

## CLINICAL REPORT

# The Use of Ear Acupuncture to Promote Vaginal Delivery After Previous Caesarean Section

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*Keywords:* Acupuncture, ear acupuncture, Caesarean Section, childbirth, vaginal delivery, obstetrics, midwifery, ovarian cyst, abdominal scar.

*Abstract:* Six obstetrical patients with a transverse lower abdominal surgical scar were treated near term with ear acupuncture to assess whether “ear balancing” could help bring about a normal vaginal delivery. Five of the patients had a previous Caesarean section, and one had previous surgery for an ovarian cyst. The results suggest that this simple procedure could smooth out many situations involving labour and delivery, and possibly reduce the Caesarean section rate.

The practice of obstetrics has long resided in the domain of conventional medicine where few doctors have experience in acupuncture and related systems of medicine. Similarly, few acupuncturists practice obstetrics. It is, therefore, not surprising that there has been little information regarding the possibility of using acupuncture to assist the process of labour and delivery. As a family doctor practicing acupuncture and obstetrics in my practice, I have had a unique opportunity to use some of the emerging energetic techniques in certain obstetrical situations.

### The Issue of Caesarean Section

All is not well in the halls of conventional obstetrics. The Caesarean section rate in many North American hospitals has become alarmingly high. In Canada, the rate per 100 deliveries increased from 5.7 in 1970 to 15.9 in 1980.<sup>i</sup> Meanwhile, in the United States the section rate increased from 5.5 in 1970 to 22.7 in 1985.<sup>ii</sup> As much as 60% of this increase has been attributed to repeat Cesarean sections, but there have also been increases in the primary Cesarean section rate from indications such as dystocia, breech presentation of foetal distress.<sup>iii</sup> While maternity units and obstetricians are well aware that the figure is unacceptably high, few hospitals are able or willing to do anything about the issue.

Several reasons have been proposed to explain why this situation has occurred:

1. Patients often have an expectation that modern medicine should guarantee a perfect outcome. That, combined with the physician's natural fear of lawsuits, has led physicians in difficult situation to opt for a Caesarean section rather than risking a more difficult forceps delivery.

2. In the past, many obstetricians have had a policy of doing repeat Caesarean sections in cases where a woman has had a previous C-section, rather than seeing whether she could deliver vaginally. The idea “Once a Caesarean section, always a Caesarean section” is now being questioned, and vaginal delivery after Caesarean section (VDACS) is becoming more commonplace.
3. The introduction of electronic foetal monitoring has led to an over-diagnosis of foetal distress in utero, thus, leading to unnecessary surgical intervention.
4. The same emphasis on high technology in hospitals has turned the delivery room into a fearsome experience for women, thus, leading to a situation in which all parties are rather anxious.

The use of high technology in the delivery room may actually do more harm than good.<sup>iv</sup> For example, at least eight studies have suggested that the routine use of foetal monitoring during labour increases the Caesarean section rate, with no improvement in outcome, even in high risk pregnancies.<sup>v,vi,vii,viii,ix,x,xi,xii</sup> Other studies have confirmed the safety of freestanding birth centres that practice “home-like” birth for low risk women.<sup>xiii,xiv</sup> Additionally, other studies have shown the safety and effectiveness of low-tech deliveries by midwives.<sup>xv</sup> But, in spite of this information, the trend toward delivering babies in high-tech institutions continues.

### ***The Role of Fear in the Delivery Room***

Hospitals have responded to the alarming C-section rates by introducing birthing rooms, which look like family bedrooms, while hiding the technology away in cupboards, and the sterile atmosphere of the old delivery rooms has certainly disappeared. To some extent, this has improved the situation, however the tendency toward active intervention remains. This is because although the trappings of technology may be hidden, the fear of a poor outcome remains in both doctor and patient. No amount of hiding away the technology can get away from the fact that doctors and patients alike are scared. Doctors fear they will be sued if they don't deliver a perfect baby, and patients are fearful they will receive unnecessary and unwarranted intervention.

