Safe motherhood : severe maternal morbidity in the Netherlands. The LEMMoN study

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CHAPTER 13

Recommendations

1. Ongoing registration of SAMM for the purpose of quality assurance in reproductive health is mandatory to detect epidemiologic trends. The National Surveillance Centre of Obstetrics and Gynaecology (NSCOG) provides the infrastructure to collect data on SAMM and other rare conditions during pregnancy, like the United Kingdom Obstetric Surveillance System (UKOSS) does in the UK. Like in several other European countries, funding should be provided by the government (in the UK) or by professional societies (in Scandinavia).

2. We recommend routine local auditing of all cases of SAMM. Auditing of SAMM should be an item during the regular quality assurance visits taking place every five years in each obstetric ward in the Netherlands.

3. Routine national or regional audit of a selection of SAMM cases in addition to the ongoing maternal mortality audit could improve the quality of obstetric care in the Netherlands. This could be incorporated in the perinatal audit system which is established in the Netherlands at present.

4. Important risk factors like body mass index, ethnicity and previous caesarean section are not registered in The Dutch Perinatal Registry at present. Registration of these items is urgently needed. The registry should include all deliveries in the Netherlands, also those under guidance of general practitioners.

5. The inclusion criteria used in the LEMMoN study are appropriate for use in Western countries. For logistical reasons, we recommend elevating the threshold for major obstetric haemorrhage to five or more units of packed cells.

6. Internationally agreed criteria for SAMM should be developed by the World Health Organization for the purpose of quality assurance in reproductive health.

7. More aggressive antihypertensive treatment and insult prophylaxis is warranted in women with severe hypertensive disorders of pregnancy to reduce the increased incidence of eclampsia in the Netherlands. This reduction should be assessed by ongoing registration of SAMM cases (see 1.)

8. A multi-language patient leaflet should be developed with warning signs for complications of pregnancy and childbirth, especially pre-eclampsia.

9. Women considering an elective caesarean section should be counselled that the absolute risk of major obstetric haemorrhage necessitating arterial embolisation or peripartum hysterectomy is 1 in 250. Regarding long term consequences, uterine rupture in women with a previous caesarean section is 1 in 200, with perinatal mortality in 9% of cases.

10. The results of this thesis highlight the proper functioning of the Dutch obstetric system with selection of high-risk and low-risk pregnancies. The risk of SAMM during home delivery was 10-fold reduced as compared with hospital delivery.

11. Centralisation of obstetric care in large birth centres will yield more experience with the treatment of rare obstetric complications. We did not find any evidence, however, that the incidence of severe obstetric complications was reduced in larger birth centres as compared to smaller ones.

12. In case of fetal heart rate abnormalities or continuous abdominal pain during vaginal birth after caesarean (VBAC), uterine rupture should be strongly suspected and immediate caesarean should be expedited without further assessment with fetal blood sampling.