"CROSS SECTIONAL STUDY OF INDICATIONS FOR CESAREAN SECTION"

BY

Dr. Aruna Biradar

Dissertation submitted to the

BLDE UNIVERSITY, BIJAPUR

IN PARTIAL FULFILMENT

OF THE REQUIREMENT FOR THE DEGREE OF

MASTER OF SURGERY

IN

OBSTETRICS AND GYNAECOLOGY

Under the guidance of

Dr. G.R.SAJJAN M.D. DGO
PROFESSOR, DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

B.L.D.E. UNIVERSITY, BIJAPUR

2011

B.L.D.E.U's UNIVERSITY
SHRI B.M.PATIL MEDICAL COLLEGE HOSPITAL & RESEARCH CENTRE, BIJAPUR

DECLARATION BY THE CANDIDATE

I solemnly declare that the dissertation titled **"CROSS SECTIONAL STUDY OF INDICATIONS OF CESAREAN SECTION"** has been prepared by me under the direct supervision and guidance of Dr**. G.R.SAJJAN,** professor, department of **OBSTETRICS AND GYNAECOLOGY, BLDE** university, Bijapur and is submitted in partial fulfillment of its regulations for the award of the degree of **"MASTER OF SURGERY IN OBSTETRICS AND GYNAECOLOGY".** This work has not been submitted by me for award of any other degree or diploma by any other university.

Date : **Dr. Aruna Biradar**

Time :

B.L.D.E.U's UNIVERSITY
SHRI B.M.PATIL MEDICAL COLLEGE HOSPITAL & RESEARCH CENTRE, BIJAPUR

CERTIFICATE BY THE GUIDE

This is to certify that this dissertation entitled "**CROSS SECTIONAL STUDY OF INDICATIONS OF CESAREAN SECTION"** is the bonafide work of **Dr. ARUNA BIRADAR ,** a post graduate student in **OBSTETRICS AND GYNAECOLOGY** and is done under my direct supervision and guidance at **BLDE** university , Bijapur for the award of the degree of **"Master of Surgery in OBSTETRICS AND GYNAECOLOGY"** I have satisfied myself that her observations noted in this dissertation are authentic and also that these confirm with the standards of **BLDE** University, Bijapur. I have great pleasure in forwarding this dissertation to the university.

Date:

Place: Bijapur

DR.G. R. SAJJAN

PROFESSROR,
DEPARTMENT OF OBSTETRICS & GYNECOLOGY, B.L.D.E.U's SHRI B.M.PATIL MEDICAL COLLEGE &RESEARCH CENTRE, BIJAUR

B.L.D.E.U's UNIVERSITY
SHRI B.M.PATIL MEDICAL COLLEGE HOSPITAL & RESEARCH CENTRE, BIJAPUR

ENDORSEMENT BY THE HOD, PRINCIPAL/ HEAD OF INSTITUTION

This is to certify that this dissertation entitled "**CROSS SECTIONAL STUDY OF INDICATIONS OF CESAREAN SECTION"**a bonafide work of Dr. ARUNA BIRADAR, in partial fulfillment of the regulation of BLDE University, Bijapur for the award of the degree of "**Master of Surgery in OBSTETRICS AND GYNAECOLOGY",** under the guidance of **Dr. G.R.SAJJAN,** professor, department of **OBSTETRICS AND GYNAECOLOGY,** BLDE University, Bijapur.

I have great pleasure in forwarding this dissertation to the BLDE University.

Dr.(Mrs).S.V.REDDY
PROFESSOR AND HOD
Department Of Obstetrics
And Gynaecology
BLDE University, Bijapur.

Date :

Place :

Dr.R.C.BIDRI
PRINCIPAL,
Shri.B.M.Patil Medical College
BLDE University,
Bijapur.

Date:

Place:

COPYRIGHT

DECLARATION BY THE CANDIDATE

I hereby declare that the BLDE University Bijapur Karnataka shall have the right to preserve and use this dissertation / thesis in print or electronic format for academic / research purpose.

Date : **Dr. ARUNA BIRADAR**

Place :

ACKNOWLEDGEMENT

On completion of this scientific document it gives me deep pleasure to acknowledge the guidance provided to me by my distinguished mentors.

With privilege and respect I would like to express my profound gratitude and indebtedness to my guide and esteemed teacher **Dr. G. R. SAJJAN,** Professor, Department of Obstetrics & Gynaecology, Shri. B. M. Patil Medical College, Bijapur, for her constant inspiration, extensive encouragement and support, which she rendered in pursuit of my post-graduate studies and in preparing this dissertation.

I express my sincere thanks to my dear teachers **Dr. (Prof) S. V. Reddy,** our esteemed Head Of Department **Dr (Prof) V. R. Gobbur, Dr.(Prof) P. B. Jaju, Dr.(Prof) S. R. Mudanur, Dr(Prof) Manpreet Kaur, Dr. S. R. Bidri, Dr. Jyoti Korbu, Dr. Deepa Patil, Dr. Girija Hanjagi, Dr. Rajashri Yaliwal, Dr. Neelamma Patil, Dr. Jayashree Sajjanar, Dr. Sumedha Katti, Dr. Shobha** and **Dr. Nirmala** for their kind co-operation and guidance.

I am thankful to **Dr.R.C.Bidri,** Principal, B.L.D.E.U's Shri. B. M. Patil Medical College Hospital and Research Centre, Bijapur, for permitting me to conduct & utilize resources in completion of my work.

I am deeply indebted to my **Parents** and my **Sister – Ashwini, and my friends Dr.Shruti, Dr.Shreedevi and Dr.Akshay.Jadhav whose**

constant encouragement and inspiration led me to the successful completion of my dissertation work.

I am also thankful to my fellow post graduates and friends for their suggestions and support.

My thanks to all **non teaching staff** of my department, **the Nursing staff** and all hospital staff for their co-operation in my study.

I would convey my gratitude to all the patients without whose co-operation, this study would not have been possible.

Last but not the least, I thank **GOD** and pray for his continued blessings and success.

Date :

Place: Dr.Aruna.Biradar

ABSTRACT

Background:

Cesarean section is defined as the birth of the fetus through the incision on the abdominal wall & the uterine wall [16]. This definition does not include the removal of the fetus from the abdominal cavity in case of rupture of uterus or in case of abdominal pregnancy.

In recent era the rising trends of cesarean section is common in primary cesarean delivery with the most common indication being non-reassuring fetal status, labor arrest, multiple gestation, pre-eclampsia, suspected macrosomia, maternal request[16].

The need for this study is to know the rate & the common indications for the rising trends of cesarean section in the present days.

Objective :

To estimate the cesarean section rate and to analyse the various indications at BLDE University's Shri. B . M .Patil Medical College, Hospital and Research Center, Bijapur from Oct 2009 to July 2010.

Method :

All patients undergoing cesarean section at BLDE University's Shri. B. M. Patil Medical College, Hospital and Research Center, Bijapur from Oct 2009 to July 2010.

It is a cross sectional study.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF GRAPHS

LIST OF PHOTO GRAPHS

INTRODUCTION

Legend has it that the first successful cesarean section was performed to deliver Julius Caesar; persistence of this legend gave rise to the name of the procedure. However, given the fact that his mother survived his birth, most authorities' doubt Caesar really was born in this manner (because surviving cesarean section was virtually unknown until the twentieth century. [1]

By the middle ages, delivery of a baby through an incision in the mother's abdomen was well described and so was the subsequent death of the mother[2]. In the nineteenth century, the method of cesarean delivery was well known in medical practice, yet rarely performed. Prior to the mid-nineteenth century, cesarean delivery was associated with an essentially 100% death rate for the mother. Looking back at medical practice at that time, it is not hard to understand why. [3]

Firstly, doctors had no understanding of what today is called the **germ theory of disease** [4](the theory that diseases are due to the presence of microorganisms in the body); therefore, they made no attempts to sterilize surgical instruments or wash their hands. Thus, many women acquired serious infections during the birthing process and since antibiotics were unknown until a century later, these infections resulted in many deaths.

Secondly, blood transfusions were not performed until the twentieth century, and many women died from blood loss during delivery before this time. Even today, blood transfusions are sometimes necessary as a result of blood loss at the time of cesarean section; in the past, there was no way to help these women.

Finally, until well into the twentieth century, anaesthetic techniques were very primitive. This not only made the operation more difficult for the doctor but also made it a horrendous experience for the mother. Undoubtedly, this also increased the rate of complications.

For the most part, these problems have been solved today and death or serious disability resulting from cesarean section is an extremely rare event. On the contrary, cesarean section can be credited with saving the lives of innumerable mothers and infants over the past century, and it can truly be considered one of the major achievements of modern medicine.

AIMS AND OBJECTIVES

To estimate the Cesarean Section rate and to analyse the various indications at BLDE University's Shri. B. M .Patil Medical College, Hospital and Research Center, Bijapur from Oct 2009 to July 2010.

HISTORY

The Roman Lex Regia, (later the Lex Caesarea) of Numa Pompilius (715–673 BC), required that the child of a mother, dead in childbirth be cut from her womb[(5)]. This seems to have begun as a religious requirement that mothers are not to be buried pregnant, and a way of saving the foetus. Roman practice requiried a living mother to be in her 10th month of pregnancy, before the procedure was resorted to.[(5)].

The term has also been explained as derived from the verb caedere, 'to cut', with children delivered this way referred to as caesones. Pliny the Elder refers to a certain Julius Caesar as ab utero caeso, "cut from the womb".

Finally, the Roman praenomen (given name) Caeso was said to be given to children who were born via cesarean section. While this was probably just folk etymology made popular by Pliny the Elder, it was well known by the time the term came into common use.

Successful Caesarean section was performed by indigenous healers in Kahura, Uganda, as observed by R. W. Felkin in 1879.

Bindusara, the second Mauryan emperor of India after Chandragupta Maurya the Great, is said to be the first child born by surgery.The History of classical sanskrit literature: being an elaborate account of how his mother, wife of Chandragupta Maurya, accidentally consumed poison and died when she was close to delivering him. Chanakya, Chandragupta's teacher and advisor, made up his mind that the baby should survive. He cut open the belly of the queen and took out the baby, thus saving the baby's life.

European travelers in the Great Lakes region of Africa during the 19th century, observed caesarean sections being performed on a regular basis[6]. The expectant mother was normally anesthetized with alcohol, and herbal mixtures were used to encourage healing. From the well-developed nature of the procedures employed, European observers concluded that they had been employed for some time.

The first successful caesarean section to be performed in America took place in what was formerly Mason County, Virginia (now Mason County West Virginia) in 1794[7]. The procedure was performed by Dr. Jesse Bennett on his wife Elizabeth.

On March 5, 2000, Inés Ramírez performed a Caesarean section on herself and survived, as did her son, Orlando Ruiz Ramírez. She is believed to be the only woman to have performed a successful Caesarean section on herself. [8]

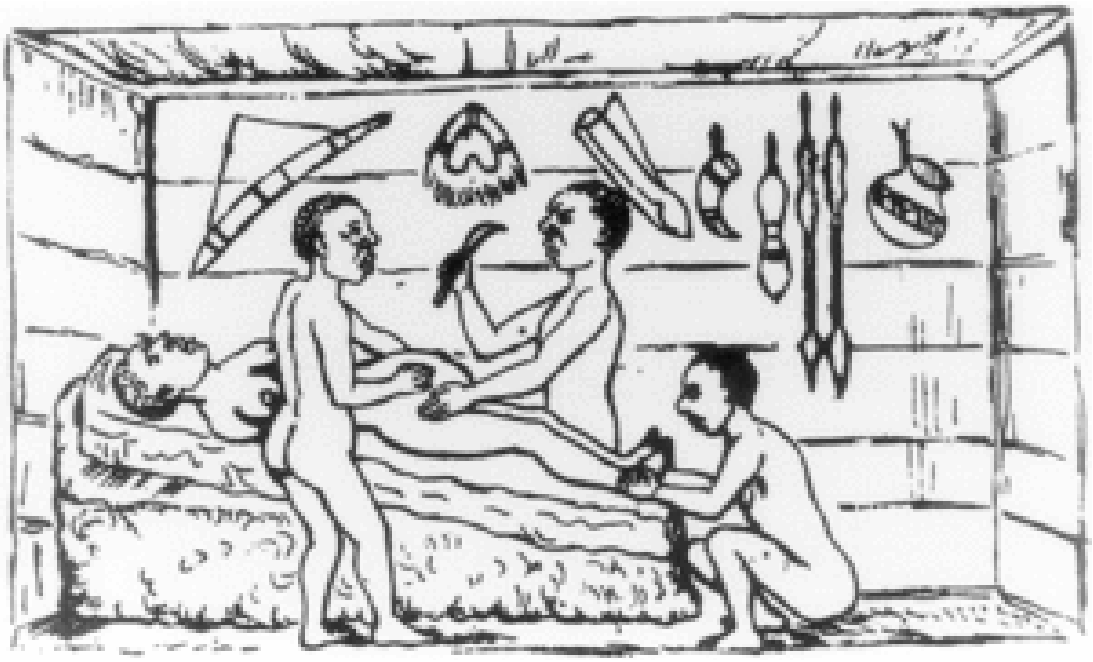


FIGURE 1 : Showing the ancient way of cesarean section

Indications

Caesarean section is recommended when vaginal delivery might pose a risk to the mother or baby. Not all of the listed conditions represent a mandatory indication, and in many cases the obstetrician must use discretion to decide whether a caesarean is necessary or not. Indications for caesarean delivery are:

1. Fetal distress
2. CPD
3. Dystocia
4. Previous cesarean section
5. Failed induction
6. Malpresentations
7. Placenta previa type IV, III, II posterior
8. Bad obstetric history
9. Precious pregnancy
10. Medical disorders : pre-eclampsia, eclampsia, diabetes mellitus
11. Others : cord prolapse, pelvic mass, carcinoma cervix, HIV , genital herpes
12. Lack of Obstetric Skill Obstetricians not being skilled in performing breech births, multiple births, etc. [In most situations women can birth under these circumstances naturally. However, obstetricians are not always trained in proper procedures.
13. Improper Use of Technology (Electronic Fetal Monitoring [EFM][(9)]

REVIEW OF LITERATURE

A study conducted by Mukherjee. SN[10] showed that the incidence of cesarean delivery is alarmingly high all over the world .Their study showed that the cesareans are invariably performed to benefit the fetus and not the mother. Their analysis showed that the indications of CS are – fetal distress, prolonged labour, breech presentation, multiple gestations, previous cesarean section, and CS on demand. They were also of the opinion that it is possible to maintain the CS rate close to 10-15% and still have very low maternal and perinatal mortality.

Kambo.I, Bedi.N, Dhillon.BS et.al [11] conducted a study to estimate the CS rate and examine the indications and consequences at teaching hospitals in India. The overall rate of CS has increased from 21.8% in 1993-94 to 25.4% in 1998-99. Among the 7017 section cases, the indications of CS were dystocia (major indication) 37% fetal distress (with or without meconium aspiration) ,repeat cesarean malpresentation and PIH.

Mehta.A, Apers.L, Verstralean.H and Temmerman.M [12] conducted a retrospective study at Nowrosjee Wadia Maternity Hospital (NWMH) Mumbai, using data from 1957-1998 , when the CS rate increased from 1.9% to 16% and PNMR decreased to 20-40/1000 from 140/1000.

Shah JM, Mehta MN, [13] conducted a prospective study in 385 women with previous LSCS from Jan 2005 to Dec-2006. Women with both recurrent and non-recurrent indications of CS were included. Those with previous LSCS for non-recurrent indications were given trial of vaginal delivery [according to ACOG

guidelines] .There was no statistical difference in maternal and perinatal morbidity rates in elective CS versus trial of vaginal delivery groups. They came to a conclusion that proper selection, appropriate timing and close supervision during trial of vaginal delivery eliminates the need for a large proportion of repeat CS.

Shakti.V, Behera RC, Sandha GS , Singh Anita ,Bandhu HC [(14)] conducted a study on the efficacy and safety of attempted vaginal birth after a cesarean delivery (VBAC) and they had an opinion that VBAC should be considered in cases of previous one cesarean delivery for non recurrent indications.

McMahon JM, Luther. R.E, Bowes.A.W and Olshan.Andrew [(15)] conducted a longitudinal study of 6138 women who had previously undergone cesarean section and had delivered a singletone live infant in the period from 1986 to 1992 and they opined that the major maternal complications are almost twice likely among those whose deliveries are managed with a trial of labour as compared to those who underwent an elective second cesarean section.

A study was conducted by Chhabra S and Arora G in department of OBG, Mahatma Gandhi Institute of Medical sciences, Sevagram,[(16)] to know the outcome of trial of vaginal birth after previous cesarean section with special reference to induction of labour at a rural institute with resource constraint and opined that trial of labour and induction of labour are safe modalities in these women with previous cesarean section even in such settings.

