CLASSICAL CAESAREAN SECTION IN MODERN OBSTETIC FRACTICE

(A review on 24 Cases)

by

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Classical Caesarean Section is one of the obstetric operations of bygone days, which has lost its reputation. The superiority of lower segment caesarean section has been universally acknowledged since 1940 (Moir, 1956) and there is no scope for the former in routine cases. Unfortunately, there is a tendency in some quarters to denounce this operation outright, as if it is an obsolete operation. But, even in present-day obstetric practice, sometimes under compelling circumstances, or to save the situation, one has to resort to classical section, on rare occasions.

The indications for it must be very few indeed but this operation cannot be dismissed without some discussion as it is still practiced (Donald, 1969).

Material and Methods

This study comprises of 24 cases of classical caesarean section done in Eden Hospital, Calcutta, during the period of January, 1972 to October, 1979, among 7085 caesarean sections in 72,174 deliveries. The incidence of classical section, among all sections, was 1 in 295 (0.33%). Eight cases were booked and the rest unbooked.

Results

Majority of the cases (58.33%) were aged between 26-30 years and 66.66% were para 2 to 4. Of 10 post-caesarean cases, 4 had elective and 6, emergency operations. All the cases of placenta praevia had emergency section. Six of them were in severe shock with profuse haemorrhage, the haemoglobin being 3.2 to 5.8 gm%. Blood was not available for them before operation. One case proved to be placenta praevia accreta had total hysterectomy. The case of accidental haemorrhage was opened with a diagnosis of placenta praevia. Table I, shows the other indications.

The hand prolapse case required classical section as the cervix did not dilate from 5 cm. in 12 hours and at operation the lower segment was found poorly formed. Kyphotic patient was 4' in height (Fig. 1). Epidural awaesthesia failed and there was cardiac arrest on induction of general anaesthesia. She was resuscitated and operation was done after

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TABLE I
Indications in 24 Cases

Indication	Number	Indication	Number
Non-approachable L.U.S.	10 (41.66%)	Gross C.P.D.	2 (8.33%)
Post C.S.—1		Osteomalacia—1	
Repeat C.S.—9		Kyphosis and Osteomalacia—1	
Placenta Praevia	8 (33.33%)	Transverse lie, hand	
Moribund cases—6		prolapse	1 (4.16%)
Type III anterior		Advanced carcinoma Cervix	2 (8.33%)
with venous net work—2			
Accidental haemorrhage	1 (4.16%)		

3 hours, under local anaesthesia as she was in obstructed labour.

Ten cases had blood transfusion from 300 to 1200 ml. 22 cases had tubectomy and 1, hysterectomy for placenta praevia accreta. Classical section in placenta praevia excepting the case of hysterectomy took on average 17 mins. In osteomalacic case, tubectomy was not done as she was a primigravida.

Morbidity and mortality

Three cases of placenta praevia developed severe postoperative shock, of whom 2 died within 6 hours of operation. There was oliguria lasting 48 hours in 1, urinary tract infection in 2 and burst abdomen on 4th day in a case of carcinoma cervix.

Foetal outcome

There were 8 stillbirths and 1 neonatal death. Fifteen babies weighed below 2000 gms., 7 between 2100-3000 and 3 over 3000 gms., among 25 babies in 24 cases (one twin in a case of placenta praevia).

Discussion

The object of this review is to discuss critically the scope and limitations of classical caesarean section (classical C.S.). It's drawbacks are well-known and need no elaboration. But even in modern obstetric practice there are some valid indications although some indications are debatable. The incidence of classical C.S. in this study was 0.33%, compared to 1.1% in a series of 612 sections reported by Chaubal *et al* (1978). Dutta (1978) found that 4.7% of 232 post-caesarean cases had previous classical C.S. As to this high incidence, he observed that many of these cases were done by general surgeons in mofussil areas.

Non-approachable lower segment due to extensive adhesion was found to be the major indication (41.66%) in this study. This is the most valid indication. Fibroid on lower segment on proposed incision line may be a factor (Donald, 1969; Chaubal *et al*, 1978). In 4 cases of this series, the parietal peritoneum was entirely adherent to the anterior surface of uterus and in 6, advancement of bladder peritoneum with omental adhesion was noted. A rectangular raw area could be made out and classical C.S. done. Attempt for a lower segment incision might have invited extensive injury to bladder. Eastman (1961) reported such a case in which lower segment operation was persisted with and the patient died.

