SUMMARIES OF PAPERS ON MATERNAL MORTALITY READ AT THE XVTH ALL-INDIA OBSTETRIC AND GYNAECOLOGICAL CONGRESS HELD AT GOA ON 28TH DECEMBER 1969.

MATERNAL MORTALITY IN TAMILNADU (MADRAS) STATE

by

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Summary

1. Annually about 3,000 women, eight per day, die due to child birth in the Tamil Nadu (Madras State).
2. Though the state has the highest number of maternal and child health centres in India, over 50% of the deliveries are unattended except in urban areas.
3. The maternal mortality rate for the state has gradually declined from 4.97/1000 in 1956 to 2.87/1000 in 1967.
4. Over 45% maternal deaths were due to associated causes, mainly anaemia, cerebral venous thrombosis and infections.
5. Among the direct causes, prolonged labour, rupture uterus and haemorrhages were responsible for 60-75% of maternal deaths. Toxaemias and sepsis accounted for 15-30%.
6. Comparative study of different causes of maternal deaths in teaching institutions in Madras State has been made.
7. Analysis of 826 maternal deaths in the Government Erskine Hospital, Madurai, during 1960 to 1968 has been given. Commonest cause of death was obstetric trauma (rupture uterus), forming 31.8% of direct deaths.
8. In 78-85% of cases, deaths were preventible.
9. The avoidable factors and the measures to reduce the maternal mortality in the State are discussed.

MATERNAL MORTALITY IN A BACKWARD COMMUNITY

by

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In Bastar (M.P.) and Koraput (Orissa) districts, the maternity service is still in its infancy. The majority of our patients, particularly local adivasis, come from a comparatively primitive community plagued by a pastoral economy, illiteracy, ignorance, poverty, malnutrition, poor communication, inadequate medical aids, apart from serious tropical diseases like malaria, hookworm, kala-azar.

The maternal deaths among total live and still-births (deaths from abortion, and those before delivery were excluded) as recorded in the six local hospitals during January, 1967 to June, 1969 were found to vary from 19 to 60 per thousand. Although adivasis constituted about 25-30% of total hospital deliveries, 85% of deaths were shared by them.

Obstructed labour and rupture uterus together contributed to nearly 50% of total maternal deaths. In the

Dandakaranya Project Central Hospital, one out of every 23 labour cases was admitted with a ruptured uterus.

Of the original inhabitants of different tribes some are known for their short stature and small pelvis. Cephalopelvic disproportion seems to be surprisingly common in them.

Some of the adivasis mothers use some native drugs supposed to have an oxytocic effect, which is considered to have contributed to the high incidence of ruptured uterus.

Symphysiotomy proved invaluable in these cases. Besides being a simple procedure, it makes a permanent artificial enlargement of the pelvis and thus, ensures safe future vaginal delivery.

CRANIOTOMY

by

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1. Craniotomy formed 0.98% of all deliveries in Erskine Hospital, Madurai; 464 craniotomies done from 1959 to 1968 have been analysed in this study.
2. Most of the patients (38%) were young primigravidae.
3. In 88% it was for the forecoming head and in 12% for the aftercoming head.
4. The main indications were obstructed labour 66.5%, hydrocephalus 15% and inertia with severe intrapartum sepsis 12.3%.
5. The mortality was 8.2%—mostly due to endotoxic shock and in some due to associated post-partum haemorrhage.
6. Amongst late complications, 8.4% showed obstetric palsy, 5.9% vesicovaginal fistula and in 2% urinary stress incontinence.
7. The place of craniotomy in obstetrics in a developing country is discussed.

MATERNAL MORTALITY AT GOVERNMENT MATERNITY HOSPITAL, HYDERABAD, ANDHRA PRADESH
(A review of 431 cases)

by

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and

SALEHA QURESHI, M.D.**

A review of 431 maternal deaths with the trends in mortality over 3 periods of 3½-4 years each, from January 1958 to December 1968, is presented. A steady decline was registered. Associated maternal diseases led to a higher mortality. Maternal age and parity had no significant influence. Forty-seven per cent of the deaths were intra-partum, 35 per cent were post-partum and 18 per cent were ante-natal. Haemorrhage, pre-eclampsia, eclampsia, sepsis and anaemia were the major causes in their order of frequency.

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There was a sharp decline in deaths due to infection. A detailed scrutiny showed that 58.2 per cent were avoidable. The 3 major avoidable factors were delay by the patient, delay by the doctor and lack of facilities.

