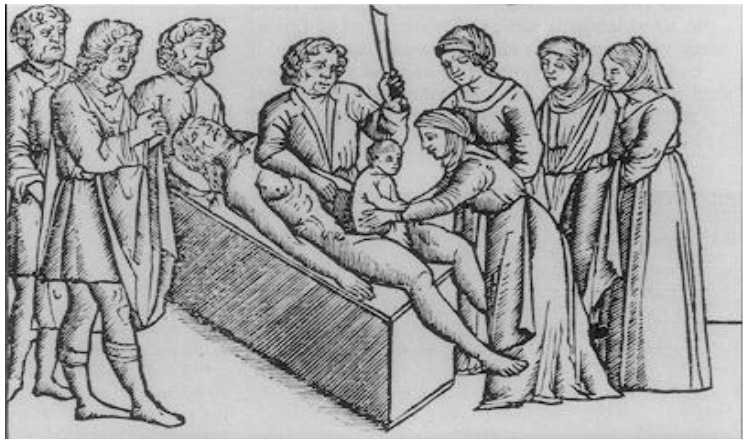
Sezaryen veya Normal doğum

Üriner inkontinans?



Prof. Dr. Fuat AKERCAN

Ege Üniversitesi Tıp Fakültesi

Kadın Hastalıkları ve Doğum AD

Maternal Sonuçlar
Mortalite / Morbidite

Erken Sonuçlar

- 1. Mortalite
- 2. Enfeksiyon
- 3. Anestezi
- 4. Kanama / Kan Transfüzyonu
- 5. Histerektomi
- 6. Tromboemboli
- 7. Cerrahi komplikasyon
- 8. Yoğun bakım gereksinimi
- 9. Yara yeri problemleri
- 10. Laktasyon
- 11. Ağrı
- 12. Psikolojik sorunlar
- 13. Hastaneye tekrar yatış
- 14. Hastanede kalış süresi
- 15. Annenin normal hayata geçişi

Geç Sonuçlar

- 1. Üriner fonksiyon
- 2. Anorektal fonksiyon
- 3. Pelvik organ prolapsusu
- 4. Seksüel fonksiyon
- 5. Endometriosis
- 6. Pelvik ağrı
- 7. Üreme potansiyeli
- 8. Ektopik gebelik riski
- 9. Uterin rüptür riski
- 11. İUMF/ Ölü doğum riski
- 12. Psikolojik sorunlar
- 13. Geç dönem cerrahi gereksinimi
- 14. Fistül

National Collaborating Centre for Women's and Children's Health

Commissioned by the National Institute for Clinical Excellence

Effects around the time of birth	Absolute risk (%) CS	Absolute risk (%) Vaginal birth	Relative Risk (95% CI) CS compared with vaginal birth
Reduced after a planned CS			
Perineal pain	2	5	0.3 (0.2, 0.6)
Increased after a planned CS			
Abdominal pain	9	5	1.9 (1.3, 2.8)
Bladder injury[a]	0.1	0.003	36.6 (10.4, 128.4)
Ureteric injury[a]	0.03	0.001	25.2 (2.6, 243.5)
Need for further surgery such as laparotomy or dilatation and curettage[a]	0.5	0.03	17.5 (9.4, 32.1)
Hysterectomy[a,b]	0.8	0.01	95.5 (67.7, 136.9)
	0.7	0.02	44.0 (22.5, 85.8)
Admission to Intensive Care Unit[a]	0.9	0.1	9.0 (7.2, 11.2)
Thromboembolic disease[b]	Overall risk 0.04–0.16		3.8 (2.0, 4.9)
Longer length of hospital stay[c]	3–4 days	1–2 days	
Readmission to hospital[a]	5.3	2.2	2.5 (1.1, 5.4)
Maternal death[a]	82.3 per million	16.9 per million	4.9 (3.0, 8.0)

NICE, 2004

National Collaborating Centre for Women's and Children's Health

Commissioned by the National Institute for Clinical Excellence

Effects around the time of birth	Absolute risk (%) CS	Absolute risk (%) Vaginal birth	Relative Risk (95% CI) CS compared with vaginal birth
Not different			
Haemorrhage[4] (blood loss in excess of 1000mls)	0.5	0.7	0.8 (0.4, 4.4)
Infection[4] (wound infection or endometritis)	6.4	4.9	1.3 (1.0, 1.7)
Genital tract injury (extension of uterine incision, cervical laceration)	0.6	0.8	1.2 (0.4, 3.4)

NICE, 2004

National Collaborating Centre for Women's and Children's Health

Commissioned by the National Institute for Clinical Excellence

Effects around the time of birth	Absolute risk (%) CS	Vaginal birth	Relative Risk (95% CI) CS compared with vaginal birth
Long term effects			
Reduced after a planned CS			
Urinary incontinence (at 3 months after birth)	4.5	7.3	0.6 (0.4, 0.9)
Utero-vaginal prolapse[a]	Overall prevalence 5		0.6 (0.5, 0.9)
Not different (at 3 months after birth)			
Faecal incontinence	0.8	1.5	0.5 (0.2, 1.6)
Back pain	11.3	12.2	0.9 (0.7, 1.2)
Post natal depression	10.1	10.8	0.9 (0.7, 1.2)
Dyspareunia	17.0	18.7	0.9 (0.7, 1.1)
Implications for future pregnancies			
Increased after CS			
Having no more children[a]	42	29	1.5 (1.1, 2.0)
Placenta praevia in a future pregnancy[b]	0.7	0.5	1.4 (1.1, 1.6)
	0.8	0.5	1.6 (1.3, 2.0)
	0.4	0.2	1.3 (1.0, 1.7)
Uterine rupture in a future pregnancy[a]	0.4	0.01	42.2 (31.1, 57.2)
Antepartum Stillbirth in a future pregnancy[a]	0.4	0.2	1.6 (1.2, 2.3)

