

# OLD PROCEDURES ARE STILL VALUABLE: AVOIDING UNNECESSARY CESAREAN SECTION TO DECREASE RISK IN THE NEXT PREGNANCY

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## SUMMARY

**Objective:** In the past, obstetricians were highly skilled in obstetric procedures. An increase in cesarean section rates, especially in developed countries, has led to a gradual loss of obstetric skills.

**Case Reports:** Two cases are reported, the first being a case of face presentation in the mentoposterior position and the second a case of transverse lie with a prolapsed hand, both with intrauterine death.

**Conclusion:** Cesarean sections in both cases, although justified, were avoided after a successful trial of other obstetric procedures. [*Taiwan J Obstet Gynecol* 2009;48(1):76-78]

**Key Words:** cesarean section, intrauterine death, obstetric procedures

## Introduction

Obstetric procedures have a long history. Internal podalic version has been performed from the times of Hippocrates, and obstetric forceps have been in use since the 1600s. In the past, obstetric procedures were commonly practiced, because obstetricians were highly skilled in them and cesarean section (c-section) was neither as popular nor as safe as it is today. There has been an alarming increase in c-section rates, especially in developed countries, with a gradual loss of obstetric skills, as the c-section has become an easy answer to most obstetric problems. This trend towards a high c-section rate, with its consequences, can now be seen in the third world. An international campaign was started to decrease the c-section rate worldwide and the World Health Organization stated that no region in the world is justified in having a c-section rate of more than 10–15% [1]. We want to report two cases where c-sections, although justified, were avoided after a successful trial of other obstetric procedures.

## Case Reports

In the first case, a non-booked primigravida, 22 years of age, presented in emergency after 12 hours of labor pains. On examination, her fundal height was 36 weeks. Lie was longitudinal and cephalic with an estimated fetal weight of 3,000 g. Fetal heart sounds were absent. She was having 3–4 moderate uterine contractions. On vaginal examination, the cervix was fully dilated and fully effaced with face presentation in the mentoposterior position. The station was +1. Informed consent was given for an attempt at manual rotation followed by c-section in case of failure. An intravenous line was maintained, blood was sent for cross-matching, and routine baseline investigations including complete blood analysis, random blood sugar measurement, hepatitis serology and routine urinalysis were carried out. Complete preparation took place for an emergency c-section. With each uterine contraction, manual rotation of the face was attempted towards the mentoanterior position. This required more than half an hour to be completed. A forceps delivery with an episiotomy followed. The birth weight of the baby was 3,200 g. No maternal complication was encountered postpartum.

The second case was a non-booked case of a 32-year-old, gravida 5, woman with four healthy children, who presented in emergency with labor pains lasting one night. On examination, her general condition was



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stable. She had a fundal height of 32 weeks with a transverse lie and estimated fetal weight of 3,200 g. Fetal heart sounds were absent. Vaginal examination showed a fully dilated cervix with a hand prolapsed outside the vagina. Consent was given for internal podalic version and emergency c-section in case of failure of the procedure. An intravenous line was maintained, and the patient was prepared and transferred to the operating theatre. Halothane inhalation was given for uterine relaxation. When adequate relaxation achieved, the prolapsed hand was replaced inside the cervix, followed by successful internal podalic version and breech extraction. The birth weight of the baby was 3,000 g. There was no maternal complication (e.g. uterine rupture, postpartum hemorrhage), and the patient was discharged the next day.

## Discussion

As a result of the availability of safe anesthesia and antibiotics and the adoption of aseptic techniques, c-section has now become a common mode of delivery. In the United States and Canada, over one-third of all c-sections are repeat cesareans [1], and according to the United States' National Centre for Health Statistics, the c-section rate is 29% while that in Australia is 34% [2]. C-section has replaced the old procedures and instrument use, but there has been no recognition that c-section comes with its own complications, including anesthesia hazards, hemorrhage, sepsis, possible damage to other organs, the dangers of blood transfusion and possible re-hospitalization [3]. A c-section costs nearly twice as much as a vaginal birth. It also leads to a scarred uterus and an increased risk in the next pregnancy with respect to labor induction and the use of oxytocin. There is a decreased threshold for repeat c-section and above all, the risks associated with non-booked patients with uterine scars being delivered by untrained birth attendants at home, a very common practice in third world countries. Face presentation is a real problem with an incidence of 0.2%, and when it is mentoposterior, a c-section is indicated [4]. Manual rotation to the mentoanterior position followed by forceps extraction is another option, which is safer than application of Kielland's rotational forceps particularly when the fetus is dead. Similarly, internal podalic version has, for centuries, been the practice for a neglected transverse lie, but c-section is indicated nowadays for a neglected transverse lie with hand prolapse to prevent maternal and fetal trauma [5], although the procedure itself becomes difficult in those circumstances [6] and is associated with multiple complications [7].

