"CAESAREAN SECTION FOR DEAD FETUS" A CRITICAL REVIEW OF 29 CASES (1980-1990)

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SUMMARY

The present series consists of the study of 29 cases of caesarean section for dead fetus during the period January 1980 to July 1990. At our hospital the incidence of caesarean section for dead fetus is 0.7%. Our critical review traces the trend in the change in indications for caesarean section for dead fetus over the years. In our series the common indications were rupture uterus, threatened rupture and antepartum haemorrhage with the incidence of maternal mortality being 6.7%. A comprehensive analysis including the intra-operative and post-operative periods alongwith complications and treatment has been presented herewith.

INTRODUCTION

Caesarean section has become one of the commonest operations in obstetrics. The safety of the operation has widened the scope of its indications and difficult vaginal deliveries are gradually being replaced by caesarean section. The present study was carried out with a view to analyse and discuss a few cases where the mother had to be subjected to a caesarean section even when the baby was dead. The impact of "the scar", on the future obstetric career should be weighed against the pros and cons of the destructive operations especially with the modern obstetrician opting to do a caesarean in which he is well versed as against conducting difficult vaginal deliveries or destructive operations.

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MATERIAL AND METHODS

This retrospective study encompasses 29 cases of caesarean section for dead fetus during the period from January 1989 to July 1990. The incidence of caesarean section in our series is 3.64% while the incidence of caesarean section for dead fetus is 0.7%. Out of 29 cases, 7 patients were booked cases and 22 emergency. Table I clearly shows that the highest incidence is in the age group of 21-30 days years. In the present series the rate of caesarean section for a dead fetus declines after III para (Table II).

OBSERVATIONS

Some important indication for caesarean section for dead fetus in the present series are rupture uterus, threatened rupture of uterus and antepartum haemorrhage which account for nearly 60% of total case. (Table III). Table III also shows incidences of indications of 2 other series viz. Hibbard (1969) and Richard (1956). And outlines the trend in the change in indications for caesarean section for dead fetus over the years. While the caesarean section in the presence of fetal death benefits only the mother, it is sometimes a more prudent course of action than vaginal delivery. According to Myerscough (1982) and, Quilligan and Zuspan (1982) a caesarean is definately indicated if the pelvis is markedly deformed and the head free or more than 3/5ths palpable per abdomen. It is clear that caesarean section in placenta praevia is performed primarily to safeguard the life of the mother and according to Zlatnik (1986) may therefore be the most judicious method of treatment even though the fetus has succumbed, especially in all cases of total placenta praevia.

In the present series there were 2 patients who had developed fever in the post-operative period and 1 patient who developed a vesico-vaginal fistula which healed spontaneously. There were 2 maternal mortalities in our series (6.7%).

In 4 cases in our study, after the removal of the dead fetus, the uterus did not contract, it remained flabby and there was continuous bleeding. All were treated with blood transfusion and hysterectomies. We had one extra-peritoneal caesarean section done for dead fetus with tonic contraction of uterus with amnionitis; post-operative recovery was unevenful.

DISCUSSION

Where there is mechanical difficulty during labour, but the fetus is alive, the safest way to deliver the fetus is by caesarean section. If labour has been prolonged and neglected and the fetus is dead, other considerations may come into play regarding the mode of delivery:

1) Sufficiently skilled staff to carry out caesarean section at short notice.
2) The risk of overwhelming infection following caesarean section in patients who invariably already have genital infection.
3) Obsession with having a vaginal delivery may make the patient or her relations refuse consent for abdominal delivery.
4) The patient may not have access to skilled supervision in her subsequent pregnancy.

In most developed countries with high

TABLE I

AGE DISTRIBUTION

AGE IN YEARS	NO. OF CASES
16 - 20	2
21 - 25	11
26 - 30	9
30 AND ABOVE	7
TOTAL	29

TABLE II

PARITY DISTRIBUTION

PARITY	NO. OF CASES
PRIMI (0)	5
I	7
II	9
III	5
IV	0
V	1
VI	1
VII	1
TOTAL	29

TABLE 3

TRENDS IN INCIDENCE OF INDICATIONS OF THREE SERIES

SR. NO.	INDICATIONS	PRESENT SERIES1969 JAN 1980 TO JULY 1990	HIBBARD L.T. 1956	RICHARD B.D.
1.	Rupture Uterus	31.04%	11.11%	-
2.	Threatened Rupture	10.35%	-	-
3.	Accidental Haemorrhage	20.68%	22.23%	52.87%
4.	Placenta Praevia	20.68%	11.11%	12.64%
5.	Cephalo Pelvic Disproportion	6.9%	11.11%	-
6.	Deep transverse Arrest	3.45%	-	2.3%
7.	Tonic contraction of Uterus with Amnionitis	3.45%	-	-
8.	Twins with previous LSCS	3.45%	-	-
9.	Failed induction	-	11.11%	-
10.	Previous Myomectomy	-	5.55%	-
11.	Malpresentation	-	16.67%	6.89%
12.	Prolonged Labor	-	-	4.60%
13.	Diabetes	-	-	3.45%
14.	Cord Prolapse	-	-	2.3%
15.	Rh sensitisation	-	-	2.3%
16.	Pre-eclampsia	-	-	2.3%
17.	Eclampsia	-	-	1.15%
18.	Congenital malformations	-	-	1.15%
19.	Obstructed labor	-	-	1.15%
20.	Cause not known	-	-	6.9%

literacy rates, availability of a wide range of antibiotics, large number of skilled personnel and good communications; the circumstances summarised above no longer exist. But in most developing countries most of the considerations listed above apply and so alternatives like destructive operations and symphysiotomy may be considered even today. But treatment must be individualised. If one argument in favour of a destructive operation is that necessary expertise to perform a caesarean section in the circumstances may not be available, it is important to remember that it is unlikely that a practitioner who cannot safely perform a caesarean section will be competant to do a destructive operation. Besides destructive operations are attended by high risk of maternal injuries like extensive vaginal and cervical lacerations, VVF and post partum haemorrhage.

CONCLUSION

From the study a conclusion can be drawn in favour of caesarean section even when the fetus is dead. The indication sounds very inhuman. But considering the possible puerperal morbidity and in the present 'lawsuit' era destructive operations are going out of vogue and caesarean section remains no longer a danger. Thus, in selected cases, it is wise to subject the patient to a caesarean section even though the fetus is dead.

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