A study was conducted by Barber, Emma L, Lundsberg L et.al[(17)] to know the indications contributing to increasing cesarean delivery rate & concluded that 50% of

primary cesarean births accounted for increasing cesarean rate & the indications being non-reassuring fetal status, arrest of dilation which are subjective.

Souza JP, Giilmezoglu AM, Lumbiganon P et.al[1] conducted a study i.e., "cesarean section without medical indications is associated with an increased risk of adverse short term maternal outcome" & concluded that cesarean section were associated with an intrinsic risk of increased severe maternal outcomes & should be performed when clear benefit is anticipated.

A study conducted by Stiernholm, Petason Y. V, Eneroth E[18] on changed indications of cesarean section & found an increased rate of elective cesarean for psychosocial indications. A standardized protocol aiding a physician in making decisions concerning the cesarean section practice should be developed.

A study conducted by Unnikrishnan B, Rakshith P, Aishwarya A, Nithin K, Rekha T et.al[2] on trends and indications of cesarean section in a tertiary care centre obstetric hospital in coastal south India concluded that cesarean section has serious complications on maternal and child health, 3.6 times more compared to vaginal delivery.

A study conducted by R P Porreco on high cesarean section rate: a new perspective[3] and showed that the rate of cesarean section at first service is 5.7% and total cesarean section rate on comparison service was 17.6%. The major indications for repeat cesarean section were cephalopelvic disproportion, breech presentation, fetal distress & genital herpes & the data showed excellent perinatal outcome achieved with modest abdominal delivery rates.

Chris McCourt, Jane Weaver, Helen Statham et.al,[6] conducted a study on Elective cesarean section and decision making: a critical review of the literature and

concluded that research conducted between 2000-2005 shows evidence of very small number of women requesting a cesarean section. A range of personal and social reasons, including fear of birth and perceived inequality and inadequacy of care, underpinned these request.

A study conducted by Weaver JJ, Statham H, Richards M[7] concluded that psychological issues and maternal perceptions of risk appear to be significant factors in many maternal requests. Despite this maternal request is perceived by obstetricians to be a major factor in driving the cesarean section rate upward.

TYPES :

There are several types of Caesarean section (CS). An important distinction lies in the type of incision (longitudinal or transverse) made on the uterus, apart from the incision on the skin.

- The classical Caesarean section involves a midline longitudinal incision which allows a larger space to deliver the baby. However, it is rarely performed today as it is more prone to complications.
- The lower uterine segment section is the procedure most commonly used today; it involves a transverse cut just above the edge of the bladder and results in less blood loss and is easier to repair.
- A crash/emergent/emergency Caesarean section is a Caesarean performed in an obstetric emergency, where complications of pregnancy occur suddenly during the process of labour, and swift action is required to prevent the deaths of mother, child(ren) or both.
- Traditionally other forms of Caesarean section have been used, such as extraperitoneal Caesarean section or Porro Caesarean section.
- A repeat Caesarean section is done when a patient had a previous Caesarean section. Typically it is performed through the old scar.

STEPS OF CESAREAN SECTION [19]

A) SKIN INCISIONS :

1. Abdominal incision can be midline vertical, paramedian or a suprapubic transverse incision
2. Vertical incision- This is the quickest incision, which is subumblical either median or paramedian.
3. Transverse incision – This is, modified pfannenstiel incision, in which the skin, subcutaneous tissue are incised using a lower, transverse, slightly curvilinear incision. The incision is made at the level of pubic hairline & extended somewhat beyond the lateral borders of rectus muscles.
4. Maylard incision – In this incision the rectus muscles are divided sharply or with electro cautery. The incision also may be especially useful in women with significant scaring from previous transverse incision [18].

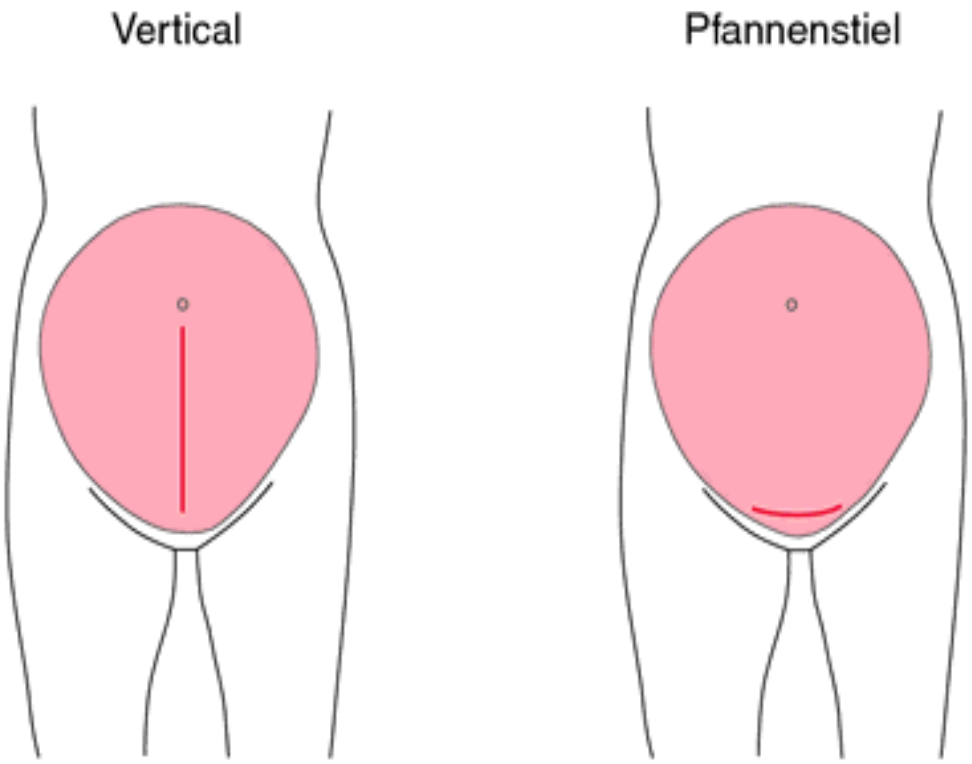


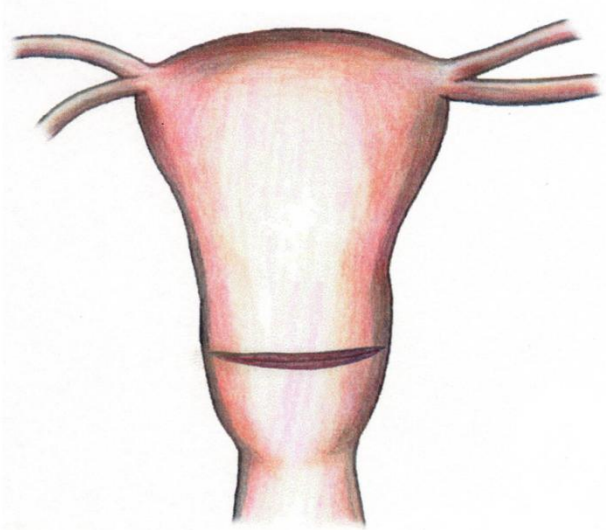
FIGURE 2 : Showing different skin incisions taken during cesarean section

B) Abdomen opened in layers till the pre peritoneal fat is identified [9].

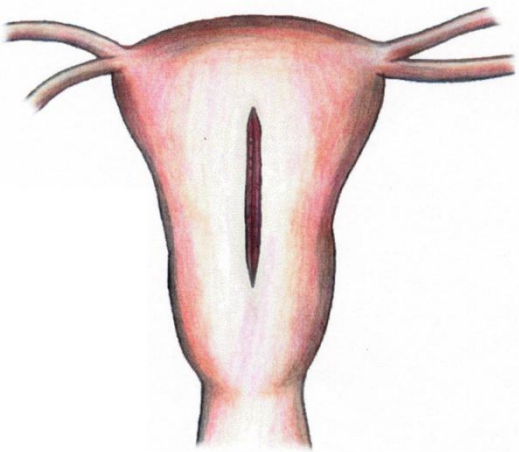
C) The peritoneum near the upper end is identified & opened carefully. Peritoneum is incised superiorly in the upper part of the incision & downwards to just above the peritoneal reflection over the bladder[9].

D) UTERINE INCISIONS :

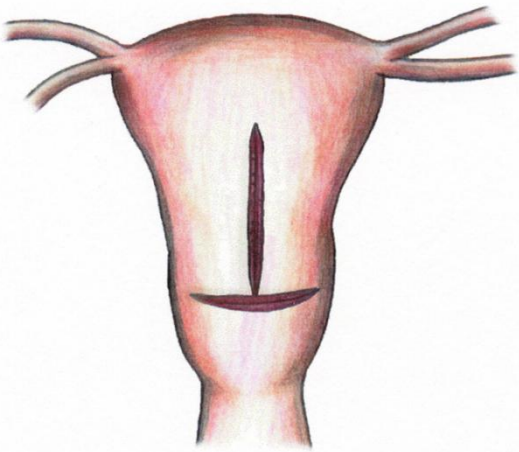
Most often lower uterine segment is incised transversly as described by Kerr in 1921[9]. Occasionally a low segment vertical incision as described by Kronig in 1912[9] may be used. The so called Classical incision is a vertical incision into the body of the uterus above the lower uterine segment reaching the uterine fundus. This is used seldom today. Transverse incision is easier to repair & has less chances of rupture during subsequent pregnancies & less adhesions.



Low transverse uterine incision



Classical uterine incision



T-incision of uterus

FIGURE 3 : Showing different uterine incisions taken during cesarean section

E) In lower segment cesarean section, uterus is stabilised & is entered through the lower uterine segment, approximately 1cm below the upper margin of peritoneal reflection. It is important to place a higher uterine incision in women with advanced dilation of cervix to minimize lateral extension into uterine arteries & unintended entry into the vagina. Uterus is entered carefully avoiding injury to the fetal head. Then incision is extended bilaterally with blunt or sharp dissection. Then the fetal presenting part is held & extracted with caution taking care not to extend the uterine incision. If extraction is difficult, forceps/ vacuum can be used. After the shoulders are delivered oxytocics can be given & then the placenta is delivered.

FIGURE 4: Showing the Extraction of baby and clamping of umbilical cord

F) UTERINE REPAIR :

The uterus is closed in either single / double layer with a absorbable / delayed absorbable suture material with continuous interlocking sutures as they prevent additional haemostatic sutures.

FIGURE 5 : Showing the uterine closure

G) Hemostasis is achieved. Mops & instruments counted.

H) Abdomen closed in layers

I) SKIN SUTURING :

Skin can be sutured with mattress sutures using barber, thread or ethilon or subcuticular sutures using vicryl or prolene.Recently stapling is being used.

RECOVERY SUITE [9]:

- Monitoring for vaginal bleeding & uterine palpation for contractility
- Adequate analgesia instituted
- Deep breathing exercises
- Monitoring for vitals every 15 minutes for 2 hours and then every hourly for 24 hours
- Fluid therapy : 3liters is proved adequate for 24hours post section, exception is to this pattern of fluid therapy is – severe pre-eclampsia
- Catheter removed by 12 hours. Retention of urine is seen in 3% of patients [36]
- Bladder and bowel function :
    a) Solid food offered within 8 hours of surgery in uncomplicated cases [37,38]
    b) pathlogy of adynamic ileus is complex and involves hormonal, neural & local factors that are incompletely understood [39]
- Ambulation : these patients have 20 fold increased risk of pulmonary embolism compared to those delivering vaginally. Risk factors include age>35yrs, BMI >30, parity >3, emergency cesarean , concurrent infection, major illness, pre-eclampsia, gross varicosities, recent immobility & prior deep vein thrombosis or thrombophilias [40]
- Wound care: Dressing changed on 4^{th} day and sutures are removed on 7^{th} day, routinely. In obese patients removed on 10^{th} day.

Recovery period

Typically, the recovery time depends on the patient and their pain/ inflammation levels. Doctors do recommend no strenuous work i.e. lifting objects over 10 lbs., running, walking up stairs or athletics for up to six weeks.

Risks

Maternal

The mortality rate for both caesarean sections and vaginal births continues to drop. However, it is misleading to directly compare the mortality rates of vaginal and caesarean deliveries. Women with severe medical conditions, or high risk pregnancies, often require a caesarean section which can distort the mortality figures.

A study published in the 13 February 2007 issue of the Canadian Medical Association Journal[19] found that the absolute difference in severe maternal morbidity and mortality was small between a cesarean and vaginal delivery, but that the additional risk should be considered by women contemplating an elective Caesarean delivery and by their physicians.

As with all types of abdominal surgery, a caesarean section is associated with risks of post-operative adhesions, incisional hernias (which may require surgical correction) and wound infections.[19] If a caesarean is performed under emergency situations, the risk of the surgery may be increased due to a number of factors. The patient's stomach may not be empty, increasing the anesthesia risk[19]. Other risks include severe blood loss and post spinal headache.

A study published in the June 2006 issue of Obstetrics and Gynecology [20] found that women who had multiple Caesarean sections were more likely to have problems with later pregnancies, and recommended that women who want larger families should not seek Caesarean section as an elective procedure. The risk of placenta acreta, a potentially life-threatening condition, is only 0.13% after two Caesarean sections but increases to 2.13% after four and then to 6.74% after six or

more surgeries. Along with this is a similar rise in the risk of emergency hysterectomies at delivery. The findings were based on outcomes from 30,132 Caesarean deliveries[20].

It is difficult to study the effects of Caesarean sections because it can be difficult to separate out issues caused by the procedure itself versus issues caused by the conditions that require it. For example, a study published in the February 2007 issue of Obstetrics and Gynecology [21]found that women who had just one previous caesarean section were more likely to have problems with their second birth. Women who delivered their first child by caesarean delivery had increased risks for malpresentation, placenta previa, antepartum hemorrhage, placenta acreta, prolonged labor, uterine rupture, preterm birth, low birth weight, and stillbirth in their second delivery. However, the authors conclude that some risks may be due to confounding factors related to the indication for the first caesarean, rather than due to the procedure itself [21].

Fetal

This list of risks to the fetus given below is incomplete and cannot be taken as comprehensive or reflective of current research. It covers some of the most commonly discussed risks to the child posed by the procedure itself rather than the medical indications that may call for it. Some risks are rare, and as with most medical procedures, the likelihood of any risk is highly dependent on individual factors such as whether other pregnancy complications exist, whether the operation is planned or done as an emergency measure, and how and where it is performed.

- Wet lung: retention of fluid in the lungs can occur if not expelled by the pressure of contractions during labor [(22)].

- Potential for early delivery and complications: Pre-term delivery is possible if due date calculation is inaccurate. One study found an increased risk of complications if a repeat elective caesarean section is performed even a few days before the recommended 39 weeks [(23)].

- Higher infant mortality risk: in cesarean sections which are performed with no indicated risk (singleton at full term in a head-down position) , the risk of death in the first 28 days of life has been cited as 1.77 per 1,000 live births among women who had c-sections, compared to 0.62 per 1,000 for women who delivered vaginally.[(24)]

Incidence

The World Health Organization recommends the rate of Caesarean sections to be between 10% and 15% of all births in developed countries. However, in 2004, the Caesarean rate was about 20% in the United Kingdom, while the Canadian rate was 22.5% in 2001–2002[(25)].

Studies have shown that continuity of care with a known carrier may significantly decrease the rate of Caesarean delivery, but there is also research that appears to show that there is no significant difference in Caesarean rates when comparing midwife continuity care to conventional fragmented care.[26]

More emergency Caesareans about 66%, are performed during the day rather than during the night [(27)].

Analyzing the rise in Caesarean section rates

The World Health Organization has determined an "ideal rate" of all cesarean deliveries (such as 15 percent) for a population. One surgeon's opinion is that there is no consistency in this ideal rate, and artificial declarations of an ideal rate should be discouraged. Goals for achieving an optimal cesarean delivery rate should be based on maximizing the best possible maternal and neonatal outcomes, taking into account available medical and health resources and maternal preferences. This opinion is based on the idea that if left unchallenged, optimal cesarean delivery rates will vary over time and across different populations according to individual and societal circumstances [(28)].

There has been a rapid growth in the number of cesarean sections performed. For example, there has been a fourfold increase from 1971 to 1991. This may be accredited to the improved technology in detecting pre-birth distress. Some argue that the higher costs of cesarean section births compared to regular births make physicians quicker to recommend a cesarean section. Usually, if a doctor makes a recommendation people are quick to take it to heart and act upon it.

However, some commentators are concerned by the rise and have noted several evidence-based studies. Louise Silverton, deputy general-secretary of the Royal College of Midwives, says that not only has society's tolerance for pain and illness been "significantly reduced", but also that women are scared of pain and think that if they have a Caesarean there will be less, if any, pain.

