Maternal mortality and Caesarean section: Another pricey paradox in Bangladesh

ISHTIAQ MANNAN

Maternal mortality and Caesarean section (C-section) operation are closely linked. Physically, women are designed to give birth through normal delivery. Only in case of about 15% of all delivering women, severe complications may arise where C-section is necessary to save lives and to prevent morbidities. At the country level, there is an interesting interaction between these two.

Maternal Mortality Ratio (MMR) is hovering at 196/100,000 live births for the last one decade in Bangladesh, which is at a higher range and we rank 155 among countries. And, the C-section rate is more than 31% which is way above the World Health Organisation (WHO) recommended range of 10-15%. These two interlinked indicators being at higher range put Bangladesh in a very complex and challenging situation. Bangladesh's journey towards 2030 milestones is in serious jeopardy. Let's see where are we.

Countries can be categorised into four scenarios. Category 1 countries are Finland, Israel or the Netherlands where MMR is low and C-section rate is within or around the WHO range. This is the ideal situation that we want to achieve. Here every woman has proper access to C-section and C-sections are done strictly on medical requirement – no unnecessary surgery.

Category 2 countries, like the USA and Sri Lanka, have low MMR and high C-sections. These countries are like the previous category but, after meeting the need for all necessary C-sections, the quality control systems allow unnecessary C-section.

Countries in Sub-Saharan Africa fall under the third category where MMR is high but C-section is low. These countries have weaker health systems and access to C-section is still low, a lot of women who need, cannot access C-section.

Bangladesh, Nepal fall under the fourth category where MMR is high and C-section is also high. This means, we have a weaker health system which at one hand cannot ensure access to C-section for all women on the other, the quality control is weak enough to allow a lot of unnecessary C-sections. Are there ways out?

The Ministry of Health & Family Welfare (MOH&FW) needs to prioritise a two-pronged concerted approach. Out of over 3 million total births in a year, 53% (over 1.7 million) is still taking place at homes. It is estimated that of these women - some 160,000 women - who need C-section are deprived of getting so, left with a high probability of dying or ending up being severely morbid. The task is to shift these home deliveries to health facilities at the soonest possible.

Our primary care facilities need to be prepared to handle the caseload. There are about 4,000 Union Health and Family Welfare Centres built and meant to provide normal delivery care. By ensuring physical preparedness and by appropriate manning of these facilities with skilled providers we could achieve this objective in the short run – a low hanging fruit to avail indeed.

The second approach is to stop the skyrocketing of C-section rate and to make sure that these surgeries are done only when absolutely necessary. This huge undertaking is largely quality control and regulatory enforcement. For the last few decades, there is a positive trend of shifting from home delivery to facilities which now stands at 47%. Unfortunately, almost two-thirds of that is at private clinics which, in the country's context remain practically unregulated. Unbelievably, 83% of deliveries at private clinics are done by C-section!

The entire achievement of increased care-seeking is substantially outweighed by unethical, profit-driven, sub-standard care. As a consequence, women are exposed to a myriad of physical risks leading to fatal conditions and chronic morbidities, families are burdened with a high cost of C-section paid out of pocket and the health system is overloaded with unnecessary surgical procedure. The immediate task for the MOH&FW is to expedite production of midwives, place and retain them at primary health care facilities, build the capacity of obstetricians and enforce stringent quality control on all facilities providing delivery care and C-section services.

Childbirth through normal delivery is the most beautiful moment and the most rewarding phenomena of the entire creation. Neither, failure to ensure surgery for those who develop complication nor, unnecessarily taking mothers to the surgical table for profit, is a demonstration of 'respectful maternity care' – the theme of this year's Safe Motherhood Day.

It is a pity that mothers themselves are paying a very high price to that national disrespect – 6,000 maternal deaths every year; should not that be unacceptable?

