News

NICE advises against caesarean section on demand

Zosia Kmietowicz *London*

Pregnant women who request a caesarean section should not automatically get one if there are no medical reasons to support it, say new guidelines.

Instead they should be properly counselled about the merits and demerits of caesarean section and vaginal birth and how labour can be managed so that they can make a fully informed choice about the best care for themselves and their baby. If a doctor still thinks that a caesarean section is inappropriate then the request can be declined, but the woman should be referred to another doctor.

The new guidelines, published by the National Collaborating Centre for Women's and Children's Health for the National Institute for Clinical Excellence, outline the possible benefits and risks of caesarean section on the basis of available research.

They also suggest how rates of caesarean section can be reduced—for example, by introducing fetal blood sampling alongside more standard tests, such as fetal heart monitoring, or by using external cephalic version at 36 weeks' gestation for women with a breech presentation.

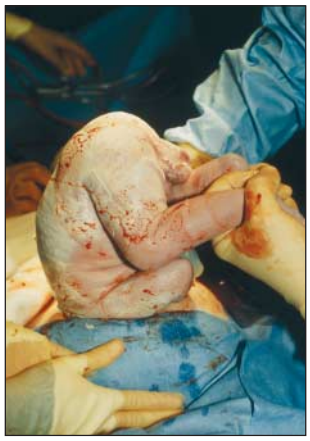
The rate of caesarean sections has been climbing for the past 25 years, and many people with an interest in obstetrics feel it is too high.

Figures from the national sentinel caesarean section audit carried out for 2001 show that 21.5% of pregnant women in England and Wales had a caesarean section, although the rates varied—from 18% to 25%—around both countries. Of those women who did have a caesarean section, 7% (representing 1.5% of all births) were the result of the mother's request.

Professor David James, professor of fetomaternal medicine and director of medical education at Queen's Medical Centre in Nottingham, estimates that 10% of indications for caesarean section are invalid. Since 2001, his unit has reduced its rate of caesarean deliveries from 29% to 21-22%. It has done this by reducing the incidence of unnecessary induction of labour, moving from a two hourly to four hourly review of progress during labour, and encouraging women who have had a previous caesarean to opt for a vaginal birth.

"There is no doubt that a smaller number of women having vaginal birth have complications than do those who have a caesarean section, but there are risks associated with both types of birth. If there was clear evidence that one way was better than another we would not need a guideline," said Professor James. □

The guidelines can be accessed at www.rcog.org.uk or www.nice.org.uk



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Seven per cent of caesarean sections in 2001 were the result of the mother's request

Hepatitis C carriers must be found and treated to avert crisis

Paul Stephenson *London*

Considerable extra resources to improve detection and treatment rates for hepatitis C are urgently needed to avoid a public health crisis that could overwhelm liver units, says new guidance from the Royal College of Physicians of Edinburgh.

It calls for high priority to be given to finding cases among former injecting drug users, for the development of new, community based and specialist nurse led services, and for broader access to treatment.

The guidance also says it is no longer essential to carry out a liver biopsy to determine the selection of patients.

The hepatitis C virus is thought to have infected up to 600 000 people in the United Kingdom and up to 200 million worldwide. It is estimated that up to a fifth of carriers of the hepatitis C virus could develop cirrhosis and need liver transplantation.

Consultant gastroenterologist Professor Peter Hayes from the Royal College of Physicians of Edinburgh said it was certain that "if we do not invest adequately now, we will not be able to afford the consequences of failing to tackle this epidemic."

He said services had to be redesigned, that clinics had to improve their attendance rates (as non-attendance was around 50%), and that measures such as treatment in prisons needed to be examined.

The guidance says a new, community focused model of care is needed, using outreach nurse led clinics in primary care, prisons, and drug treatment services. It also says healthcare workers need training and GPs need clear guidelines about suitability for referral.

Charles Gore, chief executive of the national charity Hepatitis C Trust, said the guidance was very welcome and that public awareness was key to increasing detection rates. He said: "We are very aware that huge numbers are not yet diagnosed. One of the key things we want to do is identify people. You can't afford to ignore this. Managing end stage liver disease is so expensive and so labour intensive.

"Managed clinical networks are a key point, and patient groups are saying this is what we need. You can really change your life expectancy by looking after yourself, and that doesn't cost much, except setting up support networks."

The primary aim of treatment for hepatitis C is viral clearance. A sustained viral response is defined as the absence of hepatitis C virus RNA in serum 24 weeks after the end of treatment.

Combination therapy with pegylated interferon alfa and ribavirin is recommended for all patients suitable for treatment. Patients with genotypes 1 and 4-6 should receive therapy for 48 weeks and genotypes 2 and 3 for 24 weeks. In genotype 1, quantitative polymerase chain reaction (a test of viral load) at 12 weeks will determine if patients continue therapy. □

The statement is accessible at www.rcpe.ac.uk/esd/consensus/hep_c_04.html

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