Caesarean Section clincial guideline (update)

SCOPING WORKSHOP – NICE 25-01-10

Background

The stakeholder scoping workshop is held in addition to the formal consultation on the scope which is taking place from 24th of February 2010 to the 24th of March 2010.

The objectives of the scoping workshop were to:

• obtain feedback on the key clinical issues included in the first draft of the scope
• identify which patient or population subgroups should be specified
• seek views on the composition of the guideline development group (GDG)
• encourage applications for GDG membership.

The scoping group (technical team, NICE and GDG chair) presented a summary of the proposed scope, the timetable for guideline development, the guideline development process, the nature of stakeholder input into the guideline, the processes for recruitment to the GDG and a suggested constituency for this group. The stakeholder representatives were then divided into 3 groups which included a facilitator and a scribe and each group had a structured discussion around the key issues.

Summary of Group discussion points

Clinical questions

a) What is the diagnostic value of colour-flow ultrasound in diagnosing a morbidly adherent placenta in pregnant women with previous caesarean section currently diagnosed with placenta praevia?

Group comments

- This was considered an important question which should be addressed in the Update.
- It was suggested that there should be an additional question assessing whether having the diagnosis from ultrasound affects subsequent management and improves outcomes.

- RCOG Green Top Guideline already exists and includes this topic though it is now 5 years old (#27, 2005).
- There is a recent article on this subject by Sarah Paterson Brown.
- Colour flow Doppler may be difficult to implement in some trusts if it becomes a recommendation.
- It was suggested that the question should be broadened out to the management of intrapartum and postpartum haemorrhage in more general terms.

b) What is the effectiveness of the uterine artery embolisation/balloon as compared with standard care at improving maternal outcomes in pregnant women with previous caesarean section suspected in late pregnancy to have a morbidly adherent placenta?

Group Comments

- The Groups did not feel that this was an important question to address in the Guideline Update.
- The term “standard care” is misleading. Hysterectomy is not the only option; others include intrauterine balloons and compression sutures. The search strategy would require multiple comparisons between different interventions, not just embolisation/balloon.
- It was not thought there would be much evidence in this area.
- The question was raised of whether morbidly adherent placenta should be considered alone, or whether the guideline could consider haemorrhage more generally.

- It was commented that it would be useful to have figures for hysterectomy rates associated with CS.

c) **What is the effectiveness of elective caesarean section as compared with unplanned caesarean section at improving maternal and neonatal outcomes in women with dichorionic twin pregnancy in which the first baby's presentation is cephalic?**

Group Comments

- This question was supported generally by the Groups especially as it is not covered in the Multiple Pregnancy Guideline Scope which only covers the antenatal period and not labour and delivery

- Monochorionic, diamniotic (MCDA) pregnancies are addressed in an RCOG Green Top Guideline.

- There is a large, international, multicentre twin birth study being conducted (see: http://www.controlled-trials.com/ISRCTN74420086). This trial is proceeding well and the results are predicted to be published in 2012.

- It was noted that that the question would be better phrased to look at "planned CS vs. planned vaginal delivery".

- It was argued that including psychological outcomes would be important for this question. It would be good if health economics could take psychological outcomes into account. However, it was thought that most studies will not have this included as an outcome measure.

- It was suggested that the question should not be confined to cephalic babies, but look at breech babies as well. However, since the term breech trial it was unlikely that there would be many recent studies comparing vaginal birth with CS when

the first baby was presenting as a breech. In this context it was commented that the follow-up data from the twin breech study could be relevant to a reconsideration of this. There was a suggestion that the question should not just address dichorionic babies, but could simply look at “healthy term” twins instead (dichorionic and monochorionic). However, it was acknowledged that there is a problem in defining “healthy term” twins.

d) **What is the effectiveness of elective caesarean section as compared with vaginal delivery at decreasing the mother-to-child transmission of the virus in pregnant women with HIV and low or high viral load respectively? What information should women receive on the risks and benefits of modes of birth when planning for birth?**

Group Comments

- The BHIVA recommendations were produced at the end of 2008 and are a popular resource. They are regularly updated and the question was asked ‘why repeat the exercise for the CS update?’
- One group felt this should be addressed especially as the impact of retroviral therapy on viral load may make vaginal delivery safe. The existing NICE guideline states that CS should be undertaken with HIV positive pregnancies. But that cannot stand if the management recommendations should be contrary to that. If the recommendation is to be changed then it has to be reviewed as a clinical question in the context of a Guideline Update and cannot refer to another resource.
- It would be useful to know if the BHIVA guideline is based on a systematic review. If it is, this could be a quick review.

