



CAESAREAN SECTION – WHERE WE STAND (Primary C/S – Role of Obstetrician, If We Reduce the Primary C/S Rate, the Over All C/S Rate Can Be Reduced Effectively)

KEYWORDS

Big Data, Data mining, Hadoop, Library retrieval, Library management.

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ABSTRACT *OBJECTIVE: The Aim of this Study is to assess and analysis the rate of caesarean section with particular reference to primary caesarean delivery.*

MATERIALS AND METHODS : Retrospective study done in a teaching institute collecting the data of C/S particularly primary C/S, which is done in cases of primigravida over a period of one year i.e., from Jan to Dec 2011.

RESULTS : The overall C/S rate in our institute was 24.73% and primary C/S 27.87% where cephalopelvic disproportion was the leading cause of C/S.

CONCLUSION : The raising rate of primary C/S is very alarming since it determines the overall C/S rate in the society. With a good mix of staff in the labour wards both consultants and midwives and judicious of electronic fetal heart monitoring we can reduce the rate of C/S/

INTRODUCTION : The rising rates of caesarean sections have been a concern for over two decades. An acceptable rate of caesarean sections is between 10% to 15% according to the World Health Organisation (WHO)¹ C/S rates in the United States have terrifyingly risen to 32.8% in 2010². This rate is alarming since there are many negative risks associated with C/S like higher mortality and morbidity. Risks encountered during the operation may include anaesthetic complications and difficulty in controlling the bleeding. Later risks include infections, wound healing problems increased risk of problems in subsequent pregnancies including placenta previa, accrete, increta and uterine rupture and even the risk of subfertility in future³.

Wide spread perception amongst the population is that the C/S is of little or no risk to healthy women resulted into an increased elective primary C/S up to 42.4%⁴ leading to a proportionate increase in repeat C/S as well.

MATERIALS AND METHODS : This study was carried out in Govt. General Hospital attached to Post Graduate teaching institute, Kurnool Medical College, Kurnool, Andhra Pradesh. This is a retrospective study where in we analyse all the primary C/S done in the year 2011 Jan to Dec for various indications both emergency and elective in a primigravida.

RESULTS : Total number of deliveries in the year 2011 were 8616 of there the number of C/S were 2131(24.73%). Among them the primary caesarean deliveries were 594 (27.87%). Most of the cases were unbooked and taken up for C-Section on emergency basis.

The various indications for C-Section are tabulated as follows.

Table -1:

Indication	No. of Cases	%	33.5	
CPD	Brim	68		11.44
	Midcavity	130		21.88
	Out let	1		0.16

Indication	No. of Cases	%
Fetal distress	117	19.696
Breech Presentation	53	8.922
Oligohydramnios	38	6.397
PROM with failed progress	76	12.794
Other abnormal position	29	4.882
Obstructed labour	23	3.872
PIH/ Eclampsia	34	5.723
Twin gestation	7	1.178
Placenta previa	5	0.841
Abruptio placenta	3	0.505
Previous surgical repair of prolapsed	1	0.168
Precious pregnancy	2	0.336
Miscellaneous	7	1.178
Total	594	99.992

Age wise distribution of primary C-Section is as follows.

Table -2 :

Age in years	No.of cases	%
15-19	145	24.41
20-24	325	54.713
25-29	106	17.845
30-34	15	2.525
>35	3	0.505
Total	594	99.998

Table -3 : Showing the incidence of total C-Section from the year 2005-2011

Year	No.of delivery	No.of C/S	%
2005	6956	1814	26.078
2006	7670	1877	24.471
2007	8729	2116	24.241
2008	9216	2495	27.072
2009	9167	2475	26.999
2010	8265	2016	24.392
2011	8616	2131	24.733

DISCUSSION : In our institute the C/S rate ranges between 24-27% in the previous 7yrs. This rate is almost twice than the WHO recommended rate of C/S, but less than the rate of C/S in United States i.e., 32.8% in 2010². In recent years 46% of C/S noted in China and 25% and above in many asian countries⁵. The primary C/S rate in USA is 24% in 2005 and 23.8% in 2008⁶. It is 27.87% in our institute, a little higher since it is a referral centre which gets high risk cases from the neighbouring 5 districts.

In our study cephalo-pelvic disproportion, contributes to the major indication for C/S i.e., 33.5% followed by fetal distress (19.69%). Most diagnoses of fetal distress using fetal heart rate patterns occur when obstetricians lose confidence or cannot assuage doubts about fetal condition. Thus increased application of electronic monitoring did not improve perinatal results, but it increased the frequency of

caesarean delivery for fetal distress⁷.

Next to this is poor progress of labour which accounts as a major contributor of C/S which is inconsistency with the study conducted by Gordon C.S.Smith, Cambridge University⁸.

For various reasons women between 20 to 24 years of age had maximum incidence of C/S (54.71%).

CONCLUSION : The rates of primary caesarean delivery were increasing at and unprecedented pace. It is advisable to embark on the first C/S with great care and not rush into it despite its immediate safety under modern conditions because the morbidity is seven times higher in C/S compared to vaginal delivery⁹. The US Department of Health and Human Sciences Healthy People 2020 initiative include objectives to reduce the primary C/S rate and to increase the VBAC rate by at least 10% each¹⁰ because the primary C/S is an important determinant of overall C/S rates.

In order to meet the recommendations of WHO we should have a good mix of staff on the labour wards, including senior midwives and consultants. If we set a target people focus on that target. What we should be doing is giving optimal care to the mother. That way we minimise the reasons for a C/S. Deteriorating skills and inexperience in forceps delivery has increased the rates of C/S. Hence use of forceps and training of junior obstetricians in operative obstetrics is the need of hour. Judicial use of electronic fetal heart monitoring is very essential in labour monitoring.

" Having a caesarean section is reasonable option, but its about the appropriate treatment for appropriate people".

REFERENCE

1. Villar J, Vallarade E, Worjdyia D et al, Caesarean delivery rates and pregnancy outcome the 2005, WHO Global Survey on Maternal and Perinatal Health in Latin America lancet 2006; 367: 1819-2. | 2. <http://nynaturalbirth.info/how-to-avoid-caesarean-section.html>. | 3. Smith GCS, wood AM, Pell JP, Dobbie R, first caesarean birth and subsequent fertility fertil steril 2006 ; 85:90-95. | 4. Kambo I, Bedi N, Dhillion BS et al , A Critical appraisal of caesarean section of rates in teaching hospitals in India. Int.J. Gynecology, Obstet. 2001 ; 79: 151-8. | 5. "C-Section rates around globe at epidemic levels". | <http://www.msnbe.msn.com/id/34826185/ap/msnbc.com> Jan12, 2010. Retrived Feb21, 2010. | 6. Rates for total caesarean section, Primary Caesarean Section and VBAC United States, 1989 – 2006. (<http://www.childbirthconnection.org/pdfs/caesarean-section-trends.pdf>) child birth connection (<http://www.childbirthconnection.org/aboutus.asp>) 2008. | 7. Cunningham, Ievano, Bloom et al Williams obstetrics 23rd edition intrapartum assessment page 411-443. | 8. Gordon C.S. Smith, Yolande Cordeaux et al, The effects of delaying child birth on primary caesarean section rates page 1-15. | <http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0050144>. | 9. Mudaliar & Menons clinical obstetrics tenth edition page 348-355. | 10. ^ab <http://www.healthypeople.gov/2020/topics/objectives/2020/objectives-list.aspx?topic-id=26>. |