NICE, 2004

Author, Year Relevance/Quality Rating	Measure	Outcomes for Comparison Groups						Statistical Test Results
Hannah et al., 2000[20] T/Fair		Planned CD	Planned VD					
	Wound infection	1.5%	1.0%					$P = 0.32$
	Maternal systemic infection	1.5%	1.3%					$P = 0.71$
Burrows et al., 2004[39] Moderate/Fair		Primary Prelabor CD	Repeat Prelabor CD	Primary Labored CD	Repeat Labored CD	SVD (ref grp)	Operative VD	
	Endometritis	3.0%	2.7%	9.4%	4.6%	0.4%	0.7%	Significantly different for all other than operative VD
	Adj OR (95% CI)	10.3 (5.9; 17.9)	9.9 (5.8; 16.9)	21.2 (15.4; 29.1)	14.6 (9.2; 23.1)	1.0	0.9 (0.6; 1.5)	

Author, Year Relevance/Quality Rating	Measure	Outcomes for Comparison Groups						Statistical Test Results
Hannah et al., 2000[20] T/Fair		Planned CD	Planned VD					
	Deep vein thrombophlebitis or pulmonary embolism	0	0					NR
Leiberman et al., 1995[84] T/Fair		Planned CD (ref grp)	Planned VD					
	Combined measure of maternal morbidity (includes febrile morbidity, endometritis, wound infection, UTI and thrombophlebitis)	31.0%	17.8%					*P* = 0.01
	OR (95% CI)	1.0	0.48 (0.25; 0.89)					
Burrows et al., 2004[39] Moderate/Fair		Primary Prelabor CD	Repeat Prelabor CD	Primary Labored CD	Repeat Labored CD	SVD (ref grp)	Operative VD	
	Deep vein thrombosis	0.2%	0	0.3%	0.1%	0.1%	0.04%	Signficantly different for primary labored CD
	Adj OR (95% CI)	2.3 (0.3; 17.8)	NA	3.9 (1.7; 8.9)	1.9 (0.2; 14.2)	1.0	0.5 (0.1; 2.2)	

Author, Year Relevance/ Quality Rating	Measure	Outcomes for Comparison Groups		Statistical Test Results
Hannah et al., 2000[20] T/Fair		Planned CD	Planned VD	
	Genital tract injury: vertical uterine incision, serious extension to transverse uterine incision, cervical laceration extending to lower uterine segment, vulvar/perineal hematoma requiring evacuation.	0.6%	0.6%	*P* = 1.0
	Note: There were no genital tract fistula, bowel obstructions, injury to bladder, ureter or bowel.			

Sezaryen Doğum sonrası Gebeliklerde Riskler

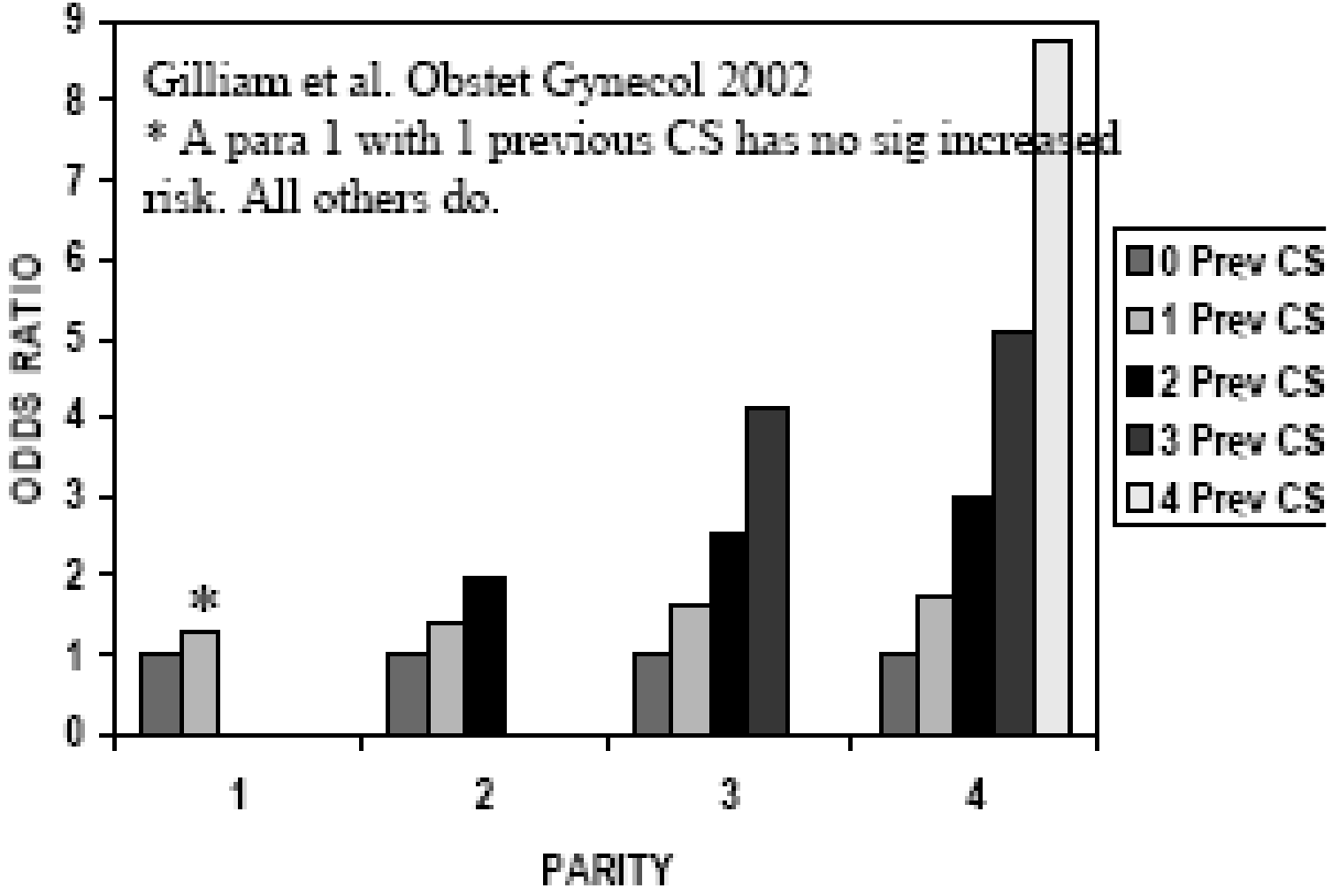
- Plasenta previa: 1.6-2.6
- Plasenta accreta:
  - % 24 - 38 / % 4.5 (skar yok)
  - 1 / 19,000 (1960-70) , 1/533 (2005)
- Ablasyo plasenta, %50
- İUMF ve ölü doğum riskinde artma
- Uterin rüptür, 90 kat fazla

