**Impact of “natural” cesarean delivery on peripartum blood loss: A randomized controlled trial**

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**Abstract**

**Objective:** Early skin to skin contact (ESTSC) after vaginal delivery increases lactation and may increase oxytocin release and reduce postpartum hemorrhage. The present trial aims to examine the impact of “natural” cesarean deliveries on peripartum maternal blood loss.

**Study Design:** A randomized controlled trial was conducted at a single hospital between August 2016 and February 2018 and included 214 term singleton gestations scheduled for a cesarean delivery (CD). Women were randomized at a ratio of 1:1 to natural CD (study group) or traditional CD (control group). Women in the study group were able to watch fetal extraction, initiate ESTSC immediately, and breastfeed during surgery. Neonates in the control group were presented to the mother for few minutes, and breastfeeding was not offered. Blood samples drawn from all women during fascia closure were analyzed to determine oxytocin and postpartum hemoglobin levels.

**Results:** There were no significant differences in demographic and obstetric variables between the groups. Postpartum hemoglobin levels were 10.1±1.1 and 10.3±1.3 g/dL in the study and control groups, respectively (*P* = .19). There were no significant differences in estimated blood loss, blood transfusion, or need for additional uterotonics. Exclusive breastfeeding rate at discharge did not differ between the 2 groups (*P* = .39). Maternal oxytocin blood levels were 389.5±183.7 and 408.5±233.6 pg/mL in the study and control groups, respectively (*P* = .96). Every neonatal outcome examined was similar between the groups.

**Conclusion:** Natural CD does not affect maternal blood loss. Maternal oxytocin blood levels in both groups were similar.

Clinical Trial Registration: clinicaltrials.gov Identifier: NCT02768142

**Abstract**

**Objective:** Early skin to skin contact (ESTSC) after vaginal delivery increases milk production and lactation and may increase oxytocin release, leading to reduction in postpartum hemorrhage (PPH) rate. The present trial aims to examine the impact of “natural” cesarean deliveries (NCD) on peripartum maternal blood loss.

**Study Design:** A randomized controlled trial was conducted at a single hospital between August 2016 and February 2018. The laboratory component was completed in February 2019. Term singleton gestations scheduled for a planned cesarean delivery (CD) under spinal anesthesia were included. Women were randomized at a ratio of 1:1 to NCD (study group) or traditional CD (control group). Women in the NCD group were able to watch fetal extraction through the abdominal incision, initiate ESTSC immediately after cord clamping, and breastfeed until the end of surgery. Neonates in the control group were presented to the mother for few minutes, and breastfeeding was not offered. A blood sample was drawn from all women during fascia closure and was subsequently analyzed to determine oxytocin levels using an ELISA kit (IBL international GmbH:RE52331; Flughafenstrasse 52a, D-22335 Hamburg, Germany). The primary outcome was postpartum hemoglobin (Hb) levels. In order to detect a difference of 0.5 g/dl between the groups with α = .05 and β = 80%, 214 women in both groups were needed.

**Results:** Of all 214 women who gave consent and were randomized, 23 were excluded from the final analysis. There were no significant differences in demographic and obstetric variables between the groups. Postpartum Hb levels were 10.1±1.1 and 10.3±1.3 g/dL in the study and control groups, respectively (*P* = .19). There were no significant differences in estimated blood loss, blood transfusion, or need for additional uterotonics. Pain scores and analgesia use were comparable. The maternal satisfaction score was similar as well (*P* = .68). Exclusive breastfeeding rate at discharge did not differ between the 2 groups (*P* = .39). Maternal oxytocin blood levels were 389.5±183.7 and 408.5±233.6 pg/mL in the study and control groups, respectively (*P* = .96). Every single neonatal outcome examined was similar between the groups.

**Conclusion:** NCD does not affect maternal blood loss. Maternal oxytocin blood levels in NCD and traditional CD are similar.

