"SAFETY AND EFFICACY OF ADDING SINGLE DOSE ADJUNCTIVE AZITHROMYCIN PROPHYLAXIS FOR EMERGENCY CESAREAN DELIVERY"

BY

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In partial fulfilment of requirements for the award of the degree of

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Under the guidance of

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I hereby declare that this dissertation titled "**SAFETY AND EFFICACY OF ADDING SINGLE DOSE ADJUNCTIVE AZITHROMYCIN PROPHYLAXIS FOR EMERGENCY CESAREAN DELIVERY**" is a bonafide and genuine research work carried out by me under the supervision and guidance of **Dr. SHOBHA SHIRAGUR (prof)**, Department of Obstetrics and Gynaecology, Shri B. M. Patil Medical College and Research Centre, Vijayapura.

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ABBREVIATIONS

S.No	ABBREVIATIONS	EXPANSION
1	ACOG	American College of Obstetrician and Gynaecology
2	CS	Caesarean Section
3	SSI	Surgical Site Infection
4	DCC	Delayed cord clamping
5	AZM	Azithromycin
6	IUGR	Intra Uterine Growth Retardation.
7	LBW	Low Birth Weight
8	LSCS	Lower Segment Caeserean Section
9	VTE	Venous Thromboembolism
10	SD	Standard deviation
11	SE	Standard error
12	SGA	Small for Gestational age.
13	SFH	Symphysio fundal Height.
14	SD	Standard Deviation.
15	USG	Ultrasonography
16	AFI	Amniotic fluid index
17	WHO	World Health Organisation
18	VBAC	Vaginal birth after cesarean section

19	PTVD	Pre-term vaginal delivery
20	FTVD	Full term vaginal delivery

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ABSTRACT

Introduction

Cesarean sections have seen a significant increase in India from 17.2% to 21.5% between 2016 and 2021, driven by factors such as increased maternal requests, physician preference, financial incentives, social-cultural and religious reasons, and fear of legal consequences. These surgeries can be lifesaving but can also lead to adverse health outcomes like maternal infection, uterine bleeding, infant respiratory distress, and hypoglycemia. Surgical site infections (SSI) are a prevalent complication in emergency cesarean sections in India, with a prevalence of 5%-10%. Preventive measures include prophylactic antibiotics, aseptic techniques, early skin-to-skin contact, and breastfeeding. A 2014 Cochrane review found that routine antibiotic prophylaxis reduced wound infection, postpartum endometritis, and maternal severe infectious complications by 60% to 70%. Azithromycin is being researched as a possible preventive measure to decrease SSI during cesarean sections.

Aim and objectives of the study

The study evaluates the safety and effectiveness of single-dose adjunctive Azithromycin prophylaxis for emergency cesarean delivery. It aims to monitor postoperative complications like endometritis, surgical site infections, fever, skin erythema, re-admissions, and hospital stay duration. Secondary objectives include preventing neonatal complications like sepsis, respiratory distress syndrome, and NICU stay duration.

Materials and methods

This study was conducted at Shri B.M. Patil Medical College Hospital in Vijaypura, India, involving pregnant women with singleton pregnancies and gestational age of 24 weeks or more in labour. The study included patients undergoing emergency cesarean sections, membrane rupture within 12 hours or PROM, and previous cesarean sections. Exclusion criteria included patients unable to provide consent, known allergies to azithromycin, use of azithromycin 7 days before randomisation, chronic conditions, liver diseases, increased serum creatinine level, dialysis patients, cardiomyopathy, pulmonary oedema, electrolyte abnormalities, pre-eclampsia, and PROM more than 12 hours. The study lasted from September 2022 to March 2024, with 520 participants. Statistical analysis was performed using JMP-SAS Software, with results presented as mean ± S.D., counts and percentages, and diagrams. Comparisons were made using independent t-tests, Mann-Whitney U tests, Chi-square test/Fisher's Exact tests, and regression analysis for relative risk. A p-value of <0.05 was considered statistically significant.

Results

The study revealed several statistically significant differences between Group A, which received azithromycin before a cesarean section, and Group B, which did not. Postoperative symptoms were one key area where the two groups differed. Group B had significantly higher incidences of erythema ($p=0.002$), induration ($p=0.003$), and wound discharge ($p=0.025$) compared to Group A. These findings suggest that the administration of azithromycin prior to surgery may help reduce the occurrence of these postoperative complications.

Furthermore, the follow-up assessments on the 7th and 14th days after surgery showed that Group A had a significantly higher proportion of normal findings than Group B. At the second follow-up on the 7th day, the difference was statistically significant (p=0.041), indicating that patients who received azithromycin were usually more likely to recover. This trend continued at the third follow-up on the 14th day, with Group A having a significantly higher proportion of normal findings (p=0.023) than Group B.

The study also found significant differences in NICU admissions and the need for secondary suturing between the two groups. Group B had a significantly higher percentage of NICU admissions (p=0.024) compared to Group A, suggesting that the use of azithromycin before cesarean section may have a protective effect on newborns. Additionally, Group B had a significantly higher percentage of participants requiring secondary suturing (p=0.048) than Group A, indicating that the antibiotic may help reduce the need for additional surgical interventions post-cesarean.

Conclusion

In conclusion, administering azithromycin before cesarean section in Group A was associated with better postoperative outcomes across several key indicators. The group that received the antibiotic had lower rates of postoperative symptoms, abnormal follow-up findings, NICU admissions, and secondary suturing than the group that did not receive azithromycin. These statistically significant differences highlight the potential benefits of azithromycin prophylactically in cesarean section procedures.

Keywords

Azithromycin, Cesarean section, NICU admissions, Postoperative symptoms

INTRODUCTION

Cesarean sections are the most commonly performed surgical intervention for childbirth on a worldwide scale. From 2016 to 2021, the incidence of C-sections in India has increased from 17.2% to 21.5%. [1]

The rise of the percentage of cesarean section births worldwide, and specifically in India, has been the subject of several research. [2] The incidence of cesarean sections (C-sections) exhibits substantial variation across different nations and regions. Conversely, sub-Saharan Africa has the most minimal rates, with a mere 5% of newborns relying on cesarean procedures. The rates of CS have risen Globally from 7% in 1990 to 21% today, surpassing the WHO's acceptable rate of 10%-15%. These trends will increase to a globally to a rate of 29% by 2030. The rapid rise in cesarean section (CS) rates can be linked to various nonmedical factors, including increased maternal requests due to anxiety, pain, or desire to have a baby on some specific day, and incentives from hospitals with more CS rates. Social-cultural and religious reasons also influence and discourage cesarean requests in some societies. Fear of legal consequences due to adverse outcomes from vaginal delivery (VD) also influences the clinicians to perform LSCS. [2]

Cesarean section (CS) deliveries could be helpful for mother and child. Still, they can lead to adverse health outcomes like maternal infection, uterine bleeding, infant respiratory distress, and hypoglycemia.[3] Cesarean delivery causes a higher rate of infection at site of surgery (5-10 times higher than vaginal delivery). [4] Due to the consistent global rise in CS rates, SSI has become a significant problem. Surgical site infections (SSI) may lead to substantial illness, extended hospital stays, and diminished quality of life. At times, SSI may result in sepsis and

maternal mortality. [5] Surgical site infection (SSI) is a prevalent complication in surgeries, particularly in emergency cesarean sections (ECS) in India, with a prevalence of 5%-10%. Factors contributing to SSI include prolonged membrane rupture, multiple vaginal examinations, obesity, diabetes, and urgency. Preventive measures include prophylactic antibiotics, aseptic techniques, early skin-to-skin contact, and breastfeeding.

Antibiotic prophylaxis is very much suggested for women undergoing cesarean section until they receive antibiotics with coverage of broad-spectrum. It prevents infection at site of surgery by reducing bacterial contamination during surgery. [6]

A first-generation cephalosporin, a narrow-spectrum antibiotic, should be used routinely before a cesarean section, according to current guidelines for antibiotic prophylaxis.[5] The first-generation cephalosporins include extended-spectrum antibiotics. The ACOG approved the inclusion of azithromycin in the standard antibiotic treatment for women on whom non-elective C-sections (Cs) are done in September 2018. [7] Various randomized control trials conducted at a single site have shown that the administration of azithromycin-based extended-spectrum prophylaxis, which involves a one dose of Tab azithromycin in addition to cephalosporin prophylaxis, leading to a reduced likelihood of infection after cesarean section than the use of standard prophylaxis alone. Effectiveness of this prophylactic has been attributed to its ability to provide coverage against ureaplasma species, often linked to infections after cesarean delivery. [8]

Azithromycin is an antibacterial drug belonging to the macrolide class. It binds to a specific part of the bacterial ribosomal subunit called 23S, found in the larger 50S subunit. This binding action prevents the production of bacterial proteins by

blocking the movement of aminoacyl-tRNA and developing protein. [9] It has a lower susceptibility to dissociation from the ribosome in gram-negative bacteria, which enhances its efficacy against gram-negative pathogens. Azithromycin functions as a bacteriostatic drug, impeding the development of bacteria instead of outright exterminating them. It had bactericidal properties at higher concentrations. It rapidly traverses from circulation into tissues and passes cellular membranes, making it very efficient against intracellular infections. Azithromycin hinders the functioning of the 50S ribosome in the apicoplast of non-bacterial organisms. Although azithromycin is known for its efficacy, it is typically well-tolerated and associated with a low incidence of adverse effects. Frequent adverse reactions include symptoms such as diarrhea, nausea, and vomiting. Azithromycin, frequently prescribed for a range of bacterial infections, is currently being researched as a possible preventive measure to decrease the likelihood of surgical site infection (SSI) during cesarean sections. ACOG acknowledges azithromycin prophylaxis as a viable option for high-risk women, with future guidelines influenced by further research and clinical considerations. [9]

NEED FOR STUDY

Emergency cesarean deliveries are linked to an increased risk of post OP infection as compared to vaginal deliveries. Current standard care involves administering prophylactic antibiotics, such as cefazolin, before surgical incision. However, post-cesarean, infectious morbidities like infection of wound, endometritis, and urinary tract infection persist. Azithromycin, a broad-spectrum macrolide antibiotic, has shown efficacy in reducing infectious complications when combined with standard prophylactic antibiotic regimens. However, existing evidence has limitations, including small sample sizes and varying dosing regimens. A RCT will be required to definitively evaluate the safety and efficacy of adding a one dose of adjunctive azithromycin to prophylactic antibiotic regimens for emergency cesarean deliveries.

AIM & OBJECTIVES OF STUDY

AIM

To study the safety and effectiveness of single-dose adjunctive Azithromycin prophylaxis for emergency cesarean delivery

OBJECTIVES: to observe for the following postoperative complications

1. Endometritis

2. Surgical site infections include wound gaping, serous, and purulent discharge.

3. Fever, cough

4. Erythema of skin, cellulitis, induration.

5. Unscheduled visits and re-admissions.

6. Length of hospital stay.

Secondary Objectives: The addition of azithromycin will prevent neonatal complications like:

1. Sepsis.

2. Respiratory distress syndrome.

3. Periventricular leukomalacia, intra-ventricular hemorrhage.

4. Systemic inflammatory response syndrome (SIRS)

5. Bronchopulmonary dysplasia.

6. Duration of NICU stay

REVIEW OF LITERATURE

Cesarean delivery is defined as delivery of the fetus through surgical incisions which are made through the abdominal wall (laparotomy) and the uterine wall (hysterotomy). The early days of CS are a mix of myth and mystery. In Germany, the operation was termed 'Kaiser Schnitt' (Emperor's cut) until the end of the First World War. Early reports showed operations were done on the dead mother in an attempt to save baby. Still, there were other accounts of desperate women in obstructed labor being operated upon by their husbands or even operating on themselves and with the survival of mother and child. More recent descriptions have appeared of eyewitnesses who have recorded such events. [10]

The first cesarean section was done in the British Isles and was performed by an experienced, midwife named Mary Donnelly in the year 1738. The patient was a farmer's wife, aged 33, who already had several children and had been in labor for 12 days. The midwife opened the abdomen and the uterus with a razor and delivered a dead fetus. She held the wound meanwhile a neighbor ran a mile to get a tailor's needle and thread to close the abdominal wall.

William Smellie is considered as the father of 'modern' obstetrics. The standard practice in those days involved the management of obstructed labor was to perform a destructive operation on the fetal head (craniotomy) and deliver the fetal parts

piecemeal. The introduction of anaesthesia in the 1840s, first using ether made the cesarean section more painless and safer. In earlier days, indications were mostly for obstructed labour due to deformities in pelvis or obstruction from an ovarian or another pelvic tumor. [10]

A gynaecologist named Max Sanger who was German introduced the suturing technique of the vertical uterus incision, which was a common and sometimes leads to complication which can be lethal.[10] TG Thomas first successfully performed the lower segment operation for mother and child in 1878.

India's cesarean deliveries increased from 17.2 to 21.5% between 2015-16 and 2019-21, [1] with Karnataka seeing a significant increase from 30.7% in 2018-19 to 41.8% in 2023-24, according to data from the Health and Family Welfare Department. [11] Today, the Dominican Republic – having the highest rate at 62.9%. [10] Social factors, healthcare professionals' attitudes towards the procedure, and women's attitudes contribute to this high rate. Planned sections are now the most commonly used for breech presentations, and placenta previa. The prevalence of cesarean births in India has seen a significant surge, rising from 3% in 1992-93 to 17% in 2015-16 and further to 21.5% in 2019-21. [12]

Cesarean Section

Definition

Caesarean delivery is the surgical method defined as the birth of a fetus through incisions made in both the abdominal wall (laparotomy) and the uterine wall (hysterotomy). [12] It is important to note that this definition excludes explicitly

instances involving the removing of fetus from abdominal cavity in cases of abdominal pregnancies or in situations where there is a uterine rupture. [14]

Types of Cesarean Section

Multiple Cesarean section (CS) methods are available, which are essentially classified according to the specific incisions done on the uterus and skin.

A) Classification by Dissection Method

1. Classical Cesarean Section: A longitudinal incision along the midline provides a larger delivery region. Nevertheless, its execution seldom results from increased complexity.

2. Lower Uterine Segment Section: This often performed operation involves making a cross-sectional incision just above the bladder's margin, which leads to less blood loss and easier healing.

3. One other kind of uterine incision is the **Lower Vertical Incision.**

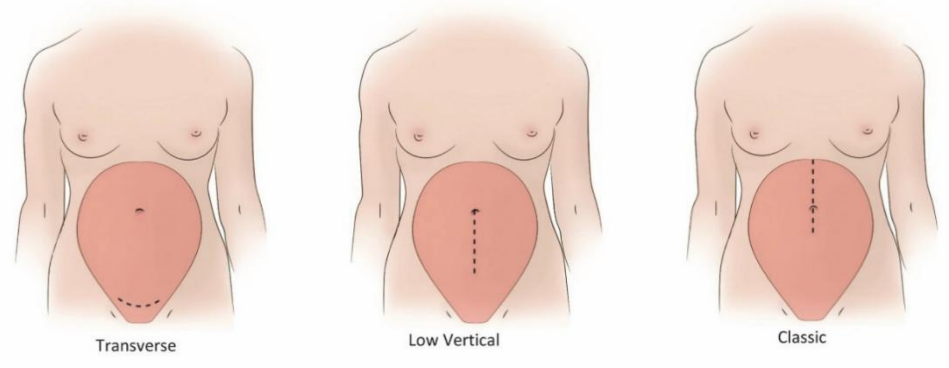


Fig 1 Classification of Cesarean Section based on dissection [uterine incision]

B) According to the timing [14]

1. Crash/Emergent/Emergency Cesarean Section: Executed during sudden obstetric emergencies in labor to avert maternal, fetal, or dual fatalities.

2. Planned Cesarean (Elective/Scheduled): This procedure is pre-planned, mostly for patients nearing the EDD.

C) Other types

1**. Cesarean Hysterectomy:** This procedure involves performing a CS followed by the removal of the uterus, usually in situations when there is excessive bleeding or difficulties with the placenta.

2. Conventional Approaches: Historically used techniques, such as extraperitoneal sections.

3. **Repeat Cesarean Section:** It is performed on patient who previously had CS, with the procedure applied via the previous scar.

Indications for CS

A CS is advised when the potential danger to the mother or baby's well-being arises from the risks connected with vaginal birth. Some circumstances indicate they do not need a Caesarean section, and the obstetrician often decides the choice. [12]

Absolute Indications [14]

- CPD
- central placenta previa
- abruptio placentae
- transverse lie
- triplet pregnancy, monochorionic monoamniotic twins

- mechanical obstruction of vaginal birth
- vasa previa
- HIV-infected pregnancy and Genital Herpes
- Precious fetus [high-risk fetus]
- Postmortem delivery

Relative Indications [14]

- Non-reassuring fetal status,
- Maternal complications
- twin pregnancy
- Malpresentation, shoulder presentation
- Previous Cesarean Section
- Prior Problems with Perineum Healing
- Bicornuate Uterus
- Dystotica
- Bad obstetric history
- Failure of progression

C-Section Procedure

Anesthetics

Cesarean sections can be performed using general and regional anesthesia, with regional anesthesia being preferred for immediate mother-baby interaction. Standard techniques include spinal and and epidural anesthesia. Regional anesthesia provides more intense nerve block due to heightened pain during surgery, unlike labor analgesia. Dermatomal anesthesia for Caesarean delivery will set at a higher level than labor analgesia. [14]

Advantages of Regional anesthesia

The use of anesthesia in Caesarean section deliveries, particularly in the immediate interaction between mother and newborn, is a preferred method due to its effectiveness in pain relief during surgical procedures, reducing typical risks.

Key Factors to Consider in General Anesthesia

General Anesthesia is essential in cases where regional anesthesia poses risks to the mother or child, particularly in heavy bleeding where hemodynamic effects may be poorly tolerated, and preferred in cases like severe fetal distress. [12]

Ensuring the comfort and safety of the mother during the C-Section is a critical stage, whereby the selection of anesthetic is customized to suit individual circumstances and medical needs.

Preoperative Examination and Preparation [14]

Maternal Examination

Pre-operative testing includes blood, respiratory function, chest radiography, ECG, and urine analysis. Before entering the surgical room, vaginal douching, cervical dilation, and fetal station confirmation are done. If the cervix is closed, Hegar dilators should be ready for cervical canal dilation. Confirming the fetal position is crucial since it affects fetal head delivery difficulties. Before cesarean section, it is crucial to check the presentation of fetus with examination and ultrasound.

If a repeat cesarean section is needed, gather information regarding the prior procedure. Preoperative ultrasonography checks if there is adhesion between walls or if the bladder has been lifted. Our hospital provides a checklist for the standard record. The checklist includes Bishop's score during surgery, indication, abdominal cavity state, and items to remember for future cesarean sections. It helps forecast abdominal cavity status during the following operation.

Fetal Examination

Ultrasonography should assess fetal lie, body weight, placenta placement, and amniotic fluid.

Complications and Informed Consent

Cesarean-section complications include bleeding, bladder/ureteral injuries, intestinal tract injuries, fetal injuries, sleeping babies, postoperative DVT, and scarring. The difficulty level varies based on past surgery, weight, maternal problems, and other factors. The following criteria should be considered when getting informed consent:

Preparation for Caesarean Section

To avoid compression of the vena cava and supine hypotension syndrome, it is recommended to tilt the mother's right side laterally at a 15-degree angle. [15] For women with ruptured membranes and those in labor, preparing the vagina using iodine solution can reduce the risk of endometritis. [16] While fixing an catheter is common for cesarean sections, a randomized controlled trial (RCT) revealed that the uncatheterized group experienced a significantly lower incidence of UTI, shorter time to patient movement and better postoperative micturition. Until evidence proves otherwise, it is prudent to continue the practice of urinary bladder catheterization to avoid bladder or ureteral injury.

Prophylactic Antibiotics

Prophylactic antibiotics are beneficial in decreasing the frequency of endometritis and infection of wound in labour and nonlabour cesarean sections (CDs). They should be given 30-60 minutes before skin incision. [17] First-generation cephalosporin is the most preferred antibiotic for prophylaxis. [18] No advantage

was shown with broad-spectrum prophylaxis, except for women who does not receive antibiotic prophylaxis for CD. One-dose therapy is as useful as multidrug therapy. For women with clinical chorioamnionitis, combination therapy can supplant prophylaxis if given within the appropriate time frame of the skin incision.

This rigorous preparation prevents infection, reduces aspiration risks, and guarantees medical experts are available for the mother and infant before and after the Caesarean delivery.

Precesarean thromboprophylaxis

Venous thromboembolism (VTE) is a grave medical condition that can result in maternal mortality. The risk of VTE is heightened after cesarean delivery, making thromboprophylaxis a crucial prevention measure. Mechanically it is done by compression stockings or pneumatic compression devices is recommended during and after every cesarean delivery until the patient can walk. [19]

Site preparation

Adequate skin preparation is vital for successful wound healing as it minimizes the risk of infection by removing skin contaminants and flora. While shaving is not mandatory, some suggest trimming the hair at the site of surgery on the day of surgery for improved skin edge alignment. The incision area is then cleansed with a surgical scrub, with chlorhexidine-alcohol scrub being the more practical option for reducing infection risk compared to povidone-iodine scrub. [20]

Abdominal Skin Incision and Abdominal Entry

Choosing the proper surgical technique is crucial to minimise blood loss and tissue trauma during cesarean delivery (CD). [21] This decision, which involves selecting

between a transverse or vertical incision, is a testament to the surgeon's precision and expertise. The transverse Pfannenstiel incision, most commonly used in the US, is often chosen based on factors such as the urgency of the delivery, placental disorders, and to explore the abdomen for non-obstetric reasons. [22] Vertical incisions, once routine in the US and Europe, have been replaced mainly by transverse incisions since the 1980s.

The Pfannenstiel incision is widely favoured worldwide. It was initially designed for abdominal hysterectomy, offers more accessibility as a vertical incision and is preferred. The prior skin incision is utilised for most repeat CDs, highlighting the global preference for the Pfannenstiel incision. [23] (Figure 1)

Transverse skin incisions, particularly the Pfannenstiel type, are preferred over vertical incisions. In transverse Pfannenstiel incision is used, it is made about two finger breadths above the symphysis in the midline. The incision needs to be done on basis of the fetal size. This detailed process helps the surgeon to understand the procedure better.

Sometimes incision of muscles can be required for exposure and space to deliver the fetus. In this, only the medial half of the muscle is incised to prevent laceration of epigastric vessels. Complete transection of the rectus muscles is referred to as the Cherney incision, which will require identification of the epigastric vessels and ligation. [24]

Once the fascial incision is completed, the fascia is separated from the rectus muscles by dissection. The point of entry is consistently chosen as superior as possible to avoid injury of bladder, particularly in repeat operations where the bladder may adhere superiorly. These safety measures helps ensure the surgeon's confidence and the patient's safety.

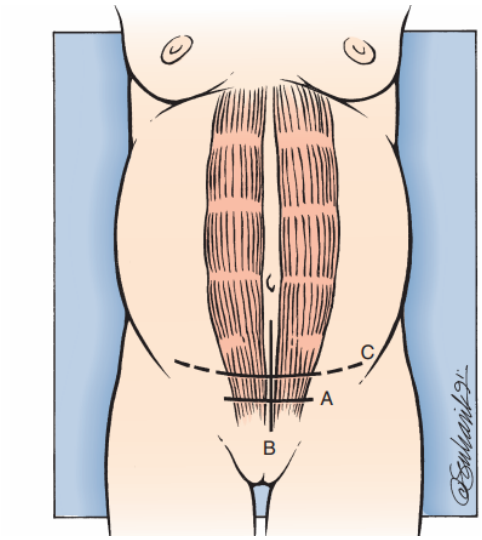


Figure 2. Different abdominal incisions

Bladder Flap

A study comparing the creation of a bladder flap and a direct uterine incision above the bladder fold in 581 women found no significant difference in injury to bladder, total operating time and blood loss. The trials were heterogeneous, with two being of poor methodologic quality and one unpublished. [25] The study concluded that creating a bladder flap does not gain any direct advantage.

