



Caesarean Section: Review at Full Dilation and Fetomaternal Outcome

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Introduction

In 1954 Friedmann narrated different curves for progress of labour in multiparous and nulliparous females. Any divergence is failure to progress⁽¹⁾. In 1969 active management of labour was introduced to decrease the caesarean rate.⁽²⁾ Various surgical, medical and instrumental interventions are described when there is arrest in second stage of labour⁽³⁾

Methodology

In this study the objective was to decide the indication of caesarean section and fetomaternal outcome. It is a retrospective study of 2 years at Kamla Raja Hospital, Gajara Raja Medical College with-

Inclusion Criteria

- 1) Singleton pregnancy irrespective of gravidae
- 2) Period of gestation >37 weeks with presentation being cephalic

Exclusion Criteria

Twins, preterm and other comorbid conditions.

Results

PTS studied were 6200 in 2 years. Average maternal age was 24.75 years of which 200 caesarean section were done at full dilation. Induction of labour was done in 68% Gestational age of these patients were 37-40 weeks with postdatism beingMost common cause of caesarean section was CPD 45% and fetal distress 25%.

Technique by which deeply engaged head was delivered was:

Technique	Number	percentage
Vertex	110	55%
Patwardhan	65	32.5%
Push	25	12.5%

Labour was induced in 68 % patients and 32% patients had spontaneous labour. Indication of Caesarean section

	Number	%
CPD	90	45%
Fetal distress	50	25%
NPOL	22	11%
Persistent occipito posterior	16	8%
Deep Transverse Arrest	12	6%
Failed Instrumentation	10	5%

Patients had more than one indication so total number does not match with above result .Vaccum

application in 20% and failed following which emergency caesarean section performed.

Maternal complications	No	%
Atonic PPH medical management	10	05%
Surgical management	05	2.5%
Postoperative fever	24	12%
Uterine incision extension	20	10%
Haematuria	30	15%
Component transfusion	03	1.5%
Wound infection requiring resuturing	05	2.5%

Maternal mortality was present owing to post partum haemorrhage and severe anaemia as patient was referred from periphery at late stage .PPH was present in 15 patients out of which 10 were medically managed and 5 were surgically managed. These tears which were present in lower uterine segment were extensions, broad ligament haematoma or avulsion of uterine artery. Bladder was high up in many accounting for haematuria in 30 cases and pyrexia in 24%. Component transfusion was required in 3 cases. Majority babies weighed between 2.5 to 3.5 kg .NICU admission was 29 Apgar <7 at 5 minutes 13.

Fetal & Neonatal Complications

	Number	%
Fresh still birth	1	0.5%
Cephalhaematoma	2	1%
NICU admissions	29	14.5%
Neonatal jaundice	11	5.5%
Apgar <7 at 5 min	13	6.5%
Meconium stained liquor	10	5%
Neonatal death	1	0.5%

Discussion

Last three decades have seen an increase in second stage arrest⁽⁴⁾. In our study primigravidae had more rate of caesarean section in second stage as compared to first stage owing to rigid perineum, cephalopelvic disproportion and lack of experience. This study was similar to Feinstein^(4,5). With prolongation of second stage, there is distension of lower segment which keeps thinning out and then vertex becomes more impacted in pelvis. This increase the operative time and increase the need of applying Patwardhan's technique and other technique. This causes an extension of uterine incision which in our case

was 20%. Owing to inflation of second stage there is increased atonic PPH⁽⁶⁾. In our study PPH was there in 15 patients. Shalha Baloch^(4,5) had 12 % PPH. , 5.4% extension of uterine incision. In our study Patwardhans manouvre was applied in 65 cases similar to the observation by Shalha Baloch. In our cases caesarean section causes were commonly due to cephalopelvic disproportion (45%) followed by fetal distress (25%) nonprogress of labour (11%). This data was coherent with David G and Untersheider^(6,7). Post operative fever was present in 24%. Which was lower than study by Baloch and Babre^(8,9) accounting for 33%.This caused an increment in the number of hospital stay of patients .

In our study NICU admission rate was 22-29%. This is consistent with the study by David G⁽⁶⁾. The reason was mainly due to neonates requiring sepsis screening and parenteral antibiotics administration. Neonatal death was one and fresh still birth was one which was lesser than that reported by Umbeli⁽¹⁰⁾. Our study revealed 13 babies with Apgar <7 at 5 minutes similar to study by Umbeli. As our study was retrospective in nature, therefore suggestion are to be taken with caution. Presence of caput, moulding and asyncyticism had poor documentation.

Conclusion

A senior obstetrician is required to determine suitable decisions as regards to trial or caesarean section in full dilation. Adequate supervision and skill improvement will minimize morbidity and mortality in second stage caesarean section and fetomaternal outcome. Proper partogram, pain relievers, labour augmentation and all effective techniques to deal with shoulder dystocia, Patwardhan and other techniques should be implemented.

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