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STUDY OF INDICATIONS OF CAESAREAN SECTION IN PRIVATE & PUBLIC HOSPITALS IN RURAL AREAS OF NASIK REGION

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Introduction:

Pregnancy & delivery are considered as normal physiological states in women. In today's situation when the access to obstetric care is growing day by day, there has been a concern over the rising caesarean rates over the world. Caesarean section is the surgical intervention in case of serious delivery complications. This surgical procedure has been saving lives for a long period of time. Evidence from research studies indicates that there is a growing tendency for caesarean section deliveries during complications at the time of pregnancy and delivery. The proportion of births conducted by cesarean section in India is on the rise[1] (I. Kambo et al , 2002) .Cesarean section is a highly invasive procedure and involves more skill, resources and risks as compared to vaginal delivery. Furthermore, abdominal delivery following an uncomplicated pregnancy is associated with increased morbidity in the newborn. A caesarean section may have serious implications on the health of the mother with a 3.6 times greater risk of postpartum and neonatal death than with vaginal delivery [7]. According to WHO Standards approximately 8 % of the deliveries are considered as high risk of which may lead to LSCS. In last few decades the rate of caesarean section delivery is steadily increasing in developing country like India. In India data collected from 30 medical colleges & teaching hospitals revealed that caesarean section rate increased from 21.8 % in 1988-89 to 25.4% in1993-94 (I Kambo et al, 2002). The Caesarean Section (CS) rates have been increasing over the last ten to fifteen years; however, the major indications for CS have not changed. These remain previous CS, foetal distress, prolonged labour, breech presentation, multiple gestations and CS on demand. The increasing trend of CS rates may indicate a trend towards more costly medical delivery systems.

This study was conducted to find out the frequency of indications for CS in rural setup. Further, these studies also explore the hierarchy in indications for LSCS & compare it for rural population in public & private hospital settings. The results of this study will highlight the utilization of obstetric facilities in the rural areas and focus on the causes of LSCS in the area.

Method

This study is a hospital-based retrospective study. It was conducted in a tertiary government health care set up specializing in Obstetrics and Gynaecology in Nasik and two private hospitals in rural areas of Nasik district, Maharashtra, India. All the patients who underwent Caesarean Section in the period Jan 1st 2009 to Dec 31st 2009 were included in the study. Demographic and clinical data (gestational age in weeks, indications for CS and complications) were recorded in a structured questionnaire. The data was collected from the Medical Records of the hospital & data analysis was done.

Objective

- To study the pattern of mode of delivery in public and private facilities in rural Maharashtra.
- To study and compare the indications for LSCS in public and private facilities in rural Maharashtra.

Materials and Methods

This study was undertaken to explore the prevalence of LSCS delivery with indication as recorded in the registers in a period 1st Jan 2009 to 31st Dec 2009 in public and private hospitals in rural areas of Nasik district. This is a cross-sectional study aimed at studying the pattern of prevalence of LSCS as the mode of delivery in rural healthcare settings.

Sampling frame

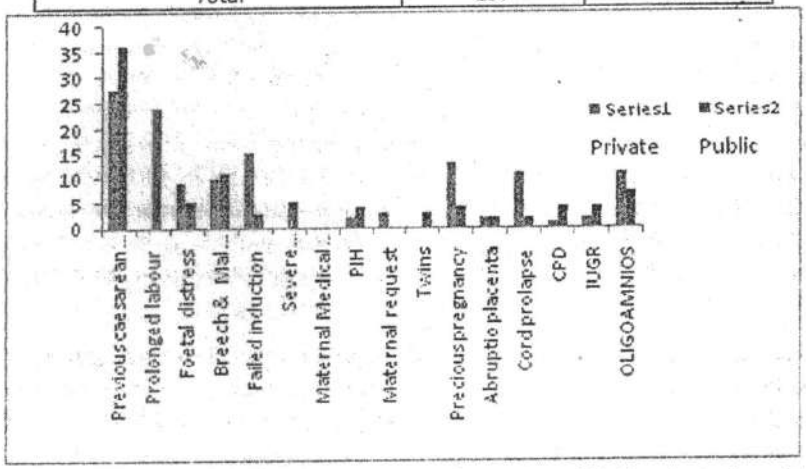
From all those cases data such as mode of delivery, sex of a baby & complications at the time of delivery were collected. All the cases delivered at the above mentioned hospitals during 2009 served as the sampling frame. Both booked and unbooked cases were included. Cases brought to the institution after home deliveries were excluded.