Sezaryen Doğum
Plasenta Previa ile birlikte Plasenta Accreta

Number of previous c/sections	Total number of patients $n = 97\,799$	Number with placenta praevia $n = 286$ (% of total)	Number with placenta accreta $n = 29$ (% of total)	Proportion of placenta praevias with placenta accreta
0	92 917	238 (0.26)	12 (0.01)	5%
1	3820	25 (0.65)	6 (0.16)	24%
2	850	15 (1.8)	7 (0.82)	47%
3	183	5 (3.0)	2 (1.09)	40%
⩾4	29	3 (10.0)	2 (6.9)	67%
Overall	97 799	286 (0.29)	29 (0.03)	10%

[a] Adapted from Clark et al (1985, *Obstetrics and Gynecology* **66**: 89–92).

Parity, Previous Cesarean, and Placenta Previa



FETAL MORTALİTE

- **Fetal mortalite:**
  - **DSÖ 'ün Latin Amerika Çalışması**
  - **SpVagD < S/C (p=0,007)**

Lancet, 9525- 2006; 1819-29

- **Neonatal mortalite:**
  - **SpVagD : 1 / 10,000**
    - **Vakum: 3/ 10,000**
    - **Forseps: 5/ 10,000**
    - **Vakum + forseps: 6/10,000**
    - **SpVagD vs Vakum (OR= 1.5; 95% CI, 0.8-2.8) NS**
    - **SpVagD vs Forseps (OR=1.9; 95% CI, 0.60- 5.4) NS**
    - **SpVagD vs Vakum + Forseps (OR = 2.6; 95% CI, 0.4- 5.4) NS**
  - **S/C: 8 /10,000**
  - **SpVagD < S/C (OR = 3.7; 95% CI, 2.6-5.4) !! p < 0,05**

  - **Ancak, altta yatan maternal ve fetal koşullar ?**

Evidence Report
Agency for Healthcare Research and Quality,
U.S. Department of Health and Human Services, Mart 2006

SOLUNUMSAL PROBLEMLER

- **YENİDOĞANIN GEÇİCİ TAKİPNESİ:**
  - Elektif S/C $_{(\% 0,93)}$ = SpVagD $_{(\%0,85)}$ (p> 0,05)

    Zanardo et al. 2004

  - Elektif S/C $_{(\%1,42)}$ > **SpVagD**$_{(\% 0,51)}$ (OR: 1,86 % 95 CI: 1,48- 2,33)

    Dani et al. 1998
  - Elektif S/C $_{(\%3,10)}$ > **SpVagD**$_{(\%1,10)}$ (OR: 2,8 % 95 CI: 2,1- 3,8)

    Levine et al. 2001
  - Elektif S/C $_{(\% 1,54)}$ > **SpVagD**$_{(\%0,51)}$ (p< 0,05)

    Yalaz M ve ark. EÜTF, 2003

  - Eylemsiz S/C $_{(\%2,26)}$ > **SpVagD**$_{(\%0,41)}$ (OR: 6,8 % 95 CI: 5,2- 8,9)

    Eylemli S/C $_{(\%0,84)}$ > **SpVagD**$_{(\%0,41)}$ (OR: 2,38 % 95 CI: 1,6- 2,5)

    Morrison et al. 1995

SOLUNUMSAL PROBLEMLER

- **RESPİRATUAR DİSTRES SENDROMU:**
  - Elektif S/C $_{(\%1,43)}$ > **SpVagD**$_{(\%\ 0,49)}$ (OR: 1,88 % 95 CI: 1,42- 2,48)

    Dani et al. 1998
  - Elektif S/C $_{(\%0,20)}$ > **SpVagD**$_{(\%0,16)}$ (OR: 3,0 % 95 CI: 1,6- 5,3)

    Levine et al. 2001
  - Elektif S/C $_{(\%\ 2,26)}$ > **SpVagD**$_{(\%0,39)}$ (p< 0,01)

