Percentage of all live births to women with no indicated risk factors* and associated rate of primary caesarean delivery,† United States, 1991-2001, and percentage change 1991-2001

Age (years) and parity	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	Percentage change between 1991 and 2001
All ages and parities	46.3	45.5	45.2	44.6	44.4	43.5	42.6	42.1	42.1	41.9	41.8	-10
Primary caesarean rates: all parities												
All ages	3.3	3.3	3.4	3.4	3.6	3.7	3.9	4.1	4.4	4.9	5.5	67
<20	3.0	3.1	3.1	3.2	3.3	3.3	3.5	3.7	4.0	4.5	5.1	70
20-24	3.0	3.0	3.0	3.1	3.1	3.2	3.4	3.4	3.8	4.2	4.7	57
25-29	3.3	3.3	3.3	3.3	3.4	3.5	3.7	3.9	4.2	4.8	5.1	55
30-34	3.5	3.4	3.5	3.6	3.8	3.9	4.2	4.4	4.8	5.3	5.9	69
35-39	4.3	4.5	4.6	4.6	4.8	4.9	5.3	5.6	5.9	6.6	7.4	72
≥40‡	6.1	6.2	6.5	6.8	7.0	6.8	7.4	7.9	8.2	9.7	10.2	67
Primiparous women												
All ages	5.6	5.7	5.6	5.7	5.8	6.1	6.3	6.7	7.1	8.0	8.9	59
<20	3.6	3.7	3.6	3.7	3.8	3.9	4.0	4.3	4.6	5.2	5.9	64
20-24	4.9	5.0	4.9	4.9	5.0	5.3	5.5	5.6	6.1	6.8	7.7	57
25-29	6.3	6.4	6.3	6.3	6.3	6.7	6.8	7.4	7.7	8.9	9.6	52
30-34	8.6	8.2	8.2	8.4	8.7	8.9	9.3	9.6	10.4	11.2	12.3	43
35-39	12.4	13.4	13.2	13.1	13.4	13.4	13.5	14.6	15.6	16.8	18.5	49
≥40‡	18.2	17.6	19.5	18.3	19.7	18.2	19.7	21.1	21.9	25.1	25.7	41
Multiparous women												
All ages	2.1	2.1	2.1	2.1	2.2	2.3	2.5	2.6	2.8	3.2	3.5	67
<20	1.7	1.7	1.8	1.8	1.9	1.9	1.9	2.1	2.3	2.5	2.8	65
20-24	1.7	1.7	1.8	1.8	1.7	1.8	1.9	2.0	2.2	2.4	2.7	59
25-29	1.9	2.0	1.9	2.0	2.0	2.1	2.2	2.3	2.6	2.9	3.0	58
30-34	2.3	2.2	2.3	2.2	2.4	2.5	2.6	2.8	3.1	3.4	3.8	65
35-39	3.0	3.0	3.1	3.0	3.2	3.3	3.6	3.8	3.9	4.5	5.1	70
≥40‡	4.5	4.7	4.6	5.1	4.9	5.0	5.4	5.7	5.9	7.0	7.5	67

Source: Natality Data Sets, 1991-2001. National Center for Health Statistics.

*Proportion of women with full term, vertex, singletons with birth weight <4000 g with no reported medical risk factors or complications of labour and delivery.

†Number of primary caesareans per 100 live births to women who have not had a previous caesarean.

‡Beginning in 1997, data are for women aged 40-54 years.

Comment

The proportion of no indicated risk primary caesareans is growing rapidly in the United States, adding to the overall rise in primary caesareans. The major limitation of this study is the quality of reporting of items on the US birth certificate.¹ However, we would expect that “defensive medicine” would encourage the reporting of a risk factor associated with the resulting caesarean. Also, in the trend analysis there is no inherent reason to expect a bias that would cause a shift in the measurement of these variables at different time periods. It would also be inappropriate to equate no indicated risk caesareans with “patient choice” caesareans, as birth certificate data provide no record of the mother’s intent.

Although some recent editorials have suggested that vaginal births carry risks comparable to caesarean births,² health problems associated with caesareans have been amply documented.³ All of these risks may be easily outweighed by the potential benefits to a mother or infant with a condition that could have been avoided by a timely caesarean, but what if the caesarean was done without a medical indication? In the case of no indicated risk primary caesareans, particularly for younger mothers who plan to have more children and may be denied a vaginal birth after a caesarean,⁴ additional research is needed to elucidate whether the risks of a no indicated risk primary caesarean will be offset by associated benefits.

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Endpiece

The distresses of the indigent

When I consider the distresses of the indigent, I rather admire that the instances of their misconduct should be so rare: when they behold the affluence, ease, and indulgence of their superiors, when, in spite of their utmost industry, they can with difficulty support their families, and when sickness and disappointments supervene, it is not to be wondered at, if some expressions of discontent should break forth among them.

Lettsom JC.

The improvement of medicine in London on the basis of public good. 2nd ed. London: T Phillips, 1775:22

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