CAESAREAN SECTION

Dr. Anuradha
SRM Medical College & Research center
• **Definition:**

Caesarean section is the removal of a child through an incision in the abdominal wall of an intact uterus.

• **Incidence:** Increased during last 20 years.

Due to: Rpt caesarean deliveries.

dystocia.

fetal distress.
• INDICATIONS:
Maternal, fetal, fetomaternal.
1. Maternal: CPD and contracted pelvis.
2. Inadequate uterine forces
3. Previous classical cesarean section
4. Previous LSCS
5. Placenta previa
6. Eclampsia or preeclampsia
7. Dystocia due to soft parts
8. Ca Cx
• FETAL INDICATIONS
  1. Fetal distress
  2. Prolapse of the umbilical cord
  3. Malpresentation
  4. BOH & habitual IUD of fetus
  5. Abruptio placentae
  6. Multiple pregnancy
  7. Maternal HIV infection
Elective caesarian section (Planned operation)
Advantages are:-
Patient with empty stomach and surgeon usually with full breakfast
Best anesthetist available at that time
Best assistant and nursing staff.
Disadvantages are :-
If wrong judgment, premature child may be born.
Cervix may not be dilated and hence poor drainage of lochia
Lower segment is not formed and hence uterine incision in lower part of upper segment.

Emergency caesarian section (Unplanned)
Working under adverse circumstances:-
Patient may be with full stomach and surgeon may be with empty belly
Odd working hours either of day or night
Anesthetist, assistant and nursing staff may not be of your choice
Advantage is :-
Mature child as patient is in labor
Cervix is open, better drainage of lochia.
Lower segment is well formed
PROCEDURE:

PRE OP PREPARATION:
1. Antacids to reduce the risk of aspiration of acid gastric contents
2. Abd preparation
3. Catheter the bladder
4. Moderate Trendelenburg position with 15 degrees left lateral tilt to prevent supine hypotension
• ABDOMINAL INCISION

1. Transverse incision:
   Adv : Excellent functional & cosmetic results.
   Dis adv : Slower to perform more liable to hematoma formation

2. Vertical incision:
   Lower segment unapproachable because of fibroids or intraabdominal adhesion
• **UTERINE INCISION:**

Lower segment uterine incision:

**Adv**
- Better approximation
- Better healing
- Rupture in subsequent Pregnancy and labour
- Is less frequent
- Convalescence is also smoother

**Dis adv**
- Difficulty in reflection the rectus sheath from the muscle during next surgery
2. CLASSICAL UTERINE INCISION:

DIFFICULTIES ENCOUNTERED DURING CS:

1. Floating head
2. Deeply engaged head
3. Impacted shoulder presentation
4. Dilated blood vessels in the lower segment
5. Excessive bleeding
6. Bladder injury
Complications of Cs

1. Bleeding
2. Wound infection
3. Urinary tract infection
4. Paralytic ileus
5. Scar rupture
• MATERNAL MORTALITY AND MORBIDITY

Seven times higher at caesarean section than vaginal delivery.

Morbidity: Infection, hemorrhage, UTI & thromboembolism
PREGNANCY FOLLOWING CAESAREAN SECTION

RISK OF RUPTURE OF CAESAREAN SECTION SCAR
1. Type of previous uterine incision
   - 0.3-2% - LSCS
   - Classical Cs – 9%
3. Post op period, convalescence and use of oxytocin and prostaglandins to induce or augment labour.
CHANCE OF A SUCCESSFUL VAGINAL DELIVERY

60 TO 80%

1. Indication of Prev. Cs.:
   90% non-recurring indication:
   Breech, fetal distress, placenta previa, abruption/maternal bleeding.

60% - recurring indication like dystocia

2. Prev. vaginal delivery

3. Clinically adequate pelvis
MANAGEMENT OF LABOUR FOLLOWING CS:

(VBAC)
1. Careful monitoring
2. Sedation
3. FHR & Maternal pulse – every 15 minutes
4. Signs of commencing rupture.
   - Maternal pulse rate
   - Tenderness over the hypogastrium
   - Irregularities of the fetal heart
   - Vaginal bleeding / bld stained urine
5. Head on perineum, delivery may be completed by outlet forceps.
6. Delay in separation of placenta
   heavy bld loss
   evidence of rupture

Cs: Unsatisfactory progress
   PROM, unengaged head
   inefficient uterine action

Uterus is explored

Operation theater must be ready for Emerg.
Section bld kept ready.
• TIMING OF ELECTIVE Rpt LSCS: GA : 39 weeks by UPT/FHS/USG in first trimester

If GA not confirmed – await spontaneous onset of labour.

Confirm fetal maturity by amniotic fluid surfactant assessment
PERIPARTUM HYSTERECTOMY

Hysterectomy done following vaginal delivery / after Cs delivery

INDICATIONS: Rupture of uterus
PPH
Placenta accreta
Ca Cx
THANK YOU