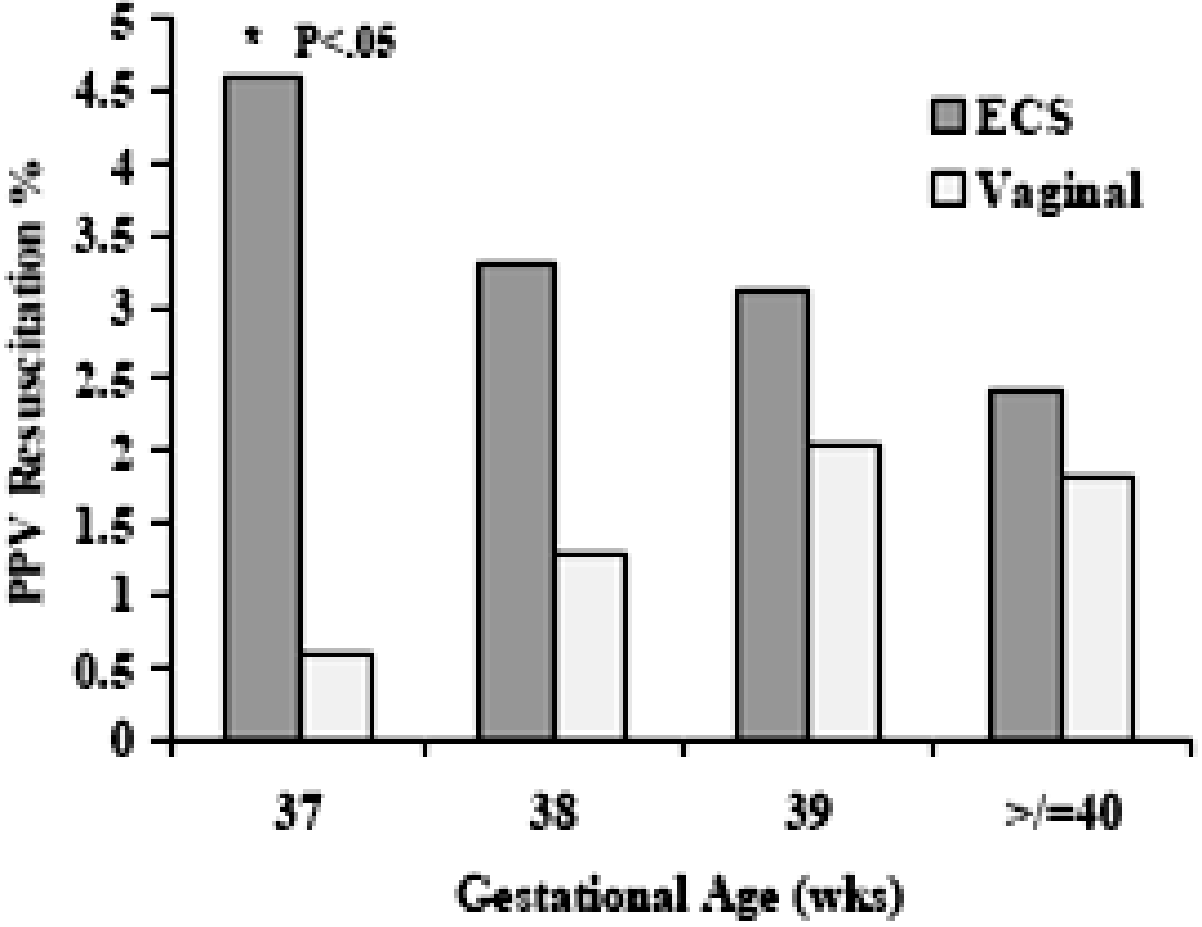
    Zanardo et al. 2004

  - Eylemsiz S/C $_{(\%,1,28)}$ > **SpVagD**$_{(\%0,11)}$ (OR: 6,8 % 95 CI: 5,2- 8,9)
    Eylemli S/C $_{(\%0,38)}$ > **SpVagD**$_{(\%0,11)}$ (OR: 2,38 % 95 CI: 1,6- 2,5)

    Morrison et al. 1995
- **PRİMER PULMONER HİPERTANSİYON:**
  - Elektif S/C $_{(\%0,37)}$ > **SpVagD**$_{(\%0,08)}$ (OR: 4,6 % 95 CI: 1,3- 6,1)

    Levine et al. 2001

Elektif Sezaryen Doğum ve Neonatal Resisutasyon Riski



Zonardo, Pediatric Critical CareMed, 2004

DOĞUM TRAVMALARI

- **İntrakranial kanamalar**
  - S/C ile **SpVagD** arasında anlamlı fark yok

Evidence Report

Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, Mart 2006

  - S/C ile **SpVagD** arasında anlamlı fark yok

Kolas T et al.

Planned cesarean versus planned vaginal delivery at term: Comparison of newborn infant outcomes

Am J Obstet Gynecol, 2006

  - Subdural hemoraji $\Rightarrow$ S/C $_{(6,7/10.000)}$ > NSpD $_{(2,9/10.000)}$

    İntraventriküler kanama $\Rightarrow$ S/C $_{(2,1/10.,000)}$ > NSpD $_{(1,1/10.000)}$

    Subaraknoid kanama $\Rightarrow$ **SpVagD** $_{(1,3/10.000)}$ > S/C $_{(0,9/10.000)}$

Towner et al.

Effect of mode of delivery in nulliparus women on neonatal intracranial injury

N Engl J Med 1999

DOĞUM TRAVMALARI

- **Fasial sinir hasarı**
  - S/C vs **SpVagD** arasında fark yok (OR = 1.5; % 95 CI, 0.8-2.6)
    - Ancak, forsepsle belirgin artış (OR = 13.6; % 95 CI, 10.0-18.4)
- **Brakial pleksus felci**
  - S/C $_{(4,1/10.000)}$ < NSpD $_{(7,7/10.000)}$ (OR = 0.5; % 95 CI, 0.3-1.0)
- **Fetal laserasyon**
  - Acil S/C da fazla (OR: 1,7)
  - Elektif S/C $_{(\% 0,8)}$ < 1. acil S/C $_{(\% 1,4)}$ < Sekonder acil S/C $_{(\%1,5)}$
- **Klavikula / Humerus kırıkları**
  - S/C vs **SpVagD** : arasında fark yok

