

Choosing a cesarean birth to 'protect' your pelvic floor? Here's why that won't necessarily work

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Credit: AI-generated image ([disclaimer](#))

It's commonly understood that having a baby can be a primary cause of later pelvic floor problems, such as bladder leakage. While giving birth can be a very special and joyful time, it can sometimes be difficult returning to day-to-day activity postpartum.

About one in three women who've have had a baby experience [urinary incontinence](#). A similar proportion will have [prolapse symptoms](#) like vaginal heaviness or bulging.

You might guess that choosing a cesarean section—that is, a surgical birth via the abdomen—rather than a [vaginal birth](#) could be a sensible way to avoid such symptoms. You could assume doing so would avoid any direct stretching and trauma to the [pelvic floor muscles](#).

However, it's not that simple. It turns out pregnancy itself, [regardless of the mode of delivery](#), is a significant risk factor for pelvic floor dysfunction.

Under pressure

During pregnancy, there is a rapid increase in pressure and strain on the pelvic floor from the growing baby and increasing fluid load. Add to this a [high likelihood of constipation](#) during and after pregnancy causing straining that further weakens already stretched muscles.

A growing belly also stretches and weakens the [muscles of the abdominal wall](#) and changes our posture, impacting core stability and the function of the trunk and pelvis.

[Changes in hormones](#) during pregnancy soften our muscles, tendons and ligaments to allow the pelvis to widen during labor and delivery. This reduces the stability of the pelvic floor and supporting tissues.

So the risk for pelvic floor compromise is already there—well before any type of delivery.

Other risk factors

Add to this other non pregnancy-related [risk factors](#) for pelvic floor weakness such as:

- being a woman (our widened pelvis and extra gap in the muscles for the vaginal canal compromise pelvic floor strength)
- being overweight
- previous pelvic surgery
- advancing age
- ethnicity and genetics
- family history of incontinence, prolapse and connective tissue disorders
- participation in repetitive high impact sports like dancing, CrossFit and running
- repetitive heavy lifting (occupational or with sports like weightlifting)
- a history of excessive coughing, sneezing or vomiting
- constipation and straining.

It's a long list of contributing factors to pelvic floor dysfunction that don't have anything to do with having a vaginal or cesarean delivery.

That said, a vaginal delivery (particularly a difficult one) does add risk factors. This is especially [true if](#):

- the baby is large (weighing more than 4 kilograms) on delivery
- instrumental assistance is required, especially forceps
- the second stage of labor (the pushing phase) is [longer than an hour](#)
- muscle damage or high-grade perineal tearing ([damage](#) to the tissues between the vagina and the anal sphinter) occurs.

A cesarean is certainly not the "easy way out" either. [Recovery from a C-section](#), even a planned one, can be challenging as it is major abdominal

surgery. It means avoiding lifting anything heavier than your baby for six weeks, not driving until medically cleared, reduced mobility, and incision pain. As with any surgery, it carries the risk of complications such as infection, reaction to the anesthetic, surgical injury and [blood clots](#).

Birth planning with your pelvic floor in mind

There are pros and cons to [both modes of delivery](#) when considering potential long-term impacts on function. Individualized counseling with your medical provider during pregnancy is highly recommended, as everyone's personal [risk factors](#), circumstances and preferences are unique.

Using a [risk calculator tool](#) may be a useful starting point when discussing with your care team whether a vaginal or cesarean birth may be more suitable for you.

If you are planning a vaginal delivery, there are a few things [research shows](#) can reduce your risk of pelvic floor injury and dysfunction:

- maintain a healthy [body weight](#)
- practice [pelvic floor exercises](#) during pregnancy, under the guidance of a suitably trained professional such as a pelvic floor physiotherapist
- participate in supervised exercise classes specifically tailored for pregnancy and pelvic floor awareness
- start [perineal massage](#) from 35 weeks of [pregnancy](#) to improve [muscle](#) flexibility and blood flow
- adopt [upright positions](#) for labor and delivery if it feels right and is safe and comfortable, which may allow for gravity assistance, more efficient contractions and a widened pelvic outlet
- push when you [feel urges](#) rather than following "directed

pushing" from others

- use a [warm compress](#) on the perineum during crowning to relax the muscles
- a mediolateral episiotomy (planned cut to the perineal muscles) with [forceps-assisted deliveries](#) rather than allowing uncontrolled tearing towards the anal sphincter muscles. This is not the same as a midline episiotomy, which carries [different risks](#).

Whether you choose to birth vaginally or via cesarean is a decision that is very personal and involves many factors. Due to unforeseen complications, sometimes this decision can be taken out of our hands so it is beneficial to be well-informed on both options.

Regardless of mode of [delivery](#), it's important to learn how to [effectively exercise your pelvic floor muscles](#) for prevention and treatment of [pelvic floor](#) symptoms such as incontinence and prolapse. Today's a great day to get started.

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