Uterine incision

The uterine incision is a crucial procedure in pregnancy, involving the surgeon palpating for fetal presentation, placing a bladder retractor to look for the lower uterine segment. The low transverse uterine incision has replaced the vertical uterine incision at the beginning of the 20th century due to its lower blood loss, ease of performance and repair. (Figure 2)

A low transverse incision begins at least two cm above the bladder margin. If considerable bleeding occurs, tamponade with sponges can be performed, allowing

better visualization and minimizing the chance of laceration. The incision is extended laterally and superiorly by index fingers.

Vertical uterine incisions are performed very rarely and are low or classical. The disadvantages of a classical incision include more excellent adhesion and a greater risk of uterine rupture in next pregnancy. (Figure 3) [26] [27]

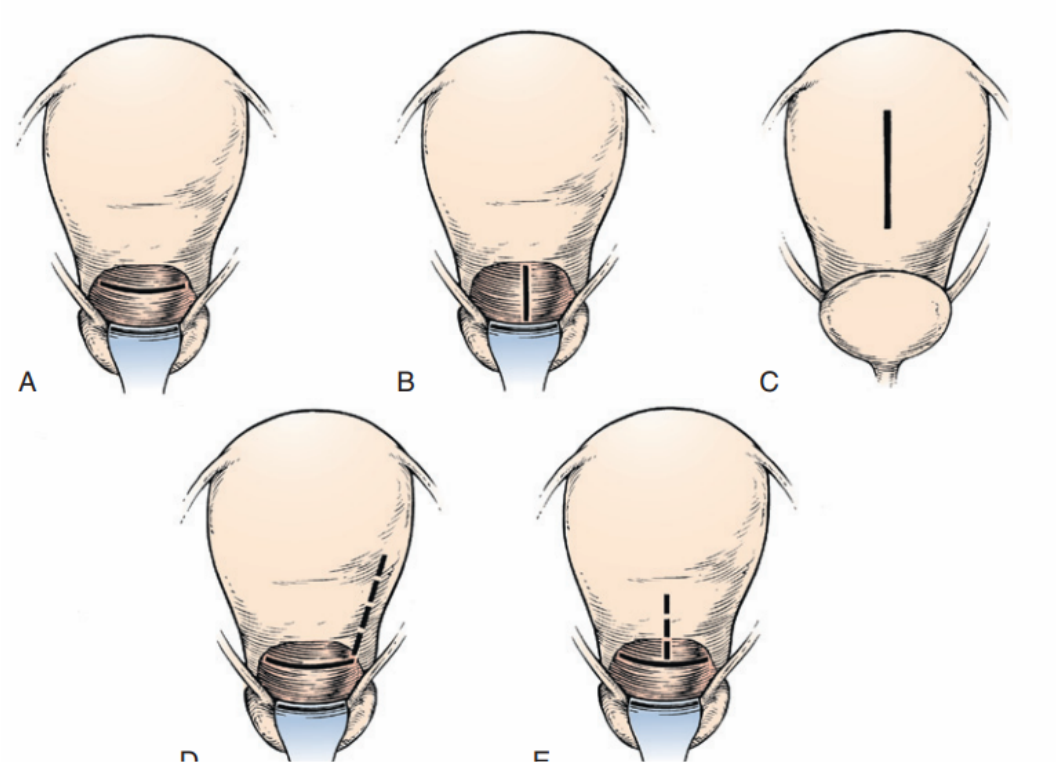


Figure 3. Uterine incisions for cesarean delivery

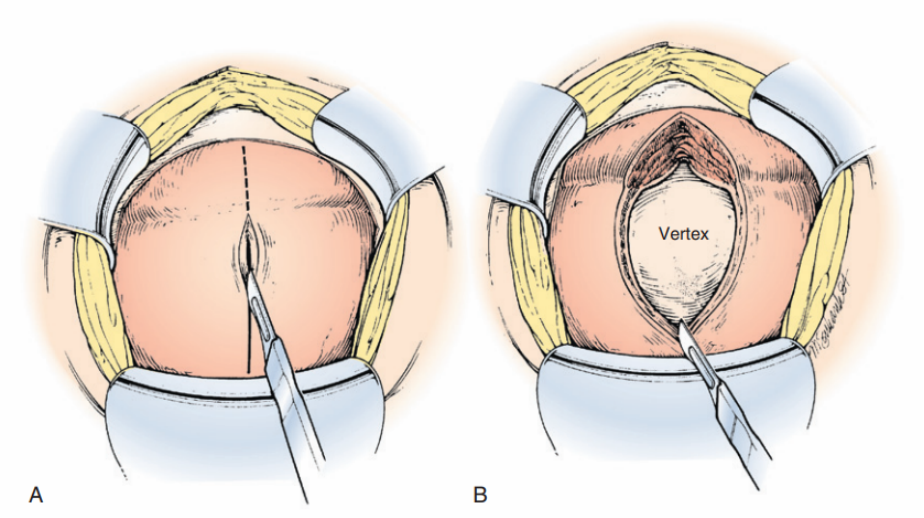


Figure 4: Low vertical incision

Delivery of the fetus

Postpartum surgery involves the extraction of the fetal head by elevating and flexion using the operator's hand as a fulcrum. Adequate pressure on fundus is crucial for delivery, and if the head is not efficiently delivered, the uterine incision may be extended. Forceps and vacuum extraction are rarely needed and should be avoided. Reverse breech extraction, often used in advanced second-stage arrest. Vacuum extraction should be avoided as they are not necessary if the steps are done correctly. Delayed cord clamping (DCC) for 30 to 120 seconds can cause increased placental transfusion, increasing neonatal blood volume at birth. DCC is suggested for all deliveries before 37 weeks. Preventing postpartum haemorrhage and phototherapy is crucial for a healthy pregnancy. [28] [29]

Prevention of postpartum hemorrhage

Postpartum hemorrhage can be prevented by intravenous (IV) oxytocin administration, which is given as drip after delivery. Studies suggest that 10 IU of oxytocin diluted in 1 L infusion over 4 to 8 hours prevents uterus atony and postpartum haemorrhage. Misoprostol should not be preferred instead of oxytocin. Pre-incision administration of tranexamic acid (10 mg/kg IV) decreased blood loss and the need for uterotonics. Postdelivery carbetocin administration (100 μg) also reduces the need for uterotonics. [24]

Placenta extraction

Placental extraction using spontaneous expulsion with gentle cord traction leads to lower blood loss and a lower endometritis rate. So, it is recommended to perform this method with uterine massage, as intraoperative changing of glove will not reduce endometritis risk. [24]

Uterine Repair

Uterine repair is a surgical procedure that involves lifting the fundus and delivering the uterus through an abdominal incision. Compared to intraabdominal repair, uterine exteriorisation allows for better visualisation of the incision without significantly increasing risk of blood loss, infection, hypotension, or nausea and vomiting. Whether to perform uterine exteriorisation depends on preference of surgeon. [24]

The first layer of uterus closure is done using continuous suturing. Full-thickness repair involves endometrial layer with improved healing. Lower uterine incisions can be closed with either a single or double layer of sutures. Single-layer closure causes less reduction in loss of blood, duration of the procedure, and postoperative pain when compared with double-layer closure. (Figure 4) [24]

A vertical uterine incision generally requires at least a double-layer, or more often a triple-layer, closure technique. The uterine incision should be looked for hemostasis before placing the uterus into the peritoneal cavity, and individual bleeding points are cauterised or ligated. (Figure 5)

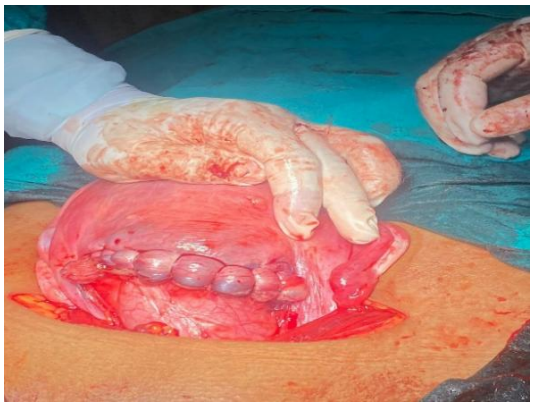


Figure 5: Closure of Uterine Incision

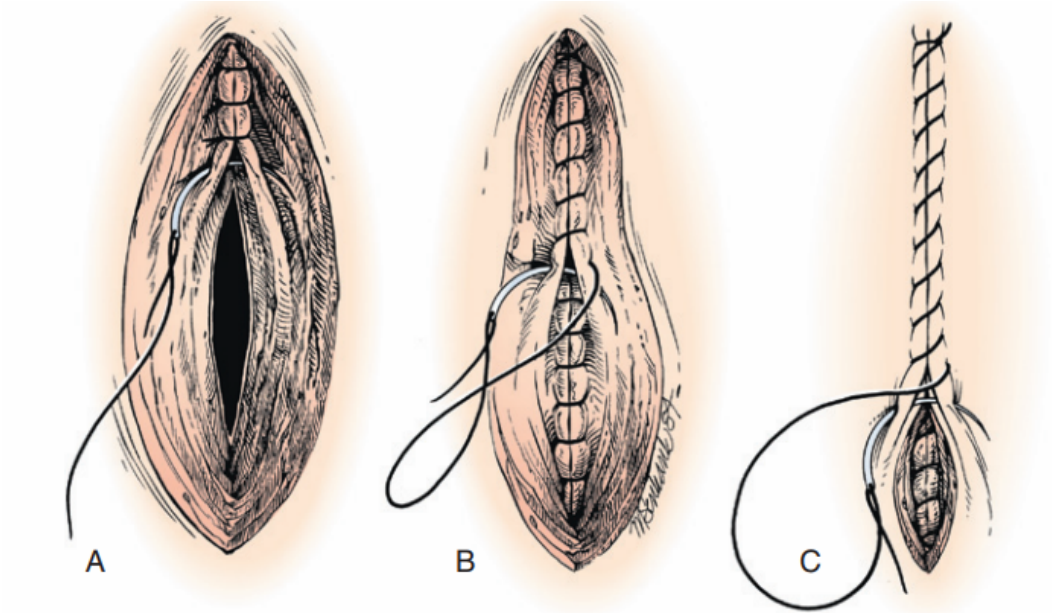


Figure 6 Repairing a classical incision involves a three-layer closure

Abdominal closure

The parietal and the visceral peritoneum are not sutured together again, as they naturally close on their own after a few days. This approach, not suturing the peritoneum, has significantly reduced surgery time, fever incidence, hospital stay, and the need for pain relief medication compared to suturing. While closing the parietal peritoneum may potentially reduce subsequent adhesions, more reliable data is needed to confirm this benefit.

No studies have assessed the technical elements of closing the fascia during cesarean section (CD). The rectus fascia, a dense connective tissue layer, is often sutured continuously nonlocking, but some individuals may choose interrupted sutures with vicryl no 1 reverse cutting. Due to the fascia's low vascularity, meaning it has a limited blood supply, it is not tightly secured to prevent strangling, which might lead to an increased risk of fascial dehiscence. Any suture with high tensile strength should be absorbed at a slower rate.

Synthetic monofilament sutures are recommended for transverse incisions. Position the sutures at least 1 cm away from the edge of the incision and insert them at intervals of around 1 cm. Patients who are at risk of wound disruption will be benefitted from a specific technique known as the Smead-Jones procedure, which involves interrupted figure-of-eight suturing using delayed absorption of suture material. Subcutaneous tissue should be sutured if it will aid in the skin's closure. Closure of subcutaneous tissue with sutures of at least 2 cm in length is linked to a reduced occurrence of wound complications. (Figure 6) [32] [33]

Subcuticular sutures are recommended over staples. Subcuticular sutures are closed with monocryl 3-0. T mattress sutures are closed with ethilon 2-0 when

sealing the transverse cesarean skin incision. Suture closure has shown to decrease the risks of wound complications, including wound separation, by a significant 57%. While staple closure may result in a time reduction of about 7 minutes compared to suture closure, the latter's benefits in patient outcomes make it the preferred option. [34][35]

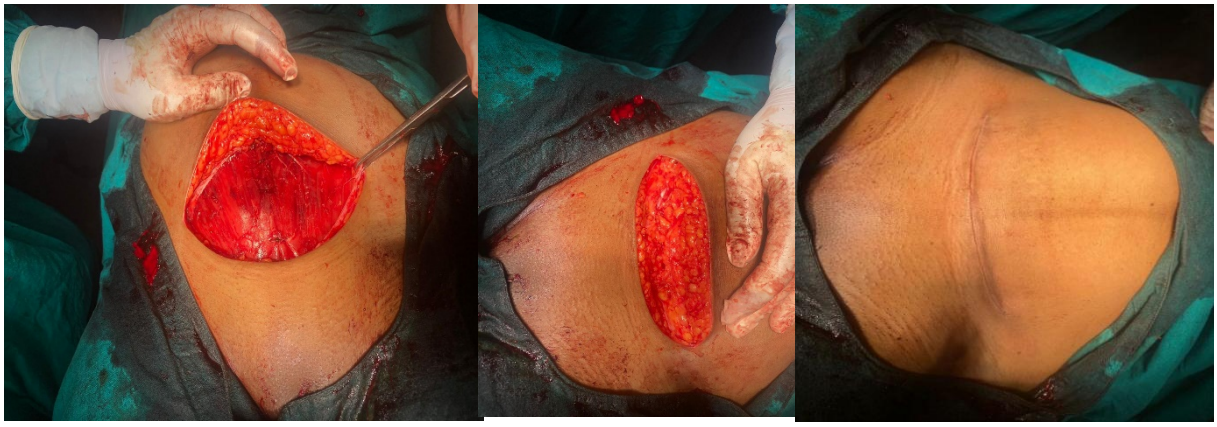


Figure 7 Muscle closure, Rectus sheath closure, Skin closure

Postoperative Management [14]

Postoperative care following a cesarean section is crucial for the mother's well-being and a smooth recovery. The management plan aligns with standard protocols for significant surgery patients, with specific considerations tailored to the obstetric context. Key measures include preventing thrombophlebitis and thromboembolism, removing the urinary catheter, promoting early oral feedings, and individualised discharge planning.

Thrombophlebitis and thromboembolism are emphasised, with spontaneous leg movement and early ambulation being emphasized to reduce complications.

Urinary catheter removal is typically done on the first postoperative day to facilitate early mobilization.

Early initiation of oral feedings replenishes energy levels, supports healing, and ensures the mother's nutritional needs are met.

Discharge planning is individualised based on medical condition, with reasons for extended hospital stay documented in the patient's record. Home care support is essential for patients opting for early discharge, ensuring the mother receives necessary assistance and monitoring during the initial stages of recovery.

The postoperative management plan promotes a holistic recovery, addressing surgical aspects and unique considerations of postpartum care. A collaborative approach between healthcare providers and the patient contributes to a successful postoperative outcome.

Risks of Caesarean Section

Maternal risks

Maternal complications associated with cesarean birth include the occurrence of preoperative or post-operative issues. According to the ACOG, there is a significantly increased risk of pregnancy-related mortality in women who have cesarean delivery, with a rate of 35.9 deaths per 100,000 live births, as compared to women who can deliver vaginally, who experience a rate of 9.2 deaths per 100,000 live births. [13] It is important to acknowledge that women who have serious medical issues or pregnancies with more significant risk may need a Caesarean section, which might distort mortality statistics.

COMPLICATIONS OF CAESARIAN SECTION [14]

1. **Anesthesia-related**

   Aspiration syndrome

   Hypotension

Spinal headache

2. **Hemorrhage**

   Uterine atony, Placenta previa/accreta, Lacerations

3. Injury to nearby organs
4. Post OP

   Respiratory: Pneumonia

   Gastrointestinal: Ileus

   UTI

   Thromboembolism
5. Endometritis
6. Wound infection

Neonatal Risks

1. Respiratory Distress Syndrome (RDS)
2. Hypothermia
3. transient tachypnea or meconium aspiration
4. Delayed Skin-to-Skin Contact
5. Infection Risk for the Newborn
6. Skin lacerations
7. Cephalohematoma
8. Clavicular fracture
9. Brachial plexopathy
10. Skull fracture
11. Facial nerve palsy

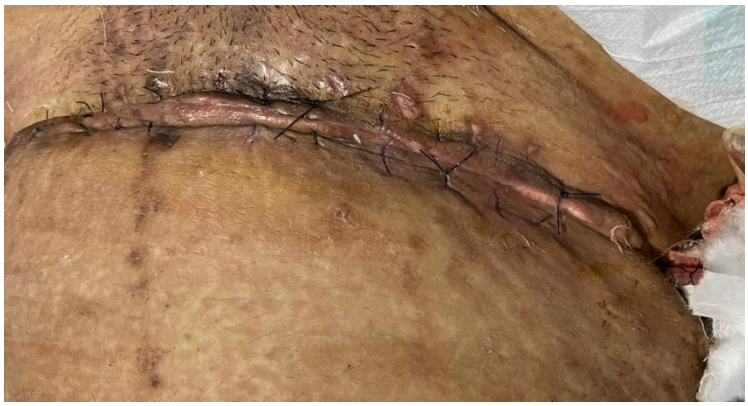


Figure 8: Wound discharge

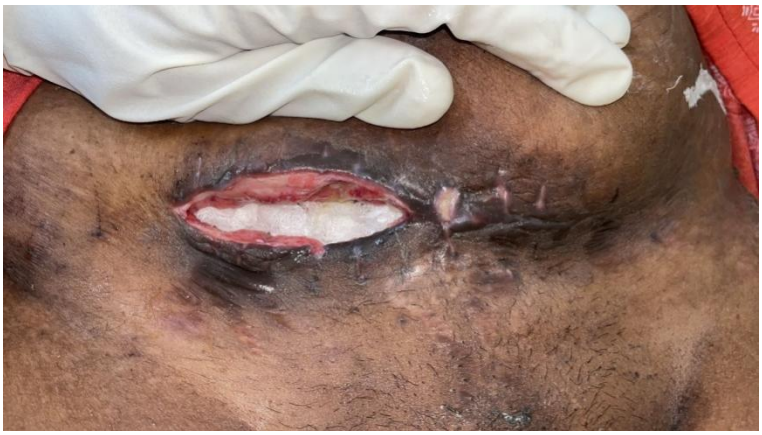


Figure 9: Wound gaping

LUCAS CLASSIFICATION OF URGENCY OF CAESAREAN DELIVERY

[36]

It has been recognised that the traditional categorisation of caesarian sections as either "elective" or "emergency" is relatively insufficient for conducting thorough data collecting and audits of obstetric and anaesthetic outcomes. The primary cause of this issue may be attributed to the tendency to oversimplify the degrees of urgency under the single category of "emergency." Lucas et al. (2000) introduced a categorisation method that incorporates clinical criteria, offering a more intricate approach.

This innovative categorisation approach evaluates the immediacy of a cesarean section by taking into account the existence or nonexistence of maternal or fetal impairment. Using a colour scale underscores the need to acknowledge a "continuum of urgency" rather than imposing inflexible classifications on events. Dupuis et al. used a three-colour code in research to classify risk, indicating that this method might simplify the time it takes to choose emergency caesarian sections. It is recognised, therefore, that, in the context of audits, the use of the four specified categories continues to be pragmatic.

Assigning a distinct classification to a given caesarian segment allows the whole team to comprehend the degree of urgency linked to that specific instance. This methodology guarantees a more thorough evaluation of the level of urgency, recognising the ever-changing character of obstetric circumstances.

Figure 10: Lucas Classification of Urgency Of Caesarean Delivery

Figure 1. A classification relating the degree of urgency to the presence or absence of maternal or fetal compromise

Urgency	Definition	Category
Maternal or fetal compromise	Immediate threat to life of woman or fetus	1
	No immediate threat to life of woman or fetus	2
	Requires early delivery	3
No maternal or fetal compromise	At a time to suit the woman and maternity services	4

AZITHROMYCIN

A macrolide antibiotic compound known as Azithromycin [AZM] has been developed by a team of Croatian pharmacists and was named in recognition of a significant accomplishment within Croatia. [19] The inhibition of protein synthesis and hindrance of bacterial growth is seen as a result of the reversible cutting of the 50S bacterial ribosomal subunit by Azithromycin. [37] Furthermore, it can infiltrate bacterial extracellular vesicles, which serve as a secretory defensive mechanism.

Structure

AZM, also known as 9-deoxo-9a-methyl-9a-aza-9a-homo erythromycin A, is synthesized by substituting carbonyl(9a) in the aglycone ring with methyl nitrogen, resulting in the chemical formula $C_{38}H_{72}N_2O_{12}$. In contrast to erythromycin (ERY), AZM exhibits enhanced durability and strength, inhibits the internal process responsible for hemiketal production.

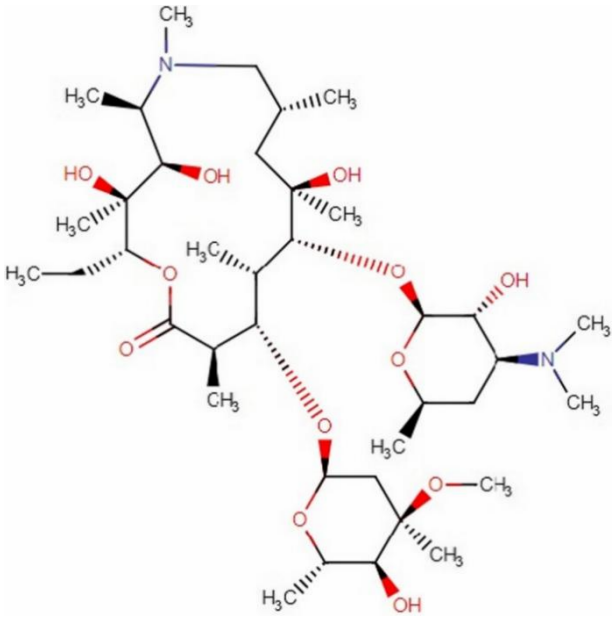


Figure 11 Azithromycin chemical structure

Mechanism of action

AZM is a macrolide antibiotic that targets the 50S subunit of the bacterial ribosome to inhibit protein synthesis. Its increased antimicrobial activity is due to its higher membrane passage rate at alkaline pH. AZM binds at a site near the peptidyl transferase center on 23S rRNA.

The drug has faster penetration of the outer membranes and increasing activity against Gram-negative bacteria. AZM shows anti-inflammatory effects, as demonstrated by Cigana et al., which reduced TNF-α mRNA expression, TNF-α protein levels, and NF-κB DNA-binding activity in human cystic fibrosis (CF) cell lines. This reduction is associated with inhibiting the degradation of IκBα.

