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## Research Article

### INCREASING RATE OF CAESAREAN SECTION IN LALLA DED HOSPITAL, SRINAGAR

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#### ABSTRACT

Increasing rate of caesarean section is matter of concern to obstetrician and society as a whole. The WHO published guidelines regarding caesarean rates in 1985 which was revised in 1994. The guideline states that the proportion of caesarean births should range between 5%-15%. This study was conducted to find out the increasing rate and indication for caesarean section and measures to decrease this rising trend. This study showed fetal distress (29.84%) as the leading cause of increasing rate of caesarean section and rising trend in caesarean section and falling trend in vaginal section.

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#### INTRODUCTION

Increasing rate of caesarean section is matter of concern to obstetrician and society as a whole. The WHO published guidelines regarding caesarean rates in 1985 which was revised in 1994. The guideline states that the proportion of caesarean births should range between 5%-15%<sup>1</sup>. According to this guideline increasing rate of Caesarea nis alarming. Caesarean section nowadays is performed to benefit fetus not mother. Caesarean section remains an important area of controversy because of increase in the rate of this operation worldwide. Breech presentation, prematurity, increased use of electronic fetal monitoring, on demand and fear of litigation has been implicated, and obstetricians have been largely blamed for the rising trend of CS deliveries<sup>2</sup>. India is also not excluded from this trend. Though the estimates of CS rates in India is 7.1 per cent in the year 1998 and there is 16.7 per cent change in the rates annually in India<sup>3</sup>, which is one of the highest among the countries. Though the constraint of data has masked the actual rates, but still the pace of change is very high. A five-year audit from a large teaching hospital in Kolkata showed a caesarean section rate of 49.9 per cent<sup>4</sup> and another study in Madras showed an alarming caesarean section rate of 50 per cent<sup>5</sup>. All women undergoing caesarean section are exposed to complications. Immediate risk of anaesthesia, intraoperative complications like uterocervical and bladder lacerations, blood loss, need for hysterectomy; post operative complications like

fever, UTI, sepsis, etc; fetal complications like RDS, iatrogenic prematurity, etc; late consequences like placental abruption, placenta previa, adherent placentation in subsequent pregnancies. The increasing rate on caesarean section will increase the risk of above mentioned complications so obstetricians should keep these complications in their mind and ready to face them before taking the decision of performing caesarean section.

#### MATERIAL AND METHODS

This study was carried out in the department of obstetrics and gynaecology, Lalla Ded Hospital, GMC, Srinagar. From April 2014 To April 2015, data on all births were collected from medical record and labor log, including type of delivery and, if caesarean, indication for the same and from April 2010 to April 2014, data on type of delivery was collected, whether vaginal or caesarean delivery.

#### RESULTS

From April 2014 to 2015, a total of 21084 births occurred in LALL DED, hospital; 12668 (60.08%) of those were delivered by caesarean (Table no. 1) and the most common indication was fetal distress (Figure no.1).

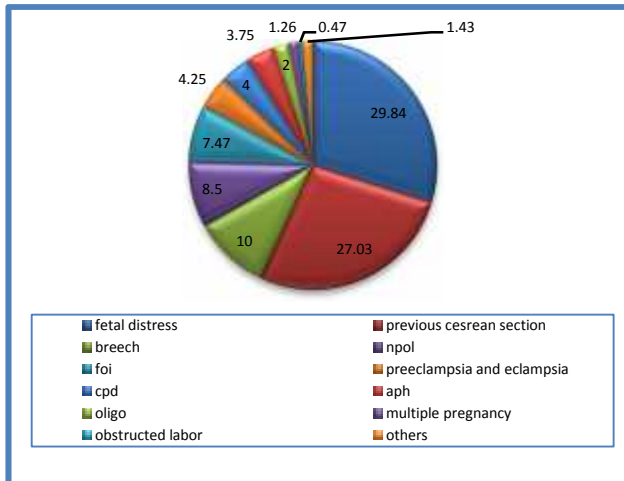
From April 2010 to 2015, there has been increasing rate of caesarean section and decreasing trend in vaginal delivery (Figure no.2).

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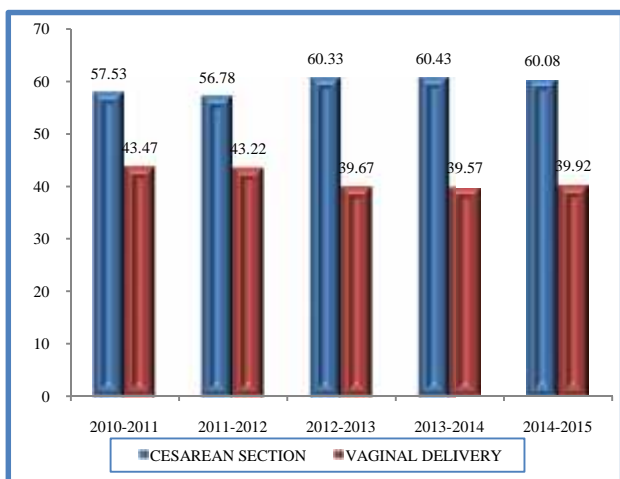
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**Table No. 1** Incidence

