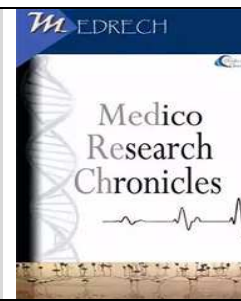




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CLINICAL PRESENTATION AND MANAGEMENT OF POST CAESAREAN SECTION COMPLICATION ADMITTED IN DMCH AS REFERRED CASE

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ABSTRACT

Background: Caesarean Section (CS) is the most frequent obstetric surgical treatment carried out today. With development of anesthesia and method ensuing in expanded consequence and safety, its rate has been rising. Nevertheless, it includes chance of issues ensuing in morbidity and sometimes mortality. Therefore, CSs completed barring medial indications, stays questionable. **Objectives:** The aim of this study is to assess the Clinical presentation and management of post caesarean section complication admitted in DMCH as referred case. **Methods:** This is an observational study. The study used to be carried out in the admitted patient's Department of Gynecology and Obstetrics, Dhaka Medical College Hospital, Dhaka, Bangladesh. In Bangladesh for the duration of the period from January 2007 to June 2008. **Results:** Type of complication the Postpartum haemorrhage, Shock, DIC, Abdominal distension, Paralytic ileus, Hemoperitoneum, Injury to the viscera, Wound infection, Wound dehiscence, Ureter injury, Bladder injury, ruptured uterus, Intrauterine infection, Subrectal hematoma and Anaesthetic hazards were 20(20.62%), 20(20.62%), 4(4.12%), 10(10.31%), 1(1.03%), 14(14.44%), 1(1.03%), 2(2.06%), 2(2.06%), 1(1.03%), 3(3.09%), 5(5.15%), 2(2.06%), 4(4.12%), 5(5.16) and 6(6.18%) respectfully. **Conclusions:** Most of the cases operation done of EOC and general practioner. Most of the cases need laparotomy. Those who are working as a service provider in UCH or district hospital must have appropriate training before the they start any surgery in his respective site. They must be confident enough to handle the cases.

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INTRODUCTION

A Caesarean section, also known as C-section or Caesar, is a surgical procedure in which incisions are made through a mother's abdomen (laparotomy) and uterus (hysterotomy) to deliver one or more babies. It is usually performed when a vaginal delivery would put the baby's or mother's life or health at risk, although in recent times it has been also performed upon request for childbirths that could otherwise have been natural. The World Health Organization (WHO) recommends that caesarean sections rates 15% in any institution. [1]

Delivery of the baby by an abdominal and uterine incision known as Caesarean section (CS) operation. It is increasingly used for safe delivery for fetus or maternal reasons either electively or as an emergency [2]. Based on timing of CSI the indications are grouped into four categories: Category 1 or Emergency CS- when there is immediate threat to the mother or fetus, the conditions like, abruption, cord prolapse, scar rupture. scalp blood PI-I <7.20 and prolonged FHR deceleration <80 beats/mm. Here ideally the CS should be done within 30 minutes. [2]

Category 2 or Urgent CS - there is maternal or fetal compromise but was not immediately life threatening. Here the delivery should be completed within 60-75 minutes and cases are those with FHR abnormality is of concern [2]. Category 3 or scheduled CS the mother needed early delivery but there is no maternal or fetal compromise there may be concern that continuation of pregnancy is likely to affect the mother or fetus in hours or days to come. For example, a case with pre-eclampsia where the liver or renal function tests are gradually deteriorating where the CS in planned for within hours to days, before further deteriorations occur [2].

Category 4 or Elective CS — this type of CS planned to do at time suitable to mother and operation staff there are some cases where is an indication for CS but there is no urgency.

Examples include placenta previa with no active bleeding, mal presentations (brow, breech), history of previous repeated C/S or vertical incision CIS, past history of repair of VVF [2]. Morbidity and mortality associated with the procedure cannot be totally avoided. Immediate per operative complications are hemorrhage, extension of the wound, difficulty in delivery of the body, uterine inversion & Mendelson's syndrome and post-operative immediate complications are primary postpartum hemorrhage, retention of urine, abdominal distension, shock, DIC, Paralytic Hues, Hemoperitoneum, Injury to the viscera, urinary tract infection, wound infection, wound dehiscence and burst abdomen, secondary postpartum hemorrhage, deep vein thrombosis and pulmonary embolism. The late complications may be incisional hernia and scar rupture in subsequent pregnancy. [3] Caesarean hysterectomy may be needed for uncontrolled postpartum hemorrhage; placenta accrete or uterine rupture. [4] Maternal mortality is extremely low and is usually related to the reason for which a CS was done or due to anesthetic or hemorrhagic complications and is estimated to be less than 0.33 per 1000. [5]

The longer the operative procedure, the greater the likelihood of postoperative complications. As Victor Bonny noted in an early edition of his classic gynecological surgery, "An operation rapidly yet correctly performed has many advantages over one technically as correct, yet laboriously and tediously accomplished,' Most caesarean section should be completed in less than 1 hour unless significant technical problems are encountered. [6]

METHODS

This is an observational study. The study used to be carried out in the admitted patient's Department of Gynecology and Obstetrics, Dhaka Medical College Hospital, Dhaka, Bangladesh. In Bangladesh for the duration of the period from January 2007 to

June 2008. This study was carried out on 60 patients the find out about the population including male and female patients above 20 years of age in the Department of Gynecology and Obstetrics, Dhaka Medical College Hospital, Dhaka., Bangladesh. The medical Pediatricians, Neonatologist and the surgeon were primarily involved in the decision-making process. The choice of treatment was made by the patient after a full discussion with

RESULTS

the multidisciplinary team consisting of pediatricians, neonatologists and pediatric endocrinologists and surgeons.