AZM affects neutrophils directly and indirectly through its anti-inflammatory properties, such as reduction in IL-8 release and neutrophil airway infiltration, reduce neutrophil oxidative burst, and decrease leukotriene B4. AZM facilitates the

transition of macrophages from the M1 type to the M2 alternative-like phenotype under laboratory conditions by suppressing the production of pro-inflammatory cytokines and alter the expression of the surface receptors. [38]

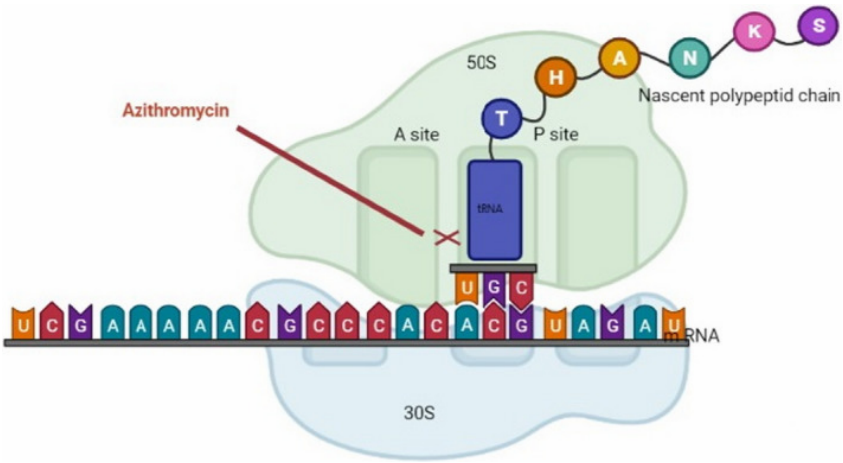


Figure 12 Mechanism of action of azithromycin

PHARMACOKINETICS

Absorption

AZM, a medication, is primarily metabolized through demethylation and has no significant antimicrobial activity. Its bioavailability is 37% when oral, and absorption can be reduced by up to 50% when combined with a large meal. The mean plasma clearance is 630 ml/min after a single dose of 1000 mg. AZM's primary route of elimination is through biliary excretion, with faeces being a prominent route. AZM has a half-life of 35-40 hours.

Adverse Effects

Studies have not shown any carcinogenic potential. Possible adverse effects include GI upset, headache, dizziness, hearing loss, and arrhythmias. In rare cases, hepatotoxicity can be seen. Caution should be taken with patients with prolonged QT interval and disturbed hepatic function.

USES

- Asthma
- Bronchiolitis
- Cronic obstructive pulmonary disorders
- Sexually transmitted infections
- GI infections

Pregnancy-associated infections are most important cause of maternal death. Cesarean delivery is a common surgical procedure, with a rate of SSI higher than vaginal delivery. Studies suggest that azithromycin-based extended-spectrum prophylaxis, one dose of azithromycin plus standard cephalosporin, can decrease infection after cesarean section. It also acts against ureaplasma species which are also a cause of infections after C-section. This study aims to check whether adding azithromycin to standard antibiotic prophylaxis before skin incision can reduce the incidence of infection after cesarean section without increasing the risk to mother and fetus.

The safety and efficacy of integrating single-dose add on azithromycin for emergency cesarean delivery have been subject to rigorous investigation. This approach seeks to minimise postoperative complications, notably surgical site infections (SSI) and endometritis, which present significant risks to maternal health and healthcare resources. Research consistently indicates a reduction in infection rates when azithromycin is included alongside standard antibiotic prophylaxis regimens. The single-dose nature of azithromycin administration offers practical advantages, enhancing patient compliance and simplifying treatment protocols. Moreover, studies highlight a generally favorable safety profile for azithromycin, with limited adverse effects observed in both mothers and newborns. Despite ongoing considerations regarding optimal timing and cost-effectiveness, the

accumulating evidence underscores the potential benefits of incorporating azithromycin prophylaxis into emergency cesarean delivery practices, necessitating further exploration to establish comprehensive guidelines.

I Did a Literature Search about same topic.

Sanusi et al. (2022) conducted a study on the Timing of Adjunctive Azithromycin for Unscheduled Cesarean Delivery and Postdelivery Infection. A study analyzed the association of azithromycin prophylaxis with outcomes in singleton gestation patients undergoing unscheduled cesarean delivery. A study of 2,013 participants found that antibiotics were initiated after skin incision in 14% of cases, 0-30 minutes before in 68.5%, more than 30-60 minutes before in 14%, and more than 60 minutes before in 96.8%. The risk of infectious composite outcome for azithromycin compared to placebo was significantly lesser for groups initiated after skin incision or within 1 hour before. However, risks were not significantly different in patients receiving azithromycin more than 60 minutes before skin incision. Results were similar when endometritis and wound infections were analyzed separately. No difference in neonatal outcomes was seen. Adjunctive azithromycin administration up to 60 minutes before or 3 minutes after skin

incision reduces maternal composite postoperative infection risks in unscheduled cesarean deliveries. [38]

Yang M et al. (2022) conducted a metanalysis of the Efficacy of adding azithromycin to antibiotic prophylaxis in caesarean delivery**.** The study showed that adding azithromycin significantly reduced the risk of endometritis and wound infection and also risk of surgical site infections in patients undergoing CD. [39]

Jabs C et al. (2021) was conducted a study of Evaluation of Adjunctive Azithromycin Prophylaxis in Women Undergoing Cesarean Delivery. The primary outcome measure was the change in the incidence of SSI up to 30 days following surgery. The study found that surgical site infection rates reduced from 3.5% to 2.9% after azithromycin is added in prophylaxis. However, the results were not statistically significant, and there were no differences in SSI rates between both groups. [6]

Subramaniam et al. (2021) conducted a multicenter, three-group, double-blind randomised controlled trial about one dose of oral azithromycin with or without amoxicillin to reduce peripartum infection in prolonged labor or rupture of membranes at term. The study involved 6,531 women and 756 randomized participants. The study found that more than 60% of women in each group received usual-care antibiotics, with more than 90% penicillin and around 50% for prolonged rupture of membranes. Composite outcome incidences were similar in antibiotic groups 1 and 2 compared to placebo group 3. Chorioamnionitis and wound infection were significantly lower in group 2 compared to group 3. There were no differences in other maternal or neonatal outcomes, including neonatal infection. The study concluded that a single dose of oral azithromycin with or without amoxicillin for prolonged labor or rupture of membranes at term did not reduce maternal peripartum or neonatal infection. [40]

Hume-Nixon M et al. (2021) conducted a Systematic Review and meta-analysis of the effect of administration of azithromycin during pregnancy on perinatal and neonatal outcomes. The study analyzed 5777 studies between January 1990 and June 2021, focusing on randomized control trials (RCTs) involving the administration of azithromycin alone or in combination. The results showed that azithromycin reduced the risk of low birthweight (LBW) and prematurity compared to controls. There was no substantial evidence of its effect on neonatal mortality and infections. The review was limited by differences in intervention types and study populations and inconsistency in outcome reporting between studies. The interpretation is that it reduces low birth weight and prematurity, but it's action is unclear about perinatal and neonatal outcomes. Further investigation is needed to determine the potential harm to stillbirth rates. [41]

Cai Y et al. (2020) conducted a double-blind, parallel-control randomised clinical trial on the efficacy of adjunctive azithromycin versus single-dose cephalosporin prophylaxis for caesarean scar defect at the International Peace Maternity and Child Health Hospital, involving 220 eligible patients. The primary outcome will be the prevalence of caesarean section delivery (CSD), with characteristics assessed by transvaginal ultrasound and saline infusion Sono hysterography at 42 days, 6 months, and 12 months after delivery. There was no substantial evidence of its effect on neonatal mortality and infections. [42]

Tita ATN et al. (2016) conducted a study on Adjunctive Azithromycin Prophylaxis for Cesarean Delivery at 14 US centers and found that prophylaxis with add on azithromycin was found more effective in reducing the risk of postoperative infection in women undergoing CS. There was significant differences between both the groups in rates of endometritis, wound infection, and

maternal adverse effects. There was no significant difference in neonatal outcome. [4]

MATERIALS AND METHODS

STUDY DESIGN: Randomized Prospective observational study

SOURCE OF DATA

The study was conducted in the Department of Obstetrics and Gynaecology of SHRI B.M. PATIL MEDICAL COLLEGE AND RESEARCH CENTRE, B.L.D.E. (DEEMED TO BE UNIVERSITY), VIJAYPURA. All pregnant women who had a singleton pregnancy with a gestational age of 28 weeks or more in labour visiting the Department of Obstetrics and Gynaecology and were willing to participate were included as per the inclusion and exclusion criteria mentioned below.

Inclusion criteria

1. Singleton pregnancy

2. Gestational age of 28 weeks or more

3. Patients undergoing emergency cesarean section

4. After membrane rupture within 12 hours or PROM

5. Previous 1 or 2 cesarean section

Exclusion criteria

1. Patients who are unable to provide consent.

2. Known allergy to azithromycin.

3. Use of Azithromycin 7 days till randomization.

4. Chorioamnionitis, fever, UTI requiring antibiotic treatment.

5. In patients with liver diseases, increased serum creatinine level of >2.0mg/dl.

6. Patients in need of dialysis.

7. Cardiomyopathy, pulmonary oedema, known case of electrolyte abnormalities.

8. Pre-eclampsia.

9. PROM more than 12 hours.

Methodology

The study was conducted at S.H.R.I. B.M. Patil Medical College Hospital and Research Centre. Women with a singleton pregnancy of gestational age 28 weeks or more who underwent emergency cesarean section or were within 12 hours of rupture of membranes were selected and given azithromycin 1000mg IV along

with routine antibiotic prophylaxis. Patients were given antibiotics (ceftriaxone along with IV azithromycin) half an hour to one hour before taking skin incisions. Patients were observed for 6 weeks postpartum for any infections like endometritis, wound infection, sepsis, etc.

As the patient got hospitalised, a detailed history and examination were carried out. Once the decision was made to take the patient for an emergency cesarean section, oral and written informed consent was obtained for participation in this study.

The patient was prepared for emergency cesarean section, and one dose of adjunctive IV azithromycin was given along with regular cephalosporin prophylaxis 0-60 minutes before skin incision.

Mother and Baby were followed up for 6 weeks postpartum for any complications like endometritis, surgical site infections, wound discharge, erythema, induration of skin, neonatal respiratory distress syndrome, NICU admission, and length of hospital stay.

Study Period: September 2022 – April 2024

Method of collection of data

All patients were explained about the study, and written informed consent was obtained. The patient's demographic parameters, chief complaints, and past medical and obstetric history were taken. A general and systemic examination was done. Baseline investigations like Complete Blood Count, Peripheral Blood Smear, Random Blood Sugar, HIV test, HBsAg test, Routine urine, and Obstetric U.S.G. were done in all patients, and necessary investigations depending upon suspected underlying medical conditions were performed. All patients received a standard medical line of management per the diagnosis. The duration of hospitalisation and outcome of pregnancy were noted.

Sample size

520

Statistical analysis

The data obtained was entered into a Microsoft Excel sheet, and statistical analysis was performed using JMP-SAS Software. Results were shown as Mean ± S.D., counts and percentages, and diagrams. For normally distributed continuous variables between 2 groups, comparisons were made using an independent t-test. The Chi-square test was used to compare categorical variables between two groups. Regression analysis was used to find the relative risk. A p-value of <0.05 was considered statistically significant.

RESULTS

The study, a randomized prospective observational study, was conducted in the Department of Obstetrics and Gynaecology of SHRI B.M. PATIL MEDICAL COLLEGE AND RESEARCH CENTRE, VIJAYPURA. The study included pregnant women with gestational age of 28 weeks or more, undergoing emergency cesarean section or within 12 hours of rupture of membranes, who were willing to participate and met the inclusion criteria. The study excluded patients unable to provide consent, those with known allergies to azithromycin, those who used azithromycin 7 days before randomization, and those with various medical conditions.

Women who met the inclusion criteria were given azithromycin 1gram IV and routine antibiotic prophylaxis (ceftriaxone) half an hour to one hour before the skin incision. Patients were observed for 6 weeks postpartum for any infections like endometritis, wound infection, or sepsis.

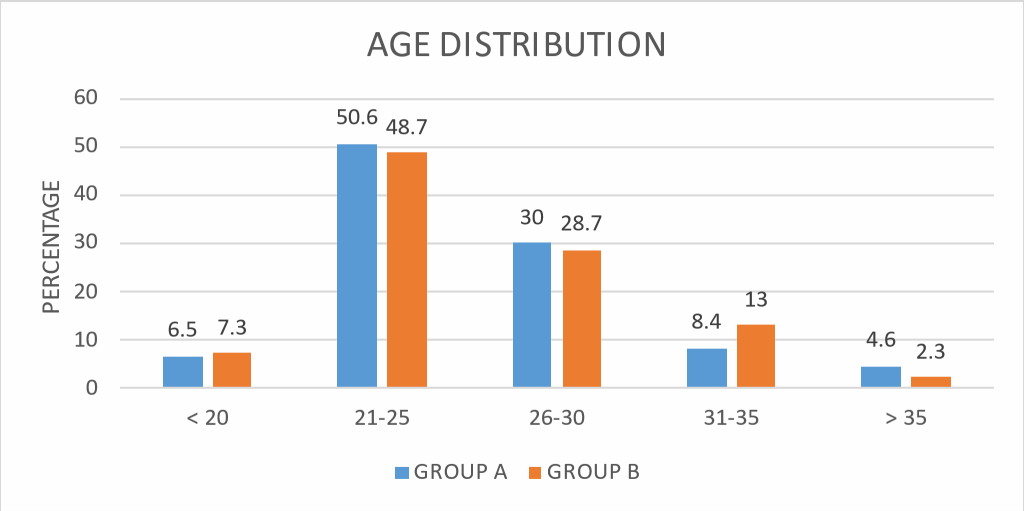
All patients were informed about the study, and written informed consent was obtained. Demographic parameters, chief complaints, and medical and obstetric history were recorded. General and systemic examinations were performed, and baseline investigations were conducted. All patients received standard medical management based on their diagnosis. Hospitalisation duration and pregnancy outcomes were noted.

Age distribution

Table 1. Comparison of Age distribution

AGE	GROUP A		GROUP B	
	N	%	N	%
< 20	17	6.5	19	7.3
21-25	133	50.6	127	48.7
26-30	79	30	75	28.7
31-35	22	8.4	34	13
> 35	12	4.6	6	2.3
p-value	0.295			

Chart 1. Cluster bar chart of the age distribution



The age distribution between both the groups in a study population was done. The age categories are divided into < 20, 21-25, 26-30, 31-35, and > 35 years old. The frequency and percentage of participants in each age group are showed.

In both groups, most participants fall within the 21-25 age group, with 50.6% and 48.7%, respectively. The second-largest age group is 26-30, with 30% in Group A and 28.7% in Group B. The 31-35 age group has a slightly higher percentage of participants in Group B (13%) than in Group A (8.4%). The < 20 and > 35 age groups have the lowest percentages of participants in both groups.

The age ranged between 18-28 years in Group A with a mean age of 24.47 and 18-39 years in Group B with a mean age of 24.81.

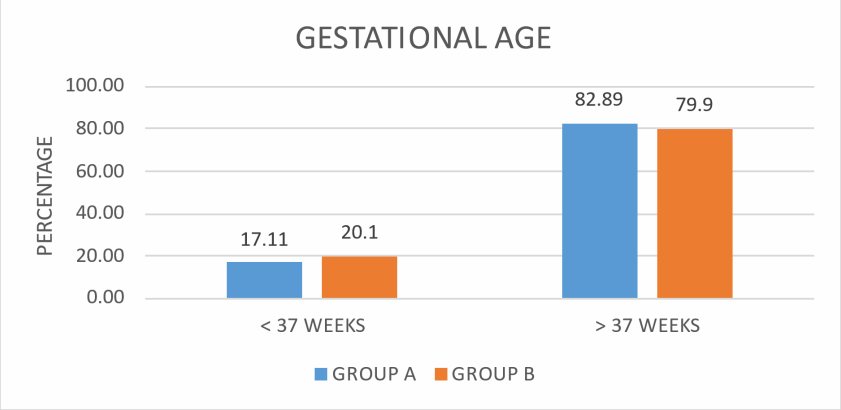
The age distribution between both groups shows p-value of 0.295 which is more than 0.05, thus implying there is no statistical significance.

Comparison of gestational age distribution

Table 2. Comparison of gestational age distribution

GESTATIONAL AGE	GROUP A		GROUP B	
	N	%	N	%
< 37 WEEKS	45	17.11	52	20.1
> 37 WEEKS	218	82.89	209	79.9
p-value	0.407			

Chart 2. Cluster bar chart of the gestational age distribution



Comparison of gestational age distribution between both groups in a study population. The gestational age is categorised into < 37 weeks and > 37 weeks.

The frequency and percentage of participants in each gestational age group are provided for both groups.

In Group A, 17.11% of the participants have a gestational age of < 37 weeks, while the remaining 82.89% have a gestational age of > 37 weeks. Similarly, in Group B, 20.1% of the participants have a gestational age of < 37 weeks and 79.9% have a gestational age of > 37 weeks.

The age distribution between both groups shows p-value of 0.407 which is more than 0.05, thus implying there is no statistical significance.

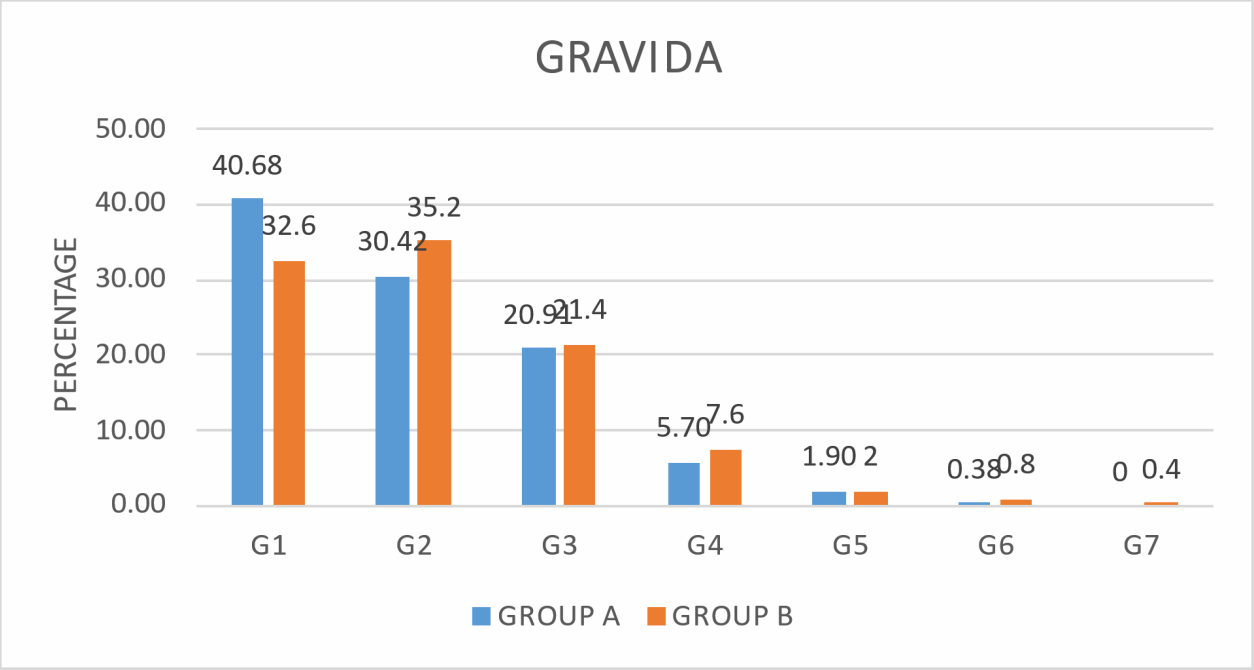
Comparison of the distribution of gravida (number of pregnancies) between two groups

Table 3. Comparison of the gravida (number of pregnancies) of the study population

GRAVIDA	GROUP A		GROUP B	
	N	%	N	%
G1	107	40.68	85	32.6
G2	80	30.42	92	35.2
G3	55	20.91	56	21.4
G4	15	5.70	20	7.6
G5	5	1.90	5	2
G6	1	0.38	2	0.8
G7	0	0	1	0.4

p- value	0.492

Chart 3. Cluster bar chart of the gravida (number of pregnancies) of the study population



Comparison of the distribution of gravida (number of pregnancies) between two groups. The gravida categories range from G1 (first pregnancy) to G7 (seventh pregnancy). The frequency and percentage of participants in each gravida category are presented for both groups.

In Group A, the majority of participants are in the G1 category (40.68%), followed by G2 (30.42%), G3 (20.91%), G4 (5.70%), G5 (1.90%), and G6 (0.38%). There are no participants in the G7 category.

In Group B, the distribution of gravida is slightly different. The highest percentage of participants is in the G2 category (35.2%), followed by G1 (32.6%), G3 (21.4%), G4 (7.6%), G5 (2%), G6 (0.8%), and G7 (0.4%).

The distribution of gravida between both groups shows p-value of 0.492 which is more than 0.05, thus implying there is no statistical significance.

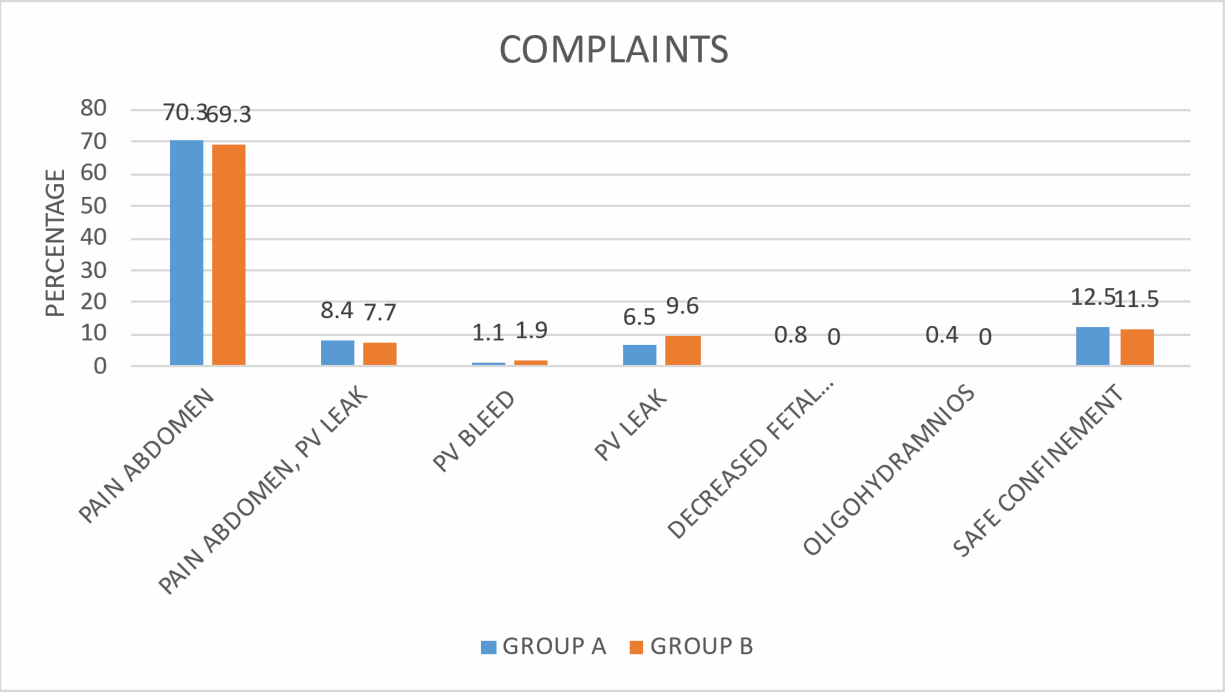
Comparison of the distribution of complaints

Table 4. Comparison of the distribution of complaints

COMPLAINTS	GROUP A		GROUP B	
	N	%	N	%
PAIN ABDOMEN	185	70.3	181	69.3
PAIN ABDOMEN, PV LEAK	22	8.4	20	7.7
PV BLEED	3	1.1	5	1.9
PV LEAK	17	6.5	25	9.6
DECREASED FETAL MOVEMENTS	2	0.8	0	0
OLIGOHYDRAMNIOS	1	0.4	0	0

SAFE CONFINEMENT	33	12.5	30	11.5
p-value	0.506			

Chart 4. Cluster bar chart of the distribution of complaints



Comparison of complaints between two groups in a study population. The complaints include pain abdomen, pain abdomen with PV (per vaginal) leak, PV bleed, PV leak, decreased fetal movements, oligohydramnios, and safe confinement. The frequency and percentage of participants with each complaint are provided for both groups.

