

# PRIMARY CAESAREAN SECTION IN GRAND MULTIPARA

by

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Since Solomons's publication in 1934, the grand multiparity is being recognized as a clinical entity in its own right. There have been frequent impressive reports in the World literature which remind us that such cases are liable to a series of complications which remain unsuspected and therefore undiagnosed until late in labour. The indications for primary caesarean section in patients who have successfully delivered 5 or more term babies by the vaginal route, have been reviewed in this paper to emphasize on the adverse effects of high parity. Grand multiparity is an arbitrary term used by most French and British authors applied to cases who have had five or more previous viable babies. Barns (1965) and Feeney (1953) restricted this term to women of eighth parity or above.

## Materials and Methods

During the period November 1, 1969, through Oct. 31, 1971, there was a total of 1726 live births in this hospital. Of these, 147 were delivered by caesarean section, a rate of 8.52 per cent. Fifty-one grand multiparas had primary caesarean section which represents 34.7 per cent of the total deliveries by caesarean section and 2.95 per cent of the total deliveries (Table I). Bilateral tubectomy was done

in all patients to prevent further conceptions.

TABLE I  
*Classification of Deliveries*

Childbirths	Total	Percentage
Total deliveries of all types	1726	100%
Total caesarean sections	147	8.52%
Total primary caesarean sections in multiparas	51	2.95%

## Observations

It will be seen from Table I that the total number of caesarean sections performed in grand multiparas is markedly high. The indications for performing these primary caesarean sections are given in Table II. The most common indication was dystocia due to malpresentation or malposition, cephalopelvic disproportion or uterine dysfunction.

Eighteen Caesarean sections were done for dystocia associated with malpresentations and malpositions which included 11 with a transverse lie, 4 with occipito posterior 2 with a compound and 1 with a mento posterior position. Twelve caesarean sections were done for dystocia associated with foetopelvic disproportion, while 5 caesarean sections were done in women with inertia in labour. Dystocia is invariably due to some kind of spacial inadequacy. It is common that more than one factor may be present, such as asso-

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TABLE II  
Indications for Primary Caesarean Section in the Grand multiparas

Indications	No. of patients
<i>Dystocia</i>	35
Malposition and malpresentation	18
Foetopelvic disproportion	12
Uterine dysfunction	5
<i>Haemorrhage</i>	12
Placenta praevia	10
Premature separation of placenta	2
Toxaemia pregnancy	1
Cord presentation	1
Carcinoma of cervix	1
Hydramnios	1

ciation of a large baby, a minor alteration in pelvic size and malposition.

The Second most important indication for caesarean section in multipara was haemorrhage secondary to placenta praevia in 10 cases and premature separation of the placenta in 2 cases. Toxaemia of

pregnancy, carcinoma of cervix with pregnancy, hydramnios and cord presentation contributed one case each.

There were two maternal deaths, 3.82 per cent maternal mortality (Table-III). One maternal death was due to postpartum haemorrhage in a patient who had placenta praevia and a classical caesarean section, while the other death was due to post-operative shock in a patient who had hand prolapse, transverse lie and suspected rupture of the uterus. Lower segment caesarean section was done in this case.

There were ten perinatal deaths, 19.6 per cent foetal mortality in the present series (Table III).

#### Discussion

A large number of our patients do not seek antenatal care. Most of them are poor and many of them are anaemic. They are likely to develop calcium depletion during the course of rapid successive pregnancies and periods of lactation. It follows that most of them are usually seen for the first time in late pregnancy

TABLE III  
Foetal Outcomes for the entire series

Indications for Caesarean Sections in multiparas	Total Series	Perinatal loss			Percentage
		SB	Neonatal death	Total	
<i>Dystocia</i>					
Malpresentation	18	2	1	3	16.67%
Foetopelvic disproportion	12	3	0	3	25%
Uterine dysfunction	5	0	0	0	-
<i>Haemorrhage</i>					
Placenta praevia	10	2	1	3	30%
Premature separation of placenta	2	0	0	0	-
Toxaemia of pregnancy	1	0	0	0	-
Cord presentation	1	0	0	0	-
Carcinoma of cervix	1	0	0	0	-
Hydramnios	1	1	0	1	100%
<b>Total</b>	<b>51</b>				



or in labour. Due to a wide variety of complications which they are likely to develop during pregnancy and in labour, the frequency of caesarean section is very high among the grand multiparas in this area. 34.7 per cent of all the caesarean sections have been performed in grand multiparas in this series.

