

# “CROSS SECTIONAL STUDY OF INDICATIONS FOR CESAREAN SECTION”

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## CHAPTER 1

# INTRODUCTION

*Dr. Aruna M Biradar*

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.<sup>(1)</sup>

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<sup>(2)</sup>. 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.<sup>(3)</sup>

Firstly, doctors had no understanding of what today is called the **germ theory of disease**<sup>(4)</sup> (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

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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.

## CHAPTER 2

### HISTORY

*Dr. G.R.Sajjan*

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<sup>(5)</sup>. 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 required a living mother to be in her 10th month of pregnancy, before the procedure was resorted to.<sup>(5)</sup>

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<sup>(6)</sup>. The expectant mother was normally anesthetized with alcohol,

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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<sup>(7)</sup>. 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.<sup>(8)</sup>



**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])<sup>(9)</sup>

## CHAPTER 3

### LITERATURE SEARCH

*Dr. Aruna M Biradar*

A study conducted by Mukherjee. SN<sup>(10)</sup> 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<sup>(11)</sup> 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<sup>(12)</sup> 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,<sup>(13)</sup> 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.

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Shakti.V, Behera RC, Sandha GS , Singh Anita ,Bandhu HC <sup>(14)</sup> 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 <sup>(15)</sup> conducted a longitudinal study of 6138 women who had previously undergone cesarean section and had delivered a singleton 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, <sup>(16)</sup> 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<sup>(17)</sup> 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<sup>(1)</sup> 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<sup>(18)</sup> on changed indications of cesarean section & found an increased rate of elective cesarean for psychosocial indications. A standardized protocol aiding a

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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<sup>(2)</sup> 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<sup>(3)</sup> 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,<sup>(6)</sup> 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<sup>(7)</sup> 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.

## CHAPTER 4

### TYPES and Steps of Cesarean section (CS)

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There are several types of Cesarean 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 Cesarean 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 Cesarean section is a Cesarean 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 Cesarean section have been used, such as extraperitoneal Cesarean section or Porro Cesarean section.
- A repeat Cesarean section is done when a patient had a previous Cesarean section. Typically it is performed through the old scar.

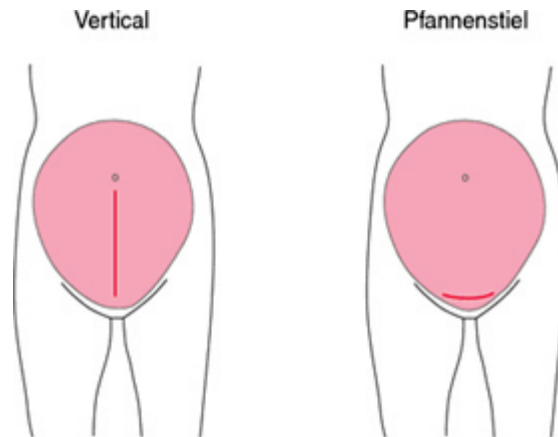
#### **STEPS OF CESAREAN SECTION <sup>(19)</sup>**

##### **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 subumbilical 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.

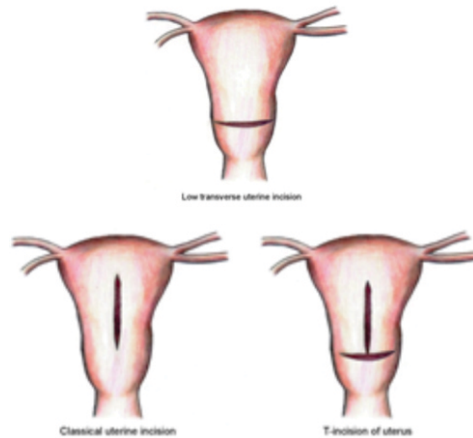
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Maylard incision – In this incision the rectus muscles are divided sharply or with electro cautery. The incision also may be especially useful in women with significant scarring from previous transverse incision<sup>(18)</sup>.



**FIGURE 2 : Showing different skin incisions taken during cesarean section**

- A)** Abdomen opened in layers till the pre peritoneal fat is identified<sup>(9)</sup>.
- B)** 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<sup>(9)</sup>.
- C) UTERINE INCISIONS:**  
Most often lower uterine segment is incised transversely as described by Kerr in 1921<sup>(9)</sup>. Occasionally a low segment vertical incision as described by Kronig in 1912<sup>(9)</sup> 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.