Clinical Trial Registration: clinicaltrials.gov Identifier: NCT02768142

**Background**

Early skin to skin contact (ESTSC) after vaginal delivery increases milk production and lactation and may improve outcomes.1-3 Studies published as early as the 1970s showed a change in maternal and neonatal behavior after ESTSC.1 Mothers practicing ESTSC and suckling breastfed their infants longer than did routine-care mothers.2 A Cochrane meta-analysis concluded that ESTSC promotes breastfeeding, though other conclusions were challenging due to methodological quality and small sample size of the included trials.3

Breastfeeding, nipple stimulation, and ESTSC increase oxytocin levels postpartum.4-8 Therefore, ESTSC is expected to reduce the incidence of postpartum hemorrhage (PPH).9 A retrospective study found that women who did not have ESTSC were almost twice as likely to have PPH compared to women who both had ESTSC and began breastfeeding within 30 minutes of birth.10

Although the delivery goal for many women is to experience a vaginal birth, a cesarean delivery (CD) is sometimes mandatory due to medical maternal or fetal indications. Recent attention has focused on the description and putting into practice of techniques in the operating ward to incorporate ESTSC and breastfeeding. The first approach of modifying the CD was described in 2008 by Smith et al. and was termed *natural CD* (NCD).11 One of the main aspects was to mimic the situation of vaginal birth and to give parents a better birthing experience (family-centered CD).

Nevertheless, there is a lack of adequate methodological studies on the impact of CD incorporating ESTSC and breastfeeding, i.e., NCD, and maternal outcomes.11

The present trial aims to examine the effect of NCD on peripartum blood loss compared to traditional CD and to examine the impact on women’s satisfaction, exclusive breastfeeding, and other maternal and neonatal outcomes.

**Methods**

This randomized controlled trial was conducted in the labor and delivery ward of a single university teaching hospital in Afula, Israel. The clinical trial was conducted between August 2016 and February 2018, while the laboratory component was completed in February 2019. The local institutional review board approved the study protocol (registration number 0137-15-EMC); Clinical Trial Registration: clinicaltrials.gov Identifier: NCT02768142.

Pregnant women scheduled for planned CD at our institution were given the option to participate in the trial. Eligible women were randomly assigned in a 1:1 ratio to NCD (study group) or traditional CD (control group). The inclusion criteria of both groups included maternal or fetal indication for CD, planned CD under spinal anesthesia at term, maternal age between 18 and 45 years, viable fetus, and confirmed dating by last menstrual period and first- or early second-trimester ultrasound. Women with unplanned CD who had multifetal gestation, major fetal malformations, fetal conditions requiring immediate neonatologist evaluation, estimated fetal weight below the 5th percentile, noncontrolled diabetes mellitus, or severe preeclampsia were excluded, as were women who were human immunodeficiency virus carriers or who were unable to give informed consent. Women were excluded from the analysis after recruitment if they had failed spinal anesthesia, thus requiring general anesthesia, or if their newborns needed immediate medical care after delivery.

In the study group only, the intravenous line was inserted in the nondominant hand. In the operating room, the blood pressure cuff was placed on the nondominant side or on the leg. The pulse oximeter was placed on the toe. Women’s arms were not tied down, and at least one arm was free from clothing. The electrocardiogram stickers were placed on the mother’s back, leaving the chest free. The drape separating the surgical field was placed closer to the abdomen in a way that allowed smooth lowering down and created a relatively large free chest area. At head delivery, the surgical drape was lowered in women electing to watch the slow “walk” of the baby out. The scrubbed midwife received the neonate from the surgeon and directly put the neonate on the naked skin of the mother’s breast to initiate ESTSC and encourage suckling. The neonate was covered with a warm blanket. At this stage, the surgical drapes were lifted up again before removing the placenta. Usual neonatal care, such as assigning an Apgar score and placing a name tag, was done during ESTSC. Weighing the neonate was postponed until ESTSC was terminated. The midwife remained alongside the mother constantly as long as the neonate was on the mother’s chest. ESTSC was terminated on maternal request, at any compromise in maternal or neonatal well-being mandating medical care, or at the end of the surgical procedure.

Women in the control group, i.e., traditional CD, were not given the option to watch extraction and did not breastfeed during surgery. After the midwife received the neonate and assessed the need for medical care, she dried, weighed, name tagged, and covered the neonate. Following that, the neonate was held adjacent to its mother, allowing her to see it, or was given to the escort to be held for a few minutes and then was transferred to the nursery unit.

