**Name of Journal:** *World Journal of Clinical Cases*

**Manuscript NO:** 52805

**Manuscript Type:** ORIGINAL ARTICLE

***Retrospective Study***

**Factors affecting failed trial of labor and countermeasures: A retrospective analysis**

Wang JG *et al*. Countermeasures of failed trial of labor

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**Author contributions:** All authors helped to perform the research; Wang JG wrote the manuscript, performed the procedures, and analyzed and interpreted the data; Sun JL designed the research; Shen J collected the materials and clinical data from patients.

**Supported by** Liaoning Provincial Natural Science Foundation Guidance Program, No. 2019-ZD-1037.

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**Received:** April 7, 2020

**Revised:** May 4, 2020

**Accepted:** July 14, 2020

**Published online:**

**Abstract**

BACKGROUND

Vaginal delivery is the ideal mode of delivery for the termination of a pregnancy. However, the cesarean section rate in China is much higher than the published by the World Health Organization in the *Lancet* in 2010.

AIM

To retrospectively analyze the factors related to failed trial of labor and the clinical indications for cesarean section conversion, explore how to promote the trial of labor success rate, and determine the feasibility of reducing the rate of conversion to cesarean section.

METHODS

A retrospective analysis was performed on 9240 maternal women who met vaginal delivery conditions and required a trial of labor from January 2016 to December 2018 at our hospital. Among them, 8164 pregnant women who had a successful trial of labor were used as a control group, and 1076 pregnant women who had a failed trial of labor and converted to an emergency cesarean section were used as an observation group. The patients’ clinical data during hospitalization were collected for comparative analysis, the related factors of the failed trial of labor were discussed, and reasonable prevention and resolution strategies were proposed to increase the success rate of trial of labor.

RESULTS

The analysis revealed that advanced age (≥ 35 years old), macrosomia (≥ 4000 g), delayed pregnancy (≥ 41 wk), use of uterine contraction drugs, primipara, and fever during labor were associated with conversion to an emergency cesarean section in the failed trial of labor. Multivariate regression analysis showed that age, gestational age, primipara, use of uterine contraction drugs, fever during birth, and newborn weight led to a higher probability of conversion to an emergency cesarean section in the failed trial of labor. The analysis indicated that the following clinical indications were associated with the conversion to cesarean section in the failed trial of labor: Fetal distress (44.3%), social factors (12.8%), malpresentation (face presentation, persistent occipitoposterior position, and persistent occipitotransverse position) (9.4%), and cephalopelvic disproportion (8.9%).

CONCLUSION

The conversion to emergency cesarean section in failed trial of labor is affected by many factors. Medical staff should take appropriate preventive measures for the main factors, increase the trial of labor success rate, improve the quality of delivery, ensure the safety of mother and child during the perinatal period, and improve the relationship between doctors and patients.

**Key words:** Trial of labor; Vaginal delivery; Cesarean section; Dystocia; Retrospective analysis

Wang JG, Sun JL, Shen J. Factors affecting failed trial of labor and countermeasures: A retrospective analysis. *World J Clin Cases* 2020; In press

**Core tip**: The cesarean section rate in China is much higher than the threshold of the World Health Organization. The purpose of this study was to explore how to promote the success rate of trial of labor, and determine the feasibility of reducing the rate of conversion to cesarean section.

**INTRODUCTION**

After China’s two-child policy was fully liberalized, the country officially entered the “universal two-children” era, and the obstetrics industry faced enormous challenges brought about by the birth peak. Vaginal delivery is the ideal mode of delivery for the termination of a pregnancy. Cesarean section is only a means of solving dystocia and saving the lives of mothers and children, rather than the usual mode of delivery. In recent years, with the attention of the state and the Ministry of Health, the cesarean section rate has decreased[1]. In 2010, the rate of cesarean section in China was 46%, and in 2018, it was 36.7%. However, the cesarean section rate in China is much higher than the 10-15% threshold cesarean section rate published by the World Health Organization in the *Lancet* in 2010[2-4]. Caesarean section is an invasive procedure, and the potential risk is much higher than that of natural delivery. Studies have shown that maternal risk of infection, bleeding, long-term scar pregnancy, placenta previa, and placenta increta are increased after cesarean section. At the same time, the risk delivering newborns who need to enter the neonatal intensive care units, and having children with overweight, obesity, type 1 diabetes, asthma, *etc.* is also increased[2,5-8]. Therefore, it is necessary to strictly control the indications for cesarean section in the vaginal delivery process, rationally apply cesarean section, improve the quality of obstetric work, and ensure the safety of mother and child in the perinatal period. This study retrospectively analyzed the clinical data of pregnant women with vaginal trials of labor at our hospital in recent years and explored the reasons for the conversion to cesarean section in the failed trial of labor and the corresponding solutions, with an aim to promote the success rate of vaginal trial of labor, provide a new basis for the prenatal prediction by clinicians, and improve perinatal results.