Year	Caesarean section	Vaginal delivery	Total deliveries	% of caesarean section	% of vaginal deliveries
2010-2011	12850	9782	22632	56.78	42.47
2012-2013	14192	9332	23524	60.33	43.22
2013-2014	14252	9334	23586	60.43	39.67
2014-2015	12668	8416	21084	60.08	39.57



**Figure No. 1** Indications of Caesarean Section (April 2014 - April 2015)



**Figure No.2** Increasing trend of caesarean section and falling trend of vaginal delivery

## DISCUSSION

In this study, there is increasing trend of caesarean section and we have come across fetal distress as most common indication. Most of cases of fetal distress are genuine but in some cases like fetal distress seen on CTG, oligohydramnios, IUGR, presence of thin meconium in absence of irregular fetal heart caesarean section is performed in our setup to escape controversy.

The next common indication is previous cesraean section. Vaginal birth after caesarean section is one of the strategies developed to control the rising rate of Caesareansection. It is a trial of vaginal delivery in selected cases of a previous Caesareansection in a well equipped hospital<sup>6</sup>. There is reluctance to permit a trial of labor after previous Caesareansection, it is probably due to either the obstetrician considering that a repeat Caesareansection is much safer and convenient and is less likely to give rise to the complication

and possible subsequent litigation or due to maternal preference. In the Royal College of Obstetrics and Gynaecologists (RCOG's) National Sentinel Caesarean Section Audit (NSCCA) of 2000<sup>7</sup>, 50% of women with a previous caesarean section attempted VBAC, and the success rate was 64%. In our setup, trial of vaginal delivery in previous section is given but not with enthusiasm.

Breech is next frequent indications. It can be reduced by external cephalic version but it is not attempted very often as it requires skill and has its own risks. A review of the randomized trials on external cephalic version at term (>37 weeks) showed a reduction in non-cephalic births by 60% and in Caesareansection rate by 50%. There was no significant effect on the perinatal mortality<sup>8</sup>.

Next frequent indications are failure of induction and non-progression of labor. Preinduction cervical scoring, judicious use of pharmacological agents and use of partogram reduces the rate of Caesareansection.

One of indication for increasing rate of Caesareansection is ON DEMAND. Mackenzie *et al*<sup>9</sup> observed that maternal request one of the main indication for Caesareansection on 1996. This is because women are inadequately informed about risks and benefits of Caesareansection and women choose Caesareansection to avoid painful vaginal delivery. FIGO states that performing Caesareansection for non medical reasons is ethically not justified<sup>10</sup>. Obstetricians should abide by ethics in clinical practice and carefully evaluate the indication in every Caesareansection and take an unbiased decision before performing Caesareansection on demand/request<sup>11</sup>.

Good antenatal care can detect problems like Pregnancy Induced Hypertension, Intrauterine Growth Retardation, Oligohydraminos etc earlier and early management can prevent these complication and need for Caesareansection.

## CONCLUSION

There is increasing trend of caesarean section because of indications which can be ignored. So in our set up, it is expected that doctors should always do a proper counselling about risk benefits about caesarean section antenatally and provide prompt, competent, skilled and evidence based services to patients.

## References

1. World Health Organisation. Appropriate technology for birth. *Lancet* 1985; (8452): 436-7.
2. Kimberly D, Lisa M, Lawrence D. Variations in elective primary caesarean delivery by patient and hospital factors. *Am J Obestet Gynecol.* 2001; 184(7).
3. Stanton Cynthia K, Holtz Sara. A. Levels and Trends in Caesarean Birth in the Developing World. *Studies in Family Planning* 2006; 37(1): 41-48.
4. Pahari K, A. Ghosh. Study of Pregnancy Outcome over a Period of Five Years in a Postgraduate Institute of West Bengal. *Journal of Indian Medical Association* 1997; 95(6): 172- 74.
5. Sreevidya S, Sathiyasekaran BW. High caesarean rates in Madras (India): a population-based cross sectional study. *British Journal of Obstetrics and Gynaecology.* 2003 Feb; 110(2): 106-11.

6. Pickrell K. An inquiry into the history of caesarean section. *Bull Soc Med Hist (Chicago)* 1935; 4: 414 RCOG.
7. Caesarean Section: The National Sentinel Audit Report. 2001. Royal College of Obstetricians and Gynaecologists, London, UK.
8. Hofmeyr GJ, Kulier R. external cephalic version for breech presentation at term. *Cochrane Database Syst Rev* 2000; (2): CD000083.
9. Mackenzie IZ, Cooke I, Annan B. Indications for caesarean section in a consultant unit over the decades. *J Obstet Gynecol.* 2003; 23: 233-8.
10. FIGO Committee for the Ethical Aspects of Human Reproduction and women's Health. Ethical aspects regarding caesarean delivery for non-medical reasons. *Int J Obstet Gynecol.* 1999; 64: 217-21.
11. SN Mukherjee. Rising caesarean section rate. Maulana Aazad Medical College and Hospitals, New Delhi. *J Obstet Gynecol India* 2006 Jul/Aug; Vol. 56, No. 4: Pg 298-300.

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