The data for this study about had been accumulated from patients' medical information and radiographs. Statistical evaluation of the results used to be got via the use of a window-based computer software program devised with Statistical Packages for Social Sciences (SPSS-24).

Table 1s: Distribution of the study according to age (n=60)

Age (years)	Number	Percentage
20-25	23	38.33
26-30	26	43.33
31-35	8	13.33
36-40	3	5.00

Table 1 demonstrated and distribution of the study according to age of 60 Patients aged 20 to 40 years. Here according to Age

distribution, 23(38.33%) were 20-25 years, 26(43.33%) were 26-30 years, 8(13.33%) were 31-35 and 3(5.00%) were 36-40 years.

Table 2: Distribution of the study according to Gestational age (weeks)

Gestational age (weeks)	Number	Percentage
30-35	4	6.67
36-40	48	80.0
40+	8	13.33

Table 2 demonstrated and distribution of the study according to Gestational age (weeks). Here according to Gestational age, 4(6.67%) were 30-35 years, 48(80.0%) were 36-40 years, and 8(13.33%) were 40+ years.

Table 3: Distribution of the study according to Respondent

Respondent	Number	Percentage
Laparotomy	3	5
Cholecystectomy	3	5
Absent	48	80

Table 3 demonstrated and distribution of the study according to Respondent. Here according to Respondent, 3(5%) were Laparotomy, 3(5%) were Cholecystectomy, and 48(80%) were Absent.

Table 4: Distribution of the study according to Type of surgeon

Type of surgeon	Number	Percentage
Professor		0.00
Consultant	7	11.67
Junior Consultant	10	16.67
EOC trained medical officer	30	50
General practioner	13	21.67

Table 4 demonstrated and distribution of the study according to Type of surgeon. Here according to Type of surgeon the Professor, Consultant, Junior Consultant, EOC trained

medical officer and General practioner were 0(0.00%), 7(11.67%), 10(16.67%), 30(50%) and 13(21.67%) respectfully.

Table 5: Distribution of the study according to Complication

Complication	Number	Percentage
Postpartum haemorrhage	20	20.62
Shock	20	20.62
DIC	4	4.12
Abdominal distension	10	10.31
Paralytic ileus	1	1.03
Hemoperitoneum	14	14.44
Injury to the viscera	1	1.03
Wound infection	2	2.06
Wound dehiscence	2	2.06
Retained foreign body	1	1.03
Ureter injury	3	3.09
Bladder injury	5	5.15
ruptured uterus	2	2.06
Intrauterine infection	4	4.12
Subrectal hematoma	5	5.16
Anaesthetic hazards	6	6.18

Table 5 demonstrated and distribution of the study according to Complication. Here according to Type of complication the Postpartum haemorrhage, Shock, DIC,

Abdominal distension, Paralytic ileus, Hemoperitoneum, Injury to the viscera, Wound infection, Wound dehiscence, Ureter injury, Bladder injury, ruptured uterus,

Intrauterine infection, Subrectal hematoma and Anaesthetic hazards were 20(20.62%), 20(20.62%), 4(4.12%), 10(10.31%), 1(1.03%), 14(14.44%), 1(1.03%), 2(2.06%), 2(2.06%), 1(1.03%), 3(3.09%), 5(5.15%), 2(2.06%), 4(4.12%), 5(5.16) and 6(6.18%) respectfully.

DISCUSSION

Hager et al [7] mentioned that the incidence of greater than one intraoperative or post-operative complication in caesarean delivery was once 21.4%, and post-partum problems have been greater serious than these for vaginal delivery [8].

In our study, according to age of 60 Patients aged 20 to 40 years. Here according to Age distribution, 23(38.33%) were 20-25 years, 26(43.33%) were 26-30 years, 8(13.33%) were 31-35 and 3(5.00%) were 36-40 years. And according to Gestational age (weeks). Here according to Gestational age, 4(6.67%) were 30-35 years, 48(80.0%) were 36-40 years, and 8(13.33%) were 40+ years.

PPH is regularly managed satisfactorily with conservative treatment such as vaginal packing and intravenous administration of oxytocic drugs and prostaglandin-E2 analogues. In refractory cases, however, hysterectomy or hypogastric artery ligation may be carried out to manage intractable PPH. This surgical method is related with an excessive morbidity and mortality and with loss of subsequent fertility. This process may additionally fail to quit the bleeding. The negative aspects of surgical treatment additionally encompass the low success rate of hypogastric artery ligation (50%) [9]. Evans and McShane [10] mentioned that post-partum hemorrhage endured after hypogastric artery ligation in 57% of the patients.