In both groups, complete blood count (CBC) was taken on admission as part of surgical preparation. Antibiotic prophylaxis before skin incision was given to all participants prior to surgical incision. Women in both groups were allowed an escort of their choice in the surgery suite after confirmation of adequate spinal analgesia. Delayed cord clamping for nearly 60 seconds was made similar. Uterotonic medications to prevent PPH were given according to the department protocol; following the delivery of the neonate, 5 units of oxytocin was given in a slow intravenous push followed by 20 units in a 1000-mL lactated Ringer’s solution as the standard regimen. Higher doses of oxytocin or the use of other uterotonic medications were considered if needed to treat uterine atony. Other surgical techniques were identical between the 2 groups. Perioperative analgesics or sedatives were given according to the anesthesiologist’s discretion.

Maternal oxytocin levels were examined in both groups to attain another reliable evidence of the impact of ESTSC and lactation on oxytocin release. For that purpose, blood samples were obtained from all women during fascia closure and were subsequently analyzed in a designative laboratory for determining oxytocin levels among the groups using an ELISA kit (IBL International GmbH: RE52331; Flughafenstrasse 52a, D-22335 Hamburg, Germany). Blood samples were drawn into chilled serum or EDTA (1 mg/mL blood) tubes containing aprotinin (500 KIU/mL of blood) and were centrifuged within 10 minutes at 1600 x g for 15 minutes at 4°C. The serum of all participants was stored in a plastic tube at –70°C until kit application after completion of the clinical trial. Oxytocin extraction from an equal volume (500 µl) of serum spiked with 100 pg of oxytocin across all samples was carried out with a standard protocol using the C18 Sep-Pak column, according to the manufacturer’s instructions. An oxytocin standard curve was provided in the ELISA kit with a limit of detection of 15 pg/mL.

Postoperative pain relief medication during hospitalization was given according to a department protocol. Postoperative pain score was measured according to visual analog scale (VAS) from 0 to 10 cm, where *no pain* scored 0 and *worst pain* scored 10.

Postoperative routine CBC was drawn within 24 hours after surgery. Additional CBC was taken 2 to 3 days after delivery. Other blood tests were drawn according to clinical judgment. Prior to discharge, women were asked to complete a self-reporting satisfaction questionnaire related to their childbirth experience. A satisfaction questionnaire that was previously validated for use in clinical trials was used.12 The questionnaire contains 38 questions, and each answer scores on a scale of 1 to 6 (1 = *least satisfied* and 6 = *most satisfied*). An average score was calculated rather than the total score, since a number of women did not answer all questions because they assumed that some were not relevant.

Neonates in both groups were assessed at the nursery on admission, including measurement of temperature and glucose level as indicated.

**Primary outcome**

ESTSC after vaginal delivery increases milk production and lactation and may improve outcomes. Additionally, oxytocin release, responsible for early PPH reduction, has been reported to increase following ESTSC.4-8 Accordingly, the primary outcome examined was the level of postpartum hemoglobin (Hb) at 2 to 3 days after delivery.

Secondary outcomes included the need for additional use of perioperative uterotonics, the need for blood transfusion, maternal pain scores, the need for additional analgesia or sedatives during and in the immediate postoperative period, maternal infections until discharge, exclusive breastfeeding at discharge, maternal satisfaction, and maternal oxytocin levels. Neonatal outcomes included Apgar scores and a composite outcome that comprised neonatal hypothermia, hypoglycemia, jaundice, and neonatal intensive care unit (NICU) admission.

**Sample size**

Power analysis was based on Hb level after CD. We examined Hb levels of 150 women who underwent planned CD during the year before study initiation. The average Hb level found was 10.4±1.3 g/dL. In order to detect a 0.5-g/dL difference in favor of women undergoing NCD, 214 women in both groups were needed with a level of signiﬁcance of 95% (α = .05) and a power of 80% (β = 0.2). The analysis was performed according to the intention-to-treat principle.