In Group A, the most common complaint is pain in the abdomen (70.3%), followed by safe confinement (12.5%), pain in the abdomen with PV leak (8.4%), PV leak (6.5%), PV bleed (1.1%), decreased fetal movements (0.8%), and oligohydramnios (0.4%).

Similarly, in Group B, the most common complaint is also pain in the abdomen (69.3%), followed by safe confinement (11.5%), PV leak (9.6%), pain abdomen with PV leak (7.7%), and PV bleed (1.9%). There have been no reported cases of decreased fetal movements or oligohydramnios.

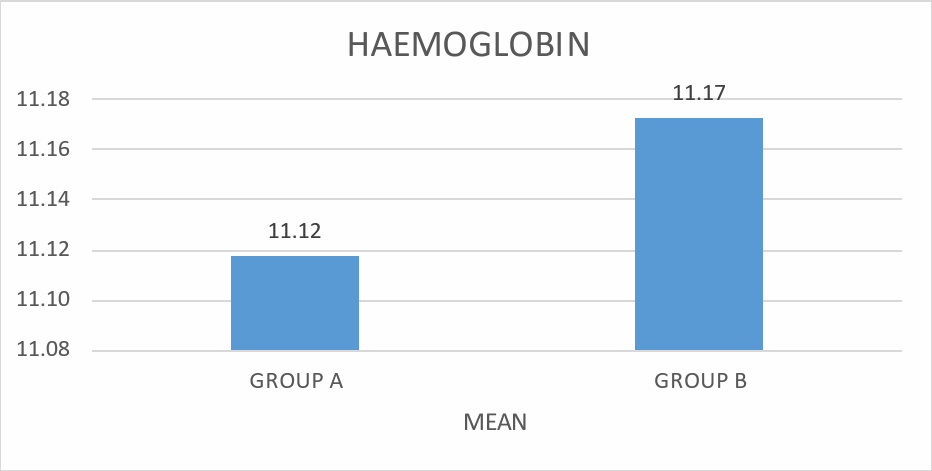
The p-value of 0.506 suggests no statistically significant difference between the complaints between both groups.

Comparison of haemoglobin levels

Table 5. Comparison of haemoglobin levels

HAEMOGLOBIN	GROUP A	GROUP B
MEAN	11.12	11.17
SD	1.26	1.23
p- value	0.383	

Chart 5. Bar chart of the haemoglobin levels



Group A's mean haemoglobin level is 11.12 and in Group B the mean haemoglobin level is 11.17.

The p-value of 0.383 indicates no statistically significant difference in the haemoglobin levels between both groups.

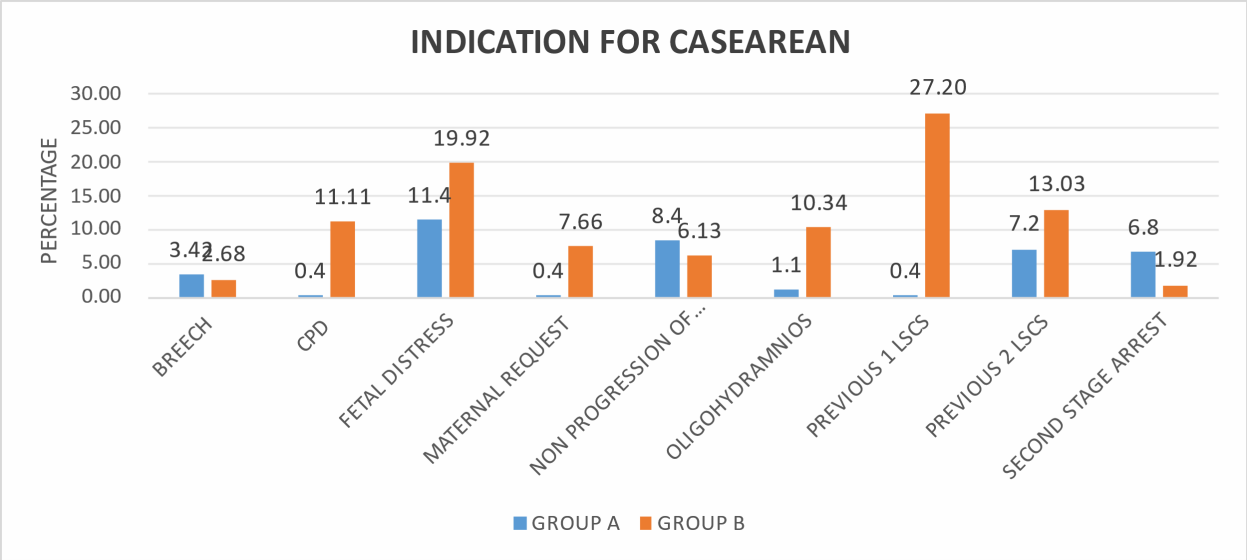
Indications for cesarean section

Table 6. Comparison of the indications for cesarean section

INDICATION FOR CASEAREAN	GROUP A		GROUP B	
	N	%	N	%
BREECH	9	3.42	7	2.68
CPD	30	0.4	29	11.11
FETAL DISTRESS	57	11.4	52	19.92
MATERNAL REQUEST	19	0.4	20	7.66
NON-PROGRESSION OF LABOR	16	8.4	16	6.13
OLIGOHYDRAMNIOS	32	1.1	27	10.34
PREVIOUS 1 LSCS	72	0.4	71	27.20

PREVIOUS 2 LSCS	22	7.2	34	13.03
SECOND STAGE ARREST	6	6.8	5	1.92

Chart 6. Cluster bar chart of the indications for cesarean section



Comparison of the indications for cesarean section in a study population. The indications include breech presentation, CPD, fetal distress, maternal request, non-

progression of labor, oligohydramnios, previous 1 LSCS (lower segment cesarean section), previous 2 LSCS, and second stage arrest. The frequency and percentage of participants with each indication are provided for both groups.

In Group A, the most common indications for cesarean section is previous 1 LSCS (72 cases, percentage not clearly stated), fetal distress (57 cases, 11.4%), and oligohydramnios (32 cases, 1.1%). Other indications include CPD (30 cases, 0.4%), previous 2 LSCS (22 cases, 7.2%), maternal request (19 cases, 0.4%), non-progression of labor (16 cases, 8.4%), breech presentation (9 cases, 3.42%), and second stage arrest (6 cases, 6.8%).

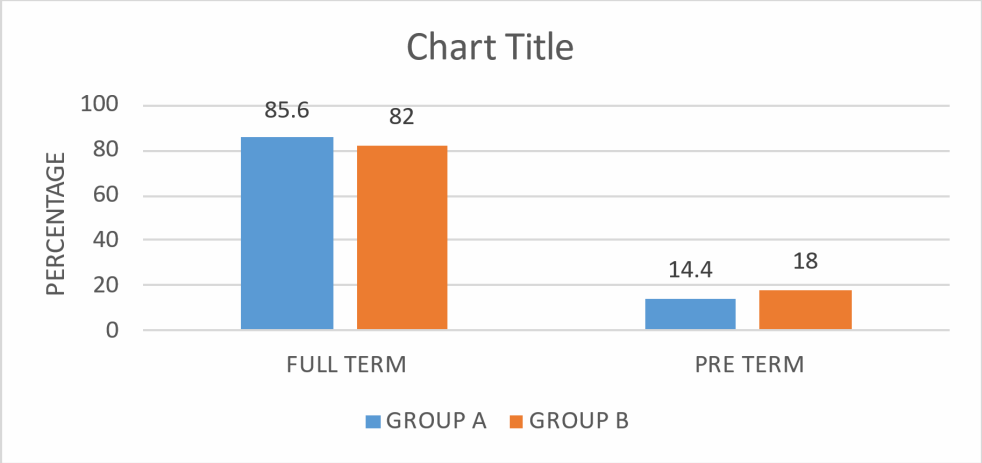
Similarly, in Group B, the most common indications are previous 1 LSCS (71 cases, 27.20%), fetal distress (52 cases, 19.92%), and previous 2 LSCS (34 cases, 13.03%). Other indications include CPD (29 cases, 11.11%), oligohydramnios (27 cases, 10.34%), maternal request (20 cases, 7.66%), non-progression of labor (16 cases, 6.13%), breech presentation (7 cases, 2.68%), and second stage arrest (5 cases, 1.92%).

Comparison of Term Status Distribution

Table 7. Comparison of Term Status Distribution

TERM	GROUP A		GROUP B	
	N	%	N	%
FULL TERM	225	85.6	214	82
PRE-TERM	38	14.4	47	18
p- value	0.269			

Chart 7. Cluster bar chart of the Term Status Distribution



This is a comparison of the distribution of term status (full term or pre-term) between both groups in a study population. The frequency and percentage of participants in each term category are provided for both groups.

In Group A, most participants (225 cases, 85.6%) are full-term, while a smaller proportion (38 cases, 14.4%) are pre-term. Similarly, in Group B, most participants (214 cases, 82%) are full-term, and a smaller proportion (47 cases, 18%) are pre-term.

The p-value of 0.269 indicates no statistically significant difference in the distribution of term status between both groups.

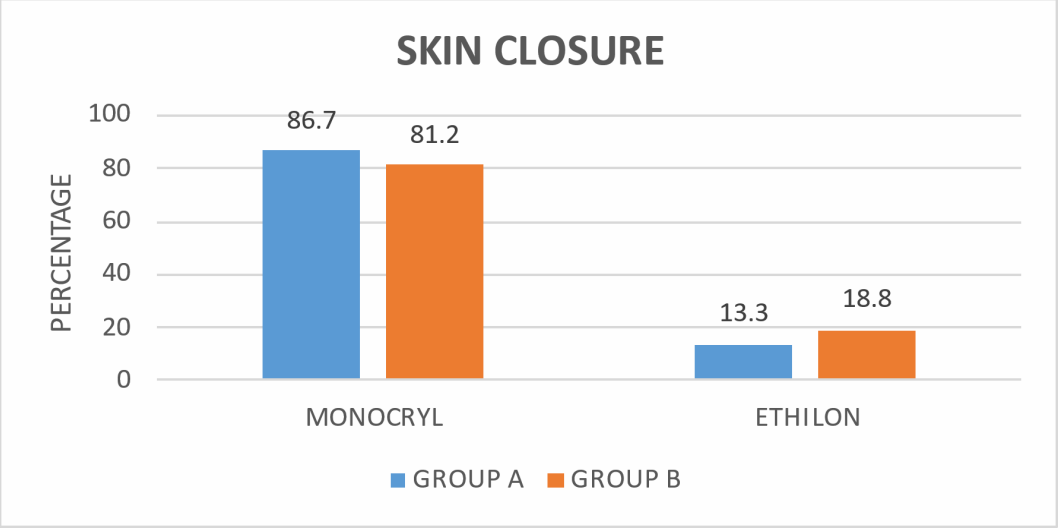
Comparison of the closure methods used for different layers

Table 8. Comparison of the closure methods used for different layers

CLOSURE OF WOUND	GROUP A		GROUP B	
	N	%	N	%
UTERUS CLOSURE				
VICRYL ROUND BODY	263	100	261	100
RECTAL SHEATH				

CLOSURE				
VICRYL REVERSE CUTTING	263	100	261	100
SKIN CLOSURE				
MONOCRYL	228	86.7	212	81.2
ETHILON	35	13.3	49	18.8

Chart 8. Cluster bar chart of the skin closure methods



The closure methods are described for the uterus, rectal sheath, and skin.

For uterus closure, Group A and Group B used the same method for all participants (263 cases, 100% in Group A; 261 cases, 100% in Group B), which is Vicryl round body suture.

Similarly, for rectal sheath closure, both groups used the same method for all participants (263 cases, 100% in Group A; 261 cases, 100% in Group B): Vicryl reverse-cutting suture.

Two methods are used for skin closure: Monocryl and Ethilon. In Group A, most participants (228 cases, 86.7%) have their skin closed with Monocryl, while a smaller proportion (35 cases, 13.3%) have their skin closed with Ethilon. In Group B, a slightly lower percentage of participants (212 cases, 81.2%) have their skin closed with Monocryl, and a slightly higher rate (49 cases, 18.8%) have their skin closed with Ethilon.

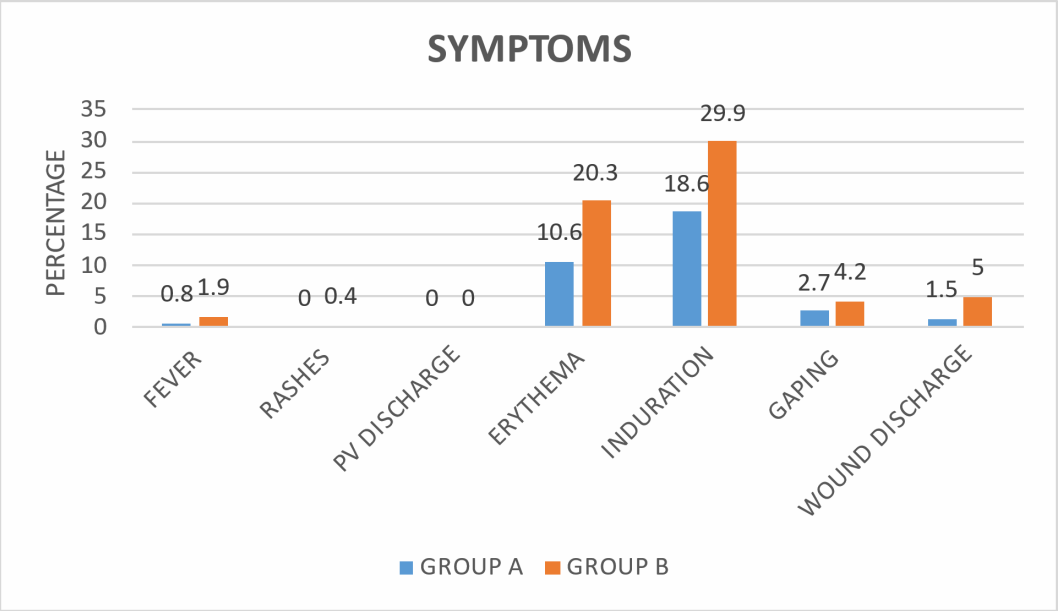
Frequency and percentage of various postoperative symptoms

Table 9. The frequency and percentage of various postoperative

SYMPTOMS	GROUP A		GROUP B		p-value
	N	%	N	%	
FEVER	2	0.8	5	1.9	0.249
RASHES	0	0	1	0.4	0.315
PV DISCHARGE	0	0	0	0	-
ERYTHEMA	28	10.6	53	20.3	0.002
INDURATION	49	18.6	78	29.9	0.003
GAPING	7	2.7	11	4.2	0.329

WOUND DISCHARGE	4	1.5	13	5	0.025

Chart 9. Cluster bar chart of the various postoperative symptoms



The distribution of various postoperative symptoms between both in a study population. The symptoms include fever, rashes, PV (per vaginal) discharge, erythema, induration, gaping, and wound discharge. The frequency and percentage of participants experiencing each symptom are provided for both groups, along with the corresponding p-values.

Fever: In Group A, 2 participants (0.8%) experienced fever, while in Group B, 5 participants (1.9%) had fever. The p-value of 0.249 suggests that there is no significant difference between both groups.

Rashes: In Group A, no participants experienced rashes, while in Group B, 1 participant (0.4%) had rashes. The p-value of 0.315 suggests that there is no significant difference between both groups.

PV Discharge: Neither group had any participants experiencing PV discharge.

Erythema: In Group A, 28 participants (10.6%) had erythema, while in Group B, 53 participants (20.3%) experienced erythema. The p-value of 0.002 suggests that there is statistically significant difference between both groups, with Group B having a higher incidence.

Induration: In Group A, 49 participants (18.6%) had induration, while in Group B, 78 participants (29.9%) experienced induration. The p-value of 0.003 suggests that there is statistically significant difference between both groups, with Group B having a higher incidence.

Gaping: In Group A, 7 participants (2.7%) had gaping, while in Group B, 11 (4.2%) experienced gaping. The p-value of 0.329 suggests that there is no significant difference between both groups.

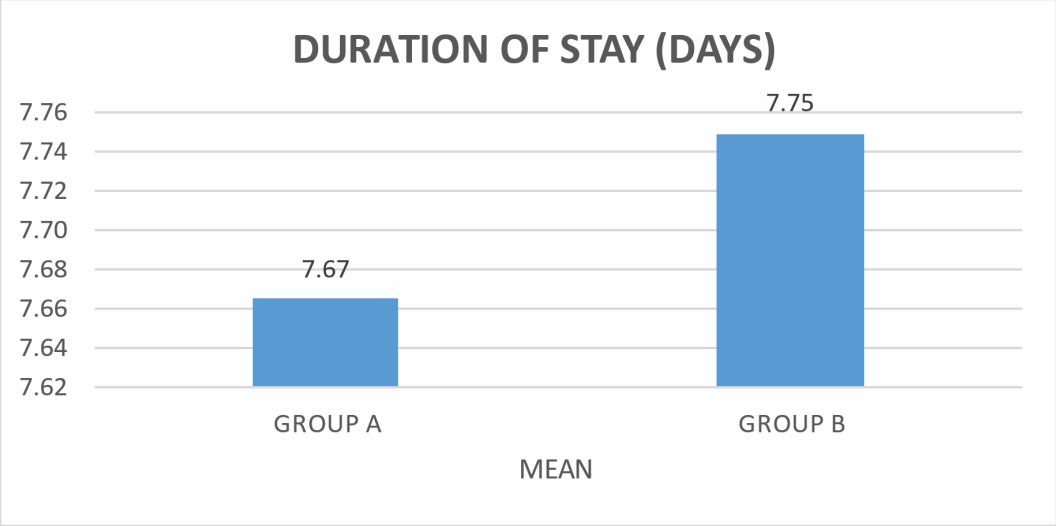
Wound Discharge: In Group A, 4 participants (1.5%) had wound discharge, while in Group B, 13 (5%) experienced wound discharge. The p-value of 0.025 suggests that there is statistically significant difference between both groups, with Group B having a higher incidence.

Comparison of the duration of hospital stay

Table 10. Comparison of the duration of hospital stay

DURATION OF STAY (IN DAYS)	GROUP A	GROUP B
MEAN	7.67	7.75
SD	1.98	3.31
p- value	0.477	

Chart 10. Cluster bar chart of the duration of hospital stay



Comparison of the duration of hospital stay (in days) between both groups in a study population.

In Group A, the mean duration of stay is 7.67 days. In Group B, the mean duration of stay is slightly higher at 7.75 days.

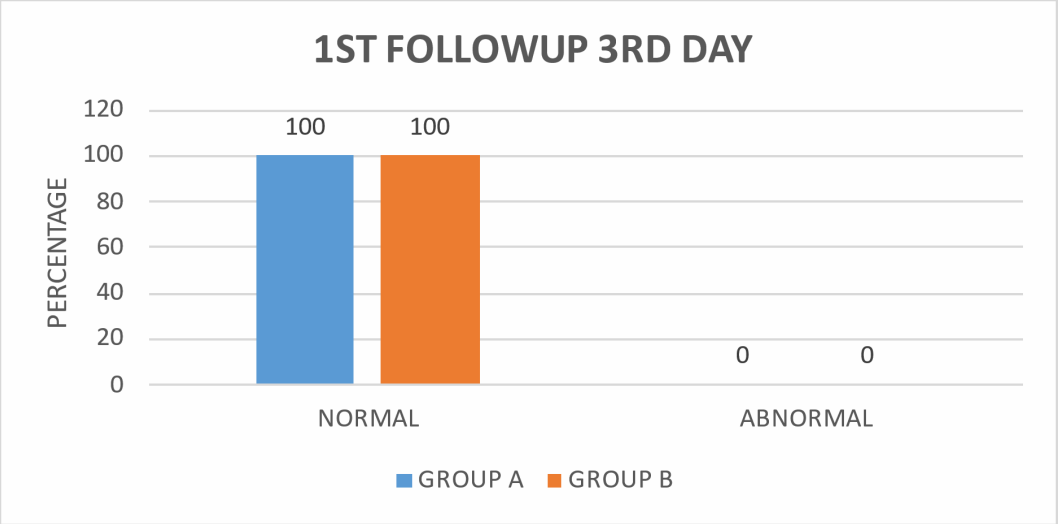
The p-value of 0.477 suggests that there is no significant difference between both groups.

Frequency and percentage of the findings of the 1st follow-up on the 3rd day

Table 11. The frequency and percentage of the findings of the 1st follow-up on the 3rd day

1ST FOLLOWUP 3RD DAY	GROUP A		GROUP B	
	N	%	N	%
NORMAL	263	100	261	100
ABNORMAL	0	0	0	0

Chart 11. Cluster bar chart of the findings of the 1st follow-up on the 3rd day



The findings of the 1st follow-up on the 3rd day after the intervention between both groups in a study population.

In both groups, all participants (263 and 261, respectively) had normal findings during the 1st follow-up (3rd day), representing 100% of each group. There were no participants with abnormal findings in either group.

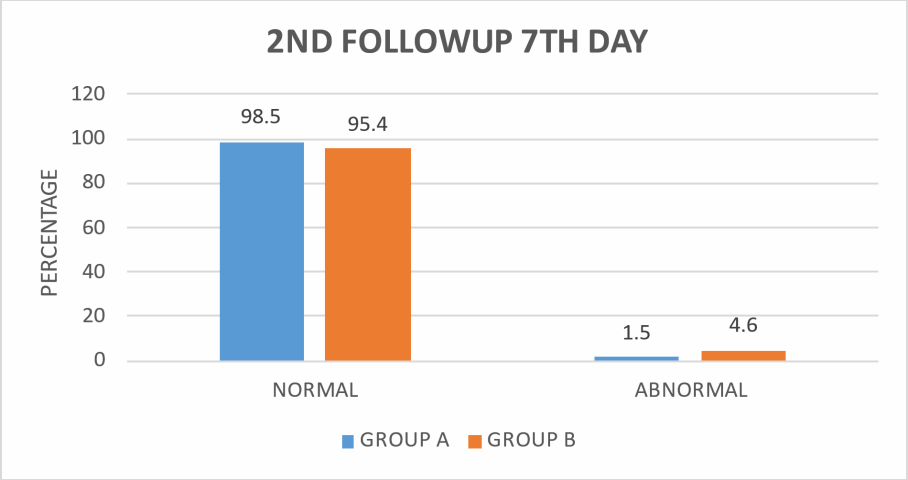
Comparison of the findings of the 2nd follow-up on the 7th day

Table 12. Comparison of the findings of the 2nd follow-up on the 7th day

2ND FOLLOWUP	GROUP A	GROUP B

7TH DAY	N	%	N	%
NORMAL	259	98.5	249	95.4
ABNORMAL	4	1.5	12	4.6
p- value	0.041			

Chart 12. Cluster bar chart of the findings of the second follow-up on the 7th day



This is a comparison of the findings of the 2nd follow-up (7th day) after the intervention between two groups, Group A and Group B, in a study population. The frequency and percentage of participants with normal and abnormal findings are provided for both groups, along with the corresponding p-value.

