AIMS For a better birth...

Research Roundup

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Risk of uterine rupture

A single-layer, rather than a double-layer, closure of the incision after a caesarean may greatly increase the risk of uterine rupture in a later pregnancy. Single-layer closure is becoming popular with doctors because it can be done more quickly, and mothers have fewer problems afterwards.

Obstetricians in Montreal up to 1988 used the doublelayer closure - a continuous interlocking thread through the myometrium followed by a continuous second layer, and finally closure of the peritoneum. In the 'new' method, the entire thickness of the uterine wall is closed with a single continuous suture.

Researchers looked at records of over 2000 women who had had only one caesarean section and a trial of labour for their next baby during 1988-2000. The uterus ruptured in 3.1 per cent of the women who had single-layer closure vs 0.5 per cent of those with a double-layer closure. It was found that single-layer closure was the biggest risk for rupture, increasing the risk by nearly four times. The second greatest risk factor was having another baby within two years of the section, which could increase risk by nearly two-and-a-half times.

If the scar doesn't rupture, but only comes apart (dehiscence), this may not be detected unless the woman has a section. Among those who had another caesarean, twice as many in the single-layer group (7.3 per cent) had a dehiscence as in the double-layer group (3.1 per cent).

It was suggested that, for women who may give birth vaginally next time, surgeons should use the double-layer technique.

AIMS comments

A randomised trial of the two methods of closure is ongoing in the UK. It is interesting to see that, in the above trial, they did not use prostaglandins, and use of oxytocin did not significantly increase the risk of rupture. We have certainly seen cases where the use of prostaglandins was associated with scar rupture.

Reference

- Bujold E et al. The impact of a single-layer or double-layer closure on uterine rupture. Am J Obstet Gynecol, 2002; 186: 1326-9

Return to top

Antidepressants in pregnancy

If certain antidepressants are taken during pregnancy, the growth and gestation of the baby may be affected, and APGAR scores (measuring the initial state of the baby at birth) may be lower.

Doctors in Seattle analysed data from the Group Health Cooperative in Washington State involving over 400,000 people. They compared birth outcomes for women with depression in pregnancy treated with drugs and those who were reported to have given birth, but not taken those drugs.

In all, 209 mothers had taken tricyclic antidepressants (such as amitriptyline or imipramine) and 185 had taken SSRIs or selective serotonin reuptake inhibitors (such as fluoxetine or sertraline).

Babies whose mothers had taken tricyclics did not differ significantly from controls in terms of length of pregnancy, weight, size of head or Apgar scores-and they were followed up to the age of two years.

However, babies whose mothers had taken SSRIs were more likely to be born at 36 weeks or less and have a lower birth weight-even if the drugs were taken earlier in pregnancy. But although they still weighed less than control babies at four months, by six months, they had caught up.

These infants were also more likely to have an APGAR score of 7 or less at five minutes after birth, though only when the drugs were taken within the last three months.

How big is the risk? Taking SSRIs doubled a woman's risk of having a premature birth, but the absolute risk was still only 10 per cent.

Although there was no significant increase in malformations with any of these drugs, the study is too small to exclude the possibility that it might happen. There were eight cases of seizures in babies whose

mothers had taken an antidepressant vs only one of the controls. But again, as the numbers are small, this could have arisen by chance.

AIMS comments

As the authors point out, the risks of taking antidepressants during pregnancy have to be weighed against the risk of not taking them. We know from our helpline that women become pregnant when they are already taking SSRIs, and have to reduce the dose gradually, and the risk of side-effects has to be balanced with the risk of recurrence of possibly severe depression. There are also reports of babies suffering from withdrawal after birth.

This study only looked at live births, so we have no data for miscarriages or stillbirths.

Reference

- Simon GE et al. Outcomes of prenatal antidepressant exposure. Am J Psychiatry, 2002; 159: 2055-61

Return to top

Fear of childbirth: does counselling help?

That about 6 per cent of pregnant women have an intense fear of childbirth has led many Swedish maternity hospitals to set up 'fear of childbirth' teams. This latest study looks at the effectiveness of counselling by specially trained midwives.

The experiences of 62 'afraid' women were compared with 56 controls: 30 per cent of the treated group were childless vs 43 per cent of women who were mothers (so 'afraid' women were more likely already to have experienced giving birth).

The women had an average of four consultations (range one to 14) when pregnant. When they were confident enough to imagine birth in a more positive manner, an individual birth plan was devised. However, they were to be attended by any midwife on duty when they went into labour. To be attended by a named midwife, the woman had to have a planned induction. In a few cases, elective caesarean was recommended. However, the aim was to make the birth as rewarding as possible, whatever the kind of birth.

Of the 20 women who asked for a caesarean before counselling, 14 had sections (8 elective and 6 emergency). The cae AIMS JOURNAL vol 16 no 1 2004 17 sarean rate in the counselled women was 26 per cent-in a department where the usual rate is 11 per cent. Five of the group, and two controls, had

instrumental vaginal deliveries (of course, we don't know what the section rate would have been had they not been counselled).