**MATERIALS AND METHODS**

***Subjects***

A total of 9240 women who met the criteria for vaginal delivery and required vaginal trials at our hospital from January 2016 to December 2018 were selected. Among them, 8164 pregnant women with a successful trial of labor were used as a control group, and 1076 pregnant women who converted to emergency cesarean section in the failed trial of labor were used as an observation group. The pregnant women in the control group were aged 16 to 44 years, with an average age of 29.13 ± 3.45 years; gestational age was 230 to 295 d, with an average of 277.59 ± 7.18 d. The pregnant women in the observation group were 18-44 years old, with an average age of 29.33 ± 3.04 years; gestational age was 240-294 d, with an average of 279.85 ± 7.01 d. All pregnant women and their families provided informed consent for vaginal delivery.

***Methods***

The inclusion criteria for the control group were as follows: Single fetal head position pregnancy; gestational age > 28 wk; no vaginal delivery contraindications; and patients requiring vaginal delivery. The exclusion criteria were: Vaginal delivery contraindications; patients insisting on cesarean section to terminate pregnancy; and severe medical or surgical complications. The observation group was required to meet the above selection criteria, plus the failure of the vaginal trial of labor. The hospital electronic medical record system was reviewed, and the following factors were recorded to investigate their effects on the conversion to cesarean section in the failed vaginal trial of labor: Age (years), parity (times), painless delivery, termination of gestational age (days), amniotic fluid condition, maternal fever, neonatal weight (g), scarred uterus, use of oxytocin, stagnation or prolongation of labor, cephalopelvic disproportion, fetal distress, induction of labor failure, placental factors (placenta previa, placental abruption), fetal heart condition, *etc*.

***Statistical analysis***

Statistical analyses of the data were performed using SPSS 22.0 statistical software. The count data were represented by *n* (%), and the *χ*2 test was performed. The measurement data were represented by the mean ± SD, and the *t* test was performed. *P* < 0.05 was considered statistically significant.

**RESULTS**

***Risk factors for conversion to cesarean section in failed trial of labor***

Univariate analysis showed statistically significant differences between the two groups in age, parity, primipara, fever during birth, neonatal weight, termination of gestational age, and use of uterine contraction drugs (*P* < 0.05). The above factors were related to the failure of the vaginal trial of labor (Tables 1 and 2).

***Multivariate analysis of conversion to cesarean section in failed trial of labor***

Multivariate analysis showed that the differences between the control group and the observation group were statistically significant (*P* < 0.05) in the following factors: Termination of gestational age; primipara; use of labor analgesia; fever during labor; neonatal weight; and use of uterine contractions drugs. These factors were related to the failed trial of labor and were the most important factors affecting the conversion to emergency cesarean section in failed trial of labor, as shown in Table 3.

***Indication analysis of conversion to cesarean section in failed trial of labor***

The main indications for the cesarean section of the observation group included fetal distress in 447 (44.3%) cases, social factors in 138 (12.8%), malpresentation in 101 (9.4%; face presentation, persistent occipitoposterior position, and persistent occipitotransverse position), and cephalopelvic disproportion in 96. Among the indications for cesarean section caused by fetal distress, there were 475 newborns (99.6%) with a 1-min Apgar score of ≥ 8 and 2 newborns (0.4%) with a score of 4-7 (Tables 4 and 5).