In our view, the high Caesarean section rate needs to be understood in the context of the presence of “fear and mistrust” in the physician-patient relationship. Few people recognize that that fear is the root difficulty, and fewer still understand the phenomenon of fear projection. In fear projection, the inner fear is placed or projected onto something outside of the self. Psychologists understand the phenomenon, but obstetricians and patients usually do not. The effect of fear projection is that doctors project their fear onto the patients, seeing every patient as a potential lawsuit; similarly, patients project their fear onto the doctors, seeing every physician as someone who may very well violate their bodies. In such a climate of mutual projections, it is hard to see how there will be any meaningful positive impact on the Caesarean section rate through the measures currently being instituted.

Patients have responded to the perceived problems of hospital deliveries in novel ways. Some have demanded that absolutely no intervention at all be implemented, thus tying their doctor's hands. This approach could be likened to asking a carpenter to build a house without the use of a hammer. Others have taken a belligerent attitude to their physicians, threatening legal action should anything go wrong. Yet others have opted to have their babies at home, either delivering

the baby themselves, or using a midwife or doctor who is willing to attend a home birth. The difficulty with that approach can often be that of finding a doctor or midwife willing to come to the home to deliver babies. Doctors risk the ire of their associations if they attend a home birth, and, therefore, are loath to be involved. Midwives who attend home births may actually be breaking the law, and risk criminal prosecution in addition to a lawsuit should something go wrong.

Thus, the attempt to circumnavigate the problem in hospitals only leads to more fear which is, in fact, the root issue.

### ***The Paradox of Fear and Previous Caesarean Section***

For women who have had a previous Caesarean section, the fear of having another similar delivery experience becomes an overriding concern. They may become obsessive in their attempts to avoid a repeat Caesarean section, with the unfortunate result that their original anxiety becomes amplified. Some of them are so frightened of repeating their previous experience they try to over-control the process of labour-delivery, making virtually impossible demands of non-interference from their physicians. Some women, after reading about Caesarean section rates, feel that their previous section was perhaps unnecessary and blame the physicians for their experience. These ladies pose a difficult problem for their physicians, because, their inner anxiety does not make for an easy delivery the second time round. Thus, paradoxically, the fear of intervention may lead to the inability to relax during labour, and hence predispose the expectant mother to further intervention.

No one has suggested an approach based primarily on addressing the root fear (beyond simply acknowledging it and perhaps talking about it), since 1) few people acknowledge that fear is a real issue, and 2) few physicians are aware that techniques exist which could help release the tension associated with that fear.

### ***The Role of Acupuncture***

In China, acupuncture has been used for thousands of years as an adjunct to conventional management of pregnancy-labour-delivery. Protocols for treating various common situations have been well described, and now appear in English translations.<sup>xvi</sup> A few reports have also been published in the West.<sup>xvii,xviii,xix</sup> However, these techniques have never been in common usage in the West. Few Western physicians have an inkling of how acupuncture might best be used. Few Western physicians read the journals in which this information is contained. It is, therefore, unlikely that the present situation will change quickly. In addition, since physicians are already anxious about the outcome of labour-delivery, few physicians would see the sense in using alternative techniques, especially in problem situations, when they are already having a difficult enough time staying out of trouble. In some communities a physician who tries using acupuncture must do so in secret, with the cooperation of his patients and without telling anyone he is doing so, since he could risk criticism from his colleagues for using techniques untested by conventional medicine.

In many ways, physicians are damned if they do and damned if they don't. If they don't do something new to improve matters, the Caesarean section rate won't change and they will face continuing lawsuits. If they do something new without the sanction of conventional medicine, they will be criticized for not following standard procedure. That is, of course, why so many interventionist techniques continue to be untested or unchallenged for years. They were implemented at a time when technology was thought to be good, and now no one dares question the wisdom of their predecessors.

