

Elective C-sections may not be optional

Ob/gyns in Canada still advocating for vaginal deliveries where possible

By KAREN RICHARDSON

OTTAWA – For patients inquiring about C-sections, ob/gyns may need to reinforce the message that for most women vaginal delivery poses a lower risk, said Dr. Jan Christilaw, a past-president of the Society of Obstetricians and Gynecologists of Canada (SOGC).

Some confusion was created by the “Elective C-sections gaining acceptance” commentary in the March 2 *Canadian Medical Association Journal (CMAJ)*.

It said Canadian experts will be releasing guidelines similar to those of the American College of Obstetricians and Gynecologists, which support the permissibility of elective cesarean delivery in a normal pregnancy, after adequate informed consent. But the ethics committee of the SOGC has, to date, made no decision to support elective C-sections, according to a recent media advisory from the society. It will release its position

statement in late spring.

Nevertheless, the *CMAJ* commentary attracted an outpouring of media headlines that C-sections will be available “on demand” for Canadians without the presence of a medical indication.

Dr. Mary Hannah, principal investigator of the Term Breech Trial published in 2000 that found C-section best for breech, authored a different article in the March 2 *CMAJ* about elective cesarean section. She is director of the Maternal, Infant and Reproductive Health Research Unit at the University of Toronto.

In addressing the quandary now faced by Canadian physicians if a woman without an accepted medical indication requests delivery by C-section, the article by Dr. Hannah suggests the request should be supported if, after a thorough discussion about the risks and benefits, a woman continues to perceive the benefits outweigh the risks.

In her article, Dr. Hannah acknowledged there is higher maternal mortality associated with C-section birth, as well as a longer recovery time and operative complications with C-section.

“But the highest mortality is associated with emergency ce-



The SOGC is still considering guidelines for elective C-sections.

sarean, which is not something done electively, but happens because planned vaginal birth failed,” said Dr. Hannah in an interview with the *Medical Post*.

“It is reasonable in some situations to respond positively to a woman’s request (for a C-section), if the woman understands the pros and cons,” she said.

But it is speculative to draw conclusions about the risks and benefits of C-sections from the *CMAJ* commentary, which referred to the women in the Term Breech Trial who were at higher risk for C-sections than the general population, said Dr. Christilaw, a clinical professor of obstetrics and gynecology at the University of British Columbia in Vancouver, and an obstetrician-gynecologist in White Rock, B.C.

Canadian ob/gyns will want to carefully consider a patient’s request for a cesarean section without medical indication, she added.

“Often the primary motivator is fear of pain and labour . . . However, they may not be aware of postoperative pain that can occur up to six weeks after surgery, as well as the risks associated with surgery itself, such as a higher risk of thromboembolic complications and complications with future pregnancies.”

While the society is deliberating on this topic, Dr. Hannah said the delay of a committee opinion from the society could be an opportunity for physicians in Canada to influence the development of the society’s recommendations.

Bone mineral density tests now standardized

By KAREN RICHARDSON

HAMILTON – The Canadian panel of the International Society of Densitometry has developed standards for the appropriate use of bone mineral density testing (BMD) in premenopausal women, men and children.

“There needed to be a document to give some guidance and ensure that practice right across Canada is of good quality,” said lead author Dr. Aliya Khan, chairwoman of the panel.

The standards—which define the minimum level of acceptable performance in Canada for assessment of BMD—were developed in conjunction with the Osteoporosis Society of Canada and international colleagues.

“Unfortunately, we’re seeing a lot of variation in practice,” added Dr. Khan, an associate clinical professor of medicine in the divisions of endocrinology and geriatrics at McMaster University in Hamilton, Ont.

She said the guidelines address who to test and how to interpret tests in men, premenopausal women and children—a grey area where standards have not yet been established. “We’re seeing a lot of poor

quality practice in those specific areas—inappropriate testing, interpretation and management.”

Young women

There is a trend to overtreatment of osteoporosis because of the emphasis placed on treating postmenopausal women. As a consequence, many healthy, young women are being inappropriately labelled as having osteoporosis, said Dr. Khan.

“We’ve seen a knee-jerk reaction. The T-score comes back, it’s low . . . and the patient is stuck on bisphosphonates.”

Dr. Khan said clinicians need to remember that some women may simply have a genetic makeup for low bone density. “We need to find out if this bone density is normal for this person or if it is a pathological problem . . . We don’t give short women hormones to reach the average height, for instance.”

Dr. Khan recommends clinicians keep in mind there are variations. “Fifteen per cent of healthy young women between the ages of 30 and 40 have a T-score of minus 1, which doesn’t necessarily mean osteopenia.”

The T-score is the number of standard deviations that a patient’s bone density is above or

below the young adult mean value (a value of -1 or higher is normal).

Dr. Khan said in fact the Z-score, not the T-score, should be used premenopausally and should not be weight-adjusted. (The Z-score is the number of standard deviations that a patient’s bone density is above or below the mean age-matched reference value.)

“It is also important to make sure the scan was valid, and if the patient was positioned properly as this will affect the results.”

The new guidelines outline four scenarios for premenopausal women who should be tested. These include women who have been on prednisone therapy, those who have had premature ovarian failure, those who have diseases/conditions associated with bone loss and those who have had fragility fractures.

Children’s diagnosis

Children are also being overdiagnosed with osteoporosis, said Dr. Khan. She said T-scores are often inappropriately used in children, who should be matched to their age peers, not to the healthy,

adult population.

The panel also identified how to interpret bone density testing in children. “It’s very important to children that the bone density test be interpreted in the clinical context of the height and weight and the growth of the child. If the child is at the fifth percentile for height and weight and they’re

small for their age and their weight is also appropriately small for their age, their bone density is not going to be normal.”

The new guidelines recommend children only be tested if they have been on long-term glucocorticoid therapy, if they have chronic illness, prolonged immobilization or low-trauma, recurrent fractures.

The Canadian standards also outline indications for testing in men, which include conditions associated with bone loss such as hypogonadism or hyperparathyroidism. Testing is recommended also for men over age 65 years, men on glucocorticoid or prednisone therapy, those who’ve had vertebral fractures and those who have X-ray evidence of osteopenia.



Dr. Aliya Khan

The Medical Post

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