e) **What is the optimum decision-to-delivery interval in caesarean section in cases of maternal or fetal compromise?**

Group Comments

- The Groups all supported this question even it were to end up saying ‘there is no evidence to support a specific D2D interval’ because of the way in which “30 min” has become a medico-legal threshold rather than an audit standard. This was despite the fact that the original Guideline did use the term “audit standard” and made the points very clearly.
- There was discussion about the classification system and a view expressed that this could be reduced or simplified to lessen confusion.
- It would be useful to look at this question again to change the emphasis contained within the recommendation for practice.
- There is likely to be a lack of evidence in this area.

f) **What is the effectiveness of planned vaginal birth (VBAC) vs. elective caesarean section at improving maternal and neonatal outcomes in women at term with a previous caesarean section?**

Group Comments

- The Groups felt this topic was important and should be retained
- There was a need to include physical, psychological and emotional outcomes.
- Women need to be fully informed of the relative risks of each mode of delivery.

- A case was made by two Group members for studying the outcome of VBAC after two CS though it was not certain that there would be much evidence on this topic to study
- There was a discussion about whether there should be a sub-question about elective C-section for primips. It was agreed that this would have to be a question in its own right if it was to be covered at all but there was little support in the rest of the group for this.
- There was a comment that studies may be poor at distinguishing planned from emergency CS with some papers combining the two with no sub-group analysis. Also records relating to maternal request may be incorrect.
- The fact that record keeping is poor suggests that previous recommendations on documenting discussions have not been taken up and these may need to be strengthened or reinforced.
- It was noted that previous recommendations on VBAC are sensible but that they may need strengthening.

Other possible topics/questions

- Haemorrhage in association with CS – this is an increasing problem. No specific clinical question was suggested. There is an RCOG GT Guideline (52) dealing with post-partum haemorrhage (PPH). Certainly blood loss would be included as an important outcome for the Scope.
- Evidence on studies which use mathematical methods such as logistic regression to identify the risks of failed vaginal delivery and/or the risks for emergency CS. However, it was thought that whilst such predictive and scoring studies exist it was unlikely that there would be any prospective studies using these predictors.
- A suggestion was made that there should be a review of the literature on issues such as communication with women, informed choice, patient satisfaction, and the relation of woman's decision to ultimate

mode of delivery. However, it was also noted that these areas were very well covered in the original CS guideline and the problem might be, not that the Guideline was flawed, but that health care professionals were not implementing the good Guidelines in practice.

- Whilst obesity in pregnancy is an important topic it has already been identified as a priority topic for Public Health.
- There were recommendations in the original CS Guideline about antibiotic prophylaxis and the need for more information to direct clinical practice. Specifically two issues were mentioned
    - Timing of administration (at induction vs. at cord clamping)
    - Duration of administration (one dose vs. more than one dose)
- The subject of skin preparation was raised though it was commented that this may already be addressed in the Surgical Site Infection (SSI) guideline
- There was a suggestion that the guideline could examine the value of the WHO Surgical Safety Checklist and its relevance to improving CS outcome. However, as the Checklist had only recently been introduced it was thought too early for there to be any information of relevance for the Guideline Update.
- There was a request that Table 3-1a should be updated.

Equal Opportunities Issues

No particular equality issues were identified by the groups at this stage.

Outcomes

These would vary with the specific questions under review but would include criteria from:

- **Diagnostic accuracy** of colour-flow ultrasound for Q(a).
- **Maternal outcomes:** mortality; blood loss; ICU admission; Thromboembolic disease; infection; uterine rupture will be an additional outcome for VBAC: trauma (inc hysterectomy): emotional/psychological; physical mobility issues/long term pain/effects on family life

- **Baby outcomes:** 5min Apgar; preterm delivery rates; respiratory complications; neurological complications; length of stay; mother to child transmission will be added for HIV positive women, neonatal mortality, breastfeeding rate, “skin to skin” contact with mother; NNICU admissions

GDG Composition

The following represents a summary of the main suggestions from the three groups:

Healthcare professionals

- Two obstetricians including the chair
- Two midwives (one community and one from large hospital)
- One anaesthetist
- Perinatal mental health expert
- Health service commissioner

Lay members

- Two/three – may be from organisations representing women’s interests or individual women with experience of CS

Expert advisors (as required)

- Radiologist for Doppler question
- HIV expert
- Microbiologist

Health Economic Issues

The following were discussed:

- Financial incentives to trusts on the basis of normal delivery, ‘normal’ CS and ‘complicated’ CS
- Costs of litigation
- Need to consider long term outcomes including psychological outcomes