Study Of Primary Caesarean Section In Multiparous Women

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Abstracts: **Background:** This prospective study was carried out to assess, indication, maternal & fetal outcome of primary caesarian in multiparous women. **Materials & Methods**: 50 women with primary CS (caesarean section) studied in multiparous women studied and analysed. **Results:** Most of women belonged to >25yrs age group, rural, & low socio-economic group, Malpresentation, Low AFI (amniotic fuid index), Fetal Distress were most common indications. Post operative uneventful in majority of cases. **Conclusion:** Antenatal care in multigravida, USG (ultra-sonography) Analysis Close monitoring can reduce CS(caesarean section) in multipara. [Saluja J K NJIRM 2014; 5(2) :27-29]

Key Words: primary caesarean section, caesarean section in multipara

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Introduction: Caesarean section is one of the most commonly performed major surgical procedure. WHO recommends that a CS rate of more than 15 per cent is not justified. Between 1970and1988 caesarean delivery rate in the United States increased dramatically from 5% to25% [1].The causes were many: viz declining practice of midpelvic cavity forceps and breech vaginal deliveries and,increasing safety of caesarean sections and increasing reliance on continous electronic FHR (foetal heart rate) monitoring.According to a study by Indian council of medical research (ICMR) caesarean rate increased from 21.8 percent in 1993-1994 to 25.4 percent in 1998-1999 [2]. Increasing maternal age and parity is associated with significantly high risk of pregnancy complications and increased risk for caesarean section [3,8,16]. The major causes of MMR (Maternal Mortality Rate) among these women were rupture uterus, hypertensive disease, placenta previa & malpresentations. Caesarean delivery is an important issue of concern because it leads to an increased risk of a repeat caesarean delivery [4,5]. In our country every operative delivery is a nightmare for whole family. The present study focuses on the indications for caesarean section in multiparous women who had delivered vaginally earlier.

Aims and Objectives: To study indications of primary caesarean section in multiparous women & maternal and fetal outcome.

Materials and Methods: Prospective study in Department of Obstetrics and Gynaecology, R.D. Gardi Medical College Ujjain from January2013 to October2013. Multiparous women who underwent caesarean section for the first time who had delivered vaginally in previous pregnancies were included in this study. Women that had caesarean section in previous pregnancy, previous uterine surgery or hysterotomy were excluded from this study.

Data Collection: Age, income, details about previous deliveries, booking status was collected. General, systemic and obstetric examination was done.

Routine investigations: Analysis of urine, HB gms/dl, Blood Grouping, VDRL, HIV, HBsAg, RBS done. Ultrasound with fetal Doppler study was done whenever found necessary Cardiotocographic monitoring was done during labour. Indication for caesarean delivery, colour of liquor, puerperium; weight of baby, maturity and Apgar score noted. Maternal and foetal complications were recorded.

Observation and Results : Result are tabulated in following tables

Table 1 (Socio Demographic data):

Parameters		(n=50)	%
Age in years	*<25*	*15*	*30*
	>25	*35*	*70*
Locality distribution	*Urban*	*13*	*26*
	Rural	*37*	*74*
S.E. Status	*<5000*	*38*	*76*
	>5000	*12*	*24*

Subjects in age group>25yrs formed 70% age. Rural were 74%. Income < Rs 5000 formed 76%.

Table 2

Obst. History		n = 50	%
Booked / Unbooked	*Booked*	*14*	*28*
	Unbooked	*36*	*72*
Elective / Emergency	*Elective*	*03*	*06*
	Emergency	*47*	*94*
Parity wise	*< para 2*	*34*	*68*
	> para 2	*16*	*32*
Interval between Admission & C.S.	*< 2hrs*	*27*	*54*
	> 2 hrs	*23*	*46*
Colour of liquor	*Clear*	*15*	*30*
	Meconium	*35*	*70*

Unbooked were 72%. Emergency CS 94. < Para 2 were 68% & CS done within 2 hrs of admission were 54%. Muconium stained liquor in70%.