**Randomization**

Computer randomization sequence generation was used to produce the randomization. Eligible women who signed informed-consent forms were randomly assigned in a 1:1 ratio to one of the two groups. The randomization sequence was kept in a sealed envelope, and the sequence was concealed until intervention was assigned. Women were allocated to randomization code numbers in chronological order. Due to the nature of the intervention, women and the dedicated staff were not blinded to group allocation. The data analysis individuals were unaware of the group assignments. Quality control of screening, handling of data, and verification of compliance to protocol was implemented by a local data monitoring committee.

**Statistical analysis**

A series of χ2 tests or Fisher exact tests (when the assumptions of the parametric χ2 test had not been met) and Student *t* tests or nonparametric Mann–Whitney U tests (in the case where the underlying distribution was not normal) were conducted to analyze the differences between characteristics of the women in both groups. We computed the 2-tailed *P* values, where *P* < .05 was considered a statistically significant result. Statistical analyses were performed using the SAS software package version 9.4 (SAS Institute, Cary, NC).

Oxytocin levels were calculated using a 4-parameter logistic curve-fitting model (Excel, Microsoft), and results were compared using a 2-tailed Student *t* test.

**Results**

During the study period, 7240 deliveries took place; of those, 1286 were cesarean deliveries (17.8%). Of all CDs, 625 were planned (48.6%). Of all planned CDs, 214 eligible women gave consent and were randomized to either NCD (n=108) or to traditional CD (n=106). Of all randomized women, 23 (10.7%) women were excluded from the final analysis: 7 (2 in the study and 5 in the control group) had general anesthesia due to failed spinal, 5 (2 in the study and 3 in the control group) underwent emergent CD within 24 hours before the scheduled CD, and 11 withdrew consent (2 and 9 in the study and control groups, respectively), leaving 102 women assigned to NCD and 89 to traditional CD (Figure 1). Among the study group, all had ESTSC. Forty-two (41.2%) women succeeded to breastfeed during the entire period of surgery. Twenty-six (25.5%) elected to watch extraction. None of the controls had ESTSC or breastfed.

Demographic and obstetric data of the study and control groups were comparable and are presented in Table 1. Postpartum Hb levels were 10.1±1.1 and 10.3±1.3 g/dL in the study and control groups, respectively (*P* = .19). Estimated blood loss >1000 mL, differences in Hb and hematocrit levels before and after the cesarean, and use of uterotonic agents did not differ between the groups (Table 2). The length of maternal stay and rate of scar infection were comparable between the groups. Exclusive breastfeeding rate at discharge also did not differ between the groups (*P* = .39; Table 2).

Pain scores were comparable between the groups as well as analgesia use during the operation and in the immediate postoperative period. The maternal satisfaction score was similar between the 2 groups (5.4±0.74 and 5.4±0.5 in the study and control groups, respectively; *P* = .68; Table 3).

Subgroup analysis was performed among the NCD group, comparing only women who succeeded to breastfeed during the entire surgery to the controls. The primary outcome, i.e., postsurgical Hb levels, was comparable between the 2 groups *(P* = .88). There was a higher rate of exclusive breastfeeding at discharge (52.4% and 33.7% in the study and control groups, respectively; *P* = .04). Other outcomes examined did not differ significantly between the groups.

Neonatal outcomes are presented in Table 4. None differed between the groups; nevertheless, the incidence of composite outcome that included neonatal hypothermia, hypoglycemia, jaundice, and NICU admission was higher among the NCD group compared to the controls (*P* = .04).

Oxytocin levels were successfully determined in 182 out of 191 women (95.3%) who were included for analysis of the primary outcome (97 and 85 in the study and control groups, respectively). There were no significant differences in demographic and obstetric variables or Hb levels before or after surgery between the groups. Maternal oxytocin blood levels were 389.5±183.7 and 408.5±233.6 pg/mL in the study and control groups, respectively (*P* = .96).

**Discussion**

The results of this randomized trial demonstrate that NCD leads to a similar perioperative blood loss compared to traditional CD. Perioperative Hb-level decline, blood transfusion rate, and total perioperative uterotonics use were identical. Moreover, ESTSC and breastfeeding resulted in comparable maternal oxytocin levels, as measured via the ELISA kit, compared to traditional CD. Furthermore, maternal pain scores, need for additional analgesia or sedatives during the operation and in the immediate postoperative period, and maternal satisfaction were all comparable. There were no adverse maternal or perioperative effects related to NCD. In terms of neonatal outcome, there was no difference in any particular outcome examined; nevertheless, the incidence of composite outcome that included hypothermia, hypoglycemia, jaundice, and NICU admission was higher among the study compared to the control groups.