**DISCUSSION**

***Analysis of risk factors for failed trial of labor***

This study and related reports[11-14] showed that the age of pregnant women was significantly associated with cesarean section. This study showed that the rate of conversion to cesarean section in trial of labor for elderly parturient women was 8.7%. The incidence of conversion to cesarean section in the labor process was 43.1% due to fetal distress, 12.1% due to malpresentation, 12.1% due to cephalopelvic disproportion, and 6.9% due to social factors. The gradual delay in childbearing age is a global problem, and the study by Rydahl *et al*[12] shows that the proportion of women who have given birth at age 35 years or older has increased from 15% (1998) to 21% (2015). We believe that the fertility of older women is lower, the incidence of pregnancy complications is higher, the placental function and placental blood supply are relatively poor, and the incidence of fetal distress increases during labor. The physical strength, endurance, and muscle and skin elasticity of the elderly parturient are significantly decreased, the function of the myometrium may be impeded, and the difficulty of childbirth is increased. In the process of labor, abnormal conditions such as fetal extension and flexion may occur, and the incidence of malpresentation, cephalopelvic disproportion, and other indications for cesarean section may increase. The fetus of the elderly parturient is relatively precious. If the fetus is slightly abnormal during the labor process, the parturient and family members are willing to give up the trial of labor. This is the reason for an increase in the cesarean section rate caused by social factors.

Related studies[15-17] showed that macrosomia was a risk factor for conversion to cesarean section in trial of labor, which was confirmed to be an independent risk factor in our study. Our data showed that the cesarean section conversion rate in the trial of parturient labor with macrosomia was 18.0%. During the labor process, 24.7% of the cesarean section conversion cases were due to fetal distress, 10.7% due to cephalopelvic disproportion, 9.3% due to social factors, and 8.0% due to malpresentation. In macrosomia, the degree of calcification of the fetal skull increases, which limits the plasticity of the fetal head and increases the risk of malpresentation in the trial of labor, such as cephalopelvic disproportion, persistent occipitoposterior position, and persistent occipitotransverse position. Most cases of macrosomia are accompanied by overdue pregnancy, placental function is relatively decreased, labor is relatively prolonged, and fetal distress is relatively increased. At the same time, the patient is worried about the risk of mother's lateral episiotomy, postpartum hemorrhage, newborn shoulder dystocia, clavicle fracture, *etc.*, directly abandoning the trial of labor, and increasing the cesarean section caused by social factors.

Our study found that the cesarean section rate of delayed pregnancy (≥ 41 wk) was higher than that of normal pregnancy, consistent with the results of Wang *et al*[18] and Mya *et al*[19]. Our study showed that the cesarean section conversion rate in the trial of labor of delayed pregnancy was 19.58%. Among those who converted to cesarean section in delayed pregnancy, 23.9% were due to fetal distress, 13.0% due to abnormal labor, 11.2% to social factors, and 5.1% to malpresentation. Smith *et al*[20] believed that the effect of overdue pregnancy on maternal outcomes primarily lies in placental function and morphological changes. If the maternal placenta function is normal, the fetus is over-expanded, the risk of macrosomia increases, the labor process is prolonged, the active period is stagnant, and persistent occipitoposterior and occipitotransverse positions are a risk, leading to dystocia. Conversely, if maternal placental function is attenuated, the risk of intrauterine distress and even intrauterine fetal deaths increases. At this point, the solution is cesarean section.

Our study concluded that primiparity was an independent risk factor for cesarean section, consistent with the studies by Wang *et al*[21] and Vaughan *et al*[22]. Our data showed that the cesarean section conversion rate in the trial of labor in primiparas was 13.54%. The conversion was due to fetal distress in 33.5%, to social factors in 12.6%, to abnormal labor in 9.1%, and to malpresentation in 11.5%. The primipara may have an insufficient understanding of labor and labor pain. During the labor process, there are negative emotions such as fear, pain, anxiety, nervousness, depression, and decreased appetite, which may lead to uterine atony and abnormal labor. At the same time, most of the patients with negative emotions have hyperventilation and increased oxygen consumption, so the fetal oxygen supply is relatively reduced, and the intrauterine distress is increased. Primiparity at an advanced age may lead pregnant women, their families, and their obstetrician doctors to subconsciously think that the fetus is extremely "precious", the labor process is slightly abnormal, and the requirements for cesarean section indications will be relaxed, increasing the incidence of cesarean section caused by social factors.