Table 3 (Indications for LSCSs)

Indications	n = 50	%
Malpresentation	15	30
PROM with Oligohydrominos	13	26
Fetal Distress	09	18
Placenta previa	05	10
Cephalo-pelvic disproportion (CPD)	03	06
Deep transverse arrest (DTA)	02	04
Obstructed labour	02	04
Cord Prolapse	01	02

Most commonest Indications for CS were Malpresentations30%, followed by PROM (premature rupture of membranes) with Oligohydramnios26%,FetalDistres18%, Placenta Previa10% CPD(Cephalo-pelvic disproportion) 6%, DTA (Deep transverse arrest), Obstructed Labour4% each & Cord Prolapse 2%

TABLE 4 Malpresentations

Malpresentation	n = 50	%
Transverse lie	17	34
Breech	15	30
Brow	11	22
Compound Presentation	07	14

Transverse Lie 34% Breech Presentation 30%. Brow Presentation 22% , Compound Presentation14%.

Table 5 Post operative maternal Morbidity

Parameters		n = 50	%
Maternal morbidity	*No Morbidity*	*35*	*70*
Morbidity	*P fever*	*07*	*14*
	UTI	*06*	*12*
	SSI	*02*	*04*

No Morbidity in70% , Puerperial Fever 14% ,UTI 12% Surgical Site Infection 4%.

Table 6

Parameters		n = 50	%
Birth weight	*<2.5 kg*	*20*	*40*
	>2.5 kg	*30*	*60*
Apgar at birth	*<6*	*08*	*16*
	>6	*42*	*84*
Fetal Outcome	*Alive*	*40*	*80*
	SB	*06*	*12*
	Perinatal mortality	04	08

Fetal Outcome Fetal Wt >, 2.5Kg60% .Agar at birth >6 were 84 %. Alive80%, SB 12%, Perinatal Mortality 8%.

Discussion: Multiparity is a problem associated with low age of marriage, literacy, income,& high perinatal mortality, preference for male child and ignorance about family planning measures [6,7] . Contraception not practiced because of social taboos, culture practices and religious beliefs. Eastman [8] stated, high parity is cause of maternal and perinatal mortality. “The dangerous multipara” by, Dr. Bethel Solomons [9] stated that the primigravida gives the impression of difficult labour because she is an unknown entity, so more attention is focused on her, than the women who have gone in labour before. The dangerous multipara in1934 was found to be genuine about risks associated with grand multiparity [10] . It is noteworthy to keep in mind that while progressing from low parity to multiparity the average labor curve continues to change but not toward an ever improved progress [11]. Feeny[12] stated that the problems associated with multiparous patients should be emphasized periodically. Since most of them have easy vaginal deliveries in past they are not paid much attention to the antenatal care they deserve. Due to these factors, the multiparous woman passes through the stage of pregnancy and

labour in a subnormal state of health. These patients get expert supervision only when unforeseen emergencies either during pregnancy or labour arise with potential risk and then a caesarean section becomes inevitable. Mostly due to Geographical conditions, lack of qualified medical attention, and delayed referral resulting in CS . In this series most of women belong to age group belong to>25yrs, rural, low socioeconomic group. Most of patients were unbooked, less than Para 2 , Emergency CS done in 2hrs, and meconium stained.Mal-presentation was the most common indication followed by PROM with *Oligohydramnios*, fetal distress, Placenta praevia, obstructed labour.

Intra and postpartum care have eliminated maternal deaths in our study. Postoperatively most of patient had no morbidity. Few suffered puerperal fever, UTI, and surgical site infection (SSI). 80 % foetus were born alive. Percentage of .LSCS in this institution is 24.64%. Among these 3.82% were LSCS done in multipara with no caesarean in previous pregnancies.

Conclusion : Primary caesarean sections in multipara constitute only a small percentage of total deliveries (3.82%) but are associated with high maternal and fetal morbidity [13,14]. Unrecognized cephalopelvic disproportion leading to obstructed labour (in referred cases) has increased the maternal morbidity [15]. Hence a multiparous woman in labour requires the same attention as that of primigravida. Primary caesarean in a multipara is a sensitive indicator of health delivery system. A multipara who has earlier delivered vaginally may still require a caesarean section for safe delivery. Good antenatal and intrapartum care and early referral will reduce the maternal and perinatal morbidity and incidence of caesarean section.

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