**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.

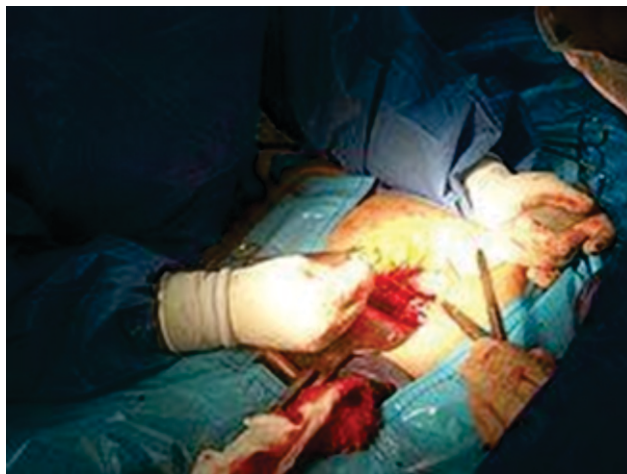




**FIGURE 4: Showing the Extraction of baby and clamping of umbilical cord**

**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 <sup>(9)</sup>:**

- 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<sup>(36)</sup>

Bladder and bowel function :

- a) Solid food offered within 8 hours of surgery in uncomplicated cases (37,38)
- b) pathology of adynamic ileus is complex and involves hormonal, neural & local factors that are incompletely understood<sup>(39)</sup>

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<sup>(40)</sup>

Wound care: Dressing changed on 4<sup>th</sup> day and sutures are removed on 7<sup>th</sup> day, routinely. In obese patients removed on 10<sup>th</sup> 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.

## CHAPTER 5

### Risks Maternal and Fetal

*Dr Aruna M Biradar*

#### **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<sup>(19)</sup> found that the absolute difference in severe maternal morbidity and mortality was small between a caesarean 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.<sup>(19)</sup> 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<sup>(19)</sup>. Other risks include severe blood loss and post spinal headache.

A study published in the June 2006 issue of Obstetrics and Gynecology<sup>(20)</sup> 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 accreta, 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<sup>(20)</sup>.

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*<sup>(21)</sup> 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 accreta, 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<sup>(21)</sup>.

### **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<sup>(22)</sup>.
- 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<sup>(23)</sup>.
- 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.<sup>(24)</sup>

### **Incidence**

The World Health Organization recommends the rate of Caesarean

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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<sup>(25)</sup>.

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.<sup>(26)</sup>

More emergency Caesareans about 66%, are performed during the day rather than during the night<sup>(27)</sup>.

### **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<sup>(28)</sup>. 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<sup>[29]</sup>.

### **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.<sup>[30]</sup> 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) .<sup>[31]</sup> 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<sup>[32]</sup>. The finding was that Caesarean sections are not more likely in women of higher social class than in women in other classes<sup>[33]</sup>. Some have suggested that due to the comparative risks of Caesarean

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section with an uncomplicated vaginal delivery, patients should be discouraged or forbidden<sup>(34)</sup> 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<sup>(35)</sup>.

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<sup>(4)</sup>. 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 amore intense nerve block. The dermatomal level of anesthesia required for Caesarean delivery is also higher than that required for labor analgesia<sup>(35)</sup>.

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.

## **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 accrete & 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.

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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 :  
1<sup>st</sup> Trimester :  
2<sup>nd</sup> Trimester :  
3<sup>rd</sup> Trimester :

**Obstetrics history** :  
Married Life :  
Obstetric Score :  
Last child birth :  
Last abortion :

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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)

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**Per Vaginal Examination**

	<b>At admission</b>	<b>II</b>	<b>III</b>	<b>At CS</b>
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 :  
 HBsAg :  
 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 :  
Prolonged dilatation :  
Prolonged 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 I stage  
II stage  
Type of distress With CTG Without CTG

**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 :

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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

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 or 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  
(DR. ARUNA.BIRADAR)

DATE:

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:

## ABBREVIATIONS

1. B- BOOKED
2. UB- UNBOOKED
3. CP- CONTRACTED PELVIS
4. BB- BIG BABY
5. MP- MAL POSITION
6. A- ACCELERATION PHASE
7. D- DECELERATION 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 – DEHISCENCE
  47. TO – THINNED OUT
  48. F – FEMALE
  49. M – MALE
  50. CS – CESAREAN SECTION
  51. CTG – CARDIO TOCOGRAPHY
  52. FD – FETAL DISTRESS
  53. CPD – CEPHALO 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 – 2ND 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