Administration of artificial oxytocin in the third stage of labor has been approved in reducing the rate of PPH.13 Given that, it is reasonable to suggest that the reduction of the occurrence of PPH in cases of NCD as previously reported is related to both ESTSC and breastfeeding, which stimulate endogenous oxytocin release.5,9 Accordingly, the effect is supposed to be absent or diminished with the separation of the newborn from the mother immediately after birth. Separation also has been reported to create a state of distress that may block the release of oxytocin, and atony may result.9,10 A previous study found that women who did not practice ESTSC or did not breastfeed within 30 minutes of birth were almost twice as likely to have PPH,10 although the study had several limitations, including the retrospective nature that could lead to several errors. Additionally, the association found may be related to reverse causation, i.e., absent ESTSC due to PPH, as the authors stated. Moreover, the collected data were not controlled, and the ESTSC technique was not standardized.

Lack of effect of ESTSC on blood loss, shown in the present study, was also described in a randomized trial among women delivered vaginally.14 The comparable oxytocin levels found in the current study support this observation.

There is little information on pain scores and the need for analgesia or sedatives during CD combined with ESTSC. The findings of the current study showed that pain scores and the use of additional analgesia or sedatives during surgery and the immediate postpartum hours were comparable. The results are consistent with the finding of Nolan et al.15 Others reported a decrease in the need for sedatives in women who elected to breastfeed during CD; however, this study was not controlled, and the results were compared to historical control.16

Maternal satisfaction was comparable between the study and the control group. In contrast, Armbrust et al. showed in a randomized trial that ESTSC improved both maternal satisfaction and rate of breastfeeding.17 Nevertheless, the groups were not entirely similar, since women from the ESTSC group had a significantly higher level of education, a factor that may affect satisfaction. Additionally, Baethge et al.18 reported that influential conclusions could not be drawn from this study17 due to critical errors in design and interpretation.

The impact of NCD on exclusive breastfeeding at discharge is conflicting.19 Prior studies have found an increase in exclusive breastfeeding rates for women undergoing a CD from 8% to 19% following initiation of ESTSC in the operating ward.20 Although exclusive breastfeeding was comparable between the groups in the current study, both groups had higher rates at discharge (nearly 34% to 43%) compared to the cited article.

There is a paucity of literature regarding the impact of ESTSC on neonatal outcomes. ESTSC was described as a helpful tool in maintaining neonatal thermoregulation and blood glucose level after vaginal delivery,21 yet hypothermia after a cesarean can occur.22 Consistent with another report,23 the results of the current study did not show a difference in any particular neonatal outcome examined; nevertheless, a composite of neonatal outcomes that included hypothermia, hypoglycemia, jaundice, and NICU admissions was higher in cases of NCD compared to traditional CD. Similarly, one study reported an increase in the rate of unplanned NICU admission from 7% to 21% after the introduction of family-centered CD.19

The strengths of this study are its randomized nature and the objective measures examined. Measuring oxytocin levels is a significant contribution that further strengthens the results.

Limitations of this study are worth mentioning. The trial was not designed to detect significant differences in secondary outcomes. Additionally, compared to multicenter studies, interventions examined in a distinct institution may be less generalizable. However, an advantage linked to a single-center trial is that the same surgical, perinatal, neonatal, and laboratory teams managed all the cases and applied the same peripartum management and oxytocin measurement technique.

Following the promising publication of NCD in 2008 by Smith et al.,11 the editor commented that no outcomes or safety data are presented to justify widespread use of this technique and that the technique should be adequately studied with appropriate clinical trials.24 Additionally, Newman et al. reported that the term *natural* implies a process associated with fewer adverse outcomes than the traditional technique, although the practice changes suggested by Smith et al. do not reduce any significant adverse effects related to CD.25 To date, only small-sample-size studies regarding safety have been published,26,27 with a lack of consistency and missing data that do not enable the drawing of conclusions.