Dystocia is the most common indication for caesarean section in the grand multiparas. Cephalopelvic disproportion may be recognized for the first time not only due to the increasing size of the baby in the successive pregnancies, but on some occasions due to pelvic abnormalities which are likely to develop in grand multiparas even in the absence of signs of active osteomalacia. Donald suggests two reasons for pelvic capacity reduction; firstly, the increasing inclination of the pelvic brim resulting from associated lordosis of the spine and secondly, the occasional sub-luxation forwards of the sacrum upon the sacro-iliac joints so that the sacral promontory advances and the true conjugate is effectively reduced. Malpresentations are much more common and are favoured by a pendulous abdomen and the lordosis of the lumbar spine. Transverse lie occurred in 11 out of 18 patients with malposition. According to Eastman the common causes of transverse lie are, abnormal relaxation of the abdominal wall resulting from grand multiparity, pelvic contraction, and placenta praevia. The incidence of transverse lie increases with parity, occurring 10 times more frequently in patients of parity of four or more than in primigravidas. Relaxation of the abdominal wall with a pendulous abdomen allows the uterus to fall forward, deflecting the long axis of the foetus away from the axis of the birth canal into an oblique or transverse position. Placenta praevia and pel-

vic contraction act similarly by preventing engagement. The cases of transverse lie associated with placenta praevia have not been included in patients with malposition in this series. They have been counted as cases of placenta praevia complicating pregnancies.

Eleven cases of placenta praevia constitute the second most important complication in this series. The results of various reports in literature suggest that multiparity and age favour the occurrence of placenta praevia. Little is known about the etiology of placenta praevia. Defective vascularization of the decidua as the result of inflammatory or atrophic changes seems to be the possible explanation for its causation. Atrophic changes are favoured by age and/or repeated pregnancies in rapid succession. The limited blood supply to the placenta causes it to be spread over a greater area of the uterus than usual.

Accidental antepartum haemorrhage occurs in large number of multiparas. In Solomons's series, 130 out of the 148 patients who had accidental antepartum haemorrhage, were multiparas. There has been a radical change in the management of accidental haemorrhage for the last two decades. It is probably due to conservative treatment of these patients in our hospital that we came across only two cases who had caesarean section.

The major indications for primary caesarean section in the present study were malpositions, placenta praevia, foetopelvic disproportion, uterine dysfunction and premature separation of the placenta. Other minor indications for caesarean section in this study do not require further elucidation. The two maternal deaths and 10 foetal deaths are very high which is probably due to the delay in patients seeking medical advice.

In light of the above facts there is no guarantee that a multiparous woman who had previous normal vaginal deliveries will have subsequent uneventful vaginal deliveries. Unfortunately, an attitude of complacency still exists in the minds of some well experienced doctors who expect every grand multipara to deliver normally. Nothing is more dangerous than such a complacent attitude. This study reemphasizes the need of antenatal care and thorough care and vigilance in the management of labours of multiparas. Most of the patients who are reluctant to get admission into hospital for their personal obligations to their families actually require proper antenatal and postnatal cares. Some compromise must exist between the patient and her obstetrician to enable her to deliver in the hospital and to go home after a short stay in the hospital. Thus, maternal and foetal mortality is likely to be reduced.

#### Summary

1. Indications for primary caesarean Section in 51 grand multiparas are reviewed.

2. Dystocia is a real problem which should receive much attention.

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