A previously unexplored hypothesis for the increasing section rate is the relation of birth weight and maternal pelvis size. It is proposed that since the advent of successful Caesarean birth over the last 150 years, mothers with a small pelvis and babies with a large birth weight have survived and contributed to increasing in number of such population who will require cesarean section. Such a hypothesis is based upon the idea that even, without maternal obesity and diabetes, and without other widely quoted factors, the Cesarean section rate would continue to rise simply due to slow changes in population genetics[(29)].

Elective Caesarean sections

Caesarean sections are in some cases performed for reasons other than medical necessity. Reasons for elective caesareans vary, with a key distinction being between hospital or doctor-centric reasons and mother-centric reasons. Critics of doctor-ordered caesareans worry that caesareans are in some cases performed because they are profitable for the hospital, because a quick caesarean is more convenient for an obstetrician than a lengthy vaginal birth, or because it is easier to perform surgery at a scheduled time than to respond to nature's schedule and deliver a baby at an hour that is not predetermined.[30] Another reason for doctors to recommend cesarean section is money. In China, doctors are paid based on the monetary value of medical treatments offered. As a result, doctors have an incentive to persuade mothers to choosing the more expensive cesarean section.

In this context, it is worth remembering that many studies have shown that operations performed out-of-hours tend to have more complications (both surgical and anesthetic) .[31] For this reason, if a caesarean is anticipated to be likely to be needed in a woman, it may be preferable to perform this electively during daylight operating hours, rather than wait for it to become an emergency, with the increased risk of surgical and anesthetic complications that can follow from emergency surgery.

The women in some studies have indicated that their preference for caesarean section is more likely to be partly due to considerations of pain and vaginal tone [(32)]. The finding was that Caesarean sections are not more likely in women of higher social class than in women in other classes [(33)]. Some have suggested that due to the comparative risks of Caesarean section with an uncomplicated vaginal delivery, patients should be discouraged or forbidden [(34)] from choosing it.

Anesthesia

FIGURE 9 : Showing the Spinal anesthesia technique in sitting position

Both general and regional anesthesia (spinal, epidural or combined spinal and epidural anesthesia) are acceptable for Caesarean section. Regional anesthesia is preferred as it allows the mother to be awake and interact immediately with her baby. Other advantages of regional anesthesia include the absence of typical risks of general anesthesia: pulmonary aspiration (which has a relatively high incidence in patients undergoing anesthesia in late pregnancy) of gastric contents and endotracheal intubation [(35)].

Regional anesthesia is used in 95% of deliveries. Spinal and combined spinal and epidural anesthesia being the most commonly used regional techniques in scheduled Caesarean section[(4)]. Regional anesthesia during Caesarean section is different to the analgesia (pain relief) used in labor and vaginal delivery. The pain that is experienced because of surgery is greater than that of labor and therefore requires a

more intense nerve block. The dermatomal level of anesthesia required for Caesarean delivery is also higher than that required for labor analgesia [35].

General anesthesia may be necessary because of specific risks to mother or child. Patients with heavy, uncontrolled bleeding may not tolerate the hemodynamic effects of regional anesthesia. General anesthesia is also preferred in very urgent cases, such as severe fetal distress, when there is no time to perform a regional anesthesia.

MATERIALS AND METHODS

All the patients who underwent cesarean section at Shri B M Patil Medical College, Bijapur between October 2009 to July 2010 were studied. Decision of cesarean section was taken based on maternal or fetal conditions, by the doctor on duty.

A complete history including duration of amenorrhea, duration of labour pains (when patient presented in labour) and any other significant history like premature rupture of membranes, per vaginal bleeding, fever, etc, were recorded. If history of previous cesarean section, present then the indication of cesarean section, whether the section was elective or emergency, and what was the fetal and maternal outcome of that cesarean and any post operative complications was taken. Menstrual, past, family and personal history of the patient were recorded.

All patients were examined, including general examination, systemic examination, per speculum (if needed) and per vaginal examination to note the stage of labour, assessment of pelvis and CPD .

Gestational age was assessed by the knowledge of the date of last menstrual period, findings of initial prenatal examination and ultrasonographic examination.

The patients were monitored and the labour was augmented when needed and the indication of the patients undergoing cesarean section were noted. The intra-operative findings, perinatal and maternal outcome noted and also post operative period observed for any complications following cesarean section.

Inclusion criteria

All patients undergoing primary and 1st repeat CS in BLDE University's Shri. B. M. Patil Medical College, Hospital and Research Center, Bijapur.

Exclusion Criteria

All patients with previous two or more CS.

Outcome measures

1. To estimate the incidence of CS.
2. Analyze the indications of CS for both primary and repeat CS.

Method of study

Collection of data from case papers of patients who underwent CS.

OBSERVATION AND RESULTS

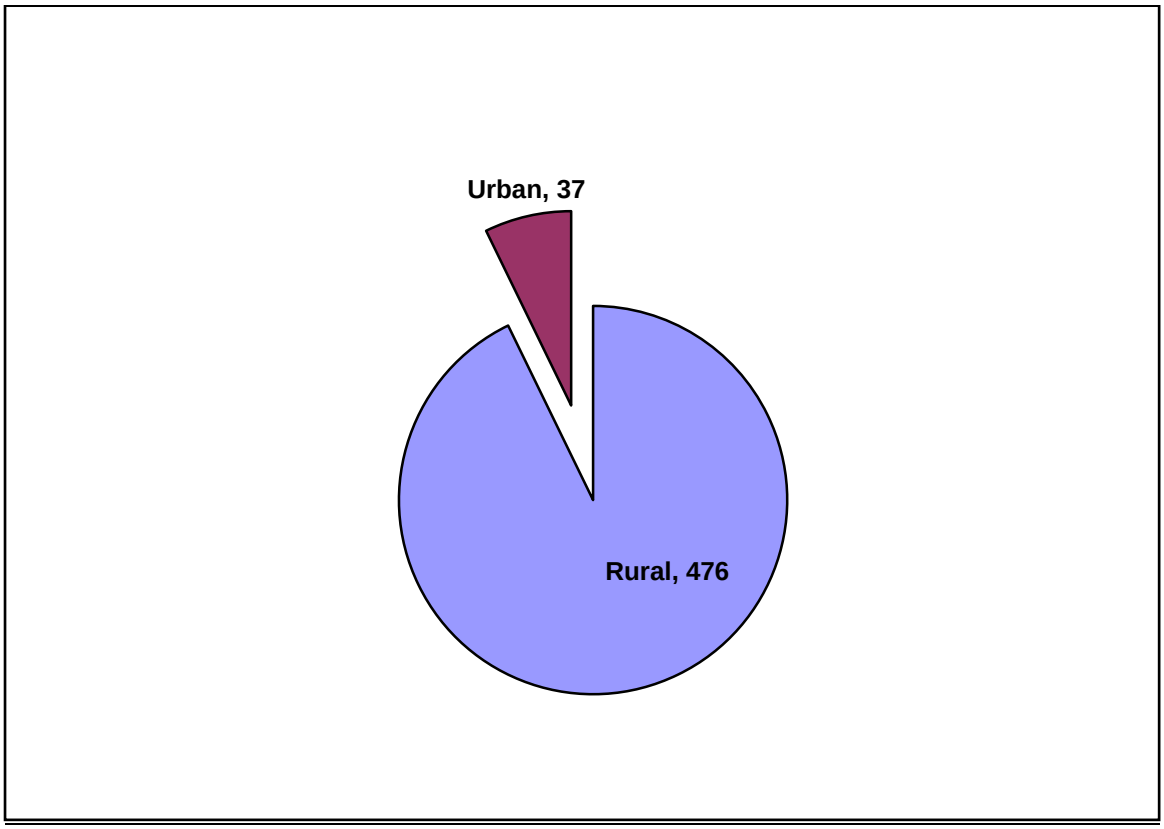
Table : 1. Incidence of cesarean section

Total No. of cases	No. of cases undergoing CS	Incidence
513	200	38.98%

Out of 513 patients during the study period between October 2009 to July 2010, 200 cases underwent primary and repeat cesarean section giving the incidence of 38.98% in our study.

Table : 2. Distribution of cases depending upon Rural / Urban areas

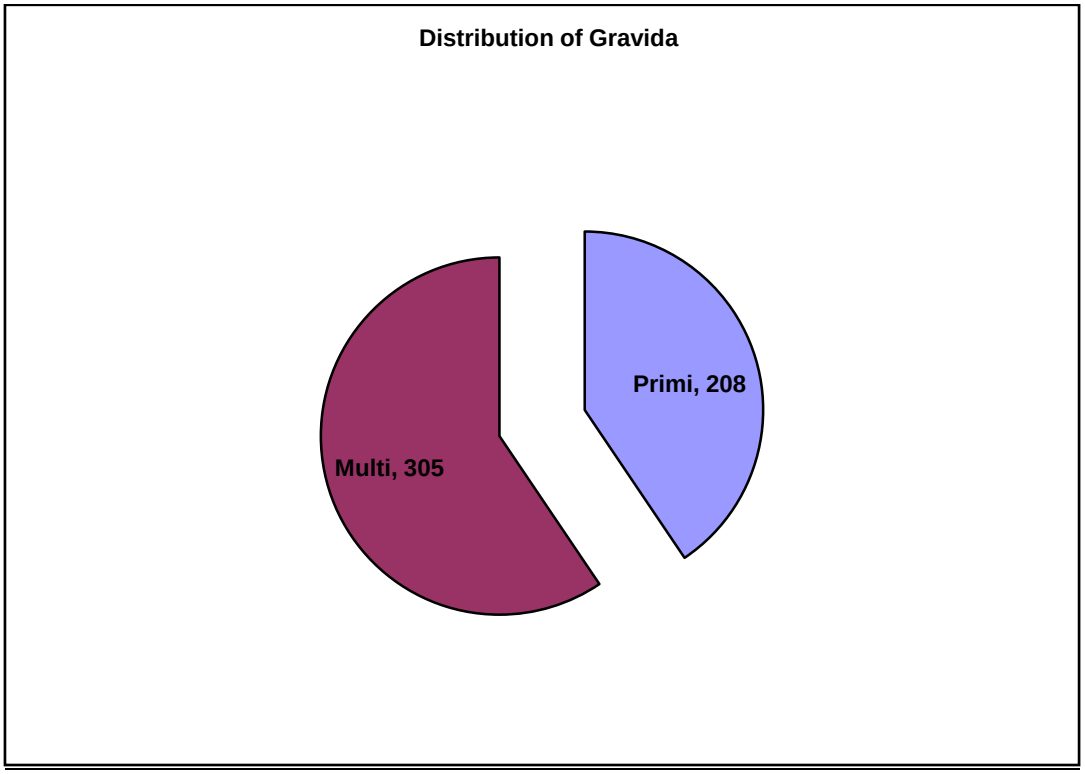
	Primigravida	Multigravida	Total no of cases
Rural	86	390	476
Urban	22	15	37



Graph 1: Shows that out of 513 cases, 476 cases were from rural and 37 cases are from urban area

Table : 3. No of cases depending upon the Gravidity

Sl. No.	Gravidity	No of Cases
1	Primigravida	208
2	Multigravida	305
3	Total	513



Graph 2: shows the total no of Primigravida and Multigravida in our study

Table : 4. Incidence of CS depending upon the Gravidity

Gravidity	No of Cases	Percentage
Primigravida Undergoing CS	83/208	39.90 %
Multigravida Undergoing CS	117/305	38.36 %
Multigravida Undergoing CS primary CS	66/229	28.82 %
Multigravida Undergoing Repeat CS	51/76	67.10 %

This reveals that 39.90% of Primigravida underwent, 38.36% Multigravida underwent CS, out of which, 28.82% underwent CS for the 1st time and 67.10% underwent repeat CS.

Table: 5. Incidence of primary & repeat cesarean section & VBAC

	Total no of cases	Percentage (%)
Primary CS	149	74.5%
Repeat CS	51	64.10%
VBAC	25	32.89%

The above table shows that the incidence of primary CS which is very high as 74.5%, repeat cesarean section is 67.10% , where as VBAC is 32.89%, which is very less.

Table:6. Indications for cesarean section

Indications	No of cases	Incidence
Fetal distress	71	35.5%
CPD	42	38%
Others *	87	26.5%

*They are listed in table no 11

Table : 7. No of cases undergoing cesarean section for Fetal Distress in different stages of labour

Fetal Distress	Primigravida	Multigravida	Total
Latent	30	17	47
Active	19	5	24
Total	49	22	71

Above table reveals that out of 200 cases studied, 71 cases underwent CS for fetal distress (35.5%), among them 47 (66.19%) cases were in latent phase of labour, giving a P value <0.05 which is statistically significant. This shows that there is significant difference between stages of labour and gravidity and diagnosis of FD as an indication for CS.

Table:8. Method of Diagnosing Fetal Distress

Fetal Distress	Primigravida	Multigravida	Total
CTG	15	10	25
Clinical	34	12	46
Total	49	22	71

This reveals that out of 71 cases undergoing CS for fetal distress, 25 were diagnosed by CTG and 46 clinically, which gives a P value of <0.001, which is highly significant. This shows that there is significant difference between the diagnosis of FD by CTG and by clinical methods.

Table: 9. No of cases undergoing cesarean section for CPD

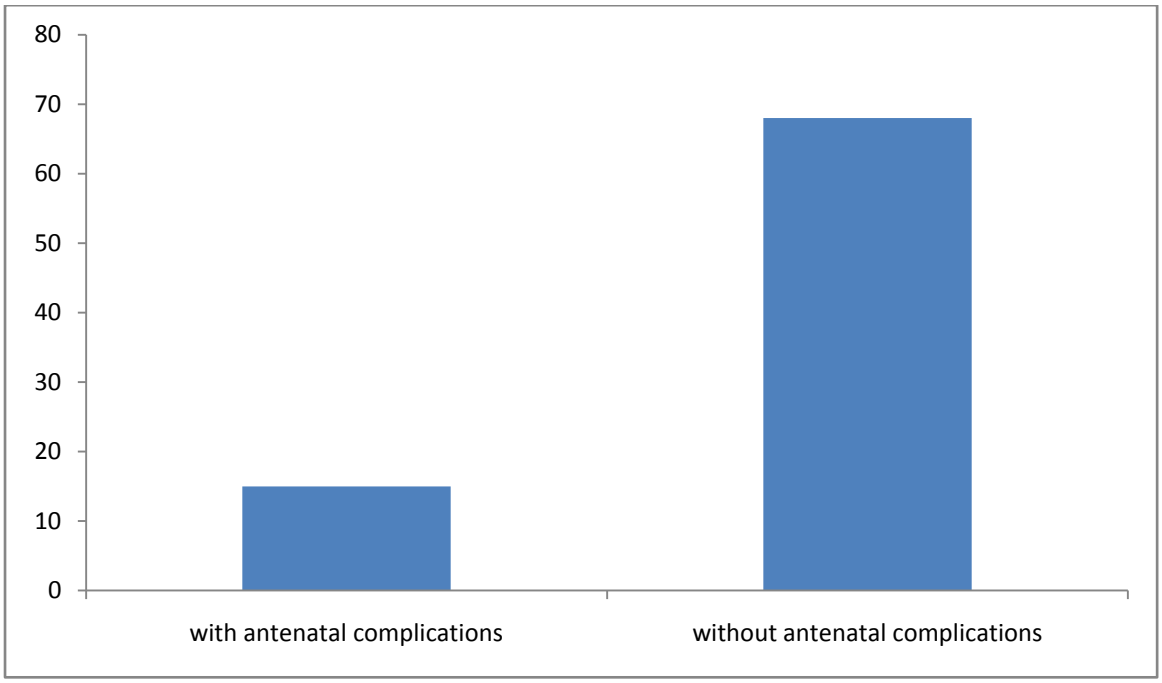
Gravidity	Latent	Active
Primigravida	6	13
Multigravida	10	13

The above table reveals the total no of cases undergoing cesarean section for CPD which was 42. Incidence of CPD was almost similar both in primigravida and multigravida (P value >0.05). Among which 38% of CPD's were diagnosed in latent phase of labour.

Table : 10. Shows antenatal complications in patients undergoing primary CS

Total no of primary CS	Antenatal complications present	Antenatal complications absent
83	15 (18.07%)	68 (81.92%)

Table showing total no of cases with and without antenatal complications undergoing primary cesarean section.