Wax JR ,Obstet Gynecol Surv 2004
Evidence Report ,Mart 2006

1 Brakial pleksus hasarını engellemek için 333 SC gerekmektedir.

EMZİRME

- **Sosyal ve medikal bir çok faktör etkili**
- İlk saat içinde emzirme:
  - **SpVagD** : % 77,6 S/C: % 73,3 (p > 0,05)
- 3. ayda ve 1. yılda emzirme oranlarında fark yok

Evidence Report
Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services,
Mart 2006

- İlk saat içinde emzirme:
  - **SpVagD** : % 69.4 S/C: % 30.6 (p< 0,05)
  - Daha çok motivasyon gerekiyor

Çakmak H et al.
Comparison of the breastfeeding patterns of mothers who delivered their babies per vagina and via cesarean section: Int J Nurs Stud. 2006

- Doğum şekli vs ilk saat içinde emzirme (p < 0,001)
- Doğum şekli vs 6 ay emzirme (p< 0,001) (OR:1,34 % 95 CI: 1,18-1,52)

Ünsal H,
Toplumda anne sütü verme eğilimi ve buna etki eden faktörler
Çocuk Sağlığı ve Hast. Der. 2005

Pelvik Taban Disfonksiyonu

- Üriner inkontinans (UI)
- Pelvik organ prolapsusu (POP)
- Anal/faecal inkontinans

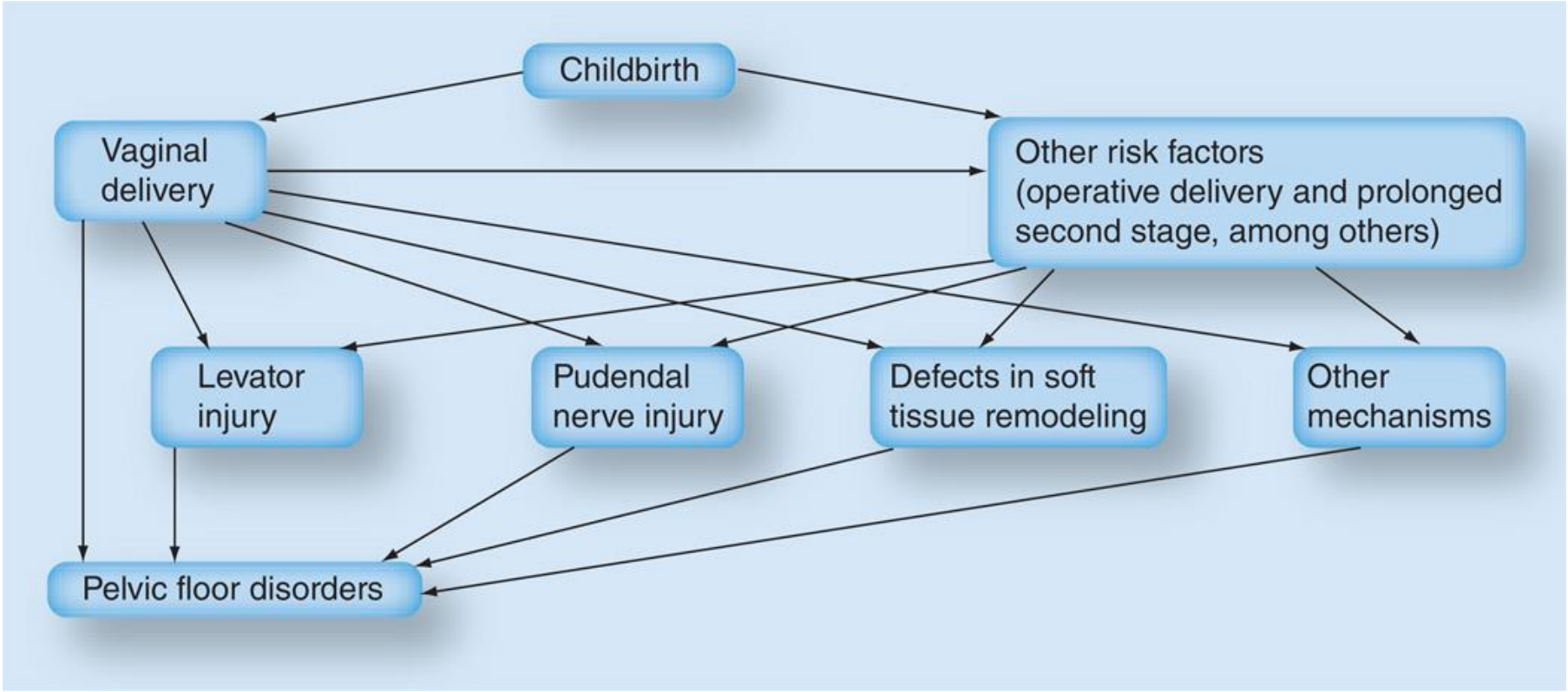
- Prevalans % 25, 80 yaş sonrası % 50
- Hayat kalitesine negatif etki
- Maliyet