Extension of obstetric services to the villages, institution of Flying Squads and periodic reviews of maternal mortality at all levels, will help reduce the death rate among our mothers. All the cases were unbooked.

MATERNAL MORTALITY IN CAESAREAN SECTION

by

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and

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In Cama and Albless hospitals the maternal mortality dropped from 15.8 per thousand in 1930 to 4.2 per thousand in 1968.

The mortality rate for caesarean section, during the same period, reduced from 5 per cent to 0.8 per cent, which figure compares well with international figures. Yet, this figure was nearly double that for vaginal deliveries. As such, an attempt was made to review retrospectively 340 cases to see if this figure could be further minimised.

Avoidable factors like sepsis, post-operative shock, haemorrhage and anaesthetic mishaps were still of prime importance and were responsible for two-thirds of the deaths. Hence, it may be concluded that to reduce the mortality in caesarean section, the incidence of caesarean section should not be allowed to rise and effective ante-natal care, expert intranatal management and improved blood transfusion facilities and better anaesthetic management should be made available to all pregnant patients.

RUPTURE UTERUS
Review of 82 cases

by

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and

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Rupture of the uterus is a serious complication of pregnancy and in the majority of the cases, the accident is avoidable. Our study is based on 82 cases of rupture during the 15 year period from 1953-1967, giving an incidence of one in 314. Its incidence is high in India as in other developing countries. We have divided the causes of rupture under 4 headings. Rupture of previous caesarean scar 17.06%, (14 cases), spontaneous rupture 65.88%, (54 cases), traumatic rupture 13.4%, (11 cases) and rupture due to pitocin drip 3.8% (3 cases).

We had 14 scar ruptures giving an incidence of 17% of all ruptures; 6 were classical scar ruptures, 7 were lower segment scar ruptures and one was hysterotomy scar rupture. Among the 6 classical scar ruptures, 4 occurred in pregnancy and 2 in labour. All the 7 lower segment scar ruptures and hysterotomy scar rupture occurred in labour. The greatest

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number of ruptures occurred in second gravida, thus proving that there is a greater strain on the scar in the absence of a previous vaginal delivery.

We had 54 cases of spontaneous rupture and the causes of ruptures were grand multipara 21, contracted pelvis 9, transverse lie 9, hydrocephalus 1, prolapse cervix 1, previous manual removal of placenta 1, cause not recorded 11. Among 54 ruptures, 46 occurred before admission and 8 after admission.

We had 11 cases of traumatic ruptures. Seven were due to forceps delivery, 3 due to craniotomy and 1 due to manual removal of placenta. Among the 11 traumatic ruptures, 5 were admitted with rupture and 6 occurred in the hospital.

We had 3 ruptures due to pitocin drip; one admitted with rupture and 2 occurred in the hospital.

There were 2 cases of colporrhexis, one anterior and one posterior. Anterior colporrhexis occurred in a young primigravida. The foetus had escaped extraperitoneally through the bladder and was lying under the rectus sheath. Bilateral cutaneous ureterostomy was done. Patient expired on the 4th day. Posterior colporrhexis occurred in a grand multipara following craniotomy.

We had 8 cases of bladder injury and one ureteral injury and 8 of them were emergency admissions.

73.2% of uterine ruptures were treated by repair with a maternal mortality of 76.7%. 19.5% were treated by hysterectomy with a mortality of 18.7%, which is 3 times more than in repair. Among the 13 deaths, the causes of death were shock in 7, peritonitis and septicaemia 3, anaesthetic death 1, jaundice and hepatic coma 1, intestinal obstruction, septicaemia and pulmonary oedema in 1. 58% of deaths occurred within 60 hours. Over all maternal mortality was 15.8%.

The foetal mortality in complete rupture was 100.0% and in incomplete rupture 54.1%. The over all foetal mortality was 86.6%.

ABORTION AS A CAUSE OF MATERNAL DEATH

by

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One hundred and eighty-five cases of maternal deaths, including 35 cases of abortion, out of a total of 83,135 outpatient cases, 29,027 admissions, 8,121 deliveries and 808 abortions are presented from a large district hospital of Northern India in the years 1965-67 The incidence is analysed in detail. Though the number of cases studied is rather small, one is struck by the fact, not without some alarm, that though the overall maternal mortality is decreasing, the mortality due to abortion is on the increase.

The various causes of death from abortion have been discussed, the commonest in our series being haemorrhage, next being sepsis and then the shock of perforated gravid uterus and in one case the bladder also.

The factor of criminal or induced abortion has been discussed and the role of legalisation of abortion as a family planning measure brought to light in this context.