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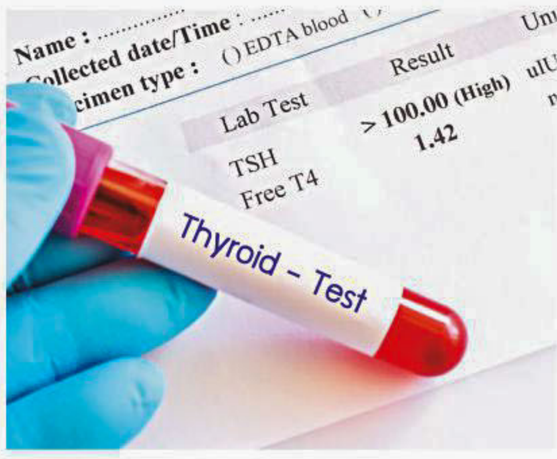
EXPERT OPINION



Do not treat subclinical hypothyroidism!

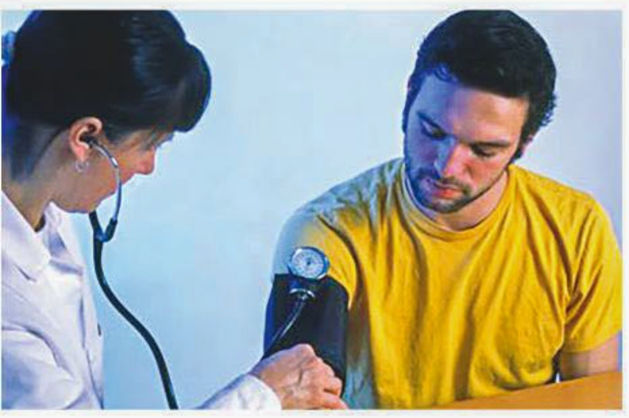
Adults with subclinical hypothyroidism should not be treated with thyroid hormones, according to a new guideline from The BMJ's Rapid Recommendations panel.

The recommendation, characterised as "strong," applies to those with elevated thyroid-stimulating hormone levels (but still below 20 mIU/L) plus normal thyroxine levels noted on two or more consecutive tests. Patients may or may not have mild-to-moderate symptoms.

The recommendation was driven by data from a 2018 meta-analysis, plus a large 2017 trial of treatment in elders. The panel concluded that there are "no important benefits from treatment," while the possibility of treatment harms — including a potentially higher mortality risk — could not be excluded.

The guideline does not apply to women who are attempting a pregnancy. Additionally, it may not apply to those with severe symptoms or adults aged 30 and younger.

HEALTH *bulletin*



Globally only 1 in 3 with high blood pressure has it under control

A pioneering global initiative by the International Society of Hypertension (ISH) to screen the blood pressure of as many people globally as possible managed to screen just over 1.5 million people across countries of all incomes in 2018, discovering that 1 in 3 had hypertension (high blood pressure).

Furthermore, only a small proportion (1 in 3) of those found to have hypertension had their condition under control, either because they were unaware, not on treatment, or both - or, their treatment was not working well enough.

According to the most recent Global Burden of Disease study (2017), raised blood pressure is the biggest contributor to disease and mortality worldwide, with 10.4 million raised blood pressure related deaths in 2017.

"The simplest way to save lives is to increase awareness and get people's blood pressure checked," explains Professor Neil Poulter, Chief Investigator for the study, Immediate Past-President of ISH, Professor of preventive cardiovascular medicine and Director of the Imperial Clinical Trials Unit at Imperial College London, UK.

Diabetes during Ramadan

DR PRONAB CHOUDHURY

The month of Ramadan is a special time for the Muslim where fasting and feasting are integral to religious life, social interaction and communal celebration. Understanding the spiritual significance of this month to the Muslim as well as the practical aspects can put the physician in a much stronger position to gain patient trust and facilitate communication.

