3 (95% CI 4.4 to 6.2) OR: 1.0	Results are for total number of deliveries. The study then calculated risk of RR with each gestation. Significant decrease after 39 weeks of gestation	Prospective audit	3

6.3 Preoperative testing before CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Ransom, 1999 ⁶⁰	Women transfused with blood during an admission for CS at a tertiary care hospital	Retrospective case review	Identifiable risk factors and risk of transfusion	122/125 women who had a blood transfusion had an identifiable risk factor 3/125 had no risk factor Overall urgent blood transfusion rate without risk factor is 0.8/1000 CS		Case review	3
Rayburn, 1988 ⁶¹	124 women for CS	Ultrasound pre-CS compared with 84 retrospectively collected controls		No difference in any of the outcomes: of incision of the placenta Blood loss intra operatively > 1000 ml Difficult delivery Injury of infant Injury of umbilical cord Injury to adjacent structures		Cohort	2b
Lonky, 1989 ³⁰¹	46 antenatal women with a previous CS and 30 control antenatal women	Ultrasound to determine CS scar	Proportion of uterine scars visualised	Overall 13/47 (27.7%) scars were visualised on ultrasound. Only transverse scars were visualised		Cohort	3
Qureshi, 1997 ³⁰³	43 women with transverse CS scars, 80 cohorts	Ultrasound to measure thickness of wall of lower uterine segment	Whether thickness of lower uterine wall can be used as a predictor for poor wound healing	< 2mm thickness –sensitivity = 86.7%; specificity = 100%. PPV = 100%; NPV = 86.7	Methodology of study unclear	Cohort	3
Suzuki, 2000 ³⁰²	39 women for repeat elective CS, 20 had preoperative diagnosis of wall thinning and 19 did not	Manual and ultrasound examination to determine uterine wall thinning at 36 weeks of gestation	Scar dehiscence diagnosed antenatally by examination or ultrasound and confirmed at surgery	Ultrasonographic sensitivity for scar dehiscence = 100%; specificity = 83% No surgical findings of dehiscence in patients who felt pain and tenderness	Preoperative diagnosis of wall dehiscence was defined as wall thickness of < 2 mm on ultrasound and pain or tenderness on examination	Cohort	3

6.4 Anaesthesia for CS

General versus regional anaesthetic for CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Lertakyamane, 1999 ³³	341 well women at term scheduled for elective CS	CS with general (GA), epidural (EA) or spinal anaesthesia (SA)	Maternal outcomes: Success rate Total blood loss Satisfaction of mothers	Success rate: GA: 96.1% EA: 90.0% SA: 80.5% Total blood loss: GA: 378.3 ml EA: 323.8 ml SA: 257.2ml p = 0.0001 (GA > EA, SA) No difference between the satisfaction scores in the different groups	Success rate not defined. Non successful defined as needing to change to another method of analgesia	RCT	1b
Lertakyamane, 1999 ³⁴	341 well women at term scheduled for elective CS	CS with general (GA), epidural (EA) or spinal anaesthesia (SA)	Neonatal outcomes: Cord blood pH Apgar score NACS	Cord blood pH : GA: 7.29 EA: 7.31 SA: 7.30 p = 0.045 (GA<EA) Apgar 1 minute: GA: 6.7 EA: 8.3 SA: 8.7 p = 0.001 (GA<EA,SA) Apgar 5 minutes: GA: 9.2 EA: 9.7 SA: 9.8 p = 0.004 (GA<EA,SA) NACS: GA: 34.4 EA: 34.9 SA: 34.8 p: NS	NACS = neurologic and adaptive scores, normal value not given	RCT	1b

6.4 Anaesthesia for CS (continued)

General versus regional anaesthetic for CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Kavak, 2001 ³¹⁶	104 well women at term scheduled for elective CS	CS with general (GA) or spinal anaesthesia (SA)	Neonatal outcomes: 1. Umbilical artery blood gas 2. Neonatal depression 3. Total hospital stay 4. Apgar	1. No difference in any blood gas parameters 2. 4/38 infants in the GA group vs 3/46 infants in SA group were treated with oxygen and bag and mask. None needed further respiratory support ($p > 0.05$) 3. No difference between the groups 4. No difference between the groups. All infants were vigorous at birth	Under powered for the outcomes. Infants well in both groups	RCT	1b
Wallace, 1995[14718]	88 women with severe pre-eclampsia, decision already made to deliver by CS	CS with general (GA), epidural (EA) or spinal anaesthesia (SA)	1. Apgar scores 2. Arterial blood gas parameters 3. Maternal BP changes 4. Complications	No difference between the two groups was found for any of the outcomes. No adverse outcomes were found in either group	Underpowered for the outcomes as no adverse outcomes occurred	RCT	1b
Hong, 2002 ³¹⁹	25 women with grade-4 placenta praevia	CS with general (GA), epidural (EA)	1. Blood loss, post operative transfusions, urine output, Apgar at 1 and 5 minutes 2. Circulatory changes 3. Haematological changes	Blood loss: GA: 1623 ml EA: 1418 Transfusions: GA: 1.08 units EA: 0.38 units Urine output: GA: 118 ml EA: 153 ml Apgar 1 minute: GA: 8 EA: 8 Apgar 5 minutes: GA: 10 EA: 9 $p > 0.05$ for each outcome Circulatory changes graphically represented; no differences Haematological changes graphically represented; immediate postoperative haematocrit significantly lower in the GA group	Underpowered for the outcomes. One adverse outcome occurred (emergency hysterectomy)	RCT	1b

Health economics

Study	Population	Intervention details	Cost Outcomes	Results	Comments	Study type	EL
Riley 1995 ³²⁵	94 women undergoing CS	Epidural versus spinal anaesthesia for non-emergency CS	Effectiveness data from a single institution/ study of 94 women randomly selected to receive spinal (intervention) or epidural (control) analgesia Effectiveness data were collected retrospectively from patient records Hospital and patient costs were collected prospectively (materials, drugs, nursing time) based on data from patient records (1990–92) for all resources not common to both 1992 prices	Total operating room time: Spinal 67–99 minutes Epidural 81–121 minutes (p < 0.001) Post-anaesthesia care unit time: Spinal 64–140 minutes Epidural 52–136 minutes (NS) Need for intraoperative analgesia: Spinal 17% Epidural 38% (p = 0.04) Need for postoperative pain relief: Spinal 23% Epidural 15% (p value not given) Complication rates: Spinal 0% Epidural 13% (p = 0.003) Total costs: Spinal US\$23.21–25.46 depending upon needle Epidural US\$43.62 Spinal anaesthesia is the dominant option	No synthesis of costs and benefits No sensitivity analysis No detailed economic analysis	Cost-consequence study	

Place of induction of regional anaesthesia

Study	Population	Intervention details	Cost Outcomes	Results	Comments	Study type	EL
Soni, 1989 ³²⁶	100 women scheduled for elective surgery in general, orthopaedics or ENT surgery	Anaesthesia induced in anaesthetic room or in theatre	Mean changes in indices of anxiety (baseline to induction)	LAAS: anaesthetic room 4.9; theatre 5.3; difference between groups 0.4 NS Heart rate (bpm): anaesthetic room 1.72; theatre 0.12; difference between groups 1.6 NS Systolic BP (mmHg): anaesthetic room 8.8; theatre 12.7; difference between groups 3.6NS Respiratory rate (breaths/min): anaesthetic room –0.6; theatre –1.58; difference between groups 0.98 p < 0.05	LAAS = linear analogue anxiety score	RCT	1b

Procedures to avoid hypotension

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Emmett, 2002 ³³⁷	Women having spinal anaesthesia for CS	Use of an intervention to prevent hypotension	Reduction in the incidence of hypotension during spinal anaesthetic for CS	Crystalloid 20 ml/kg vs. control: RR 0.78 (95% CI 0.6 to 1.0) Pre-emptive colloid vs. crystalloid: RR 0.54 (95% CI 0.37 to 0.78) Ephedrine vs. control: RR 0.70 (95% CI 0.57 to 0.85) Lower-limb compression vs. control: RR 0.75 (95% CI 0.59 to 0.94)		Systematic review 1a	
Sutherland, 2001 ³³⁹	100 women for elective CS (ASA I) Thigh circumference > 64 cm excluded	Sequential compression device in addition to elastic stockings	1. Number of women developing hypotension 2. Umbilical artery pH (mean) 3. Proportion of neonates with Apgar scores < 9 (mean)	Number of women developing hypotension: Intervention group: 65% Control group: 80% p = 0.12 RR of developing hypotension 1.2 (95% CI 1.0 to 1.6) Umbilical artery pH (mean) Intervention group: 7.32 (0.10%) Control group: 7.34 (0.07%) p = 0.24 Proportion of neonates with Apgar scores < 9 (mean): Intervention group: 2 (4%) Control group: 2 (4%) p = 1.0	Due to difference in outcome measures the results of this trial could not be added to the trials in the above review on limb compression	RCT	1b
Fong, 1996 ³⁴¹	50 normotensive women for elective CS	Epidural administration of ephedrine	Incidence of hypotension, nausea and vomiting and itching	Hypotension was defined as < 90 mmHg or < 70% of baseline. It was measured in 3 phases: start of epidural to attainment of T4 level; T4 level to delivery of infant; delivery to end of CS. No difference at any of these phases. No difference in terms of nausea, vomiting or itching	Due to difference in outcome measures the results of this trial could not be added to the trials in the above review	RCT	1a

Procedures to manage hypotension

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Lee, 2002 ³⁴²	292 women undergoing elective CS (7 RCTs)	Ephedrine vs. phenylephrine for the treatment of hypotension during spinal anaesthesia for CS	Maternal hypo- and hypertension and bradycardia; neonatal umbilical cord pH and Apgar scores	Ephedrine vs. phenylephrine: Maternal: Hypotension management and treatment: no difference (RR1.00, 95% CI 0.96 to 1.06) Bradycardia more likely with phenylephrine than with epinephrine (RR 4.79, 95% CI 1.47 to 15.6) Neonatal: Women given phenylephrine had neonates with higher umbilical arterial pH values than those given ephedrine (WMD 0.03, 95% CI 0.2 to 0.04) No difference in terms of true acidosis, defined as umbilical artery pH < 7.2 (RR0.78, 95% CI 0.16 to 3.92) No difference in Apgar scores at 1 minute and 5 minutes	Either drug can be used for the management of hypotension with spinal anaesthesia	Systematic review	1a

Failed intubation

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Han, 2001 ³⁴⁸	1067 cases of women for elective CS with general anaesthesia (ASA 1–2)	Laryngeal mask used after rapid sequence induction	Effective airway obtained; air leakage or partial airway obstruction; need for intubation; hypoxia	Effective airway obtained in 1060 (99%) of women Air leakage or partial airway obstruction occurred in 22 (2.1%) Intubation was needed in 7 women (0.71%) No episodes of hypoxia occurred		Case series	3

Use of antacid before CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Stuart ⁶²	385 women undergoing emergency CS under GA, Hong Kong, 1991–94	<p>Metoclopramide 10mg iv + 0.3M sodium citrate 30 ml orally (MC)</p> <p>0.3M sodium citrate 30 ml orally</p> <p>Ranitidine 50 mg iv + 0.3M sodium citrate 30 ml orally (RC)</p> <p>Omeprazole 40 mg iv + 0.3M sodium citrate 30 ml orally (OC)</p>	1-minute Apgar score < 7 gastric volume and pH	<p>C (n = 120); MC (n = 65); RC (n = 50); OC (n = 50); RMC (n = 49); OMC (n = 50)</p> <p>Apgar score 1 minute < 7: C: 19 MC: 18 RC: 12 OC: 17 RMC: 13 OMC: 12</p> <p>pH median (range): C: 5.01 (0.86 to 6.99) MC: 4.88 (0.76 to 6.98) RC: 5.70 (2.08 to 7.31) OC: 5.76 (2.26 to 7.25) RMC: 5.58 (1.29 to 7.50) OMC: 5.92 (1.1 to 6.86)</p> <p>Gastric volume ml median (range): C: 55 (9360) MC: 50 (230) RC: 46 (3204) OC: 6 (7210) RMC: 40 (8210) OMC: 41 (3270)</p> <p>pH < 2.5, vol > 25 ml: C: 17 (14%) MC: 9 (14%) RC: 1 (2%) OC: 1 (2%) RMC: 3 (6%) OMC: 4 (8%)</p> <p>pH < 3.5, vol > 25 ml: C: 28 (23%) MC: 15 (23%) RC: 4 (8%) OC: 3 (6%) RMC: 5 (10%) OMC: 6 (12%)</p>	Randomisation not described Not blinded	RCT	1b

Use of antacid before CS (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
		Ranitidine 50 mg + metoclopramide 10 mg iv +0.3M sodium citrate 30 ml orally (RMC)					
		Omeprazole 40 mg + metoclopramide 10 mg iv +0.3M sodium citrate 30 ml orally (OMC)					
Rout ³⁵⁷	Women with term singleton pregnancies undergoing emergency CS under GA, South Africa 1993 Exclusion criteria: History of gastrointestinal disorder except heartburn Those receiving antacids or H2 receptor blockers	50 mg ranitidine iv + 30ml 0.3M sodium citrate Placebo (saline) + 30 ml 0.3M sodium citrate	At risk of aspiration defined as pH < 3.5, volume > 25 ml	50 mg ranitidine iv + 30 ml 0.3M sodium citrate (n = 292): At risk of aspiration: 7 Placebo (saline) + 30 ml 0.3M sodium citrate (n = 303): 12 p = 0.5	Patients and assessors blinded Randomisation not described	RCT	1b

Use of antiemetics

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Stein ³⁶⁹	75 healthy women undergoing elective CS under spinal anaesthesia, USA, 1997 Exclusion criteria: – History of nausea or vomiting associated with previous surgery or anaesthesia – Nausea or vomiting within 24 hours prior to CS – Diabetes mellitus – Morbid obesity	Acupressure wrist bands + 2 ml iv saline Placebo wristbands + 10 mg slow iv metoclopramide Placebo wristbands + 2 ml iv saline	Nausea Sedation during surgery assessed using a visual analogue scale 0–10 (score greater than 2 considered positive for these outcomes) Hypotension Apgar score < 7 at 5 minutes	Nausea: Acupressure (n = 25): 6 (24%); RR 0.3 (95% CI 0.1 to 0.7); 1.5 (0.5 to 4.7) Metoclopramide (n = 25): 4 (16%); RR 1.00 (95% CI 0.2 0.1 to 0.5) Placebo (n = 25): 19 (76%); 1.00 Vomiting: Acupressure (n = 25): 3 (12%); RR 0.5 (95% CI 0.1 to 1.8) Metoclopramide (n = 25): 1 (4%); RR 0.2 (95% CI 0.0 to 1.3) 1.00 Placebo (n = 25): 6 (24%); 1.00 Hypotension: Acupressure (n = 25): 64% Metoclopramide (n = 25): 68% Placebo (n = 25): 76% 5-minute Apgar < 7: Acupressure (n = 25): 0 Metoclopramide (n = 25): 0 Placebo (n = 25): 0 p > 0.05	Randomisation 'using envelopes' Women and assessors blinded to treatment group	RCT	1b

Use of antiemetics (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Numazaki ³⁶⁴	60 ASA I parturients, 21–38 years, undergoing elective CS, Japan 2000 Exclusion criteria: Gastrointestinal diseases History of motion sickness History of nausea or vomiting in intraoperative or postdelivery period Those who received antiemetics 24 hrs before surgery	iv lignocaine 0.1 mg/kg + placebo iv lignocaine 0.1 mg/kg + propofol 1mg/kg/h (drugs administered after clamping of the cord, stopped at end of surgery)	Intraoperative and postdelivery emetic episodes Sedation (assessed using linear numeric scale 0–10) Requirement for antiemetic rescue medication	Propofol (n = 30): Emesis free: 23 (77%) Nausea: 3 (10%) Retching: 2 (7%) Vomiting: 3 (10%) Rescue antiemetics: 2 (7%) Severity of nausea: median (range): 0 (0–7) Sedation: median (range): 1 (0–5) Placebo (n = 30): Emesis free: 11 (37%) Nausea: 9 (30%) Retching: 4 (13%) Vomiting: 8 (27%) Rescue antiemetics: 10 (33%) Severity of nausea: median (range): 0 (0–10) Sedation: median (range): 1 (0–5) RR (95% CI) propofol vs. placebo: Emesis free: 2.1 (1.2 to 3.5) Nausea: 0.3 (0.1 to 1.1) Retching: 0.5 (0.1 to 2.5) Vomiting: 0.4 (0.1 to 1.3) Rescue antiemetics: 0.2 (0.0 to 0.8) Severity of nausea: median (range): p = 0.03 Sedation: median (range): p = 0.63	Randomisation process not described Women and assessors blinded	RCT	1b
Fuj2 ³⁶⁵	120 ASA I parturients , 22–35 years undergoing spinal anaesthesia for elective CS, Japan 1998 Exclusion criteria: Gastrointestinal diseases History of motion sickness History of nausea or vomiting in intraoperative or post delivery period Those who received antiemetics 24 hours before surgery	Granisetron (G) 3 mg Droperidol (D) 1.25 mg Metoclopramide (M) 10 mg Placebo (saline) (P) Administered iv after clamping of the cord	Intraoperative post delivery and post operative emetic episodes	Nausea, vomiting: Granisetron (n = 30): 4 (13%) Droperidol (n = 30): 5 (17%) Metoclopramide (n = 30): 6 (20%) Placebo (n = 30): 19 (63%) G vs. P: RR 0.2 (95% CI 0.1 to 0.5) 1.00 G vs. D: RR 0.8 (95% CI 0.2 to 2.7) 1.00 G vs. M: RR 0.8 (95% CI 0.3 to 2.4) 1.00 D vs. P: RR 0.3 (95% CI 0.1 to 0.6) 1.00 D vs. M: RR 1.00 M vs. P: RR 0.3 (0.1 to 0.7) 1.00	Randomisation using random numbers list Women and assessors blinded	RCT	1b

Use of antiemetics (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Lussos ³⁶³	42 ASA I–2 parturients at term undergoing elective CS under spinal anaesthesia, USA, 1991 Exclusion criteria: History of nausea or vomiting in the week before surgery Diabetes Maternal history suggestive of chronic uteroplacental insufficiency	10 mg iv metoclopramide Placebo Given before spinal anaesthesia for delivery	Self-reported Nausea Vomiting Umbilical artery pH	Metoclopramide (n = 21): Nausea: 3 (14%) Retching and vomiting: 1 (5%) Umbilical artery pH: 7.21 (SD 0.21) Placebo (n = 21): Nausea: 17 (81%) Retching and vomiting: 9 (43%) Umbilical artery pH: 7.22 (SD 0.09) RR (95% CI) metoclopramide vs. placebo: Nausea: 0.2 (0.1 to 0.5) Retching and vomiting: 0.1 (0.0 to 0.8) Umbilical artery pH: p > 0.05	Randomisation not described Women and assessors blinded	RCT	1b
Pan ³⁶⁶	48 healthy ASA I, 2 parturients scheduled to undergo non-urgent CS, USA, 1996 Exclusion criteria: Nursing women Psychiatric disease History of motion sickness	8 mg ondansetron 0.625 mg droperidol saline (placebo) All given after clamping of umbilical cord	Number of episodes of nausea/vomiting	Ondansetron (O) (n = 16); droperidol (D) (n = 16); placebo (P) (n = 16) At least 1 episode of nausea: O: 5 (31%) D: 4 (25%) P: 11 (70%) O vs. P: RR 0.4 (95% CI 0.2 to 1.0); 1.00 O vs. D: RR 1.2 (95% CI 0.4 to 3.8); 1.00 D vs. P: RR 0.4 (0.1 to 0.9); 1.00 At least 1 episode of vomiting O: 1 (6%) D: 2 (13%) P: 7 (44%) O vs. P: RR 0.2 (0.0 to 1.5); 1.00 O vs. D: RR 0.5 (0.0 to 5.0); 1.00 D vs. P: RR 0.4 (0.1 to 1.8); 1.00	Computer-generated random assignment Women and assessors blinded	RCT	1b

Use of antiemetics (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Pan ³⁶⁷	164 healthy ASA I, 2 parturients scheduled to undergo non-urgent CS, USA, 2000 Exclusion criteria: Nursing women Psychiatric disease Those taking antiemetics	10 mg metoclopramide 4 mg ondansetron 10 ml physiological saline (placebo) All given after clamping of umbilical cord	Number of episodes of nausea/vomiting Rescue medication	Metoclopramide (M) (n = 51); ondansetron (O) (n = 54); Placebo (P) (n = 51) At least 1 episode nausea: M: 26 (51%) O: 14 (26%) P: 36 (71%) M vs. P: RR 0.7 (95% CI 0.5 to 1.0) M vs. O: RR 2.0 (95% CI 1.2 to 3.3) O vs. P: RR 0.4 (95% CI 0.2 to 0.6) At least 1 episode vomiting: M: 9 (12%) O: 8 (15%) P: 19 (37%) M vs. P: RR 0.5 (95% CI 0.2 to 0.9) M vs. O: 1.2 (95% CI 0.5 to 2.8) O vs. P: 0.4 (95% CI 0.2 to 0.8) Rescue medication required: M: 3 (6%) O: 2 (4%) P: 13 (25%) M vs. P: 0.2 (95% CI 0.1 to 0.8) M vs. O: 1.6 (95% CI 0.3 to 9.1) 0.1 (95% CI 0.0 to 0.6)	Computer-generated random assignment Women and assessors blinded	RCT	1b
Abouleish ³⁶⁸	74 women with term pregnancies, ASA I,2 , 18–40 years undergoing CS under spinal; anaesthesia, USA, 1999 Exclusion criteria: Fetal distress Intent to breastfeed Maternal medical problems Psychiatric disease Pregnancy-induced hypertension History of motion sickness Morbid obesity History of vomiting 24 hours preoperatively	4 mg ondansetron 0.9% physiological saline (placebo)	Nausea	Ondansetron (n = 36): 21 (58%) Placebo (n = 38): 30 (79%) RR (95% CI) ondansetron vs. placebo: 0.7 (0.5 to 1.0)	Computer-generated random assignment Women and assessors blinded	RCT	1b

Use of antiemetics (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Mandell ⁶⁶³	135 healthy term parturients ASA I, 2, singleton pregnancies, elective or non-urgent CS under epidural anaesthesia, USA 1992	0.5 mg droperidol Placebo Given after clamping of umbilical cord	Nausea Vomiting	Droperidol (n = 67): Nausea: 9 (13%) Vomiting: 3 (4%) Placebo (n = 61): Nausea: 25 (41%) Vomiting: 8 (13%) RR (95% CI) droperidol vs. placebo: Nausea: 0.3 (0.2 to 0.6) Vomiting: 0.3 (0.1 to 1.2)	Randomisation not described Women and assessors blinded	RCT	1b
Cohen ³⁶²	58 healthy parturients undergoing elective CS under GA	10 mg metoclopramide iv Saline (placebo) Given before induction of GA	Apgar scores Umbilical artery pH	Metoclopramide (n = 30): 1-minute Apgar score < 7: 2; 5-minute Apgar score < 7: 0 Umbilical artery pH: 7.23 (SD 0.01) Placebo (n = 28): 1-minute Apgar score < 7: 3 5-minute Apgar score < 7: 0 Umbilical artery pH: 7.24 (SD 0.01)	Randomisation not described Women and assessors blinded	RCT	1b
	Metanalysis of 7 RCTs that evaluate the effectiveness of antiemetics (n = 618)	Ondansetron vs. placebo Metoclopramide vs. placebo Droperidol vs. placebo Ondansetron vs. metoclopramide Ondansetron vs. droperidol	Nausea Vomiting	Ondansetron vs. placebo (n = 271): Nausea: pooled RR 0.4 (95% CI 0.2 to 0.8) Vomiting : pooled RR 0.3 (95% CI 0.2 to 0.7) Metoclopramide vs. placebo (n = 254): Nausea: pooled RR 0.3 (0.1 to 0.7) Vomiting : pooled RR 0.3 (95% CI 0.2 to 0.6) Droperidol vs. placebo (n = 128): Nausea: pooled RR 0.3 (95% CI 0.2 to 0.5) Ondansetron vs. metoclopramide (n = 165): Nausea: pooled RR 0.5 (95% CI 0.3 to 0.9) Vomiting : pooled RR 0.8 (95% CI 0.3 to 2.0) Ondansetron vs. droperidol (n = 92) Nausea: pooled RR 1.0 (95% CI 0.4 to 2.3) Vomiting : pooled RR 0.5 (95% CI 0.0 to 5.0) (fixed effects)		Meta-analysis	1a