Results and discussion

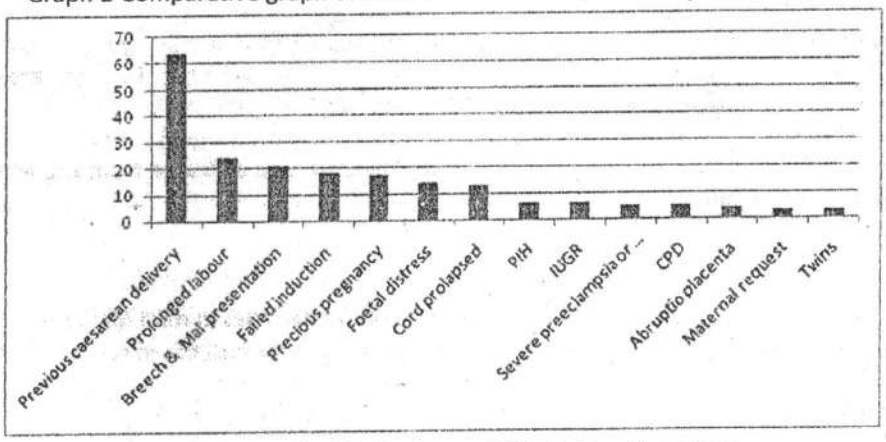
The Caesarean Section rate in the public hospital under study was found to be 35.67 % where as that in the private hospital was found to be 41.6 per cent.

Table 1 shows Indications of CS in the Public Hospital & Private Hospitals over the year

Indication	Private Hospital	Public Hospitals
Previous caesarean delivery	28	36
Prolonged labour		24
Foetal distress	9	5
Breech & Mal presentation	10	11
Failed induction	15	3
Severe preeclampsia or eclampsia		5
PIH	2	4
Maternal request	3	
Twins		3
Precious pregnancy	13	4
Abruptio placenta	2	2
Cord prolapsed	11	2
CPD	1	4
IUGR	2	4
Oligoamnios	11	7
Total	107	114



Graph 1-Comparative graph of indications of LSCS in Public & private hospital.



Graph 2 -Graph of indications of LSCS in Rural hospitals.

The most common opverall indication for CS in our set up was found to be previous CS. This finding emphasizes the need for a careful evaluation for the rationality of conducting a LSCS in cases of primigravidae. The occurrence of a LSCS in the first pregnancy greatly determines the chance of occurrence of LSCS in the subsequent pregnancy. Vaginal Birth After Caesarean (VBAC) also known as trial of labour is a very useful practice to evaluate the need of LSCS in a woman with previous LSCS. However, there is no consensus about the safety of VBAC. One study by McMahon et al noted that higher rates of maternal and foetal morbidity exist with VBAC as compared to elective caesarean. In the UK, the rate of VBAC is high at 33% [3] (Guise JM, Hashima J, Osterweil P). We were unable to obtain proper documentation of attempted VBAC. In our study, foetal distress accounted for 19.6% of the indications for CS. A study conducted in South

Africa, the rates for LSCS due to foetal distress were lower at a rate of 9.1%[2] (Naidoo N., Moodley J).The literature regarding diagnosis of foetal distress mentions The accurate method for establishment of foetal distress is to perform foetal scalp blood pH estimation which is considered the gold standard for the assessment of foetal well-being However this procedure is not performed in the study setup. In this study the indication stating ' non-progress of labour' is 3.8 percent of the total LSCS indications. Judicious use of oxytocics in cases of failure to progress will help reduce the rate of LSCS resulting from cases of failure of vaginal delivery to progress. Maintenance of a partogram is also found to be beneficial [5] (Singh A, Channawar Reema). In this study the failure of induction of labour is attributed to 9.6 percent of the total non absolute indications for CS

Breech presentation accounted for a significant percentage of the non absolute indications for CS. External Cephalic Version (ECV) has been suggested as an intervention to reduce high CS rates at 37 weeks of gestation. However, ECV has its drawbacks; it requires skill and might not be successful. Among the absolute indications, major degree of placenta praevia was the most common indication amounting to 3.35% of the total CSs . Placental abruption, a non-absolute indication amounted for another 0.3%; in all, antepartum haemorrhage accounted for 3.7% of the total CS. Malpresentations like transverse lie or oblique lie accounted for 3.13% of the CS. obstructed labour made up 0.5% of the indication for CS. Minimising the injudicious use of oxytocics & prostaglandins, proper assessment of the pelvis & diagnosis of the presentation, position and stage of labour can help to ring down the rate of obstructed labour and uterine ruptures.

Conclusion

This study starkly outlines the need for careful evaluation and rationality of CS in case of a primigravidae. Previous LSCS has emerged to be the most common indication for which subsequent pregnancies result in repeated LSCS. This is a viscious cycle and greatly affects the rate of occurrence as well as the mortality and morbidity associated with LSCS. In other cases, a supervised vaginal delivery after LSCS needs to be encouraged by promoting the trial of labour.

However, all these observations heavily rely on the authenticity of the reporting of the indication of CS. It was found by the researcher that there was a lot of discrepancy and lack of documentation regarding the circumstances that lead to the decision to conduct an LSCS. This underlines the need to implement stringent regulations regarding conducting an LSCS. This will not only curb the malpractices in the obstetric practice but also ensure rational treatment for the pregnant lady.

Limitation of the study

The author has found that there are many gaps and discrepancies in the reporting of LSCS from many institutions, especially private setups. These discrepancies could have a bearing on delineating the exact proportion of LSCS in private set ups in the study. However a greater implication is the lack of stringent and far-sighted outlook towards recognizing the growing trend of LSCS as a potential public health threat.

Also, the retrospective nature of the study limited the information which could be collected from the hospital records.

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