Greenwood et al [11] informed a number of mechanisms by using which hysterectomy can also fail to manipulate bleeding. They consist of bleeding from extrauterine sites, the presence of abundant collateral vessels such as center sacral, last

lumbar and inferior epigastric arteries, or insufficient arterial ligation. In addition, they insisted that it can be hard to detect the bleeding site due to the fact of engorged and friable pelvic vessels in the post-partum nation [11].

The TAE method for PPH used to be first described in 1979 [12]. Unlike hysterectomy, TAE is a technique with an excessive technical success rate (96%), few problems (6%) and the attainable of keeping fertility [13, 14]. Many researches have mentioned the effectiveness and protection of TAE in the manage of post-operative, post-arboretum and postpartum intractable bleeding [14].

In this study, according to Respondent. Here according to Respondent, 3(5%) were Laparotomy, 3(5%) were Cholecystectomy, and 48(80%) were Absent. And according to Type of surgeon. Here according to Type of surgeon the Professor, Consultant, Junior Consultant, EOC trained medical officer and General practioner were 0(0.00%), 7(11.67%), 10(16.67%), 30(50%) and 13(21.67%) respectfully.

Two instances of post-caesarean haemoperitoneum with abdominal wall haematoma introduced with extravasation of the inferior epigastric artery, as recognized by using angiography. Massive bleeding into the abdominal wall from the inferior epigastric artery can be tough to realise at the beginning and harm of the inferior epigastric artery is no longer common; therefore, abdominal wall haematoma is frequently ignored as a doable motive of pelvic haemorrhage. However, the inferior epigastric artery ought to be viewed as a feasible supply of arterial haemorrhage and a selective angiogram ought to be carried out if the major haemorrhage is now not vaginal bleeding however a haemoperitoneum, if no apparent abnormality is recognized in the course of uterine artery angiography, or if apparent belly wall haematoma is recognized by using laparotomy or on ultrasound or CT

scan. There have been some published reports of profitable embolisation to deal with pseudoaneurysm of the inferior epigastric artery in patients with PPH after caesarean part [15].

In this present study, according to Type of complication the Postpartum haemorrhage, Shock, DIC, Abdominal distension, Paralytic ileus, Hemoperitoneum, Injury to the viscera, Wound infection, Wound dehiscence, Ureter injury, Bladder injury, ruptured uterus, Intrauterine infection, Subrectal hematoma and Anaesthetic hazards were 20(20.62%), 20(20.62%), 4(4.12%), 10(10.31%), 1(1.03%), 14(14.44%), 1(1.03%), 2(2.06%), 2(2.06%), 1(1.03%), 3(3.09%), 5(5.15%), 2(2.06%), 4(4.12%), 5(5.16) and 6(6.18%) respectfully..

Vendantham et al [16] pronounced complication rates of 6–7% after post-partum pelvic embolisation. Complications of this manner are quite rare; they encompass fever, pelvic or genital infection, irreversible ischaemia of pelvic organs (uterine necrosis, transient ovarian failure or bladder wall necrosis), vaginal fistula, muscle pain, neurological damage, irreversible harm to the ovaries, vaginal abscess, small-bowel infarct, and exterior iliac artery perforation or occlusion [17]. We stated no foremost complication in affiliation with the TAE procedure. Minor problems such as pelvic ache and again ache had been cited in patients, more often than not on the first day after treatment, resolving inside a number of days and all controllable with conservative treatment.

The majority of caesarean sections are carried out for maternal scientific or fetal reasons; however, there are growing quantity of female requesting for a caesarean section except a clinical indication. It is additionally notion that the growing litigious surroundings of the developed world and diminished quantity of training time, and consequently experience of junior medical doctors in hard instrumental deliveries, may also additionally

be contributing to the increase. Although, the security of this manner has notably improved, there is big debate related to the advantages of caesarean area in contrast with vaginal delivery.

Limitations of the Study

The present study was conducted in a very short period due to time constraints and funding limitations. The small sample size was also a limitation of the present study.

CONCLUSION

This study showed post caesarean section main complication of the patients admitted in the Dhaka Medical College Hospital referred from outside, were postpartum haemorrhage, shock, abdominal distension, hemoperitoneum, intrauterine infection, wound infection, subrectal hematoma. Most of the cases operation done of EOC and general practioner. Most of the cases need laparotomy. Those who are working as a service provider in UCH or district hospital must have appropriate training before the they start any surgery in his respective site. They must be confident enough to handle the cases.

RECOMMENDATION

This study can serve as a pilot to a much larger research involving multiple centers that can provide a nationwide picture, validate regression models proposed in this study for future use and emphasize points to ensure better management and adherence.

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DECLARATION

Conflict of interest: None declared.

Ethical approval: The study was approved by the ethical committee of Dhaka Medical College, Dhaka.

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