Avoiding aortocaval compression

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Wilkinson, 1995 ³³³	293 women (3 trials) for CS	Lateral tilt (10–15 degrees) vs. no lateral tilt (supine) at CS	Low Apgar scores; severe neonatal depression; umbilical artery pH	<p>Low Apgar: Lateral tilt: 9/111 Control: 20/136 Peto OR 0.53 (95% CI 0.25 to 1.16)</p> <p>Severe neonatal depression: Lateral tilt: 2/50 Control: 2/50 Peto OR 1.00 (95% CI 0.14 to 7.32)</p> <p>Umbilical artery pH: WMD 0.03 (95% CI 0.01 to 0.04)</p> <p>Only data from two trials was used for analysis</p>	Methodological quality of trials poor	Systematic review	1a
Rees, 2002 ³³⁵	60 healthy women having elective CS	15-degree lateral tilt vs. full lateral tilt	Arm and leg blood pressure; ephedrine requirements; symptoms; fetal heart rate; cord gases; Apgar scores	<p>Leg–arm pressure over time was significantly lower in the 15-degree tilt ($p < 0.001$). Mean leg systolic arterial pressure lower for all readings in the 15-degree tilt group ($p < 0.05$) at 4, 5, 6 and 8 minutes</p> <p>No difference: Arm systolic pressure Ephedrine requirements Symptoms Fetal outcomes</p>	Full lateral tilt and 15-degree tilt are both associated with aortic compression	RCT	1b
Matorras, 1998 ³³⁴	204 women for emergency CS	Lateral tilt vs. supine	<ol style="list-style-type: none"> 1) Fetal heart rate tracing 2) Uterine activity 3) Umbilical artery acid-base status 4) Newborn evaluation 5) Maternal parameters 	<ol style="list-style-type: none"> 1) Mean basal heart rate was higher in the lateral tilt group (137.5 vs. 131.1, $p = 0.02$). No difference in accelerations or decelerations 2) No difference 3) PO_2 significantly lower in left lateral group (14.03 Hgmm vs. 16.02, $p = 0.04$). No difference in pH, pCO_2, O_2 saturation or bicarbonate 4) Proportion of neonates with Apgar < 7 same in both groups 5) No difference in maternal infectious or haematological parameters 		RCT	1b

6.5 Surgical techniques for CS

Methods to prevent HIV transmission

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Tanner, 2002 ³⁷⁷	All members of the surgical team practicing in a surgical theatre in any surgical discipline 18 trials identified	Comparison of 2 or more of: single gloves, double gloves, glove liners, coloured puncture indicator systems, cloth outer gloves, steel outer gloves	Primary objective – measure of number of postoperative wound infections in surgical patients Secondary: objective – measure of the number of blood-borne infections in postoperative patients or number of perforations	Single vs. double latex 1: 8 studies (5267 participants); OR 0.90 (95% CI 0.74 to 1.08) Single vs. double latex 2: 8 studies (5264 participants); OR 3.72 (95% CI 2.82 to 4.91) Single latex orthopaedic vs. double latex 1: 1 study (682 participants); OR 0.16 (95% CI 0.08 to 0.3) Single latex orthopaedic vs. double latex 2: study (682 participants); OR 0.98 (95% CI 0.43 to 2.22) Double latex outermost vs. double latex indicator outermost: 2 studies (562 participants); OR 1.28 (95% CI 0.61 to 2.69) Double latex innermost vs. double latex indicator innermost: 2 studies (562 participants); OR 1.32 (0.65) Double latex outermost vs. double latex with liner outermost: 2 studies (357 participants); OR 0.72 (95% CI 0.46 to 1.11) Double latex innermost vs. double latex with liner innermost: 2 studies (331 participants); OR 8.66 (95% CI 0.68 to 109.77) Double latex innermost vs. latex liner with cloth innermost: 2 studies (190 participants); OR 8.49 (95% CI 2.89 to 24.94) Double latex innermost vs. latex inner with steel weave innermost: 1 study (223 participants); OR 1.30 (95% CI 0.64 to 2.64) 1= outermost glove perforations 2= innermost glove perforations	Only glove perforations measured in the identified trials	Systematic review	1a

6.5 Surgical techniques for CS (continued)

Methods to prevent HIV transmission

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Eggleston, 1997 ³⁷⁶	162 CS were randomised	Use of surgical pass trays	Glove perforation. All gloves used at CS were tested for perforation using warm water installation Mean surgical time Blood loss	Glove perforation: Pass tray (221 pairs gloves): 19% No pass tray (223 pairs gloves): 16.1% p = 0.5 Mean surgical time: Pass tray (221 pairs gloves): 47.1 minutes No pass tray (223 pairs gloves): 49.5 minutes p = 0.7 Blood loss: Pass tray (221 pairs gloves): 907 ml No pass tray (223 pairs gloves): 889 ml p = 0.05 No difference in rates of perforation between different surgical team members, i.e. surgeon, assistants and technicians		RCT	1b
Eggleston, 1997 ³⁷⁶	Surgical team members from 192 CS (USA) were randomised	Control group: to employ normal instrument pass techniques Intervention group: used surgical pass trays for instruments 444 pairs of gloves were collected and tested. 223 from the control group and 221 from the intervention group This included 38 sets from double-gloving	Perforations in gloves	Control (n = 223): 36 Intervention (n = 221): 42 RR 1.2 (95% CI 0.8 to 1.8) 11 perforations occurred in the double glove set		RCT	1b

Use of adhesive drapes

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Ward, 2001 ³⁷⁹	620 women undergoing CS	Plastic adhesive wound drapes vs. no plastic drape	Wound infection and hospital stay	Infected: Drapes (n = 305): 34 No drapes (n = 298): 30 p = 0.933 Hospital stay: Drapes (n = 305): 10.6 days (SD 3.9) No drapes (n = 298): 10.2 days (SD 3.9) p = 0.6964		RCT	1b
Cordtz, 1989 ³⁸⁰	1340 women for CS	CS with adhesive drape vs. no adhesive drape (women were randomised to 4 groups, drapes and re-disinfection being the variables)	Wound infection	No difference in wound infection between drape group (58, 17.2%) and no drape group (43, 12.1%)		RCT	1b

Abdominal-wall incision

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Mathai, 2002 ³⁸⁶	101 women with singleton, term pregnancy for CS with spinal anaesthesia	Joel Cohen (JC) vs. Pfannensteil (P) incision for CS	Primary: 1) Women receiving first dose of analgesia within 4 hours of surgery Secondary: 2) Time between surgery and first dose of analgesia 3) Time from skin incision to delivery of the infant 4) Time from skin incision to closure 5) Blood loss 6) Time from surgery to intake of food 7) Total dose of analgesics 8) Febrile morbidity 9) Preoperative haematocrit 10) Postoperative haematocrit 11) Time to breastfeeding 12) Duration of stay in SCBU 13) Duration of hospital stay	Results given as means/group: Outcome JC* P** p 1 23 41 0.0001 2 (hours) 4.1 3.3 0.0164 3 (min) 3.7 5.6 < 0.0001 4 (min) 33.1 44.5 < 0.0001 5 (ml) 410 468 0.0239 6 (hours) 10.68 12.78 0.0191 7 2.05 2.94 < 0.0001 8 3 12 0.0104 11 6.9 12.4 < 0.0001 13 (days) 4.4 5.9 < 0.0001 * (n = 51); ** (n = 50) No difference between the groups for preoperative haematocrit or postoperative haematocrit or duration of stay in SCBU		RCT	1b

Abdominal-wall incision (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Stark, 1994 ³⁸⁵	245 women for CS	Pfannenstiel vs. Joel Cohen incision	Duration of the operation; febrile morbidity; duration of requirements for analgesia; doses of analgesia required	<p>Duration of operation: Joel Cohen incision: 21.7 minutes Pfannenstiel incision: 23.3 minutes p < 0.05</p> <p>Febrile morbidity: Joel Cohen incision: 7.4% Pfannenstiel incision: 18.6% p < 0.05</p> <p>Duration of requirements for analgesia: Joel Cohen incision: 166 hours Pfannenstiel incision: 20.1 hours p: NS</p> <p>Doses of analgesia: Joel Cohen incision: 2.9 Pfannenstiel incision: 3.3 p: NS</p>	Details of randomisation not given	RCT	1b
Ayers, 1987 ³⁸⁷	97 women for CS	Maylard vs. Pfannenstiel incision	Blood loss; febrile morbidity; total operating time; incision sizes; difficulty with delivery; long term complications at 6 weeks	<p>Data was not given or else depicted graphically not numerically. Authors comment that there was no difference for blood loss or febrile morbidity. Maylard incision had a significantly larger median and mean. Difficulty with delivery correlated negatively and significantly with incision < 13cm.</p> <p>No difference in 6 week complications</p>	No data given	RCT	1b
Giacolone, 2002 ³⁸⁸	97 women for CS	Maylard vs. Pfannenstiel incision	Febrile morbidity; length of hospital stay; blood transfusion; post operative pain (VAS); number of analgesic tablets used; quality of life scores; 3-month follow up; isokinetic measurements of abdominal muscles	<p>No difference between the two incisions for any of the outcomes</p> <p>Incomplete data given</p>		RCT	1b

Method of skin incision

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Hasselgren, 1984 ³⁸⁹	586 women undergoing elective abdominal surgery	One knife for the skin and a second knife for the deep incision vs. one knife for both skin and deep layers	Wound infection	Wound infection rate in the one-knife group was 3.6% and 5.5% in the two-knife group This was not statistically different	Method of randomisation not described Not CS patients Patient data not given	RCT	1b
Johnson, 1990 ³⁹¹	240 women undergoing abdominal surgery	Abdominal incision with knife vs. abdominal incision with diathermy	Inflammation and wound infection rate	No difference in inflammation and infection between scalpel group (26/130, 20%) and diathermy group (18/110, 16.4%); p 0.47	Not CS patients	RCT	1b

Method of opening the abdomen

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Burger, 2002 ³⁸¹	Review of prospective RCTs comparing midline, paramedian, transverse and oblique abdominal incisions	Comparison between different abdominal incisions	Wound infection, wound dehiscence, incisional hernia	Wound infection: 10 RCTs (3586 women), 4 non-RCTs (2548 women); p: NS Dehiscence: 9 trials (2551 women); p: NS Hernia: 9 trials (2551 women); p: NS Postoperative pain: 2 trials (209 women); p < 0.001		Systematic Review	1a
Hendrix, 2000 ³⁸²	48 cases of fascial dehiscence following CS or gynaecological surgery complicating 17,995 operations, 8950 CS and 9405 gynaecology operations. 144 controls	Case-control study	Univariate analysis identified independent variables and risk factors	Risk for dehiscence with vertical incisions not increased with respect to risk with Pfannensteil incisions (p = 0.39, 2 tailed test). This was true for all patients including obstetric patients (OR 1.3, 95% CI 0.5 to 3.4) 47/48 of the cases had wound infection compared with 1/144 controls) p < 0.0001, OR 37.8, 95% CI 14.8 to 96.8	Wound infection most significant risk factor for fascial dehiscence	Case-control	3
Lindholt, 1994 ³⁸³	108 women undergoing CS	Percutaneous vs. intracutaneous suture	Wound complications, Mean satisfaction score with the cosmetic appearance of the scar	Wound complications—no difference Cosmetic satisfaction—no difference between suture method Transverse commented on as being preferred more to midline		Non-randomised controlled trial	2a

Extension of the uterine incision

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Rodriguez, 1994 ²⁹⁵	296 women for CS	Blunt vs. sharp extension (scissors) of the uterine incision	Extensions of incisions Endometritis Mean length of extension Postpartum Hb Decrease in Hb Umbilical cord pH Delivery time	Extensions of incisions: Blunt (n = 139): 16 Sharp (n = 147): 20 p = 0.61 Endometritis: Blunt (n = 139): 63 Sharp (n = 147): 65 p = 0.81 Mean length of extension: Blunt (n = 139): 3.2 cm Sharp (n = 147): 3.2 cm p = 0.98 Postpartum Hb: Blunt (n = 139): 10.27 g/dl Sharp (n = 147): 9.92 g/dl p = 0.12 Decrease in Hb: Blunt (n = 139): 1.8 g/dl Sharp (n = 147): 2.2 g/dl p = 0.15 Umbilical cord pH: Blunt (n = 139): 7.26 Sharp (n = 147): 7.27 p = 0.49 Delivery time: Blunt (n = 139): 11.5 minutes Sharp (n = 147): 11.7 minutes p = 0.84	No differences for any of the outcomes	RCT	1b

Extension of the uterine incision (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Magann, 2002 ³⁹⁴	945 women for CS	Blunt vs. sharp (scissors) extension of the uterine incision	Mean blood loss (ml) Oxytocin ≥ 1l fluid Haemabate Mean HCT change > 10% decrease in HCT Transfusion Uterine scar extension > 3 cm Postpartum endometritis	Mean blood loss: Sharp (n = 470): 886 ml Blunt (n = 475): 843 ml p = 0.001 Oxytocin ≥ 1l fluid: Sharp (n = 470): 35 Blunt (n = 475): 31 RR 1.07 (95% CI 0.84 to 1.35) Haemabate: Sharp (n = 470): 22 Blunt (n = 475): 19 RR 1.08 (95% CI 0.80 to 1.45) Mean HCT change: Sharp (n = 470): 6.1 Blunt (n = 475): 5.5 p = 0.003 > 10% decrease in HCT: Sharp (n = 470): 62 Blunt (n = 475): 42 RR 1.23 (95% CI 1.03 to 1.46) Transfusion: Sharp (n = 470): 9 Blunt (n = 475): 2 RR 1.65 (95% CI 1.250 to 2.221) Uterine scar extension > 3 cm: Sharp (n = 470): 69 Blunt (n = 475): 24 RR 0.48 (95% CI 0.34 to 0.69) Postpartum endometritis: Sharp (n = 470): 66 Blunt (n = 475): 51 RR 1.16 (95% CI 0.97 to 1.38)		RCT	1b
Wilkinson, 2003 ³⁹⁶	526 women in 4 RCTs undergoing CS	Stapler used to extend uterine incision vs. extension digitally or with scissors	Total operating time, time to deliver the baby, blood loss, perinatal morbidity	Operating time: WMD -1.17 (95% CI -3.57 to 1.22) Time to deliver baby: WMD 0.85 (95% CI 0.48 to 1.23) Blood loss: WMD -41.22 ml (95% CI -50.63 to -31.8) No difference in perinatal morbidity outcomes	No difference in transfusions but only reported by one trial	Systematic review	1a

Fetal lacerations

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Smith, 1997 ⁶⁴	896 neonates records reviewed from infants delivered by CS USA	None	Total 17/896 laceration injuries were reported (1.9 % lacerations/indications) Reason for caesarean delivery in relation to laceration injuries: – Failure to progress: 8/450, (1.8 % lacerations/indications) – Fetal intolerance of labour: 2/156 (1.3 % lacerations/indications) – Repeat elective 1/101 (1.0% lacerations/indications) – Nonvertex presentation: 6/100 (6.0 % lacerations/indications)			Retrospective review	3

Use of forceps

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Bofill, 2000 ⁶⁶⁵	44 women for repeat elective CS	Vacuum vs. forceps vs. manual delivery of the fetal head	Time for delivery, uterine incision extension, post operative Hb, Hb drop, pain scores, Apgar at 1 and 5 minutes, cord artery pH	<p>Vacuum delivery (n = 15): Time: 86.1 seconds Uterine incision: 1 Postoperative Hb: 10.08 Hb drop: 1.78 Pain scores: 1.17 Apgar 1 minute: 8.2 Apgar 5 minutes: 8.93 Cord pH: 7.23</p> <p>Manual delivery (n = 14): Time: 84.1 seconds Uterine incision: 2 Postoperative Hb: 9.25 Hb drop: 2.2 Pain scores: 3.68 Apgar 1 minute: 7.6 Apgar 5 minutes: 8.5 Cord pH: 7.21</p> <p>Forceps delivery (n = 15): Time: 125.6 seconds Uterine incision: 2 Postoperative Hb: 10.0 Hb drop: 1.96 Pain scores: 2.68 Apgar 1 minute: 7.4 Apgar 5 minutes: 8.7 Cord pH: 7.26</p> <p>p value: Forceps delivery (n = 15): Time: 0.061 Uterine incision: 0.777 Postoperative Hb: 0.077 Hb drop: 0.321 Pain scores: 0.015 Apgar 1 minute: 0.2 Apgar 5 minutes: 0.06 Cord pH: 0.5</p>		RCT	1b

Cord clamping

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Mercer, 2001 ⁴⁰²	Cord clamping studies from 1980-2001 for vaginal and caesarean births 7 RCTs and 2 nonrandomised trials	Cord clamping Hyperviscosity Hyperbilirubinaemia	Polycythaemia	Polycythaemia: no difference T/PT: both		Review of RCT and non-RCT evidence	1b
McDonnell, 1997 ⁴⁰⁵	185 infants from 26 to 33 weeks of gestation delivered by CS or vaginal birth	Delayed cord clamping	Infant haematocrit (Hct) at 1 and 4 hours Feasibility of delayed cord clamping	Haematocrit 1 hour: Hct delayed: 55 Hct control: 52.9 p: NS Haematocrit 4 hours: Hct delayed: 55 Hct control: 52.5 p: NS		RCT	1b

Use of uterotonics

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Dennehy, 1998 ⁴⁰⁷	40 parturients scheduled for elective CS	5 iu oxytocin intravenous (n = 20) vs. 20 iu oxytocin intramyometrial (n = 19)	A) Mean decrease in systolic blood pressure one min after oxytocin B) Time till systolic blood pressure return to baseline C) Uterine tone D) Haemoglobin first day postoperative	A) 8.4 mmHg vs. 14.6 mmHg (p < 0.001) B) 2 minutes vs. 3 minutes (p < 0.05) C) No difference (graphical result) D) 107.7 ± 13.4 vs. 109.8 ± 10.4	Randomisation according to a computer-generated series of random numbers 1 dropout	RCT Placebo-controlled double blind	1b

Use of uterotonics (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Munn, 2001 ⁴⁰⁸	321 women admitted for labour and delivery	10 u/500 ml oxytocin (n = 163) vs. 80 u/500 ml oxytocin (n = 158) infused over 30 minutes after cord clamping	A) Percentage receiving additional uterotonic medication B) Percentage receiving methylergonovine, 15 methyl prostaglandin F _{2α} or both C) Regional anaesthesia D) Mean duration of surgery E) Percentage receiving intravenous bolus of crystalloid, press agents or both F) Mean estimate of blood loss G) Mean change in hematocrit	A) 39% vs. 19%, p < 0.001, RR 2.1, 95% CI 1.4 to 3.0 B) 9 % vs. 2%, RR 4.8, 95% CI 1.4 to 16.0 C) No significant difference D) No significant difference E) No significant difference F) 957 ± 148 ml vs. 937 ± 159 ml, p = 0.08 G) No significant difference	Randomisation scheme was stratified by whether the woman had been receiving parenteral magnesium sulphate for either pre-eclampsia or preterm labour	RCT Double blind	1b
Chou, 1994 ⁴¹¹	60 women undergoing elective CS	Intramyometrial 15-methyl prostaglandin F _{2α} , 125 g (n = 30) vs. intravenous oxytocin 20 u (n = 30)	A) Mean estimated blood loss B) Mean fall in haemoglobin C) Mean fall in hematocrit D) Side effects E) Lochial discharge Maternal arterial oxygen saturation F) Intraoperative infusion volume G) Additional oxytocics (n) H) Post delivery hospitalisation	A) No significant difference: 645 ml (SD 278, range 400 to 1500) vs. 605 ml (SD 303, range 200 to 1750) B) No significant difference: 0.98 gm/dl (SD 0.95) vs. 0.65 gm/dl (SD 0.79) C) No significant difference: 2.58 % (SD 2.96) (n = 30) vs. 2% (SD 2.96) (n = 29) D) No significant difference E) No significant difference F) 753 ml (330) vs. 632 ml (174) G) 3 (10%) vs. 1 (3%) H) No significant difference	Random allocation through opaque sealed envelopes	RCT Double blind	1b

Use of uterotonics (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Lokugamage, 2001 ⁴⁰⁹	40 women undergoing elective or emergency CS	500 g oral misoprostol given immediately after delivery vs. bolus intravenous injection 10 iu Syntocinon	Mean estimated blood loss Drop in serum haemoglobin Need for additional oxytocics Degree of shivering Percentage of women requiring blood transfusion Percentage of operations described as technically difficult Method by which the placenta was delivered No. of episodes of intraoperative hypertension immediately after the uterotonic agent was given Temperature	No significant difference in any outcome	Randomisation by computer-generated numbers in sealed envelopes	RCT Placebo-controlled double blind	1b
Gambling	Awaiting paper	Single dose iv carbetocin vs. 8-hour infusion of oxytocin					
Dansereau, 1999 ⁴¹⁴	694 women undergoing elective CS in Canada	Single dose of 100 microgrammes of intravenous carbetocin compared with an 8-hour infusion of oxytocin at CS	Primary: proportion of women requiring additional oxytocic intervention for uterine atony	Overall oxytocic intervention rate was 7.4% (47 women) OR of intervention 2.03, 95% CI 1.1 to 2.8. 15/317 (4.7%) in the intervention group compared with 32/318 (10.1%) in the control group		Multicentre double blind RCT	1b

Method of placental removal

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Wilkinson ⁴¹⁵ 3	RCTs including 224 women who underwent CS Inclusion criteria: Randomised and quasi-RCTs comparing manual removal of placenta with spontaneous separation and controlled cord traction for delivery in pregnant women undergoing CS	Manual removal of placenta at CS vs. spontaneous separation	Blood loss Postoperative haematocrit Fetomaternal bleeding Postpartum endometritis	Mean difference in blood loss: 3 trials (162 women); effect size 436 ml (95% CI 348 to 525) Mean difference in post operative drop in haematocrit: 2 trials (100 women); 4.3 (95% CI 3.3 to 5.4) Transplacental bleeding (Kleihauer): 1 trial (62 women); Peto OR 2.19 (95% CI 0.69 to 6.93) Endometritis: 1 trial (62 women); Peto OR 5.44 (1.25 to 23.75)	Trials were of reasonable quality although no mention was made of attempts to blind outcome assessment, outcomes were objective	Systematic review	1a
Cernadas ⁴¹⁹	108 women undergoing CS (USA) Exclusion criteria: Multiple gestation, pre-existing maternal conditions e.g. urinary tract infections, upper respiratory tract infections, pneumonia, clinically documented infections other than chorioamnionitis	Glove change vs. no glove change Manual placental delivery vs. expressed placental delivery	Febrile morbidity Postpartum endometritis	Febrile morbidity: No glove change vs. glove change: RR 0.7 (95% CI 0.3 to 1.4) Manual placental delivery vs. expressed placental delivery: RR 1.4 (95% CI 0.6 to 3.5) Postpartum endometritis: No glove change vs. glove change: RR 1.2 (95% CI 0.5 to 2.8) Manual placental delivery vs. expressed placental delivery: RR 1.5 (95% CI 0.6 to 3.6)	Study used consecutively numbered and sealed envelope containing computer-generated random group assignments	RCT	1b
Atkinson ⁴²²	643 women undergoing CS (USA)	Glove change vs. no glove change Manual placental delivery vs. expressed placental delivery	Endometritis Postoperative drop in haematocrit Blood transfusion	No glove change vs. glove change: Postpartum endometritis: RR 1.0 (95% CI 0.79 to 1.3) Manual placental delivery vs. expressed placental delivery: Postpartum endometritis: RR 1.4 (95% CI 1.1 to 1.8) Postoperative drop in haematocrit: p = 0.14 Blood transfusion: p = 0.09	Study used consecutively numbered and sealed envelope containing computer-generated random group assignments	RCT	1b

Method of placental removal (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Chandra ⁴²¹	386 women undergoing CS (USA) Exclusion criteria: Chorioamnionitis, placenta accreta, urgent CS	Manual removal of placenta at CS vs. spontaneous separation	Estimated blood loss Endometritis	Manual placental delivery vs. expressed placental delivery: Estimated blood loss (ml): Mean difference -0.91 (-1.13 to -0.70) Endometritis: OR 1.87 (0.46 to 7.59)	Randomisation by random numbers and series of sealed envelopes	RCT	1b
Lasley ⁴²⁰	333 women undergoing CS (USA) Exclusion criteria: Intrapartum antibiotics for chorioamnionitis, group B streptococcal prophylaxis	Manual removal of placenta at CS vs. spontaneous separation	Endometritis Wound infection	Manual placental delivery vs. expressed placental delivery, RR (95% CI): Endometritis: 1.83 (1.02 to 3.29) Wound infection: 2.24 (0.80 to 6.31)	Randomisation by computer-generated random numbers table with group assignments sealed in opaque envelopes	RCT	1b
Turrentine ⁴²³	228 women in labour undergoing CS Exclusion criteria: Chorioamnionitis, use of antibiotics	Glove change v no glove change	Endometritis	No glove change vs. glove change, RR (95% CI): Postpartum endometritis: 1.1 (0.75 to 1.47)	No description of how randomisation was achieved	RCT	1b
Notelovitz ⁴¹⁸	62 women undergoing CS. (Durban) Exclusion criteria: Rhesus negative women	Controlled cord traction v manual removal of placenta	Rate of fetomaternal transfusion	Controlled cord traction vs. manual removal of placenta, (RR 95% CI): Rate of fetomaternal transfusion: 0.37 (0.13 to 1.07)	No description of how randomisation was achieved	RCT	1b