The holy month of Ramadan, which sees Muslims all over the world fast during day time hours, does having type 2 diabetes (T2D) exclude a person from fasting? Obviously not necessarily. This holy month people with T2D can manage the condition by maintaining a healthy lifestyle including doing exercise and keeping a healthy diet. In more serious cases, people with T2D may need to take medications such as metformin, sulfonylureas, or other glucose-lowering tablets, or self-administer insulin injections.

During Ramadan, most people have two meals per day, at sunset and before sunrise. In general, patients with type 1 diabetes (T1D) should be strongly advised to not fast. Patients with T1D who have a history of recurrent hypoglycaemia or hypoglycaemia and unaware of it or who are poorly controlled are at very high risk for developing severe hypoglycaemia.

On the other hand, an excessive reduction in the insulin dosage in these patients (to prevent hypoglycaemia) may place them at risk for hyperglycaemia and diabetic ketoacidosis. This can also be risky

for people with T2D – particularly those who use insulin or certain oral diabetes.

Low blood glucose levels can cause symptoms of sweating, shakiness and confusion. If severe, they feel to seizures, coma, or even death. High blood glucose levels make people feel tired and can lead to dehydration and poor concentration. Extremely high levels are a medical emergency.

According to Islamic teachings, the elderly, pregnant, or those with illnesses requiring regular medication – like diabetes – can be exempted from fasting on medical grounds. Now we can discuss about nutrition and exercise on Ramadan and breaking the fast when it required:

Nutrition: The diet during Ramadan should not differ significantly from a healthy and balanced diet.

The common practice of taking large amounts of food rich in carbohydrate and fat, especially at the sunset meal, should be avoided. Because of the delay in digestion and absorption, ingestion of foods containing 'complex' carbohydrates may be advisable at the predawn meal, while foods with simpler carbohydrates may be more appropriate at the sunset meal.

It is also recommended that fluid intake be increased during non-fasting hours and that the predawn meal be taken as late as possible before the start of the daily fast.

Exercise: Normal levels of physical activity may be maintained. However, excessive physical activity may lead to higher risk of hypoglycaemia and should be avoided, particularly during the few hours before the sunset meal.

If Tarawih prayer is performed, then it should be considered a part of the daily exercise programme. In some patients with poorly controlled type 1 diabetes, exercise may lead to extreme hyperglycaemia.

Breaking the fast: All patients should understand that they must always and immediately end their fast if hypoglycaemia (blood glucose of <3.3 mmol/l) occurs, since there is no guarantee that their blood glucose will not drop further if they wait or delay treatment. The fast should also be broken if blood glucose reaches 3.9 mmol/l in the first few hours after the start of the fast, especially if insulin, sulfonylurea drugs, or meglitinide are taken at predawn.

Finally, the fast should be broken if blood glucose exceeds 16.7 mmol/l.

The management plan must be highly individualised. Close follow-up is essential to reduce the risk for development of complications.

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Diabetes drug class associated with Fournier gangrene

Sodium-glucose cotransporter-2 (SGLT2) inhibitors are associated with increased risk for Fournier gangrene, according to an FDA analysis published in the Annals of Internal Medicine. The agency first issued a warning about the potential association in 2018.

In the 6 years after SGLT2 inhibitors were first approved, some 55 cases of Fournier gangrene were reported in treated patients. Diagnostic criteria included necrotising infection of the perineum plus surgical debridement. In contrast, just 19 cases were reported over 35 years in patients taking other diabetes drugs.

Here are some details of the cases associated with SGLT2 inhibitors:

- Roughly 70% were in men.
- The time from treatment initiation to Fournier gangrene ranged from 5 days to 49 months.
- Complications included diabetic ketoacidosis, sepsis, and kidney injury.
- Eight patients underwent faecal diversion surgery, and two patients developed necrotising fasciitis of a lower extremity that led to amputation.
- Three patients died.

The researchers conclude that clinicians "should be aware of this possible complication and have a high index of suspicion to recognise it in its early stages."