In Group A, 259 participants (98.5%) had normal findings during the 2nd follow-up on the 7th day, while 4 participants (1.5%) had abnormal findings. In Group B, 249 participants (95.4%) had normal findings, and 12 (4.6%) had abnormal findings.

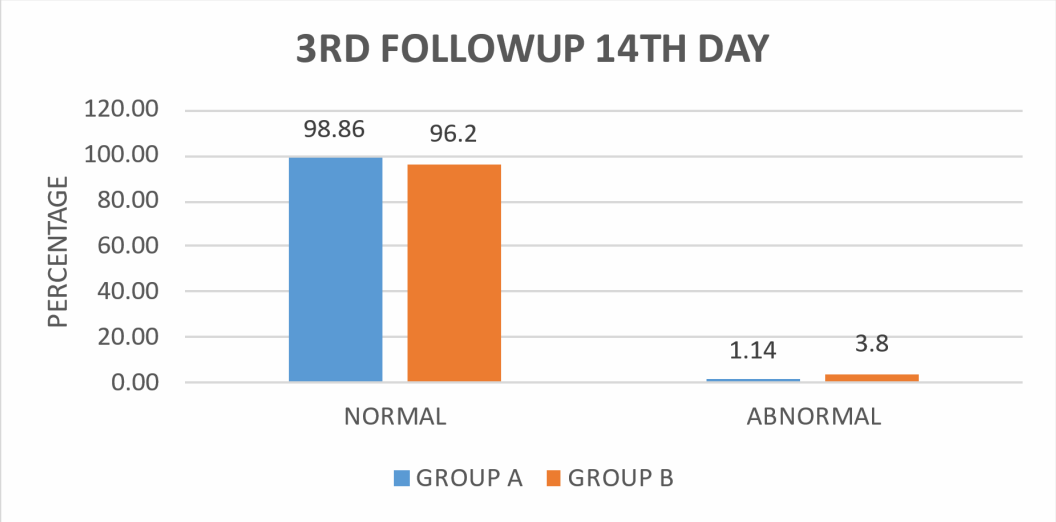
The p-value of 0.041 suggests that the difference in the distribution of normal and abnormal findings between both groups is statistically significant.

Frequency and percentage of 3rd follow-up on the 14th day

Table 13. The frequency and percentage of the findings of the of 3rd follow-up on the 14th day

3RD FOLLOWUP 14TH DAY	GROUP A		GROUP B	
	N	%	N	%
NORMAL	260	98.86	251	96.2
ABNORMAL	3	1.14	10	3.8
p- value	0.023			

Chart 13. Cluster bar chart of the findings of the 3rd follow-up on the 14th day



The findings of the 3rd follow-up on the 14th day after the intervention between both groups in a study population. The frequency and percentage of participants with normal and abnormal findings are provided for both groups, along with the corresponding p-value.

In Group A, 260 participants (98.86%) had normal findings during the 3rd follow-up on the 14th day, while 3 participants (1.14%) had abnormal findings. In Group B, 251 participants (96.2%) had normal findings, and 10 participants (3.8%) had abnormal findings.

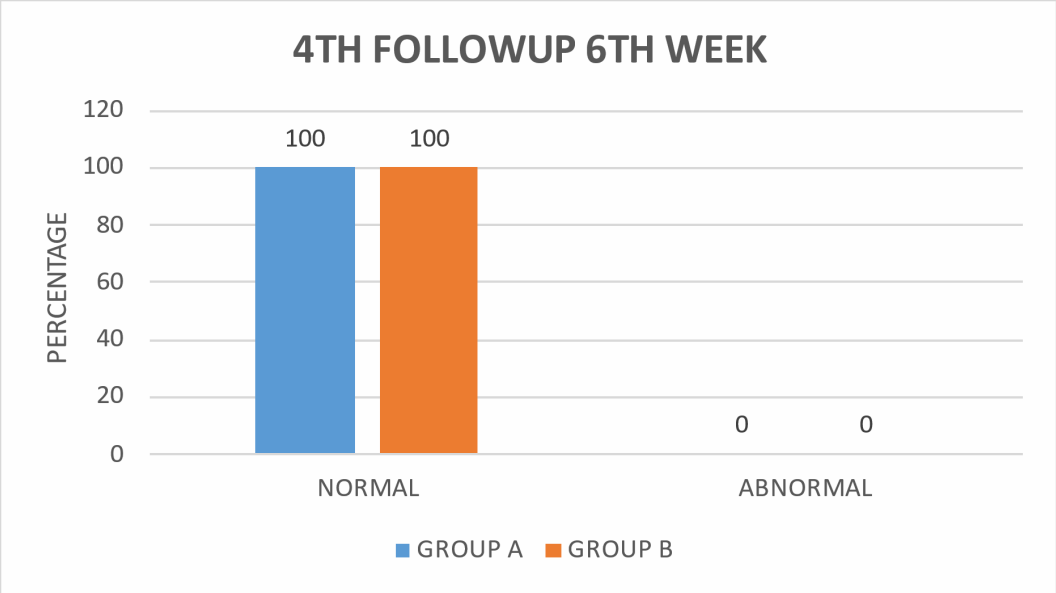
The p-value of 0.023 indicates that the difference in the distribution of normal and abnormal findings between both groups is statistically significant.

Frequency and percentage of the findings of the 4th follow-up in the 6th week

Table 14. The frequency and percentage of the findings of the 4th follow-up in the 6th week

4TH FOLLOWUP 6TH WEEK	GROUP A		GROUP B	
	N	%	N	%
NORMAL	263	100	261	100
ABNORMAL	0	0	0	0

Chart 14. Cluster bar chart of the findings of the 4th follow-up in the 6th week



The findings of the 4th follow-up in the 6th week after the intervention between both groups in a study population. The frequency and percentage of participants with normal and abnormal findings are provided.

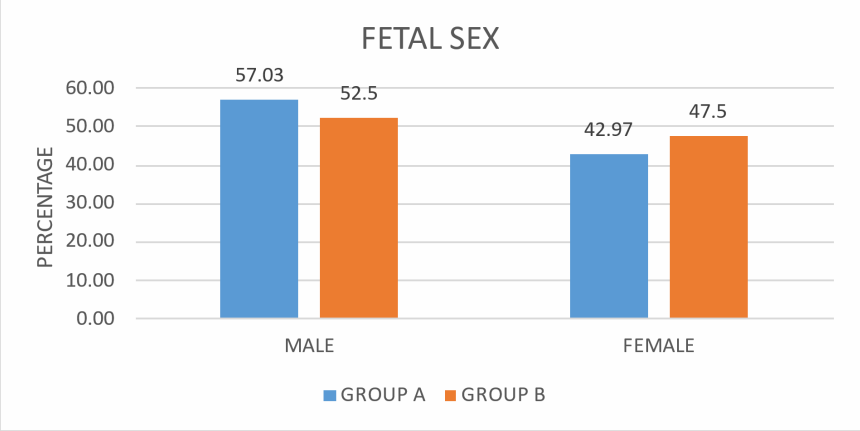
In both groups, all participants (263 and 261, respectively) had normal findings during the 4th follow-up at the 6th week, representing 100% of each group. There were no participants with abnormal findings in either group.

Frequency and percentage of the distribution of sex of fetus

Table 15. The frequency and percentage of the distribution of sex of fetus

FETAL SEX	GROUP A		GROUP B	
	N	%	N	%
MALE	150	57.03	137	52.5
FEMALE	113	42.97	124	47.5
p- value	0.296			

Chart 15. Cluster bar chart of the distribution of sex of fetus



The distribution of fetal sex between both groups in a study population. The frequency and percentage of male and female foetuses are provided for both groups, along with the corresponding p-value.

In Group A, 150 foetuses (57.03%) were male, and 113 foetuses (42.97%) were female. In Group B, 137 foetuses (52.5%) were male, and 124 foetuses (47.5%) were female.

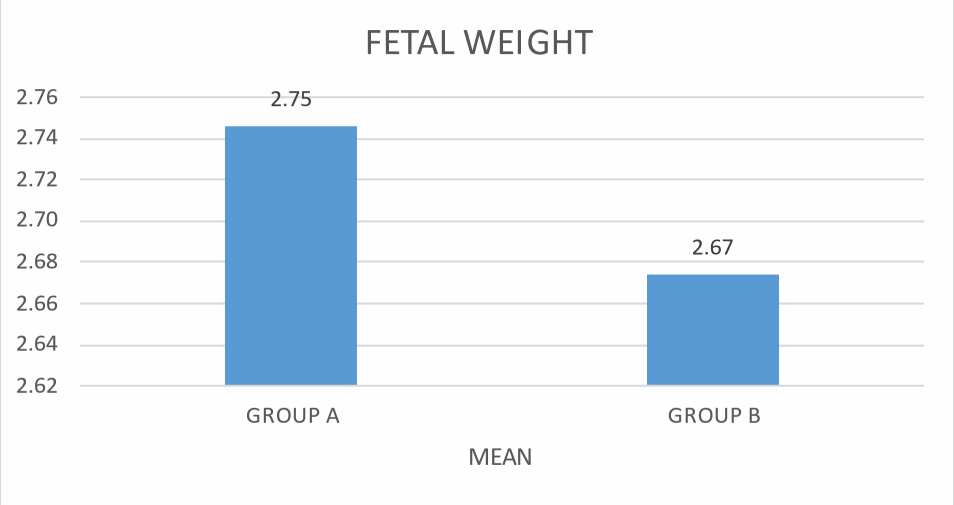
The p-value of 0.296 suggests that the difference in the distribution of fetal sex between both groups is not statistically significant.

Comparison of fetal weight

Table 16. Comparison of the fetal weight

FETAL WEIGHT	GROUP A	GROUP B
MEAN	2.75	2.67
SD	0.45	0.51
p-value	0.477	

Chart 16. Bar chart of the fetal weight



Comparison of the fetal weight between both groups. The fetal weight's mean and standard deviation (SD) are provided for both groups, along with the corresponding p-value.

Group A's mean fetal weight is 2.75. Group B's mean fetal weight is slightly lower at 2.67.

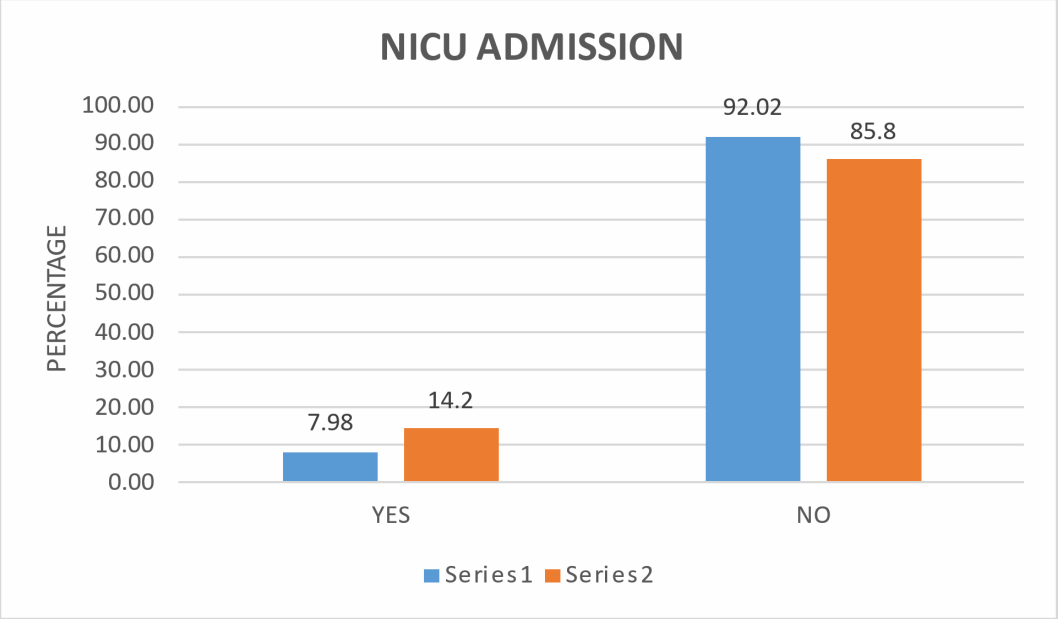
The p-value of 0.477 indicates that the difference in the mean fetal weight between both groups is not statistically significant.

Frequency and percentage of NICU admissions

Table 17. The frequency and percentage of NICU admissions

NICU ADMISSION	GROUP A		GROUP B	
	N	%	N	%
YES	21	7.98	37	14.2
NO	242	92.02	224	85.8
p-value	0.024			

Chart 17. Cluster bar chart of the NICU admissions



The frequency of NICU (Neonatal Intensive Care Unit) admissions between both groups in a study population. The frequency and percentage of NICU admissions (YES) and non-admissions (NO) are provided for both groups, along with the corresponding p-value.

In Group A, 21 neonates (7.98%) were admitted to the NICU, while 242 neonates (92.02%) were not admitted. In Group B, 37 neonates (14.2%) were admitted to the NICU, and 224 neonates (85.8%) were not admitted.

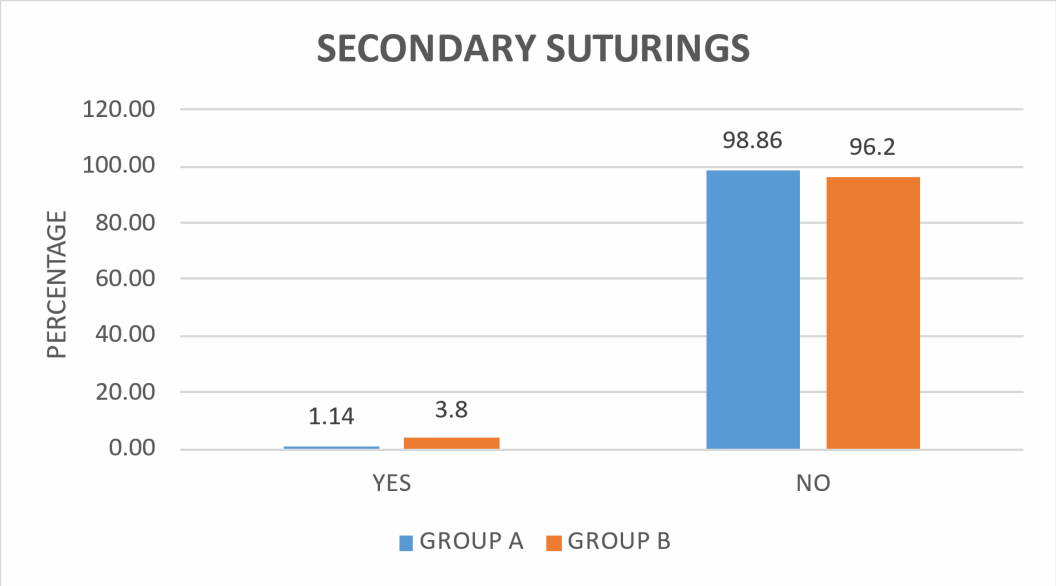
The p-value of 0.024 suggests that the difference in the distribution of NICU admissions between both groups is statistically significant.

Frequency and percentage of secondary suturing

Table 18. The frequency and percentage of secondary suturing between two Groups

SECONDARY SUTURING	GROUP A		GROUP B	
	FREQUENCY	PERCENTAGE	FREQUENCY	PERCENTAGE
YES	3	1.14	10	3.8
NO	260	98.86	251	96.2
p- value	0.048			

Chart 18. Cluster bar chart of the secondary suturing



The frequency of secondary suturing in a study population between both groups. The frequency and percentage of participants requiring secondary suturing (YES) and those not requiring secondary suturing (NO) are provided for both groups, along with the corresponding p-value.

In Group A, 3 participants (1.14%) required secondary suturing, while 260 participants (98.86%) did not require secondary suturing. In Group B, 10 participants (3.8%) required secondary suturing, and 251 participants (96.2%) did not require secondary suturing.

The p-value of 0.048 indicates that the difference in the distribution of secondary suturing between both groups is statistically significant.

DISCUSSION

This significant research was undertaken at the Department of Obstetrics and Gynaecology at SHRI B.M. PATIL MEDICAL COLLEGE AND RESEARCH CENTRE, B.L.D.E. (DEEMED TO BE UNIVERSITY), VIJAYPURA.

It is a randomised prospective observational study on the 'Safety and efficacy of adding single-dose adjunctive azithromycin prophylaxis for emergency cesarean delivery'.

We studied 520 pregnant women at or after 28 weeks gestation who had an emergency cesarean section or imminent rupture of membranes. Before the procedure, they were given azithromycin 1000mg IV and routine antibiotic prophylaxis. Postpartum, we observed them for 6 weeks for infections such as endometritis, wound infection, sepsis, etc.

Table 19. Comparison of Maternal Mean age (yrs) at delivery among different studies

Study	Cases	controls
Pierce et al. [45]	29	29
Huang D et al. [43]	30.0	30.4
Alan TN et al. [4]	28.2	28.4
Our study	24.5	24.8

The above table shows that both cases and controls had a mean maternal age of 29 at delivery. According to studies by Pierce et al. [45] and Huang D et al. [43], the mean maternal age for cases is 30.0 years, slightly lower than the 30.4 years for controls. Similarly, **Alan TN et al.'s**[4] cases have a mean maternal age of 28.2 years, while controls are somewhat older at 28.4 years. In **our study**, the mean maternal age is notably younger, with cases at 24.5 years and controls at 24.8 years. The younger age of cases and controls in this study indicates a demographic variation compared to the other studies, potentially reflecting differences in the population or the study setting. Our study's younger mean maternal age could reflect a population with different reproductive behaviours, possibly due to cultural, social, or economic factors. This may influence the generalizability of the findings to other populations with different maternal age distributions.

Table 20. Comparison of gravid women with studies from other researchers

GRAVIDA	**Huang D et al.**[43]		**Our study**	
	Cases n (%)	**controls n (%)**	**Cases n (%)**	**controls n (%)**
G1	84 (69.42)	89 (73.6)	107 (40.68)	85(32.6)
G2	23 (19)	25(20.7)	80(30.42)	92(35.2)
G3	11(9.1)	5(4.13)	55(20.92)	56(21.4)
G4	2(1.7)	1(0.83)	15(5.70)	20(7.6)
G5	0	1(0.83)	5(1.90)	5(2)
p-value	0.439		0.492	

The above table shows that most cases and controls are in gravida 1, with 69.42% of cases and 73.6% of controls from a study by Huang et al. [43] with insignificant p-value (0.439). The percentages decrease with increasing gravida, with very few individuals in gravida 4 (G4) and gravida 5 (G5). In contrast, "Our study" shows fewer cases and controls in G1, with only 40.68% of cases and 32.6% of controls. The distribution in "Our study" is more spread out across G1 to G3, with higher percentages of cases in G2 (30.42%) and G3 (20.92%) with insignificant p-value (0.492). Both studies show no statistically significant differences in gravida distributions between cases and controls, as indicated by their p-values. These discrepancies might be attributed to differences in the demographics of the research participants or the criteria used to choose the cases and controls. Considering the context when analysing and comparing pregnancy data from various studies is crucial.

Table 21. Comparison of Indication for Casearean among different studies

INDICATION FOR CASEAREAN	**Lingam KR et al.** [44]		**Huang D et al.** [43]		**Our study**	
	Cases n (%)	**controls n (%)**	**Cases n (%)**	**controls n (%)**	**Cases n (%)**	**controls n (%)**
Breech presentation	4 (3.57%)	4(4.56%)	4(3.57%)	3(2.47)	9 (3.42)	7 (2.68)
Fetal distress	10 (8.92%)	13(14.77%)	39(32.23)	43(35.5)	57 (11.4)	52 (19.92)
CPD	6(5.35%)	6(6.81%)	5(4.13)	5(4.13)	30 (0.4)	29 (11.11)
Failed Induction	11 (9.82%)	11(9.82%)	7(5.8)	12(10)	16 (8.4)	16 (6.13)
Previous C/S	34(30.35%)	23(26.13%)	33(27.27)	28(23.13)	72 (0.4)	71 27.20
Previous 2 C/S	25(22.32%)	6(6.81%)	30(24.79)	30(24.79)	22 (7.2)	34 (13.03)

From the above, it is observed that our study, Lingam KR et al. [44], and Huang D et al. [43] For breech presentation, the percentages are relatively consistent across all studies, with our research reporting 3.42% of cases and 2.68% of controls, similar to the figures from Lingam KR et al. and Huang D et al. This could be due to nulliparity, uterine anomalies, placental location, and fetal size. Secondly, the

diagnostic criteria and methods used to identify breech presentation may be comparable across the studies, leading to consistent results.

Regarding fetal distress, our study reports 11.4% of cases and 19.92% of controls, which is lower compared to Huang D et al. [43], where 32.23% of cases and 35.5% of controls were due to fetal distress. In contrast, Lingam KR et al. [44] showed lower percentages for cases and controls in this category. This discrepancy might reflect different clinical practices or patient populations.

Our study shows a higher cephalopelvic disproportion (CPD) prevalence in 10.4% of cases and 11.11% of controls. In contrast, Lingam KR et al. [44] and Huang D et al. report lower and consistent percentages for both cases and controls. Differences in population characteristics such as ethnicity, maternal age, nutritional status, and overall health can influence the prevalence of CPD.

The incidence of failed induction is relatively similar across the studies. However, our study reports a slightly lower percentage of controls (6.13%) compared to Lingam KR et al. [44] and Huang D et al. [43]. Notably, the rate of previous C-sections in our study is significantly higher (40.4% of cases and 27.20% of controls) compared to the other studies, indicating a higher recurrence of C-sections among our participants. This could be attributed to factors such as differences in maternal age, parity, or other obstetric complications.

Our study shows 27.2% of cases with a history of two previous C-sections, higher than Lingam KR et al. [44] and Huang D et al. [43]. This trend suggests that our study population may have more repeat C-sections. These comparisons highlight the variations in the primary reasons for C-sections across different studies, reflecting differences in clinical practice, study populations, and regional healthcare protocols. The higher rates of previous C-sections in our study suggest a trend

towards more repeat C-sections in our patient population, emphasising the need for targeted clinical strategies to manage these cases effectively.

These studies highlight the diverse range of indications for CS, with previous CS, failure to progress, and fetal distress being among the most common reasons. The distribution of CS indications may vary depending on the study population and setting, but there are some consistent patterns across the studies. Understanding the most frequent indications for CS can help guide efforts to optimise maternal and fetal outcomes and reduce unnecessary cesarean deliveries.

Table 22. Comparison of post-CS haemoglobin levels (g/l) with other studies

Study	Cases (mean ±SD)	controls (mean ±SD)
Huang D et al. [43]	113.0 ± 12.7	112.8 ± 12.2
Our study	111.2 ±12.6	111.7 ±12.3

From the above table, Huang D et al.'s [43] mean haemoglobin level for cases is 113.0 ± 12.7 g/l, and for controls, it is 112.8 ± 12.2 g/l. Similarly, our study reports mean haemoglobin levels of 111.2 ± 12.6 g/l for cases and 111.7 ± 12.3 g/l for controls. Both studies show a minimal difference in haemoglobin levels between cases and controls, indicating consistent outcomes across different populations. The slight discrepancies in mean values and standard deviations suggest that while individual variations exist, the overall impact of cesarean sections on haemoglobin levels is similar in both studies.