Exteriorisation of the uterus

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Wilkinson, 1995 ⁴²⁴	486 women for CS (2 trials)	Exteriorisation of the uterus vs. intraperitoneal closure	Blood loss, postoperative febrile morbidity, side effects	No difference for blood loss Exteriorisation associated with fewer postoperative febrile days (OR 0.40, 95% CI 0.17 to 0.94) Nonsignificant trend to fewer infections and more nausea and vomiting with exteriorisation		Systematic review	1a
Edi-Osagie, 1998 ⁴²⁵	194 women for CS	Exteriorisation of the uterus vs. intraperitoneal closure	1) Intraoperative changes in pulse rate, MABP and arterial O ₂ saturation 2) Perioperative changes in Hb concentration 3) Incidence of intraoperative vomiting and pain 4) Postoperative complications, febrile and infectious morbidity 5) Immediate and late pain scores 6) Satisfaction with the operation	1) No difference 2) No difference 3) No difference 4) No difference 5) Pain scores reached significance after day 3 (exteriorisation 4.4 mean pain score vs. 3.7 for intraperitoneal repair, p = 0.046) 6) No difference		RCT	1b
Wahab, 1999 ⁴²⁶	288 women for CS	Exteriorisation of the uterus vs. intraperitoneal closure	Primary: 1) Perioperative Hb change 2) Duration of operation 3) Maternal morbidity 4) Length of hospital stay Secondary: intraoperative pain, nausea, vomiting, pulling or tugging	Postoperative drop in Hb: GA: Exteriorised (n = 8): mean 1.0 (SD 1.5) Not exteriorised (n = 10): mean 1.7 (SD 0.8) Total (n = 18): mean 1.4 (SD 1.2) SA: Exteriorised (n = 82): mean 1.1 (SD 0.9) Not exteriorised (n = 85): mean 1.3 (SD 1.2) Total (n = 167): mean 1.2 (SD 1.1) EA: Exteriorised (n = 49): mean 1.9 (SD 1.1) Not exteriorised (n = 54): mean 2.2 (SD 1.1) Total (n = 103): mean 1.5 (SD 1.1) All anaesthesia: Exteriorised (n = 139): mean 1.4 (SD 1.1) Not exteriorised (n = 149): mean 1.7 (SD 1.2) p < 0.05 Total (n = 288): mean 1.5 (SD 1.1) No difference for the other outcomes		RCT	1b

One- vs. two-layer closure of uterus

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Enkin, 2003 ⁴²⁹	2 RCTs, 1006 women having lower segment CS, elective or emergency	Single-layer closure vs. two-layer closure	A) Use of extra haemostatic sutures B) Postpartum endometritis C) More than 8% decrease in haematocrit D) Use of blood transfusion E) Moderate/major deformity of scar on radiography	A) OR 0.88 (95% CI 0.67 to 1.14) (n = 906) B) OR 1.28 (95% CI 0.89 to 1.82) (n = 784) C) OR 1.12 (95% CI 0.82 to 1.52) (n = 906) D) OR 0.80 (95% CI 0.33 to 1.94) (n = 906) E) OR 0.19 (95% CI 0.07 to 0.51) (n = 100)	Hauth (1992) 5.6-minute reduction in operating time with single layer (p = 0.0003) Lal (1988)	Systematic review, meta-analysis	1a/1b
Batioglu (1998) ⁴³²	118 women having lower segment CS Exclusion criteria: PROMs, chorioamnionitis, gestational age ≥ 36 weeks	Single layer closure [continuous unlocked] (n = 63) vs two-layer closure [continuous, 1st locked] (n = 55) Suture material: Vicryl	Operating time Duration of hospital stay Postoperative complications Difference in pre- & post-operative haematocrit values of groups	None of the outcomes differed significantly between the groups	Method of randomisation not recorded Groups matched on maternal age, gestational age, birth weight, parity and repeat CS rate	RCT	1b
Ohel (1996) ⁴³³	200 women undergoing lower-segment CS	Single-layer closure (continuous unlocked) (n = 100) vs. two-layer closure (n = 100) Suture material: Vicryl	Mean operating time (minutes) Number of pethidine ampoules	Mean operating time (minutes): 32 ± 11 vs. 44 ± 16 (p < 0.0001) Number of pethidine ampoules: 0.9 ± 0.6 vs. 1.3 ± 0.9 (p < 0.004) No significant differences found for maternal fever, wound infection, positive urine culture, pain score	Randomised by last digit of patient's identity no., even numbers allocated to single layer group; age of women not mentioned	RCT	1b
Bujold (2002) ⁴³⁴	1980 women from a tertiary care hospital in Montreal, Canada, who underwent trial of labour 1988–2000	Measure impact of single layer (n = 489) vs. two-layer closure (n = 1491)	Uterine rupture at subsequent delivery Inter-delivery interval ≤ 24 months	Occurred in 3.1% of single layer and in 0.5% two-layer Uterine rupture at subsequent delivery: OR [95%] 3.95 [1.35, 11.49] (p = 0.01) Inter-delivery interval ≤ 24 months: OR [95%] 2.31 [0.97, 5.52] (p = 0.06)	Initially, 2142 women met study criteria CS rates comparable in both groups, 25.2% vs. 21.7%	Observational retrospective cohort	3
Chapman (1997) ⁴³⁵	145 women identified from a previous RCT, who had a subsequent pregnancy	Single layer closure (n = 70) vs. two-layer closure (n = 75)	Length of labour Mode of delivery Hospital stay Blood transfusion Etc.	None of the outcomes differed significantly between groups		Long term cohort 3 follow-up of Hauth '92 trial	

Closure of the peritoneum

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Wilkinson, 1997 ⁴³⁷	1194 women (4 trials) for CS	Closure vs. no closure of the peritoneum at CS	Operating time, postoperative morbidity, analgesic requirements length of hospital stay.	Non-closure saved operating time: weighted mean difference of -6.12 minutes, 95% CI -8.00 to -4.27 No difference in the other outcomes	One of the 3 trials had sound methodology. The other 3 trials were randomised according to e.g. days of the week so potential for bias	Systematic review	1a
Hojberg, 1998 ⁴⁴¹	40 women for elective CS	Closure vs. no closure of the parietal peritoneum at CS	Postoperative pain measured twice daily from day 1 to 5 using VAS	Results given graphically but no difference between the two groups for postoperative pain	Double blinded for postoperative observations	RCT	1b
Grundsell, 1998 ⁴⁴²	361 women for CS	Closure vs. no closure of the visceral and parietal peritoneum at CS	Febrile morbidity, wound infection, wound dehiscence, urinary tract infection, return to normal bowel action, operating time and hospital stay	Febrile morbidity: Closure (n = 182): 35 Non-closure (n = 179): 14 p < 0.001 Wound infection: Closure (n = 182): 7 Non-closure (n = 179): 4 p < 0.05 Operating time: Closure (n = 182): 41.3 minutes Non-closure (n = 179): 33.4 minutes p < 0.01 Hospital stay: Closure (n = 182): 6.4 days Non-closure (n = 179): 5.03 days p < 0.01		RCT	1b
Balat, 2000[14157]	266 women for CS	Closure vs. no closure of the visceral and parietal peritoneum at CS	Operation time, hospitalisation time and postoperative complications	Fever: Closure (n = 132): 88 Non-closure (n = 134): 46 p < 0.05 Wound dehiscence Closure (n = 132): 13 Non-closure (n = 134): 7 p < 0.05 Operating time (minutes): Closure (n = 132): 41 Non-closure (n = 134): 20 p < 0.001 Hospital stay: Closure (n = 132): 6.6 days Non-closure (n = 134): 3.7 days p < 0.05	Randomisation method not clear	RCT	1b

Closure of the peritoneum (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Galaal, 2000 ⁴⁴⁴	60 women for CS	Closure vs. no closure of the visceral and parietal peritoneum at CS	Duration of operation, drop in Hb, blood transfusion, estimate of blood loss, hospital stay, postoperative pyrexia, ileus, wound infection	Operating time less with non-closure) 61.9 minutes vs. 53.56 minutes, $p < 0.01$ No difference with other outcomes		RCT	1b
Ferrari, 2001 ⁴⁴⁵	158 women for CS	Closure vs. no closure of the visceral and parietal peritoneum at CS	Operating time, postoperative fever, number of sutures used	Operating time less with non closure (31.6 vs. 44.4, $p = 0.0001$) Fewer sutures used (3.6 vs. 6, $p = 0.001$) No difference in post operative morbidity		RCT	1b
Chanrachakul, 2002 ⁴⁴⁶	60 women for elective CS	Closure vs. no closure of the visceral and parietal peritoneum at CS	Postoperative pain using VAS, at rest, when moving in bed, while walking, measured twice daily from day 0 to 4 Use of analgesics	No difference in postoperative pain using VAS or consumption of analgesics Results given graphically	Controlled for indicators for CS, tubal ligation and epidural narcotics	RCT	1b
Rafique, 2002 ⁴⁴⁷		Closure vs. no closure of the visceral and parietal peritoneum at CS	Analgesic requirement assessed by morphine usage via PCA pump over first 24 hour period, oral analgesia, patient pain using VAS and verbal rating scale and patient satisfaction using verbal rating scale	In first 24 hours non closure group used less morphine than closure group (0.64 mg/kg body weight vs. 0.82 mg/kg. $p = 0.04$) Satisfaction scores higher in non closure group Pain scores and other outcomes no difference		RCT	1b

Closure of the abdominal wall

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Van' t Riet, 2002 ⁴⁸	15 studies of women with midline laparotomy incisions closed with different closure techniques	Closure with: – Continuous rapidly absorbable suture – Continuous slowly absorbable suture – Nonabsorbable suture	Primary: Incisional hernia Secondary: wound dehiscence; wound pain, wound infection, suture sinus formation	Closure by continuous rapidly absorbed suture was followed by more hernias than slowly absorbable ($p < 0.009$) or nonabsorbable ($p = 0.001$) More wound pain occurred with nonabsorbable sutures ($p < 0.005$) and more suture sinuses ($p = 0.02$)		Systematic review	1a
Weiland, 1998 ⁴⁹	12,249 women with abdominal wound closure	Different methods of closure: continuous versus interrupted suture, absorbable versus nonabsorbable and mass versus layered closure	Hernias, dehiscence	Mass closures produced less hernias and dehiscence than layered closure ($p=0.002$).		Met analysis	1b

Closure of subcutaneous tissue

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Del valle, 1992 ⁴⁵¹	438 women for CS	Closure of subcutaneous tissue (plain catgut) vs. no closure	Wound disruption	6/222 women who had subcutaneous suture and 16/216 with no suture had superficial wound disruption (p = 0.03)	Other risk factors described were more vaginal examinations during labour and higher BMI Emergency and elective CS included Randomisation not clearly described Physicians not blinded	RCT	1b
Chelmow, 2002 ⁴⁵⁰	327 women for CS	Closure of subcutaneous tissue (plain catgut) vs. no closure	Wound complications	Before discharge: Subcut group 4/162, 2.5% had complications vs. 12/165, 7.3% in control group, RR 0.34, 95% CI 0.11 to 1.0 Follow up complications: no difference Skin separation, seroma or haematoma formation: no difference	Emergency and elective CS included	RCT	1b
Cetin, 1997 ⁴⁵³	164 women, 70 women who had subcutaneous tissue thickness of < 2 cm and 94 with > 2 cm subcutaneous tissue	Each group was individually randomised to subcutaneous tissue closure or nonclosure	Wound complications	For group with > 2 cm subcutaneous tissue: Closure group (n = 47): Seroma: 3 Haematoma: 1 Infection: 1 Total: 5 Non-closure group (n = 44): Seroma: 6 Haematoma: 3 Infection: 3 Total: 12 (p = 0.041) For group with < 2 cm subcutaneous tissue there was no difference for any of the above parameters		RCT	1b

Use of superficial wound drains

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Ochsenbein-Imbof ⁴⁵⁶	305 women undergoing CS (Switzerland) Exclusion criteria: refusal to participate, increased bleeding risk (e.g. HELLP), emergency CS, severe fetal deformity	Suction wound drainage (n = 151) vs. no wound drainage (n = 154)	Decrease in preoperative–postoperative Hb Fever > 38 degrees, at least 2 days No. of opiate injections 3-dimensional sonographic hematoma Complications requiring revision Operating time Length of hospital stay	Decrease in Hb: no significant difference Fever > 38, at least 2 days: no events in either group Opiate use: Suction group: 4.5 injections SD 2.8 No suction group: 2.8 injections SD 1.4 p = 0.0001 Sonographic hematoma: Suction group: 5 No suction group: 4 p > 0.05 Complications requiring revision: Suction group: 1 No suction group: 1 p > 0.05 Operating time: Suction group: 36.1 min SD 10.5 No suction group: 32.7 min SD 11.3 p = 0.007 Length of hospital stay: Suction group: 7.4 days SD 2.8 No suction group: 6.5 days SD 2.4 p = 0.006	Randomisation by opaque sealed envelopes All women received perioperative antibiotic prophylaxis	RCT	1a
Saunders ⁴⁵⁴	200 women undergoing CS (UK) Exclusion criteria: cases where bleeding was severe enough to warrant elective drainage	Suction wound drainage (n = 100) vs. no wound drainage (n = 100)	Wound assessment using a scoring system	Moderate wound infection (score of at least 40): Suction wound drainage (n = 100): 4 (4%); RR 1.33 (95% CI 0.33 to 5.8) No wound drainage (n = 100): 3 (3%); RR 1.00	Randomisation using sealed envelopes Sample size calculation not included	RCT	1a
Allaire ⁴⁵²	76 obese women undergoing elective CS (USA) Inclusion criteria: at least 2 cm subcutaneous layer	Suture closure of subcutaneous layer vs. subcutaneous closed suction drain vs. no suture and no drainage	Wound complications of either: Wound separation Wound infection Haematoma	Any wound complication: Subcutaneous suture closure (n = 26): 5 (19.6%); RR 0.45 (95% CI 0.18 to 1.12) Subcutaneous drain (n = 24): 1 (4.2%); RR 0.10 (95% CI 0.01 to 0.71) No intervention (n = 26): 11 (42.3%); RR 1.00	Randomisation was computer-generated, placed in opaque sealed envelopes All women given perioperative prophylactic antibiotics	RCT	1a

Use of superficial wound drains (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Maharaj ⁴⁵⁵	440 women undergoing emergency CS (Durban) Exclusion criteria: midline incisions, clinical signs of intrauterine infection	Corrugated wound drainage vs. no wound drainage	Wound infection Duration of operation	Wound infection: Corrugated wound drainage (n = 217): 37 (17%); RR 1.09 (95% CI 0.71 to 1.66) No wound drainage (n = 223): 35 (16%); RR 1.00 Duration of operation: Corrugated wound drainage (n = 217): 44 minutes (SD 17.3) No wound drainage (n = 223): 34 minutes (SD 11.7) (p = 0.0001)	Randomisation was computer-generated, placed in opaque sealed envelopes All women given perioperative prophylactic antibiotics	RCT	1a

Closure of the skin

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Alderdice, 2002 ⁴⁵⁸	One trial included in the review, described below	Subcuticular suture vs. staples		See below		Systematic review	1a
Frishman, 1997 ⁴⁵⁹	66 women for CS, 50 available for analysis	Subcuticular suture vs. staples	Wound infection, wound pain (at discharge and 6 weeks follow up), wound appearance, time to close wound	Wound infection: Sutures: 0.0 Staples: 0.1 p = NS Pain scale at discharge: Sutures: 5.1 Staples: 6.6 p = 0.003 Pain scale at follow up: Sutures: 0.5 Staples: 2.0 p = 0.0001 Wound appearance: data not given, described as sutures found to be more attractive by patient and doctor Time to close wound: Sutures: 605 seconds Staples: 47 seconds p < 0.001		RCT	1b
16012	See 15.1 ET						

Use of antibiotics

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Small, 2002 ⁴⁶³	Women undergoing CS, elective and non elective (81 trials, 11,937 women)	Prophylactic antibiotics at CS	Fever Wound infection Endometritis Urinary tract infection Serious infections	Fever: ECS: RR 0.49 (95% CI 0.32 to 0.75) NECS: RR 0.40 (95% CI 0.31 to 0.51) All: RR 0.45 (95% CI 0.39 to 0.52) Wound infection: ECS: RR 0.73 (95% CI 0.53 to 0.99) NECS: RR 0.36 (95% CI 0.26 to 0.51) All: RR 0.41 (95% CI 0.35 to 0.48) Endometritis: ECS: RR 0.38 (95% CI 0.22 to 0.64) NECS: RR 0.39 (95% CI 0.34 to 0.46) All: RR 0.36 (95% CI 0.30 to 0.44) Urinary tract infection: ECS: RR 0.57 (95% CI 0.29 to 1.11) NECS: RR 0.43 (95% CI 0.30 to 0.60) All: RR 0.42 (95% CI 0.46 to 0.64) Serious infections: ECS: RR 1.01 (95% CI 0.04 to 24.21) NECS: RR 0.28 (95% CI 0.13 to 0.61) All: RR 0.42 (95% CI 0.28 to 0.65)		Systematic review	1a
Hopkins, 2001 ⁴⁶⁴	Women undergoing CS, elective and nonelective (31 trials)	Trials comparing at least 2 different prophylactic antibiotic regimens	Fever Wound infection Urinary tract infection Serious infections	Ampicillin vs. 1st generation cephalosporin: OR 1.27 (95% CI 0.84 to 1.93) Ampicillin vs. 2nd or 3rd generation cephalosporins: OR 1.21 (95% CI 0.97 to 1.51) Multiple dose vs. single dose: OR 0.92 (95% CI 0.7 to 1.23)		Systematic review	1a

Use of antibiotics (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Harrigill, 2003 ⁴⁶⁵	196 women undergoing routine CS	Intra-abdominal irrigation with normal saline after closure of the uterus but before abdominal wall closure	Maternal morbidity - one of the following: Infections (endometritis) Haemorrhage Anaemia Urinary retention Other secondary outcomes mentioned	Infections: Control group (n = 99): 7 Intervention group (n = 97): 9 p = 0.61 Haemorrhage: Control group (n = 99): 2 Intervention group (n = 97): 1 p > 0.999 Anaemia: Control group (n = 99): 2 Intervention group (n = 97): 3 p = 0.68 Urinary retention: Control group (n = 99): 0 Intervention group (n = 97): 0 p > 0.999	No difference in maternal morbidity for any of the outcomes RCT 1b		
Pitt, 2001 ⁴⁶⁹	224 women undergoing CS, > 24 weeks and no overt infection and no metronidazole allergy	Intravaginal metronidazole gel	Endometritis Febrile morbidity Wound infection Antibiotic use Postpartum stay	Endometritis: Intervention group (n = 112): 8 (7%) Control group (n = 112): 19 (17%) p = 0.04 Febrile morbidity: Intervention group (n = 112): 15 (13%) Control group (n = 112): 21 (19%) p = 0.28 Wound infection: Intervention group (n = 112): 5 (4%) Control group (n = 112): 3 (3%) p = 0.50 Antibiotic use: Intervention group (n = 112): 4 (3–5%) Control group (n = 112): 4 (3–5%) p = 0.50		RCT	1b

Use of antibiotics (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Reid, 2001 ⁴⁶⁸	Women having caesarean births	Vaginal preparation with povidone iodine	Fever Endometritis Use of iv antibiotics Wound separation	Intervention group (n = 217): Fever: 44 (20.3%) Endometritis: 19 (8.8%) Antibiotic use: (16.6%) Wound separation: 12 (5.5%) Control group (n = 213) Fever: 44 39 (18.3%) Endometritis: 12 (5.6%) Antibiotic use: (16.9%) Wound separation: 18 (8.4%) Fever: RR 1.1 (95% CI 0.8 to 1.6) Endometritis: RR 1.6 (95% CI 0.8 to 3.1) Wound separation: RR 0.6 (95% CI 0.3 to 0.3)	No difference in morbidity	RCT	1b
Magann, 1993 ⁴⁶⁷	100 women undergoing CS, both elective and emergency (USA) Exclusion criteria: presence of chorioamnionitis at CS, emergency CS for fetal distress with inadequate time for skin preparation, patient refusal to participate in study	Standard skin preparation (povidone-iodine 7.5% scrub followed by povidone-iodine 10% solution) vs. 5-minute scrub with parachlorometaxlyenol followed by povidone scrub and solution Intraoperative pelvic irrigation with physiological saline vs. 1-g cefazolin sodium in 500 ml physiological saline	Endometritis Wound infection	Endometritis: Special skin preparation (n = 50): 17 (34%) Standard skin preparation (n = 50): 24 (48%) RR (95% CI): 0.71 (0.44 to 1.48) Antibiotic irrigation (n = 50): 11 (22%) Physiological saline irrigation (n = 50): 30 (60%) RR (95% CI): 0.37 (0.21 to 0.65) Wound infection: Special skin preparation (n = 50): 1 (2%) Standard skin preparation (n = 50): 5 (10%) RR (95% CI): 0.2 (0.02 to 1.65) Antibiotic irrigation (n = 50): 2 (4%) Physiological saline irrigation (n = 50): 4 (8%) RR (95% CI): 0.5 (0.09 to 2.61)	Randomisation method: combination of random number tables and sealed opaque envelopes	RCT	1b

Use of antibiotics (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Kellum, 1985 ⁶⁶⁶	262 women undergoing emergency CS (USA) Inclusion criteria: Prolonged rupture of membranes, numerous pelvic examinations, intrauterine catheter placement, fetal distress, placenta praevia, prolonged labour for CPD, poor nutrition, poverty Exclusion criteria: Current use of antibiotics, known infection, elective CS with low risk of infection, allergy to cephalosporins	No intrauterine lavage V Uterine lavage with 2 g cefamandole + 800 ml physiological saline vs. uterine lavage with 800 ml physiological saline	Serious infection defined as either endometritis or wound infection	No intrauterine lavage (n = 92): Serious infection: 38 (41%), RR 1.00 Uterine lavage with 800 ml physiological saline (n = 86): Serious infection: 29 (34%), RR 0.82 (95% CI 0.56 to 1.20) Uterine lavage with 2 g cefamandole + 800 ml physiological saline (n = 84): Serious infection: 9 (11%), RR 0.26 (95% CI 0.13 to 0.50)	Randomisation determined by last digit of hospital number	RCT	1b

Use of antibiotics health economics

Note: Level of evidence is not relevant to economic models and therefore has not been included here

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Duff, 1987 ⁴⁷⁰	100 hypothetical high-risk women undergoing emergency CS	Antibiotics to treat endomyometritis	Cost: Wholesale cost of antibiotic regimens to treat endomyometritis is assumed to be US\$140 Outcome: Model assumes endomyometritis in 40 women. Prophylaxis reduces incidence by 50%, therefore 20 unnecessary infections	Total cost of treating 20 women US\$2,800. Plus two days additional hospitalisation at US\$441/day. Total cost US\$17,640. Not including additional pharmacy preparation and medical personnel costs Total costs for 100 doses US\$300–600. Net cost saving US\$17,000 for every 100 emergency surgical procedures Two courses of antibiotics, net savings around US\$16,000		Cost effectiveness with simple modelling	

Use of antibiotics health economics (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Ford, 1987 ⁶⁶⁷	Woman undergoing CS	Cost (including cost of failure) of prophylactic antibiotics during CS Piperacillin, cefotaxin, ceftazidime, cefazolin cefotaxime, ampicillin	Efficacy of antibiotic Costs of prophylactic failure based on mean inpatient stay (mother and baby). Laboratory tests, drugs costs, pharmacy preparation and intravenous equipment	Effectiveness of antibiotic: Piperacillin 98% Cefotaxin 91% Ceftazidime 82% Cefazolin 82% Cefotaxime 80% Ampicillin 77% Cost of failure of antibiotic US\$7,442 Cost/woman associated with prophylactic failure by antibiotic: Piperacillin US\$277 Cefotaxin US\$811 Ceftazidime US\$82% Cefazolin US\$1,391 Cefotaxime US\$1,695 Ampicillin US\$1,820 Most effective (piperacillin) vs. least effective (ampicillin) £1418 savings/woman	These drugs are not used in the UK	Cost study using effectiveness data from prospective cohort studies undertaken in one institution Effectiveness studies not described in any detail, only results summarised	
Mugford, 1989 ⁴⁷¹	7777 women undergoing CS	Use of prophylactic antibiotic at CS with either placebo or no treatment	Cost data derived from real cost data from a single institution and regional health authority. Activity/resource use data was derived from direct observation of clinical practice, pharmacy and microbiology departments	Estimation of mean cost of inpatient care (1986-87) with and without wound infection Women with wound infection: £163/day £1435/woman Mean length of stay of 8.8 days Women without wound infection: £107/day £719/woman with mean length of stay of 6.7 days Incremental cost for women with wound infection: £56/day £716/woman Chi-square test for difference between medians: p< 0.005 Assuming 70% effectiveness for ampicillin at £3/woman (1988 prices), average costs would reduce by £3,939/100 CS, at 50% £2,700/100 CS For cefoxitin at £17/woman (1988 prices), the cost at 70% effectiveness would be £2,543/100 CS and at 50% effectiveness, £1,300/100 CS	Cost differences accounted for by increased midwifery costs	Cost analysis based on review of 58 controlled trials	