Our study found that fever during labor increased the cesarean section rate, consistent with related reports[23,24]. Our study showed that fever in the labor process was due to fetal distress in 22.0% of cases, due to cephalopelvic disproportion in 11.0%, and due to malpresentation in 9.4%. Fever during labor can lead to an increase in maternal heart rate, a relative increase in fetal heart rate, and an increase in the incidence of fetal distress and misdiagnosis. At the same time, the labor process of patients with cephalopelvic disproportion and malpresentation increased relatively, the infection rate increased, and the incidence of fever increased; the two factors affected each other.

Our study showed that the cesarean section conversion rate in the labor induced by uterine contraction drugs was significantly higher than that of natural labor, and uterine contraction drug use was an independent risk factor for the conversion to cesarean section in the trial of labor. The conversion rate of cesarean section in the uterine contraction drug-induced trial of labor was 21.0%. Among them, fetal distress accounted for 32.7%, social factors accounted for 12.4%, malpresentation accounted for 11.5%, and cephalopelvic disproportion accounted for 9.2%. Kominiarek *et al*[25] showed that the immature cervix required oxytocin to induce labor, and uterine inertia and slowed progress in labor were risk factors for cesarean section. Neal *et al*[26] and Kauffman *et al*[27] found that, in patients with natural labor, those with uterine openings less than 4 cm at admission had an increased risk of obstetric intervention, such as oxytocin, and an increased cesarean section rate. Induction of contractions and promotion of cervical ripening during labor may lead to excessive contractions, fetal distress, abnormal fetal position, *etc.*, leading to secondary uterine inertia. At the time of antenatal care, patients and their families who are willing to have a vaginal delivery should be referred for that indication at admission.

***Indication analysis for cesarean section conversion in failed trial of labor***

Natural childbirth itself is a complex dynamic process with many uncertainties. Cesarean section has many indications, including abnormalities in the labor process, birth canal, force of labor, and fetal and maternal factors; some indications are for the obstetric medical staff to make a diagnosis and give advice at the time of birth. Therefore, it is the duty of the obstetrician to strictly control the indications for cesarean section conversion in the failed trial of labor, to guide the mother to choose the correct mode of delivery and to improve the trial of labor success rate.

Our study shows that fetal distress and social factors, which are subjective, are the main indications for cesarean section. These indications for cesarean section have plasticity and may be effective indications for reducing cesarean section. Other indications include malpresentation, cephalopelvic disproportion leading to prolonged labor, and active stage retention.

The diagnosis of intrauterine distress in the fetus is mainly based on fetal movement, electronic fetal heart monitoring, and amniotic fluid status, but there is no uniform standard both in China and other countries. At present, the interpretation of fetal heart monitoring results is mostly judged by clinician experience; there are certain false positive and false negative rates, and some false positive results are very common. Heelan-Fancher *et al*[28] showed an increased cesarean section rate and vaginal assistance rate in continuous electronic fetal heart monitoring applications. In the past, it was thought that intrauterine hypoxia caused an increase in intestinal peristalsis and anal sphincter relaxation, leading to amniotic fluid meconium staining; however, recent studies have shown that vagus nerve stimulation caused by fetal maturation, umbilical cord compression, and other factors will also make the amniotic fluid turbid. Therefore, the traits of the amniotic fluid cannot be used as an independent indication for the conversion to cesarean section based on the diagnosis of intrauterine distress. Continuous electronic fetal heart monitoring will cause the mother to pay too much attention to the fetal heart rate, reduce the accuracy of fetal movement counting, and increase the anxiety during birth; the mother will gradually lose confidence in the possibility of a vaginal delivery. We suggest that fetal heart monitoring can be intermittently performed during the labor process, and comprehensive evaluation of the characteristics of amniotic fluid and the maternal count of fetal movement can be used to reduce the diagnosis of intrauterine distress due to self-protection of the doctor. The pros and cons should be comprehensively analyzed to reduce the cesarean section rate. At the same time, because the fetus of older patients is relatively precious, clinicians will slightly relax the diagnostic indications for fetal distress. Therefore, the incidence of intrauterine distress is increased.