### ***Acupuncture and Scars***

Acupuncture has proved very useful in the helping patients who experience atypical pain resulting from surgical scars. In some cases, other inexplicable postsurgical symptoms also clear up with acupuncture therapy, leading to the conclusion that scars have an effect on the whole body-mind.<sup>xx</sup> The notion that scars may have an effect on the body beyond the physical scar is perhaps a difficult notion to accept. Reference to the Caesarean section scar, however, can help to bring this idea into focus. For example, since the scar leaves the expectant mother in a heightened state of anxiety regarding the possibility of a repeat Caesarean section, the scar can be conceptualized as including an "emotional" dimension. It, therefore, impacts on the whole body-mind of the patient. Further, since ignoring the psychological effects of the scar can leave the physician in an impossible situation vis-à-vis the patient's demands, physicians would be well advised to acknowledge the emotional component of the previous Caesarean section scars, or continue to suffer the possible consequences.

### ***Auricular Medicine***

Ear acupuncture also has a lengthy Chinese history, but in recent years much new work has been done in that field by Nogier in France.<sup>xxi</sup> Nogier had the insight to see that the huge number of seemingly unrelated points on the ear could easily be represented by projecting an upside-down fetus on the ear-lobe. In a stroke, Nogier transformed ear acupuncture from an esoteric field into a simple and powerful modality.

Over the last 30 years, ear acupuncture has been expanded and developed into a system of medicine known as "auricular medicine". One commonly accepted technique uses the interaction of a series of filters with the body's bioelectric field to determine suitable acupuncture points for individual treatment.<sup>xxii</sup> The acupoints are located by a fairly complex procedure involving the palpation of the radial pulse and feeling for the "auricular cardiac reflex" more commonly referred to as the VAS (vascular autonomic signal). A positive VAS will occur when a filter or tissue sample crosses the edge of the bioelectric field or when an electrically active point in the ear is being appropriately stimulated. Through the use of various filters, tissue samples, and reading the vascular autonomic reflex (VAS), the body "tells" the practitioner which points are most appropriate to be treated for any particular condition. IN this way the practitioner does not need to know any particular conceptual framework, he just needs to master the techniques of feeling the VAS.

Auricular medicine has been used to treat the effect of scars on the body-mind in much the same way that body acupuncture has been used. The points representing scars in the ear can be located

using two standard penthonium filters place on the arm and the neck, reading the VAS and scanning the ear with Kodak no. 24 light, or the black/white hammer (Sedatelec, Irigne, France). Once the point is located, stimulation can be performed with a needle, gold button, or an electrical stimulator.

In this particular series we used a NET 2 neuro-electrical stimulator.<sup>xxiii</sup> The NET 2 is a pocket-sized transcutaneous micro-electrical current stimulator which makes the finding and treating of ear points extremely simple and quick (*see Figure 1*). It puts out five simultaneous body-frequencies with harmonics as defined by Nogier, thus simplifying treatment to the press of a button. A typical treatment session will take no longer than twenty minutes, so treatment can be incorporated into an obstetrical office visit without much inconvenience. What is more, since no needles are used, there is no fear of being accused later of having transmitted hepatitis, AIDS, or any other infectious disease to the patient.

### ***Scars and TCM***

Most of the patients were concerned about the possibility of having another surgical intervention, and wondered if there was anything we could do with acupuncture to mitigate the possibility.

Although the individual circumstances of each patient was unique, the common underlying imbalance was an overriding concern that something was “out of balance”, or that the Caesarean section scar was somehow making the weak.

Although a Caesarean scar may be vertical or horizontal, many section scars are horizontal due to the patient’s demands to hide the scars below the bikini line. This kind of scar crosses the Liver, Spleen, Stomach, Kidney and Conception Vessel meridians, and therefore poses much more of an energetic hazard than a simple vertical midline incision.

One most common energetic configuration in the diagnosis of North American women is a stagnation of Liver Qi. When this pre-existing configuration is combined with a transverse Pfannenstiel incision, stagnation of the flow of Qi in the pelvis can occur, and may result in obstruction of labour. Since most maternity patients are young, they usually have lots of innate energy. Their “Qi” is strong, so to speak. The effect of the surgical scar in most women is, therefore, one of stagnation, rather than an inherent energy deficiency, although there is of course much individual variation.

