Analysis of the Indications for Repeated Cesarean Section

MÜKERRER SEZARYEN ENDİKASYONLARININ ANALİZİ

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SUMMARY

An attempt has been made to study the indications that let to repeat cesarean section with a retrospective analysis of the hospital files of 86 women, who gave birth with Cesarean section in a period of one year. It was found that almost one third of the patients could have been delivered vaginally. The role of the obstetrician is also discussed.

Key Words: Repeat cesarean, Cesarean rate, Obstetrician's role

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ÖZET

Bir yıllık süre içinde gerçekleştirilen 86 mükerrer sezaryen vakalarının retrospektif analizi yapılmıştır. Analiz sonucunda vakaların üçte birinin vaginal yol ile doğum yapma imkânlarının olduğu ortaya çıkmıştır. Ayrıca karar verme aşamasında doğum uzmanının rolü tartışılmıştır.

Anahtar Kelimeller: Mükerrer sezeryan, Sezaryan oranı, Doğum uzmanının rolü

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One of the most Comman indication for cesarean section is previous abdominal delivery. Together with fetal distress, dystocia and breech presentation form a group of four, that are usuallly blamed for the increased cesarean rate (1, 2, 3).

Reduction of therepeat abdominal deliveries is a way. Repeated abdominal delivery reduction is a way to stop rising the percentage of abdominall delivery (2, 4, 5), so the aim of our work was to analyze the decision for surgery and obstetrician's role.

MATERÎAL&METHODS

A retrospective analysis of the indications for repeat cesarean was done for the period 01.01.1990-31.12.1990 in the deparment of obstetrics and gynecology-Medical University, Pleven, Bulgaria. There were 86 cases: 19 with repeat cesarean, 6- operated for the third time and one for the fourth.

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The reasons that justified the surgery have been separated in three major groups - group A (inevitable operation; correct decision): previons abdominal delivery within 18 months, ddystocia, premature or early membrane rupture with very low Bishop's score, incompetent uterine scar, fetal distress, multiple pregnancy, pathologic presentations or combined; group B (uncertain; disputable decision): previous abdominal delivery 18 to 24 months ago, more than three years of infertility, more than one cesarean, complicated obstetric history, extragenital diseases, mechanical dystocia, postterm pregnancy or combined; group C (unneccessary surgery, wrong decision): elderly gravida, "valuable child", desire for sterilization, refusal to deliver "per vias naturales", "dystocia" and others.

Having a team of three obstetricians on duty, the decision is made by the one with longest practice and administrative power.

RESULT

Shown on table I is the relative percentage of the indications, that led to the decision for abdominal delivery.

Table 1. Relative percentage of the indications justifying the decision for surgery

INDICATION	GROUP A	B	C
Cesarean up to 18 months ago	20.93%	–	–
Cesarean 18 to 24 months ago	5.81 %	11.68%	3.39%
Dystocia	31.39%	–	20.93%
"Incompetent scar"	11.68%	–	1.16%
Fetal distress	3.49%	–	3.49%
Pathological presentations	3.49%	–	–
Post term pregnancy	6.98%	8.14%	3.49%
More than one cesarean section	3.49%	–	–
Extragenital diseases	3.49%	–	–
Complicated obstetric history	6.98%	3.49%	–
"Broad* indications	–	–	15.12%
Other indications	4.65%	–	–
Combined	18.60%	–	9.30%

DISCUSSION

Dystoci has been found as one of the most common indication in group AA and C. In group A 31.39%, mainly as a dynamic one (early rupture of teh membranes with low pelvic score), while in group C as a mechanical one, usually a result of the obstetrician's fear of the "large fetus". Like P. Yudkin and C. Redman (6), we presume, that dystocia will probably remain as one of the main indication for ceserean section in the future, but the malpractices could be reduced if the estimation of the fetal body weight is done precisely during at least two sonographic examinations. Continious electronic monitoring of teh uterine activity during labour is absolutely neccessary, if teh woman has had one or more cesarean operations.

Fetal distress - to our experience, the data form electronic fetal monitoring should be interpreted very carefully. Always must bu remembered, that the electronic fetal monitoring is really informative only in combination with exact partogram according to E. Friedman, but this is not routine in our department, because most of the decision making obstetricians still follow the old French and German obstetrical practice (Lacommb, Jung). Nevertheless we think Friedman's nomogram (7) is essential for revealing the disturbances of the delivery process. This is an effective way to reduce the 20.93% wrongly put to our opinion indications for surgery.