However, in experienced hands with proper precautions, and assessment and selection of cases, c-section can be avoided in such circumstances. The main problem arising from the cesarean-oriented culture for new obstetricians and trainee residents is that they are neither familiar with nor well trained in assessment of such cases and in performance of various procedures. This has resulted in a c-section rate and associated maternal mortality that is 2–4 times higher with a c-section than a vaginal delivery. Even for a live fetus, the most common argument presented by high c-section rate physicians is the safety of the fetus. However, various studies have shown that low c-section rates reduce maternal complication rates without any increase in perinatal mortality [8], and there is actually a decrease in perinatal mortality [9]. It is particularly important for developing countries to transfer these almost lost skills to junior doctors, because the success rate of internal podalic version is high when carried out by a competent and experienced operator and when certain criteria are met [10,11], e.g. a relaxed uterus, absence of a previous uterine scar, exclusion of fetal macrosomia and availability of an operating theatre in case of a failed procedure. Similarly, manual rotation is an effective technique for reducing the cesarean delivery rate in patients with fetal malposition [12]. This not only prevents scarring of the uterus but also reduces the risk of uterine rupture in a pregnant woman who lives far from a hospital and does not attend an antenatal clinic because of logistic problems or lack of awareness of the need to do so.

## References

1. Cesarean fact sheet. Available at: <http://www.childbirth.org/section/CSFact.html> [Date accessed: 15 October 2007]
2. Walker R, Turnbull D, Wilkinson C. Increasing cesarean section rates: exploring the role of culture in an Australian community. *Birth* 2004;31:117–24.
3. Lydon-Rochelle M, Holt VL, Martin DP, Easterling TR. Association between method of delivery and maternal rehospitalization. *JAMA* 2000;283:2411–6.
4. Napolitano PG, Parker J. Face presentation. Available at: <http://www.emedicine.com/med/topic3273.htm>. Updated: 18 June 2007. [Date accessed: 15 October 2007]
5. El-Mowafi DM. Face presentation. In: El-Mowafi DM, ed. *Obstetrics Simplified*. El-Mansoura, Egypt, 1997. Available at: [http://www.gfmer.ch/Obstetrics\\_simplified/face\\_presentation.htm](http://www.gfmer.ch/Obstetrics_simplified/face_presentation.htm) [Date accessed: 2 November 2007]
6. Chamberlain G, Steer P. ABC of labour care: unusual presentations and positions and multiple pregnancy. *BMJ* 1999; 318:1192–4.
7. Khattak NN, Majid SS, Haleemi M, Utman N. Maternal and foetal complications in neglected transverse lie. *J Postgrad Med Inst* 2006;20:126–30.

8. Li T, Rhoads GG, Smulian J, Demissie K, Wartenberg D, Kruse L. Physician cesarean delivery rates and risk-adjusted perinatal outcomes. *Obstet Gynecol* 2003;101:1204–12.
9. Abu-Heija AT, Ziadeh SM. Correlation of decrease in cesarean section rates and decrease in perinatal mortality at Princess Basma Teaching Hospital in North Jordan. *Ann Saudi Med* 1995;15:29–31.
10. Mahendru A, Ogueh O, Gajjar K, Rawat C. Role of internal podalic version in developing countries. *Internet J Gynecol Obstet* 2006;6(1). Available at: <http://www.ispub.com/ostia/index.php?xmlFilePath=journals/ijgo/vol6n1/podalic.xml>
11. Chandra M, Chaturvedi B. Internal podalic version a forgotten art: a review of transverse lie at Sultania Zanana Hospital, Bhopal. *J Obstet Gynecol India* 2002;52:80–2.
12. Le Ray C, Serres P, Schmitz T, Cabrol D, Goffinet F. Manual rotation in occiput posterior or transverse positions: risk factors and consequences on the cesarean delivery rate. *Obstet Gynecol* 2007;110:873–9.