Use of antibiotics: health economics (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Keane, 1993 ⁶⁶⁸	200 women undergoing CS	Introduction on a policy of routine antibiotic prophylaxis (100 in each group)	Hospital costs and regional health authority Retrospective analysis of effectiveness data from medical notes, reviewed blind for outcome	Incidence of wound infection, length of stay and administration of post natal antibiotics same in both groups Cost for care of 100 women (pharmacy and bacteriology only, since wound infection rates the same) Prophylaxis group: £580 Non-prophylaxis (control) £214 Antibiotics improve outcome but at greater cost Significant difference between groups in number of women undergoing labour prior to CS. Sub-group analysis of women who underwent labour showed no difference in infection rates between treatment and control group.	Hospital audit data. Small sample size for a study of rare events	Cost effectiveness	

Thromboprophylaxis after CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Gates, 2003 ⁴⁷⁴	649 women who were pregnant or recently delivered, included in 8 RCTs	Pharmacological: Unfractionated (UF) heparin Low molecular weight (LMW) heparin	Maternal death Symptomatic Thromboembolic events Symptomatic pulmonary embolism Symptomatic deep venous thromboembolic events Asymptomatic Thromboembolic events Blood transfusion Bleeding episodes Serious wound complications Side effects sufficient to stop treatment Side effects sufficient to stop treatment	LMW or UF vs. placebo: Maternal death: no data Symptomatic thromboembolic events: 2 studies; 126 participants; RR 2.85 (95% CI 0.12 to 67.83) Symptomatic pulmonary embolism: 1 study; 50 participants; effect size not estimable Symptomatic deep vein thrombosis: 2 studies; 126 participants; RR 2.85 (95% CI 0.12 to 67.83) Asymptomatic thromboembolic events: no data Blood transfusion: 2 studies; 126 participants; RR 0.24 (95% CI 0.03 to 2.13) Bleeding episodes: 1 study; 76 participants; effect size not estimable Serious wound complications: 2 studies; 126 participants; effect size not estimable Side effects sufficient to stop treatment: no data Side effects not sufficient to stop treatment: 1 study; 76 participants; effect size not estimable LMW vs. UF: Maternal death: no data Symptomatic thromboembolic events: 1 study; 17 participants; event size not estimable Symptomatic pulmonary embolism: 1 study; 17 participants; event size not estimable Symptomatic deep vein thrombosis: 1 study; 17 participants; event size not estimable Blood transfusion: no data Bleeding episodes: 1 study; 17 participants; event size not estimable Serious wound complications: no data Side effects sufficient to stop treatment: no data Side effects not sufficient to stop treatment: no data	Small studies, not of high methodological quality	Systematic review	1a

Need for further surgery (including hysterectomy)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Ashton, 1985 ⁴⁸⁶	29,488 women having obstetrical or gynaecological treatment in theatre between 1971 and 1982 in an Australian hospital	Observational study	Return to theatre after delivery	Further surgery by mode of delivery: CS: 31/6145 (0.5%); unadjusted RR 17.35 (95% CI 9.37 to 32.11) VD: 15/51576 (0.03%); unadjusted RR 17.35 (95% CI 9.37 to 32.11)		Cohort	2b
Stanco, 1993 ⁴⁸²	94,689 women delivering in a US hospital between January 1 1985 and July 1 1990	Observational study	Hysterectomy following delivery	1 Hysterectomy in 1300 deliveries Hysterectomy by mode of delivery: CS: 116/13996 (0.8) VD: 7/80693 (0.01) Unadjusted RR 95.5 (95% CI 67.7 to 136.9)	Unadjusted risk for hysterectomy was nearly 100 times for CS compared with vaginal delivery Study also gave risk of hysterectomy with prior CS adjusted for placenta praevia as 10.78 (95% CI 7.56 to 15.37)	Cohort	2b
Clark, 1984 ⁴⁸⁴	68,653 women delivering at a US hospital between 1978 and 1982	Observational study	Hysterectomy following delivery	1 hysterectomy/1373 deliveries Hysterectomy by mode of delivery: CS: 60/8243 (0.7) VD: 10/60410 (0.02) Unadjusted RR 43.97 (95% CI 22.52 to 85.85)	Unadjusted risk for hysterectomy was 40 times for CS compared with vaginal delivery For obstetric haemorrhage alone	Cohort	2b

Chapter 7 Care of the baby born by CS

7.2 Neonatal encephalopathy and cerebral palsy

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Scheller, 1994 ⁵⁰⁵	Term, singleton, vertex infants	Vaginal versus caesarean birth	Cerebral palsy	No RCT identified, no observational studies only epidemiological data available.	For breech and LBW births evidence available. CS vs. CP rates also compared: no impact of CS on CP rates	Systematic review	1a

7.3 Birth injuries

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL									
Annibale, 1995 ⁴⁹⁷	11,702 women, uncomplicated pregnancies identified retrospectively from a perinatal database. VD = 10,871, CS = 831 (538 = elective CS)	CS performed electively, for cephalopelvic disproportion or for failure to progress	Neonatal mortality; 1 minute Apgar scores; mode of resuscitation; nursery of admission; highest level of nursery care required; type of respiratory support needed	VD: 12 deaths/10,871 CS: 1 death/831 p 0.93 Neonatal morbidity results shown in table below	Only vertex, term gestation pregnancies included.	Cohort	2a									
Towner, 1999 ⁵⁰⁷	583,340 live infants, full term, weight 2500–4000 g, (breech excluded)		Mode of delivery and morbidity	<table border="1"> <tr> <td></td> <td>CH</td> <td>BPI</td> </tr> <tr> <td>VD</td> <td>2.9</td> <td>7.7</td> </tr> <tr> <td>CS</td> <td>6.7</td> <td>3.0</td> </tr> </table> <p>Ch = cerebral haemorrhage; BPI = brachial plexus injury</p>		CH	BPI	VD	2.9	7.7	CS	6.7	3.0	Incidence of all forms of cranial haemorrhage were higher with CS even when there was no labour	Audit	3
	CH	BPI														
VD	2.9	7.7														
CS	6.7	3.0														
McFarland, 1986 ⁵⁰⁸	106 cases of Erb's palsy; 382 controls		Mode of delivery (and other outcomes)	CS: 4 (3.8%); OR 0.5, 95% CI 0.1 to 1.9 SVD: 47 (44.3%); OR 1.0	Study was unable to show any difference between CS and VD once controlled for birth weight and presentation	Case-control	3									

7.5 Maternal contact (skin to skin)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Anderson, 2003 ⁵¹²	Mothers and their babies after vaginal birth and CS	Early skin-to-skin contact	Breastfeeding; Maintenance of infant temperature; Infant blood glucose; Infant crying; Maternal affection scores	OR/WMD 2.15, 95% CI 1.1 to 4.22 OR/WMD 12.18, 95% CI 2.04 to 72.91 OR/WMD 1.07, 95% CI 3.97 to 18.17 OR/WMD 21.89, 95% CI 5.19 to 92.3 OR/WMD 0.73, 95% CI 0.36 to 1.11	Some benefit of skin to skin in terms of breastfeeding and infant crying	Systematic review	1a
McClellan 1979 ⁵¹³	Women having a repeat CS (40)	Early skin-to-skin contact between mother's and babies post CS	Pre-designed tools to evaluate neonatal perception and maternal satisfaction as an indirect means of evaluating good mothering showed that early contact between mother and baby affect mothering but this effect is only significant during the early postpartum period and by one month there is no difference			RCT	1b

7.6 Breastfeeding

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Hannah, 2002 ³¹⁴	1596 women from 110 centres worldwide who responded to a follow up questionnaire three months after international randomised controlled trial of planned CS vs. vaginal delivery	Planned CS vs. planned vaginal delivery	Breastfeeding rates a few hours after birth and at three months	<p>Breastfeeding rates few hours after birth: Planned CS: 571/779 (73.3%) Planned vaginal delivery: 602/776 (77.6%) RR 0.94 (95% CI 0.89 to 1.00)</p> <p>Breastfeeding rates at 3 months after birth: Planned CS: 533/781 (68.3%) Planned vaginal delivery: 539/776 (69.5%) RR 0.98 (95% CI 0.92 to 1.05)</p>	There was no difference in breastfeeding rates at three months between the groups	RCT	1b
Penn, 1996 ⁴²	<p>13 women in preterm labour (defined as gestational age of 26 to 32 weeks)</p> <p>Women were randomised if in spontaneous preterm labour and when the decision about the mode of delivery would have been made</p> <p>Multicentre randomised controlled trial in 26 hospitals in England, UK</p> <p>Trial closed after 17 months (Nov 1989-June 1991) because of low recruitment</p> <p>Exclusion criteria: Known IUD Clear indication for vaginal delivery or CS Congenital malformation</p>	Intention to deliver vaginally or intention to deliver by CS	Breastfeeding rates	<p>Planned CS: 4/5 (80.0%) Planned vaginal delivery: 7/8 (87.5%)</p>	<p>Central telephone randomisation was used</p> <p>This analysis is by intention to treat</p>	RCT	1b

7.6 Breastfeeding (continued)

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Lumley, 1984 ⁴⁰	6 women in delivering a single live very low birthweight infants from 26 to 31 weeks inclusive (vertex or breech) Period of recruitment July to December 1980 Australian hospital Trial terminated December 1980 due to problems with recruitment Exclusion criteria-fetal abnormality on ultrasound	Immediate CS vs. observed labour	Breastfeeding	Breastfeeding rates at discharge: Elective CS: morbidity events 4/4 (100.0%) Vaginal delivery: morbidity events 1/2 (50.0%)	Unpublished data obtained from systematic review Unclear how allocation sequence was generated and how allocation sequence was concealed	RCT	1b
Leung, 2002 ⁵¹⁸	7825 women who delivered in 1997 in Hong Kong	Observational study	Breastfeeding at any time and breastfeeding at 1 month after delivery	Breastfeeding rates by mode of delivery: VD: n = 5593; ever breastfed 1967 (35.2%); breastfeeding at 1 month: 1158 (20.7%) CS: n = 2084; ever breastfed 614 (29%); breastfeeding at 1 month: (15.5%)	Study adjusted for the potential confounders of Parental smoking status Maternal age Parental educational level, Parental education and employment Gender Birth weight and birth order of infant Gestational age at birth and Residential region of mother.	Cohort	2b
Ever-Hadani, 1994 ⁵¹⁷	8486 women who delivered between Nov 1974 and December 1976, Jerusalem	Observational study	Initiation of breastfeeding Breastfeeding at 3 months	Initiation of breastfeeding: VD: n = 8114; initiating breastfeeding 6491 (80%) CS: n = 372; initiating breastfeeding 219 (60%) Breastfeeding at 3 months: VD: n = 6659; breastfeeding at 3 months: 3096 (46.5%) CS: n = 227; breastfeeding at 3 months: 103 (45.5%) Unadjusted RR 1.02 (95% CI 0.89 to 1.18)	Study adjusted for the potential confounders of: Maternal age Birth order Maternal education Social class Father orthodox or unorthodox Jew Occupation of mother Parent's age at marriage Maternal smoking Place of birth of mother Birth weight	Cohort	2b

7.6 Breastfeeding (continued)

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Bruce, 1991 ⁵¹⁵	202 women who delivered in a UK hospital	Observational study	Breastfeeding status at 6 week interview	Breastfeeding rates at 6 weeks by mode of delivery: VD: n = 139; breastfeeding at 6 weeks: 105 (76%) CS: n = 23; breastfeeding at 6 weeks: 9 (39%)		Cohort	2b
Vestermark, 1990 ⁵¹⁹	370 women who delivered between 1 April and 30 June 1986 in a Danish hospital.	Observational study	Initiation of breastfeeding Breastfeeding at 4 days, 3 months and 6 months	Initiation of breastfeeding: VD: n = 268; initiating breastfeeding: 258 (96%) CS: n = 100; initiating breastfeeding: 84 (82%) Breastfeeding at 4 days: VD: n = 268; breastfeeding at 4 days: 264 (98%) CS: n = 102; breastfeeding at 4 days: 96 (96%) Breastfeeding at 3 months: VD: n = 262; breastfeeding at 3 months: 195 (74%) CS: n = 72; breastfeeding at 3 months: 52 (72%) RR 0.97 (95% CI 0.84 to 1.11) Breastfeeding at 6 months: VD: n = 140; breastfeeding 6 months: 261 (54%) CS: n = 47; breastfeeding 6 months: 22 (47%) Unadjusted RR 1.15 (95% CI 0.83to 1.59)	Unadjusted RR	Cohort	2b
Samuels, 1985 ⁵²⁰	632 women who delivered live children between May and August 1980 California, USA	Observational study	Initiation of breastfeeding as assessed by case note records	Breastfeeding rates/mode of delivery: VD: n = 518; initiating breastfeeding: 357 (69%) CS: n = 114; initiating breastfeeding: 59 (52%)		Cohort	2b
Tamminen, 1983 ⁵¹⁶	1701 women who delivered live children between October 1978 and March 31 1979 Finnish hospital	Observational study	Breastfeeding rates as assessed by case register	Breastfeeding rates/mode of delivery VD: n = 1465; initiating breastfeeding: 1433 (98%) CS: n = 109; initiating breastfeeding: 103 (94.5%)		Cohort	2b

Chapter 8 Care of the woman after CS

8.1 HDU/ITU admission

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Panchal, 2000 ⁵²²	822,591 hospital admissions for delivery in a US state between January 1984 and December 1997 1023 cases admitted for delivery and subsequently admitted to ICU 1023 controls admitted for delivery without intensive care admission.	Observational study	ICU admission following delivery	Rate of ICU admission following delivery 0.12% ICU admission by mode of delivery: Delivery by CS: Cases: 742/1023 (72.5%) Controls: 234/1023 (22.9%) Adjusted OR 9.0 (95% CI 7.24 to 11.16) Deaths following ICU admission by mode of delivery: Delivery by CS: Deaths: 23/34 (67.6%) Survivors: 719/989 (72.7%) Adjusted OR 0.58 (95% CI 0.47 to 1.27)	CS was associated with a nine-fold increase in the risk of being admitted to ICU Women who were admitted to the ICU following CS were 40% less likely to die Adjusted for: Age Race Marital status Payment source Hospital type Source of admission	Case-control	3

8.2 Pain management after CS

Intrathecal analgesia

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Graham, 1995 ⁵²⁹	40 women undergoing elective CS, UK, 1995	2.5 ml heavy bupivacaine +0.3 mg diamorphine intrathecally vs. 2.5 ml heavy bupivacaine +0.3 ml physiological saline	Time to first request for analgesia Total morphine requirements Apgar scores		Women and assessors blinded Randomisation not described	RCT	1b
Swart, 1997 ⁵²⁷	60 women undergoing elective CS, UK, 1996 Exclusion criteria: ASA grade 3 or higher Regular use of analgesic drugs Contraindications to the anaesthetic technique or drugs used in the study	0.1 mg preservative free morphine + bupivacaine vs. 0.1 ml saline + bupivacaine	Visual analogue scales (VAS) for pain, nausea, overall satisfaction At 4 and 24 hours Low scores = less pain, satisfaction	Intrathecal morphine (n = 30) Intrathecal saline (n = 30) Median (IQR) p value VAS pain 4 hours VAS nausea 4 hours VAS satisfied 4 hrs Morphine consumption 4 hours VAS pain 24 hours VAS nausea 24 hours VAS satisfied 24 hours Morphine consumption 24 hours	Random allocation by shuffled sealed envelopes Women and assessors blinded	RCT	1b

8.2 Pain management after CS (continued)

Intrathecal analgesia

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Husaini, 1998 ⁵²⁸	40 women undergoing elective CS, UK 1998	0.5% heavy bupivacaine + 0.2 mg diamorphine vs. 0.5% heavy bupivacaine + 0.2 mg preservative-free morphine	VAS scores for pain, sedation and itch PCA morphine requirement	No difference in PCA morphine use between the 2 groups VAS scores Diamorphine (n = 20) Morphine (n = 20) p value For sedation (median IQR): End of surgery 30 (3,45) 30 (0,45) > 0.05 2 hours 40 (3 to 70) 38 (20 to 61) > 0.05 3 hours 40 (20 to 70) 30 (10 to 50) > 0.05 4 hours 45 (6 to 74) 45 (10 to 70) > 0.05 6 hours 25 (0 to 50) 60 (25 to 80) 0.05 8 hours 10 (0 to 49) 50 (33 to 84) 0.01 12 hours 38 (0 to 70) 70 (50 to 80) 0.06 24 hours 10 (0 to 29) 20 (1 to 50) > 0.05 For itch (median IQR): End of surgery 0 (0 to 0) 0 (0 to 0) > 0.05 2 hours 10 (0 to 28) 30 (0 to 55) > 0.05 3 hours 25 (0 to 44) 40 (25 to 60) 0.03 4 hours 20 (0 to 38) 50 (31 to 60) 0.003 6 hours 10 (0 to 20) 30 (13 to 55) 0.01 8 hours 0 (0 to 26) 45 (11 to 76) 0.002 12 hours 10 (0 to 14) 50 (18 to 70) 0.0002 24 hours 5 (0 to 20) 20 (0 to 40) > 0.05 No significant differences in VAS scores for pain between the 2 groups	Randomisation using sealed envelopes Women and assessors blinded	RCT	1b
Graham, 1997 ⁵³⁰	40 women undergoing elective CS	Women received either 0.3 mg of diamorphine with 0.5% bupivacaine vs. saline with bupivacaine	Time to first morphine demand delivered by PCA and total morphine requirements	Median time to first morphine request: Diamorphine group: 340 minutes Control group: 80 minutes (p = 0.0006, 95% CI 60 to 1235 minutes) Total morphine requirements over 24 hours: Diamorphine group: 5mg Control: 45 mg (p = 0.0045, 95% CI 12 to 46 mg)		RCT	1b

8.2 Pain management after CS (continued)

Intrathecal analgesia

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Hallworth, 1997 ⁵³³	50 women undergoing planned CS under regional anaesthesia in a UK hospital	All women received a combined spinal epidural anaesthetic and an intrathecal dose of 10 mg bupivacaine + 250 microgrammes intrathecal diamorphine or 5 mg epidural diamorphine All women received 100 mg of rectal diclofenac	Post operative assessment: 1. VAS scores for pain 2. VRS scores 3. Respiratory rate 4. Pruritis 5. Sedation scores 6. Time to first analgesic request 7. Type of analgesic 8. Nausea and vomiting	No difference in outcomes except in epidural group (24%, n = 6) compared with spinal group (4%, n = 1) p < 0.05	Abstract only available. No data provided for outcomes 1 to 7	RCT	1b
Duale, 2003 ⁵³⁴	53 women undergoing planned CS under regional anaesthesia in a hospital in France	Injection of epidural (ED) morphine: 2 mg + 1 ml of normal saline (n = 28) vs. injection of 0.075 mg of morphine intrathecal (IT) + 2ml normal saline (n = 25)	1. Time to first demand of morphine 2. Side effects 3. VAS pain scores during first 24 hours postoperation 4. Additional postoperative morphine consumption	1. No difference 2. No difference 3. Cumulative VAS pain scores were greater in the IT group. Data expressed as median, range (95% CI 25 to 75, p = 0.04) 4. Cumulative postoperative morphine consumption was greater in the IT group. 4 mg vs. 1.5 mg over 24 hours (p = 0.03)		RCT	1b

Patient-controlled analgesia

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Howell, 1995 ⁵³⁸	37 women undergoing CS under G.A. (elective and emergency), Canada 1992 Exclusion criteria: Women unable to communicate in English Opioid allergy Morbid obesity Cholestasis of pregnancy	Morphine Fentanyl	100 mm visual analogue scale (VAS) for pain, itching, nausea, sleepiness, satisfaction with pain relief	19 women received morphine, 18 received fentanyl No difference in VAS scores for pain, nausea and itching between the groups No difference in VAS scores for patient satisfaction between the groups	Results presented as figures/graphs Women and assessors blinded Method of randomisation not described	RCT	1b
Ngan Kee, 1999 ⁵³⁷	80 Asian women undergoing elective CS under epidural anaesthesia, ASA I, 2	Pethidine PCia for 12 hours followed by PCEA for 12 hours Pethidine PCEA for 12 hours followed by PCia for 12 hours Fentanyl PCia for 12 hours followed by PCEA for 12 hours Fentanyl PCEA for 12 hours followed by PCia for 12 hours	VAS scores for pain PCA demands	Peth I/E: PCA demands: median 1.5 (IQR 0 to 3) Peth E/I: PCA demands: median 0 (IQR 0 to 1) p = 0.04 Fent I/E: PCA demands: median 3 (IQR 2 to 7) Fent E/I: PCA demands: median 0 (IQR 0 to 1) p = 0.00001	Randomisation by drawing of shuffled coded envelopes No numerical data on VAS pain scores	RCT	1b

Nonsteroidal anti-inflammatory analgesia

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Lim, 2000 ⁵⁴³	48 ASA 1 or 2 women for elective CS under regional anaesthesia	Single dose of diclofenec suppository immediately post-CS vs. no suppository (all women used EPCA with bolus doses of local anaesthetic)	Use of EPCA, pain scores and satisfaction scores	Patients who received the suppository used 52.8 ml local anaesthetic while those with no suppository used 74 ml ($p < 0.005$) No difference between pain and satisfaction scores		RCT	1b
Bush, 1992 ⁵⁴⁴	50 women for elective CS under GA	Single dose of IM diclofenac (group A) after CS vs. placebo (group B) All women had PCA which gave bolus doses of 3–5 mg papaveratum	At 6,12 and 24 hours post op pain, nausea and sedation were assessed using scoring scales and injection site discomfort	Cumulative papaveratum consumption at 18 hours was more in group B, mean 91.4 (SD 23.4) than group A mean 61.4 (30.2), $p < 0.05$ Linear analogue scores for pain were less in group A at 0 to 6 hours ($p < 0.05$), no difference at 12 hours Sedation scores were lower in group A at 6 hours, no difference at 12 hours No difference in nausea scores at any time No difference in injection site pain	No individual patient data given	RCT	1b
Dennis, 1995 ⁵⁴²	50 women undergoing elective CS with spinal anaesthesia	Rectal diclofenac 100mg immediately postoperative to study group	VAS for pain, mean time to first analgesia, side effects of nausea and vomiting	Mean time to first analgesia: Diclofenac group: 13 hours, 45 minutes Control group: 18 hours, 58 minutes ($p < 0.03$) No differences in other outcomes		RCT	1b

Health economics: pain management after CS

Note: level of evidence is not relevant to economic models and therefore not been included here

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Gerancher 1999 ⁵³⁶	40 women requesting spinal analgesia who underwent planned CS, and 15 women who had PCEA	Small doses of intrathecal morphine added to a regimen of oral analgesia and post-CS medication	Rate of pain relief (no need for additional units of iv morphine). Evidence for outcomes derived from one non-randomised historical cohort Costs included nursing time and drug costs derived from cost survey at one institution Cost and resources reported separately	Success rate 62.5%. No statistical difference between intervention and control group for pain or side-effects Cost: Intrathecal morphine US\$15 (± 4.40) PCEA US\$35 (± 15.55) Nursing time Intrathecal morphine 150 minutes (± 57) PCEA 148 minutes (± 61)	No synthesis of costs and benefits so not a full cost-effectiveness analysis No sensitivity analysis Small sample size Cost consequence study		

