Reclassification of Category 1-Caesarean Section

Dear Editor,

The obstetric units in UK and Ireland use RCOG; Good Practice Guideline No 11 ''Classification of urgency of Caesarean section –A continuum of risk''[1] to establish the timeline for the urgency of the operation which ultimately helps in clear communication among the multidisciplinary team involved; avoiding any delays or confusion.

However there may be a need to re-classify Category 1 caesarean section guidance to provide more robust and clear guidance to all the multidisciplinary team staff involved in labouring women. It will provide more clarity in terms of urgency as when to deliver within 15 minutes as opposed to 30 minutes. In the proposed classification; Category 1A can be specified for acute hypoxic cases where decision to delivery time required is 15min; like prolonged bradycardia or deceleration not recovering @6minute, placental abruption, suspected uterine rupture and cord prolapse with Bradycardia on CTG. Category 1B can be specified where decision to delivery time required is 30 minutes. This may include case of cord prolapse in the absence of bradycardia. Also, in the cases of sub-acute hypoxia with decelerations on CTG lower than 80 bpm with duration two to three times greater than the time spent by the foetus on the baseline or variable – late decelerations which are repetitive with tachycardia and marked reduction or no baseline variability (all three features being abnormal) then it need to be considered as category 1B in the absence of FBS. These patterns of sub-acute hypoxia are not described in NICE guideline CG55. Secondly, Category 1A may qualify for operation under general anaesthesia whereas Category 1B may be safely done under regional anaesthesia.

This classification may provide an extra guidance to junior doctors while making decisions in difficult CTG interpretation scenarios. Clinicians must be aware that it's not always possible to follow one specific protocol since trace-to-trace variations exist, and also while interpreting CTG; taking into account parity, cervical dilatation, rate of progress and other clinical features of meconium, temperature, IUGR. Hence, this is an effort and a proposition not to completely replace the RCOG Good Practice Guideline 11, but to assist and provide a robust tool to junior doctors on labour wards in decision making. However, further opinion and consensus among obstetricians in individual units will be required before implementation.

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Reference

1: RCOG Classification of urgency of Caesarean Section – A continuum of risk. Good Practice Guidance No 11. London. April 2010. [https://www.rcog.org.uk/globalassets/documents/guidelines/goodpractice11classificationofurgency.pdf]