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SL. IP/NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS	INDICATION	STAGES	AC PHASE	CERVICA	CP/BB/MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
1	37	2/1/2010	12/1/2010	2	UB	P	?	?	?	EMG	IE WITH FD	AC	A	5-6cm		1.70/1.72			
2	55	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	2/1/2010	9/1/2010	3	B	P	24/03/09	3/1/2/09	40+2-dys	EMG	SPE WITH CPD	AC	A	4-5cm	CP	2.95	142	70	28.5
4	388	7/1/2010	14/0/1/0	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	8/1/2010	15/1/10	4	B	G3P1L1A1	30/03/09	6/1/2010	40+2 days	EMG	PRVLSCS WITH CPD	AC	A	5-6cm	CP	2.95	140	52	27.3
6	47	1/1/2010	8/1/2010	5	B	G5P1L1A3	?	?	38+4 days	ELC	PRVLSCS WITH CPD	LT			CP	3.14	150	65	28.8
7	481	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	16/1/10	23/1/10	3	UB	G2P1L1	?	?	39	EMG	PRVLSCS WITH CPD	LT		3-4cm	CP	2.84	143	50	26.3
9	801	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	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	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	17/1/10	24/1/10	4	B	G4P1L1A2	20/4/09	27/2/10	38+5	EMG	PRVLSCS WITH PROM	LT		3-4cm		3.28	156	65	26.7
13	966	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	22/1/10	29/1/10	4	UB	G3P2D2	?	?	37+4	EMG	SOIU	LT		1-2cm		1.18	156	60	24.6
15	1280	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	28/1/10	4/2/2010	6	B	G4P3L2 DI	26/4/09	5/3/2010	39+3	EMG	RELATIVE CPD 2 SL	D	D	FULLY DILATED	OP	3.27	158	55	22
17	1869	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	4/2/2010	11/3/2010	2	B	G3P1L1A1	4/5/2009	11/2/2010	38+4	EMG	PRVLSCS WITH ST	LT		2-3cm		3.08	158	58	23.3
19	1967	5/2/2010	14/2/10	3	UB	G3P1L1D1	?	?	40	EMG	PRVLSCS WITH BRECH	AC	A	5-6cm		2.83	160	55	21.4

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SL NO	IPNO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS	INDICATION STAGES	AC PHASE	CERVICA	CP/BB/MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
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	29/1/09	30	EMG	SPE WITH CPD	AC	6-7cm	CP	2.92	147	65	34.2
22	14583	20	4/10/2009	10/10/2009	11/2	B	P	28/12/08	4/10/2009	40w	EMG	FD	LT	3-4cm		2.3	150	50	22.2
23	14872	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	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	3/10/09	10/11/2010	5	B	G2P1D1	22/02/09	29/1/09	35+6	EMG	PRV/LSCS WITH CPD	AC	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	7/5/12/09	7/12/11/09	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	11/2	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	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	5-6cm	A	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	6-7cm	OP	3.01	142	55	21.4
36	17743	25	26/11/09	4/12/2009	7	UB	G4P3L2D1	7/26/3/09	7/23/12/09	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	5-6cm	A	2.72	162	60	23

Cross Sectional Study of Indications for Cesarean Section

SL NO	IPNO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POG	LSCS	INDICATION	STAGES	AC PHASE	CERVIC AL	CP /BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
39	14767	18	6/10/2009	14/10/09	1	B	P	28/12/09	4/10/2009	40+2	EMG	EMG FD	LT		3-4cm		312	152	60	27.2
40	548	28	11/1/2010	18/1/10	2	UB	P	?	?	40+2	EMG	EMG FD	AC	M	5-6cm		2.98	150	65	28.8
41	15622	21	2/10/09	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	28/4/09	2/2/2010	39+2	EMG	PRV LSCS WITH THICK MSL	AC	A	4-5CM		2.91	146	58	23.3
44	15588	30	2/10/09	28/10/09	8	UB	G3P2L2	4/1/2009	1/10/2009	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	11/2	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	2/11/09	3	B	G2P1L1	9/2/2009	16/11/09	39+5	EMG	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	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	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	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	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	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	17/11/10	42+3	EMG	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	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	EMG ST	LT		3-4cm		3.08	160	55	21.4

