

# Adopting the O’Driscoll regime may optimize caesarian section rate in the primiparous woman.

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## Re Global rising rates of caesarean sections

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**Running head** O’Driscoll regime may optimize CS rate

**Adopting the O’Driscoll regime may optimize caesarian section rate in the primiparous woman.**

*Dr Chen asks, “What is the optimum rate of caesarean section delivery? This is a question that has bedevilled many obstetricians over the last half century.”* [ 1] We believe our recently published OASIS study may shed some light on this important question, albeit from a different angle. We examined the effect of passive management of labour on OASIS [2] and found that the O’Driscoll active management method vastly reduced OASIS in primiparas without increase in caesarian section (CS). Routine adoption of this method may go a long way towards answering Dr Chen’s question. The genius of the O’Driscoll method is that it is a “zero sum”\*protocol which is tailors CS to an individual patient. It automatically takes into account all three “Ps”, powers, passengers, passages, irrespective of which one is causing the problem.

\*it will come through in 12 hours, or it will not. If not, a CS is performed.

We carried out a comparative study of third and fourth degree anal sphincter tears in all primiparas delivering at term in the years 2010–2015 in six Sydney public teaching hospitals, which were under MANDATORY direction from the Director General of NSW Health for labour to proceed without augmentation. The study comprised 130,000 women. We compared teaching hospital data with data from patients delivered in six adjacent Sydney private hospitals which used augmented labour. A second comparator was from the National Women’s Hospital, Dublin, where the O’Driscoll active management is performed under midwife direction. The mean third and fourth degree anal sphincter tear rate was 8.17% for NSW public teaching hospitals, 1.52% for the adjacent private hospitals in the same period ( $p < 0.0003$ ) and 2.6% for NWH Dublin. The emergency CS rate between 2010–2015 was 13.7% private, 12.7% public, 7.9% NWH Dublin. However, there was an increase in rate of epidurals, forceps/ventouse and lower Apgar scores in NSW public hospitals.

We attributed the rise in OASI to poor contractions causing deflexion of the head, increasing the cephalic diameter from 9.5cm to 11.2 cm with consequent increased stress on the sphincters.

In an accompanying editorial [3], we examined the longer-term damaging effect of a larger diameter head pushing through the pelvis on the ligaments, tissues and muscles with regard to future prolapse, bladder, bowel symptoms. In this context, we described OASIS as “the canary in the coalmine”, a harbinger of such problems in the future for the OASIS women.

It would seem that the O’Driscoll active management regime, which limits labour to 12 hours without increasing the caesarean section rate, may not only protect from OASIS, POP and incontinence, but also, provide an optimum caesarian section rate *for the individual woman*.

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