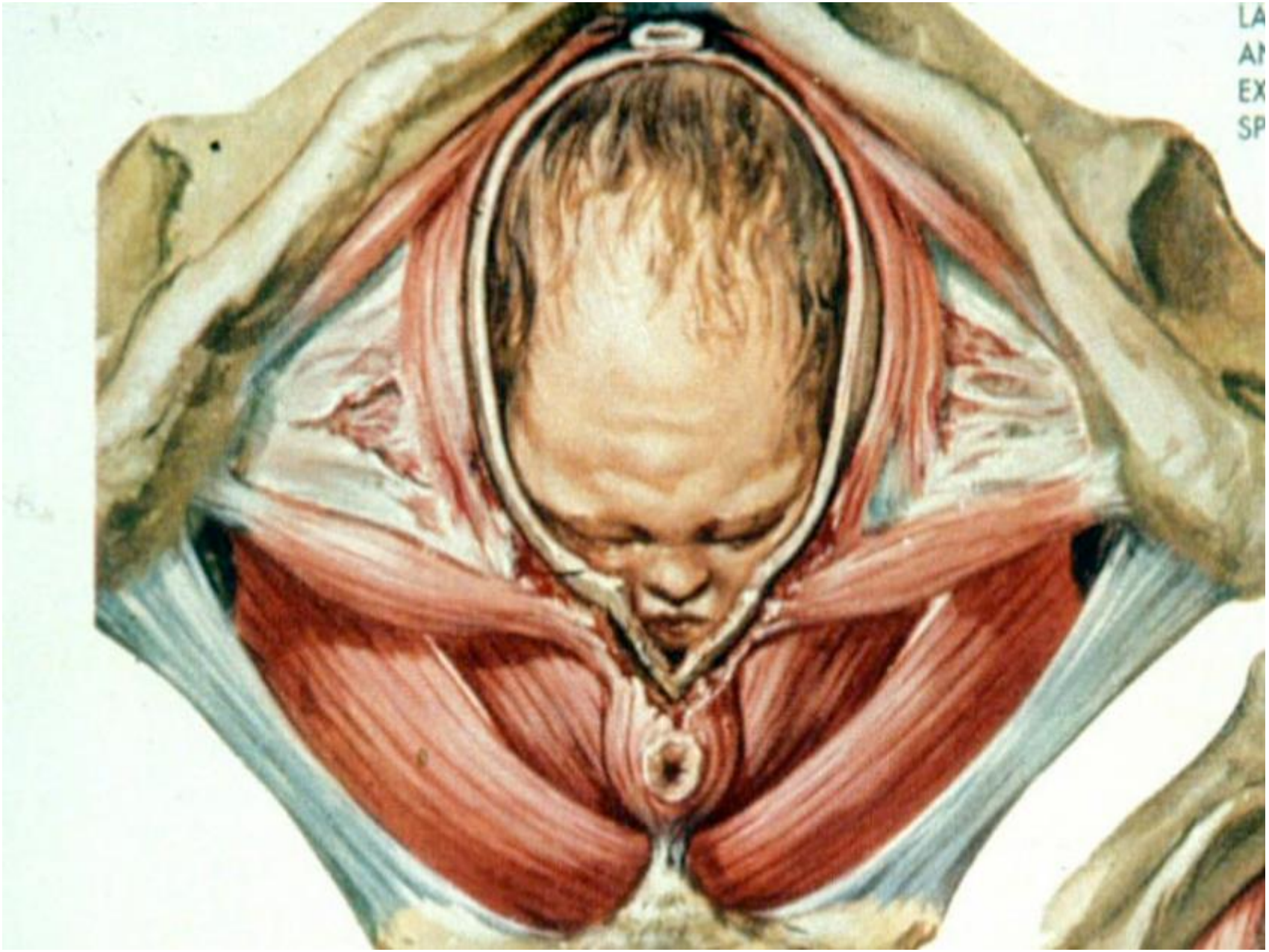
Pelvik Taban Disfonksiyonu

Önemli risk faktörleri

- Gebelik
- Doğum paremetreleri
- Doğum şekli
- Kilo
- Kalıtsal faktörler

Pelvik Taban Disfonksiyonu





Urinary Incontinence after Vaginal Delivery or Cesarean Section

Guri Rortveit, M.D., Anne Kjersti Daltveit, Ph.D., Yngvild S. Hannestad, M.D., and Steinar Hunskaar, M.D., Ph.D., for the Norwegian EPINCONT Study

N Engl J Med 2003;348:900-7.

Table 4. Odds Ratios for Incontinence According to Mode of Delivery.

Comparison	Any Incontinence	Moderate or Severe Incontinence	Stress Incontinence	Urge Incontinence	Mixed-Type Incontinence
	odds ratio (95 percent confidence interval)				
Cesarean sections as compared with no deliveries					
Univariable analysis	1.7 (1.3–2.1)	1.6 (1.1–2.3)	1.6 (1.1–2.2)	1.5 (0.9–2.8)	1.9 (1.3–2.8)
Age-adjusted analysis	1.5 (1.2–1.9)	1.4 (1.0–2.1)	1.4 (1.0–2.0)	1.4 (0.8–2.6)	1.7 (1.2–2.5)
Vaginal deliveries as compared with no deliveries					
Univariable analysis	2.8 (2.5–3.2)	3.3 (2.7–4.0)	3.7 (3.1–4.4)	1.4 (1.0–1.9)	2.6 (2.1–3.2)
Age-adjusted analysis	2.3 (2.0–2.6)	2.6 (2.1–3.1)	3.0 (2.5–3.5)	1.2 (0.9–1.6)	2.1 (1.7–2.6)
Vaginal deliveries as compared with cesarean sections					
Univariable analysis	1.7 (1.4–2.1)	2.1 (1.5–2.9)	2.3 (1.7–3.1)	0.9 (0.5–1.5)	1.4 (1.0–1.9)
Multivariable analysis*	1.7 (1.3–2.1)	2.2 (1.5–3.1)	2.4 (1.7–3.2)	0.9 (0.5–1.6)	1.3 (0.9–1.9)