8.3 Early eating and drinking after CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Mangesi, 2002 ²⁴⁹	Women within the first 24 hours after CS (sis trials)	Early vs. delayed oral feeding	Time to first food intake; time to return of bowel sounds; postoperative stay; abdominal distension; nausea; vomiting; time to first bowel action; paralytic ileus and number of analgesic doses	<p>Early oral feeding associated with:</p> <p>Reduced time to first food intake: 1 trial (118 women); WMD -7.2 hours (95% CI -13.26 to -1.14)</p> <p>Reduced time to return of bowel sounds: 1 trial (118 women); WMD -4.3 hours (95% CI -6.78 to -1.82)</p> <p>Reduced postoperative stay: 2 trials (220 women); WMD -0.75 days (95% CI 0.55 to 1.11)</p> <p>No difference in nausea; vomiting; time to first bowel action; paralytic ileus and number of analgesic doses</p>		Systematic review	1a
Kubli, 2002 ²⁸⁰	60 women in early labour (cervical dilatation < 5 cm) in a UK hospital	<p>Intervention: women received 'isotonic' sports drinks during labour (n = 30). Women were encouraged to drink 500 ml in the first hour and the a further 500 ml every 3 to 4 hours. The isotonic drink used contained 64 g/l of carbohydrate, sodium of 24 mmol/l and a tonicity of 300 mOsm/kg</p> <p>Control: women received water only during labour (n = 30). Women were encouraged to drink as much or as little water as they wanted</p>	<p>Primary outcomes:</p> <p>1. Metabolic changes: measured using plasma beta hydroxybutyrate (BHB), NFEA's and glucose (G) levels in early labour and at the end of the first stage of labour</p> <p>2. Gastric volumes: ultrasound measurement of gastric volume</p> <p>3. Incidence and volume of vomiting</p> <p>Secondary outcomes:</p> <p>1. Maternal outcomes: duration of labour, use of oxytocin, use of epidural analgesia</p> <p>2. Baby outcomes: Apgar scores and umbilical gases</p>	<p>Primary:</p> <p>1. Estimate of difference between early labour and end of first stage of labour between groups: BHB: -0.63 mmol/l; 95% CI -0.85 to -0.42 (p = 0.000) NFEA: -0.36 mmol/l; 95% CI -0.46 to -0.25 (p = 0.000) G: 0.76 mmol/l; 95% CI 0.22 to 1.5 (p = 0.007)</p> <p>2. Estimate of difference of gastric volumes and incidence and volume of vomiting between groups: Gastric volume (cm³): -00.63; 95% CI -1.12 to 0.7 (p = 0.64) Numbers vomiting: 0.03; 95% CI -0.16 to 0.29 (p = 0.74) Volume vomited (ml): 65; 95% CI -141 to 271 (p = 0.42)</p>	<p>Women who requested IM meperidine were excluded</p> <p>No difference in any of the secondary maternal or baby outcomes</p>	RCT	1b

8.4 Urinary catheter removal

Study	Population	Intervention	Outcomes	Results	Comments	Design	EL
Tangtrakul, 1994 ⁵⁵²	107 women undergoing CS under general anaesthesia in Thailand Urine specimen sent with initial catheterisation and 9 women were excluded due to initial positive culture Clean catch specimens were taken on day 3 post-CS	Group 1 (n = 51): intermittent catheterisation. Women were catheterised just before the CS and the catheter was removed at the end of the CS. Intermittent post-CS catheterisation if no urine voided for 6 hours when awake or unable to void in the presence of a full bladder Group 2 (n = 47): indwelling catheterisation. Indwelling catheter was placed just before the CS and then removed the day after the CS	Post-CS urinary tract infection Post-CS urinary retention	UTI: Group 1 (n = 51): yes 16, no 35 Group 2 (n = 47): yes 9, no 38 RR1.64, (95% CI 0.80 to 3.34, p > 0.05) 20 (39.2%) women in group 1 developed post-CS urinary retention. None in group 2 developed urinary retention		RCT	1b
Dunn, 2000 ⁵⁵⁴	78 women, 29 underwent CS, 11 abdominal hysterectomy and 38 vaginal hysterectomy in a US hospital	Foley catheter sited for the operation was removed either immediately postoperatively or on the first day postoperatively	Recatheterisation Febrile morbidity Symptomatic urinary tract infection Pain	Recatheterisation: NS Febrile morbidity: NS Symptomatic urinary tract infection: NS Less pain with immediate removal (p = 0.0001). For CS this was also significant (p = 0.001)	Abstract only available, no data given	RCT	1b

8.4 Urinary catheter removal (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Ghoreishi, 2003 ³⁰⁸	270 women undergoing CS with general or regional anaesthesia in Iran	Urinary bladder catheterisation for CS (n = 135, 68 general anaesthetic, 67 regional anaesthetic) or no catheterisation (n = 135, 70 general anaesthesia, 65 regional anaesthesia)	Mean time to first void: 8–11 hours: Uncatheterised (n = 135): – Catheterised (n = 135): 54 (p < 0.05) 5–8 hours: Uncatheterised (n = 135): – Catheterised (n = 135): 52 (p < 0.05) Hospital stay (hours): Uncatheterised (n = 135): 46.5 ± 11.7 (p < 0.05) Catheterised (n = 135): 64 ± 10.7 (p < 0.05) Ambulation time (hours): Uncatheterised (n = 135): 6.8 ± 2.9 (p < 0.05) Catheterised (n = 135): 12.9 ± 3.4 (p < 0.05) Discomfort at first void: None: Uncatheterised (n = 135): 127 (p < 0.05) Catheterised (n = 135): 9 (p < 0.05) Mild: Uncatheterised (n = 135): 5 (p < 0.05) Catheterised (n = 135): 92 (p < 0.05) Severe: Uncatheterised (n = 135): 3 (p < 0.05) Catheterised (n = 135): 34 (p < 0.05) Catheterisation: In theatre: 6 (p < 0.05) On postpartum ward: 2.4 (p < 0.05)			RCT	1b
Kerr-Wilson, 1986 ³⁰⁷	50 women undergoing elective CS under epidural anaesthesia in Scotland	Group 1: Nelaton catheter inserted before the CS and removed at the end of the CS Group 2: Foley's catheter inserted before the CS and left in situ until the woman was ambulant after the CS	1. Recatheterisation 2. Volume of urine obtained 3. Time of spontaneous micturition 4. Significant bacteriuria: urine microscopy in women with indwelling catheters at time of insertion and removal	Catheter: In/out (n = 25): 1: 11 2: 0 4: 3 Indwelling (n = 25): 1: 0 2: 873 ± 108 4: 3		RCT	1b

8.5 Respiratory physiotherapy after CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Kaplan, 1994 ⁵⁵⁵	120 women undergoing CS under GA, Israel 1993	Respiratory physiotherapy on first 3 postoperative days vs. no postoperative physiotherapy	Chest auscultation Chest expansion Productive cough	<p>Abnormal chest auscultation:</p> <p>Physiotherapy (n = 60): Postoperative D1: 9 Postoperative D2: 3 Postoperative D3: 0</p> <p>Control (n = 60): Postoperative D1: 15 Postoperative D2: 3 Postoperative D3: 0 p > 0.05</p> <p>Abnormal chest expansion:</p> <p>Physiotherapy (n = 60): Postoperative D1: 0 Postoperative D2: 0 Postoperative D3: 0</p> <p>Control (n = 60): Postoperative D1: 9 Postoperative D2: 0 Postoperative D3: 3 p > 0.05</p> <p>Productive cough:</p> <p>Physiotherapy (n = 60): Postoperative D1: 18 Postoperative D2: 6 Postoperative D3: 0</p> <p>Control (n = 60): Postoperative D1: 24 Postoperative D2: 12 Postoperative D3: 0 p > 0.05</p>	Randomisation not described Assessor blinded	RCT	1b

8.6 Debriefing for women after CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Small, 2000 ⁵⁵⁸	1041 women who had given birth by CS, forceps or vacuum extraction, Australia 2000	Debriefing before discharge from hospital	Depression: score of at least 13 on the Edinburgh postnatal depression scale 6 months after birth Assessment by postnatal questionnaire	Debriefing (n = 467): 81 depressed (17%); OR 1.24 (95% CI 0.87 to 1.77) Standard care (n = 450): 65 depressed (14%); OR 1.00	Telephone randomisation with allocation determined by a separate computer generated, adaptive biased coin randomisation schedule	RCT	1b
Gamble, 2003 ⁵⁶⁰	400 women recruited from an Australian antenatal clinic were interviewed 72 hours after birth. 103 women reported a distressing birth experience and were then randomised	An intervention to address psychological trauma following childbirth was developed and tested. Focus groups with women and midwives were used to develop the intervention and consisted of a counselling framework for use by midwives for debriefing women after childbirth. Women in the intervention group had the opportunity to de-brief at an initial post natal interview (less than 72 hours postpartum) and 4–6 weeks postpartum	Presence of post-traumatic stress disorder symptoms (PTSD)	PTSD was strongly associated with obstetric interventions including emergency CS. In the intervention group 34% (n = 17) had symptom profile PTSD, compared with 32% (n = 16) in the control group (RR 1.06 95% CI 0.61, 1.84). Fewer women in the intervention group had PTSD symptoms at 3 for months, although this was not statistically significant. However this is a small RCT had 2% power to detect a 2% difference in prevalence of symptoms of post traumatic stress disorder	Baseline studies of 400 women prior to the RCT reported a high prevalence of PTSD following childbirth, 9.6% of women meeting the diagnostic criteria for PTSD at 4–6 weeks postpartum	RCT	1b

8.7 Early discharge from hospital after CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Brooten, 1994 ⁵⁶⁷	122 women who had had an unplanned CS	Early discharge (discharged once 24 hours afebrile and no other complications) vs. usual discharge	Maternal satisfaction (using a score system); maternal and neonatal rehospitalisation	Mean satisfaction score: intervention: 187; control 164 (p < 0.001) No difference between rehospitalisations		RCT	1b

Chapter 9 Recovery following CS

Pain

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Hannah, 2002 ²¹⁴	1596 women from 110 centres worldwide who responded to a follow-up questionnaire 3 months after being recruited into a trial to assess the maternal and baby outcomes for planned CS vs. planned vaginal delivery for term breech presentation	Planned CS vs. planned vaginal delivery	Pain	<p>Site of pain in relation to intended mode of delivery:</p> <p>In back: CS: 90/796 (11.3%) VD: 97/797 (12.2%) RR 0.93 (95% CI 0.71 to 1.22)</p> <p>In head: CS: 38/796 (4.8%) VD: 34/797 (4.3%) RR 1.12 (95% CI 0.71 to 1/76)</p> <p>On outside of abdomen: CS: 79/796 (9.9%) VD: 45/797 (5.7%) RR 1.76 (95% CI 1.24 to 2.50)</p> <p>Deep inside abdomen: CS: 70/796 (8.8%) VD: 37/797 (4.6%) RR 1.89 (95% CI 1.29 to 2.79)</p> <p>In bottom or genital area: CS: 14/796 (1.8%) VD: 44/797 (5.50%) RR 0.32 (95% CI 0.18 to 0.58)</p> <p>In other location: CS: 13/796 (27.3%) VD: 16/797 (2.0%) RR 0.81 (95% CI 0.39 to 1.68)</p> <p>Any pain: CS: 217/796 (27.3%) VD: 199/797 (25.0) RR 1.09 (95% CI 0.93 to 1.29)</p> <p>Amount of pain: p = 0.30</p> <p>Took pills or medicine for pain in last 24 hours: CS: 46/795 (5.8%) VD: 46/793 (5.8%) RR 1.00 (95% CI 0.67 to 1.48)</p>	<p>Women delivering by CS were 90% more likely to experience pain deep inside the abdomen but 70% less likely to experience pain in the bottom or genital area.</p> <p>Computer generated randomisation and central allocation.</p> <p>Analysis by intention-to-treat.</p>	RCT	1b

Chapter 9 Recovery following CS (continued)

Pain							
Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Thompson, 2002 ⁵⁶⁴	1295 women who gave birth to a live baby from March to October 1997	Observational study	Backache Perineal pain	<p>Backache:</p> <p>0–8 weeks by mode of delivery: CS: 116 (51%) Instrumental delivery: 91 (54%) Vaginal delivery: 452 (53%) p = 0.87</p> <p>9–16 wks by mode of delivery: CS: 105 (47%) Instrumental delivery: 88 (53%) Vaginal delivery: 374 (45%) p = 0.15</p> <p>17–24 weeks by mode of delivery: CS: 107 (57%) Instrumental delivery: 78 (47%) Vaginal delivery: 348 (43%) p = 0.19</p> <p>Perineal pain:</p> <p>0–8 weeks by mode of delivery: CS: 4 (2%) Instrumental delivery: 86 (51%) Vaginal delivery: 187 (22%) p = < 0.0001</p> <p>9–16 weeks by mode of delivery: CS: 2 (1%) Instrumental delivery: 25 (15%) Vaginal delivery: 52 (6%) p = < 0.00001</p> <p>17–24 weeks by mode of delivery: CS: 2 (1%) Instrumental delivery: 20 (12%) Vaginal delivery: 27 (3%) p = < 0.00001</p>	There was no difference in backache by mode of delivery	Cohort	2b
Brown, 1998 ⁵⁶⁹	1366 women who gave birth in a two-week period in September 1993 in 127 hospitals in an Australian region	Observational study	Backache at 6–7 months parity.	<p>Backache during first 6–7 months postpartum by mode of delivery: Elective CS: 60 (48.0%) Emergency CS: 54 (45.8%) Instrumental delivery: 80 (48.8%) Vaginal delivery: 382 (41.3%) p = 0.2</p>	There was no difference in backache by mode of delivery	Cohort	2b

Chapter 9 Recovery following CS (continued)

Pain

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Glazener, 1995 ⁵⁶³	1249 women who delivered in a Scottish region between June 1990 and May 1991	Observational study	Backache at 2–18 months postpartum Perineal pain at 0–13 days (hospital) Up to 8 weeks 2–18 months	Backache 2–18 months postpartum by mode of delivery: CS:19/65 (29%) Instrumental delivery: 15/63 (24%) Vaginal delivery: 53/310 (17%) p = 0.058 Perineal pain: 0–13 days in hospital by mode of delivery: CS: 9/181 (5%) Instrumental delivery: 145/172 (84%) Vaginal delivery: 376/896 (42%) At home up to 8 weeks by mode of delivery: CS: 6/161 (4%) Instrumental delivery: 88/149 (59%) Vaginal delivery: 153/806 (19%) At home 2–18 months by mode of delivery: CS: 1/65 (2%) Instrumental delivery: 19/63 (30%) Vaginal delivery: 12/310 (7%)	There was no difference in backache by mode of delivery	Cohort	2b
Lydon-Rochelle, 2001 ⁵⁷⁰	Primiparous women 7 weeks postpartum: all modes of delivery	Observational study	Bodily pain	Mode of delivery: CS Assisted vaginal Unassisted vaginal Health status score 66.4, 74.7, 78.3	Pain assessment was the extent to which pain interfered with usual activities. A 0–100 scale was used with: 10 “Yes, interfered a lot” 20 “Yes interfered a little” 30 “No, not interfered at all” Scale was SF-36 (four scales) There were worse scores for CS than for both vaginal routes of delivery. Potential confounders were accounted for including age, race social support and only primiparous women were included to exclude confounding from parity	Cohort	2b

Bladder/bowel/ureteric injury

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Rajasekar, 1997 ⁵⁷⁸	117,847 deliveries including 11,284 CS from 1976 to 1993 in the Grampian district of Scotland	Observational study	Urinary tract injuries following delivery by mode of delivery	Bladder: CS: 13/11,284 (0.115%) VD: 3/95279 (0.003%) Ureter: CS: 3/11,284 (0.027%) VD: 1/95279 (0.001%)	All women who sustained bladder and ureteric injury in the vaginal delivery group did so following Kjellands forceps deliveries	Case-control	3

Maternal morbidity and CS

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Hannah 2000 ⁶⁹	<p>2088 women with a singleton fetus in a frank or complete breech presentation</p> <p>International randomised trial at 121 centres in 26 countries (low perinatal mortality rate and high perinatal mortality rate countries)</p> <p>Trial stopped recruitment after reviewing results on first 1600 women randomised, since difference in rate of the primary outcome was significant</p> <p>Exclusion criteria: Evidence of feto-pelvic disproportion Clinically large fetus (≥ 4 kg) Hyperextension of head Fetal anomaly. Contraindication to labour or delivery, e.g. placenta praevia</p>	Planned CS vs. planned vaginal delivery	<p>Postpartum bleeding*</p> <p>Infection*</p> <p>Need for blood transfusion*</p> <p>Need for further surgery (D+C)*</p> <p>Hysterectomy*</p> <p>Length of hospital stay*</p> <p>Early postnatal depression</p> <p>Genital tract injury*</p> <p>Composite maternal morbidity defined as: death or one of above marked with *</p>	<p>Blood loss > 1000 ml: Planned CS: 4/1041 (0.4%) Planned vaginal delivery: 8/1041 (0.8%) RR 0.50 (95% CI 0.15 to 1.66)</p> <p>Blood loss >1500 ml: Planned CS: 2/1041 (0.2%) Planned vaginal delivery: 4/1042 (0.4%) RR 0.50 (95% CI 0.09 to 2.73)</p> <p>Need for blood transfusion: Planned CS: 4/1041 (0.4%) Planned vaginal delivery: 8/1041 (0.8%) RR 0.50 (95% CI 0.15 to 1.66)</p> <p>Infection: Planned CS: 32/1041 (3.1%) Planned vaginal delivery: 23/1041 (2.2%) RR 1.39 (95% CI 0.82 to 2.36)</p> <p>Bladder/bowel/ureteric injury: Planned CS: 0/1041 (0%) Planned vaginal delivery 0/1041 (0%)</p> <p>Genital tract injury: Planned CS: 6/1041 (0.6%) Planned vaginal delivery: 6/1041 (0.6%) RR 1.00 (95% CI 0.32 to 3.09)</p> <p>Need for further surgery (D&C): Planned CS: 3/1041 (0.3%) Planned vaginal delivery: 4/1041 (0.4%) RR 0.75 (95% CI 0.17 to 3.34)</p> <p>Hysterectomy: Planned CS: 0/1041 (0%) Planned vaginal delivery: 0/1041 (0%)</p> <p>Thromboembolic disease: Planned CS: 0/1041 (0%) Planned vaginal delivery: 0/1041 (0%)</p> <p>Median length of hospital stay: 5th to 95th centile: Planned CS: 4.0 (95% CI 1.7 to 7.4) Planned vaginal delivery: 2.8 (95% CI 0.8 to 6.9) $p < 0.0001$</p> <p>Postnatal depression: Planned CS: 3/1041 (0.3%) Planned vaginal delivery: 0/1042 (0.0%)</p> <p>Composite maternal morbidity: Planned CS: 41/1041 Planned vaginal delivery: 33/1042 RR 1.24 (0.79 to 1.95)</p>	<p>Adequate generation of allocation sequence and concealment of allocation sequence (central telephone randomisation)</p> <p>Non-blinded trial</p> <p>Intention-to-treat analysis</p> <p>Emergency CS rate in planned vaginal birth group was (451/1042) 43.5%</p> <p>Adequate generation of allocation sequence and concealment of allocation sequence (central telephone randomisation)</p> <p>Non-blinded trial</p> <p>Intention-to-treat analysis RCT 1b</p>		

Maternal morbidity and CS (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Gimovsky, 1983 ⁴³	<p>105 women with non-frank breech presentations at term, defined as between 36 and 42 weeks</p> <p>Women randomised over a 13 month period: April 1981 to May 1982</p> <p>Included those excluded from a trial of labour because of inadequate pelvic dimensions on X-ray examination</p> <p>Exclusion criteria: Severe PIH Previous CS History of stillbirth History of infertility Maternal diabetes Hyperextension of head Contraindication to labour IUGR Abnormal antepartum testing Abnormal amniotic fluid volume Multiple gestation</p>	Trial of labour vs. elective CS	<p>Need for blood transfusion</p> <p>Infection</p> <p>Length of hospital stay</p> <p>Febrile morbidity</p>	<p>Need for blood transfusion: Elective CS: 3/35 (8.6%) Vaginal delivery: 3/70 (4.3%) RR2.00 (95% CI 0.43 to 9.40)</p> <p>Infection: Elective CS: 2/35 (16.7%) Vaginal delivery: 0/70 (0.0%)</p> <p>Length of hospital stay: Planned/intended delivery: hospital stay in days (mean ± SD): Vaginal/vaginal: 2.2 ± 0.5 Vaginal/CS: 5.5 ± 1.9 CS/CS: 5.2 ± 2.0 CS/vaginal: 2.0 ± 0.5</p> <p>Febrile morbidity: Elective CS: 18/35 (51.4%) Vaginal delivery: 23/70 (33.0%) RR 1.56 (95% CI 0.98 to 2.49)</p>	<p>Generation and concealment of allocation sequence unclear</p> <p>Emergency CS rate in planned vaginal delivery group was 55.7% (39/70)</p>	RCT	1b

Maternal morbidity and CS (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Collea, 1980 ⁴⁴	208 women with frank breech presentation at term Randomised over a 4-year period: July 1975 to May 1979 in a US hospital Exclusion criteria: Hyperextension of fetal head Congenital abnormalities Elderly primigravida Obstetric indications for CS Maternal diabetes Floating station Involuntary infertility Pelvic contracture by previous X-ray pelvimetry History of previous difficult/traumatic delivery	Trial of labour vs. elective CS	Blood loss Need for blood transfusion Infection Bladder/bowel or ureter injury Hysterectomy	Blood loss > 1000 ml: Planned CS: 2/93 (2.15%) Planned vaginal delivery: 0/115 (0.0%) Blood loss > 1500 ml: Planned CS: 3/93 (3.2%) Planned vaginal delivery: 0/115 (0.0%) Need for blood transfusion: Planned CS: 7/93 (7.5%) Planned vaginal delivery: 8/115 (7.0%) RR 1.08 (95% CI 0.41 to 2.87) Infection: Planned CS: 39/93 (42.0%) Planned vaginal delivery: 37/115 (32.2%) RR 1.30 (95% CI 0.91 to 1.86) Bladder/bowel/ureteric injury: Planned CS: 1/93 (1.1%) Planned vaginal: 0/115 (0%) Hysterectomy: Planned CS: 1/93 (1.1%) Planned vaginal delivery: 0/115 (0.0%)	Generation and concealment of allocation sequence unclear Emergency CS rate in planned vaginal delivery group was (60/115) 52.2%	RCT	1b
Penn, 1996 ⁴²	13 women in preterm labour (defined as gestational age of 26 to 32 weeks) Multicentre randomised controlled trial in 26 hospitals in England, UK Women were randomised if in spontaneous preterm labour and when the decision about the mode of delivery would have been made Exclusion criteria: Known IUD Clear indication for vaginal delivery or CS Congenital malformation	Intention to deliver vaginally or intention to deliver by CS	Maternal stay > 10 days Maternal puerperal pyrexia	Maternal stay > 10 days: Planned CS: 1/5 (20%) Planned vaginal delivery: 1/8 (12.5%) RR 1.60 (95% CI 0.13 to 20.22) Maternal puerperal pyrexia: Planned CS: 2/5 (40.0%) Planned vaginal delivery: 0/8 (0.0%)	Central telephone randomisation was used This analysis is by intention to treat Trial closed after 17 months (Nov 1989 to June 1991) because of low recruitment Emergency CS rate in planned vaginal birth group was (2/8) 25%	RCT	1b

Maternal morbidity and CS (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Zlatnik, 1993 ³⁹	<p>38 women in premature labour with a breech presentation</p> <p>Premature labour defined as 28–36 weeks of gestation</p> <p>Women randomised over a 52 month (October 1978 to January 1983) study period in a single US hospital</p> <p>Exclusion criteria: Contraindications to additional labour Contraindications to CS Fetal distress in labour Lethal anomaly</p>	Immediate CS vs. observed labour	<p>Infection</p> <p>Length of hospital stay > 10 days</p> <p>Maternal puerperal pyrexia</p>	<p>Infection: Elective CS: 1/18 (5.6%) Vaginal delivery: 0/20 (0.0%)</p> <p>Length of hospital stay > 10 days: Elective CS: 1/18 (5.6%) Vaginal delivery: 2/20 (10.0%) RR 0.56 (95% CI 0.05 to 5.62)</p> <p>Maternal puerperal pyrexia: Elective CS: 9/18 (50.0%) Vaginal delivery: 4/20 (20.0%) RR 2.50 (95% CI 0.93 to 6.73)</p>	<p>Adequate generation of allocation sequence.</p> <p>Adequate concealment of allocation sequence (sealed envelopes).</p> <p>The emergency CS rate in the planned vaginal delivery group was (7/20) 35%</p>	RCT	1b
Lumley, 1984 ⁴⁰	<p>6 women in delivering a single live very low birthweight infants from 26 to 31 weeks inclusive (vertex or breech) in Australia</p> <p>Period of recruitment July to December 1980</p> <p>Trial terminated December 1980 due to problems with recruitment</p> <p>Exclusion criterion fetal abnormality on ultrasound</p>	Immediate CS vs. observed labour	<p>Infection</p> <p>Need for blood transfusion</p> <p>Maternal puerperal pyrexia</p>	<p>Infection Elective CS: 1/4 (25.0%) Vaginal delivery: 2/2 (100.0%) RR 0.25 (95% CI 0.05 to 1.36)</p> <p>Need for blood transfusion: Elective CS: 0/4 (0.0%) Vaginal delivery: 2/2 (100.0%)</p> <p>Maternal puerperal pyrexia: Elective CS: 3/4 (75.0%) Vaginal delivery: 2/2 (100.0%)</p>	<p>Unpublished data obtained from systematic review</p> <p>Unclear how allocation sequence was generated and how allocation sequence was concealed</p> <p>There is no information on emergency CS rate in planned vaginal birth rate</p>	RCT	1b

