



High Time for Routine Implementation of the Robson Ten-Group Classification for Cesarean Sections Reporting in India!!!

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This is in reference to the article titled “Trend Prediction for Cesarean Deliveries Based on Robson Classification System at a Tertiary Referral Unit of North India” published in your esteemed journal in March–April, 2020 issue. ¹ In 1985, World Health Organization (WHO) made a remark regarding cesarean delivery (CS) rate and suggested that it should not be more than 10–15%. CS rates have risen from what the “ideal rate” should be to a rate which needs to be proved apposite considering the pros and cons of cesarean delivery in modern Obstetrics. Nowadays, the Obstetricians are being increasingly accused as a factor behind this rate hike. In view of striking improvement in clinical Obstetrics outcome, there is rising demand by the clinicians for re-appraisal of the existing recommended rate proposed by WHO. The cited article has audited cesarean deliveries using Robson system on a very huge database and also predicted future trend based on the same giving an opportunity to plan and check in advance, the major contributory populations to cesarean deliveries.

The Robson Ten-Group Classification System (TGCS) proposed by Michael Robson (2001) is a simple, reliable, globally applicable system to gather standardized data across the international boundaries for easy comparisons. Thus, it can enable us to determine adequate CS rate which was definitely a great challenge till now. TGCS is a standard classification system of ten mutually exclusive (hence preventing data duplication) and comprehensive classes, allowing easy

analysis. This classification can be used for local/regional/national/international comparisons.

It categorizes women according to very basic Obstetric characteristics (data) which are routinely collected at all Obstetrics center. Hence, it allows comparisons with the least confounding variables. These are parity (primi/multiparous, with or without previous cesarean section), onset of labor (spontaneous/induced or pre-labor CS), gestational age (preterm/term), fetal presentation (cephalic/breech/transverse) and number of fetuses (single/multiple). This is further divided into ten groups which can easily allow intergroup and intragroup comparison and analysis. An expert panel meeting convened by WHO at Geneva in October 2014 has recommended the routine application of Robson classification to categorize every woman admitted for delivery and whenever possible the results should be made publicly available. With this, recently TGCS has been adopted in many countries like UK, Scandinavia and Canada.

Vogel et al. (2015) analyzed contributions of specific Obstetric population to changes in CS rates by using Robson classification in two WHO multi-country surveys of deliveries in 287 healthcare facilities in 21 countries across the globe published in Lancet Global Health. These two surveys were WHO Global Survey of Maternal and Perinatal Health (WHOGS; 2004–2008) in Latin American, African and Asian countries and the WHO Multi-country Survey of Maternal and Newborn Health (WHOMCS; 2010–2011). They concluded that use of Robson criteria allows standardized comparisons of data across the countries. It identifies the main contributor subpopulation responsible for changing cesarean rate and thus can help to formulate strategies to reduce CS rate. The main subgroup contributing to CS belonged to group 5, i.e., multiparous, term, cephalic, singleton with previous CS.

Globally, different health authorities and teaching institutes have reported their encouraging experience with the use of this system and recommend its widespread use.

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A PubMed search with keywords “Robson” and “Cesarean” and “India” revealed only six studies (two from Maharashtra and one each from Bihar, Bengal, Gujarat and Delhi) highlighting its positive application in India [1–6]. Currently, the need for standardized Obstetrics practice analysis is need of the hour. It is high time to inculcate TGCS as a routine for data recording and CS rate reporting in India, hereafter. This will enable us to identify the main contributor group and plan strategies to decrease the number of CS wherever possible. The multicentric data thus collected can further help in formulating a new ceiling rate of CS for our population.

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