### ***Methods***

Patients with appropriate obstetrical concerns were seen at or near term, or even post-term in some cases. Sessions of ear balancing were performed three times per week until delivery. Location of blocks was performed by initially using penthonium filters placed on the arm and the neck. Next a melanine filter was used to locate the root points. Stimulation was performed with a NET 2 neuro-electrical stimulator at mid-range frequency setting (56-66 micro-amps) while gauging the result by monitoring the VAS for a pulse change. (Acupuncture needles could be used instead. For stagnant Qi we suggest point sedation).

Most cases required only one or two treatments although in some cases up to four were used (see Table 1).

### ***Case Studies***

**Case 1.** P.H., age 33, gravida 3, para 1. Spontaneous miscarriage at 12 weeks at age 29. Previous Caesarean section at age 32 for failure to progress during the first stage of labour for her first born daughter.

This patient was seen one week after her due date. She said that she felt weak in the lower abdomen in the area where she had her Caesarean section scar. She asked me if there was anything I could do about it. She said she felt almost certain to have another Caesarean section. Under the circumstances I thought she was probably correct, and so we decided to see if ear acupuncture might be helpful.

Examination of the auricle revealed much electrical activity in the abdominal area representing the scarred area, and a point in the liver area correlation with the stagnant Liver Qi. Four hours after stimulating these points P.H. delivered a healthy baby girl weighing 2330 gm. (This was on case in which I did not even make it to the delivery room. When I saw P.H. the next day she was beaming and in no way disturbed by my absence the day before). She said that after the treatment she had felt quite differently, stronger and had no doubts about her ability to deliver. Labour had started almost immediately and delivery was quick and uneventful.

**Case 2.** A.T., age 36, gravida 2, para 0. Ovarian cystectomy at age 16, miscarriage at 24 weeks at age 34.

This patient was somewhat frightened by her previous experience in the hospital in which she had miscarried at 24 weeks and lost her baby. Consequently she had decided to allow only minimal medical interference for her second attempt at having a child. She hired a midwife to oversee the pregnancy. (In 1992 in British Columbia, midwives were not a legal profession). The pregnancy proceeded without problems until a few days before the due date when her membranes ruptured. A.T. refused to go to the hospital, reasoning that the obstetricians would probably try to induce labour. She was terrified that an attempted induction would simply lead to Caesarean section or to other surgical interference. She elected instead to stay at home, with the midwife monitoring her condition closely. This situation continued for five days before she finally contacted me. At this point there was no sign of foetal distress, and the mother's temperature was quite normal. There had been slow leakage of amniotic fluid over the five days.

A.T. asked me to perform acupuncture to induce a natural labour, and under the circumstances I found it difficult to refuse. Examination of her ear revealed two large and congested veins in the abdominal area, with much electrical reactivity in the same area. There was also a very active point in the Liver areas correlating with the stagnant Liver Qi (*see Figure 2*). After the field was balanced, A.T. got up and said she felt "quite different". She said she was no longer tired and depressed, but instead felt a surge of energy and was ready to deliver.

Six hours later she delivered a 3350 gm baby girl without even an episiotomy. Second stage lasted 30 minutes. This case was particularly gratifying, as I believe A.T. had a very good chance of ending up with a Caesarean section, had standard protocol been applied.

**Table 1.**  
Case summaries

CASE	AGE/PARITY	TREATMENTS	OBSTETRICAL HISTORY	LABOUR	OUTCOME
1. P.H.	33 G3,P1	1	41 weeks, previous C-section	Stage 1: 33 min stage 2: 22 min vag. del.	Girl, 2330 gm. healthy
2 A.T.	36 G2,P0	2	40 weeks ruptured membranes for 5 days; previous surgery for ovarian cyst	Stage 1: 4 hrs. stage 2: 48 min	Girl, 3350 gm. meconium aspiration
3. L.S.	30 G2,P1	2	40 weeks previous C-section	Stage 1: 8 hrs. stage 2: 1 hr. vag. del.	Boy, 3050 gm. healthy
4. A.M.	33 G2,P1	1	40 weeks previous C-section	Stage 1: 5.5 hrs. stage 2: 1.5 hr. vag. del.	Girl, 3668 gm. healthy
5. A.M.	29 G2,P1	1	Early induction at 38 weeks for ?VDACS, previous C-section, mild disproportion	Stage 1: 12 hrs. stage 2: 2 hrs. vag. del.	Boy, 3680 gm. healthy
6. S.M.	32 G2,P1	4	41 weeks, thick cervix probable C-P disproportion body acupuncture used to induce labour	Stage 1: 12 hrs. C-section. No progress beyond 3 cm. dilation	Boy, 4445 gm. healthy
ABBREVIATIONS G = GRAVIDA; P = PARA; VAG. DEL. = VAGINAL DELIVERY					