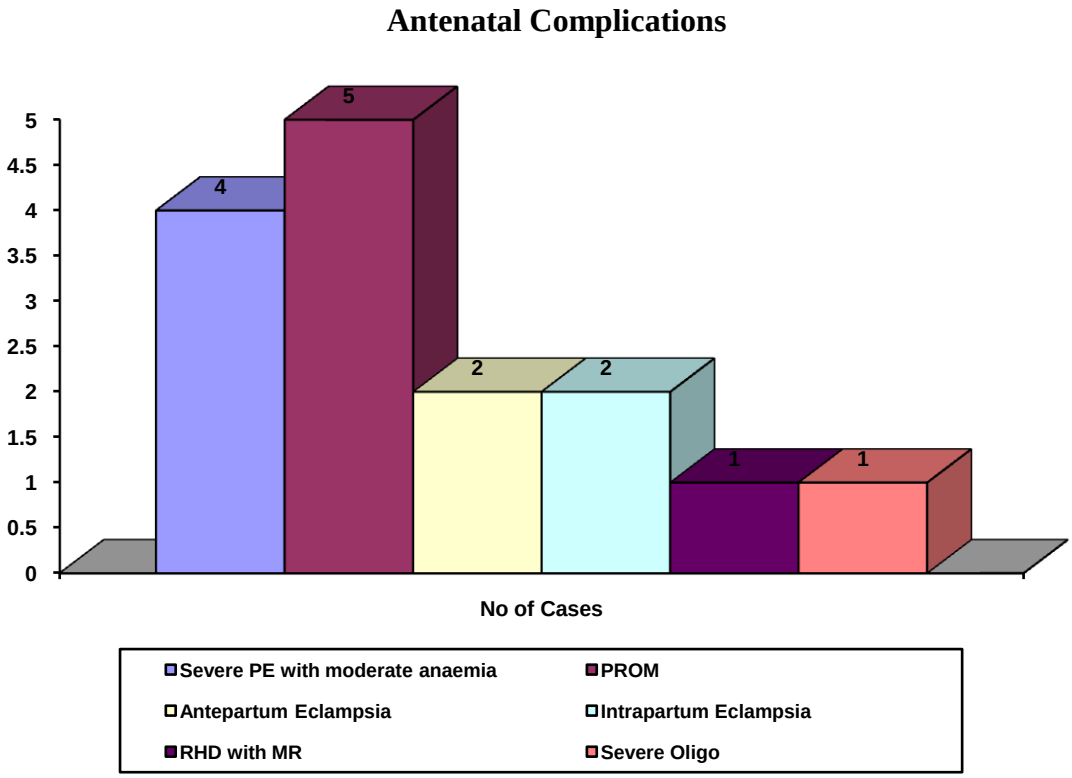


Graph 3 : Showing the no of cases with and without antenatal complications

Table: 11. Antenatal Complications associated with cases undergoing CS

Sl.No	Complications	No of Cases
1	Severe PE with moderate anaemia	4
2	PROM	5
3	Antepartum Eclampsia	2
4	Intrapartum Eclampsia	2
5	RHD with MR	1
6	Severe Oligohydromnios	1
7	Total	15

This table shows that only 18.02% of patients undergoing primary cesarean section had antenatal complications. Others were normal primigravida with singleton pregnancy with vertex presentation.



Graph 4 : Showing different antenatal complications in patients who underwent primary CS

Table :12. Other indications for cesarean section

Sl.No	Indications	Primigravida				Multigravida			
		E	L	A	2nd Stage	E	L	A	2nd Stage
1	Cord prolapse	0	0	1	0	0	0	1	0
2	Obstructed labour	0	1	0	3	0	0	0	2
3	DTA	0	0	0	1	0	0	0	0
4	APH	1	1	0	0	1	1	0	0
5	Twins	0	1	0	0	0	0	0	0
6	BOH with Precions Pregnancy	0	0	0	0	1	2	1	0
7	Compound Presentation	0	0	0	0	0	1	1	0
8	Mal presentation	2	4	1	0	1	3	6	0
9	Severe IUGR with Oligohydromnios	1	2	0	1	0	5	1	0
10	Scar Tenderness	0	0	0	0	0	0	8	0
11	PIH a. Severe PIH b. Eclampsia	 0 0	 3 0	 0 0	 0 0	 0 0	 0 1	 0 0	 0 0
12	Failure to progress a. CPD b. Secondary arrest of dilation c. Mal position	2 0 1 0	5 1 3 1	0 0 0 1	2 0 2 0	2 0 1 0	2 1 0 0	0 2 0 0	0 0 0 0

Table: 13. No of cases undergoing Elective / Emergency CS

Distribution of Cases	Primigravida	Multigravida	No of Cases
Emergency	97	87	184
Elective	3	13	16

The table shows that incidence of emergency CS is similar in both Primigravida and multigravida

Table :14. Perinatal mortality rate

Total no of cases	No of mortality	Incidence
513	23	46.93%
200	8	41.66%

This is a table showing the incidence of PMR in our study i.e, out of 200 cases studied, there were 8 PMR/ 1000 live births.

Table : 15. Maternal mortality rate

	Total no of deliveries (513)	Total no of CS (200)
MMR	1	0

Out of 200 cases in our study there were no MMR.

DISCUSSION

Out of 513 patients during the study period from October 2009 to July 2010, 204 patients underwent cesarean section, out of which 4 cases underwent >2 cesareen section & hence excluded giving an incidence of 38.98% (Table-1) in our study including primary & repeat cesarean section. This is comparable with studies conducted by Chhabra et.al [41] giving an incidence of 37.96%, Chaudhury Ap et.al [43] giving an incidence of 30%. The incidence of cesarean section of our study is more comparaed to study done by Ann SB et.al [44], with an incidence of 28%, Qazi et.al [45] having an incidence of 13.2% & Elhag et.al [46] having an incidence of 9.6%.

This is very high compared to the optimal section rate as recommended by WHO which is 10-15%. [60]

But in countries like Netherland & Sweden, which has the best maternal & perinatal outcome, the cesarean section rate is as low as 10-14% & 17% respectively [61]. Unlike the overall section rate is 57.87% in medical college of Dhakka [47]. In Brazil there are hospitals with 100% cesarean section rate & health districts with 85% cesarean section rate & an entire state with cesarean section rate of 47.7%. [64] The cesarean section epidemic seen in laten American countries is not evident in most of the Arab countries where cesarean section rate ranges only between 5-15%.[62]

Incidence of cesarean section in both Primigravida and Multigravida in our study is 39.90% & 38.36% respectively (Table – 4 & Graph- 2) which is same in both. 83/208 primigravida underwent cesarean section, 117/305 multigravida delivered by cesarean section out of them 66 (28.82%) were primary cesarean section in multigravida & 51 were repeat section in Multigravida with previous 1 cesarean section (67.10%).

Hence VBAC after 1 previous cesarean section is only 32.09%. The incidence of VBAC is comparable to a study done by Amin AF et.al[49] where the incidence was 39.8%. (Table-5).

Out of 200, 149 were primary cesarean section i.e., the incidence of primary cesarean section is 74.5% (149/200) as shown in the (Table-5). No of primary cesarean section have increased drastically. The no of VBAC have decreased significantly (Table-5). So once a cesarean section is always a cesarean section seems true for 67.10% of cases. Incidence of primary cesarean section as reported by Saha L et.al [47] is 74.34%, which is comparable to our study. 50% of increase in cesarean section rate is due to increase in primary cesarean section by Barber et.al [42].

One of the main indication of cesarean section in our study was FD. Among 200 cases in the study group, total of 71 ie., 35.5% underwent cesarean section for FD (Table-7) , which is comparable to studies conducted by Saha L[47], giving an incidence of 35%. Whereas the incidence in our study is high compared to study done by Ann SB et.al[44], Qazi GR et.al [45], Velasco MV et.al[54], Bukar M et.al[51], Mukhurji J et.al[55] where the incidence was 19%, 18.5%, 14.1%, 8.8% & 14.1% respectively.

Surprising feature (Table-7) is that 47 cases (66.19%) of FD were diagnosed in latent phase of labour when uterine contractions are not strong. The P value for the cases who have undergone cesarean section in the latent & active phase of labour is <0.05 which is statistically significant.

Diagnosis of FD was by Electronic fetal monitoring (CTG) in 25 cases & by clinical diagnosis in 46 cases (Table-8). Again the P value of both CTG diagnosis & clinical diagnosis is <0.001 which is highly significant. Subjective variations occur in diagnosis of FD by clinical methods.

Table-10 shows another striking feature about nature of cases undergoing cesarean section. Among 83 primigravida undergoing cesarean section only 15 cases(18%) had antenatal complications, which may be responsible for FD. Remaining 68 cases were clear cut Primigravida with singleton pregnancy with vertex presentation with no complications (Graph 3). This puts question mark on our diagnosis of FD especially when FD was diagnosed in majority in latent phase of labour in low risk group. Even in US, the primary cesarean section for the low risk group is increasing since 1996 (3.7%) and it was 11.2% in 2003. [(63)]

Table 9 shows that 42/200 (i.e., 38%) (Table-9) cases have undergone cesarean section for CPD. The distribution was 19 in primigravida & 23 in multigravida, which is again alarming. It is dictum that if first delivery is normal usually 2nd delivery will be normal. The incidence of CPD in both primigravida and multigravida is same which gives a P value >0.05 which is not statistically significant. Out of 42 cases, 16 (38%) were diagnosed as having CPD in latent phase of labour, which is again not correct as CPD is ideally assessed in active phase of labour. This is comparable with study conducted by Onanpka B et.al (56), Amin AF et.al (49) where in the incidence of CPD is 39.8% & 41% respectively. Whereas the incidence of CPD is high compaired to study conducted by Chanthasenanount et.al (57) i.e., 24.64%. the incidence is decreased compaired to a study conducted by Qazi GR et.al (45) i.e., 42.8% (Table-9).

Other indications for cesarean section in our study were malposition, giving an incidence of 1.5% which was less compared with a study conducted by Krychowsk et.al[(58)], giving an incidence of 12.45%. the incidence of cesarean section for malpresentation in our study is 8.5% which is comparable with the study done by

Sheiner et.al[50] giving an incidence of 7.5% & is less compaired to study conducted by Qazi GR et.al [45] where in the incidence is 32.1%, as per Table-12.

The incidence of cases undergoing cesarean section for obstructed labour/ DTA is 35%, which is more compaired to study done by Mukhurji J et.al [55] & Onanpka et.al[56] where in the incidence is 15.7% & 10.2% respectively.(Table 12).

Out of 200 cases, 3 underwent cesarean section for Eclampsia (1.5%), which is less compared to study done by Mukhurji J et.al[55], Bukar et.al[51] where in the incidence is 3.1% & 18.8% respectively.(Table-12).

The incidence of cesarean section for cervical dystocia in our study is 1.5%, which is comparable with a study conducted by Florica M et.al[59], where in the incidence is 0.8%. The incidence is less compaired to studies conducted by Barber et.al [42], Sheiner E et.al[50], Saha L et.al[47], giving an incidence of 18%, 6.1% & 12% respectively. (Table-12).

2% of the cases underwent cesarean section for APH which is comparable with the study conducted by Krychowska et.al [58] where in the incidence is 1.38% and less compared to studies done by Mukhuji J et.al[55], Bukar Met.al [51], Ann SB et.al[44] giving an incidence of 31.4%, 14.1% & 6% respectively.

Table-13 shows that the incidence of primigravida and multigravida who underwent emergency cesarean section is same.

The PMR in our study is 46.9%/1000 live births during the study period, out of which 8 PMR were out of 200 cases of cesarean section studied i.e., 40%/1000 live births which is comparable to a study by Onnankpa B et.al[57], where in the PMR is 43.7/1000 live births (Table-14). There were no maternal mortality in cases who underwent cesarean section (Table-15)

SUMMARY

A total of 200 cases who underwent caesarean section were studied. Detailed history, Clinical examination were undertaken to confirm the indication of cesarean section. Effects of age, parity, if previous history of LSCS if present then the indication is noted. What was the indication of cesarean section in present pregnancy was studied and its association with the stage of labour and parity was also noted.

The complications associated with the pregnancy, the maternal and perinatal outcome following caesarean section were also noted. The post operative period was also noted. The various indications of caesarean section were noted.

CONCLUSION

The incidence of cesarean section is increased in the present days. The main indication for cesarean section being fetal distress, dystocia because of CPD , failure to progress & repeat cesarean section which are all subjective. There is no increase in the cesarean section for objective indications like malpresentations, placenta previa etc. The increased incidence of cesarean section in Primigravida & primary cesarean section in Multigravida shows the changes in physician attitude of practice which is mainly responsible. This shows that the physicians threshold for deciding cesarean section is lowered. So, when primary cesarean section rate is increased, naturally repeat cesarean section is increased. Hence, overall rate of cesarean section will show a rising trend.

Applying stringent criteria for diagnosis of fetal distress & CPD which are subjective indications, change in physicians practice & raising the threshold of physician for performing cesarean section, will decrease the cesarean section rate. This also will be a step in improving not only the obstetric health but also general health of women in long run.

Cesarean section lowers the fertility compared to vaginal birth. Cesarean section also associated with intrinsic risk for adverse maternal outcome like blood transfusion, ICU admission & peripartum hysterectomy. Cesarean section is responsible for obstetric complications like placenta previa, placenta acrete & the operative interference in next pregnancy. So, by lowering the cesarean section rate all the above can be avoided.

In conclusion, cesarean section should be performed when a clear benefit is anticipated, a benefit that might compensate for the higher cost & additional risk associated with operation.

BIBLIOGRAPHY

1. JP Souza, AM Gülmezoglu, P Lumbiganon et.al.,Cesarean section without medical indications is associated with an increased risk of adverse short- term maternal outcomes : the 2004-2008 Who Global Survey on Maternal and Perinatal health
2. Unnikrishnan B, Rakshith P, Aishwarya A et.al., Trends and Indications for cesarean section in a tertiary care obstetric Hospital in coastal south India. Australian Medical Journal 2010 3,12,821-825
3. By RP Porreco. High cesarean section rate : a now perspective.. Obsterics and gynaecology (1985) volume:65, issue:3, Pages:307-311
4. Bucklin BA, Hawkins JL, Anderson JR, Ullrich FA (2005). "Obstetric anesthesia workforce survey: twenty-year update". *Anesthesiology* 103 (3): 645–53.
5. Pieter W.J. van Dongen. Caesarean section?: etymology and early history South African Journal of Obstetrics and Gynaecology, August, 2009.
6. Birth Berkeley Calif . Elective cesarean section and decision making : a critical review of the literature. (2007) volume: 34, Issue: 1, Pages: 65-79
7. Weaver JJ, Statham H, Richards M . Are the "unnecessary" cesarean sections? Percepions of women and obstetricians about cesarean sections for nonclinical indications. 2007 March;34(1):32-41
8. History of cesarean section. Natural pregnancy mentor URL "http://www.natural-pregnancy-mentor.com
9. Text Book of Williams Obstetrics 23rd edition section VI Cesarean Delivery and Postpartum Hysterectomy :549-555

10. `Mukherjee SN . Rising caesarian section rate. The journal of obstetrics and gynecology of India Vol. 56 No. 4: July/August 2006 :298-300.
11. Kambo.I, Bedi.N, Dhillon BS, Saxena NC . A critical appraisal of cesarean section rates at teaching hospitals in India. International journal of gynecology and obstetrics 79 (2002) : 151-158.
12. Mehta A, Apers L, Verstraelen H, et all. Trends in caesarian section rates at a maternity hospital in Mumbai India. J Health Popul Nutr 2001 Dec;19(4):306-312.
13. Shas Jitesh Mafattal , Mehta Meghana Narendrabhai et al. Analysis of mode of delivery in women with previous one caesarian section. The journal of obstetrics and gynecology of India Vol. 59, No. 2: March/ April 2009 pg 136-139.
14. Shakti.Vardhan, Behera RC ,Sandhu GS , Singh Anita , Bandhu HC. Vaginal birth after caesarian delivery. Obstetric and Gynecology India vol 56, No. 4: July/ Aug 2006:320-323.
15. McMahon.J.Micheal, Edwin R. Luther, Watson A. Bowes, and Olshan.F.Andrew. Comparison of a trial of labour with an elective second cesarean section. The New England Journal Of Medicine; Vol 335 september 5,1996 number 10.
16. Chhabra S, Arora G. Delivery in women with previous caesarian section. Obstetric and Gynecology India Vol 56, No. 4: July/ Augus: 304-307.
17. Barber, Emma L, Lundsberg et.al.,Indications Contributing to the Increasing Cesarean Delivery Rate : 2011 American College Of Obstetricians and Gynaecologists

18. Stjernholm YV, Petersson K, Eneroth E. Changed indications for cesarean sections. Acta Obstet Gynecol Scand 2010;89(1):49-53.
19. Pai, Madhukar (2000. “Medical Interventions: Cesarean Sections as a Case Study”. Economic and Political Weekly 35(31):2755-61
20. Silver RM, London MB, Rouse Dj et.al.,(2006) “ Maternal morbidity associated with multiple repeat cesarean deliveries”. Obstet Gyneacol 107(6):1226-32
21. Kennare R, Tucker G, Heard A, Chan A (2007). "Risks of adverse outcomes in the next birth after a first cesarean delivery". *Obstet Gynecol* **109** (2 Pt 1): 270–6.
22. G Cassady, (1971), "Effect of cesarean section on neonatal body water spaces", New England Journal of Medicine.
23. Study: Early Repeat C-Sections Puts Babies At Risk. Npr.org (2009-01-08).
24. "High infant mortality rate seen with elective c-section," Reuters Health, September 2006. Medicineonline.com (2006-09-14).
25. "Canada's Caesarean section rate highest ever". CTV. April 21, 2004.
26. Hodnett ED; Hodnett, Ellen (2000). Hodnett, Ellen. ed. "Continuity of caregivers for care during pregnancy and childbirth". *Cochrane Database Syst Rev*(2): Hodnett ED; Henderson, Sonja (2008). Henderson, Sonja. ed. "WITHDRAWN: Continuity of caregivers for care during pregnancy and childbirth". *Cochrane Database Syst Rev* (4)
27. Goldstick O, Weissman A, Drugan A (2003). "The circadian rhythm of "urgent" operative deliveries". *Isr Med Assoc J* 5 (8): 564–6. PMID 12929294.
28. NIH (2006). “State of the science conference statement. Cesarean delivery on maternal request”. Obstet Gynecol 107(6):1386-97

