Appendices

Summary of Recommendations for the Safe Prevention of Primary Cesarean Delivery

Adapted from ACOG/SMFM Obstetric Care Consensus Statement (2014)

1 In the First Stage of Labor

- A prolonged latent phase of greater than 20 hours in nulliparas and 14 hours in multiparas is not an indication for cesarean delivery
- Slow but progressive labor is not an indication for cesarean delivery
- Before 6 cm dilation, standards of active labor progress should not be applied to nulliparous or multiparous patients
- Patients who undergo cesarean delivery for active phase arrest in the first stage of labor should be at or beyond 6 cm dilation WITH ruptured membranes AND:
  - 4 hours of adequate contractions without cervical change, OR
  - At least 6 hours of oxytocin with inadequate contractions and no cervical change

2 In the Second Stage of Labor

- An absolute maximum length of time for the 2nd stage has not been identified
- As long as maternal and fetal condition permits, the diagnosis of arrest of the labor in the 2nd stage should not be made prior to:
  - At least 2 hours of pushing for multiparous patients
  - At least 3 hours of pushing in nulliparous patients (longer durations may be appropriate on an individualized basis, for example with epidural anesthesia or fetal malposition as long as progress is documented)
- Operative vaginal delivery by an experienced, well-trained physician is a safe and reasonable alternative to cesarean delivery
- Manual rotation of the fetal occiput of the malpositioned fetus in the 2nd stage of labor is a reasonable intervention to consider before operative vaginal delivery or cesarean delivery. Furthermore, assessment of fetal position in the 2nd stage of labor is essential, especially when abnormal descent is noted

3 Fetal Surveillance

- Amnioinfusion is recommended as a safe intervention for repetitive variable decelerations and may reduce the rate of cesarean
- Scalp stimulation can be used to assess fetal acid-base status in the presence of an abnormal or indeterminate fetal tracing e.g. minimal variability

4 Induction of Labor

- Induction of labor before 41 0/7 weeks of pregnancy should be performed if medical indications for the patient or fetus are present. Inductions at 41 0/7 weeks and beyond should be performed to reduce the risk of cesarean delivery
- When a woman with an unfavorable cervix must be induced, cervical ripening methods should be used
- If maternal and fetal status permit, a longer latent phase should be allowed in patients undergoing induction of labor (24 hours or longer) and oxytocin should be administered for at least 12-18 hours after rupture of membranes before a failed induction is diagnosed

5 Fetal Malpresentation

- Fetal presentation should be assessed and documented at 36 0/7 weeks. External cephalic version should be offered to patients with a noncephalic-presenting fetus

6 Suspected Macrosomia

- Patients should be counseled that estimates of fetal weight at term gestation are imprecise. Cesarean delivery for suspected macrosomia should be limited to estimated fetal weights of:
  - At least 5000g in non-diabetic women
  - At least 4500g in diabetic women

7 Excessive Maternal Weight Gain

- Women should be counseled on the IOM maternal weight guidelines in order to avoid excessive weight gain

8 Twin Gestations

- Women with cephalic/cephalic-presenting twins or cephalic/noncephalic-presenting twins should be counseled to attempt vaginal delivery

9 Other

- Stakeholders (individuals, providers, policy makers) should work together to ensure research is conducted to further guide decisions regarding cesarean delivery and encourage policies that safely reduce the rate of primary cesarean delivery