Cross Sectional Study of Indications for Cesarean Section

SL NO	IPNO	AGE (yrs)	DOA	DOD	ML B/UB	OBS SCORE	LMP	EDD	POC	LSCS	INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	IBMI
60	2354	23	11/2/2010	21/2/10	4 UB	G2P1L1	?	?	ftp	ELC	EMG EMG DTA WITH OIL	25L	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 OLLGIO	-	-	-	-	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 OLLGIO	-	-	-	-	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	28/9/09	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	7/7/7/09	7/4/5/10	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	LWMS	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 25L	25L	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	25L	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

Cross Sectional Study of Indications for Cesarean Section

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	
83	17711	28	27/5/10	6/6/2010	6	UB	G3P1L1A1	?	38	ELC EMG	EMG SEVERE OLICOHYDROMINIOS	LT		2-3cm		2.4	150	50	21.4
84	11776	20	29/5/10	5/6/2010	3	UB	P	27/8/09	39+6	EMG	FD	AC	M	7-8cm		21	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	37+2	EMG	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	37	EMG	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	39+3	EMG	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	39+3	EMG	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	36WK	EMG	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	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	33+3	EMG	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	40+6	EMG	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	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	40+1	EMG	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	39+4	EMG	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	40+3	EMG	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	39+2	EMG	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	40+6	EMG	EMG OLICOHYDROMINIOS 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	40+1	EMG	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	37+6	EMG	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	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	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	40+5	ELC	PRV LSCS	-		-		2.61	162	60	23
105	13581	28	22/6/10	29/6/10	4	UB	G2P1L1	10/9/2009	40+5	EMG	EMG FAILURE TO PROGRESS	LT		3-4cm		3.42	158	55	22

Cross Sectional Study of Indications for Cesarean Section

SL NO	IPNO	AGE (Yrs)	DOA	DOD	ML B/AUB	OBS SCORE	LMP	EDD	POC	LSCS	INDICATION	STAGES	AC PHASE	Cervical Dilatation (cms)	CP / BB/ Dilatation Mp	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
106	13658	24	23/6/10	1/7/2010	3	B	C1P1L1	18/10/09	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	C4P2L1D1A1	?	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 WSL	LT		2-3cm		2.31	156	65	26.7
109	13755	34	24/6/10	2/7/2010	4	B	C4P1L2A1	30/10/09	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	13913	25	24/6/10	3/6/10	4	B	G3A2	3/10/2009	38+4	ELC	PRECIOUS PREGNANCY	-		-		2.11	150	50	22.2
112	1412	20	28/6/10	5/7/2010	2	UB	P	4/10/2009	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	C3P2L1D1	?	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	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	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	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	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	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	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	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	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	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	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	36	EMG	FD	LT		3-4cm		2.4	150	65	28.8
128	15732	25	7/7/10	24/7/10	2	B	P	5/10/2009	40+5	EMG	FD	LT		3-4cm		2.5	156	65	26.7

Cross Sectional Study of Indications for Cesarean Section

SL NO	IPNO	AGE (yrs)	DOA	DOD	ML B/U B	OBS SCORE	LMP	EDD	POG	LSCS	INDICATIO N	STAGES	AC PHASE	CERVICAL DILATATIO N (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
129	15759	25	18/7/10	28/7/10	1 UB	P	10/10/2009	17/7/10	40+1	ELC	EMG	25L	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 PPRM 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	2/10/09	2 B	P	?	?	ftp		EMG FTP WITH SAD	25L	D	FULLY DILATED		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	2/11/09	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	16156	24	29/10/09	6/11/2009	4 UB	G2P1L1A1	?	?	ftp		EMG PRV 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	?	?	POSTDAT ED		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



Cross Sectional Study of Indications for Cesarean Section

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									
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 OLLIGO	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	26/5/10	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

Cross Sectional Study of Indications for Cesarean Section

SL NO	IP/NO	AGE (yrs)	DOA	DOD	MLB/UB	OBS SCORE	LMP	EDD	POG	LSCS	INDICATION	STAGES	AC PHASE	Cervical Dilatation (CMS)	CP /BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
174	6978	27	31/3/10	7/4/2010	3 B	G3P1L1A1	7/6/2009	14/3/10	40+2	EMG	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	ELC	EMG FD WITH OL	25L	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	17/2009	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	3/5/2010	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	25L	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 TI-BREECH, T2-TL	LT		2-3CM		1.83, T2-	150	65	29