Maternal morbidity and CS (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Wallace, 1984 ⁴¹	38 women with very-low-birthweight infants (< 1500 g) Vertex presentation Enrolled over a 6-month period in a US hospital Exclusion criteria: Multiple gestation Known congenital anomaly Malpresentation Amnionitis Advanced labour (> 7 cm) Cord prolapse Vaginal haemorrhage Previous CS	Attempted vaginal birth vs. attempted CS	Maternal morbidity not defined	No maternal morbidity events occurred (data from systematic review, Grant and Glazener)	No description of randomisation given Trial terminated because of an unacceptably high frequency of infants consistently weighing in excess of 1500 g Emergency CS rate in planned vaginal delivery group was (9/20) 45%	RCT	1b
Viegas, 1985 ³⁸	23 women with preterm breech babies Preterm defined as < 37 weeks of pregnancy Women enrolled over a 20 month period in 4 Singaporean hospitals Randomised on admission in established labour Exclusion criteria: Contraindications for CS or vaginal delivery Maternal diseases Severe congenital malformation Severe pre-eclampsia or IUGR	CS vs. vaginal delivery	Infection Length of hospital stay > 10 days	Infection: Elective CS: 2/12 (16.7%) Vaginal delivery: 0/15 (0.0%) RR 6.15 (95% CI 0.32 to 117.21) Length of hospital stay > 10 days: Elective CS: 2/12 (16.7%) Vaginal delivery: 1/15 (6.7 %%) RR 2.50 (95% CI 0.26 to 24.38)	Generation and concealment of allocation sequence unclear There is no information on emergency CS rate in the planned vaginal delivery group	RCT	1b

Maternal morbidity and CS (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Rabinovici, 1987 ⁴⁵	60 women in spontaneous or induced labour with twin pregnancy; both twins alive, first twin vertex, 2nd twin breech/transverse lie Gestational age 35–42 weeks Exclusion criteria: Fetal anomaly Signs of abruption or acute placental insufficiency Indication for CS or vaginal delivery Cervix > 7 cm dilated	CS for birth of non-vertex 2nd twin vs. vaginal birth	Need for blood transfusion Length of hospital stay Maternal febrile morbidity	Need for blood transfusion: Elective CS: 3/27 (11.1%) Vaginal delivery: 2/27 (7.4%) RR 1.50 (95% CI 0.27 to 8.28) Length of hospital stay in days (mean ± SD): Elective CS: 8 ± 2 Vaginal delivery: 4.9 ± 2.9 Patients discharged on schedule: Elective CS: 13/27 (48.2%) Vaginal delivery: 18/27 (66.7%) RR 0.72 (95% CI 0.45 to 1.16) Maternal febrile morbidity: Elective CS: 11/27 (40.7%) Vaginal delivery: 3/27 (11.1%) RR 3.67 (95% CI 1.15 to 11.69)	Unclear how allocation sequence was generated and how allocation sequence was concealed The emergency CS rate in the planned vaginal delivery group was (2/33) 6.1%	RCT	1b

Urinary incontinence

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Hannah, 2002 ³¹⁴	1596 women from 110 centres worldwide who responded to a follow up questionnaire three months after international randomised controlled trial of planned CS vs. vaginal delivery	Planned CS vs. planned vaginal delivery	Urinary incontinence 3 months after delivery assessed by questionnaire concerning loss or leakage of urine in the previous 7 days	Urinary incontinence Planned CS: 36/798 (4.5%) Planned vaginal delivery: 58/798 (7.3%) RR 0.62 (95% CI 0.41 to 0.93)	There was a 40% reduction in the CS group compared with the vaginal delivery group in women indicating that they had lost or leaked urine	RCT	1b
Farrell, 2001 ⁵⁷⁵	690 primiparae recruited in a Canadian hospital from Jan 1996 to Dec 1998 Inclusion criteria: Nulliparity No history of UTI or pelvic surgery No significant medical illness No medication that would alter urinary function	Observational study	Incidence and relative risk of urinary incontinence/mode of delivery as assessed by questionnaire in the antepartum period, at 6 weeks and 6 months after delivery	Comparison groups at 6 weeks postpartum: RR of urinary incontinence: SVD vs. CS: 2.8 (95% CI 1.5 to 5.3) Forceps vs. SVD: 1.5 (95% CI 1.1 to 2.2) Forceps vs. CS: 4.3 (95% CI 2.2 to 8.2) Comparison groups at 6 months postpartum: RR of urinary incontinence: SVD vs. CS: 2.1 (95% CI 1.1 to 3.7) Forceps vs. SVD: 1.5 (95% CI 1.0 to 2.3) Forceps vs. CS: 3.1 (95% CI 1.7 to 5.9)	Study showed a 2- to 3-fold increased risk of urinary incontinence at 6 weeks and 6 months postpartum from spontaneous vaginal delivery compared with delivery by CS The increased risk of vaginal delivery to CS was 3 to 4 fold if vaginal delivery was by forceps Follow up rate was 70%	Cohort	3

Urinary incontinence (continued)

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Meyer, 1998 ⁵⁷⁷	149 white nulliparae recruited in a Swiss hospital Exclusion criteria: Pregnancy complications Onset of labour History of UTI	Observational study	Urinary incontinence as assessed by: History Examination Urodynamic testing of urethral sphincter function 9 weeks after delivery	Comparison groups at 9 weeks postpartum (unadjusted): RR of urinary incontinence: SVD vs. CS: 0.15 (95% CI 0.02 to 1.11) Forceps vs. SVD: 1.72 (95% CI 0.89 to 3.33)	Study did not show any significant difference in the incidence of urinary incontinence/mode of delivery	Cohort	3
Wilson, 2000 ⁵⁷⁶	1505 women who were 3 months postpartum resident in an area in New Zealand	Observational study	Urinary incontinence as assessed by leakage of urine and the use of a pad	Urinary incontinence at 3 months postpartum by mode of delivery: All women (n = 1505): SVD: OR for any urinary incontinence: 1.0 Forceps: OR for any urinary incontinence: 1.1 (95% CI 0.8 to 1.6) CS: OR for any urinary incontinence: 0.4 (95% CI 0.3 to 0.6) All women with no previous incontinence (n = 667): SVD: OR for any urinary incontinence: 1.0 Forceps: OR for any urinary incontinence: 1.3 (95% CI 0.8 to 2.3) CS: OR for any urinary incontinence: 0.3 (95% CI 0.1 to 0.6) All primiparae (n = 607): SVD: OR for any urinary incontinence: 1.0 Forceps: OR for any urinary incontinence: 1.1 (95% CI 0.7 to 1.7) CS: OR for any urinary incontinence: 0.4 (95% CI 0.2 to 0.7) Primiparae with no previous incontinence (n = 345): SVD: OR for any urinary incontinence: 1.0 Forceps: OR for any urinary incontinence: 1.0 (95% CI 0.5 to 1.9) CS: OR for any urinary incontinence: 0.2 (95% CI 0.0 to 0.6)	Study showed no significant risk of urinary incontinence following instrumental delivery compared with spontaneous delivery, but a 60–80% decreased risk of urinary incontinence following delivery by CS compared with vaginal delivery Confounding factors accounted for in logistic regression included: History of incontinence Pelvic floor exercises Parity BMI Response rate was 70%	Cross-sectional	3

Urinary incontinence (continued)

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Viktrup, 1992 ⁵⁷²	300 primigravidae interviewed during pregnancy, at 3–5 days postpartum, 3 months postpartum and 1 year postpartum (for those with symptoms of stress incontinence) in a Danish city Median age 26 years	Observational study	Stress incontinence as assessed by questions concerning leakage of urine Stress incontinence defined as International Continence Society	Stress incontinence in women with no prior history by mode of delivery: 3–5 days postpartum: VD: 21/167 (13%) CS: 0/35 RR 4.53 (95% CI 0.63 to 32.58) 3 months postpartum: VD: OR for any urinary incontinence: 6/167 (4%) CS: OR for any urinary incontinence: 0/35 RR 1.29 (95% CI 0.16 to 10.42)	Study did not show a significant difference in urinary incontinence comparing vaginal to caesarean delivery These figures are unadjusted	Cohort	3
Persson, 2000 ⁵⁷³	1942 women who had surgery for urinary incontinence between 1987–1996 in Sweden Exclusion criteria: Women born outside Sweden Women who had their first delivery before 1973 Women with surgery prior to pregnancy Unknown birth weight Erroneous year of delivery	Observational study.	Urinary incontinence as assessed by the need for operation	Surgery for urinary incontinence by mode of delivery: CS vs. VD: 0.34 (95% CI 0.23 to 0.52)	Study showed a 70% reduction in the need for surgery for urinary incontinence if delivery was by CS compared with vaginal delivery Confounding factors analysed for included: Year of delivery Maternal age at first and last delivery Parity at last delivery	Cohort	3
Rortveit, 2003 ⁵⁷⁴	15,307 women under 65 years of age who were either nulliparous, or had CS only or vaginal births only	Observational study	Urinary incontinence ascertained by questionnaire with questions about involuntary loss of urine, frequency, circumstances and amount of leakage and how much of a problem leakage was perceived to be	Odds ratios for any incontinence according to mode of delivery: CS vs. no deliveries: OR 1.5 (95% CI 1.2 to 1.9)* Vaginal deliveries vs. no deliveries: OR 2.3 (95% CI 2.0 to 2.6)* Vaginal deliveries vs. CS: OR 1.7 (95% CI 1.3–2.1)** * adjusted for age **adjusted for age, parity, years since last delivery and body mass index	Attributable risk: the proportion of any incontinence among women who delivered vaginally that would be preventable by CS was 35%	Cohort	3

Faecal incontinence

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Hannah, 2002 ⁵¹⁴	1596 women from 110 centres worldwide who responded to a follow up questionnaire three months after international randomised controlled trial of planned CS vs. vaginal delivery	Planned CS vs. planned vaginal delivery.	Faecal incontinence 3 months after delivery assessed by questionnaire.	Faecal incontinence: Planned CS: 5/619 (0.8%) Planned vaginal delivery: 9/607 (1.5%) RR 0.54 (95% CI 0.18 to 1.62) Incontinence of flatus: Planned CS: 66/616 (10.7%) Planned vaginal delivery: 59/606 (9.7%) RR 1.10 (95% CI 0.79 to 1.54)	Study did not show any difference between groups in terms of incontinence to faeces or flatus	RCT	1b
Abramowitz, 2000 ⁶⁷⁰	259 women who delivered in a hospital in France	Observational study	New anal incontinence 3 months after delivery as assessed by questionnaire Anal incontinence defined as incontinence to flatus or liquid or solid stools for at least once a week	Anal incontinence by mode of delivery 6–8 weeks postpartum: New anal incontinence: CS vs. No CS: 0.0% vs. 10.1% (p = 0.001) Forceps vs. no forceps: 22.9% vs. 6.5% (p = 0.001)	There is a significant reduction in the risk of anal incontinence with CS and a significant increase in the risk of anal incontinence with forceps delivery Possible confounders corrected for included Baby anterior or posterior presentation Age Parity Anal sexual intercourse Delivery characteristics.	Cohort	2b
Groutz, 1999 ⁵⁸⁴	300 women who delivered in an Israeli hospital in November 1997 Mean age 30.1 years	Observational study	Prevalence of anal incontinence 3 months after delivery as determined by telephone interview Anal incontinence defined as any involuntary leakage of solid or liquid faeces or gas	Anal incontinence by mode of delivery 3 months postpartum: SVD: 9/235 (3.8%); unadjusted RR 1.00 Vacuum: 10/40 (25%); unadjusted RR 6.53 (95% CI 2.83 to 15.06) Forceps: 1/3 (33%); unadjusted RR 8.70 (95% CI 1.55 to 48.79) CS: 1/22 (4.5%); unadjusted RR 1.18 (95% CI 0.16 to 8.94)	There was no adjusting for possible confounders.	Cohort	2b
Fynes, 1998 ⁵⁸⁷	234 women who attended the antenatal clinic in the National Maternity Hospital, Dublin between June 1993 and December 1994	Observational study	Anal incontinence as assessed by questionnaire 6 weeks postpartum	Faecal incontinence postpartum: CS (n = 15): 0 (0%) SVD (n = 200): 38 (19%)	Study shows a higher percentage of women with spontaneous vaginal delivery had anal incontinence postpartum No clear controlling for confounders	Cohort	2b

Faecal incontinence (continued)

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Donnelly, 1998 ⁵⁸⁶	184 primiparous women who attended the antenatal clinic in the National Maternity Hospital between June 1993 and July 1994	Observational study Exclusion criteria: Diabetes mellitus Anorectal disease Previous anorectal surgery Irritable bowel syndrome	Anal incontinence assessed at postpartum follow up by questionnaire	Faecal incontinence postpartum: CS (n = 16): 0 (0%) SVD (n = 146): 2 (1.4%) Instrumental vaginal delivery (n = 22): 5 (23%) Instrumental delivery vs. SVD adj OR 7.2 (95% CI 2.8 to 18.6)	Study shows that vaginal and especially instrumental vaginal delivery is associated with a higher risk of faecal incontinence postpartum. Confounders adjusted for included length of labour and second stage, mode of delivery, epidural use and episiotomy.	Cohort	2b
MacArthur, 1997 ⁵⁸⁵	906 women who delivered in a maternity hospital in Birmingham, UK, between April and September 1992	Observational study Women assessed before and 6 weeks after delivery	Faecal incontinence as assessed by home-based interviews and hospital case-notes	Faecal incontinence by mode of delivery (unadjusted figures): Primiparae: SVD: new 5; none 184 CS: new 5; none 67; RR 0.38 (95% CI 0.11 to 1.28) Forceps: new 5; none 81; 2.20 (95% CI 0.65 to 7.39) Vacuum: new 3; none 11; 8.10 (95% CI 2.15 to 30.46) Multiparae: SVD: new 13; none 366 CS: new 1; none 100; RR 0.29 (95% CI 0.04 to 2.18) Forceps: new 3; none 21; RR 3.64 (95% CI 1.11 to 11.93) Vacuum: new 1; none 3; RR 7.29 (95% CI 1.23 to 43.20)	Study failed to show in primiparous women an association between delivery by CS and forceps and faecal incontinence compared with spontaneous delivery. It showed an increase in risk of 8 times with vacuum delivery compared with spontaneous delivery In multiparae, forceps delivery and vacuum delivery were associated with a 3- and 7-fold increase respectively in faecal incontinence compared with spontaneous delivery. There was no increase or decrease in the risk of faecal incontinence with CS compared with vaginal delivery	Cohort	2b

Sexual intercourse

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Hannah, 2002 ⁵¹⁴	1596 women from 110 centres worldwide who responded to a follow up questionnaire three months after international randomised controlled trial of planned CS vs. vaginal delivery	Planned CS vs. planned vaginal delivery	Sexual function as assessed by questionnaire on No sex since the birth and pain during sex on most recent occasion	No sex since the birth: Planned CS: 129/795 (16.2%) Planned vaginal delivery: 115/796 (14.5%) RR 1.12 (95% CI 0.89 to 1.42) Pain during sex on most recent occasion: Planned CS: 111/655 (17.0%) Planned vaginal delivery: 325/798 (40.7%) RR 1.03 (95% CI 0.91 to 1.16)	Study did not show any difference between the two groups in terms of no sex since the birth or pain during sex on the most recent occasion	RCT	1b
Lydon-Rochelle, 2001 ⁵⁷⁰	971 primiparous women who delivered a singleton infant between August and December 1991 in the US Washington State	Observational study	Sexual activity as measured by questionnaire 7 weeks postpartum Reported as a general health status score with a higher score as indicative of a better health status	Mode of delivery and health status score: CS: 56.2 Assisted vaginal: 47.9 Unassisted vaginal: 54.1 Differences by delivery mode: CS–unassisted vaginal: p NS Assisted vaginal–unassisted vaginal: p < 0.05	Study did not demonstrate any significant differences between sexual function of women delivered by CS and women with unassisted vaginal delivery postpartum but women with assisted vaginal delivery had significantly poorer scores than their counterparts with unassisted vaginal delivery Maternal, hospital and newborn characteristics were adjusted for as potential confounders	Cohort	2b
Hyde, 1996 ⁵⁹⁰	570 women recruited in the in the US for a maternity leave and health project	Observational study	Resumption of intercourse one month after delivery	Resumption of intercourse: VD: 82/455 (18%) CS: 25/93 (27%) p < 0.05	Study did not correct for instrumental delivery or episiotomy	Cohort	2b
Goetsch, 1991 ⁵⁹¹	62 women attending postnatal clinics at 2 and 8 weeks in the US in May to December 1989	Observational study	Postpartum nonfocal introital dyspareunia assessed by history and swab touch test examination	Postpartum dyspareunia by mode of delivery: VD: 20/48 (42%) CS: 4/14 (29%) p > 0.5	Study was unable to demonstrate any difference between women with a CS and vaginal delivery in terms of postpartum nonfocal introital dyspareunia	Cohort	2b

Sexual intercourse (continued)

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Barrett, 2000 ⁵⁸⁹	796 primiparous women delivered of a live birth in a 6 month period at a London teaching hospital 61% response rate	Observational study	Self-reported sexual behaviour and sexual problems	89% of respondents had resumed sexual activity within 6 months of birth Pre pregnancy prevalence of sexual problems was 38% Sexual morbidity increased in the first three months after birth to 83%, declining to 64% at 6 months after birth Dyspareunia was significantly associated with vaginal deliveries and previous experience of dyspareunia in the first 3 months in the first At six months there was no significant association between dyspareunia and mode of delivery		Cohort	2b

Postnatal depression

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Johnstone, 2001 ⁵⁹²	490 women who delivered in 2 health regions in Australia between Sept 1995 and Jan 1996 and Nov 1995 and March 1996 Mean age 28 years	Observational study	Depression status assessed at 8 weeks using the Edinburgh Postnatal Depression Scale	Incidence of puerperal depression 13.1% Puerperal depression by mode of delivery: Forceps delivery: OR 2.51 Elective CS: OR 2.03 Emergency CS: OR 1.40 (all 3 not statistically significant) Only p values and not 95% CI were reported in the paper; there was not enough information to enable its calculation	No association between mode of delivery and post natal depression at 8 weeks	Cohort	2b
Fisher, 1997 ⁵⁹⁴	272 nulliparous pregnant women assessed at a mean of 33 weeks of gestation and 5 weeks post-delivery Mean age 28.25 years	Observational study	Self-esteem and depression status as assessed by the Rosenberg Self-Esteem questionnaire and Profile of Mood States. Scores in groups were compared before and after delivery	Mean change in depression score by mode of delivery: Mode of delivery p value CS (n = 42); mean change in scores +2.58; p < 0.05 Vaginal delivery (n = 200): mean change in scores -0.26	Women in the vaginal delivery group reported a reduction in symptoms of anxiety and depression	Cohort	2b

Postnatal depression (continued)

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Glazener, 1995 ⁵⁶³	1249 women who delivered in a Scottish region between June 1990 and May 1991	Observational study	Self reported tearfulness, depression	<p>Tearfulness, depression in hospital at 0–13 days:</p> <p>CS vs. all vaginal deliveries: CS: 53/181 (29%); unadjusted RR 2.02 (95% CI 1.54 to 2.64) All vaginal delivery: 155/1068 (15%)</p> <p>CS vs. spontaneous vaginal deliveries: CS: 53/181 (29%); unadjusted RR 2.24 (95% CI 1.69 to 2.79) SVD: 117/896 (13%)</p> <p>Instrumental delivery vs. spontaneous deliveries: IVD: 38/172 (22%); unadjusted RR 1.69 (95% CI 1.22 to 2.35) SVD: 117/896 (13%)</p> <p>Tearfulness, depression at home (0–8 weeks):</p> <p>CS vs. all vaginal deliveries: CS: 39/161 (24%); unadjusted RR 1.19 (95% CI 0.88 to 1.61) All VD: 194/955 (20%)</p> <p>CS vs. spontaneous vaginal deliveries: CS: 39/161 (24%); unadjusted RR 1.16 (95% CI 0.85 to 1.57) SVD: 169/806 (21%)</p> <p>Instrumental delivery vs. spontaneous deliveries: IVD: 25/149 (17%); unadjusted RR 0.83 (95% CI 0.56 to 1.22) SVD: 169/806 (21%)</p> <p>Tearfulness, depression at home (2–18 months):</p> <p>CS vs. all vaginal deliveries: CS: 10/65 (15%); unadjusted RR 0.90 (95% CI 0.49 to 1.65) All VD: 64/373 (17%)</p> <p>CS vs. spontaneous vaginal deliveries: CS: 10/65 (15%); unadjusted RR 0.90 (95% CI 0.48 to 1.67) SVD: 53/310 (17%)</p> <p>Instrumental delivery vs. spontaneous deliveries: IVD: 11/63 (18); unadjusted RR 1.02 (95% CI 0.57 to 1.84) SVD: 53/310 (17)</p>	Although in the first 2 weeks following delivery, a higher proportion of mothers who had CS or assisted vaginal delivery reported tearfulness, depression compared with those who had spontaneous vaginal delivery, there was no difference between the groups at 18 months after delivery	Cohort	2b

Postnatal depression (continued)

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Culp, 1989 ⁵⁹⁶	80 women who delivered at a US hospital 24 delivered by CS 56 delivered vaginally	Observational study	Postnatal depression assessed by a scale from Center for Epidemiological studies	Levels of maternal depression in two separate analyses of variance (ANOVA) were not significantly different between the two groups at 3 months postpartum For those clinically depressed (based on depression scores) two chi-square analyses indicated no significant differences in mothers who were clinically depressed according to mode of delivery	No absolute numbers or percentages given therefore RR cannot be calculated	Cohort	2b
Saisto, 2001 ⁵⁹⁷	211 women assessed at 17 and 36 weeks of pregnancy and 71 days post-delivery	Observational study	Disappointment with delivery and puerperal depression Depression assessed by a revised version of Beck's Depression inventory (BDI)	Emergency CS associated with disappointment with delivery but not puerperal depression	Study assessed psychosocial predictors of disappointment with delivery and puerperal depression	Cohort	2b
Boyce, 1992 ⁵⁹⁵	188 primiparous women recruited at the antenatal clinic of an Australian hospital Mean age 26.7 years	Observational study	Postnatal depression as measured by the EPDS at 1, 3 and 6 months postpartum.	Postnatal depression (EPDS scores above 12.5) by method of delivery at 1, 3 and 6 months postpartum: Follow-up (months) by emergency CS (%) VD (%) RR (95% CI) 1/12: CS 4/17 (23.5%); VD: 15/140 (10.7%); RR 2.2 (95% CI 0.82 to 5.86) 3/12: CS 6/13 (46.2%); VD 9/133 (6.8%); RR 6.82 (95% CI 2.85 to 16.15) 6/12: CS 2/18 (11.1%); VD 10/146 (6.8%); RR 1.62 (95% CI 0.39 to 6.83)	Comparison of the groups indicated a significant difference at 3 months postpartum only Emergency CS is associated with a 6-fold increase in the risk of PND compared with vaginal delivery	Cohort	2b

Post-traumatic stress disorder

Study	Population	Intervention	Outcomes	Morbidity events	Comments	Study type	EL
Ryding, 1998 ⁵⁹⁹	326 women who delivered at a Swedish hospital between January 1992 and 31 March 1993 Mean age 29 years	Observational study	Post-traumatic stress as assessed by Impact of Event Scale	Post-traumatic stress assessed at 2 days and 1 month postpartum: 2 days postpartum: Emergency CS vs. elective CS: p = 0.001 Emergency CS vs. instrumental VD: p NS Emergency CS vs. SVD: p NS 1 month postpartum: Emergency CS vs. elective CS: p = 0.01 Emergency CS vs. instrumental VD: p NS Emergency CS vs. SVD: p < 0.05		Cohort	2b
Soderquist, 2002 ⁵⁹⁸	1550 women who delivered in a Swedish hospital in 1994	Observational study	Post-traumatic stress as assessed by Traumatic Event Scale	Post-traumatic stress assessed between 1 and 2 years postpartum: Elective CS: OR NS Emergency CS: OR 6.3 (95% CI 2.0 to 20.2) Instrumental VD: OR 4.8 (95% CI 1.5 to 15.2) SVD: OR 1.00	Absolute numbers not reported Not clear if odds ratios are crude or adjusted		

Prolapse

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Parazzini, 2000 ⁶⁰¹	21,449 women who attended first-level outpatient menopause clinics in Italy from 1997 to 1999 268 centres	Observational study	Uterovaginal prolapse defined according to the Baden-Walker classification	Genital prolapse by mode of delivery: CS: no prolapse 1705 (9.8%); prolapse 66 (5.9%); OR 0.6 (95% CI 0.5 to 0.9) VD: no prolapse 15,650 (90.2%); prolapse 1048 (94.1%)	Delivery by CS was associated with a 40% reduction in the risk of developing genital prolapse Adjusted for age, education, BMI and parity	Case-control	3
Carley, 1999 ⁶⁰²	178 women who underwent corrective surgery for genital prolapse between September 1992 and August 1994 Controls: women who underwent routine screening mammography US hospital	Observational study	Genital prolapse as assessed by need for surgery	Genital prolapse by mode of delivery: At least 1 CS: 7/178 (3.9%) At least 1 VD: 168/178 (94.0%)		Case-control	3

