AIMS For a better birth...

Research Roundup

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Epidurals affect VBAC babies

VBAC babies do best if their mothers do NOT have an epidural.

What type of birth is best for the baby whose mother had previously had a caesarean? One study had shown that those born by elective caesarean were more likely to have respiratory problems and a longer hospital stay, whereas those born vaginally were more likely to have a low Apgar score at birth, and be treated for real or suspected sepsis. Another large multicentre study found no differences between them.

A recent report from researchers at Boston's Brigham Hospital looked at birth records for 1994-1995 in lower-risk women who had had one or two previous sections. They compared outcomes in babies born to 313 women who had a trial of labour with 136 women who had an elective section. Of the women who chose a trial of labour, 77 per cent had a vaginal birth. On average, they were two years younger than those who chose sections. Their babies also had longer gestation-around 39.4 weeks compared with 38.7 weeks.

Babies born after a trial of labour were more likely to have a low Apgar score (under 7) at one minute-9.6 per cent of this group vs 1.5 per cent of the elective caesarean group. But at five minutes, few babies in either group had a low Apgar, so there was no difference. Three labour mothers had rupture or separation of the scar, but all three of those babies (1 per cent of the total) had good five-minute Apgar scores of 9.

There was no difference between the two groups in respiratory symptoms after birth, resuscitation, or hypotonia. However, significantly more of the labour group (11.5 per cent) had intubation for meconium than the caesarean group (1.5 per cent). On the other hand, twice as many caesarean babies had

transient tachypnoea (8.1 per cent) vs the labour group (4.5 per cent). (The cause of this is thought to be a delay in clearing fluid from the lungs at birth because the babies have missed out on the stimulus caused by labour.)

Mild bruising was more common in babies whose mothers went for a VBAC (vaginal birth after caesarean), but there were no cases of severe bruising. Birth injury was rare, and was similar in both groups (1.5 per cent caesarean; 1 per cent vaginal); two caesarean babies had facial nerve palsy, and three VBAC babies had a haematoma on the head.

VBAC babies were more likely to be admitted to neonatal intensive care (26.2 vs 17.6 per cent), but this was not likely to be for more than four hours. They were also more likely to be checked for sepsis (23.3 vs 12.5 per cent) and to be given antibiotics (11.5 vs 4.4 per cent).

Nearly three-quarters (73 per cent) of the VBAC women had an epidural. Although the women were of similar age, with babies of similar gestation and birthweight, there was one difference: those who got an epidural were more likely to be white than black (64.4 vs 48.2 per cent, respectively).

Epidural babies were more likely to be admitted for neonatal care-31.3 vs 12.1 per cent in non-epidural mothers-and thus to have more investigations, and also more likely to stay there for more than four hours-5.2 vs 1.2 per cent. Epidurals given in labour tend to cause raised temperatures in mothers, and this often leads doctors to suspect their babies may have infection at birth. So, epidural babies were nearly five times as likely to be evaluated for sepsis (29.6 vs 6 per cent) and more than twice as likely to be given antibiotics (13.9 vs 4.8 per cent). They were not, however, more likely to have infections.

Thus, the increased problems and intervention in the trial of labour babies compared with the elective caesarean babies occurred only in those whose mothers had an epidural.

AIMS comments

Once again, we see how black women, or those in lower socioeconomic groups, may have better outcomes because of less obstetric 'help'. But canny AIMS readers will have spotted holes here-no data on induction or augmentation of labour, or duration of labour in the epidural/non-epidural groups. It could be that those who had epidurals were more likely to need them because of more painful labour, which could be a major confounding factor. (Was this the case with those who had scar separation?)

The data on raised temperature in the mother during labour, well known to be caused by epidurals, leading to subsequent investigations and maybe unnecessary treatment of the baby for suspected infection, has come up many times before. Increasingly, we are getting complaints about what mothers believe to be unnecessary separation from their babies, and suspected overinvestigation and treatment, which can be traumatic and damaging for both, as well as for breastfeeding and bonding with both parents. The current advice would seem to be: if you want a VBAC, avoid an epidural if you can!

Reference

- Fisler R et al. Neonatal outcome after trial of labour compared with elective repeat caesarean section. Birth, 2003; 30: 83-8

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Kangaroo care-where is it?

"One may hear statements like 'we practise intermittent kangaroo mother care in our hospital', but when one visits unannounced, virtually no one is ever found to be practising it, often because of real or convenient 'staff shortages' or because the individual interested is not on duty."

Giving kangaroo care to a premature baby means that the mother, or father, nestles the baby next to the skin for lengthy periods (up to 24 hours a day) rather than putting it in a cot. It was first introduced in Colombia, which could not afford incubators and sophisticated care for their premies. Studies since have shown that it regularises heartbeat, helps maintain temperature, babies put on more weight, have earlier discharge and, of course, it improves bonding enormously.

It is not yet fully accepted as 'evidence-based' (partly because babies are selected as suitable for it in the unit and at different gestations, and it is difficult to prove effects on mortality since those with a higher death rate and illness will already have been selected out), but many studies show benefits. Despite this, AIMS receives a steady stream of reports from parents whose babies seemed ideal candidates, yet parents were not given the opportunity and, what's more, they never saw other babies being kangarooed either.