NCD, according to the present study, does not improve maternal well-being or surgical results. The procedure is accompanied by higher expenses, mainly due to consuming the time of the nursing staff. Additionally, disappointment may be expressed by women and families when NCD is not available because of a shortage of nurse staffing and equipment.27 Nevertheless, efforts to change practice that might improve women’s experiences when having a CD should continuously be considered in birthing wards.

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Table 1: Demographic and obstetric variables of women according to trial group.

|  |  |  |  |
| --- | --- | --- | --- |
| Variable | Natural cesarean (N=102) | Control group (N=89) | *P*-value |
| Maternal age, years | 33.0 ± 5.2 [33.0, 29.0-37.0] | 32.7 ± 5.4 [34.0, 28.0-36.0] | 0.99 |
| Ethnicity Arabs Jews  | 42 (41.2) 60 (58.8)  | 47 (52.8)42 (47.2) | 0.11 |
| Gravidity  | 4.1 ± 2.5 [4.0, 3.0-5.0] | 4.0 ± 2.2 [4.0, 3.0-5.0] | 0.55 |
| Parity  | 2.1 ± 1.1 [2.0, 1.0-3.0] | 2.1 ± 1.4 [2.0, 1.0-3.0] | 0.76 |
| Gestational age at delivery, weeks  | 38.5 ± 0.6 [38.3, 38.1-38.6] | 38.4 ± 0.74 [38.3, 38.1-39.0] | 0.54 |
| Pregestational body mass index (kg/m2)  | 25.7 ± 5.1 [24.6, 22.8-28.2] | 27.1 ± 6.0 [26.0, 22.6-31.2] | 0.12 |
| Indication for cesarean  Previous uterine scar  Fetal1 Maternal2 | 81 (79.4)15 (14.7)6 (5.9) | 64 (71.9)13 (14.6)12 (13.5) | 0.60 |
| Any diabetes  | 10 (9.8) | 17 (19.1) | 0.07 |
| Any hypertension | 2 (1.8) | 7 (7.8) | 0.08 |
| Thrombophilia  | 7 (6.9) | 5 (5.6) | 0.72 |
| Mode of conception Spontaneous Any fertility treatment3  | 95 (93.1)7 (6.9) | 84 (94.4)5 (5.6) | 0.72 |
| Hemoglobin prior cesarean, g/dL  | 11.4 ± 1.1 [11.4, 10.7-12.0] | 11.5 ± 1.2 [11.6, 10.9-12.2] | 0.63 |
| Hematocrit prior cesarean, % | 34.0 ± 2.9 [33.8, 32.1-35.8] | 34.3 ± 2.8 [34.3, 32.6-36.1] | 0.44 |
| Surgical length, minutes  | 43.4 ± 12.5 [41.8, 34.2-49.3] | 45.2 ± 13.7 [43.9, 35.0-51.4] | 0.36 |
| Tubal sterilization during cesarean | 19 (18.6) | 21 (23.6) | 0.40 |
| Skin closure  Staples  Intracuticular sutures Glue | 12 (11.8)84 (82.3)6 (5.9) | 12 (13.5) 74 (83.1)3 (3.4) | 0.69 |

Data are mean ± standard deviation [median, IQR] or N (%) unless otherwise specified.

1Fetal indications: Breech presentation, suspect macrosomia, prior shoulder dystocia.

2Maternal indications: placenta previa or low lying placenta, maternal request.

3Fertility treatment: Clomiphene citrate, gonadotropin induction of ovulation and in vitro fertilization.