Maternal mortality

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
CEMD ⁹⁵	Women in UK	Observational study	Maternal death	<p>All maternities: 2,124,000; death rate/million 30 VD: 1,710,000; death rate/million 16.9; RR 1.0 All CS: 413,000; death rate/million 82.3; RR4.9 (95% CI 2.96 to 7.97) Emergency CS: 69,000; death rate/million 202.9; RR 12.0 (95% CI 6.32 to 22.65) Urgent CS: 137,000; death rate/million 102.2; RR 6.0 (95% CI 3.18 to 11.40) Scheduled CS: 78,000; death rate/million 12.8; RR 0.8 (95% CI 0.10, 5.55) Elective CS: 130,000; death rate/million 38.5; RR 2.3 (95% CI 0.88 to 5.86)</p>	Unadjusted relative risks		3

Chapter 10 Pregnancy and childbirth after CS

10.1 Implications for future pregnancies

Infertility

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL																																																
Hemminki, 1996 ⁶⁷¹	7 cohort studies conducted in Northern Europe and USA.	Observational study	Lowered fertility following CS in women with: At least one pregnancy (A) At least one live birth (B) All pregnancies (C) All live births (D) Fecundity (apparently able to have further children) (E)	CS and subsequent lowered fertility: studies, outcomes and risk ratios: <table border="1"> <thead> <tr> <th>Study no</th> <th>A</th> <th>B</th> <th>C</th> <th>D</th> <th>E</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>0.94*</td> <td>0.95*</td> <td>0.90*</td> <td>0.91*</td> <td>–</td> </tr> <tr> <td>2</td> <td>1.0</td> <td>1.0</td> <td>0.89</td> <td>0.88</td> <td>0.77*</td> </tr> <tr> <td>3</td> <td>–</td> <td>0.91*</td> <td>–</td> <td>0.87*</td> <td>–</td> </tr> <tr> <td>4</td> <td>–</td> <td>0.91*</td> <td>–</td> <td>0.88*</td> <td>–</td> </tr> <tr> <td>5</td> <td>0.84*</td> <td>–</td> <td>–</td> <td>–</td> <td>–</td> </tr> <tr> <td>6</td> <td>0.80*</td> <td>–</td> <td>–</td> <td>–</td> <td>–</td> </tr> <tr> <td>7</td> <td>0.83*</td> <td>0.90*</td> <td>–</td> <td>–</td> <td>–</td> </tr> </tbody> </table>	Study no	A	B	C	D	E	1	0.94*	0.95*	0.90*	0.91*	–	2	1.0	1.0	0.89	0.88	0.77*	3	–	0.91*	–	0.87*	–	4	–	0.91*	–	0.88*	–	5	0.84*	–	–	–	–	6	0.80*	–	–	–	–	7	0.83*	0.90*	–	–	–	* indicates statistically significant risk ratios 95% CI not given	Systematic review of cohort studies 2b	
Study no	A	B	C	D	E																																																		
1	0.94*	0.95*	0.90*	0.91*	–																																																		
2	1.0	1.0	0.89	0.88	0.77*																																																		
3	–	0.91*	–	0.87*	–																																																		
4	–	0.91*	–	0.88*	–																																																		
5	0.84*	–	–	–	–																																																		
6	0.80*	–	–	–	–																																																		
7	0.83*	0.90*	–	–	–																																																		
Jolly, 1999 ⁶⁴	Exposed: 250 women who had a CS in their first pregnancy Non-exposed (two groups): Group 1: 250 women who had normal vaginal deliveries in their first pregnancy Group 2: 250 women who had instrumental deliveries in their first pregnancy. UK health district	Observational study	Fertility rates	Women with no children in the five years after the birth of the first child: Normal: 43/148 (29.1%) Instrumental: 57/163 (35.0%) CS: 70/165 (42.4%) RR for having no more children following primary CS compared with normal deliveries was 1.46 (95% CI 1.07 to 1.99)	There is an increased risk of 46% of having no more children five years after having a primary CS compared with normal delivery Questionnaire response rate was 64% There is no clear controlling for confounders	Cohort	2b																																																

Placenta praevia

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Lydon-Rochelle, 2001 ⁶⁰⁶	Population Exposed (CS at first delivery): 19,875 Non-exposed (vaginal birth at first delivery): 75,755 Women delivering in a US state between 1987 and 1996	Observational study	Placenta praevia associated with second births No mention of method of assessing-taken from records	Placenta praevia in 2nd pregnancy by mode of delivery in first pregnancy: 1st pregnancy VD (n = 75,755): placenta praevia in 2nd pregnancy 356 (0.7%) 1st pregnancy CS (n = 19,875): placenta praevia in 2nd pregnancy 137 (0.5%) Adjusted OR 1.4 (95% CI 1.1 to 1.6)	There is an increased risk of 40% in the incidence of placenta praevia in a 2nd pregnancy if delivery was by CS compared with vaginal delivery OR was adjusted for maternal age	Cohort	2b
Rasmussen, 2000 ⁶⁰⁵	Based on all births in Norway from 1967 through 1992: 779,642 women 370,374 women eligible Exclusion criteria: Women with only one delivery First delivery before 1967 Multiple births Women without information on the first day of the last menstrual period in at least one pregnancy	Observational study	Placenta praevia	Placenta praevia in 2nd pregnancy by mode of delivery in first pregnancy: 1st pregnancy VD (n = 346,530): 746 (0.2%) 1st pregnancy CS (n = 23,018): 80 (0.4%) Adjusted OR 1.32 (95% CI 1.04 to 1.68)	There is an increased risk of 32% in the incidence of placenta praevia in a 2nd pregnancy if delivery was by CS compared with vaginal delivery Confounding factors controlled for included: Gestational age Birth weight Placental abruption Pregnancy induced hypertension Perinatal death Interpregnancy interval	Cohort	2b
Rageth, 1999 ⁶⁰⁷	Exposed: 29,046 women who had a CS in their first birth Unexposed: 255,453 women who had not had a CS and parity > 1 128 women in exposed had the outcome of interest 484 in unexposed had the outcome of interest Data from Swiss database	Observational study	Bleeding due to placenta praevia during pregnancy Method of diagnosing placenta praevia not stated	1st pregnancy VD (n = 226,407): 1137 (0.5%) 1st pregnancy VD (n = 29,046): 238 (0.8%) Unadjusted OR 1.63 (95% CI 1.41 to 1.87)	There is an increased risk of 60% in the incidence of placenta praevia in a 2nd pregnancy if delivery was by CS compared with vaginal delivery No adjustment for confounding in the analysis	Cohort	2b

Placenta praevia (continued)

Study	Population	Intervention	Outcomes	Results	Comments	Study type	EL
Ananth, 1997 ⁶⁷²	8 cohort studies from USA and other countries	Observational study	Placenta praevia as stated in primary research paper.	Fixed-effects OR 2.9 (95% CI 2.8 to 3.0) Random-effects OR 2.4 (95% CI 2.1 to 2.8)	Only MEDLINE database searched Studies limited to English language Criteria used to assess quality of individual studies not stated Studies heterogeneous	Systematic Review of cohort studies	2b

10.2 Childbirth following CS

Study	Population	Outcomes	Results	Comments	Study type	EL
Blanchette, 2001 ⁶²⁰	1481 women with at least one previous CS, delivering at a community hospital in USA, 1996 to 1999 Included all mothers with at least 1 previous CS, for whom VBA not medically contraindicated	Uterine rupture Maternal complications Neonatal outcomes including Apgar score	<p>Incidence of uterine rupture: All mothers with previous CS: 8/1000 Elective CS: 0 TOL group: 16/1000</p> <p>Elective CS (n = 727): Uterine rupture: 0 Perinatal mortality: 0 Maternal mortality: 0 1-minute Apgar score < 7: 47/737 (6.4%); RR 1.0 5-minute Apgar score < 7: 11/737 (1.5%); RR 1.0</p> <p>TOL (n = 754): Uterine rupture: 12 (1.6%) Perinatal mortality: 2 (0.3%) Maternal mortality: 0 1-minute Apgar score < 7: 93/755 (12.3%); RR 1.9 (95% CI 1.4 to 2.7) 5-minute Apgar score < 7: 12/755 (1.6%); RR 1.1 (95% CI 0.5 to 2.4)</p> <p>Neonatal outcomes:</p> <p>Elective CS (n = 727): Transfer to NICU: 31/737 (4.2%); 1.00 Respiratory distress syndrome: 13/737 (1.8%); 1.00 Seizure: 2/737 (0.3%); 1.00 Sepsis: 2/737 (0.3%); 1.00 Transient tachypnoea newborn: 3/737 (0.4%); 1.00</p> <p>TOL (n = 754): Transfer to NICU: 36/755 (4.8%); RR 1.1 (95% CI 0.7 to 1.8) Respiratory distress syndrome: 16/755 (2.1%); RR 1.2 (95% CI 0.6 to 2.5) Seizure: 2/755 (0.3%); RR 1.0 (95% CI 0.1 to 6.9) Sepsis: 5/755 (0.7%); RR 2.4 (95% CI 0.5 to 12.5) Transient tachypnoea newborn: 1/755 (0.1%); RR 0.3 (95% CI 0.0 to 3.1)</p> <p>Maternal complications:</p> <p>Elective CS (n = 727): Endometritis: 9 (1.2%); 1.00 Abdominal wound infection: 14 (1.9%); 1.00 Transfusion: 2 (0.3%); 1.00 Postpartum haemorrhage: 2 (0.3%); 1.00</p> <p>TOL (n = 754): Endometritis: 11 (1.4%); RR 1.2 (95% CI 0.5 to 2.8) Abdominal wound infection: 1 (0.1%); RR 0.1 (95% CI 0.01 to 0.5) Transfusion: 3 (0.4%); RR 1.4 (95% CI 0.2 to 8.6) Postpartum haemorrhage: 3 (0.4%); RR 1.4 (95% CI 0.2 to 8.6)</p>	Elective CS rate: 49% Emergency CS rate in TOL group: 23%	Prospective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Bais, 2001 ⁶²³	252 women with at least one previous CS delivering at a Dutch hospital over a 5 year period 1990–94 Included mothers with singleton pregnancies, at least 20 weeks of gestation	Uterine rupture Maternal morbidity Apgar scores Perinatal mortality	Incidence of uterine rupture: All mothers with previous CS: 4/1000 Elective CS: 0 TOL group: 5/1000 Elective CS (n = 68): Uterine rupture: 0 Maternal mortality: 0 Perinatal mortality: 0 5-minute Apgar score < 7: 0 Blood loss > 1000 ml: 6 (8.8%); 1.00 Blood transfusion: 4 (5.9%); 1.00 TOL (n = 184): Uterine rupture: 1 (0.5%) Maternal mortality: 0 Perinatal mortality: 3 (1.6%) 5-minute Apgar score < 7: 6 (3.3%) Blood loss > 1000 ml: 9 (4.9%); RR 0.5 (95% CI 0.2 to 1.5) Blood transfusion: 8 (4.3%); RR 0.7 (95% CI 0.2 to 2.4)	Elective CS rate: 27% Emergency CS rate in TOL group: 23%	Prospective cohort	3
Hook, 1997 ⁶³⁷	989 women with at least 1 previous CS delivering term singleton cephalic in 3 U.S. hospitals during a 1 year period.	Neonatal mortality Neonatal morbidity Maternal morbidity	Incidence of uterine rupture: All mothers with previous CS: 8/1000 Elective CS: 2/1000 TOL group: 14/1000 Elective CS (n = 497): Uterine rupture: 1 (0.2%); 1.00 Neonatal mortality: 0 1-minute Apgar score < 7: 20 (4.0%); 1.00 5-minute Apgar score < 7: 3 (0.6%) TOL (n = 492): Uterine rupture: 7 (1.4%); RR 7.1 (95% CI 0.9 to 52.3) Neonatal mortality: 1 (0.2%) 1-minute Apgar score < 7: 111 (22.6%); RR 5.6 (95% CI 3.5 to 8.9) 5-minute Apgar score < 7: 14 (2.8%); RR 4.7 (95% CI 1.4 to 16.3)	Elective CS rate: 50% Emergency CS rate in TOL group: 31%	Prospective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Flamm, 1994 ⁶²⁷	7229 mothers with at least one previous CS delivering at 10 hospitals in Southern California. Time period of study began 1990, not known for how long Excluded known prior classical or low vertical uterine incisions	Uterine rupture Transfusion Hysterectomy Perinatal mortality Apgar scores	Incidence of uterine rupture: TOL group: 8/1000 Incidence of uterine rupture in elective CS group not reported Elective CS (n = 2207): Maternal mortality: 0 Transfusion: 38 (1.73%); 1.00 Hysterectomy: 6 (0.27%); 1.00 Perinatal mortality: 0 5-minute Apgar score < 7: 15 (0.7%) TOL (n = 5022): Uterine rupture: 39 (0.8%); RR 0.4 (95% CI 0.3 to 0.6) Maternal mortality: 0 Transfusion: 36 (0.72%); 1.00 Hysterectomy: 6 (0.12%); RR 0.4 (95% CI 0.1 to 1.4) Perinatal mortality: 0 5-minute Apgar score < 7: 74 (1.5%); RR 2.2 (95% CI 1.2 to 3.8)	Elective CS rate: 16%–41% Emergency CS rate in TOL group: 18–30%	Prospective cohort	3
Granovsky, 1994 ⁶⁷³	52 women with at least 1 previous CS, delivered in a maternity hospital in Israel Included previous low segment transverse uterine incisions, singleton cephalic pregnancies presenting in labour	Maternal mortality Maternal morbidity Perinatal mortality	Incidence of uterine rupture: Elective CS group (n = 26): 0 TOL group (n = 26): 0 Maternal morbidity (both groups): 0 Perinatal mortality (both groups): 0	26 women in each group. Unclear whether these are results of a complete cohort	Prospective cohort	3
Miller, 1992 ⁶³⁸	318 consecutive patients with at least one previous CS delivering at a Sydney Teaching hospital, over a 1 year period.	Uterine rupture Maternal complications Neonatal outcomes including Apgar score	Incidence of uterine rupture: All women with previous CS: 3/1000 Elective CS: 0 TOL group: 8/1000 Elective CS (n = 193): Uterine rupture: 0 Maternal mortality: 0 Neonatal mortality: 1 (0.5%); 1.00 1-minute Apgar score < 7: 24 (12.4%); 1.00 5-minute Apgar score < 7: 4 (2.1%); 1.00 Neonatal seizures: 1 (0.5%); 1.00 TOL (n = 125): Uterine rupture: 1 (0.8%) Maternal mortality: 0 Neonatal mortality: 2 (1.6%); RR 3.1 (95% CI 0.3 to 33.7) 1-minute Apgar score < 7: 29 (23.2%); RR 1.9 (95% CI 1.1 to 3.0) 5-minute Apgar score < 7: 6 (4.8%); RR 2.3 (95% CI 0.7 to 8.0) Neonatal seizures: 2 (1.6%); RR 3.1 (95% CI 0.3 to 33.7)	Elective CS rate: 61% Emergency CS rate in TOL group: 36%	Prospective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Abitbol, 1993 ⁶⁷⁴	312 women with at least 1 previous CS who were part of the VBAC programme at a New York hospital Excluded unknown type of uterine scar, fetal weight estimated to be greater than 4000 g on USS, nonvertex presentations, gestational diabetes, contraindications to vaginal delivery	Maternal mortality Perinatal mortality Patient satisfaction	Incidence of uterine rupture: All women with previous CS: 3/1000 Elective CS: 0 TOL group: 5/1000 Elective CS (n = 125): Uterine rupture: 0 Maternal mortality: 0 Perinatal mortality: 0 5-minute Apgar score < 7: 1 (0.8%) 1.00 TOL (n = 187): Uterine rupture: 1 (0.5%) Maternal mortality: 0 Perinatal mortality: 2 (1.1%) 5-minute Apgar score < 7: 8 (4.3%); RR 5.3 (0.7 to 42.2)	Study aimed primarily at looking at patient views and satisfaction with VBAC Elective CS rate: 40% Emergency CS rate in TOL group: 35%	Prospective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Roumen, 1990 ⁶²²	249 women with at least 1 previous CS (low transverse uterine incision) who delivered over a 10-year period in a Dutch maternity unit 1977–87	Uterine rupture Maternal morbidity Apgar score Cord pH	<p>Incidence of uterine rupture: All women with previous CS: 4/1000 Elective CS: 0 TOL group: 5/1000</p> <p>Elective CS (n = 57): Uterine rupture: 0 Maternal mortality:0 Perinatal mortality:0 1 min Apgar score < 7: 4/58 (6.9%); 1.00 5 min Apgar score < 7: 0/58 UApH < 7.2: 4/58 (6.9%); 1.00</p> <p>TOL (n = 192): Uterine rupture: 1 (0.5%) Maternal mortality:0 Perinatal mortality: 5 (2.6%) 1-minute Apgar score < 7: 26/195 (13.3%); RR 1.9 (95% CI 0.7 to 5.3) 5-minute Apgar score < 7: 8/195 (4.1%) UApH < 7.2: 52/195 (26.7%); RR 3.9 (95% CI 1.5 to 10.2)</p> <p>Elective CS (n = 57): Blood loss > 1000ml: 7 (8.8%); 1.00 Blood transfusion: 13 (22.8%); 1.00 Pneumonia: 1 (1.7%) Endometritis: 3 (5.3%); 1.00 Wound infection: 1 (1.7%); 1.00 UTI: 5 (8.8%); 1.00</p> <p>TOL (n = 192): Blood loss > 1000ml: 17 (12.2%); RR 0.7 (95% CI 0.3 to 1.6) Blood transfusion: 15 (7.8%); RR 0.3 (95% CI 0.2 to 0.7) Pneumonia: 0 Endometritis: 5 (2.6%); RR 0.5 (95% CI 0.1 to 2.0) Wound infection: 9 (4.7%) RR 2.7 (95% CI 0.3 to 20.6) UTI: 5 (8.8%); 25 (13.0%) RR 1.5 (95% CI 0.6 to 3.7)</p>	Elective CS rate 23% Emergency CS rate in TOL group 21%	Prospective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Phelan, 1989 ⁶²⁹	1088 women with 2 previous CS who delivered singleton cephalic pregnancies over a 4-year period in a US teaching hospital Excluded known previous classical scars, multiple gestations, malpresentation	Uterine rupture Maternal morbidity Apgar score Perinatal mortality	Incidence of uterine rupture: All women with previous CS: 1/1000 Elective CS: 2/1000 TOL group: 0 Elective CS (n = 587): Uterine rupture: 1 (0.2%) Maternal mortality: 0 Perinatal mortality: 5 (0.8%); 1.00 1-minute Apgar < 7: 70 (11.9%) 1.00 5-minute Apgar < 7: 8 (1.4%) 1.00 Hysterectomy: 7 (1.2%); 1.00 TOL (n = 501): Uterine rupture: 0 Maternal mortality: 1 (0.2%) Perinatal mortality: 6 (1.2%); RR 1.4 (95% CI 0.4 to 4.6) 1-minute Apgar < 7: 87 (17.4%); RR 1.4 (95% CI 1.1 to 1.9) 5-minute Apgar < 7: 13 (2.6%); RR 1.9 (95% CI 0.8 to 4.5) Hysterectomy: 1 (0.2%); RR 5.97 (95% CI 0.7 to 48.4)	Entry criteria differed from year to year Uterus explored in all vaginal deliveries to determine incidence of uterine rupture TOL rate increased over the 4 year period from 10% to 60% Elective CS rate 54% Emergency CS rate in TOL group was 31%	Prospective cohort	3
Raynor, 1993 ⁶⁷⁵	67 women with at least 1 previous CS, delivered at a small (< 1000 annual delivery rate) rural maternity centre, level 1 nursery care in the US, 1988–1991	Maternal morbidity Apgar scores	No cases of uterine rupture TOL group: n = 51 El CS: n = 8 Not eligible for TOL: n = 8	Small descriptive study, aimed at demonstrating that high VBAC rates are achievable in rural hospitals Results not given according to intended mode of delivery	Retro-spective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Lydon–Rochelle, 2001 ⁶²¹	20,095 women with 1 previous CS (no previous vaginal deliveries) over a 10 year period in the US	Uterine rupture	<p>Incidence of uterine rupture: All women with 1 previous CS, no previous vaginal deliveries: 4/1000 Women who have elective CS: 2/1000 Women with spontaneous onset of labour: 5/1000 Women with IOL (non-prostaglandin): 8/1000 Women with IOL (prostaglandin): 24/1000</p> <p>Uterine rupture: Elective CS (n = 6980): 11; 1.00 Spontaneous onset labour (n = 10789): 56; 3.3 (95% CI 1.8 to 6.0) IOL (non-prostaglandin) (n = 1960): 15; 4.9 (95% CI 2.4 to 9.7) IOL (prostaglandin) (n = 366): 9; 15.6 (95% CI 8.1 to 30.0)</p> <p>NNT = 277 elective CS to prevent 1 uterine rupture (based on absolute risk for women in spontaneous labour)</p> <p>Postpartum complication: no uterine rupture (n = 20,004): Severe post haemorrhagic anaemia 4.8% Major puerperal infection 1.2% Bladder injury 1.2% Paralytic ileus 0.4% Hysterectomy 0.1% Surgical and anaesthetic complication 0.7% Maternal hospital stay > 5 days 4.2% Death of infant 0.5%</p> <p>Postpartum complication: uterine rupture (n = 91) Severe post haemorrhagic anaemia 10% Major puerperal infection 8.8% Bladder injury 7.7% Paralytic ileus 3.3% Hysterectomy 4.4% Surgical and anaesthetic complication 35.2% Maternal hospital stay > 5 days 26.4% Death of infant 5.5%</p> <p>p< 0.05 for all these outcomes</p>		Retro-spective cohort	2b