29. Walsh, Joseph A (2008). “Evolution And The Cesarean Section Rate”. The American Biology Teacher 70(7):401-404.
30. MacKenzie IZ, Cooke I, Annan B(2003). “Indications for cesarean section in a consultant obstetric unit over three decades”. J Obstet Gynaecol 23(3):233-8
31. Cullinane M, Gray A, Hargraves C, Lansdown M, Martin I, Schubert M. *Who operates when? – The 2003 Report of the Confidential Enquiry into Perioperative Deaths*.
32. Wagner, Marsden (registration required). *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*.
33. Barley K, Aylin P, Bottle A, Jarman B (2004). "Social class and elective Caesareans in the English NHS". *BMJ* 328 (7453): 1399.
34. Bewley S, Cockburn J. (2002). "The unfacts of 'request' Caesarean section". *BCOG* 109 (6): 597–605.
35. Afolabi BB, Lesi FE, Merah NA (2006). Afolabi, Bosede B. ed. "Regional versus general anesthesia for Caesarean section". *Cochrane Database Syst Rev*
36. Chai AH, Wongt, Mac HL et.al Prevalance & associated risk factors of retention of urine after cesarean section. International urogynaecological journal Pelvic floor dysfunction 194 (4): 537,2008.
37. Bar G, Scheiner E, Lezerovizt A, et.al : Early maternal feeding following cesarean delivery : A prospective randomized study. Acta Obstetrics Gynaecology Scand 87(1) : 68,2008.
38. Orji EO, Olabode TO, Kuti O, et.al., : Randomised control trial of early initiation of oral after cesarean scction. Journal of maternal fetal neonatal medicine 22(1) : 65,2009.
39. Livingston EH, Passaro EP : post operative ileus. Dig Dis Sci 35 :21,1990.

40. Marick PE, Plante LA : venous thromboembolic disease and pregnancy. N Engl J Med 359(19) : 2025, 2008.
41. Chhabra S, Jaiswal A et.al. Persistence of fruitless cesarean sections in Indian rural women. J Obstet Gynaecol 2009 Nov; 29(8):718-21.
42. Barber EL; Lundsberg LS; Belanger K et.al. Indications contributing to the increasing cesarean delivery rate. Obstet Gynecol 2011 Jul; 118(1):29-38.
43. Choudhury Ap; Dawson AJ. Trends in indications of cesarean sections over 7 years in a Welsh district general hospital. J Obstet Gynecol 2007 Nov; 29(8):714-7.
44. Ann SB, john FM et.al. Fetal distress in labour and cesarean section rate. Bahrain Medical Bulletin, Vol.32, No 2, June 2000.
45. Qazi GR Aktar S. Obstetrical correlates of the first time cesarean section, compaired with the repeated cesarean section. J Coll Physicians Surg Pak.2007 Oct; 17(10):611-4.
46. Elhag BI; Milaat WA; Taylouni ER. An audit of cesarean section among Saudi females in Jeddah, Saudi Arabia. Journal of the Egyptian Public health association. 1994; 69(1-2):1-17.
47. Saha L; Choudhury SB et.al. Study on primary cesarean section. Mymesingh Med J 2011 Apr; 20(2):292-7.
48. Dabbas M; Al-Sumodi A. Cesarean section rate: much room for reduction. Clin Exp Obstet Gynecol 2007; 34(3):146-8.
49. Amin AF; Misselwitz; Kunzel W. Cesarean section rate as a measure of quality assurance in obstetrics and gynaecology. 2001 Jan-Mar; 27(1-3):157-68.

50. Sheiner E, Levy A, Katz M et.al. Short stature- an independent risk factor for cesarean delivery. Eur J. Obstet Gynecol Reprod Biol.2005 Jun 1; 120(2):175-8.
51. Bukar M, Andu BM, Massa AA. Cesarean delivery at the Fedral Medical Centre Gomba: a 3-year experience. Niger J Med.2009 Apr-Jun;18(2):179-83.
52. Carol Coughlan, Rohan K et.al. What are the implications for the next delivery in primigravidae who have an elective cesarean section for breech presentation? BJOG: an international Journal of Obstetrics and Gynaecology June 2002, Vol.109, pp 624-626.
53. Dinas K; Mavromatidis G et.al. Current cesarean delivery rates and indications in a major public hospital in northern Greece. Aust NZJ Obstet Gynaecol 2008 Apr; 48(2):142-6.
54. Velasco- MV; Navarrete- HE; Pozos- CJ et.al. Indications and Justifications of cesarean section at the Instituto Mexicano del Seguro Social. Gac Mad Mex 2000 Sep-Oct; 136(5):421-31.
55. Mukherj J; Kamilya G et.al. Cesarean section for the dead baby – an unhappy reality. J Indian Med Assoc 2007 Jun; 105(6) :316, 318-9.
56. Onankpa B; Ekele B. Fetal outcome following cesarean section in a university teaching hospital. J Natl Med Assoc 2009 Jun; 101(6):518-81.
57. Chanthasenanont A; Pongrojpaw D et.al. Indications of cesarean section at Thammasat Univeersity Hospital. J Med Assoc Thai 2007 Sep;09(9):1733-7.
58. Krychowska A, Kosmska K et.al. Comparison of indications for cesarean section in 1985-86 and 2000-01 Analysis of changes. Ginekol Pol.2004 Dec; 75(12):926-31.

59. Stephansson O, Nordstom L. Indications associated with increased cesarean section rates in a Swedish hospital. Int J Gynaecol Obstet 2006 Feb; 92(2): 181-5.
60. WHO Health Organisation. Appropriate technology of birth. Lancet 1985 ; ii : 436-7.
61. Marian F, MacDorman et.al. Cesarean Birth in the United states : Epidemiology, Trends, and Outcomes. Clin Perinatol 35 (2008) 293-307.
62. Jurdi R, Khawaja M. Cesarean section rates in Arab region : a cross national study. Health policy plan 2004; 19: 101-10.
63. Declereq E, Menacker F et.al. Rise in " no indicated risk". Primary cesareans in the united states, 1991-2002 BMJ 2005; 330 : 71-2.
64. Ratner D, Sobre a hipotese de establizacao das taxas de cesarean do Estado de Sao Paulo, Brasil. Rev Saude Publ 1996; 30:19-33.

ANNEXURE A

PROFORMA

Name	**:**		
Age	**:**		
Ip. no	**:**		
Address	**:**		
Occupation	**:**	**W-**	**H-**
S.E status	**:**		
DOA	**:**		
DOD	**:**		
Time of admission	**:**		
Unit and Surgeon	**:**		
Chief complaints	**:**		
History of present pregnancy	**:**		
Antenatal history	**:**		
BOOKED/UNBOOKED	**:**		
IMMUNISED/UNIMMUNISED	**:**		
1st Trimester	**:**		
2nd Trimester	**:**		
3rd Trimester	**:**		
Obstetrics history	**:**		
Married Life	**:**		
Obstetric Score	**:**		
Last child birth	**:**		

Last abortion :

Details of previous pregnancies:	I	II	III	IV	V
Duration of pregnancy					
Spontaneous/ induced abortion					
Check curettage done or not					
Booked/Unbooked					
Mode of delivery					
Vaginal					
Home delivery					
Hospital delivery normal/instrumental					
Lscs					
Elective					
Emergency					
Indication					
Live birth/still birth					
Sex of the baby					
Wt of the baby					
Neonatal outcome					
Puerperium					
Last child birth					
Last abortion					

Menstrual History :

PaMC :

LMP :

EDD : POG :

Past History :

Family History :

Personal History :

General Physical Examination

Build and Nourishment	:		
Height	:	Pulse	:
Weight	:	BP	:
BMI	:	Temp	:
Breast	:	RR	:
Thyroid	:		
Spine	:		
Gait	:		

Pallor / icterus / cyanosis / clubbing / edema / lymphadenopathy.

Systemic Examination

CVS :

RS :

AG :

SFH :

EFW :

PER ABDOMEN :

Per speculum Examination
(if required)

Per Vaginal Examination

	At admission	II	III	At CS
Dilatation				
Effacement				
Position of the cervix				
Consistency of cervix				
Membranes				
Position of presenting part				
Station				
Pelvis				
Test for CPD				

Partogram :

CTG :

INVESTIGATIONS

Hb % :

Blood Grouping and Rh Typing :

Urine Routine :

RBS :

HBs Ag :

RVD :

USG :

BT :

CT :

PT :

TC :

DC :

ESR :

Any other investigations if required :

DIAGNOSIS

At admission :

At CS :

ANALYSIS PROFORMA

CESAREAN SECTION

Emergency / elective :

Indication :

I stage

Latent :

Active :

II stage

Arrest of dilatation :

Arrest of descent :

Protracted dilatation :

Protracted descent :

CPD

Contracted pelvis :

Malposition / big baby :

Details of previous LSCS

Elective / emergency :

Recurrent / non-recurrent :

Indication :

Post op period :

Wound infection :

Puerperal sepsis :

Date of discharge :

Intra op findings at present section

Condition of the scar : Intact/ Dehiscent / Ruptured

Any others :

Fetal distress

Type of distress	With CTG	Without CTG
I stage		
II stage		

Meconium stained liquor

1. Thin / thick :
2. Fore water :
3. Hind water :

Time interval from decision to CS

Weight of the baby :

Sex of the baby :

Gestational age assessed at birth :

Apgar score at 1’
5’
10’

NICU admission :

Day of discharge :

Condition of the baby at discharge :

Maternal morbidity :

Duration of stay :

CESAREAN SECTION CLOSURE

UTERINE CLOSURE

Single or double layer :

Catgut no.1 / no.2 :

Vicryl no.1 :

Amount of suture used
in cms :

UV FOLD
PERITAL PERITONEUM :

Closed / left open :

Catgut no.1 / vicryl no.1 :

SKIN closed with :

Skin to Extraction time :

Skin to skin closure time :

CESAREAN SECTION CATHERISATION / NON-CATHERISATION

Time of anesthesia :

Site of anesthesia :

Duration of anesthesia :

Drugs used :

Catherisation : done / not done

Duration : pre op -

post op -

Time of micturation :

Place of micturation :

Urinary problems post op :

Urine Routine

At admission :

3rd day :

5th day :

Post op morbidity :

ANNEXURE B

RESEARCH INFORMED CONSENT FORM

TITLE OF THE TOPIC : "CROSS SECTIONAL STUDY OF INDICATIONS FOR CESAREAN SECTION"

PRINCIPAL INVESTIGATOR : DR. ARUNA.BIRADAR

PG GUIDE NAME : DR.G.R.SAJJAN
Professor

PURPOSE OF RESEARCH

I have been informed that this study is to evaluate the maternal and fetal outcome in pregnancy complicated by premature rupture of membranes. I have also been given a free choice of participation in this study.

PROCEDURE

I understand that I will be a part of this study. My history and physical findings will be taken from the case paper and will be evaluated in a systematic way. I will not be asked for any follow up.

RISK AND DISCOMFORTS

I understand that this procedure is not expected to aggravate any side effect or cause detrimental effect to me or my child.

BENEFITS

I understand that my participation in the study will help to study the maternal and fetal morbidity and mortality in pregnancy complicated by Premature Rupture of Membranes.

CONFIDENTIALITY

I understand that the medical information produced by this study will become a part of hospital records and will be subject to the confidentiality and privacy regulation of BLDE University's Shri .B. M .Patil Medical college. Information of a sensitive personal nature will not be a part of the medical records, but will be stored in the investigator's research file and identified only by a code number. The code key connecting names to numbers will be kept in a secured location**.**

If the data are used for publication in the medical literature or for teaching purpose no names will be used**.**

I understand that the relevant designated authority and permitted to have an access to

my medical record and to the data produced by the study for audit purpose. However, they are required to maintain confidentiality**.**

REQUEST FOR MORE INFORMATION:

I understand that I may ask more questions about the study at any time and understand that I will be informed of any significant new finding discovered during the course of the study, which might influence my continued participation.

If during the study or later I wish to discuss my participation or concerns regarding this study with a person not directly involved I am aware that the other staff members are available to talk with me.

This copy of this consent form will be given to me to keep for careful reading.

REFUSAL FOR WITHDRAWAL OF PARTICIPATION:

I understand that my participation is voluntary and that I may refuse to participate or may withdraw consent and discontinue participation in the study at any time without prejudice to my present of future care in the hospital and also understand that the researcher may terminate my participation in the study if at any time he feels the need and explain me the reason to do and help to arrange for my further appropriate treatment.

ANNEXURE C

INJURY STATEMENT:

I understand that in the unlikely event of injury to me resulting directly from my participation in this study, if such injury were reported promptly, the appropriate treatment would be available to me. But, no further compensation would be provided by the hospital. I understand that by my agreements to participate in this study and not waiving any of my legal rights.

I have explained Mrs._____the purpose of the research, the procedures required and the possible risks to the best of my ability in her own language

INVESTIGATOR DATE:
(DR. ARUNA.BIRADAR)

I confirm that DR. ARUNA.BIRADAR, has explained to me the purpose of research, the study procedure, that I am will to undergo the investigation and the possible discomforts as well as benefits. I have been explained all the above in detail in my own language and I understand the same. Therefore I agree to give consent to participate as a subject in this research project.

PARTICIPANT DATE:

ABBREVATIONS

1. B- BOOKED
2. UB – UNBOOKED
3. CP- CONTRACTED PELVIS
4. BB- BIG BABY
5. MP- MAL POSITION
6. A- ACCELERATION PHASE
7. D- DECELERRATION PHASE
8. M- MAXIMUM SLOPE
9. OP- OCCIPITO POSTERIOR
10. DH- DEFLEXED HEAD
11. LOT – LEFT OCCIPITO POSTERIOR
12. FB – FRANK BREECH
13. FP – FOOTLING PRESENTATION
14. CD – CERVICAL DYSTOCIA
15. BP – BROW PRESENTATION
16. IE- INTRAPARTUM ECLAMPSIA
17. AE – ANTEPARTUM ECLAMPSIA
18. SPE – SEVERE PRE ECLAMPSIA
19. PROM – PRE MATURE RUPTURE OF MEMBRANES
20. PPROM – PRETERM PRE MATURE RUPTURE OF MEMBRANES
21. SOIU – SEVERE OLIGOHYDROMNIOS WITH INTRAUTERINE GROWTH RETARDATION
22. BOH – BAD OBSTETRIC HISTORY

23. CPL – CORD PROLAPSE
24. MA – MODERATE ANAEMIA
25. SA – SEVERE ANAEMIA
26. PP – PLACENTA PREVIA
27. CPP – CENTRAL PLACENTA PREVIA
28. AB – ABRUTIO
29. APH – ANTEPARTUM HAEMORRHAGE
30. G-HTN : GESTATIONAL HYPERTENSION
31. RHD WITH MR : RHEUMATIC HEART DISEASE WITH MITRAL REGURGITATION
32. GDM – GESTATIONAL DIABETES MELLITUS
33. PE – PRE ECLAMPSIA
34. SO- SEVERE OLIGOHYDROMIOS
35. PFT – PERSISTANT FETAL TACHYCARDIA
36. PFB – PERSISTANT FETAL BRADYCARDIA
37. LD- LATE DECELERATIONS
38. VD – VARIABLE DECELERATIONS
39. PVD – PERSISTANT VARIABLE DECELERATIONS
40. PLD – PERSISTANT LATE DECELERATIONS
41. ST – SCAR TENDERNESS
42. FTD – FAILURE TO DESCENT
43. PD – PROTRACTED DILATATION
44. CB – COMPLETE BREECH
45. I – INTACT
46. D – DEHISCENE