Another very big group is that of the women who already have had at least one cesarean. A. Slepih (4) writes that a scar in uterine wall does not exclude normal spontaneous delivery and the old rule of Cradin 1916 (5) is no more valid, because today usually the scar remains in the to pass between the first operation and the moment for the birth of the second child. To our oppinion 18 months are enough to have a scar mature enough in order to permit vaginal delivery. Studies on the morphology of the isthmic tissue 18 month after an operation confirm that (8) and so are the date form the sonographic investigtions (9). Before that time a repeat cesarean is the choice. If the period passed is 18 to 24 months we do not consider the previous abdominal delivery as an indication for surgery, but it is widely accepted that at least 24 months after cesarean section, vaginal delivery is safe enough. In our material, women operated 18 to 24 months ago are 11.68%. As for the repeat cesarean sections, we do not think that thy have any significant influence on the functional abitily of the lower uterine portion. Individual judgement of the leading obstetrician is the most important. We have an experience that 18 months after a cesarean section with uncomplicated healing of the wound, the trial of labour has it's place. There is a difference in the literature with some authors (1) writing that in cases with more than one cesarean section, trial of labour is not enough to decide that vaginal delivery is safe, while others (10) are much more concrete: "two or more uterine scars do not permit vaginal delivery". We assume that the combination of previous cesarean section plus one more indication, or more than theree uterine scars are an "absolute" reasons for abdominal delivery and there are three such cases in our material, making 3.49% of patients.

Incompetent scar is a indication, mixed up with the time passed, secondary healing, endometrits, T shaped scar, myomectomy etc. and all that is known as "problem scar" (7). We found that 11.68% of the cases with "problem scar", but again leading has been the individual approach of tha wound healing. In order to be able to make reliable conclusions we propose routine sonographic investigation of the scar during 36-37th weeks of gestation which has been our current practice for more than a year.

Pathologie presentation has been a reason for abdominal delivery in 3.49% in our material. We have strong reservations about a vaginal delivery after cesarean section of a fetus in breech presentation of a fetus in breech presentation or bigemini, although there are reports of such cases (11). Still it is our experience, that is this situation the labour induction with Oxytocin leads to better postoperative results.

Postterm pregnancy can be a disputable indication again. The major question is about the fetal veilbeing assessed through complex investigation and on the other hand, the obstetrical status. We think that postterm pregnancy and unsuccessful induction of labour (6.98%) is a definite indication for surgery, while postterm pregnancy without induction performed is still disputable -8.14%. The inconvincing data for postterm pregnancy put as an indication for repeat cesarean section, usually together with some other reasons we classified as uncertain - 3.49%. Nevertheless, the finding that every 5th woman with repeat cesarean section, 18.61% has this indication, and it must always be kept in mind.

Complicated obstetrical history - a questionable indication if used alone to justify the surgery. For us the decision is for abdominal delivery if it is combined with infrtility with a duration of more than theree years and previous cesarean section or surgery of the cervix. We do not accept infertilim alone as an indication for aperation, but again the subjectivity dominates the decision of the medical staff.

"Broad indications" - a group of reasons for surgery, that we nearly always clasify as wrong - 15.12%, usually found in combination with some other indications for cesarean section. One can not accept as an explanation for surgery indications like: "elderly gravida", "valuable fetus", "denial of vaginal delivery", "desire for sterilization" etc.

Fetal ddistress alone, extragenital diseases and other rare indications always will be present as reasons for abdominal delivery (4%-5%)in the material. May be the low percentage of fetal distress (3.49% is a result of planned abdominal delivery because of other reasons. Besides, the diagosis of "fetal distress" is difficult and needs contiuous electronic fetal monitoring (10).

Combined indictions - The combination of cesarean section in the past and two or more other correct indications is present in 18.60% of the cases. In 9.30% the combination of abdominal delivery in the past with some in correctly put indications gave us the reason to estimate the decision for repeat cesarean as wrong. The presumption that the more indications written, the more justified the decision for surgery is a mistake both from legal and moral point of view.

According to the above mentioned criteria, undis putably right decision for repeated cesarean was taken in 31 of the cases; in other 10, the decision wos wrong. As for the most disputable group B. there is a reserve in it for cesarean section reduction.

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