Letters

A balanced perspective on intervention at full dilation

The recently published article by Muraca and colleagues[1] highlights some key aspects of discussion and counselling around assisted vaginal birth. However, we have concerns regarding the study methodology and conclusions, which do not align with the reality and complexities of clinical intrapartum care.

Validation of the data set used by Muraca and colleagues includes only small-scale, noncontemporaneous, province-specific studies. The individual components included within the composite maternal trauma outcome are missing published, objective indicators of maternal trauma, including postpartum hemorrhage, requirement for blood transfusion and intensive care admission, which reflect true maternal morbidity.[2] The conclusions drawn by the authors stem from their findings of increased rates of third-degree perineal lacerations. However, we reject the notion that the most common type of laceration, a 3A tear (which involves disruption of the superficial fibres of the external anal sphincter), should be aggregated with the less common, but potentially disabling, disruption of both the external and internal anal sphincters (3C tear) or of the entire anal sphincter complex (fourth-degree tear), which have significantly different short- and long-term outcomes.[3] Defining terms and using appropriate composite indicators are of critical importance when using large, population-based, retrospective methods to evaluate specialized and nuanced clinical scenarios.

The specific clinical situations that are optimally suited to a vacuum-assisted birth, forceps-assisted birth or second-stage cesarean delivery are inherently different, and these modes of delivery are not readily interchangeable. The true comparator to morbidity from assisted vaginal birth is morbidity from cesarean delivery at full dilation; complications can include substantial maternal and fetal trauma.[4] These complications should also include discussion of future pregnancy risks, including preterm birth, increased perinatal death from prematurity, and placenta accreta spectrum disorders with subsequent loss of fertility. The article's exclusion of a balanced perspective, with selective choice of language and data, may be read as a polemic against assisted vaginal birth, rather than a neutral representation of a complex issue.

Obstetricians appreciate that when spontaneous vaginal delivery is not possible, patients, their families and the care team must come together to make a challenging decision to achieve the best possible outcome. Assisted vaginal births certainly have risks, and these need to be comprehensively discussed with the patient to obtain informed consent; however, the risks of the alternative, a cesarean delivery at full dilation, should also be discussed. All individuals involved in the provision and audit of assisted vaginal birth must be vigilant in checking any potential biases at the door to achieve a balanced and fulsome discussion with patients who are facing an expedited delivery at full dilation.

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