47. TO – THINNED OUT

48. F – FEMALE

49. M – MALE

50. CS – CESAREAN SECTION

51. CTG – CARDIO TOCOGRAPHY

52. FD – FETAL DISTRESS

53. CPD – CEPHLO PELVIC DISPROPORTION

54. HIV – HUMAN IMMUNODEFICIENCY VIRUS

55. EFM – EFFECTIVE FETAL MONITORING

56. BMI – BODY MASS INDEX

57. P – PRIMIGRAVIDA

58. EMG – EMERGENCY

59. ELE – ELECTIVE

60. AC – ACTIVE

61. LT – LATENT

62. 2SL – 2^{ND} STAGE OF LABOUR

63. PRV – PREVIOUS

64. LSCS- LOWER SEGMENT CESAREAN SECTION

65. FTP – FAILURE TO PREGRESS

66. ftp – FULL TERM PREGNANCY

67. VBAC – VAGINAL BIRTH AFTER CESAREAN

68. PD- POST DATISM

69. CPP - COMPOUND PRESENTATION

70. TL – TRANSVERSE LIE

71. OL – OBSTRUCTED LABOUR

72. DTA – DEEP TRANSVERSE ARREST

73. FI – FAILURE OF INDUCTION

74. LVWS – LONGITUDINAL VAGINAL WALL SEPTUM

75. LSP – LEFT SACRO SPINOUS

76. FH – FLOATING HEAD

77. SAD – SECONDARY ARREST OF DILATATION

78. CP – CONTRACTED PELVIS

SL. NO	IP.NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS		INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
											ELC	EMG									
1	37	20	2/1/2010	12/1/2010	2	UB	P	?	?	?		EMG	IE WITH FD	AC	A	5-6cm		1.70/ 1.72			
2	55	30	1/1/2010	8/1/2010	2	UB	P	26/03/09	2/1/2010	39+6 days		EMG	FD	LT		2-3cm		2.88	152	60	27.2
3	92	22	2/1/2010	9/1/2010	3	B	P	24/03/09	31/12/09	40+2 dys		EMG	SPE WITH CPD	AC	A	4-5cm	CP	2.95	142	70	28.5
4	388	21	7/1/2010	14/01/10	2 1/2	UB	P	26/03/09	2/1/2010	40+5 days		EMG	FD	AC	M	7-8cm		2.75	152	60	27.2
5	84	26	8/1/2010	15/1/10	4	B	G3P1L1A1	30/03/09	6/1/2010	40+2 days		EMG	PRV LSCS WITH CPD	AC	A	5-6cm	CP	2.95	140	52	27.3
6	47	32	1/1/2010	8/1/2010	5	B	G5P1L1A3	?	?	38+4 days	ELC		PRV LSCS WITH CPD	LT			CP	3.14	150	65	28.8
7	481	19	9/1/2010	16/1/10	2	UB	P	2/4/2009	9/1/2010	40		EMG	FD	LT		3-4cm	-	2.65	150	65	28.8
8	807	22	16/1/10	23/1/10	3	UB	G2P1L1	?	?	39		EMG	PRV LSCS WITH CPD	LT		3-4cm	CP	2.84	143	50	26.3
9	801	22	16/1/10	23/1/10	4	B	G2P1L1	16/5/09	23/2/10	37+1		EMG	CPD WITH FD	AC	A	4-5cm		2.42	156	65	26
10	798	27	16/1/10	23/1/10	3	UB	P	4/5/2009	11/2/2010	36+4		EMG	FTP	AC	A	5-6cm		2.44	158	58	23.3
11	841	20	16/1/10	23/1/10	2	B	P	15/4/09	22/2/10	39+1		EMG	FD	LT		1-2cm		2.7	156	60	24.6
12	916	25	17/1/10	24/1/10	4	B	G4P1L1A2	20/4/09	27/2/10	38+5		EMG	PRV LSCS WITH PROM	LT		3-4cm		3.28	156	65	26.7
13	966	30	19/1/10	26/1/10	7	B	G4P3L3	27/4/09	6/3/2010	37+4		EMG	AB WITH FD	LT		2-3cm		2.93	158	58	23.3
14	1168	25	22/1/10	29/1/10	4	UB	G3P2D2	?	?	37+4		EMG	SOIU	LT		1-2cm		1.18	156	60	24.6
15	1280	22	25/1/10	1/2/2010	3	B	P	7/4/2009	14/2/10	41+4		EMG	FTP	AC	A	6-7cm	CP	3.25	145	60	31.5
16	1468	32	28/1/10	4/2/2010	6	B	G4P3L2D1	26/4/09	5/3/2010	39+3		EMG	RELATIVE CPD	2 SL	D	FULLY DILATED	OP	3.27	158	55	22
17	1869	26	3/2/2010	10/3/2010	4	UB	G2P1L1	?	?	ftp		EMG	FD WITH CPD	2SL	D	FULLY DILATED	DH	2.1	160	60	23
18	1938	26	4/2/2010	11/3/2010	2	B	G3P1L1A1	4/5/2009	11/2/2010	38+4		EMG	PRV LSCS WITH ST	LT		2-3cm		3.08	158	58	23.3
19	1967	24	5/2/2010	14/2/10	3	UB	G3P1L1D1	?	?	40		EMG	PRV LSCS WITH BREECH	AC	A	5-6cm		2.83	160	55	21.4

SL. NO	IP.NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS		INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
											ELC	EMG									
20	2508	21	14/2/10	21/2/10	3	UB	P	4/5/2009	11/2/2010	40		EMG	FD	LT		3-4cm		2.93	154	54	22.7
21	14061	24	24/4/09	1/5/2009	3	UB	P	22/2/09	29/11/09	30		EMG	SPE WITTH CPD	AC	M	6-7cm	CP	2.92	147	65	34.2
22	14583	20	4/10/2009	10/10/2009	1 1/2	B	P	28/12/08	4/10/2009	40 w		EMG	FD	LT		3-4cm		2.3	150	50	22.2
23	14972	22	9/10/2009	15/10/09	8	B	G3P2L1D1	3/1/2009	7/10/2009	40+2		EMG	FD	LT		3-4cm		2.9	152	60	27.2
24	14568	22	3/10/2009	10/10/2009	15	B	G3P1L1A1	20/12/08	27/09/09	39+6		EMG	FD	AC	M	5-6cm		3.58	156	60	24.6
25	14152	22	25/09/09	10/10/2009	4	B	G3P2L1D1	21/01/09	28/10/09	35+2		EMG	ST	LT		3-4cm		2.5	150	65	28.8
26	16245	25	31/10/09	10/11/2010	5	B	G2 P1D1	22/02/09	29/11/09	35+6		EMG	PRV LSCS WITH CPD	AC	A	5-6cm	CP	2.87	144	56	29.4
27	16230	19	31/10/09	9/11/2009	1	UB	P	9/2/2009	16/11/09	39+4		EMG	IE WITH FD	LT		1-2cm		2.94	156	65	26.7
28	16894	24	11/11/2009	18/11/09	1	UB	P	-	-	37 +6		EMG	FD	LT		3-4cm		2.7	158	58	23.3
29	17012	25	12/11/2009	19/11/09	4	B	G4P1L1A2	?5/12/09	?12/11/09	40		EMG	PRV LSCS WITH CPD WITH BOH	LT		3-4cm	CP	3.2	150	68	30.2
30	16679	23	8/11/2009	15/11/09	1 1/2	B	P	20/01/09	27/11/09	41+4		EMG	CPD WITH PD	LT		2-3cm	CP	2.67	152	65	28.2
31	16960	28	12/11/2009	19/11/09	5	B	G2P1D1	21/01/09	28/10/09	42		EMG	PD WITH CPD	LT		2-3cm	LOT	3.6	156	60	24.6
32	18797	35	16/12/09	23/12/09	12	UB	G3P2L1D1	-	-	42		EMG	PD WITH CPD	LT		3-4cm	CP	3	158	55	22
33	17656	25	24/11/09	1/12/2009	12	UB	G4P3L2D1	?	?	?		EMG	CPL WITH CPP	AC	A	5-6cm		3.5	162	60	23
34	17798	26	27/11/09	4/12/2009	5	UB	G3P1L1A1	15/2/09	22/11/09	40+5		EMG	FTP WITH FD	AC	A	5-6cm		2.88	158	55	22
35	660	22	13/1/10	20/1/10	2	UB	P	18/4/09	25/1/10	38+2		EMG	FD WITH OP	AC	M	6-7cm	OP	3.01	142	55	21.4
36	17743	25	26/11/09	4/12/2009	7	UB	G4P3L2D1	?26/3/09	?23/12/09	36		EMG	FD WITH APH	LT		2-3cm		2.71	154	54	22.7
37	17492	20	22/11/09	29/11/09	3	UB	P	25/2/09	2/12/2009	38+4		EMG	CPD WITH FD	LT		3-4cm		2.9	150	50	22.2
38	17310	24	18/11/09	25/11/09	5	B	P	3/12/2009	10/4/2010	41+1		EMG	CPD WITH FD	AC	A	5-6cm		2.72	162	60	23

SL. NO	IP.NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS		INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
											ELC	EMG									
39	14767	18	6/10/2009	14/10/09	1	B	P	28/12/09	4/10/2009	40+2		EMG	FD	LT		3-4cm		3.12	152	60	27.2
40	548	28	11/1/2010	18/1/10	2	UB	P	?	?	40+2		EMG	FD	AC	M	5-6cm		2.98	150	65	28.8
41	15622	21	21/10/09	28/10/09	3	B	P	12/1/2009	19/10/09	40+2		EMG	P WITH BREECH	LT		3-4cm		2.61	156	65	26.7
42	15454	22	18/10/09	25/10/09	5	UB	G2P1L1	?	?	?		EMG	TL WITH CPL	AC	A	4-5cm		2.6	160	55	21.4
43	1541	26	29/1/10	6/2/2010	3	B	G2P1L1	26/4/09	2/2/2010	39+2		EMG	PRV LSCS WITH THICK MSL	AC	A	4-5CM		2.91	146	58	23.3
44	15588	30	21/10/09	28/10/09	8	UB	G3P2L2	4/1/2009	11/10/2009	41+3		EMG	PRV LSCS WITH BREECH	LT		3-4cm	FB	3.52	156	60	24.6
45	15803	22	24/10/09	1/11/2009	1 1/2	UB	P	28/1/09	4/11/2009	38+3		EMG	P WITH BREECH	AC	A	5-6cm		3	158	55	22
46	17125	20	14/11/09	21/11/09	3	B	G2P1L1	9/2/2009	16/11/09	39+5		EMG	FD	LT		3-4cm		3.1	162	60	23
47	17139	23	15/11/09	22/11/09	5	B	G3P1L1A1	22/2/09	29/11/09	37+4		EMG	ST	LT		2-3cm		2.6	154	54	22.7
48	18394	23	9/12/2009	16/12/09	4	UB	G2P1L1	27/2/09	6/12/2009	40+2		EMG	FD	LT		2-3cm		2.45	160	55	21.4
49	18396	19	9/12/2009	19/12/09	2	UB	P	?	?	?		EMG	IE WITH FD	LT		2cm		2.4	154	54	22.7
50	18383	20	8/12/2009	15/12/09	3	UB	P	13/3/09	20/12/09	38+5		EMG	P WITH BREECH	LT		2-3cm		2.75	150	50	22.2
51	15057	24	10/10/2009	16/10/09	8	B	G3P1L1D1	3/1/2009	10/10/2009	40		EMG	CPD WITH PRV LSCS	AC	M	6-7cm	CP	3.5	152	60	
52	18395	23	9/12/2009	16/12/09	6	UB	G2P1L1	1/3/2009	8/12/2009	40+1		EMG	ST	LT		3-4cm		2.67	150	50	22.2
53	14519	20	3/10/2009	10/10/2009	1	UB	P	28/12/08	5/10/2009	39+5		EMG	FD	LT		3-4cm		2.42	152	60	27.2
54	15130	33	12/10/2009	19/10/09	5	B	G3P1L1A1	22/1/09	29/10/09	37+4		EMG	CPD WITH PRV LSCS	LT		3-4cm	CP	2.92	152	62	26.9
55	18691	25	14/12/09	21/12/09	6	UB	G6P3A2D3	?	?	35+5		EMG	PRECIOUS PREG	LT		3-4cm		2.52	150	65	28.8
56	17919	23	30/11/09	7/12/2009	6	UB	G2P1L1	15/2/09	22/11/09	41+1		EMG	FB	AC	M	6-7cm		2.6	156	65	26.7
57	1729	32	1/2/2010	10/2/2010	4	B	G3P1L1A1	10/4/2009	17/1/10	42+3		EMG	FTP	AC	A	4-5CM		3.09	150	58	23.3
58	1934	25	4/2/2010	14/2/10	7	UB	G5P3L3A1	?	?	34		EMG	FD	AC	A	4-5CM		3.09	162	60	23
59	1946	24	8/2/2010	15/2/10	4	UB	G2P1L1	?	?	ftp		EMG	ST	LT		3-4cm		3.08	160	55	21.4

SL. NO	IP.NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS		INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
											ELC	EMG									
60	2354	23	11/2/2010	21/2/10	4	UB	G2P1L1	?	?	ftp		EMG	DTA WITH OL	2SL	D	FULLY DILATED		2.28	154	54	22.7
61	9592	22	30/4/10	7/5/2010	4	B	G2P1D1	28/7/09	5/5/2010	39+2	ELC		PRV LSCS WITH CPD	-		-		2.8	156	65	26.7
62	9708	24	3/5/2010	10/5/2010	2	B	P	?	?	38	ELC		BREECH WITH OLIGIO	-		-		2.86	158	58	23.3
63	9931	28	5/5/2010	12/5/2010	4	B	G2P1L1	31/7/09	7/5/2010	40+2	ELC		PRV LSCS WITH CPD	-		-		3.8	158	60	24.6
64	9996	34	6/5/2010	16/5/10	4	B	G2A1	9/9/2009	16/6/10	33	ELC		BREECH WITH SPE WITH SOIU	-		-		1.32	162	55	23
65	10304	27	10/5/2010	18/5/10	2	UB	P	28/8/10	4/6/2011	40+4		EMG	PROM WITH CPD	LT		3-4cm	CP	3.6	148	60	30.6
66	10535	24	13/5/10	20/5/10	3	UB	P	1/8/2009	8/5/2010	40+5		EMG	CPD WITH PD	AC	M	6-7cm	CP	3.4	150	65	29.5
67	10475	28	14/5/10	21/5/10	2	UB	P	5/8/2009	12/5/2010	40+2		EMG	PPROM WITH FI	LT		3-4cm		2.48	160	60	24
68	10704	24	13/5/10	20/5/10	4	B	G2P1L1	15/8/09	22/5/10	38+4	ELC		PRV LSCS WITH CPD WITH OLIGO	-		-		2.3	154	55	22.4
69	10671	24	15/5/10	22/5/10	3	UB	P	15/8/09	22/5/10	40		EMG	CPD	AC	D	7-8cm	CP	3	152	54	30.2
70	10809	25	17/5/10	27/5/10	2	UB	P	14/9/09	21/6/10	35		EMG	FD WITH PROM	LT		2-3cm		1.83	150	50	21.4
71	10836	25	17/5/10	30/5/10	3	B	P	28/8/09	4/6/2010	39		EMG	CPD WITH ECLAMPSIA	LT		3-4cm	CP	3.2	154	65	28.8
72	10927	20	18/5/10	25/5/10	3	B	P	16/8/09	23/5/10	39		EMG	SPE WITH FAILURE TO PROGRESS	LT		3-4cm		2.36	152	60	27.2
73	10596	27	14/5/10	20/5/10	5	B	G2P1L1	29/9/09	6/7/2010	37	ELC		BREECH WITH PRV LSCS	-		-		2.8	150	65	28.8
74	11010	25	21/5/10	28/5/10	4	B	G2P1L1	?27/7/09	?4/5/10	36		EMG	ST	LT		2-3cm		2.83	156	65	26.7
75	10739	28	22/5/10	2/6/2010	5		G3P2L2	14/9/09	21/6/10	34		EMG	SPE WITH CPD	LT		3-4cm	OP	3.1	158	70	28
76	11270	21	22/5/10	29/5/10	2	UB	P	15/8/09	22/5/10	40		EMG	LVWS	LT		3-4cm	CP	2.4	156	58	23.3
77	11288	19	24/5/10	1/6/2010	3	B	P	28/8/09	4/6/2010	38		EMG	FD	LT		3-4cm		1.93	158	60	24.6
78	11317	26	24/5/10	1/6/2010	2	UB	P	24/8/09	31/5/10	39+1		EMG	CB IN LSP IN 2SL	2SL	D	FULLY DILATED	FB	2.35	156	55	22
79	11428	35	25/5/10	2/6/2010	3	UB	P	1/10/2009	8/7/2010	2/2/1900		EMG	PP TYPE II POST	LT		2-3cm	-	2.36	158	60	23
80	11399	20	25/5/10	5/6/2010	3	B	P	?	?	36+4		EMG	DTA WITH IE	2SL	D	FULLY DILATED		2.55	162	60	21.4
81	11469	24	25/5/10	2/6/2010	4	B	G2P1L1	26/8/09	2/6/2010	38+6		EMG	PRV LSCS WITH BREECH	AC	A	5-6cm	FP	3.5	160	55	22.7
82	11546	20	27/5/10	6/6/2010	5	UB	G3P1L1A1	?	?	35+1		EMG	SOIU	LT		3-4cm		1.43	154	54	22.2