### Comments

Five of the six patients were attempting vaginal delivery after previous Caesarean section. One patient had a lower abdominal scar for other reasons. Only one patient required a repeat Caesarean section, and in that case there was clear cephalo-pelvic disproportion and a very large baby. One baby had some difficulty at birth with meconium aspiration, was in intensive care for several days, but has subsequently developed normally. In that case the mother had gone with untreated ruptured membranes for five days, a situation that might have ended in disaster.

This study produced some dramatic responses to what can only be described as a very simple procedure. One most notable observation was the appearance of the ear at or near term. In cases where there was stagnation of Qi in the pelvis, there was an engorgement of one or two veins in the auricle of the upper ear. The area in question corresponds to the mesenchyme or muscular apparatus of the lower abdomen, according to the phase 1 mapping of the ear by Nogier.

Most of the electrically active points found in the ear were located within the area circumscribed by the two veins, just inside the helix. Thus the location of the veins appeared to actually map the area which needed to be stimulated. Observation of this area in expectant mothers nearing labour, or in labour, may reveal this interesting sign, and if the veins are engorged, indicate the need for treatment.

The apex of the triangle formed by the veins coincided with the area in the concha representing the Liver or the Gall Bladder. This point could well represent the point for Stagnant Liver Qi and, therefore, represent the root point of the energetic imbalance.

## **Discussion**

The remarkable aspect about the phenomenon described in this paper is that the ear acupoints which the body-mind “wants” treated during a difficult labour seem to be elegantly displayed for any observer who cares to look. Finding the appropriate points, therefore, does not require mastering the ability to detect the VAS, no matter how useful that skill might be. Nor does treating the points require any specialized skill with the insertion of acupuncture needles.

Finding and treating appropriate points during labour-delivery could be done in just a few minutes. The more complex approach using the VAS, as described in this paper, is not actually necessary to get good results. The procedure could, therefore, be done routinely in hospital labour-delivery units without personnel having any specialized training in acupuncture, and without compromising existing regimens. Since the technique doesn't interfere with the process of labour-delivery, there is unlikely to be any downside to worry about. That cannot be said about foetal-monitoring, as we have seen. Nor can it be said for body acupuncture, which can prove to be quite difficult to perform on women in labour, for logistical reasons.

It is hard to imagine that such a simple technique might hold such promise in approaching difficult situations in labour-delivery. However, with the Caesarean section rates being what they are, anything so simple is surely worth trying.

## **Addendum 2018**

Since this article was written in 1992, there has been a steady increase in the Caesarean section rate, and according to a study published in the *Lancet* in 2018, in some countries has reached over 50%. Yet while the powers that be periodically wring their hands and say something should be done, in practice little has actually changed in the delivery room, and acupuncture remains a rare intervention.

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<sup>i</sup> Notzon FC, Placek PJ, Taffel SM: *Comparison of national Caesarean Section Rates*. N.Engl. J. Med., 1987;316:386-389

<sup>ii</sup> Taffel SM, Placek PJ, Liss T: *United States Caesarean Section rate and reasons for the 1980-83 rise*. Am.J.Public Health, 1987;77:955-959.

<sup>iii</sup> Saunders LD, Flowerdew G: *Caesarean sections in Alberta from April 1979 to March 1988*. Can Med. Assoc. J. 1991;144(10): 1243-52.

