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STUDY OF PRIMARY CESAREAN SECTION IN MULTIPAROUS WOMEN AT DISTRICT HOSPITAL

Obstetrics & Gynecology

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ABSTRACT

OBJECTIVES: A study of the analysis of cases where caesarean section was done for the first time in parous women who had previous vaginal delivery of a viable neonate. The objective of study the cesarean section in context of various indications, age incidence and to evaluate maternal and perinatal outcome.

METHODS: An observational study of primary caesarean sections performed in multiparous patients at Paota District Hospital at the Department of Obstetrics and Gynecology under Dr. S. N. Medical College Jodhpur. Detailed history and thorough examination of patient was done. Labour was monitored throughout and indication of cesarean section noted. Intra-operative details and feto-maternal outcome were noted.

RESULTS: Amongst the various indications for caesarean section in multipara, fetal distress (21.05%) and malpresentations (14.47%) were with the highest incidence.

CONCLUSION: Previous vaginal delivery gives the patient as well as her relatives a false sense of security. There are many cases where a caesarean becomes mandatory for her. The fact that a multipara has had one or more vaginal deliveries should be regarded as an optimistic historical fact, not as diagnostic-criteria for spontaneous delivery of the pregnancy at hand. A parous woman needs good obstetric care to improve maternal and neonatal outcome and still keeping caesarean section to a lower rate.

KEYWORDS

Caesarean Section, Multipara, Primipara, Cephalopelvic Disproportion.

INTRODUCTION:

Caesarean delivery is one of the most commonly performed operations today. Caesarean births have become safer. This is not to imply that they have become safer than normal uncomplicated vaginal deliveries. Multipara means those who have delivered once or more after the period of viability. Even though they have delivered once vaginally, they still may have cephalo-pelvic disproportion in view of pendulous abdomen with lordosis of the lumbar spine responsible for failure of the head to engage. Other obstetric complication like APH, malpresentations, obstructed labour, were more common in multigravida which must be seriously considered.

It includes primi-para (para 1) multipara (para 2,3,4) and grand multipara (para more than 4). In a paper entitled "The dangerous multipara" published in 1934, Dr. Bethel Solomon's stated "My object in writing this paper and giving it a sensational title is to remove if possible once and for all, from the mind of the reader, the idea that a primigravida means difficult labour, but a multipara means an easy one.[1] Feeny was of view that the problems associated with these patients should be emphasized periodically in the literature, as too often complacency on the part of both the doctor and the patient resulted in an unavoidable tragedy.[2]

It is for these reasons that one attention is directed to the indication for caesarean section in women who have previously delivered vaginally[3]

AIMS & OBJECTIVES:

1. To know the incidence of primary caesarean section in a multipara.
2. To know the maternal and perinatal outcome following caesarian section.
3. To know the Incidence of post-operative morbidity.

MATERIALAND METHODS:

The observational study was conducted in the Department of Obstetrics and Gynecology,DR.S.N. Medical college, Jodhpur in Paota Hospital, Jodhpur for a period of May 18 to Oct.19 among the multiparous women.

INCLUSION CRITERIA

1. Multipara
2. Term pregnancy
3. Singleton pregnancy

EXCLUSION CRITERIA

1. Previous LSCS
2. Known medical disorders except anemia
3. Gestational age <37 weeks

After taking detailed general and obstetrical history including any pregnancy associated complication, past or present history of any infection or medical disorders, personal and family history andall post-operative recorded onPerforma.

- Labour was monitored throughout as per protocol and indication of cesarean section noted.
- Basic investigations like CBC, RFT, LFT, RBS, HIV, HBsAg, VDRL done.
- USG done to estimate gestational age, for placental localization and to rule out any congenital anomaly.

OBSERVATIONS & RESULTS:

About 76 cases of primary caesarean section done in multipara during the study period 18 month was analyzed and the results were as follows.