*Cross Sectional Study of Indications for Cesarean Section*

SL. NO	IP.NO	AGE (yrs)	DOA	DOD	ML	B/UB	OBS SCORE	LMP	EDD	POC	LSCS	INDICATION	STAGES	AC PHASE	CERVICAL DILATATION (CMS)	CP / BB/ MP	WEIGHT (kg)	HEIGHT	WEIGHT	BMI
195	4509	25	6/3/2010	13/3/10	5	UB	G3P2D2	25/5/09	4/3/2010	40+2	ELC	PRECIOUS PREGNANCY WITH FTP WITH CPD WITH PLD	AC	A	4-5CM		261	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		317	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
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

*Cross Sectional Study of Indications for Cesarean Section*

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	UNEVENT FULL	NAD	DOUBLE	30
	VD		-	-	F	7/10 & 9/10	NO	UNEVENT FULL	NAD	DOUBLE	40
SPE			-	-	M	7/10 & 9/10	NO	UNEVENT FULL	NAD	DOUBLE	30
	LD		-	-	F	7/10 & 9/10	NO	UNEVENT FULL	NAD	DOUBLE	30
			I	-	F	7/10 & 9/10	NO	UNEVENT FULL	NAD	DOUBLE	30
			I	-	M	7/10 & 9/10	NO	UNEVENT FULL	NAD	DOUBLE	40
PROM	-		-	thick	F	7/10 & 9/10	NO	UNEVENT FULL	NAD	SINGLE	15
			I	-	F	7/10& 9/10	NO	UNEVENT FULL	NAD	SINGLE	60
	PFT		I	-	M	7/10 & 9/10	NO	UNEVENT FULL	NAD	SINGLE	25
		CD	-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
	VD		-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	35
PROM		ST	I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	20
	PFT		-	-	M	3/10,7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	15
SOIU	VD		-	-	F	7/10&9/10	yes	UNEVENT FULL	NAD	DOUBLE	30
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	45
			-	-	M	4/10,7/10 & 9/10	NO	UNEVENT FULL	NAD	DOUBLE	40
	LD		-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	30
		ST	I	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	45
	VD		I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	60

*Cross Sectional Study of Indications for Cesarean Section*

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	UNEVENT FULL	NAD	SINGLE	30
			-	thin	M	7/10&9/10	yes	UNEVENT FULL	NAD	SINGLE	20
	LD		-	-	F	4/10,7/10&9/10	yes	UNEVENT FULL	NAD	SINGLE	25
PROM	PFT		-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	15
	-		-	thick	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	20
		ST	TO	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	25
			I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	10
IE	LD		-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	15
	VD		-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	35
BOH			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	50
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	45
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	30
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	45
	LD		-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	50
		FTD	-	thick	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	40
	VD	-		-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	25
	PFT		-	blood mixed	F	7/10&9/10	yes	UNEVENT FULL	NAD	SINGLE	30
	VD		-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
	-		-	thick	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	25

*Cross Sectional Study of Indications for Cesarean Section*

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	UNEVENT FULL	NAD	SINGLE	40
			-	thick	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	40
			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	40
CPL			-	-	M	7/10&9/10	yes	UNEVENT FULL	NAD	SINGLE	40
			-	THICK	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	20
			I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	303
			-	thick	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	35
		ST	I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	20
PROM			-	thick	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	25
IE	PFT		-	-	M	4/10,7/10&9/10	yes	UNEVENT FULL	NAD	SINGLE	20
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	30
			D	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	35
		ST	D	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	45
PROM	VD		-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	45
			I	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	45
			-	-	M	7/10&9/10	yes	UNEVENT FULL	NAD	SINGLE	40
			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	40
MA			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	25
MA			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	25
-		ST	TO	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30