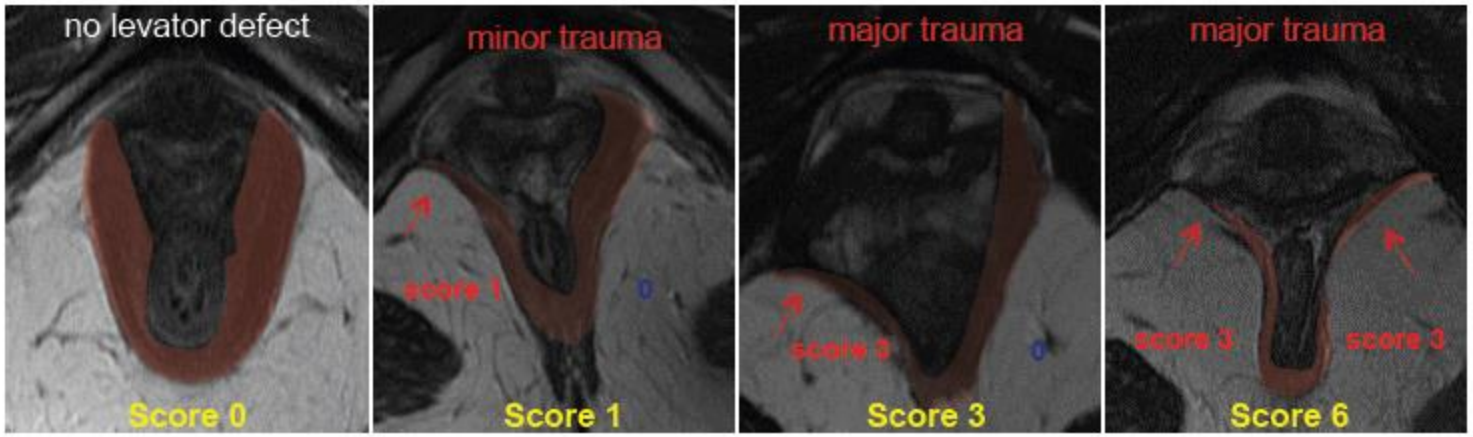
MRI Postpartum Levator ani hasarı

Spontan vaginal doğum sonrası %6-10

Vakum sonrası %17-33

Forceps sonrası %67-71

Kearney R, Fitzpatrick M, Brennan S, Behan M, Miller J, Keane D, O'Herlihy C, DeLancey JO. Int J Gynaecol Obstet. 2010



DeLancey JO et al. Obstet Gynecol 2003;209:295-302

Does cesarean section reduce postpartum urinary incontinence: a systematic review

JZ Press, MC Klein, J Kaczorowski, RM Liston, and P von Dadelszen.

Review published: 2007.

Authors' conclusions

Although Caesarean section can reduce the occurrence of postpartum stress UI, there were no differences by mode of birth for severe symptoms.

NIH Public Access
Author Manuscript
Curr Opin Obstet Gynecol. Author manuscript; available in PMC 2013 October 01.

Published in final edited form as:
Curr Opin Obstet Gynecol. 2012 October ; 24(5): 349–354. doi:10.1097/GCO.0b013e328357628b.

Pelvic floor disorders following vaginal or cesarean delivery

Hafsa Memon and **Victoria L. Handa**
Department of Gynecology and Obstetrics, Johns Hopkins School of Medicine, Baltimore, Maryland, USA

Abstract

Purpose of review—Pelvic floor disorders affect women of all ages and are associated with significant economic burden and poor quality of life. Current literature suggests an association between childbirth and these disorders. In this review, we summarize recent advancements in our understanding of this association.

Recent findings—Vaginal childbirth appears to be strongly associated with stress urinary incontinence and pelvic organ prolapse. There is less evidence to suggest an association between vaginal delivery and overactive bladder symptoms. History of more than one perineal laceration increases the likelihood of developing prolapse. Similar association has not been established for episiotomy. Disruption or denervation of structural components of pelvic floor support system, particularly levator ani muscle complex, is associated with later development of pelvic floor disorders. Imbalance in homeostasis of connective tissue remodeling of the vaginal wall from overstretching during childbirth is another possible mechanism.

Summary—Pelvic floor disorders represent a significant health problem affecting women of all ages. Identification of potential modifiable risk factors and advancement in understanding of the underlying pathophysiology is crucial for primary and secondary prevention of these disorders and for improvement in treatment strategies.

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Is there epidemiological evidence to support the prevention of urinary incontinence and other forms of pelvic floor dysfunction with Caesarean Section ?

- MacLennan et al. (BJOG 2000) could not demonstrate an increased risk for any type of UI after spontaneous VD, when compared with CS
- EPINCONT study (NEJM 2003) - community based cohort study (n = 15 307), VD vs. CS 1.7 (95% CI 1.3-2.1)
- McKinnie et al. (AMJOG 2005), a prospective multicenter study (n = 1004) no difference of risk for bothersome UI between women delivered by one or more VD compared to one or more CS OR 1.30 (0.77-3.95)
- Lukacz et al (Obst Gyn 2006) - VD vs. CS OR 1.81 (1.72-1.82)

Prevalence of urinary incontinence and urinary incontinence for more than 10 years according to mode of delivery

	VD %	CS %	OR (95% CI)
UI	40.3	28.8	1.67 (1.45-1.92)
UI>10 years	10.1	3.9	2.75 (2.02–3.75)

	Elective CS %	Acute CS %	OR (95% CI)
UI	27.1	24.4	1.15 (0.88-1.51)
UI>10 years	6.5	5.1	1.30 (0.79-2.14)

Adjusted for BMI-current, BMI at delivery, maternal age, gestational weeks, infant birth weight and head circumference.

Gyhagen et al. BJOG. 2013 Jan;120(2):144-51. The prevalence of urinary incontinence 20 years after childbirth: a national cohort study in singleton primiparae after vaginal or caesarean delivery.

Prevalence of urinary incontinence in relation to mode of delivery stratified for current BMI

Current BMI	VD %	CS %	OR (95% CI)
< 25 (normal)	35.6	24.7	1.68 (1.36-2.08)
25–29.9 (overweight)	42.4	28.1	1.88 (1.46-2.43)
≥ 30 (obese)	54.8	41.6	1.71 (1.27-2.29)

Adjusted for BMI-current, BMI at delivery, maternal age, gestational weeks, infant weight and head circumference. BMI stratified according to the WHO definition.