Cesarean section caused by social factors refers to cesarean sections without clear surgical indications and cesarean sections performed at the request of the pregnant women and their families. The main reason for cesarean section caused by social factors without trial of labor is the misunderstanding of vaginal delivery in patients. They fear labor pain, believe that vaginal delivery will affect the beauty of their body, and are concerned that vaginal relaxation may affect their sexual activity. They also believe that, with current improved medical conditions, cesarean section is safer for mothers and babies. Some mothers and family members are superstitious about the "birth time" and require cesarean section. In today's medical environment, medical staff may also relax cesarean section indications. The main reason for cesarean section caused by social factors in the trial of labor is the patient leading a life without hardship. Paroxysmal uterine contractions during the trial of labor make it intolerable for the patients, and they become anxious and fearful; patients often lack of a sufficient understanding of the labor process, which makes them lose the courage to continue the trial of labor, and negative emotions are conveyed to the family. When even the slightest abnormality appears in the labor process or with the fetus, the patient and their families are willing to give up the trial. Mothers and their family members have the right to informed consent. After the doctor fully informs the patients, those who insist on cesarean section cannot be forced to continue the trial of labor. Outpatient medical examination doctors in our hospital guide patients to control their weight, closely monitor blood pressure, blood sugar, *etc.*, and encourage patients and their families to participate in maternity schools to master pregnancy and childbirth-related knowledge, such as maternity exercises, breathing exercises, muscle relaxation, and accompanying delivery skills. Before the birth, doctors fully inform the admitted patients about the vaginal delivery process, the abnormal conditions that may occur, and the related treatment measures, increasing maternal confidence in vaginal delivery. Our study showed that painless delivery is a successful protective factor for vaginal delivery, and that analgesia is delivered to patients who cannot tolerate labor pain.

When the patient feels posterior vaginal emptiness, anal tenesmus, *etc.*, the medical staff should check the actual situation of the patient, observe whether there is cephalopelvic disproportion, malpresentation, or other abnormalities. Active and timely treatment may effectively reduce the cesarean section conversion rate in the trial of labor.

In summary, the conversion to emergency cesarean section in failed trial of labor is related to a variety of factors. Obstetricians should explain the related knowledge comprehensively, carefully conduct prenatal examination, and patiently guide and encourage the mother during the labor process. Doctors should be familiar with the indications for cesarean section, improve the judgment accuracy of the indications for cesarean section, ensure the rationality of cesarean section conversion in vaginal delivery, reduce the cesarean section rate and the trial of labor failure rate, and improve the quality of delivery.

China has 56 nationalities, with more than 1.4 billion people, and is the world's most populous country. People from different ethnic groups and regions have different ideas on the number of children and delivery methods. This data is from the only one hospital, which cannot effectively represent the phenomenon of China. We have a contingent of top-notch researchers that are still counting the follow-up data. Meanwhile, we will apply for relevant research project funding in the future, and strive for more data by combining with hospitals in different regions and ethnic groups.

**ARTICLE HIGHLIGHTS**

## *Research background*

After China’s two-child policy was fully liberalized, the country officially entered the “universal two-children” era, and the obstetrics industry faced enormous challenges brought about by the birth peak. Vaginal delivery is the ideal mode of delivery for the termination of a pregnancy. The cesarean section rate in China is much higher than the published by the World Health Organization in the *Lancet* in 2010.

## *Research motivation*

The motivation of this research was to explore how to promote the trial of labor success rate, and determine the feasibility of reducing the rate of conversion to cesarean section.

## *Research objectives*

## The research objectives were to summarize the related factors of the failed vaginal delivery, and to propose reasonable prevention and resolution strategies to increase the trial of labor success rate.

## *Research methods*

A retrospective analysis was performed on 9240 maternal women who met vaginal delivery conditions and required a trial of labor from January 2016 to December 2018 at our hospital. Among them, 8164 pregnant women who had a successful trial of labor were used as a control group, and 1076 pregnant women who had a failed trial of labor and converted to an emergency cesarean section were used as an observation group. The patients’ clinical data during hospitalization were collected for comparative analysis, the related factors of the failed trial of labor were discussed, and reasonable prevention and resolution strategies were proposed to increase the trial of labor success rate.

## *Research results*

The analysis revealed that advanced age, macrosomia, delayed pregnancy, use of uterine contraction drugs, primipara, and fever during labor were associated with conversion to emergency cesarean section in failed trial of labor. Multivariate regression analysis showed that age, gestational age, primipara, use of uterine contraction drug, fever during birth, and newborn weight led to a higher probability of conversion to an emergency cesarean section in the failed trial of labor.

## *Research conclusions*

The conversion to emergency cesarean section in failed trial of labor is affected by many factors.