Table 23. Comparison of occurrence of post-operative pyrexia

Study	Cases (n%)	Controls (n%)
Lingam KR et al. [44]	5(4.42)	4(4.12)
Our study	2(0.8)	5(1.9)

The above table notes that Lingam KR et al. [44] observed a relatively similar incidence of post-operative pyrexia in both cases (4.42%) and controls (4.12%). In contrast, our study shows a significantly lower occurrence of post-operative pyrexia in cases (0.8%) compared to controls (1.9%). This indicates a consistent rate of pyrexia regardless of the group, suggesting similar post-operative risks across their patient population. This lower incidence rate in our study, particularly among cases, may point to more effective post-operative management practices or differences in patient demographics and health profiles.

While both studies highlight the importance of monitoring post-operative pyrexia, our findings suggest that proper management can minimise its occurrence.

Table 24. Comparison of duration of hospital stay following cesarean section

Study	Cases (n%)	Controls (n%)
Lingam KR et al. [44]	7.01(2.76)	6.90(3.25)
Our study	7.67(1.98)	7.75(3.31)

The above table shows that the mean duration of hospital stay for cases was 7.01 days with a standard deviation of 2.76. In contrast, the mean duration for controls

was slightly lower at 6.90 days with a standard deviation of 3.25. In contrast, our study showed a mean hospital stay duration of 7.67 days with a standard deviation of 1.98 for cases; in controls, the mean hospital stay was 7.75 days with a standard deviation of 3.31.

Overall, the mean durations of hospital stay for both cases and controls in our study are higher than those in Lingam KR et al. [44]. The standard deviation for cases in our study was reduced. These differences could be attributed to various factors, including differences in clinical practices, patient demographics, or healthcare settings between the two studies.

Table 25. Comparison of secondary suturing following cesarean section

Study	Cases (n%)		Controls (n%)	
	Yes	No	Yes	No
Lingam KR et al. [44]	3(3.03)	96(96.97)	6(5.4)	105(94.6)
Our study	3(1.14)	260(98.86)	10(3.8)	251(96.2)

It is noted that, from the table above, in the Lingam KR et al. [44] study, secondary suturing was required in 3 out of 99 cases (3.03%) and 6 out of 111 controls (5.4%). In contrast, our study reported that secondary suturing was needed in 3 out of 263 cases (1.14%) and 10 out of 261 controls (3.8%). The percentage of cases requiring secondary suturing in our study is lower than that of the study by Lingam KR et al. Similarly, the incidence in the control group is also lower in our study than in Lingam KR et al.' 's [44] control group.

Both studies show that secondary suturing is a relatively infrequent complication following cesarean sections. However, our study demonstrates even lower rates of secondary suturing for both cases and controls compared to the study by Lingam KR et al. [44]. These differences could be due to various factors, such as differences in surgical techniques, patient management protocols, or population characteristics between the two studies.

CONCLUSION

The study, a randomised prospective observational study, which included 520 pregnant women with singleton pregnancies of gestational age 28 weeks or more, undergoing emergency cesarean section or within 12 hours of rupture of membranes, who met the inclusion criteria. Patients in the intervention group (Group A) received azithromycin 1000mg IV and routine antibiotic prophylaxis (ceftriaxone) half an hour to one hour before the skin incision, while the control group (Group B) received only routine antibiotic prophylaxis.

The study found no significant differences between the two groups in terms of age distribution, gestational age, gravida, complaints, hemoglobin levels, indications for cesarean section, term status, closure methods for uterus and rectal sheath, duration of hospital stay, 1st follow-up findings on the 3rd day, 4th follow-up findings in the 6th week, fetal sex, and fetal weight.

However, statistically significant differences were observed in the following aspects:

1.In our study, the azithromycin group had lower incidence of postoperative complications like erythema, induration, fever, wound discharge, duration of hospital stay,rate of nicu admissions,secondary suturing than the placebo group.

2. Postoperative symptoms: Azithromycin group had significantly lower incidences of erythema ($p=0.002$), induration ($p=0.003$), and wound discharge ($p=0.025$) compared to the placebo group.

3. At the second follow-up on the 7th day, Azithromycin group had a significantly higher proportion of normal findings ($p=0.041$) than the placebo group.

4. At the third follow-up on the 14th day, Azithromycin group had a significantly higher proportion of normal findings (p=0.023) than the placebo group.

5. NICU admissions: Azithromycin group had a significantly lower percentage of NICU admissions than the placebo group.

6. Secondary suturing: Azithromycin had lower percentage of secondary suturing as compared to the placebo group.

These findings suggest that administering azithromycin before cesarean section in Group A led to better postoperative outcomes, with lower rates of postoperative symptoms, abnormal follow-up findings, NICU admissions, and secondary suturing compared to the placebo Group B.

The study highlights the potential benefits of administering azithromycin as an additional prophylactic measure before cesarean section to reduce postoperative morbidity and improve maternal and neonatal outcomes. However, further research with larger sample sizes and in different settings may be necessary to confirm these findings and assess the generalizability of the results.

Limitations:

1. Conducted at a single centre, potentially limiting generalizability.
2. No mention of potential bias from blinding participants, healthcare providers, or outcome assessors.
3. Lack of long-term follow-up information beyond the 6th week.
4. Lack of information on adherence to intervention protocol or potential side effects of antibiotics.

SUMMARY

- In this randomised prospective observational study, administering azithromycin and routine antibiotic prophylaxis before cesarean section resulted in significantly better postoperative outcomes than routine antibiotic prophylaxis alone.
- The intervention group had lower rates of postoperative symptoms, abnormal follow-up findings, NICU admissions, and secondary suturing.
- These findings suggest that the addition of azithromycin to the antibiotic prophylaxis regimen before cesarean section may help reduce postoperative morbidity and improve maternal and neonatal outcomes.
- However, further research is needed to confirm these findings and assess their generalizability.
- The study contributes to the growing evidence supporting antibiotic prophylaxis in emergency cesarean section.

- It highlights the potential benefits of incorporating azithromycin into clinical practice, subject to further validation and consideration of local guidelines and patient-specific factors.

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ANNEXURE I

CONSENT FORM

B.L.D.E. (DEEMED TO BE UNIVERSITY)

SHRI B. M. PATIL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTER, VIJAYAPURA-586103

INFORMED CONSENT FOR PARTICIPATION IN DISSERTATION/ RESEARCH

I, the undersigned, _____, D/O or W/O _____, aged ____years, ordinarily resident of _____ do hereby state/declare that DR. **VINDHYAVALI NANNURI** of Shri. B. M. Patil Medical College Hospital and Research Centre has examined me thoroughly on _____ at _____ (place) and it has been explained to me in my own

language that I am suffering from _____ disease (condition) and this

disease/condition mimic the following diseases. Further **DR. VINDHYAVALI NANNURI** informed me that she is conducting a dissertation/research titled ***"SAFETY AND EFFICACY OF ADDIND SINGLE DOSE ADJUNCTIVE AZITHROMYCIN PROPHYLAXIS FOR EMERGENCY CESAREAN DELIVERY"***, under the guidance of

DR. SHOBHA SHIRAGUR requesting my participation in the study. Apart from routine treatment procedures, the pre-operative, operative, postoperative, and follow-up observations will be utilized for the study as reference data. The doctor has also informed me that during the conduct of this procedure adverse results may be encountered. Among the above complications, most of them are treatable but are not anticipated hence there is a chance of aggravation of my condition and in rare circumstances, it may prove fatal despite the anticipated diagnosis and best treatment made available. Further Doctor has informed me that my participation in this study would help in the evaluation of the results of the study which is a useful reference to the treatment of other similar cases in the near future, and I may be benefited in getting relieved of suffering or cure of the disease I am suffering.

The Doctor has also informed me that information given by me, observations made

photographs and video graphs are taken upon me by the investigator will be kept secret and not assessed by a person other than me or my legal hirer except for academic purposes.

The Doctor did inform me that though my participation is purely voluntary, based on the information given by me, I can ask for any clarification during treatment/study

related to diagnosis, the procedure of treatment, result of treatment, or prognosis. At the same time, I have been informed that I can withdraw from my participation in this study at any time if I want or the investigator can terminate

me from the study at any time from the study but not the procedure of treatment and follow-up unless I request to be discharged.

After understanding the nature of the dissertation or research, diagnosis made, and mode of treatment, I the undersigned Smt. _____ under my full conscious state of mind agree to participate in the said research/dissertation.

Signature of the patient:

Signature of doctor:

Date: Place

ANNEXURE II

PROFORMA

A Prospective Clinical Study at a Tertiary Care Hospital

NAME	
AGE/SEX	
ADMISSION NUMBER (I.P. NO)	
DATE OF ADMISSION	
DATE OF DISCHARGE	
ADDRESS AND PHONE NUMBER	

CHIEF COMPLAINTS:

HISTORY OF PRESENT ILLNESS:

HISTORY OF PRESENT PREGNANCY:

ANC:

1ST TRIMESTER:

2ND TRIMESTER:

3RD TRIMESTER:

RELATED DRUG HISTORY:

MARITAL HISTORY:

OBSTETRIC HISTORY: G: P: L: A: D:

LMP:

EDD:

POG:

TREATMENT HISTORY:

DURATION:

ANY PROCEDURE:

DISEASE COMPLICATING PREGNANCY:

PREGNANCY DETERIORATING MEDICAL DISORDER:

PERSONAL HISTORY:

GENERAL PHYSICAL EXAMINATION:

PULSE:

BLOOD PRESSURE:

RESPIRATORY RATE:

TEMPERATURE:

HEIGHT:

WEIGHT:

HEAD-TO-TOE EXAMINATION:

PALLOR:

ICTERUS:

CYANOSIS:

CLUBBING:

LYMPHADENOPATHY:

OEDEMA:

THYROID:

BREAST:

SPINE:

CARDIOVASCULAR SYSTEM:

RESPIRATORY SYSTEM:

PER ABDOMEN:

PER VAGINUM:

Cervical dilatation at the time of c-section:

PRESENTATION:

INVESTIGATIONS:

CBC:

URINE ROUTINE:

BT, CT:

BLOOD GROUP AND RH TYPING

RBS

THYROID PROFILE

HIV

HBsAg

OBSTETRIC SCAN

DATE OF DELIVERY:

EMERGENCY LSCS

INDICATION:

PRETERM: FULL TERM:

TIME OF ADMINISTRATION OF AZITHROMYCIN:

TIME OF ADMINISTRATION OF CEPHALOSPORINS:

TIME OF SKIN INCISION:

MATERNAL OUTCOME:

FEVER:

RASHES:

PV DISCHARGE:

ERYTHEMA OF SKIN:

INDURATION OF SKIN:

WOUND GAPING: YES or NO

WOUND DISCHARGE: YES or NO

IF YES,

CULTURE/SENSITIVITY:

ANY ADITIONAL ANTIBIOTICS USED: YES or NO

IF YES

DRUG GIVEN:

DURATION:

ICU ADMISSION: YES or NO

IF YES-

DURATION OF ADMISSION

VENTILATOR SUPPORT: YES or NO

IF YES –

DURATION

INOTROPIC SUPPORT: YES or NO

IF YES:

DRUGS USED -

DURATION

DURATION OF HOSPITAL STAY –

DATE OF DISCHARGE –

READMISSION TO HOSPITAL: YES or NO

IF YES,

CAUSE OF ADMISSION:

DURATION OF STAY:

REMARKS-

IMPROVED / DEATH / DISCHARGE AGAINST MEDICAL ADVICE

IF DEATH –

CAUSE OF DEATH:

POSTOPERATIVE FOLLOW UP:

3RDDAY:

7TH DAY:

14TH DAY:

6TH WEEK:

FOETAL OUTCOME:

SEX-

BIRTH WEIGHT-

APGAR SCORE: 1min- ; 5min-

RESPIRATORY DISTRESS:

FEVER:

NICU ADMISSION: YES or NO

IF YES-

INDICATION-

DURATION OF STAY-

DATE OF DISCHARGE:

NNEXURE III

ETHICAL CLEARANCE

BLDE

(DEEMED TO BE UNIVERSITY)

Declared as Deemed to be University u/s 3 of UGC Act, 1956

Accredited with 'A' Grade by NAAC (Cycle-2)

The Constituent College

SHRI B. M. PATIL MEDICAL COLLEGE, HOSPITAL & RESEARCH CENTRE, VIJAYAPURA

BLDE (DU)/IEC/ 767/2022-23 30/8/2022

INSTITUTIONAL ETHICAL CLEARANCE CERTIFICATE

The Ethical Committee of this University met on **Friday, 26th August, 2022 at 3.30 p.m. in the Department of Pharmacology** scrutinizes the Synopsis of Post Graduate Student of BLDE (DU)'s Shri B.M.Patil Medical College Hospital & Research Centre from ethical clearance point of view. After scrutiny, the following original/ corrected and revised version synopsis of the thesis/ research projects has been accorded ethical clearance.

TITLE: "Safety and efficacy of adding single dose adjunctive azithromycin proplylaxis for emergency cesarean delivery".

NAME OF THE STUDENT/PRINCIPAL INVESTIGATOR: DR.NANNURI VINDHYAVALI

NAME OF THE GUIDE: DR SHOBHA SHIRAGUR, Associate Professor, **Dept. of OBGY.**

Dr. Santoshkumar Jeevangi
Chairperson
IEC, BLDE (DU),
VIJAYAPURA

Chairman,
Institutional Ethical Committee,
BLDE (Deemed to be University)
Vijayapura

Dr.Akram A. Naikwadi
Member Secretary
IEC, BLDE (DU),
VIJAYAPURA

MEMBER SECRETARY
Institutional Ethics Committee
BLDE (Deemed to be University)
Vijayapura-586103. Karnataka

Following documents were placed before Ethical Committee for Scrutinization:

- Copy of Synopsis/Research Projects
- Copy of inform consent form
- Any other relevant document

Smt. Bangaramma Sajjan Campus, B. M. Patil Road (Sholapur Road), Vijayapura - 586103, Karnataka, India.
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College: Phone: +918352-262770, Fax: +918352-263019, E-mail: bmpmc.principal@bldedu.ac.in

ANNEXURES IV

MASTER CHART

S. NO.	IP NO.	NAME	AGE (YRS)	DATE OF ADMISSION	DATE OF DISCHARGE	COMPLAINTS	OBSTETRIC SCORE	GESTATIONAL AGE (WEEKS)	HB	INDICATION
1	381525	RANJANA	29	01-11-2022	06-11-2022	PAIN ABDOMEN	G2P1L1	38	11	MATERNAL REQUEST
2	372141	SHRUSTI	20	24-10-2022	01-11-2022	PAIN ABDOMEN	G1	37	10.8	NPOL
3	381570	ALFANABEGUM	19	01-11-2022	06-11-2022	SAFE CONFINEMENT	G1	39+4	10.8	OLIGOHYDROMNIOS
4	368908	POOJA	23	31-10-2022	07-11-2022	PAIN ABDOMEN	G1	39+6	11.2	FETAL DISTRESS
5	382765	KAVITA	25	02-11-2022	08-11-2022	PAIN ABDOMEN	G3P2L2	37+1	10.2	NPOL
6	382874	VIDYA	27	02-11-2022	10-11-2022	PAIN ABDOMEN	G1	39+3	9.7	NPOL
7	385246	SUSHMITA	20	04-11-2022	08-11-2022	PAIN ABDOMEN	G2A1	40+4	10.8	SECOND STAGE ARREST
8	387095	MEENAXI	25	06-11-2022	11-11-2022	PAIN ABDOMEN, PV LEAK	G2A1	33+4	10	OLIGOHYDROMNIOS
9	387152	SAVITRI	28	06-11-2022	11-11-2022	PAIN ABDOMEN	G1	39+2	12.6	BREECH
10	394108	SUMITRA	31	13-11-2022	22-11-2022	PAIN ABDOMEN	G2P1L1	39+6	10.5	PREVIOUS 1 LSCS
11	397008	WAHIDABEGUM	31	15-11-2022	22-11-2022	SAFE CONFINEMENT	G2P1L1	39+3	11.9	FETAL DISTRESS
12	409923	ASHWINI	28	26-11-2022	02-12-2022	PAIN ABDOMEN	G3A2	39+6	9.9	MATERNAL REQUEST
13	410569	RESHMA	30	28-11-2022	05-12-2022	PAIN ABDOMEN	G2P1L1	39+3	11.4	OLIGOHYDROMNIOS
14	366170	VIJAYALAXMI	26	04-12-2022	08-12-2022	PAIN ABDOMEN, PV LEAK	G3P1L1A1	40+3	11	PREVIOUS 1 LSCS
15	419895	VIDYA SADASHIV	21	05-12-2022	13-12-2022	SAFE CONFINEMENT	G1	39	12.6	CPD
16	422124	MAHADEVI	33	07-12-2022	14-12-2022	PAIN ABDOMEN	G2P1L1	38+2	13.4	PREVIOUS 1 LSCS
17	423680	SIDDAMMA	24	08-12-2022	14-12-2022	PAIN ABDOMEN	G3P2L2	37	12.6	PREVIOUS 2 LSCS
18	428737	CHANNAMMA	24	13-12-2022	20-12-2022	PAIN ABDOMEN	G2P1L1	39+5	11	PREVIOUS 1 LSCS
19	411846	MAHEK KORABU	27	13-12-2022	20-12-2022	SAFE CONFINEMENT	G2P1L1	39+5	12.2	OLIGOHYDROMNIOS
20	430994	SHRUTI HIREMATH	24	15-12-2022	20-12-2022	PAIN ABDOMEN	G2P1L1	39+3	14.8	PREVIOUS 1 LSCS
21	428759	RENUKA	25	13-12-2022	21-12-2022	PAIN ABDOMEN	G1	36+1	11.3	NPOL
22	432586	AKSHATA	25	16-12-2022	22-12-2022	PAIN ABDOMEN	G2P1L1	39+5	11.9	PREVIOUS 1 LSCS
23	438083	SOUMYASHREE	20	20-12-2022	26-12-2022	PAIN ABDOMEN	G1	40+2	11.8	FETAL DISTRESS
24	438085	SAVITA	21	21-12-2022	28-12-2022	PAIN ABDOMEN	G1	40+0	11	CPD
25	440667	JYOTI	21	23-12-2022	30-12-2022	PAIN ABDOMEN	G4P1L1A2	40+4	7.5	PREVIOUS 1 LSCS
26	442086	RAJAMA HUSEN	21	24-12-2022	31-12-2022	PAIN ABDOMEN	G1	39+4	12.2	NPOL
27	449262	BHARATI	26	29-12-2022	07-01-2023	SAFE CONFINEMENT	G3P1L1A1	37+5	12.4	MATERNAL REQUEST
28	451868	RENUKA	20	31-12-2022	08-01-2023	PAIN ABDOMEN	G1	36+3	10.7	MATERNAL REQUEST
29	392739	KAVERI	20	03-01-2023	12-01-2023	PAIN ABDOMEN	G1	38	10.6	CPD
30	5123	SHANKARAMMA	22	04-01-2023	11-01-2023	PAIN ABDOMEN	G2A1	39+5	11	CPD
31	5963	RENUKA	23	05-01-2023	13-01-2023	PAIN ABDOMEN	G3P2L1D1	40+5	10.1	FETAL DISTRESS
32	8177	PRIYANKA	19	06-01-2023	13-01-2023	PAIN ABDOMEN	G2P1L1	39	12.2	PREVIOUS 1 LSCS
33	17965	SUKDEVI	20	14-01-2023	21-01-2023	PAIN ABDOMEN	G2P1L1	41+3	11	PREVIOUS 1 LSCS
34	24858	POOJA	22	19-01-2023	25-01-2023	PAIN ABDOMEN	G1	39	12	NPOL
35	21429	ASHWINI	26	22-01-2023	30-01-2023	PAIN ABDOMEN	G3A2	38	9.8	FETAL DISTRESS
36	35281	LAXMI RAMESH	22	28-01-2023	04-02-2023	PAIN ABDOMEN	G2P1L1	39+3	10	PREVIOUS 1 LSCS
37	59230	ANITA SHIVRAJ	24	15-02-2023	23-02-2023	SAFE CONFINEMENT	G2P1L1	38+1	10.1	PREVIOUS 1 LSCS
38	70035	DRAKSHAYANI	28	25-02-2023	04-03-2023	PAIN ABDOMEN	G2P1L1	40	11	PREVIOUS 1 LSCS
39	70150	RABAB IRANI	24	25-02-2023	03-03-2023	PAIN ABDOMEN	G1	40+4	12	OLIGOHYDROMNIOS
40	294632	KAVERI	19	26-02-2023	04-03-2023	PAIN ABDOMEN	G1	38+6	11.8	NPOL
41	71761	GEETA BABURAO	18	27-02-2023	05-03-2023	PAIN ABDOMEN	G2P1D1	40+4	12	FETAL DISTRESS
42	73237	GEETA BIRADAR	21	01-03-2023	13-03-2023	PAIN ABDOMEN	G2P1L1	37+2	10.2	PREVIOUS 1 LSCS
43	74033	APURVA	22	01-03-2023	06-03-2023	CREASED FETAL MOVEMEN	G1	41+1	10.8	OLIGOHYDROMNIOS
44	74249	GURUDEVI	28	01-03-2023	08-03-2023	OLIGOHYDRAMNIOS	G2P1L1	36+5	10	OLIGOHYDROMNIOS
45	74262	LALITA	20	01-03-2023	08-03-2023	PAIN ABDOMEN	G2P1D1	39+6	10.8	FETAL DISTRESS
46	74247	KAVERI HOSAMATH	21	01-03-2023	10-03-2023	PAIN ABDOMEN	G1	40+5	11	NPOL
47	123119	REKHA	30	11-03-2023	16-03-2023	PAIN ABDOMEN	G1	39+1	13.5	CPD
48	86106	PRIYANKA	19	12-03-2023	18-03-2023	PAIN ABDOMEN	G1	37+6	11	FETAL DISTRESS
49	33548	SHRUTI	28	15-03-2023	23-03-2023	PAIN ABDOMEN	G1	39+2	12	CPD
50	90351	PRABHAVATI	24	15-03-2023	21-03-2023	PV LEAK	G4P3L3	30+4	12.8	OLIGOHYDROMNIOS
51	90354	REKHA	24	15-03-2023	21-03-2023	PAIN ABDOMEN	G1	39+6	14.4	OLIGOHYDROMNIOS
52	95892	KASHIBAI	28	20-03-2023	26-03-2023	SAFE CONFINEMENT	G1	40+4	12.4	OLIGOHYDROMNIOS
53	95910	ROOPA	26	20-02-2023	26-03-2023	SAFE CONFINEMENT	G2A1	38+6	11.7	OLIGOHYDROMNIOS
54	66605	SWETA	20	23-02-2023	03-03-2023	PAIN ABDOMEN	G1	38+3	10	FETAL DISTRESS
55	63432	USHA SAGAR	24	22-03-2023	29-03-2023	PAIN ABDOMEN	G2A1	40+2	10.1	CPD
56	100068	SUSHAMITA	20	25-02-2023	30-03-2023	PAIN ABDOMEN	G1	38+2	9.6	OLIGOHYDROMNIOS
57	94765	BHARATHI	35	20-03-2023	27-03-2023	PAIN ABDOMEN	G4P3L3	37+1	11.5	FETAL DISTRESS
58	100706	BHUVANESHWARI	24	25-03-2023	01-04-2023	PAIN ABDOMEN	G1	40+1	11.5	NPOL
59	101222	KAMALBAI	31	26-03-2023	01-04-2023	PAIN ABDOMEN	G2A1	39	10.1	SECOND STAGE ARREST
60	94740	BHAGYASHREE	19	19-03-2023	27-03-2023	PAIN ABDOMEN	G2P1L1	39	7.2	SECOND STAGE ARREST
61	101187	GANGA	22	25-03-2023	01-04-2023	PAIN ABDOMEN	G3A2	38+5	12.5	FETAL DISTRESS
62	101328	KAVERI ANIL	22	26-03-2023	01-04-2023	PAIN ABDOMEN	G2P1L1	38+5	12.2	PREVIOUS 1 LSCS
63	101815	PAVITRA	22	26-03-2023	02-04-2023	PAIN ABDOMEN	G2P1L1	39+1	10.9	PREVIOUS 1 LSCS
64	96885	ASMA	20	22-03-2023	07-04-2023	PAIN ABDOMEN, PV LEAK	G1	39+4	11.7	FETAL DISTRESS
65	95862	POORNIMA	22	20-03-2023	01-04-2023	PAIN ABDOMEN	G1	36+1	13.6	SECOND STAGE ARREST
66	105738	PRABHAVATI HORAKERI	21	29-03-2023	04-04-2023	PAIN ABDOMEN, PV LEAK	G3A2	36+6	12	OLIGOHYDROMNIOS
67	78879	LAXMI SANTOSH	23	27-03-2023	01-04-2023	PAIN ABDOMEN	G1	38+1	12.7	CPD
68	230818	RASHMI	25	29-03-2023	09-04-2023	PAIN ABDOMEN, PV LEAK	G2P1L1	33+2	11	FETAL DISTRESS
69	89852	SHAHISTA	22	29-03-2023	03-04-2023	PAIN ABDOMEN	G3P2L2	37+5	10.5	PREVIOUS 2 LSCS
70	98850	BHAGYASHREE VIJAY	22	24-03-2023	01-04-2023	PAIN ABDOMEN	G3P2L2	38+3	12.5	PREVIOUS 2 LSCS
71	62210	SHRUTI VINOD	24	25-03-2023	02-04-2023	PAIN ABDOMEN	G1	40+1	9	CPD
72	94932	SHRUTI SHIVANAND	31	27-03-2023	01-04-2023	PV LEAK	G1	40+0	12.1	OLIGOHYDROMNIOS
73	107133	HUSHENBEE MULLA	36	31-03-2023	07-04-2023	PAIN ABDOMEN	G4P3L2D1	39+3	8.6	BREECH
74	109904	LALITA	28	01-04-2023	07-04-2023	PAIN ABDOMEN	G1	40+5	10.2	OLIGOHYDROMNIOS
75	108624	SUREKHA	23	01-04-2023	08-04-2023	PAIN ABDOMEN, PV LEAK	G2A1	37+5	13.3	OLIGOHYDROMNIOS
76	108629	SANGEETA RATHOD	22	01-04-2023	06-04-2023	PAIN ABDOMEN	G2P1L1	39+2	12.5	PREVIOUS 1 LSCS
77	114044	DEEPA BABU	30	05-04-2023	12-04-2023	PAIN ABDOMEN	G3P2L2	39+5	10.1	PREVIOUS 2 LSCS
78	111937	JAKKAMMA	19	03-04-2023	08-04-2023	PAIN ABDOMEN	G1	39+2	11.4	CPD
79	112331	SHRUTI TALWAR	21	04-04-2023	10-04-2023	PAIN ABDOMEN	G1	37+2	10.6	OLIGOHYDROMNIOS
80	120717	PRAGATI	20	13-04-2023	20-04-2024	SAFE CONFINEMENT	G1	39+4	12.9	NPOL
81	121801	CHADRAKALA	27	13-04-2023	21-04-2023	PAIN ABDOMEN	G3P2L2	39+1	10.1	PREVIOUS 2 LSCS
82	117803	SUREKHA	18	10-04-2023	15-04-2023	PAIN ABDOMEN	G2P1L1	33	9.8	PREVIOUS 1 LSCS
83	123721	BHAGYASHREE	21	14-04-2023	21-04-2023	PAIN ABDOMEN	G2A1	38+5	12.5	CPD
84	5516	NEELAMMA	27	15-04-2023	21-04-2023	PAIN ABDOMEN	G3P2L2	36+4	11.3	PREVIOUS 1 LSCS
85	125583	NINGAMMA	20	17-04-2023	26-04-2023	PAIN ABDOMEN	G2P1L1	39+3	11	PREVIOUS 1 LSCS
86	61302	AMBIKA	21	16-04-2023	23-04-2023	PAIN ABDOMEN	G2P1L1	37	10.1	PREVIOUS 1 LSCS
87	126911	SUNITA	19	17-04-2023	24-04-2023	PAIN ABDOMEN	G1	40+1	11	FETAL DISTRESS
88	126883	PUSHPA	31	17-04-2003	22-04-2023	PAIN ABDOMEN	G2A1	39+6	12	CPD
89	107139	VIDHYASHREE	25	31-03-2023	06-04-2023	PAIN ABDOMEN	G1	37+1	13.1	OLIGOHYDROMNIOS
90	129228	BHAGYASHREE	24	19-04-2023	25-04-2023	PAIN ABDOMEN	G1	39+1	12	CPD
91	132452	SHAJADABI	32	22-04-2023	29-04-2023	PAIN ABDOMEN	G1	36+6	10	NPOL
92	130514	SUDHARANI	25	20-04-2023	26-04-2023	PAIN ABDOMEN	G4P1L1A2	40	10	FETAL DISTRESS
93	133101	LAXMI	23	23-04-2023	01-05-2023	PAIN ABDOMEN	G2P1L1	36+3	10	PREVIOUS 1 LSCS
94	111844	RENUKA	26	27-04-2023	06-05-2023	PAIN ABDOMEN	G3P2L2	37	11	PREVIOUS 2 LSCS
95	136993	SUSHMITHA	23	27-04-2023	02-05-2023	PAIN ABDOMEN	G1	39+5	12	FETAL DISTRESS
96	136940	VAISHALI	28	26-04-2023	01-05-2023	PV LEAK	G1	39+1	12	FETAL DISTRESS
97	124127	POOJA	24	29-04-2023	05-05-2023	SAFE CONFINEMENT	G1	40	10	OLIGOHYDROMNIOS
98	132546	LAXMI	22	24-04-2023	06-05-2023	SAFE CONFINEMENT	G1	37	12	CPD
99	142426	MAHANANDA	22	20-04-2023	17-05-2023	PV LEAK	G2P1L1	39	12	FETAL DISTRESS
100	142456	PAVITRA	23	02-05-2023	08-05-2023	PV LEAK	G1	36+2	12	BREECH