Gyhagen et al. BJOG. 2013 Jan;120(2):144-51. The prevalence of urinary incontinence 20 years after childbirth: a national cohort study in singleton primiparae after vaginal or caesarean delivery.

Prevalence of urinary incontinence in relation to mode of delivery stratified for infant birth weight

	VD %	CS %	OR (95% CI)
Birth weight g			
< 3000	37.4	35.5	1.08 (0.81–1.49)
3000–3499	39.1	27.3	1.71 (1.33–2.19)
3500–3999	41.3	27.6	1.85 (1.36–2.50)
4000–4499	41.3	25.3	2.08 (1.42–3.03)
≥ 4500	48.8	21.2	3.56 (1.68–7.53)

Adjusted for BMI-current, BMI at delivery, maternal age, gestational weeks, infant weight and head circumference.

Gyhagen et al. BJOG. 2013 Jan;120(2):144-51. The prevalence of urinary incontinence 20 years after childbirth: a national cohort study in singleton primiparae after vaginal or caesarean delivery.

The results of logistic regression analysis of possible risk factors for urinary incontinence (n=3488)

Risk/confounding factors	OR	95% CI
Vaginal delivery	1.71	(1.41–2.08)
Current BMI	1.08	(1.06-1.10)
Delivery BMI	0.98	(0.96-1.00)
Maternal age at delivery	1.03	(1.02–1.04)
Gestational weeks	1.01	(0.96-1.06)
Infant birth weight	1.00	(0.98-1.82)
Head circumference ≥ 36 cm	1.06	(0.84-1.34)
Hysterectomy	1.21	(0.90-1.63)
Estrogen	1.34	(0.98-1.82)

Gyhagen et al. BJOG. 2013 Jan;120(2):144-51. The prevalence of urinary incontinence 20 years after childbirth: a national cohort study in singleton primiparae after vaginal or caesarean delivery.

Conclusions

- The prevalence of UI was 40.3% after VD and 28.8% after CS. The prevalence of UI >10 years was 10.1% after VD and 3.9% after CS.
- The risk increase after VD compared to CS was 67% for UI and 275% for UI>10 years.
- Current BMI was the most important BMI-determinant for UI, which is important, as BMI is modifiable
- The prevalence of UI and UI>10 years did not differ between elective CS and acute CS
- Our data indicated that it is necessary to perform 9 caesarean sections to avoid one case of UI

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The prevalence of urinary incontinence 20 years after childbirth: a national cohort study in singleton primiparae after vaginal or caesarean delivery

M Gyhagen,[a] M Bullarbo,[a,b] TF Nielsen,[a,b] I Milsom[a]

[a] Department of Obstetrics and Gynaecology, Sahlgrenska Academy at Gothenburg University, Gothenburg, Sweden [b] Department of Obstetrics and Gynaecology, Södra Älvsborgs Hospital, Borås, Sweden
Correspondence: Professor I Milsom, Department of Obstetrics and Gynaecology, Sahlgrenska University Hospital, SE-416 85 Gothenburg, Sweden. Email ian.milsom@gu.se

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Table 4. The results of logistic regression analysis of possible risk factors for urinary incontinence (odds ratio; 95% CI)*

Risk/confounding factors	OR (95% CI)
Vaginal delivery	1.71 (1.41–2.08)
BMI current	1.08 (1.06–1.10)
BMI at delivery	0.98 (0.96–1.00)
Maternal age at delivery	1.03 (1.02–1.04)
Gestational weeks	1.01 (0.96–1.06)
Infant birthweight (kg)	1.00 (0.98–1.02)
Infant head circumference ≥36 cm	1.06 (0.84–1.34)
Hysterectomy	1.21 (0.90–1.63)
Hormone replacement therapy yes versus no	1.34 (0.98–1.82)

*A total of 3488 women contributed to the model.

Table 3. Crude and adjusted prevalence and odds ratios of urinary incontinence, and urinary incontinence persisting for more than 10 years, in relation to mode of delivery

	Caesarean section (%)	Vaginal delivery (%)	Crude OR (95% CI)	Caesarean section (%)	Vaginal delivery (%)	Adjusted* OR (95% CI)
Urinary incontinence	30.0	40.2	1.56 (1.36–1.80)	28.8	40.3	1.67 (1.45–1.92)
Urinary incontinence for >10 years	4.6	10.0	2.30 (1.73–3.08)	3.9	10.1	2.75 (2.02–3.75)

*Adjusted for BMI current, BMI at delivery, maternal age, gestational weeks, infant birthweight, and head circumference.

1 stress inkontinansı önlemek için 9-15 sezaryen

Caesarean section for non-medical reasons at term (Review)

THE COCHRANE COLLABORATION®

Lavender T, Hofmeyr GJ, Neilson JP, Kingdon C, Gyte GML

Cochrane Database of Systematic Reviews, Issue 4, 2009

Objectives

To assess, from randomised trials, the effects on perinatal and maternal morbidity and mortality, and on maternal psychological morbidity, of planned caesarean delivery versus planned vaginal birth in women with no clear clinical indication for caesarean section.

Data collection and analysis

We identified no studies that met the inclusion criteria.

Authors' conclusions

There is no evidence from randomised controlled trials, upon which to base any practice recommendations regarding planned caesarean section for non-medical reasons at term. In the absence of trial data, there is an urgent need for a systematic review of observational studies and a synthesis of qualitative data to better assess the short- and long-term effects of caesarean section and vaginal birth.

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Sezaryen vs Vaginal Doğum Sonuç

Sezaryen doğum sonrası normal doğuma göre daha az üriner inkontinans gözlenebilir. Ancak bu fark zamanla kaybolmaktadır.

Daha önce şikayeti olmayanlara pelvik taban şikayetlerini engellemek amacıyla elektif sezaryen önermeyi gerektirecek yeterli bilimsel veri yoktur.