## *Research perspectives*

The authors will still count the follow-up data and apply for relevant research project funding in the future, and strive for more data by combining with hospitals in different regions and ethnic groups.

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**Footnotes**

**Institutional review board statement:** This study was reviewed and approved by the Ethics Committee of the General Hospital of Northern Theater Command (Heping Campus).

**Informed consent statement:** All study participants, or their legal guardian, provided informed written consent prior to study enrollment.

**Conflict-of-interest statement:** We have no conflicts of interest to disclose.

**Data sharing statement:** No additional data are available.

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**Manuscript source:** Unsolicited manuscript

**Peer-review started:** April 7, 2020

**First decision:** April 22, 2020

**Article in press:**

**Specialty type:** Medicine, research and experimental

**Country/Territory of origin:** China

**Peer-review report’s scientific quality classification**

Grade A (Excellent): 0

Grade B (Very good): B, B

Grade C (Good): 0

Grade D (Fair): 0

Grade E (Poor): 0

**P-Reviewer:** Awad Z, Martelotto S **S-Editor:** Wang JL **L-Editor:** Wang TQ **E-Editor:**

**Table 1 General data analysis of the two groups (mean ± SD, *n* = 9240)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Group** | **Cases** | **Age (yr)** | **Gestational age (d)** | **Gravidity (times)** | **Neonatal weight (g)** |
| Observation | 1076 | 29.33 ± 3.04 | 279.85 ± 7.01 | 1.43 ± 0.74 | 3329.73 ± 324.57 |
| Control | 8164 | 29.13 ± 3.45 | 277.59 ± 7.18 | 1.58 ± 0.88 | 3651.35 ± 337.62 |
| *t* |  | 1.847 | 9.727 | -5.63 | 7.63 |

**Table 2 Comparison of basic data and labor management between the two groups**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Pregnancy outcome** | | | | ***χ*2** | ***P* value** |
| **Control group (vaginal delivery)** | | **Observation group (conversion to cesarean section)** | |
| **Frequency** | **Percent** | **Frequency** | **Percent** |
| Age (yr) | | | | | | |
| ≤ 20 | 34 | 0.4 | 3 | 0.3 | 0.503 | 0.478 |
| 20-35 | 7523 | 92.2 | 1015 | 94.3 |  |  |
| ≥ 35 | 607 | 7.4 | 58 | 5.4 | 6.005 | 0.014 |
| Neonatal weight (g) | | | | | | |
| < 2500 | 37 | 0.4 | 6 | 0.6 | 0.381 | 0.537 |
| 2500-4000 | 7444 | 91.2 | 920 | 85.5 |  |  |
| ≥ 4000 | 683 | 8.4 | 150 | 13.9 | 36.186 | 0.000 |
| Gestational age (wk) | | | | | | |
| < 37 | 54 | 0.7 | 5 | 0.6 | 0.303 | 0.582 |
| 37-41 | 7298 | 89.4 | 874 | 88.2 |  |  |
| ≥ 41 | 812 | 9.9 | 197 | 11.5 | 67.943 | 0．000 |
| Use of uterine contraction drugs | | | | | | |
| Yes | 2578 | 31.6 | 447 | 44.3 | 42.873 | 0. 000 |
| No | 5586 | 68.4 | 559 | 55.7 |  |  |
| Parity | | | | | | |
| Primipara | 6642 | 81.4 | 1040 | 96.7 | 158.695 | 0. 000 |
| Multipara | 1522 | 18.6 | 36 | 3.3 |  |  |
| Fever during labor | | | | | | |
| Yes | 365 | 4.5 | 191 | 17.8 | 296.479 | 0. 000 |
| No | 7799 | 95.5 | 885 | 82.2 |  |  |
| Labor analgesia | | | | | | |
| Yes | 3685 | 45.1 | 415 | 38.6 | 16.617 | 0. 000 |
| No | 4479 | 54.9 | 661 | 61.4 |  |  |
| Scarred uterus | | | | | | |
| Yes | 23 | 0.3 | 5 | 0.5 | 1.053 | 0.305 |
| No | 8141 | 99.7 | 1071 | 99.5 |  |  |
| Abnormal amniotic fluid (meconium stained or bloody) | | | | | | |
| Yes | 2158 | 26.4 | 290 | 27 | 0.131 | 0.717 |
| No | 6006 | 73.6 | 786 | 73 |  |  |
| Prolonged labor/active stage retention | | | | | | |
| Yes | 344 | 4.2 | 56 | 5.2 | 2.254 | 0.133 |
| No | 7820 | 95.8 | 1020 | 94.8 |  |  |
| Prolonged pregnancy | | | | | | |
| Yes | 7 | 0.1 | 1 | 0.1 | 0.006 | 0.94 |
| No | 8157 | 99.9 | 1075 | 99.9 |  |  |

