

Author reply

Ospan Mynbaev and colleagues are rightly concerned about the effect of surgical techniques on the integrity of the uterine scar and the presence of abdominal adhesions, arguing that unless these are studied indirectly by imaging or directly by surgical inspection, then no comments can be made on the impact of the different techniques on these outcomes. Our view is different. Take the example of the uterine incision. Although we can visualise the scar and identify apparent defects, how do we interpret these findings unless we know what features lead to scar rupture? The real outcome of clinical interest is scar rupture. The appearance of the scar is a surrogate that is only useful if we can clearly identify the link between different aspects of the appearance of the scar and the risk of a subsequent rupture. We agree that with so many women in the CORONIS trial¹ having a repeat caesarean section without labour the trial was not powered enough to explore such risk. However, this does not mean that we should rely on the appearance of the scar to make clinical decisions. The same applies to abdominal adhesions. If there are adhesions but these cause no symptoms, what is their significance? How can we justify subjecting women to laparoscopy and laparotomy to investigate the presence of adhesions if the majority of these are irrelevant to the woman's later health?

Andrea Papadia and colleagues quote guidance from the American College of Obstetricians and Gynecologists suggesting that we should perform fewer primary caesarean sections and increase the rate of vaginal birth after previous caesarean section. We strongly agree with these sentiments. In low-income and middle-income countries, the occurrence of caesarean section

appears to be increasing. CORONIS has shown a high rate of repeat elective caesarean section in the participating hospitals, which were all large, predominantly teaching hospitals that are unlikely to be representative of all hospitals in these countries. This might also explain the low incidence of complications following caesarean section in these settings. Limiting the use of caesarean section to individuals who need this intervention is important to improve outcomes and reduce costs. Nevertheless, that should not prevent us from exploring the safest possible method of undertaking caesarean sections when they become necessary. We agree with Bolla and colleagues, however, that no matter how safe a caesarean section is, it should not change the threshold for the use of this major intervention.

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- 1 The CORONIS collaborative group. Caesarean section surgical techniques: 3 year follow-up of the CORONIS fractional, factorial, unmasked, randomised controlled trial. *Lancet* 2016; 388: 62-72.