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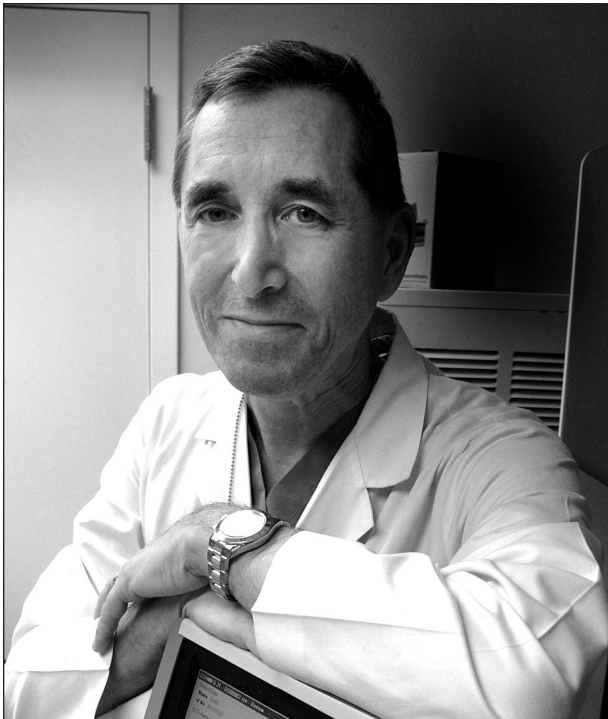
*The Journal of
Reproductive Medicine[®]*

Volume 63, No. 11-12/November-December 2018

A Note from the Editor-in-Chief

Lawrence D. Devoe, M.D.

Welcome to the November-December 2018 Editor-in-Chief's page. This editorial column will address an important clinical problem raised in one of the articles published in the current issue.



Lawrence D. Devoe, M.D., Editor-in-Chief

In This Issue

- *Clinical Variance of the Nulliparous, Term, Singleton, and Vertex-Presenting Metric*
E. M. Levine, M. Dennis, Y. Plata, and S. Locher

This is a 7-year retrospective single institutional study intended to evaluate the now often-used metric of nulliparous, term, singleton, vertex-presenting (NTSV) to designate pregnancies at low risk for cesarean delivery. NTSV has been considered as a method of comparing cesarean delivery rates both across institutions and individual providers. The authors take issue with this metric as it usually includes patients at high and low risk for a first cesarean delivery. In their study population of 6,146 nulliparas meeting the additional criteria of NTSV, nearly one-third had significant medical or obstetric complicating factors that would have placed them at high risk for cesarean delivery. Since they found a significant difference in cesarean delivery rates according to group stratification, they conclude that NTSV may not be the most appropriate identifier for comparison of interinstitutional cesarean delivery rates.

Editorial Comment

There has been a concerted effort to stem the rising tide of primary cesarean delivery in the

United States for more than 2 decades, and one most recently revisited in a 2014 Obstetric Care Consensus monograph produced by the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine. Among the numerous findings in this report was the considerable variation in cesarean delivery rates among states, hospitals, and populations of low-risk women. While such observed variations cannot be easily explained, as many factors may play roles in the decision for primary cesarean delivery, a starting point to determine optimum rates for this procedure is focusing on specific obstetric groups, such as the authors have done for nulliparous women presenting with single, term, vertex fetuses. Although the NTSV metric was developed for such a purpose, they rightfully point out that this does not account for the varying levels of risk that may exist within such a population, and, therefore, direct comparisons of cesarean delivery rates without considering other risk factors may not be appropriate across institutions.

Alternative approaches to evaluating national and international cesarean delivery rates include the Robson 10-group classification model,¹ which has already been adopted and/or modified for

this purpose by a number of countries. It should be noted that the NTSV category is included in 2 of the groups in this scheme, distinguished by whether labor was spontaneous or induced or cesarean delivery was performed before the onset of either spontaneous or induced labor. It should be recognized that simply classifying groups of patients on the basis of parity, gestational age, fetal number, or presentation is a broad-brush approach to getting a handle on how frequently cesarean delivery should be performed. Two decades ago ACOG weighed in on this issue and cited an ideal rate for primary cesarean delivery in nulliparous patients that is actually approximately half of what it is today. Such efforts should encourage practitioners to give more thought to how they should address parturition in truly low-risk patients. Levine and colleagues should be applauded for making us all think about whether it makes sense to use simplistic categorizations that blur the contributions of medical and obstetric risk factors to delivery mode decisions.

Reference

1. Robson M: Classification of caesarean sections. *Fetal Matern Med Rev* 2001;12:23-39