**Table 3 Multivariate logistic regression analysis of conversion to cesarean section in failed trial of labor**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Factor** | **β** | **SE** | **Wald** | ***P* value** | **OR** | **95%CI** | |
| **Lower limit** | **Upper limit** |
| Age | -0.274 | 0.148 | 3.413 | 0.065 | 0.760 | 0.569 | 1.017 |
| Gestational age | -0.619 | 0.090 | 47.055 | 0.000 | 0.538 | 0.451 | 0.642 |
| Primipara | -2.036 | 0.179 | 129.417 | 0.000 | 0.131 | 0.092 | 0.185 |
| Uterine contraction drugs | -0.324 | 0.070 | 21.557 | 0.000 | 0.723 | 0.631 | 0.829 |
| Fever during birth | -1.426 | 0.100 | 203.684 | 0.000 | 0.240 | 0.198 | 0.292 |
| Neonatal weight | -0.282 | 0.052 | 29.809 | 0.000 | 0.754 | 0.681 | 0.834 |
| Labor analgesia | 0.620 | 0.070 | 77.782 | 0.000 | 1.858 | 1.619 | 2.132 |

**Table 4 Analysis of indications for conversion to cesarean section in failed trial of labor**

|  |  |  |  |
| --- | --- | --- | --- |
| **Indication for conversion to cesarean section** | **Frequency** | **Constituent ratio (%)** | **Ordinal position** |
| Fetal distress | 477 | 44.3 | 1 |
| Social factors | 138 | 12.8 | 2 |
| Malpresentation | 101 | 9.4 | 3 |
| Cephalopelvic disproportion | 96 | 8.9 | 4 |
| Prolonged labor/active stage retention | 56 | 5.2 | 5 |
| Chorioamnionitis | 51 | 4.7 | 6 |
| Macrosomia | 48 | 4.5 | 7 |
| Fever during labor | 20 | 1.9 | 8 |
| Placental abruption | 16 | 1.5 | 9 |
| Pregnancy complication | 15 | 1.4 | 10 |
| Oligohydramnios | 14 | 1.3 | 11 |
| Other | 14 | 1.3 | 11 |
| Premature rupture of membranes | 10 | 0.9 | 12 |
| Umbilical abnormality | 10 | 0.9 | 12 |
| Induction failure | 5 | 0.5 | 13 |
| Scarred uterus | 5 | 0.5 | 13 |

**Table 5 Analysis of indications for conversion to cesarean section in women with high risk factors for vaginal trial of labor failure, *n* (%)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Advanced age (*n* = 58)** | **Gestational wk ≥ 41 (*n* = 197)** | **Primipara (*n* = 1040)** | **Uterine contraction drugs (*n* = 477)** | **Fever during labor (*n* = 191)** | **Macrosomia (*n* = 150)** |
| Fetal distress | 25 (43.1) | 47 (23.9) | 349 (33.5) | 156 (32.7) | 42 (22) | 37 (24.7) |
| Social factors | 4 (6.9) | 22 (11.2) | 131 (12.6) | 59 (12.4) | 13 (6.8) | 14 (9.3) |
| Malpresentation | 7 (12.1) | 10 (5.1) | 78 (7.5) | 55 (11.5) | 18 (9.4) | 12 (8) |
| Cephalopelvic disproportion | 6 (10.3) | 9 (4.6) | 95 (9.1) | 44 (9.2) | 21 (11) | 16 (10.7) |
| Abnormal labor | 4 (6.9) | 13 (6.6) | 39 (3.8) | 27 (5.7) | 10 (5.2) | 8 (5.3) |
| Other | 12 (20.7) | 96 (48.8) | 348 (33.5) | 136 (28.5) | 87 (45.6) | 63 (42) |