101	138267	RESHMA	27	27-04-2023	12-05-2023	PV LEAK	G4P2L2A1	35+1	10	FETAL DISTRESS
102	143627	SIDHAMMA	21	03-05-2023	11-05-2023	SAFE CONFINEMENT	G1	38+3	11.7	BREECH
103	141395	VANI	21	30-04-2023	06-05-2023	SAFE CONFINEMENT	G3A2	40+1	11.6	MATERNAL REQUEST
104	142291	GEETA	25	01-05-2023	09-05-2023	SAFE CONFINEMENT	G4P3L1D1	31+1	10.1	OLIGOHYDROMNIOS
105	137937	PRERANA	21	08-05-2023	15-05-2023	PAIN ABDOMEN	G1	39+2	12.2	MATERNAL REQUEST
106	150505	PAVITRA	25	08-05-2023	18-05-2023	SAFE CONFINEMENT	G1	33+2	12.5	FETAL DISTRESS
107	79977	NAJAMIN	21	07-05-2023	12-05-2023	PAIN ABDOMEN	G1	38+2	11	FETAL DISTRESS
108	147264	GEETHA SANTHOSH	25	05-05-2023	09-05-2023	PAIN ABDOMEN	G1	39+2	11	MATERNAL REQUEST
109	248833	AJMIN	25	12-05-2023	18-05-2023	SAFE CONFINEMENT	G3P2L2	39+1	10	PREVIOUS 2 LSCS
110	158391	BOURAMMA	38	16-05-2023	22-05-2023	PAIN ABDOMEN	G3P2L2	40+1	8.5	CPD
111	158394	SHILPA	22	16-05-2023	21-05-2023	SAFE CONFINEMENT	G1	38+4	10.6	OLIGOHYDROMNIOS
112	124127	POOJA	24	29-04-2023	05-05-2023	SAFE CONFINEMENT	G1	40	11.4	OLIGOHYDROMNIOS
113	64811	SUPRITA	30	21-04-2023	27-04-2023	PAIN ABDOMEN	G2P1L1	37+5	12	PREVIOUS 1 LSCS
114	159469	LAXMI ASHOK	30	16-05-2023	23-05-2023	SAFE CONFINEMENT	G4P3L1D2	35+3	12.3	PREVIOUS 2 LSCS
115	156159	POOJA	26	14-05-2023	20-05-2023	SAFE CONFINEMENT	G1	37+1	13.3	OLIGOHYDROMNIOS
116	135709	NEHA	22	12-05-2023	18-05-2023	SAFE CONFINEMENT	G1	39+5	12.1	OLIGOHYDROMNIOS
117	143572	SONALI	21	13-05-2023	18-05-2023	PAIN ABDOMEN	G2P1L1	41	7.7	PREVIOUS 1 LSCS
118	174332	BISMILLAH	28	30-05-2023	05-06-2023	PAIN ABDOMEN, PV LEAK	G1	39+2	10.7	CPD
119	172846	RADHIKA	22	28-05-2023	05-06-2023	PV BLEED	G2A1	33+2	11.4	OLIGOHYDROMNIOS
120	172279	PRIYANKA NAIK	23	28-05-2023	03-06-2023	PAIN ABDOMEN	G1	38+5	11	CPD
121	160593	MANJULA	26	27-05-2023	05-06-2023	SAFE CONFINEMENT	G1	40+2	12	OLIGOHYDROMNIOS
122	72323	SHASHIKALA	36	26-05-2023	01-06-2023	SAFE CONFINEMENT	G4P1L1A2	37+3	12.1	PREVIOUS 1 LSCS
123	167354	VIJAYALAXMI	25	23-05-2024	01-06-2023	SAFE CONFINEMENT	G3A2	37+3	10.5	OLIGOHYDROMNIOS
124	167267	BHAGYASHREE MUTTU	26	23-05-2023	01-06-2023	PAIN ABDOMEN	G3P2L2	37+1	13.2	PREVIOUS 2 LSCS
125	179284	DRAKSHAYINI	31	02-06-2023	08-06-2023	PV BLEED	G3P2L2	39+2	12.1	PREVIOUS 1 LSCS
126	179521	BHAGYASHREE BASARI	28	03-06-2023	08-06-2023	PV BLEED	G1	40	11	MATERNAL REQUEST
127	445462	PRIYANKA AGARKHED	20	03-06-2023	08-06-2023	PAIN ABDOMEN	G2P1L1	36+3	11.5	PREVIOUS 1 LSCS
128	182753	SHOBHA LAMANI	35	05-06-2023	11-06-2023	PAIN ABDOMEN	G3A2	38+4	13.1	FETAL DISTRESS
129	178190	MIRABAI RATHOD	35	01-06-2023	09-06-2023	PAIN ABDOMEN	G3P2L2	36+4	10	PREVIOUS 1 LSCS
130	180906	SHAKUNTALA PUJARI	34	04-06-2023	09-06-2023	PAIN ABDOMEN	G3P2L2	39+1	11	PREVIOUS 1 LSCS
131	182752	JYOTI MALLIKARJUN	22	05-06-2023	11-06-2023	PAIN ABDOMEN	G1	40	12.7	FETAL DISTRESS
132	172763	VIMALA	21	06-06-2023	14-06-2023	PAIN ABDOMEN	G2P1L1	37+2	10	PREVIOUS 1 LSCS
133	186647	MAYAMMA	25	08-06-2023	16-06-2023	PAIN ABDOMEN	G2P1L1	39+5	10.2	PREVIOUS 1 LSCS
134	192460	POOJA MAHANTESH	25	13-06-2023	19-06-2023	PAIN ABDOMEN	G3P1L1A1	37+4	11	PREVIOUS 1 LSCS
135	191846	KAVERI ANGADI	24	13-06-2023	21-06-2023	PAIN ABDOMEN	G5P2L2A2	38	11.7	PREVIOUS 2 LSCS
136	196670	PRATHIBA UNDI	27	16-06-2023	23-06-2023	PAIN ABDOMEN, PV LEAK	G3P1L1A1	38+5	12	PREVIOUS 1 LSCS
137	199873	SMITA	25	20-06-2023	20-06-2023	PAIN ABDOMEN	G1	41	11.9	CPD
138	214947	HAWABI	26	03-07-2023	13-07-2023	PAIN ABDOMEN	G2P1L1	40+3	11.9	PREVIOUS 1 LSCS
139	252292	BOURAMMA	25	04-08-2023	16-08-2023	PV LEAK	G3P1L1A1	40+1	12	PREVIOUS 1 LSCS
140	252332	PRIYANKA	24	05-08-2023	16-08-2023	PAIN ABDOMEN	G1	39	10	MATERNAL REQUEST
141	251129	SHASHIKALA	22	04-08-2023	16-08-2023	PAIN ABDOMEN	G1	39+3	11.1	FETAL DISTRESS
142	252281	YASHODA	22	14-08-2023	20-08-2023	PAIN ABDOMEN	G1	41	10	FETAL DISTRESS
143	260543	RENUKHA	20	15-08-2023	21-08-2023	PAIN ABDOMEN	G2P1L1	41+2	10	PREVIOUS 1 LSCS
144	268441	ISRAT	21	22-08-2023	30-08-2023	PAIN ABDOMEN	G1	39	11	FETAL DISTRESS
145	63837	PRATHIBA	26	27-08-2023	02-09-2023	PAIN ABDOMEN	G2P1L1	38+2	12.5	PREVIOUS 1 LSCS
146	270673	BHARATI	22	24-08-2023	03-Sep	PAIN ABDOMEN	G2A1	36+4	9.9	CPD
147	273821	ASHA RATHOD	30	28-08-2023	02-09-2023	PAIN ABDOMEN	G2P1L1	30+4	11	PREVIOUS 1 LSCS
148	270494	JYOTI	28	24-08-2023	01-09-2023	PAIN ABDOMEN	G3P2L2	39+2	9.2	FETAL DISTRESS
149	284122	RADHIKA	26	05-09-2023	11-09-2023	PAIN ABDOMEN	G2A1	39+3	11	BREECH
150	279698	VANITA	22	02-09-2023	09-09-2023	PAIN ABDOMEN	G1	35+6	10	MATERNAL REQUEST
151	255732	PRIYANKA	24	19-09-2023	27-09-2023	PAIN ABDOMEN	G3P1L1A1	38+1	12	PREVIOUS 1 LSCS
152	358890	NILAMMA	26	20-09-2023	27-09-2023	PAIN ABDOMEN	G1	39	11	MATERNAL REQUEST
153	83692	SAMEENA	22	13-03-2024	20-03-2024	PAIN ABDOMEN	G1	37+3	9.1	MATERNAL REQUEST
154	83567	MUSKAN HATTARA	25	13-03-2024	21-03-2024	PV LEAK	G5P1L1A3	37+6	11.6	PREVIOUS 1 LSCS
155	88070	PREMA KAMBLE	21	18-03-2024	25-03-2024	PV LEAK	G1	38	11.7	FETAL DISTRESS
156	88016	ASHWINI IRASAN	25	17-03-2024	24-03-2024	PV LEAK	G2A1	39	11.2	CPD
157	88035	PRIYANKA JIRAGI	25	17-03-2024	24-03-2024	PAIN ABDOMEN	G4P3L3	39+3	12.5	PREVIOUS 1 LSCS
158	90463	SIDDAMMA ANIL	20	20-03-2024	27-03-2024	PAIN ABDOMEN	G1	33+2	9.2	FETAL DISTRESS
159	217278	REKHA KADAM	22	18-03-2024	25-03-2024	PAIN ABDOMEN	G2P1L1	38+4	10.8	PREVIOUS 1 LSCS
160	90351	BHAGYA SHIVAPPA	19	19-03-2024	26-03-2024	PAIN ABDOMEN, PV LEAK	G2A1	41	10.5	BREECH
161	89311	SARITA SANTHOSH	27	18-03-2024	24-03-2024	PV LEAK	G1	38+1	14.3	FETAL DISTRESS
162	90438	KAMALABAI BISANAL	34	19-03-2024	25-03-2024	PAIN ABDOMEN	G5P4L4	39	11.8	PREVIOUS 2 LSCS
163	89082	ASWINI SHIVAJI	25	19-03-2024	25-03-2024	PAIN ABDOMEN	G2P1L1	37+2	11.8	MATERNAL REQUEST
164	338659	LAXMI ANIL	24	21-04-2024	26-04-2024	PAIN ABDOMEN	G2P1L1	39+2	11.9	PREVIOUS 1 LSCS
165	74184	MUSKAN ASHIF	20	20-03-2024	27-03-2024	PAIN ABDOMEN	G1	39+2	11.9	NPOL
166	91823	GANGAMMA	21	21-03-2024	28-03-2024	PV LEAK	G2P1L1	38+6	9	PREVIOUS 1 LSCS
167	288577	RAJESHWARI VATHAR	21	17-04-2024	22-04-2024	PAIN ABDOMEN	G1	38+1	10	CPD
168	129171	SUMALATHA PRADEEP	24	17-04-2024	23-04-2024	PV LEAK	G1	35+6	11	OLIGOHYDROMNIOS
169	129159	LAXMI BAJANTRI	19	17-04-2024	24-04-2024	PAIN ABDOMEN	G2P1L1	39+4	10	PREVIOUS 1 LSCS
170	134521	SHRINIDHI SRISHAIL	22	22-04-2024	29-04-2024	PAIN ABDOMEN	G2P1L1	37+5	10.6	PREVIOUS 1 LSCS
171	135989	PUSHPA	22	22-04-2024	28-04-2024	PAIN ABDOMEN, PV LEAK	G1	38+5	10.9	SECOND STAGE ARREST
172	134497	DHANAMMA SIDDAPPA	22	21-04-2024	27-04-2024	PAIN ABDOMEN	G3P2L1D1	35+4	8.9	PREVIOUS 1 LSCS
173	134513	AFREEN BHAGWAN	24	22-04-2024	29-04-2024	PAIN ABDOMEN	G3P2L2	42+2	8.8	CPD
174	135991	POOJA HANMANT	21	22-04-2024	28-04-2024	PAIN ABDOMEN, PV LEAK	G2P1L1	39+3	12.1	PREVIOUS 1 LSCS
175	314953	BALAMMA KUMBAR	19	22-04-2024	29-04-2024	PAIN ABDOMEN	G1	41	10.8	MATERNAL REQUEST
176	134863	ITTAVVA SHETAPPA	23	22-04-2024	28-04-2024	PAIN ABDOMEN	G1	41+2	10.6	FETAL DISTRESS
177	107085	BHAGYASHREE SHIVA	24	27-04-2024	04-05-2024	PAIN ABDOMEN	G2P1L1	39+3	11.8	PREVIOUS 1 LSCS
178	141852	ROOPA HADAPAD	29	27-04-2024	03-05-2024	PAIN ABDOMEN	G3A2	39+3	9.7	FETAL DISTRESS
179	141847	JYOTHI SANTHOSH	23	27-04-2024	04-05-2024	PAIN ABDOMEN	G1	39+3	11	BREECH
180	140394	SEEMA RATHOD	24	25-04-2024	03-05-2024	PAIN ABDOMEN	G1	40+2	10.5	BREECH
181	141834	ALFIYA	20	26-04-2024	04-05-2024	PAIN ABDOMEN	G3P1L1A1	38+6	10.5	PREVIOUS 1 LSCS
182	140406	ANASUYA SANJAY	29	26-04-2024	05-05-2024	PAIN ABDOMEN, PV LEAK	G4P1L1A2	40	16.6	FETAL DISTRESS
183	141830	ARIFA RAJAK	19	26-04-2024	04-05-2024	PAIN ABDOMEN, PV LEAK	G1	38+4	10.6	FETAL DISTRESS
184	143123	PUJA CHAVAN	19	27-04-2024	03-05-2024	PAIN ABDOMEN	G1	38+1	9.5	FETAL DISTRESS
185	141858	BHAGYASHREE SUTAR	25	27-04-2024	04-05-2024	PAIN ABDOMEN	G4P1L1A2	38+3	12.2	PREVIOUS 1 LSCS
186	142441	ROHINI MANE	22	27-04-2024	06-05-2024	PAIN ABDOMEN, PV LEAK	G1	38+3	11.3	CPD
187	134848	AKSHATA KOLLI	23	28-04-2024	04-05-2024	PAIN ABDOMEN	G2P1L1	38	12.1	PREVIOUS 1 LSCS
188	147035	RAJASHREE BIRADAR	35	30-04-2024	07-05-2024	PAIN ABDOMEN	G3P2L2	38+2	9	PREVIOUS 1 LSCS
189	147015	MAHANAND SUNIL	21	30-04-2024	08-05-2024	PV LEAK	G2A1	38+3	12.9	OLIGOHYDROMNIOS
190	130378	POOJA VIJAY	25	28-04-2024	07-05-2024	PAIN ABDOMEN	G3P2L2	38+5	11.1	PREVIOUS 1 LSCS
191	147605	SAVITRI SRISHAIL	24	01-05-2024	09-05-2024	SAFE CONFINEMENT	G3P2L2	40+2	12.8	PREVIOUS 1 LSCS
192	147054	PREMA CHANDAKI	23	01-05-2024	10-05-2024	PAIN ABDOMEN, PV LEAK	G1	39+4	9.9	MATERNAL REQUEST
193	147686	SOUNDARYA	22	01-05-2024	09-05-2024	PAIN ABDOMEN	G1	39+3	12.8	OLIGOHYDROMNIOS
194	147705	SUSHILA	38	01-05-2024	08-05-2024	PAIN ABDOMEN	G3P1L1A1	33+2	12.3	PREVIOUS 1 LSCS
195	147701	SIDHAMMA	20	01-05-2024	10-05-2024	PAIN ABDOMEN	G1	39+6	9.6	FETAL DISTRESS
196	148441	BHARATHI IRAYYA	26	02-05-2024	09-05-2024	PAIN ABDOMEN	G2P1L1	41	12.8	PREVIOUS 1 LSCS
197	149221	POOJA ANIL RATHOD	22	03-05-2024	11-05-2024	PAIN ABDOMEN	G3P2L2	38+1	10.5	PREVIOUS 2 LSCS
198	149186	SHARANMMA	35	02-05-2024	10-05-2024	DECREASED FETAL MOVEMEN	G2P1L1	35+1	11.1	PREVIOUS 1 LSCS
199	145010	ANITA LENKAPUR	26	03-05-2024	12-05-2024	PAIN ABDOMEN	G5P2L2A2	39+6	11.3	PREVIOUS 2 LSCS
200	150678	KASHIBAI	20	03-05-2024	11-05-2024	PAIN ABDOMEN	G1	38+5	11	FETAL DISTRESS