A month after the birth, the women answered a questionnaire rating negative or frightening birth experiences. They did not rate their experience as highly as did the controls: 19 per cent reported post-traumatic stress and even post-traumatic stress disorder (PTSD) vs 2 per cent possible PTSD (which studies suggest is usual) in the controls. Although the counselled women were satisfied with the care given, more of them than the controls said they had had a frightening delivery experience, and three were dissatisfied.

Women in both groups wanted members of staff to spend more time with them, and the authors say that "increased attendance in the delivery room is not easily arranged in times of staff shortages"; they suggest doulas may help.

The researchers found the high PTSD rate in the counselled women alarming, which raised questions as to whether midwives are the best people to do the counselling and whether cases could be better selected. They also commented that there must be close collaboration with the rest of the department and that the team "should never make promises that cannot be kept by every colleague".

AIMS comments

We owe Swedish researchers a debt of gratitude since they have looked at fear of childbirth (in childless women and in those with children), a subject ignored almost everywhere else, in a number of studies. While British obstetricians and the media only talk of women demanding caesareans because they are "too posh to push", Sweden has identified fear and bad birth experiences as a major cause of women wanting caesareans.

What's more, the Swedish studies, from the beginning, have been accompanied by efforts to give practical help, rather than merely categorising and 'labelling' women, which we see in so much psychological research here. Words cannot describe my anger when I read a late-in-the-day British article giving the problem a clever Greek name-'tokophobia'-and leaving it that. And that's the one that is quoted in the British literature, of course.

It was sad to see that these needy women did not get continuous care, and were likely not to know the staff who attended the birth: only agreeing to a (more painful) induction would get them that. Once again, the job of the counselling team was to give them not ideal care, but to make sure they had 'realistic' expectations of what would happen in the delivery suite.

The research highlights two problems already seen here in the UK: women with PTSD from previous childbirth experiences being re-traumatised by staff who will not listen, and given bad care at the next delivery; and the issue of midwives taking on 'counselling' roles that may be beyond their training and

abilities.

At AIMS, we have already seen some of the adverse effects of midwives' 'debriefing' work and its questionable links with management litigation avoidance, and the morass midwives can fall into and the distressed women that result when they find themselves treading on eggshells while wearing hobnailed boots. Women with a primary fear of childbirth or postnatal PTSD are more likely than others to have a past history of sexual abuse. Amateur or semitrained do-gooders, KEEP OUT!

Reference

- Ryding E et al. An evaluation of midwives' counselling of pregnant women in fear of childbirth. Acta Obstet Gynecol Scand, 2003; 82:10-7

Return to top

The vanished twin

Two UK researchers have carried out a sensitive study of women who had a 'vanished twin'-a twin identified by ultrasound in early pregnancy, but later found to have disappeared by 20 weeks, presumably reabsorbed by the placenta. Nine such women agreed to take part.

All of the women described "poor communication" with health professionals. The information from the scan came as a shock. They did not know what it meant-What had happened to the vanished baby? Was it rotting inside?-but they were unable to ask any questions. The shock stopped them from taking it all in and being able to ask for the information they needed. They often felt guilty and confused. They were worried throughout the whole of their pregnancies, and all of them felt that their pregnancies had continued as if they were carrying twins-their bodies behaved as if it were still carrying twins, almost like a phantom pregnancy.

Some feared that the surviving baby would miss the lost sibling; some felt that something had been "snatched away". Others feared the survivor was more likely to be abnormal and their anxiety stayed high until the child was born.

Some women would have found a miscarriage, with its physical signs, more acceptable than this 'vanishing'. Some grieved for a lost child, however brief its existence.

The lack of discussion and acknowledgement from professionals silenced them: "I kind of waited for them to take the lead and they never mentioned it and I thought, well, if they're not bothered, then I shouldn't be bothered. But I was bothered. I just didn't open my mouth."

Not surprisingly, some women developed feelings of mistrust about healthcare. There was no acknowledgement of their loss-that they had started out with two babies and now had only one. They

simply did not have enough information, advice or reassurance.

AIMS comments

I found this study deeply moving and very helpful. Every midwife, obstetrician and sonographer should read it. It is, of course, a problem largely created by ultrasound. Before this technology, women would never have known that they had conceived twins and lost one. When obstetricians claim psychological benefits for 'bonding' from scans, the downside should be also be remembered.

However, I am uneasy with the catchall label of "poor communication" being used to describe what is clearly crass ignorance and insensitivity, as described by these women. The sensitive collection of data in this study, and the openness with which they are described, give us a very clear picture of what went on. It comes as no surprise, but it sometimes makes for distressing reading.

Reference

- Briscoe L, Street C. 'Vanished Twin': an exploration of women's experiences. Birth, 2003: 30: 47-53

Return to top