<sup>iv</sup> Prentice A, Lind T: *Foetal Heart Rate Monitoring during Labour: Too frequent intervention, too little benefit?* Lancet 1987;2:1375-7.

<sup>v</sup> Haverkamp AD, Thompson HE, McPhee JG, Cetrulo C: *The Evaluation of Continuous Foetal Heart Rate Monitoring in High Risk Pregnancy*. Am.J.Obstet.Gynecol., 1976;125:310-20.

<sup>vi</sup> Renou P, Chang A, Anderson I, Wood C: *Controlled Trial of Foetal Intensive Care*. Am.J.Obstet.Gynecol., 1976;126:470-6.

<sup>vii</sup> Kelso IM, Parsons RJ, et al: *An Assessment of Continuous Foetal Monitoring in Labour*. Am.J.Obstet.Gynecol, 1978;131:526-32.

<sup>viii</sup> Haverkamp, AD, Orleans M, et al: *A Continuous Trial of the Differential Effects of Foetal Monitoring*. Am.J.Obstet.Gynecol, 1979;134:399-412.

<sup>ix</sup> Wood C, Renou P, Oats J, Farrell E, Beischer N, Anderson I: *A Controlled Trial of Foetal Heart Rate Monitoring in Low-Risk Obstetric Population*. Am.J.Obstet.Gynecol, 1981;141:527-34.

<sup>x</sup> MacDonald D, Grant A, Sheridan-Periera M, Boylan P, Chalmers I: *The Dublin Randomized Controlled Trial of Intrapartum Foetal Heart Rate Monitoring*. Am.J.Obstet.Gynecol, 1985;152:524-39.

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- <sup>xi</sup> Leveno KJ, Cunningham FG, Nelson, et al: *A Prospective Comparison of Selective and Universal Electronic Foetal Monitoring in 34,995 Pregnancies*. N. Engl.J.Med., 1986;315:625-9.
- <sup>xii</sup> Luthy DA, Shy KK, Van Belle G, et al: *A Randomized Trial of Electronic Foetal Monitoring in Preterm Labour*. Obstet.Gynecol., 1987;69:687-95.
- <sup>xiii</sup> Acheson LS, Harris SE, Zyzanski SJ: *Patient Selection and Outcomes for Out-of-Hospital Births in one Family Practice*. J.Fam.Prac. 1990;31(2): 128-36.
- <sup>xiv</sup> Rooks JP, Weatherly NL, et al: *Outcomes of Care in Birth Centres. The National Birth Centre Study*. New Engl. J. Med., 1989;321(26):1804-11.
- <sup>xv</sup> Levy BS, Wilkinson FS, Marine WM, *Reducing Neonatal Mortality Rate with Nurse-Midwives*. Am. J. Obstet. Gynecol., 1971;109:50-8.
- <sup>xvi</sup> Zharkin, NA, *Acupuncture in Obstetrics, J. Chin. Med. Part 1*, May 1990;33:10-13; *Part 2*, Sept.1990;34:14-19.
- <sup>xvii</sup> Rempp C, Bigler A: *Pregnancy and Acupuncture from Conception to Postpartum*. Am. J. Acup., 1991; 19(4):305-313.
- <sup>xviii</sup> Dorr A: *The Possibility of Inducing Labour with Acupuncture*. Am. J. Acup. 1990; 18(3):213-218.
- <sup>xix</sup> Yannai N, Salev E. et al: *The use of Electroacupuncture during Labour*. Am. J. Acup. 1987; 15(4):311-312
- <sup>xx</sup> Peck G: *The Treatment of Scars by Acupuncture*. J. Chin. Med., 1989;30:23-24.
- <sup>xxi</sup> Nogier P: *Treatise of Auriculotherapy*. Maison-neuve S.A., France, 1969.
- <sup>xxii</sup> Adams, M: *Handbook and Atlas of Auricular Medicine*. M.E.D. Servi-Systems, Canada, Ltd., 1988.
- <sup>xxiii</sup> The NET 2 is made by Auri-Stim Medical Inc., Denver, Colorado, USA.