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
McMahon, 1996 ⁶¹⁸	6138 women in Nova Scotia, with one previous CS (low transverse uterine incision), 1986–92 Excluded non vertex presentation, multiple gestations, previous CS with vertical or T shaped incision, placenta praevia, maternal herpes simplex infection, previous uterine surgery e.g. myomectomy)	Uterine rupture Major morbidity Minor morbidity Perinatal mortality	Incidence of uterine rupture: All women with one previous CS: 2/1000 Elective CS: 0.3/1000 TOL group: 3/1000 Elective CS (n = 2889): Uterine rupture: 1 (0.03%); 1.00 Maternal mortality: 0 Perinatal mortality: 14 (0.5%); 1.00 Hysterectomy: 6 (0.2%); 1.00 Operative injury: 18 (0.6%); 1.00 Blood transfusion: 39 (1.3%); 1.00 Abdominal wound infection: 63 (2.2%); 1.00 TOL (n = 3249): Uterine rupture: 10 (0.3%); RR 8.9 (95% CI 1.1 to 69.4) Maternal mortality: 0 Perinatal mortality: 29 (0.9%); RR 1.8 (95% CI 1.0 to 3.5) Hysterectomy: 5 (0.1%); RR 0.7 (95% CI 0.2 to 2.4) Operative injury: 41 (1.3%); RR 2.0 (95% CI 1.2 to 3.5) Blood transfusion: 36 (1.1%); RR 0.8 (95% CI 0.5 to 1.3) Abdominal wound infection: 43 (1.3%) RR 0.6 (95% CI 0.4 to 0.9) NNT: 366 elective CS to prevent 1 uterine rupture	Women self selected into groups Elective CS rate 47% Emergency CS rate in TOL group 40% No difference in perinatal mortality and Apgar scores (absolute numbers not shown)	Retro-spective cohort	3
Troyer, 1992 ⁶⁷⁶	567 women with at least 1 previous CS, delivered at a teaching hospital in USA, 1990–91 Singleton cephalic pregnancies, at least 36 weeks with documented transverse lower uterine scar Excluded undocumented, low vertical, classical uterine scars, multiple gestations, malpresentations and gestation under 36 weeks	Maternal morbidity Perinatal deaths Apgar scores	Incidence of uterine rupture: All women with previous CS: 9/1000 Elective CS: 7/1000 TOL group: 11/1000 Elective CS (n = 303): Uterine rupture: 2 (0.7%); 1.00 Maternal mortality: 0 Perinatal mortality: 0 5-minute Apgar < 7: 3 (1.0%) TOL (n = 264): Uterine rupture: 3 (1.1%); RR 1.7 (95% CI 0.3 to 10.2) Maternal mortality: 0 Perinatal mortality: 0 5-minute Apgar < 7: 0 NNT: 210 elective CS to prevent 1 uterine rupture	Study was designed to look at variables that predict successful TOL	Retro-spective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Obara, 1997 ⁶²⁴	310 women with at least one previous CS, delivering term (at least 36 weeks gestation) singleton infants at a Japanese hospital between 1990 to 1995 Excluded cases of placenta praevia	Uterine rupture Maternal death Hysterectomy Blood loss > 1500 ml Perinatal death Apgar scores	Incidence of uterine rupture: All women with at least 1 previous CS: 6/1000 Elective CS: 0 TOL group: 9/1000 Elective CS (n = 96): Uterine rupture: 0 Maternal mortality: 0 Hysterectomy: 0 Blood loss: 4 (4.2%); 1.00 Perinatal mortality: 0 5-minute Apgar < 7: 0 TOL (n = 214): Uterine rupture: 2 (0.9%) Maternal mortality: 0 Hysterectomy: 1 Blood loss: 3 (1.4%) RR 0.3 (95% CI 0.1 to 1.5) Perinatal mortality: 0 5-minute Apgar < 7: 5 (2.3%)	Elective CS rate: 31% Emergency CS rate in TOL group: 57% All women underwent Xray pelvimetry, those with contracted bony pelvis were recommended elective repeat CS, as were those who were not delivered after 41 weeks.	Retro-spective cohort	3
Swaim, 1998 ⁶³⁶	295 women with at least 1 previous CS, delivered at a US hospital between 1994–95 Excluded fetal deaths, unclear if these were antepartum or intrapartum, estimated fetal weight below 10th centile for gestational age, major congenital abnormalities, severe isoimmunisation	Umbilical cord pH Apgar scores	Incidence of uterine rupture: All women with previous CS: 3/1000 Elective CS: 0 TOL group: 5/1000 Elective CS (n = 113): Uterine rupture: 0 UA pH < 7.2: 29/110 (26.4%); 1.00 5-minute Apgar < 7: 2/113 (1.8%) 1.00 TOL (n = 193): Elective CS (n = 113): Uterine rupture: 1 (0.5%) UA pH < 7.2: 48/185 (25.9%); RR 1.0 (95% CI 0.7 to 1.5) 5-minute Apgar < 7: 4/193 (2.1%); RR 1.2 (95% CI 0.2 to 6.3)	Elective CS rate: 37% Emergency CS rate in TOL group: 30%	Retro-spective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Rageth, 1999 ⁶⁰⁷	29046 with at least 1 previous CS, with births registered on a Swiss database 1983 to 1996 Excluded multiple pregnancies	Maternal death Maternal morbidity Uterine rupture Perinatal death	Incidence of uterine rupture: All women with at least 1 previous CS: 3/1000 Elective CS: 2/1000 TOL group: 4/1000 Elective CS (n = 11,433): Uterine rupture: 22 (0.2%); 1.00 Maternal mortality: 0 Perinatal mortality: 10 (0.1%); 1.00 Neonatal transfer: 949 (8.3%) 1.00 Hysterectomy: 52 (0.45%); 1.00 Febrile morbidity: 262 (2.3%); 1.00 Thromboembolic complications: 49 (0.4%); 1.00 TOL (n = 17,613) Uterine rupture: 70 (0.4%); RR 2.1 (95% CI 1.3 to 3.3) Maternal mortality: 1 (0.01%) Perinatal mortality: 33 (0.2%); RR 2.1 (95% CI 1.1 to 4.3) Neonatal transfer: 1075 (6.1%); RR 0.7 (95% CI 0.7 to 0.8) Hysterectomy: 29 (0.16%); RR 0.4 (95% CI 0.2 to 0.6) Febrile morbidity: 264 (1.5%); RR 0.6 (95% CI 0.5 to 0.8) Thromboembolic complications: 39 (0.2%); RR 0.5 (95% CI 0.3 to 0.8) NNT: 488 elective CS to prevent 1 uterine rupture	Elective CS rate: 39% Emergency CS rate in TOL group: 26% Also reports relative risk of uterine rupture for women with previous CS compared with women with no previous CS, para > 1: RR 42.18 (95% CI 31.09 to 57.24)	Retro-spective cohort	3
Neuhaus, 2001 ⁶⁷⁷	1086 women with at least one previous CS delivering at a German teaching hospital between 1979 to 1995.	Uterine rupture	Incidence of uterine rupture: All women with at least 1 previous CS: 4/1000 Elective CS: 2/1000 TOL group: 6/1000 Uterine rupture: Elective CS (n = 603): 1 (0.2%); 1.00 TOL (n = 483): 3 (0.6%); RR 3.7 (95% CI 0.4 to 35.9)	Overall: Elective CS rate: 55% Emergency CS rate in TOL group: 14%	Retro-spective cohort	3
Gregory, 1999 ⁶¹⁹	All delivery discharges (n = 536,785) in California over a 1 year period (1995)	Uterine rupture	Incidence of uterine rupture: All women giving birth: 0.7/1000 All women with no previous CS: 0.2/1000 All women with previous CS: 4/1000 Elective CS: 3/1000 TOL group: 5/1000 Uterine rupture: Elective CS (n = 27760): 79 (0.3%); 1.00 TOL (n = 66856): 288 (0.4%); 1.88 (95% CI 1.45 to 2.43) NNT = 400 elective CS to prevent 1 uterine rupture	Elective CS rate: 42% Emergency CS rate in TOL group: 38%	Retro-spective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Asakura, 1995 ⁶¹⁷	1641 women with at least one previous CS, delivering at a teaching hospital in the U.S. over a 5-year period (1987 to 1992)	Uterine rupture Neonatal death 1-minute Apgar < 3	Incidence of uterine rupture: All women with previous CS: 5/1000 Elective CS: 0/1000 TOL group: 6/1000 Elective CS (n = 229): Uterine rupture: 0 Maternal mortality: 0 Perinatal mortality: 6 (2.6%); 1.00 1-minute Apgar < 3: 3/242 (4.2%); 1.00 TOL (n = 1412): Uterine rupture: 8 (0.6%) Maternal mortality: 0 Perinatal mortality: 8 (0.6%); RR 0.2 (95% CI 0.07 to 0.62) 1-minute Apgar < 3: 61/1435 (1.2%); RR 3.4 (95% CI 1.1 to 10.8)	Elective CS rate:13% Emergency CS rate in TOL group: 36%	Retro-spective cohort	3
Hibbard, 2001 ⁶²⁶	1756 women with at least one previous CS delivering in a US hospital over a 10-year period 1989–1998 Included no more than two previous low tranverse or low vertical CS, no previous additional uterine surgeries, cephalic or breech presentations, no active herpes infections and adequate pelvis.	Uterine rupture Hysterectomy Blood loss Blood transfusion Chorioamnionitis Endometritis	Incidence of uterine rupture: All women with previous CS: 6/1000 Elective CS: 0/1000 TOL group: 8/1000 Elective CS (n = 431): Uterine rupture: 0 Hysterectomy: 0 Blood loss > 1000 ml: 32 (97.4%);1.00 Blood loss > 2000 ml: 5 (1.2%); 1.00 Blood transfusion: 6 (1.4%); 1.00 Chorioamnionitis: 18 (12.8%); 1.00 Endometritis: 38 (8.8%); 1.00 TOL (n = 1324): Uterine rupture: 10 (0.7%) Hysterectomy: 6 (0.5%) Blood loss > 1000 ml: 46 (3.5%) RR 0.5 (95% CI 0.3 to 0.7) Blood loss > 2000 ml: 8 (0.6%) RR 0.5 (95% CI 0.3 to 0.7) Blood transfusion: 11 (0.8%); RR 0.6 (95% CI 0.2 to 1.6) Chorioamnionitis: 169 (4.2%) RR 3.1 (95% CI 1.9 to 4.9) Endometritis: 108 (8.1%); RR 0.9 (95% CI 0.6 to 1.3)	Elective CS rate:24% Emergency CS rate in TOL group: 31%	Retro-spective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Iglesias, 1991 ⁶⁷⁸	All 1161 mothers delivering at a 44-bed rural hospital in Canada between 1985 and 1989. 136 mothers had previous CS	CS rates Uterine rupture	Incidence of uterine rupture: All women with previous CS: 15/1000 Elective CS: 0/1000 TOL group: 28/1000 Elective CS (n = 65): Uterine rupture: 0 Maternal mortality: 0 Perinatal mortality: 0 TOL (n = 72): Uterine rupture: 2 (2.8%) Maternal mortality: 0 Perinatal mortality: 1 (1.4%)	Elective CS rate:47% Emergency CS rate in TOL group: 19%	Retro-spective cohort	3
Eriksen, 1989 ⁶³⁹	141 mothers with previous CS delivering at a U.S. military hospital 1985–1987 Included only confirmed low transverse previous CS, singleton cephalic pregnancies Excluded those with more than 2 previous CS or history of wound infection or endomyometritis	Maternal morbidity including uterine rupture Neonatal morbidity Neonatal death	Incidence of uterine rupture: All women with previous CS: 7/1000 Elective CS: 0/1000 TOL group: 14/1000 Elective CS (n = 68): Uterine rupture: 0 Maternal mortality: 0 Perinatal mortality: 0 Transient tachypnoea newborn: 6 (8.8%); 1.00 Transfer to NICU: 11 (16.2%); 1.00 Maternal blood transfusion: 0 Maternal endomyometritis: 1 (1.5%); 1.00 TOL (n = 71): Uterine rupture: 1 (1.4%) Maternal mortality: 0 Perinatal mortality: 0 Transient tachypnoea newborn: 3 (4.2%); RR 0.5 (95% CI 0.1 to 1.8) Transfer to NICU: 5 (7.0%); RR 0.4 (95% CI 0.1 to 1.2) Maternal blood transfusion: 0 Maternal endomyometritis: 2 (2.8%); RR 1.9 (95% CI 0.2 to 20.6)	Elective CS rate:48% Emergency CS rate in TOL group: 20%	Retro-spective cohort	3
Paterson, 1991 ⁶⁷⁹	36,727 singleton births in 17 maternity units, North West region, London during 1988 Included singleton cephalic pregnancies at least 37 weeks of gestation, only one previous CS and no previous vaginal deliveries	Mode of delivery Maternal mortality Neonatal death	Elective CS (n = 395): perinatal deaths 0 TOL (n = 664): perinatal deaths 1 (1.6%)	Elective CS rate 37% Emergency CS rate in TOL group: 29%	Retro-spective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Smith, 1997 ⁶³⁵	Registry data (SMR2) for all births in Scotland 1992–97 Excluded multiple pregnancies, non cephalic presentation, delivery outside range of 37–43 weeks gestation, perinatal deaths due to congenital anomaly, antepartum stillbirths	Perinatal death	Perinatal mortality: Elective CS (n = 9014): 1 (0.01%); 1.00 TOL (n = 15,515): 20 (0.1%); RR 11.6 (95% CI 1.6 to 86.6)		Retrospective cohort	3
Stone, 2000 ⁶⁸⁰	Registry data for all births in 1995 in Victoria, Australia. Included 4663 mothers whose penultimate birth was by CS and who had a singleton birth in both deliveries	Uterine rupture Perinatal mortality	Incidence of uterine rupture: All women with previous CS: 0.6/1000 Elective CS: 0/1000 TOL group: 2/1000 Elective CS (n = 3181): Uterine rupture: 0 Perinatal mortality: 1 (0.03%); 1.00 TOL (n = 1482): Uterine rupture: 3 (0.2%) Perinatal mortality: 1 (0.07%); RR 2.1 (95% CI 0.1 to 34.3)	Elective CS rate 68% Emergency CS rate in TOL group 44%	Retrospective cohort	3
Saldana, 1979 ⁶⁸¹	226 women with previous CS, delivering in a U.S.A teaching hospital between 1974–77	Uterine rupture Maternal mortality Perinatal mortality	Incidence of uterine rupture: All women with previous CS: 4/1000 Elective CS: 12/1000 TOL group: 0/1000 Uterine rupture: Elective CS (n = 81): 1 (1.2%) TOL (n = 145): 0 Maternal and perinatal mortality: 0 (both groups)	Elective CS rate 36% Emergency CS rate in TOL group 61%	Cohort study	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Chattopadhyay, 1988 ⁶³³	1847 women with a previous CS delivering in Saudi Arabia 1983–84	Uterine rupture Maternal mortality Blood transfusion Infection	Incidence of uterine rupture: All women with previous CS: 9/1000 Elective CS: 5/1000 TOL group: 10/1000 Elective CS (n = 401): Uterine rupture: 2 (0.5%); 1.00 Maternal mortality: 0 Blood transfusion: 24 (6.0%); 1.00 Infection: 89 (22.2%); 1.00 TOL (n = 1446): Uterine rupture: 15 (1.0%); RR 2.1 (95% CI 0.5 to 9.0) Maternal mortality: 0 Blood transfusion: 176 (15.6%); RR 2.6 (95% CI 1.7 to 3.9) Infection: 226 (15.2%) RR 0.7 (95% CI 0.5 to 0.8)	Elective CS rate 20% Emergency CS rate in TOL group 49% Incidence of uterine ruptures among women with no previous CS in this hospital was 2/10,000	Retro-spective cohort	3
Novas, 1987 ⁶²⁸	69 women with more than one previous CS delivering in a hospital in USA	Uterine rupture Hysterectomy Perinatal mortality	Incidence of uterine rupture: All women with previous CS: 14/1000 Elective CS: 0/1000 TOL group: 28/1000 Elective CS (n = 33): Uterine rupture: 0 Hysterectomy: 2 (6.1%) Maternal mortality: 0 Perinatal mortality: 2 (6.1%); 1.00 TOL (n = 36): Elective CS (n = 33): Uterine rupture: 1 (2.8%) Hysterectomy: 0 Maternal mortality: 0 Perinatal mortality: 1 (2.8%); RR 0.4 (95% CI 0.0 to 4.8)	Elective CS rate 48% Emergency CS rate in TOL group 20%	Retro-spective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Hansell, 1990 ⁶¹⁶	170 women with at least 2 previous CS delivering in USA, 1983 to 1987	Uterine rupture Apgar scores Maternal blood transfusion	Incidence of uterine rupture: Women with at least 2 previous CS: 6/1000 Elective CS: 7/1000 TOL group: 0/1000 Elective CS (n = 135): Uterine rupture: 1 (0.7%) 1-minute Apgar score < 5: 5 (3.7%); 1.00 5-minute Apgar score < 5: 0 Maternal Blood transfusion: 11 (8.1%); 1.00 TOL (n = 35): Uterine rupture: 0 1-minute Apgar score < 5: 3 (8.6%); RR 2.3 (95% CI 0.6 to 9.2) 5-minute Apgar score < 5: 0 Maternal Blood transfusion: 1 (2.8%); RR 0.3 (95% CI 0.05 to 2.6)	Elective CS rate 79% Emergency CS rate in TOL group 23%	Retrospective cohort	3
Stronge, 1996 ⁶⁸²	239 women with 1 previous CS, no other previous pregnancies delivering in a teaching hospital in Dublin, 1992–94	Uterine rupture Perinatal mortality	Incidence of uterine rupture: All women with 1 previous CS: 0/1000 Elective CS: 0/1000 TOL group: 0/1000 Uterine rupture: Elective CS (n = 44): 0 TOL (n = 195): 0 Perinatal mortality: Elective CS (n = 44): 0 TOL (n = 195): 3 (1.5%)	Elective CS rate 19% Emergency CS rate in TOL group 23%	Retrospective cohort	3
Bombelli, 1998 ⁶⁸³	231 women with at least 1 previous CS delivering in Italy 1996–97	Uterine rupture Apgar score Umbilical vein Ph Base excess	Incidence of uterine rupture: All women with 1 previous CS: 0/1000 Elective CS: 0/1000 TOL group: 0/1000 Elective CS (n = 149): Uterine rupture: 0 1-minute Apgar score < 7: 11 (7.4%); 1.00 5-minute Apgar score < 7: 0 Umbilical vein Ph < 7: 0 Base excess < -12: 0 TOL (n = 82): Uterine rupture: 0 1-minute Apgar score < 7: 9 (11.0%); RR 1.5 (95% CI 0.6 to 3.4) 5-minute Apgar score < 7: 0 Umbilical vein Ph < 7: 2 (2.4%) Base excess < -12: 2 (2.4%)	Elective CS rate 21% Emergency CS rate in TOL group 32%	Prospective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Phelan, 1989 ⁶³⁰	2643 women with at least 1 previous CS delivering in USA 1982 to 1984 Inclusion criteria: Patient acceptance Unknown type of scar Exclusion criteria: Known classical scar Multiple gestation Malpresentation	Uterine rupture Febrile morbidity Hysterectomy	Incidence of uterine rupture: All women with previous CS: 9/1000 Elective CS: 5/1000 TOL group: 3/1000 Uterine rupture: Elective CS (n = 847): 4 (0.5%); 1.00 TOL (n = 1796): 5 (0.3%); RR 0.6 (95% CI 0.1 to 2.2) Febrile morbidity: Elective CS (n = 847): 163 (19.2%); 1.00 TOL (n = 1796): 159 (8.8%); RR 0.5 (95% CI 0.4 to 0.6) Hysterectomy: Elective CS (n = 847): 14 (1.6%); 1.00 TOL (n = 1796): 5 (0.3%); RR 0.2 (95% CI 0.1 to 0.5)	Elective CS rate 32% Emergency CS rate in TOL group 18%	Prospective cohort	3
Paul, 1985 ⁶⁸⁴	1209 women with at least 1 previous CS delivering at a US hospital 1982 to 1984 Exclusion criteria: Multiple gestation Unknown intent for trial of labour	Uterine rupture Maternal febrile morbidity	Incidence of uterine rupture: All women with previous CS: 4/1000 Elective CS: 4/1000 TOL group: 4/1000 Uterine rupture: Elective CS (n = 458): 2 (0.4%); 1.00 TOL (n = 751): 3 (0.4%); RR 0.9 (95% CI 0.1 to 5.4) Febrile morbidity: Elective CS (n = 458): 74 (16.1%); 1.00 TOL (n = 751): 51 (6.8%); RR 0.4 (95% CI 0.3 to 0.6) Hospital stay: 2–4 days (both groups)	Elective CS rate 38% Emergency CS rate in TOL group 18%	Prospective cohort	3
Ngu, 1989 ⁶⁸⁵	1022 women with at least 1 previous CS delivering in Australia 1978 to 1981	Uterine rupture	Incidence of uterine rupture: All women with previous CS: 0/1000 Elective CS: 0/1000 TOL group: 0/1000 Elective CS (n = 566) TOL (n = 456) Uterine rupture: 0 (both groups)	Elective CS rate 55% Emergency CS rate in TOL group 40%	Retro-spective cohort	3
Molloy, 1987 ⁶⁸⁶	2176 women with at least 1 previous CS delivering in Dublin 1979 to 1984	Uterine rupture	Incidence of uterine rupture: All women with previous CS: 2/1000 Elective CS: 0/1000 TOL group: 2/1000 Uterine rupture: Elective CS (n = 395): 0 TOL (n = 1781): 4 (0.2%)	Elective CS rate 55% Emergency CS rate in TOL group 9%	Retro-spective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Meehan, 1989 ⁶⁸⁷	2434 women with at least 1 previous CS delivering in Ireland 1972 to 1987	Uterine rupture	<p>Incidence of uterine rupture: All women with previous CS: 4/1000 Elective CS: 4/1000 TOL group: 4/1000</p> <p>Uterine rupture: Elective CS (n = 1084): 4 (0.4%); 1.00 TOL (n = 1350): 6 (0.4%); 1.2 (95% CI 0.3 to 4.2)</p>	<p>Elective CS rate 44%</p> <p>Emergency CS rate in TOL group 29%</p>	Prospective cohort	3
Martin, 1983 ⁶²⁵	<p>717 women with at least 1 previous CS delivering in USA, 1981 to 1982</p> <p>Exclusion criteria: Prior classical uterine incision Suspected macrosomia Fetal malpresentation Multiple gestation</p>	<p>Uterine rupture</p> <p>Neonatal death</p>	<p>Incidence of uterine rupture: All women with previous CS: 4/1000 Elective CS: 4/1000 TOL group: 6/1000</p> <p>Uterine rupture: Elective CS (n = 555): 2 (0.4%); 1.00 TOL (n = 162): 1 (0.6%); RR 1.7 (95% CI 0.1 to 18.8)</p> <p>Neonatal death: Elective CS (n = 555): 5 (0.9%) TOL (n = 162): 0</p> <p>Elective CS (n = 555): Endometritis: 42 (7.6%); 1.00 Wound infection: 12 (2.2%); 1.00 Haemorrhage: 57 (10.3%); 1.00 Pulmonary: 31 (5.6%); 1.00</p> <p>TOL (n = 162): Endometritis: 8 (4.7%); RR1.61 (95% CI 0.77 to 3.36) Wound infection: 3 (1.8%); RR 1.17 (95% CI 0.3 to 4.1) Haemorrhage: 15 (9.2%); RR 1.1 (95% CI 0.6 to 1.9) Pulmonary: 6 (0.4%); RR 1.5 (95% CI 0.6 to 3.5)</p>	<p>Elective CS rate 77%</p> <p>Emergency CS rate in TOL group 38%</p>	Prospective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Hadley, 1986 ⁶³¹	75 women with 1 previous CS delivering in USA, 1982 to 1983 Inclusion criteria: No complications of pregnancy One previous low transverse CS Singleton fetus vertex presentation 37 weeks gestational age	Uterine rupture Apgar scores Postpartum endometritis UTI Wound infection	Incidence of uterine rupture: All women with previous CS: 13/1000 Elective CS: 0/1000 TOL group: 25/1000 Elective CS (n = 35): Uterine rupture: 0 1-minute Apgar score < 7: 4 (11.4%) 5-minute Apgar score < 7: 2 (5.7%) Postpartum endometritis: 7 (0.2%); 1.00 UTI: 1 (0.03%); 1.00 Wound infection: 1 TOL (n = 40): Uterine rupture: 1 (2.5%) 1-minute Apgar score < 7: 0 5-minute Apgar score < 7: 0 Postpartum endometritis: 6 (0.15%); RR 0.75 (95% CI 0.3 to 2.0) UTI: 2 (0.05%); RR 1.75 (95% CI 0.2 to 18.5) Wound infection: 0	Elective CS rate 53% Emergency CS rate in TOL group 20%	Retro-spective cohort	3
Jarrell, 1985 ⁶³²	604 women with at least 1 previous CS delivering in USA, 1978 to 1982	Uterine rupture Apgar score Maternal febrile morbidity requiring antibiotics Wound infection UTI	Incidence of uterine rupture: All women with previous CS: 15/1000 Elective CS: 15/1000 TOL group: 14/1000 Elective CS (n = 388): Uterine rupture: 6 (1.5%); 1.00 5-minute Apgar score < 6: 1 (0.2%); 1.00 Febrile morbidity: 19 (2.6%); 1.00 Wound infection: 2 (0.5%); 1.00 UTI: 7 (1.8%); 1.00 TOL (n = 216): Uterine rupture: 3 (1.4%); RR 0.9 (95% CI 0.2 to 3.5) 5-minute Apgar score < 6: 7 (3.2%) RR12.6 (95% CI 1.5 to 101.5) Febrile morbidity: 6 (2.8%); RR 1.1 (95% CI 0.4 to 2.9) Wound infection: 2 (0.9%); RR 1.8 (95% CI 0.2 to 12.7) UTI: 6 (2.8%); RR 1.5 (95% CI 0.5 to 4.5)	Elective CS rate 53% Emergency CS rate in TOL group 34%	Retro-spective cohort	3

10.2 Childbirth following CS (continued)

Study	Population	Outcomes	Results	Comments	Study type	EL
Eglington, 1984 ⁶⁸⁸	836 women with at least 1 previous CS delivering in USA, 1980	Uterine rupture	<p>Incidence of uterine rupture: All women with previous CS: 4/1000 Elective CS: 4/1000 TOL group: 3/1000</p> <p>Uterine rupture: Elective CS (n = 528): 2 (0.4%); 1.00 TOL (n = 308): 1 (0.3%); RR 0.8 (0.1,9.4)</p> <p>Febrile morbidity: Elective CS (n = 528): 178 (33.7%); 1.00 TOL (n = 308): 33 (10.7%); RR 0.3 (0.2, 0.4)</p>	<p>Elective CS rate 63%</p> <p>Emergency CS rate in TOL group 22%</p>	Retrospective cohort	3
NSCSA, 2000 ⁴	14,104 women with at least 1 previous CS delivering in all maternity units in England and Wales May–July 2000	Uterine rupture Stillbirth	<p>Incidence of uterine rupture: All women with previous CS: 2/1000 Elective CS: 3/1000 TOL group: 1/1000</p> <p>Uterine rupture: Elective CS (n = 6904): 8/6358 TOL (n = 7110): 24/6917</p> <p>Stillbirth: Elective CS (n = 6904): 16/6899 TOL (n = 7110): 48/7104</p>	<p>Elective CS rate 49%</p> <p>Emergency CS rate in TOL group 36%</p>	Cohort study	3