*Cross Sectional Study of Indications for Cesarean Section*

cccccccc c	CTG	OTHERS	SCAR	MECONI UM	SEX	APGAR	NICU	POST OPERATIV E PERIOD	AT DISCHAR GE	UTERUS CLOSURE	DECISION TO CS(min)
SA			-	THIN	F	6/10&9/10	YES 5	UNEVENT FULL	NAD	SINGLE	20
			I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	24 HRS
SO			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	24 HRS
			I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	24 HRS
SPE WITH SOIU			-	-	M	7/10&9/10	YES	UNEVENT FULL	NAD	DOUBLE	24 HRS
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	45
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
		CD	-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	45
SO			I	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	24 HRS
			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	35
PROM	LD		-	THIN	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
IE			-	-	M	3/10,7/10	yes	UNEVENT FULL	NAD	SINGLE	35
SPE		CD	-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	40
			I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	24 HRS
		ST	D	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	45
PE			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	40
			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	50
	VD		-	THIN	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	45
			-	-	M	5/10&9/10	yes	UNEVENT FULL	NAD	SINGLE	35
PP	-	-	-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
IE			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	20
			I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
SOIU	VD		-	-	F	6/10&7/10	yes	UNEVENT FULL	NAD	SINGLE	40

*Cross Sectional Study of Indications for Cesarean Section*

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	UNEVENT FULL	NAD	SINGLE	20
			I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	24 HRS
SO			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	24 HRS
			I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	24 HRS
SPE WITH SOIU			-	-	M	7/10&9/10	YES	UNEVENT FULL	NAD	DOUBLE	24 HRS
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	45
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
		CD	-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	45
SO			I	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	24 HRS
			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	35
PROM	LD		-	THIN	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
IE			-	-	M	3/10,7/10	yes	UNEVENT FULL	NAD	SINGLE	35
SPE		CD	-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	40
			I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	24 HRS
		ST	D	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	45
PE			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	40
			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	50
	VD		-	THIN	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	45
			-	-	M	5/10&9/10	yes	UNEVENT FULL	NAD	SINGLE	35
PP	-	-	-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
IE			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	20
			I	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
SOIU	VD		-	-	F	6/10&7/10	yes	UNEVENT FULL	NAD	SINGLE	40



*Cross Sectional Study of Indications for Cesarean Section*

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	UNEVENT FULL	NAD	SINGLE	25
CPP			-	-	M	1/10,3/10,5/10&6/10	yes	UNEVENT FULL	NAD	SINGLE	20
	VD		-	THICK	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	25
PROM	PFT		-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
CPP			-	-	M	MSB	NO	MSB	NAD	DOUBLE	25
			-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	24 HRS
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
PROM	LD		-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	35
MA WITH PROM		CB	I	-	M	4/10,7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	25
SOIU	VD		-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	45
	LD		-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	40
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	30
SPE			-	-	M	7/10&9/10	yes	UNEVENT FULL	NAD	DOUBLE	35
			I	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
AE	VD		-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	20
			-	-	M	1/10&5/10	yes	BABY TAKEN	NAD	DOUBLE	30
			-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	20
	VD		-	-	F	7/10&9/10	yes	UNEVENT FULL	NAD	DOUBLE	25
	PFT		-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
			I	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	35
		ST	D	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
PROM	LD		-	-	M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	25
	VD		-	-	F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	35

*Cross Sectional Study of Indications for Cesarean Section*

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	UNEVENT FULL	NAD	SINGLE	20
	PFB		-	THIN	F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	35
APH					M	7/10&9/10	es,lda	UNEVENT FULL	NAD	SINGLE	35
PROM				THICK	M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	20
PPROM					M	5/10,7/10&9/10	,1MO	UNEVENT FULL	NAD	SINGLE	20
			I		M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	24HRS
	LD				F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	30
					F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	25
	PFT				F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	25
G-HTN					F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	20
RHD WITH MR	LD				F	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	35
					M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	30
PE	LD				M	7/10&9/10	S,4DA	UNEVENT FULL	NAD	DOUBLE	25
					M	7/10&9/10	NO	UNEVENT FULL	NAD	DOUBLE	35
					F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	40
			I		F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
					F	6/10&8/10	NO	UNEVENT FULL	NAD	DOUBLE	25
			I		F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	24HRS
			TO		M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	25
					M	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	25
			I		F	7/10&9/10	NO	UNEVENT FULL	NAD	SINGLE	30
AE					M	FSB	NO	UNEVENT FULL	NAD	SINGLE	30

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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	-10D	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-1D	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

*Cross Sectional Study of Indications for Cesarean Section*

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
					TI-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