Placenta praevia constituted 33.33% of the indications. Classical C.S. is done for 3 reasons, viz. moribund cases where every second is vital, engorged tortuous veins and central or anteriorly placed

placenta praevia (Donald, 1969). In severe haemorrhage the abdomen should be opened by longitudinal incision as seconds may be vital (Dewhurst 1976). Six moribund cases were operated without blood (for non-availability) of whom 4 survived. The average time taken was 17 minutes as against 30 minutes needed in lower segment operation. For some years, Donald (1969) considered highly vascular lower segment an indication. Later he found that with a good technique troublesome haemorrhage can be controlled in lower segment section. We agree with Dewhurst (1976) that an experienced operator should not be afraid of massive vessels. If it is felt that time factor will influence the outcome the condition of the patient must be perilous (Dewhurst, 1976) Malpas (1960) and Eastman (1961) advocated Classical C.S. for central placenta praevia, which is even more debatable today (Dewhurst, 1976).

Carcinoma cervix, postmortem section to obtain a live baby as soon as the mother dies and when hysterectomy is contemplated, form other reasonable indications (Donald, 1969; Dewhurst, 1976). Kyphosis is also a valid indication. Vashistha *et al* (1976) did 1 case for carcinoma cervix and Chowdhury and Mukherjee (1975) 1, followed by subtotal hysterectomy in placenta percreta with fundal perforation.

Although Malpas (1960) advocated it in transverse lie and Wood and Forster (1959) did classical C.S. in 13 cases among 51 sections, nonformation of lower segment is the only justifiable indication today (Donald, 1969). Very rarely high repair of V.V.F. forms an indication.

The main objection to this operation is the high incidence of subsequent scar rupture. Dutta (1978) found an incidence of 18.2% as against 1.9% in L.U.C.S., Dewhurst (1957) found 2.2% and 0.5% respectively. Fortunately, in all but 1, sterilisation was done. Only 1 case in this series remained exposed to that risk.

About the technique, the uterine incision should be 5-6 inches. A small one may contract firmly around the baby's neck. The baby should be extracted best by grasping one or both legs and placenta removed manually, as cord traction is less effective (Moir, 1956). Haemorrhage may be excessive (Donald, 1969) in classical C.S. Green Armytage clamps help in achieving better haemostasis and in everting the thick edges to facilitate first row of sutures (Moir, 1956).

The maternal and perinatal losses were 8.33% and 37.5% respectively in this series. However, this is due to primary indications and not related to the type of operation.

Summary and Conclusion

1. This study is based on 24 classical caesarean sections, done in Eden Hospital, Calcutta, in 8 years (1972-1979) among 7085 caesarean sections—an incidence of 0.33%.

2. Non-approachable lower segment due to extensive adhesions from previous section was the major indication, followed by moribund cases of placenta praevi; tortuous veins on lower segment, gross C.P.D. carcinoma cervix and transverse lie were other indications.

3. The indications and limitations for classical C.S. have been discussed with a review of the literature. The maternal and foetal losses were high (8.33% and 37.5% respectively) but the type of operation was not responsible for it.

4. A modern obstetrician should not be sceptic about classical C.S. Although the indications are very few, he would be

safer to the patient by resorting to it on rare occasions.

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References

1. Chaubal, S. D., Thakur, V. R,, Vinekar, S. L. and Shah, S. H.: J. Obstet. Gynec. India. 28: 962, 1978.
2. Chowdhury, P. K. and Mukherjee, A. K.: J. Obstet. Gynec. India. 25: 532, 1975.
3. Dewhurts, C. J.: J. Obstet. Gynec. Brit. Emp. 64: 113, 1957.
4. Dewhurst, C. J.: 'Integrated Obstetrics and Gynaecology for Post Graduates'. Ed-2, London, 1976, Blackwell Scientific publications. P. 272, 506.
5. Donald, L.: 'Practical Obstetric Problems' Ed-4, London, 1969, Lloyd Luke. P. 754.
6. Dutta, D. C.: J. Obstet. Gynec. India. 28: 563, 1978.
7. Malpas, P.: Brit. J. Clin. Pract. 14: 879, 1960.
8. Eastman, N. J.: Obstet. Gynec. Surv. 16: 195, 1961.
9. Moir, J. C.: 'Munro—Kerr's Operative Obstetrics' Ed-6, London 1956, Baillier Tindal & Cox. P. 556.
10. Vashinstha, K., Logawney, R. and Gupta, A. N.: J. Obstet. Gynec. India. 26: 386, 1976.
11. Wood, E. C. and Forster, F. M. C.: J. Obstet. Gynec. Brit. Emp. 66: 75, 1959.

See Fig. on 'Art Paper II