There seems to be a vastly different ethos between neonatal units as to how much parental presence and contact is encouraged and, within units, differences according to who is on duty, and nursing and medical staff attitudes. 'Official' policies of parental contact-even when beautifully described in a poster-don't always work out in practice. Tactics and pressure to control parents and keep them away from babies the staff seems to 'own' can be both skilled and subtle. As a result, we are seeing long-term harm as postnatal depression, loss of confidence in parenting and even post-birth trauma.

How do we bring about change?

However desirable a policy may be, it can be hard to swing the unit around. I was therefore pleased to see a most unusual piece of research from South Africa: how to help workers and managers implement a kangaroo programme, and make it part of the institutional culture. First, an outside researcher made observations for two months, then had long interviews with 'key players' (administrators, paediatricians, nurses) and institutional issues were identified. These were fed back and used in training workshops, where participants had to find their own solutions suitable for their workplace. From this, they developed a workbook.

They particularly looked at the way these changes could be affected by the 'climate' of the institution and the way it worked. They identified the importance of "human relations, a culture of care and commitment, and respect for human rights". They comment that you have to find strategies to overcome staff resistance to losing control of 'their' babies.

AIMS comments

When the media describe improvements in healthcare, they invariably comment on new drugs, surgery or technology. But AIMS' history for the past 40 years has fundamentally been one of challenging the culture. Although we've made considerable advances in birth care, we increasingly find that the power has moved from the obstetricians to the fetal-medicine specialists and neonatologists, and their behaviour has proved, on occasions, to be authoritarian and damaging.

This article is important and has lessons for other problems we see. I hope it will be read by members of Maternity Services Liaison Groups.

Reference

- Bergh A, Pattinson R. Development of a conceptual tool for the implementation of kangaroo mother care. Acta Paed Scand, 2003; 92: 709-14

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Psychological birth trauma

"Many study women described the frustration of having to remain in bed because the doctor ordered continuous external fetal monitoring, preventing them from using techniques they had learned in childbirth education classes and making them feel powerless to control the pain."

Researchers from Emory University in Atlanta, Georgia, looked at the psychological aftermath of childbirth in 103 women. The study is prospective (women filled in questionnaires when pregnant, and were interviewed after they had given birth), and data were collected on whether women had found birth a traumatic experience and whether they also developed post-traumatic stress disorder (PTSD).

Most of the women (92 per cent) were expecting their first child, were in middle-income groups and had educational degrees. It is the first study to include black women, but they were less likely to complete the study. Some 67 per cent of the final sample were white, 27 per cent black and the remainder Asian or Hispanic. Intervention rates were higher than average for the US. More than half were induced, three-quarters had epidurals and 32 per cent had caesareans; 75 per cent of the births were attended by doctors.

About one-third of the women (34 per cent) said they had found the birth traumatic, and 40 per cent developed PTSD- and 1.9 per cent had all the symptoms. The women who found birth traumatic were more likely to have a past history of sexual abuse, less social support, higher anxiety and less coping ability. Risk was increased by having more medical intervention, more pain, a longer labour, negative experiences, a caesarean section, feelings of powerlessness, inadequate information and not having expectations met. Experience with medical personnel could have a significant effect.

Oddly, 19 women reported PTSD symptoms without seeing the birth as traumatic. The researchers suggest this may be due to women being reluctant to talk about negative experiences, and the strong pressures on women to be happy and put the baby's needs before their own.

The most important predictor of whether women developed PTSD symptoms afterwards was previous psychosocial factors, like past abuse and lack of support. However, experience of pain also predicted the development of symptoms, and they were particularly likely to feel birth was traumatic if pain was different from what they had expected. The researchers suggest pregnant women should be asked about previous sexual trauma, that childbirth classes give women realistic ideas of the experience of birth and hospital procedures, and that further studies be done to evaluate the effects of these. Doctors should aim for good communication and excellent pain control, "including allowing the woman to have a sense of control by giving her options."

AIMS comments

I read this with feelings of both pleasure that they are pursuing the subject (especially in the American South, with its sky-high caesarean rate) and frustration at their suggestions for "improvements".

We shall NOT support any plans routinely to take sexual and psychiatric histories from pregnant women until there is proof of benefit. We have seen the adverse effects of psychiatric histories, and AIMS has recently had a case where a woman reported her need for control in labour because of past sexual abuse "in confidence" to her midwife-with disastrous results. This was exactly what we predicted and warned about. And how come the team coolly report the horrendous caesarean rate and its psychological consequences without challenging it? With 53 per cent of the women being induced (they don't say how), it's not surprising that pain was a problem, despite all those epidurals.

This provides a shocking picture of birth in Georgia. To recommend prevention by giving women "realistic expectations" of abnormal childbirth that causes trauma without challenging the current pattern is a betrayal of the women who cooperated with the study.

Reference

- Soet J et al. Prevalence and predictors of women's experience of psychological trauma during childbirth. Birth, 2003; 30: 36-46 Jean Robinson's research round-up

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