SL. NO	IP.NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS		INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
											ELC	EMG									
83	17711	28	27/5/10	6/6/2010	6	UB	G3P1L1A1	?	?	38		EMG	SEVERE OLIGOHYDROMINOS	LT		2-3cm		2.4	150	50	21.4
84	11776	20	29/5/10	5/6/2010	3	UB	P	27/8/09	3/6/2010	39+6		EMG	FD	AC	M	7-8cm		2.1	152	60	27.2
85	11961	30	2/6/2010	9/6/2010	5	UB	G2P1L1	?	?	40	ELC		PRV LSCS WITH CPD	-		-		2.8	150	65	28.8
86	12059	30	3/6/2010	10/6/2010	7	UB	G6P1L1A4	10/8/2009	17/5/10	37+2		EMG	precious preg	LT		3-4cm		2.5	156	65	26.7
87	12017	26	2/6/2010	9/6/2010	5	B	G4P1L1A2	8/8/2009	15/5/10	37		EMG	PRV LSCS WITH ST	LT		2-3cm		2.35	158	58	23.3
88	12212	20	4/6/2010	14/6/10	3	UB	P	22/8/09	29/5/10	39+3		EMG	PIH WITH FD	LT		3-4cm		2.8	156	60	24.6
89	12226	25	5/6/2010	15/6/10	4	UB	G3P2L2	2/9/2009	9/6/2010	39+3		EMG	OL WITH FD	AC	A	5-6cm		2.8	158	55	22
90	11280	25	5/6/2010	1/12/1900	3	B	P	4/9/2009	11/6/2010	36WK		EMG	CPD	AC	A	5-6cm	CP	2.85	143	60	31.5
91	12377	33	7/6/2010	14/6/10	4	UB	G2P1L1	?	?	39		EMG	PRV LSCS WITH ST	LT		3-4cm		3.3	162	60	23
92	12622	26	10/6/2010	20/6/10	2	UB	P	3/10/2009	10/7/2010	33+3		EMG	P WITH FH WITH IE	LT		2-3cm		3	160	55	21.4
93	12601	22	10/6/2010	21/6/10	4	UB	G2P1L1	22/8/09	29/5/10	40+6		EMG	IE WITH FD	AC	A	6-7cm		2.8	154	54	22.7
94	12685	22	11/6/2010	18/6/10	3	UB	P	?	?	41+2		EMG	CPD	AC	A	5-6cm	CP	3.5	148	68	35.7
95	12812	21	12/6/2010	22/6/10	2	UB	P	6/9/2009	13/6/10	40+1		EMG	FD WITH FAILURE TO PROGRESS	AC	A	6-7cm		2.49	150	50	22.2
96	12845	20	14/6/10	21/6/10	2	UB	P	9/9/2009	16/6/10	39+4		EMG	PFT WITH THICK MSL	AC	A	5-6cm		2.9	152	60	27.2
97	12926	21	14/6/10	21/6/10	3	UB	P	4/9/2009	11/6/2010	40+3		EMG	OL WITH FD	2SL	D	FULLY DILATED		2.68	150	65	28.8
98	13024	20	16/6/10	23/6/10	1	UB	P	13/9/09	20/6/10	39+2		EMG	CPD	AC	M	7-8cm	CP	2.7	145	56	28.5
99	13066	21	16/6/10	23/6/10	3	B	P	3/9/2009	10/6/2010	40+6		EMG	OLIGOHYDROMNIOS WITH PROTRACTED DILATION	LT		3-4cm		2.45	156	65	26.7
100	13199	23	17/6/10	24/6/10	2	B	P	9/9/2009	16/6/10	40+1		EMG	CPD	AC	A	5-6cm	CP	3.08	146	52	27.3
101	13194	20	19/6/10	29/6/10	1	UB	P	25/9/09	2/7/2010	37+6		EMG	SPE WITH CPD WITH FD	LT		3-4cm		1.64	150	50	22.2
102	13314	24	19/6/10	29/6/10	6	UB	G3P2L2	?	?	42		EMG	PLD	LT		2-3cm		2.84	154	54	22.7
103	13343	23	19/6/10	26/6/10	1	UB	P	?	?	39		EMG	FD WITH THICK MSL	LT		2-3cm		2.9	160	55	21.4
104	13267	26	18/6/10	26/6/10	3	B	G2P1L1	2/10/2009	9/7/2010	ftp	ELC		PRV LSCS	-		-		2.61	162	60	23
105	13581	28	22/6/10	29/6/10	4	UB	G2P1L1	10/9/2009	17/6/10	40+5		EMG	FAILURE TO PROGRESS	LT		3-4cm		3.42	158	55	22

SL. NO	IP.NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS		INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
											ELC	EMG									
106	13658	24	23/6/10	1/7/2010	3	B	G1P1L1	18/10/09	25/6/10	39+5		EMG	PRV LSCS WITH CPD WITH AB	LT		3-4cm		2.37	156	60	24.6
107	13655	30	23/6/10	3/7/2010	5	UB	G4P2L1D1A1	?	?	32		EMG	APH WITH CPP	-		-		1.4	158	58	23.3
108	13684	19	23/6/10	5/7/2010	1	B	P	?	?	38+1		EMG	FD WITH THICK MSL	LT		2-3cm		2.31	156	65	26.7
109	13755	34	24/6/10	2/7/2010	4	B	G4P1L2A1	30/10/09	6/8/2010	33+6		EMG	PPROM WITH BREECH	LT		2-3cm		2.4	150	65	28.8
110	14031	25	27/6/10	7/7/2010	2	UB	P	?	?	32		EMG	APH WITH CPP	LT		1-2cm		1.34	152	60	27.2
111	13813	25	24/6/10	31/6/10	4	B	G3A2	3/10/2009	10/7/2010	38+4	ELC		PRECIOUS PREGNANCY	-		-		2.11	150	50	22.2
112	14112	20	28/6/10	5/7/2010	2	UB	P	4/10/2009	11/7/2010	38+1		EMG	P WITH BREECH	AC	A	4-5cm		2.79	154	54	22.7
113	14143	22	28/6/10	5/7/2010	3	UB	P	?	?	40		EMG	PROM WITH FD	LT		2-3cm		3.26	150	50	22.2
114	2494	20	14/2/10	24/2/10	5	UB	G3P2L1D1	?	?	ftp		EMG	PRV LSCS WITH BREECH	AC	M	5-6cm		2.5	140	50	22.7
115	14249	18	29/6/10	10/7/2010	3	B	P	24/10/09	31/7/10	35		EMG	SOIU	LT		2-3cm		2.07	158	58	23.2
116	14216	22	29/6/10	6/7/2010	3	B	G2P1L1	17/9/09	24/7/10	36+3		EMG	FD	LT		3-4cm		2.37	150	50	22.2
117	14253	24	30/6/10	7/7/2010	2	UB	P	16/9/09	23/6/10	41		EMG	PD WITH CPD	AC	M	6-7cm	CP	3.15	152	58	25.7
118	14626	25	5/7/2010	12/7/2010	1	B	P	29/9/09	6/7/2010	40+1		EMG	SPE WITH CPD	AC	A	5-6cm	CP	3.1	148	52	27.3
119	14504	30	2/7/2010	9/7/2010	6	B	G5P1L1A2E1	10/10/2009	17/7/10	36+6		EMG	PRV LSCS WITH BREECH	LT		3-4cm	FB	2.63	160	55	21.4
120	14526	26	3/7/2010	13/7/10	2	UB	P	20/10/09	27/7/10	36+4		EMG	AE	LT		1-2cm		2.06	158	55	22
121	14626	25	5/7/2010	15/7/10	1	UB	P	?	?	39+6		EMG	CPD	AC	A	4.5cm	CP	3.13	145	50	25.5
122	14990	30	9/7/2010	16/7/10	3	UB	G2P1L1	28/9/09	5/7/2010	40+4		EMG	FP	AC	A	5-6cm	FP	3.15	154	54	22.7
123	15150	25	11/7/2010	18/7/10	4	B	G2P1L1	5/10/2009	12/7/2010	39+6		EMG	BREECH WITH FD	AC	A	5-6cm		3.1	162	60	23
124	15171	21	11/7/2010	18/7/10	2	B	P	25//9/09	2/7/2010	38+4		EMG	BREECH WITH IUGR WITH FD	LT		3-4cm		1.83	150	65	28.8
125	15260	22	12/7/2010	19/7/10	3	B	G2P1L1	16/10/09	23/7/10	38+2		EMG	PRV LSCS WITH CPD	LT		2-3cm	CP	3.25	148	50	26.3
126	15272	30	12/7/2010	19/7/10	4	UB	G2P1L1	?	?	39		EMG	PREVIOUS LSCS WITH ST	LT		2-3cm		2.9	152	60	27.2
127	15730	18	18/7/10	25/7/10	4	UB	G2A1	18/11/09	25/8/10	36		EMG	FD	LT		3-4cm		2.4	150	65	28.8
128	15732	25	17/7/10	24/7/10	2	B	P	5/10/2009	12/7/2010	40+5		EMG	FD	LT		3-4cm		2.5	156	65	26.7

SL. NO	IP.NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS		INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
											ELC	EMG									
129	15759	25	18/7/10	28/7/10	1	UB	P	10/10/2009	17/7/10	40+1		EMG	OL	2SL	D	FULLY DILATED		2.4	158	58	23.3
130	15630	24	16/7/10	23/7/10	3	UB	G3P1L1A1	?	?	39		EMG	FD	LT		3-4cm		3.05	156	60.0	24.6
131	14635	25	5/10/2009	12/10/2009	4	UB	G2P1L1	?	?	33		EMG	PRV LSCS WITH APH	LT		2-3cm		2.56	156	65	27
132	14676	25	6/10/2009	16/10/09	2	B	primi	?	?	ftp		EMG	FD	LT		1-2CM		2.7	156	60	22
133	14944	20	9/10/2009	15/10/09	4	UB	G2P1L1	?	?	ftp		EMG	PPROM WITH TL	LT		3-4CM		2.8	158	55	23
134	14828	24	7/10/2009	14/10/09	4	UB	G2P1L1	?	?	ftp		EMG	PRV LSCS WITH CPD				CP	3.2	160	60	23
135	14757	22	6/10/2009	13/10/09	2	UB	P	?	?	ftp		EMG	FD	LT		2-3CM		2.7	158	58	21
136	15455	21	18/10/09	25/10/09	3	UB	P	?	?	ftp		EMG	CPD	AC	A	5-6CM	CP	3.2	154	54	22
137	15509	22	20/10/09	27/10/09	3	B	G2A1	?	?	ftp		EMG	FD	LT		3-4CM		2.8	160	55	27
138	15436	20	16/10/09	21/10/09	2	B	P	?	?	ftp		EMG	FTP WITH SAD	2SL	D	FULLY DILATED	CP	2.75	150	50	24
139	15644	21	22/10/09	2/11/2009	2	UB	P	?	?	ftp		EMG	FD	LT		3-4CM		2.46	152	60	29
140	15777	18	23/10/09	30/10/09	3	B	P	?	?	ftp		EMG	FD	LT		3-4CM		2.9	156	60	29
141	15910	22	25/10/09	2/11/2009	3	UB	P	18/1/09	25/10/09	40WKS		EMG	FD	LT		2-3CM		2.76	150	65	27
142	17462	19	21/11/09	28/11/09	2	B	P	?	?	ftp		EMG	RHD WITH CPD	LT		3-4CM	CPD	2.67	144	56	23
143	1203	22	2/4/2010	8/5/2010	5	UB	G3P1L1A1	?	?	37+5DAYS		EMG	IE WITH FD	LT		3-4CM	CPD	2.1	156	65	30
144	131	25	3/1/2010	10/1/2010	4	B	G2P1L1	29/3/09	5/1/2010	39+5DAYS		EMG	FD	AC	M	6-7CM		1.47	158	58	22
145	499	25	9/1/2010	17/1/10	5		G2P1L1	5/4/2009	12/1/2010	40+3DAYS		EMG	PRV LSCS WITH CPD	AC	A	5-6CM	CD	1.52	150	68	21
146	548	26	11/1/2010	20/1/10	3	B	G3P1L1A1	10/4/2009	17/1/10	40+6	ELC		PRV LSCS WITH CPD					1.47	158	55	23
147	16136	24	29/10/09	6/11/2009	4	UB	G2P1L1A1	?	?	ftp		EMG	PREV LSCS WITH ST	LT		2-3CM		2.12	162	60	22
148	16409	23	8/11/2009	15/11/09	2	B	P	23/2/09	3/10/2009	41+1		EMG	CPD	AC	A	5-6CM	CP	2.67	158	55	21
149	16270	30	1/11/2009	8/11/2009	4	UB	G3P1L1A1	?	?	POSTDATED		EMG	PRV LSCS WITH FTP	AC	A	5-6CM		3.09	142	55	23
150	16779	22	10/11/2009	20/11/09	2	B	P	?	?	ftp		EMG	AE WITH HELLP SYNDROME	LT		3-4CM		2.75	154	54	22

SL. NO	IP.NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS		INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
											ELC	EMG									
151	17124	20	14/11/09	21/11/09	5	UB	G2P1L1	9/12/2009	16/11/09	40+2		EMG	PREV LSCS WITH ST	LT		3-4CM		3.05	150	50	21
152	18922	26	19/12/09	27/12/09	2	B	P	23/3/09	30/12/09	38+2		EMG	CP WITH PROM	LT		1-2CM	CP	2.97	152	65	23
153	18923	29	19/12/09	26/12/09	4	B	G2P1L1	24/3/09	31/12/09	38+1		EMG	CPD WITH PREV. LSCS	LT		3-4CM	CP	3.49	152	60	22
154	19276	22	24/12/09	31/12/09	3	UB	G2P1L1	?	?	41+5		EMG	PRV LSCS WITH CP	AC	A	5-6CM	CP	2.8	144	56	22
155	19268	35	26/12/09	8/1/2010	4	B	G3P1L1A1	29/5/09	7/3/2010	30+2		EMG	SPE WITH SEVERE OLIGO	LT		1-2CM		1.38	148	50	28
156	19434	29	28/12/09	6/1/2010	7	UB	G3P2L2	?	?	39		EMG	PREV LSCS WITH FD	LT		3-4CM		3.02	152	65	27
157	19513	30	29/12/09	5/1/2010	10	UB	G5P4L4	?	?	ftp		EMG	PREV LSCS WITH FD	AC	A	4-5CM		3.32	150	65	29
158	19563	22	30/12/09	6/1/2010	2	B	P	22/3/09	29/12/09	40+1		EMG	FTP WITH FD	AC	A	4-5CM		2.5	150	68	26
159	17986	24	1/12/2010	8/1/2010	2	B	P	7/4/2009	14/1/10	35		EMG	PPROM WITH AB	LT		2-3cm		1.7	150	50	28
160	18529	22	11/12/2009	19/12/09	3	B	G2P1L1	8/3/2009	15/12/09	39+3		EMG	PRV LSCS WITH CPD DUE TO FLAT PELVIS	LT		3-4cm		3.07	150	68	29
161	18757	26	15/12/09	23/12/09	2		P	13/3/09	28/12/09	39+5		EMG	FD	LT		3-4cm		2.13	150	50	30
162	18686	22	14/12/09	21/12/09	3	UB	P	23/2/09	30/12/09	42		EMG	FD	AC	A	5-6cm		2.78	148	50	22
163	18840	20	17/12/09	24/12/09	2	B	P	10/3/2009	17/2/10	40		EMG	PROM WITH FAILURE TO PROGRESS	LT		4-5cm		3.1	154	54	30
164	8871	25	21/4/10	28/4/10	6	UB	G3P2L2	28/7/09	5/5/2010	38+1		EMG	PRV LSCS WITH BP WITH PFT	AC	A	4-5cm	BP	3.35	150	65	23
165	9435	26	29/4/10	6/5/2010	4	B	G2P1L1	18/7/09	25/4/10	40+4		EMG	PRV LSCS WITH RELATIVE CPD	AC	M	5-6CM	CP	3	145	60	29
166	9296	23	27/4/10	4/5/2010	2	B	P	16/7/09	23/4/10	40+4		EMG	FD	AC	M	5-6CM			155	68	32
167	6299	19	23/3/10	30/4/10	1	B	P	23/6/09	30/3/10	39+1		EMG	FTP	LT		2-3cm		2.82	150	65	30
168	6384	24	24/3/10	31/3/10	2	B	P	11/6/2009	18/3/10	40+6		EMG	FD WITH PFT	LT		3-4cm		3.2	140	52	29
169	6472	20	25/3/10	6/4/2010	2		P	?	?	32-34		EMG	FD WITH THICK MSL	LT		2-3cm		2.06	150	65	29
170	6549	25	26/3/10	4/4/2010	3	UB	G4A3	?	?	35		EMG	FTP WITH PRV LSCS	LT		3-4cm		2.34	150	65	29
171	6696	19	27/3/10	3/4/2010	2	B	P	13/6/09	20/3/10	41		EMG	CPD AT BRIM WITH PROM	AC	A	4-5CM	CP	3.9	143	50	26
172	6699	28	27/3/10	4/4/2010	4	UB	G4P3L2D1	5/6/2009	12/3/2010	42+1		EMG	PFT	LT		2-3cm		3.1	156	65	26
173	6744	19	28/3/10	5/4/2010	2	B	P	11/7/2009	18/4/10	38+1		EMG	FD	AC	A	4-5CM		2.25	158	58	23