Table 1: Total LSCS incidence in study period

Types	No. of cases	Percentage
Cases of primary LSCS in Nullipara	86	35.24%(n=244)
Cases of primary LSCS in Multipara	76	31.14%(n=244)
Cases of repeat LSCS	82	33.60%(n=244)
LSCS	244	14.70%
Total deliveries	1659	100%

Among 1659 deliveries, 14.70% was the incidence of LSCS in general, and 31.14% was incidence of primary caesarian section in multipara

Table 2: Age wise distribution of primary section in multigravida

Age	No. of patients	Percentage
15 – 20 years	12	15.78%
21 – 25 years	27	35.52%
26 – 30 years	21	27.63 %
>30 years	16	21.05%
Total (n)	76	100

Most of them (35.52%) were in the age group of 21 – 25 years. 27.63 % were in the age group of 26 – 30 years.

Table 3: Distribution of cases according to gravid status.

Gravid	No. of cases	Percentage
Gravid 2	35	46.05%
Gravid 3	17	22.36%
Gravid 4	13	17.10%
G 5 or>G5	11	14.47%
Total (n)	76	100

Most of them are Gravida 2 (46.05%%) and Gravida 3 are 22.36%.

Table 4: Indications of caesarean section in multigravida

Indication	No. of cases	Percentage
Fetal distress	16	21.05%
Malpresentations	11	14.47%
Cephalo pelvic disproportion	5	6.57%
PROM with failed Induction	8	10.52%
IUGR with oligohydramnios	5	6.57%
Severe PIH	8	10.52%
Obstructed labor	4	5.26%
BOH with precious pregnancy	7	9.21%
Placenta Previa	3	3.94%
Abruption	5	6.57%
Twins	4	5.26%
Total	76	100%

Most common indication for caesarean section in multigravidas was fetal distress (21.05%) followed by malpresentations (14.47%).

Table 5: Maternal outcome

S.no	Complications	No. of cases	Percentage
1.	Healthy (no complications)	64	84.21%
2.	PPH Atonic	4	5.26%
3.	Traumatic	2	2.63%
4.	Puerperal pyrexia	3	3.94%
5.	Wound Sepsis	1	1.31%
6.	Urinary tract infection	2	2.63%
	Total	76	100%

In our study complications were not observed in 64 cases. 6 cases had mild to severe PPH.

Table 6: Distribution of cases according to weight of baby.

S.no	Wt. of the baby	No. of cases	Percentage
1.	> 3kg	33	43.42%
2.	2-3 kg	39	51.31%
3.	<2 kg	4	5.26%
	Total	76	100%

About 51.31% of babies had birth weight between 2-3 kg and 43.42% of babies had birth weight > 3 kg.

DISCUSSION:

Multiparity is a problem associated with poverty, illiteracy, ignorance and lack of knowledge of the available antenatal care and family planning methods. A multipara who has earlier delivered vaginally may still require a caesarean section for safe delivery.

In this study, primary caesarean sections in multipara constitute small percentage of total deliveries (31.14%) which is quite less than primary caesarean in nulliparous, but they are actually associated with high maternal and fetal morbidity.

Fetal distress (21.05%), abnormal presentations (14.47%),PIH & Failed induction with PROM (10.52%) and BOH with precious pregnancy(9.21%) were the most common indication for caesarean sections. About 51.31% of babies' had birth weight between 2-3kg and 43.42% of babies had > 3kg. These results were compared with recent studies by Erika Desai (2013) [4]. and Jyothi H. Rao (2013) [5]. and P. Himabindu (2015) [6].

This study the need of through antenatal care and vigilance in the management of labor. Negligence in which, most of the time needs operative interventions for the good concerns of mother and baby both. Above this, there is a great need to council multipara to report to the hospital as early as possible asmany of them are likely to try a home delivery and on failing which they come down to the hospital.

Hence a multipara woman in labor requires the same attention as that of primigravida. Good antenatal and intrapartum care reduce morbidity and mortality in multipara.

CONCLUSION:

Multiparas, especially grand-multi belong to high risk group who may have many obstetric complications which were frequently overlooked due to false sense of security created by previous vaginal deliveries.

Improvement of antenatal care in multipara with early identification of high risk pregnancies, adoption of integrated and composite approach to improve the health status of women, good quality of emergency obstetric care, and lastly health education and counseling for adoption of small family norms are some of the measures to be undertaken for reducing the maternal morbidity and mortality in multiparas.

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