Table 2: Peripartum maternal outcomes according to trial group.

|  |  |  |  |
| --- | --- | --- | --- |
| Outcome | Natural cesarean (N=102) | Control group (N=89) | *P*-value |
| Hemoglobin after cesarean, g/dL | 10.1 ± 1.1[10.1, 9.5-10.9] | 10.3 ± 1.3[10.2, 9.5-11.0] | 0.19 |
| Hematocrit post cesarean, % | 30.5 ± 3.1 [30.8, 28.6-32.6] | 30.9 ± 3.1 [30.6, 9-33.1] | 0.46 |
| Estimated blood loss >1000mL | 5 (4.9) | 7 (7.9) | 0.4 |
| Need for additional uterotonics  |  15 (14.7) | 13 (14.6) | 0.98 |
| Blood transfusion  | 1 (1.0) | 0 (0.0) | 0.99 |
| Scar infection | 2 (1.96) | 0 (0.0) | 0.50 |
| Length of maternal hospitalization, days  | 4.0 ± 0.8 [3.6, 3.5-4.5] | 3.9 ± 0.7 [3.6, 3.5-3.6] | 0.24 |
| Exclusive breastfeeding at discharge | 44 (43.1) | 30 (33.7) | 0.39 |

Data are mean ± standard deviation [median, IQR] or N (%) unless otherwise specified.

Table 3: Post-surgical pain and satisfaction scores according to trial group.

|  |  |  |  |
| --- | --- | --- | --- |
| Outcome | Natural cesarean (N=102) | Control group (N=89) | *P*-value |
| VAS at the beginning of surgery | 0.01 ± 0.10[0.0, 0.0-0.0] | 0.01 ± 0.11[0.0, 0.0-0.0] | 0.90 |
| VAS at the end of the surgery | 0.03 ± 0.23[0.0, 0.0-0.0] | 0.06 ± 0.29[0.0, 0.0-0.0] | 0.30 |
| Need for any analgesics during surgery  | 6 (5.9) | 4 (4.5) | 0.75 |
| Need for any analgesics in the immediate post operation period | 43 (42.2) | 40 (45.0) | 0.70 |
| Maximal VAS reported by each women during the first 24 hours after CD | 4.3 ± 2.1[5.0, 2.0-6.0] | 4.8 ± 2.1[5.0, 2.0-6.0] | 0.15 |
| Need for any sedatives during surgery | 11 (10.8)  | 15 (16.9) | 0.22 |
| Maternal satisfaction  | 5.4 ± 0.74[5.6, 5.1-5.9] | 5.4 ± 0.5[5.6, 5.3-5.8] | 0.68 |

Data are mean ± standard deviation [median, IQR] or N (%) unless otherwise specified.

VAS; Visual Analog Scale from 0 to 10 cm where *no pain* scored 0 and *worst pain* scored 10.

Table 4: Neonatal outcomes according to trial group.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Outcome | Natural cesarean (N=102) | Control group (N=89) | *P*-value | RR (95%CI) |
| Neonatal birthweight, gr  | 3273.2 ± 479.4 [3222.5, 2975.0-3445.0] | 3285.6 ± 481.2 [3235.0,2930.0-3525.0] | 0.85 | \*\*\* |
| Male neonates  | 48 (47.1) | 41 (46.1) | 0.89 | 1.019 [0.781,1.328] |
| Cord artery pH < 7.1 | 3 (2.94) | 1 (1.14) | 0.63 | 1.410 [0.788,2.521] |
| Neonatal hypothermia1 at admission to nursery | 21 (20.6) | 11 (12.4) | 0.13 | 1.289 [0.961,1.728] |
| NICU admission  | 6 (5.9) | 1 (1.1) | 0.12 | 0.299 [0.048,1.845] |
| Neonatal hypoglycemia2 at admission to nursery  | 4 (3.9) | 3 (3.4) | 0.99 | 0.932 [0.484,1.796] |
| Neonatal jaundice | 13 (12.8) | 10 (11.2) | 0.75 | 0.937 [0.637,1.378] |
| Any neonatal morbidity3 | 37 (36.3) | 20 (22.5)  | 0.04 | 0.747 [0.577,0.968] |

Data are mean ± standard deviation [median, IQR] or N (%) unless otherwise specified.

NICU; Neonatal Intensive Care Unit.

1 Hypothermia;Temperature <36°C.

2 Hypoglycemia; glucose level ≤40 mg/dL

3 Any neonatal morbidity includes one or more of the following adverse outcomes: Neonatal hypothermia, NICU admission, Neonatal hypoglycemia, and Neonatal jaundice.

**Legends of figures**

**Figure 1.** Trial profile.