SL. NO	IP.NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS		INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
											ELC	EMG									
174	6978	27	31/3/10	7/4/2010	3	B	G3P1L1A1	7/6/2009	14/3/10	40+2		EMG	FD	LT		3-4CM		2.26	156	68	25
175	7120	20	1/4/2010	8/4/2010	2	B	P	3/7/2009	10/4/2010	38+5		EMG	CPL WITH FD	LT		3-4CM		2.89	158	65	23
176	7352	20	4/4/2010	12/4/2010	3	B	P	?	?	40		EMG	FD WITH OL	2SL	D	FULLY DILATED		3.13	148	65	36
177	7361	19	4/4/2010	11/4/2010	2	B	P	17/7/09	24/4/10	37		EMG	CDP WITH AB WITH FD	LT		3-4CM		2.19	147	65	29
178	7202	25	2/4/2010	14/4/10	4	B	G2P1D1	?	?	39	ELC		GDM					4.2	156	52	22
179	7615	21	7/4/2010	14/4/10	3		P	1/7/2009	8/4/2010	39+6		EMG	FD	LT		3-4CM		3.25	152	65	27
180	7673	19	8/4/2010	15/4/10	2	UB	P	27/6/09	3/4/2010	40+5		EMG	CPD WITH PD WITH FD	AC	A	5-6CM		2.85	148	60	29
181	8029	23	12/4/2010	19/4/10	1	UB	P	26/6/09	3/4/2010	41+2		EMG	PFT	LT		3-4CM		2.52	150	68	27
182	8165	23	13/4/10	20/4/10	3	UB	G2P1L1	22/7/09	29/4/10	37+6		EMG	THREATENED RUPTURE WITH FTP	AC	A	5-6CM		2.99	153	65	29
183	8250	25	15/4/10	23/4/10	5	UB	G5P3L2D1A1	16/7/09	23/4/10	38+6		EMG	CPP	AC	A	4-5CM		3.01	148	50	32
184	8378	19	16/4/10	23/4/10	2	UB	P	3/7/2009	10/4/2010	40+3		EMG	FD WITH FTP	AC	A	5-6CM		2.87	150	60	24
185	2729	25	16/2/10	23/2/10	3	UB	P	8/6/2009	15/3/10	36		EMG	FTP	LT		3-4CM		2.83	150	65	29
186	2574	27	15/2/10	22/2/10	2	UB	P	25/5/09	4/3/2010	38	ELC		BREECH WITH OLIGO					2.78	152	60	22
187	2730	20	17/2/10	27/2/10	1	B	P	24/5/10	3/3/2010	38		EMG	SPE WITH SOIU	LT		2-3CM		1.61	150	65	27
188	3029	24	19/2/10	26/2/10	4	B	G3P1L1A1	4/5/2009	11/2/2010	41		EMG	FD WITH PLD	LT		3-4CM		2.93	150	60	30
189	2729	25	16/2/10	24/2/10	2	UB	P	8/6/2009	14/3/10	36		EMG	FTP	LT		3-4CM		2.83	150	50	29
190	3726	25	27/2/10	9/3/2010	2	UB	P	21/5/09	28/2/10	39+6		EMG	CPD WITH SPE WITH FD	2SL	D	FULLY DILATED		2.92	147	65	29
191	3786	24	27/2/10	7/3/2010	3	UB	P	26/5/09	5/3/2010	39+1		EMG	FD	AC	A	4-5CM		2.57	147	58	23
192	3994	22	2/3/2010	9/3/2010	2	UB	P	12/5/2009	19/2/10	38+2		EMG	FD	AC	A	4-5CM		3.22	150	60	27
193	4170	25	3/3/2010	10/3/2010	4	B	G4P2L1D1	22/06/09	29/3/10	36		EMG	PFT	LT		3-4CM		2.36	157	60	23
194	6196	22	22/3/10	29/3/10	1	UB	P	26/6/09	?	38+2		EMG	T1-BREECH,T2-TL	LT		2-3CM		1.83, T2-	150	65	29

SL. NO	IP.NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS		INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
											ELC	EMG									
195	4509	25	6/3/2010	13/3/10	5	UB	G3P2D2	25/5/09	4/3/2010	40+2		EMG	PRECIOUS PREGNANCY WITH FTP WITH CPD WITH PLD	AC	A	4-5CM		2.61	146	56	22
196	5231	26	12/3/2010	19/3/10	4	UB	G2P1L1	17/5/09	24/2/10	42+2		EMG	PD WITH SEVERE OLIGO WITH FD	LT		3-4CM		3.17	150	60	27
197	5819	19	19/3/10	26/3/10	1	UB	P	4/6/2009	11/3/2010	41+1		EMG	OL WITH DTA	2SL	D	FULLY DILATED	CP	2.9	144	60	30
198	5648	26	17/3/10	24/3/10	2	UB	P	30/6/09	6/4/2010	37+3		EMG	FD	LT		3-4CM		2.9	155	50	29
199	5903	23	20/3/10	27/3/10	1	UB	P	?	?	41+1		EMG	CPD WITH FTP	AC	A	5-6CM	CP	2.86	150	60	29
200	6325	22	24/3/10	31/3/10	2	UB	P	18/8/09	25/5/10	31		EMG	PPROM WITH SEVERE OLIGO	LT		3-4CM		1.45	146	50	23

COMPLICATIONS ASSOCIATED	CTG	OTHERS	SCAR	MECONIUM	SEX	APGAR	NICU	POST OPERATIVE PERIOD	AT DISCHARGE	UTERUS CLOSURE	DECISION TO CS(min)
IE	PFT		-	-	A-M; B-M	7/10 & 9/10	yes	UNEVENTFULL	NAD	DOUBLE	30
	VD		-	-	F	7/10 & 9/10	NO	UNEVENTFULL	NAD	DOUBLE	40
SPE			-	-	M	7/10 & 9/10	NO	UNEVENTFULL	NAD	DOUBLE	30
	LD		-	-	F	7/10 & 9/10	NO	UNEVENTFULL	NAD	DOUBLE	30
			I	-	F	7/10 & 9/10	NO	UNEVENTFULL	NAD	DOUBLE	30
			I	-	M	7/10 & 9/10	NO	UNEVENTFULL	NAD	DOUBLE	40
PROM	-		-	thick	F	7/10 & 9/10	NO	UNEVENTFULL	NAD	SINGLE	15
			I	-	F	7/10& 9/10	NO	UNEVENTFULL	NAD	SINGLE	60
	PFT		I	-	M	7/10 & 9/10	NO	UNEVENTFULL	NAD	SINGLE	25
		CD	-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
	VD		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	35
PROM		ST	I	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	20
	PFT		-	-	M	3/10,7/ 10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	15
SOIU	VD		-	-	F	7/10&9/10	yes	UNEVENTFULL	NAD	DOUBLE	30
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	45
			-	-	M	4/10,7/10&9/ 10	NO	UNEVENTFULL	NAD	DOUBLE	40
	LD		-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	30
		ST	I	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	45
	VD		I	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	60

COMPLICATIONS ASSOCIATED	CTG	OTHERS	SCAR	MECONIUM	SEX	APGAR	NICU	POST OPERATIVE PERIOD	AT DISCHARGE	UTERUS CLOSURE	DECISION TO CS(min)
PROM	PFT		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
			-	thin	M	7/10&9/10	yes	UNEVENTFULL	NAD	SINGLE	20
	LD		-	-	F	4/10,7/10&9/10	yes	UNEVENTFULL	NAD	SINGLE	25
PROM	PFT		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	15
	-		-	thick	M	7/10& 9/10	NO	UNEVENTFULL	NAD	DOUBLE	20
		ST	TO	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	25
			I	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	10
IE	LD		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	15
	VD		-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	35
BOH			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	50
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	45
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	30
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	45
	LD		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	50
		FTD	-	thick	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	40
	VD	-		-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	25
	PFT		-	blood mixed	F	7/10&9/10	yes	UNEVENTFULL	NAD	SINGLE	30
	VD		-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
	-		-	thick	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	25

COMPLICATIONS ASSOCIATED	CTG	OTHERS	SCAR	MECONIUM	SEX	APGAR	NICU	POST OPERATIVE PERIOD	AT DISCHARGE	UTERUS CLOSURE	DECISION TO CS(min)
PROM	PFT		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	40
			-	thick	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	40
			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	40
CPL			-	-	M	7/10&9/10	yes	UNEVENTFULL	NAD	SINGLE	40
			-	THICK	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	20
			I	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	303
			-	thick	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	35
		ST	I	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	20
PROM			-	thick	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	25
IE	PFT		-	-	M	4/10,7/10&9/10	yes	UNEVENTFULL	NAD	SINGLE	20
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	30
			D	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	35
		ST	D	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	45
PROM	VD		-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	45
			I	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	45
			-	-	M	7/10&9/10	yes	UNEVENTFULL	NAD	SINGLE	40
			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	40
MA			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	25
MA			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	25
-		ST	TO	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30

COMPLICATIONS ASSOCIATED	CTG	OTHERS	SCAR	MECONIUM	SEX	APGAR	NICU	POST OPERATIVE PERIOD	AT DISCHARGE	UTERUS CLOSURE	DECISION TO CS(min)
SA			-	THIN	F	6/10&9/10	YES 5	UNEVENTFULL	NAD	SINGLE	20
			I	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	24 HRS
SO			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	24 HRS
			I	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	24 HRS
SPE WITH SOIU			-	-	M	7/10&9/10	YES	UNEVENTFULL	NAD	DOUBLE	24 HRS
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	45
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
		CD	-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	45
SO			I	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	24 HRS
			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	35
PROM	LD		-	THIN	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
IE			-	-	M	3/10,7/10	yes	UNEVENTFULL	NAD	SINGLE	35
SPE		CD	-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	40
			I	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	24 HRS
		ST	D	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	45
PE			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	40
			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	50
	VD		-	THIN	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	45
			-	-	M	5/10&9/10	yes	UNEVENTFULL	NAD	SINGLE	35
PP	-	-	-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
IE			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	20
			I	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
SOIU	VD		-	-	F	6/10&7/10	yes	UNEVENTFULL	NAD	SINGLE	40

COMPLICATIONS ASSOCIATED	CTG	OTHERS	SCAR	MECONIUM	SEX	APGAR	NICU	POST OPERATIVE PERIOD	AT DISCHARGE	UTERUS CLOSURE	DECISION TO CS(min)
SO	LD		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	35
	PPFT		-	THICK	M	1/10,3/10 &5/10	YES	UNEVENTFULL	NAD	DOUBLE	45
			I	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	24 HRS
			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
		ST	D	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	25
SPE	VD		-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
			-	THIN	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	20
			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	30
		ST	D	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	20
IE			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	25
IE	VD		-	-	M	1/10&3/10	YES	UNEVENTFULL	NAD	SINGLE	30
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	45
	VD	CD	-	-	M	3/10,5/10&7/ 10	NO	UNEVENTFULL	NAD	DOUBLE	40
	PFT		-	THICK	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	20
			-	THICK	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	20
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	30
SO		PD	-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	25
			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	40
SPE	VD		-	-	M	7/10&9/10	yes	UNEVENTFULL	NAD	DOUBLE	30
	LD		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	25
	PFT		-	THICK	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	20
			I	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
		CD	I	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	35

COMPLICATIONS ASSOCIATED	CTG	OTHERS	SCAR	MECONIUM	SEX	APGAR	NICU	POST OPERATIVE PERIOD	AT DISCHARGE	UTERUS CLOSURE	DECISION TO CS(min)
AB	PFB		I	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	25
CPP			-	-	M	1/10,3/10,5/10&6/10	yes	UNEVENTFULL	NAD	SINGLE	20
	VD		-	THICK	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	25
PROM	PFT		-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
CPP			-	-	M	MSB	NO	MSB	NAD	DOUBLE	25
			-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	24 HRS
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
PROM	LD		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	35
MA WITH PROM		CB	I	-	M	4/10,7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	25
SOIU	VD		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	45
	LD		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	40
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	30
SPE			-	-	M	7/10&9/10	yes	UNEVENTFULL	NAD	DOUBLE	35
			I	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
AE	VD		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	20
			-	-	M	1/10&5/10	yes	BABY TAKEN AMA	NAD	DOUBLE	30
			-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	20
	VD		-	-	F	7/10&9/10	yes	UNEVENTFULL	NAD	DOUBLE	25
	PFT		-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
			I	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	35
		ST	D	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	30
PROM	LD		-	-	M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	25
	VD		-	-	F	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	35

COMPLICATIONS ASSOCIATED	CTG	OTHERS	SCAR	MECONIUM	SEX	APGAR	NICU	POST OPERATIVE PERIOD	AT DISCHARGE	UTERUS CLOSURE	DECISION TO CS(min)
			-	-	F	2/10,7/10&9/10	yes	UNEVENTFULL	NAD	SINGLE	20
	PFB		-	THIN	F	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	35
APH					M	7/10&9/10	es,1da	UNEVENTFULL	NAD	SINGLE	35
PROM				THICK	M	7/10&9/10	NO	UNEVENTFULL	NAD	DOUBLE	20
PPROM					M	5/10,7/10&9/10	,1MOI	UNEVENTFULL	NAD	SINGLE	20
			I		M	7/10&9/10	NO	UNEVENTFULL	NAD	SINGLE	24HRS
	LD				F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
					F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
	PFT				F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
G-HTN					F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	20
RHD WITH MR	LD				F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	35
					M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
PE	LD				M	7/10&9/10	S,4DA	UNEVENTFUL	NAD	DOUBLE	25
					M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	35
					F	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	40
			I		F	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	30
					F	6/10&8/10	NO	UNEVENTFUL	NAD	DOUBLE	25
			I		F	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	24HRS
			TO		M	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	25
					M	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	25
			I		F	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	30
AE					M	FSB	NO	UNEVENTFUL	NAD	SINGLE	30

COMPLICATIONS ASSOCIATED	CTG	OTHERS	SCAR	MECONIUM	SEX	APGAR	NICU	POST OPERATIVE PERIOD	AT DISCHARGE	UTERUS CLOSURE	DECISION TO CS(min)
			D		F	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	20
PROM					F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
			TO		M	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	25
			I		M	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	35
SPE					M	4/6/2008	S-10DA	UNEVENTFUL	NAD	DOUBLE	30
	LD				M	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	35
	PFT		I		M	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	30
				THIN	M	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	35
AB					M	7/10&9/10	ES-1DA	UNEVENTFUL	NAD	DOUBLE	30
			I		M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	35
	VD			THICK	F	6/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	35
	LD			THIN	F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	40
PROM					M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	35
	PFT		TO		M	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	30
					F	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	30
	VD				M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
G-HTN WITH MA					M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
	PLD				F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	35
IE				THICK	F	5/7/2009	S-7DA	UNEVENTFUL	NAD	DOUBLE	30
					M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
PROM					M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
	PFT				M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
				THICK	F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25

COMPLICATIONS ASSOCIATED	CTG	OTHERS	SCAR	MECONIUM	SEX	APGAR	NICU	POST OPERATIVE PERIOD	AT DISCHARGE	UTERUS CLOSURE	DECISION TO CS(min)
	LD				F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	20
					F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
					M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	20
AB	PFT				M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
GDM					F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	24HRS
	VD				M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
	VD				M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
	PFT			THIN	F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
					F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	20
			D		M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
				THICK	M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	20
PROM					F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
					F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	24HRS
SPE WITH HBsAg +ve					M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
	LD				M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
PROM					F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	20
SPE	PFB				F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
	VD				M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
	LD				F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
	PVD				F	7/10&9/10	NO	UNEVENTFUL	NAD	SINGLE	30
					T1-M, T	T1-7/10&9/10, T2-7/10&9/10	YES-	UNEVENTFUL	NAD	DOUBLE	25

COMPLICATIONS ASSOCIATED	CTG	OTHERS	SCAR	MECONIUM	SEX	APGAR	NICU	POST OPERATIVE PERIOD	AT DISCHARGE	UTERUS CLOSURE	DECISION TO CS(min)
	LD				M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
					F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
					M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	30
	VD				M	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
					F	7/10&9/10	NO	UNEVENTFUL	NAD	DOUBLE	25
PPROM					M	7/10&9/10	YES-	UNEVENTFUL	NAD	DOUBLE	30