201	150617	AKSHATA	24	03-05-2024	12-05-2024	PAIN ABDOMEN	G3P1L1A1	37+3	11.8	PREVIOUS 2 LSCS
202	151514	SUSHMA	30	04-05-2024	12-05-2024	PAIN ABDOMEN	G2P1L1	38	13.5	PREVIOUS 1 LSCS
203	150697	GOURAMMA PUJARI	28	03-05-2024	12-05-2024	PAIN ABDOMEN	G3P2L2	39+2	11.8	PREVIOUS 2 LSCS
204	150716	ROOPA SUBHASH	24	03-05-2024	13-05-2024	PAIN ABDOMEN, PV LEAK	G1	40	8.2	FETAL DISTRESS
205	152958	FARJANA	36	05-05-2024	14-05-2024	PAIN ABDOMEN	g5p4l4	39	11.1	FETAL DISTRESS
206	152297	LALITHA	25	05-05-2024	15-05-2024	PAIN ABDOMEN	G4P2L2A1	33+0	10.1	FETAL DISTRESS
207	153010	SHIVAMMA	18	06-05-2024	15-05-2024	PAIN ABDOMEN	G1	42+1	10.3	FETAL DISTRESS
208	155066	PALLAVI RATHOD	22	07-05-2024	15-05-2024	PAIN ABDOMEN	G1	38	13	MATERNAL REQUEST
209	150610	MINAZ ATTAR	28	03-05-2024	10-05-2024	PAIN ABDOMEN	G3P2L1D1	36+4	9.5	FETAL DISTRESS
210	154400	MUMTAZBI	21	07-05-2024	14-05-2024	PAIN ABDOMEN	G1	41	9.3	FETAL DISTRESS
211	150739	BORAMMA	22	04-05-2024	10-05-2024	PAIN ABDOMEN	G2P1D1	34+4	10.1	FETAL DISTRESS
212	155106	DAWALABI	21	08-05-2024	16-05-2024	PAIN ABDOMEN	G1	42	11.5	SECOND STAGE ARREST
213	00032950	LAXMI	25	06-05-2024	12-05-2024	PAIN ABDOMEN	G2P1L1	38+2	10.4	PREVIOUS 1 LSCS
214	155227	SUREKHA	26	08-05-2024	16-05-2024	SAFE CONFINEMENT	G1	38+5	10.6	FETAL DISTRESS
215	156664	GOURAMMA	20	08-05-2024	17-05-2024	PAIN ABDOMEN	G1	37+6	10.7	FETAL DISTRESS
216	99186	SHARADA KIRAN	25	09-05-2024	17-05-2024	PAIN ABDOMEN	G1	37+6	10.5	NPOL
217	157976	RAJESHWARI	37	09-05-2024	17-05-2024	PAIN ABDOMEN	G1	36+5	12.7	MATERNAL REQUEST
218	157988	SUMAYYA	20	09-05-2024	16-05-2024	PAIN ABDOMEN	G2P1D1	39+4	11.4	CPD
219	157960	CHANNAMMA	28	09-05-2024	15-05-2024	PAIN ABDOMEN	G3P2L2	37+4	11.9	PREVIOUS 2 LSCS
220	158127	PRIYANKA CHAVAN	21	09-05-2024	16-05-2024	PAIN ABDOMEN, PV LEAK	G3A2	39+5	10.3	CPD
221	357022	PRIYANKA BIRADAR	26	09-05-2024	17-05-2024	PAIN ABDOMEN	G3P2L1D1	40+2	11.9	PREVIOUS 2 LSCS
222	158102	DHANUJA SANDEEP	24	09-05-2024	16-05-2024	PAIN ABDOMEN	G2P1L1	38+6	11.6	FETAL DISTRESS
223	158830	BHARATI SINGE	27	10-05-2024	17-05-2024	PAIN ABDOMEN	G4P3L3	39+1	9.5	MATERNAL REQUEST
224	158856	LALABI	28	11-05-2024	18-05-2024	PAIN ABDOMEN, PV LEAK	G2P1L1	40+6	10.6	PREVIOUS 1 LSCS
225	148354	DEEPIKA CHETAN	27	11-05-2024	20-05-2024	SAFE CONFINEMENT	G1	39+3	13.1	NPOL
226	161053	ASHWINI SALUMKE	33	12-05-2024	19-05-2024	PV LEAK	G1	38+1	11.1	FETAL DISTRESS
227	161034	LATHA AJAMANE	30	12-05-2024	20-05-2024	PV LEAK	G3P2L	32+1	9.3	PREVIOUS 2 LSCS
228	131865	SANAKOUSAR	23	12-05-2024	21-05-2024	SAFE CONFINEMENT	G2P1L1	37+4	10.6	PREVIOUS 1 LSCS
229	161885	ROOPA	21	13-05-2024	18-05-2024	PAIN ABDOMEN, PV LEAK	G2P1L1	40+3	9.7	PREVIOUS 1 LSCS
230	233960	LAXMI SHIVAPPA	19	13-05-2024	18-05-2024	PAIN ABDOMEN	G1	40	11.4	OLIGOHYDROMNIOS
231	165499	HARANAMMA BUSAGON	18	15-05-2024	20-05-2024	PAIN ABDOMEN, PV LEAK	G1	41+3	12.6	CPD
232	164419	KAVERI CHINAWALAR	20	15-05-2024	20-05-2024	PAIN ABDOMEN	G1	40	11.3	FETAL DISTRESS
233	167013	RENUKA ODEYARA	20	17-05-2024	22-05-2024	PAIN ABDOMEN	G1	39+6	9.7	CPD
234	325943	UMA KASE	25	16-05-2024	22-05-2024	PAIN ABDOMEN	G3P1L1A1	40+3	10.3	FETAL DISTRESS
235	167524	SAVITA DALAWAI	25	17-05-2024	22-05-2024	PAIN ABDOMEN	G2P1L1	38	12.5	PREVIOUS 1 LSCS
236	167398	VIJAYALAXMI	34	17-05-2024		PAIN ABDOMEN	G4P2L1D1A1	39+1	11.4	PREVIOUS 1 LSCS
237	164281	LAXMI MAHADEV	30	15-05-2024	21-05-2024	PAIN ABDOMEN	G6P2L2A3	37+2	9.6	FETAL DISTRESS
238	167948	GAJARABAI ODEYAR	21	17-05-2024		SAFE CONFINEMENT	G1	40+1	12.8	FETAL DISTRESS
239	362648	KAVERI	22	19-11-2023	25-11-2023	SAFE CONFINEMENT	G2P1L1	38+6	11	PREVIOUS 1 LSCS
240	360190	UJAMA SHEIKH	22	16-11-2023	24-11-2023	PAIN ABDOMEN	G1	33+3	10	NPOL
241	170378	SAVITRI SANJAY	25	19-05-2024		PAIN ABDOMEN	G2A1	40	10.4	FETAL DISTRESS
242	169970	MURIGEMMA	24	18-05-2024		PAIN ABDOMEN, PV LEAK	G3P1L1A1	37+5	12	PREVIOUS 1 LSCS
243	170025	SANJANA HADAPAD	22	19-05-2024	20-05-2024	PAIN ABDOMEN	G1	40+5	9.1	CPD
244	170730	LAXMI GOUDI	30	19-05-2024		SAFE CONFINEMENT	G3P2L1D1	40+5	9.1	FETAL DISTRESS
245	170756	SANJANA KATTIMANI	21	20-05-2024		PAIN ABDOMEN	G2P1L1	34+2	10.3	FETAL DISTRESS
246	172101	SIDHAMMA	23	20-05-2024		SAFE CONFINEMENT	G1	40+1	9.8	MATERNAL REQUEST
247	173306	SHANTHABAI	29	21-05-2024	29-05-2024	PAIN ABDOMEN	G3P2L2	36+5	11	PREVIOUS 2 LSCS
248	132303	LAXMI DESAI	29	21-05-2024		SAFE CONFINEMENT	G2P1L1	38+4	10.7	PREVIOUS 1 LSCS
249	165006	MUSKAN	21	19-05-2024	26-05-2024	PAIN ABDOMEN	G3P2L2	37+3	12.7	PREVIOUS 2 LSCS
250	31132	ROOPALI	21	28-01-2024	04-02-2024	PAIN ABDOMEN	G3P3L1D2	39+6	11	PREVIOUS 1 LSCS
251	30548	KAVERI SUTAR	22	27-01-2024	04-02-2024	PAIN ABDOMEN, PV LEAK	G3A2	34+3	10.2	OLIGOHYDROMNIOS
252	33776	CHANAMMA KOSALLI	27	31-01-2024	07-02-2024	PAIN ABDOMEN	G3P2L1D1	38+2	11	PREVIOUS 2 LSCS
253	34936	SAVITA BIRADAR	36	31-01-2024	08-02-2024	PAIN ABDOMEN	G3P1L1A1	37	10.2	PREVIOUS 1 LSCS
254	34993	PUSHPA SATISH	26	01-02-2024	07-02-2024	PV LEAK	G3P2L2	39	11	FETAL DISTRESS
255	36338	SHARADA SUDAKAR	28	02-02-2024	10-02-2024	PAIN ABDOMEN	G2P1L1	38+5	10	PREVIOUS 1 LSCS
256	36323	CHANDRIKA KARADI	20	01-02-2024	08-02-2024	PAIN ABDOMEN	G3P2L2	36+1	11	PREVIOUS 2 LSCS
257	308846	LAXMI MAJJAGI	23	01-02-2024	09-02-2024	PAIN ABDOMEN	G1	39+1	12	NPOL
258	37601	SHRIDEVI SUDHIR	25	02-02-2024	10-02-2024	PAIN ABDOMEN	G2P1D1	37+6	11	PREVIOUS 1 LSCS
259	38799	SHARADABAI	27	03-02-2024	08-02-2024	PAIN ABDOMEN	G2A1	37+3	10	FETAL DISTRESS
260	40789	AKSHATA	26	06-02-2024	12-02-2024	PAIN ABDOMEN	G2P1L1	39+6	11	PREVIOUS 1 LSCS
261	10915	PRIYANKA JADHAV	21	06-02-2024	14-02-2024	PAIN ABDOMEN	G1	36+1	10	BREECH
262	258619	SUJATA	24	08-02-2024	16-02-2024	PAIN ABDOMEN	G1	40+5	12	CPD
263	173841	ANJALI	23	22-05-2024	30-05-2024	PAIN ABDOMEN	G1	39+4	10.5	CPD

FT/PT	UTERUS CLOSURE	RS CLOSURE	SKIN CLOSURE	TIME OF AZITHROMYCIN	TIME OF CEPHALOSPORINS	TIME OF SKIN INCISION	FEVER	RASHES	PV DISCHARGE	ERYTHEMA	INDURATION	GAPING
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:40PM	2:45PM	3:20PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12AM	12:05AM	12:35AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8PM	8:10PM	8:40PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:15PM	12PM	12:50PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8PM	8:05PM	8:35PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:00AM	11:20AM	11:52AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	7:05PM	7PM	7:40PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:05PM	3PM	4PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:25PM	5:30PM	6PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:30PM	10:40PM	11:10PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:00AM	5:15AM	06:00AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5AM	5AM	5:40AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	7AM	7:05AM	7:40AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:35AM	4:30AM	5:05AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:30PM	2:35PM	3:15PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:30PM	6:20PM	7PM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	3:02PM	3:05PM	3:40PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:30PM	11:35PM	12AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:05PM	12PM	12:42PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:30PM	10:35PM	10:11PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:30PM	2:35PM	3PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:25PM	3:20PM	4PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	1PM	1:10PM	1:40PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:30	12:35PM	01:15	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	4:45AM	4:5OAM	5:35AM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:35AM	5:40AM	6:02AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	6:45AM	6:52AM	7:32AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:35PM	5:30PM	6:10PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:20PM	2:50PM	2:45PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:35PM	3:30 PM	4:48 PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	5:10PM	5PM	6PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:40PM	3:45PM	4:20PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:25PM	4:20PM	5PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12AM	12:02AM	12:30AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:25PM	8:30PM	9PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:20AM	4:25AM	5AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:00AM	9:05AM	9:50 AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:45 PM	5:50 PM	6:21 PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:55 PM	12:45PM	1:30 AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:05 PM	3:00 PM	3:55 PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:20PM	5:25PM	6PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:55 AM	9:58 AM	10:38AM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4PM	4:05PM	4:40PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:20 PM	11:25 PM	12:05 AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:50 PM	11:45 PM	12:25 AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2PM	2:05PM	2:45PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:30 AM	9:35 AM	10:08 AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:00 AM	2:05 AM	2:40 AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:45 PM	9:50 PM	10:28 PM	NO	NO	NO	NO	YES	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:20 PM	9:25 PM	10:10 PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:25PM	9:30PM	10:11PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:00PM	9:03PM	9:49PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:00PM	9:03PM	9:50PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	7:10AM	7AM	7:52AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:35PM	3:40PM	4:30PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	1:00PM	1:05PM	1:57PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:35pm	2:30pm	3:12pm	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:25PM	8:30PM	9:12PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:25AM	2:35AM	3:02AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	1:55AM	1:45AM	2:32AM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:48AM	5:45AM	6:18AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:35AM	8:45AM	9:43AM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:50PM	4:45PM	5:20PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:20AM	12:25AM	1:00AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:40AM	12:30AM	1:19AM	NO	NO	NO	YES	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:30PM	9:35PM	10:03PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:40PM	6:45PM	7:20PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:50AM	9:00AM	9:37AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	1:57PM	11:55PM	12:38PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	5:50AM	6:00AM	6:38AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:25PM	4:20PM	5:04PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:40AM	5:45AM	6:22AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:40AM	11:45AM	12:22PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:25PM	6:30PM	6:58PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:45AM	6:50AM	7:27AM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:45AM	6:52AM	7:28AM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	10:00PM	10:05PM	10:45PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:30PM	5:35PM	6:18PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:00PM	5:05PM	5:54PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:15AM	6:20AM	6:58AM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:10AM	6:15AM	6:53AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:02AM	6:00AM	6:30AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:10PM	4:00PM	4:58PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:00PM	4:55PM	5:32PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:55PM	7:00PM	7:30PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:00PM	5:06PM	5:50PM	NO	NO	NO	YES	YES	YES
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:15PM	5:20PM	6:02PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:50PM	5:45PM	6:32PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	7:15AM	7:20AM	8:18AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:45PM	8:50PM	9:38PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:05PM	12PM	12:40PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:05PM	12PM	12:52PM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:20PM	5:30PM	6:02PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:20PM	6:30PM	7PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:05AM	3AM	3:48AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:05PM	5PM	5:35PM	NO	NO	NO	YES	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:05PM	3PM	3:55PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3.10PM	3.20 PM	4.00PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:20PM	3:30PM	4PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:10AM	6AM	6:52AM	NO	NO	NO	NO	NO	NO

PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:20AM	6:30AM	7:12AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	12:40AM	12:30AM	1:30AM	NO	NO	NO	YES	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:20PM	8:10PM	8:50PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:30AM	4:40AM	5:20AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:25AM	4:20AM	5AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:10PM	10PM	10:56PM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	7:05PM	7PM	7:40PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:55PM	3:50PM	4:22PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:05AM	10AM	10:56AM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:10AM	5AM	5:52AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:05AM	3AM	3:52AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3PM	3:10PM	3:50PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	1:05PM	1PM	1:42PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:30AM	9:35AM	9:55AM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:30AM	10:32AM	11:10AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:40AM	10:30AM	11:18AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:10PM	4PM	4:32PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10AM	10:03AM	10:40AM	NO	NO	NO	YES	YES	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	1:02PM	1:07PM	1:52PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:30PM	10:35PM	11:14PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:20AM	6:30AM	7:05AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:45AM	9:40AM	10:18AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:55PM	10PM	10:36PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	6:10PM	6PM	6:52PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	1:35AM	1:30AM	2:08AM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:30AM	3AM	3:46AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:05AM	2AM	2:37AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:05PM	8PM	8:48PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:02PM	3PM	3:40PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:55AM	11AM	11:20AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	7:05PM	7PM	7:54PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	7:05PM	7PM	7:42PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	3:02PM	3PM	3:52PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:55PM	5PM	5:37PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	11:45AM	11:40AM	12:28PM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:35PM	9:30PM	10:02PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:25AM	4:30AM	5:08AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	3:05PM	3PM	3:40PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:22PM	6:20PM	7:04PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:20AM	6:30AM	7AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:35AM	9:30AM	10:12AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:25AM	10:30AM	11AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:20PM	12:30PM	1:05PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:35PM	3:30PM	4:14PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9AM	9:10AM	9:35AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:35AM	11:30AM	12:10PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:35AM	11:30AM	12:08PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:55AM	5AM	5:32AM	NO	NO	NO	YES	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:55PM	9PM	9:32PM	NO	NO	NO	YES	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:30AM	12:25AM	1:10AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:03PM	8PM	8:36PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	7:20PM	7:25PM	8PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11.30AM	11:35AM	12:10PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	2:45PM	2:50PM	3:32PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:02AM	6AM	6:55AM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3PM	3:10PM	4PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:20PM	6:25PM	7:10PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8AM	8:05AM	8:58AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9AM	9:05AM	9:48AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:20PM	4:25PM	5:02PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	1:50AM	2AM	2:38AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:55PM	7PM	7:40PM	NO	NO	NO	YES	YES	YES
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	11:05PM	11PM	11:56PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9AM	9:05AM	9:50AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:05AM	3AM	4AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:35AM	3:30AM	4:30AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:05PM	10PM	10:48PM	NO	NO	NO	YES	YES	YES
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:55PM	9PM	9:28PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:02PM	9PM	9:37PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	9AM	9:05AM	9:50AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:10PM	8:20PM	8:55P,	YES	NO	NO	YES	YES	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	4:08AM	4:05AM	5AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	4:50AM	4:45AM	5:22AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:30PM	8:20PM	9:10PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:05AM	9AM	9:49AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:55PM	1PM	1:30PM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:55AM	12PM	12:40PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:15AM	2:17AM	3:07AM	NO	NO	NO	YES	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:35AM	2:30AM	3:15AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:25PM	12:20PM	1:10PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:35PM	9:40PM	10:17PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8AM	8AM	8:50AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:40PM	8:45PM	9:28PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:55PM	7PM	7:50PM	NO	NO	NO	YES	NO	YES
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	4:10AM	4:15AM	5:05AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:55PM	3PM	3:50PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	8:10PM	8PM	9:10PM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	1:30AM	1:20AM	2:12AM	NO	NO	NO	YES	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:55PM	12AM	12:45AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:50AM	9:45AM	10:30AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	1:02PM	1PM	1:42PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:35PM	12:20PM	1:25PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:25PM	5:30PM	6:15PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	5:05PM	5PM	6:02PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	7:05AM	7AM	7:50AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:05PM	3:00PM	3:58PM	NO	NO	NO	YES	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:55AM	6AM	6:50AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:05PM	9PM	9:56PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	2:20PM	2:30PM	3:12PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:05PM	5PM	5:50PM	NO	NO	NO	NO	NO	NO

FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	3PM	3:05PM	3:50PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	12PM	12:02PM	12:45PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:10PM	9PM	9:50PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:15PM	8:20PM	9:15PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:15PM	6:20PM	7PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:50AM	12:45AM	1:25AM	NO	NO	NO	YES	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:10AM	6:00AM	7AM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:15PM	4PM	5PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	5:45PM	5:40PM	6:23PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:10AM	2:15AM	3:08AM	NO	NO	NO	NO	YES	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:05PM	9PM	9:46PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:20AM	12:20AM	12:22AM	NO	NO	NO	NO	YES	YES
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:05PM	3PM	3:36PM	NO	NO	NO	NO	NO	YES
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6PM	6PM	6:55PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	7:45PM	7:40PM	8:20PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:30PM	4:20PM	3:15PM	YES	NO	NO	NO	YES	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:40AM	6:45AM	7:20AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:45PM	3:40PM	4:22PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	6:05AM	6AM	6:50AM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:10PM	11:05PM	12AM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	5:20PM	5:15PM	6PM	NO	NO	NO	NO	YES	YES
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	7:55PM	8PM	8:35PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:30PM	5:20PM	6:10PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11.50PM	12AM	12:34AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:40PM	2:30PM	3:16PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:20AM	5:15AM	6AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:50PM	10PM	10:32PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:15AM	6AM	6:52AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:10PM	12PM	12:55PM	NO	NO	NO	NO	YES	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:25PM	3:20PM	4:10PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:35AM	2:30AM	3:10AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:25PM	8:20PM	9:05PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:30AM	3:20AM	4:09AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	6:20PM	6:30PM	7:05PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:20AM	11:30AM	12:12PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:50AM	10:45AM	11:20AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:40AM	5:45AM	6:20AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:40PM	8:30PM	9:12PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8AM	8:05AM	8:40AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:02AM	10:05AM	10:40AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	8:02PM	8PM	8:39PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	5:05PM	5PM	5:56PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	7:28PM	7:25PM	8:06PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	6:50PM	7PM	7:23PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:50AM	3:55AM	4:30AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:45PM	3:50PM	4:20PM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	4:05PM	4PM	4:46PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:30PM	3:35PM	4:13PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:35AM	9:30AM	10:15AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	2:25PM	2:30PM	3:06PM	NO	NO	NO	YES	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	12:20PM	12:30PM	1PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:50AM	4AM	4:27AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	8:20PM	8:25PM	9PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	10:35AM	10:30AM	11:02AM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:35AM	4:30AM	5:06AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	ETHILON	2:55PM	3PM	3:30PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	3:10PM	3PM	3:40PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	11:04PM	11PM	11:40PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:25PM	6:30PM	7:15PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	9:25AM	9:30AM	10:04AM	NO	NO	NO	NO	NO	NO
PT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	4:25PM	4:30PM	5:04PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	7:05PM	7PM	7:42PM	NO	NO	NO	NO	NO	NO
FT	VICRYL ROUND BODY	VICRYL REVERSE CUTTING	MONOCRYL	6:50AM	6:45AM	7:25AM	NO	NO	NO	NO	NO	NO

WOUND DISCHARGE	OTHER ANTIBIOTICS	DURATION OF STAY (DAYS)	READMISSION	FOLLOWUP 3RD DAY	FOLLOWUP 7TH DAY	FOLLOWUP 14TH DAY	FOLLOWUP 6TH WEEK	FOETAL SEX	WEIGHT (KG)	NICU ADMISSION	READMISSION	SECONDARY SUTURINGS
NO	NO	6	NO	N	N	N	N	F	3.2	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.6	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.5	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.8	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	2.7	NO	NO	NO
NO	NO	5	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.8	YES-CPAP	NO	NO
NO	NO	6	NO	N	N	N	N	F	2.6	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	2.3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.4	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3.2	NO	NO	NO
NO	NO	4	NO	N	N	N	N	M	2.9	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	2.4	YES-O2 HOOD	NO	NO
NO	NO	7	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.5	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.8	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3.4	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.6	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	3.2	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.6	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.9	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	10	NO	N	N	N	N	F	2.8	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	2.9	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.3	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	2.8	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.9	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.8	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	2.7	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	2.6	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	2.9	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	3.5	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.4	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	14	NO	N	N	N	N	M	3.2	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	2.8	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.4	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.8	NO	NO	NO
NO	NO	10	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.6	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.5	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	1.2	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.3	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	2.5	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.8	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.7	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.7	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	2.3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.7	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.3	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	3.5	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3.2	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.7	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	3.5	NO	NO	NO
NO	NO	15	NO	N	N	N	N	F	1.9	YES	NO	NO
NO	NO	14	NO	N	N	N	N	M	2.7	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.7	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	12	NO	N	N	N	N	M	2.1	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	2.6	NO	NO	NO
NO	NO	12	NO	N	N	N	N	F	2.8	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.6	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	3.4	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.6	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.4	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.6	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3.5	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.7	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3.1	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	2.9	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	1.8	YES	NO	NO
NO	NO	8	NO	N	N	N	N	F	3.9	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.4	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	2.7	NO	NO	NO
YES	NO	8	NO	N	ABNORMAL	GAPING	N	M	3.2	NO	YES	YES
NO	NO	8	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	2.7	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.5	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.5	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	3.2	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.5	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	2.7	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	1.9	YES	NO	NO
NO	NO	7	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.5	NO	NO	NO
NO	NO	27	NO	N	N	N	N	M	2.3	YES-DEATH	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.6	NO	NO	NO

NO	NO	15	NO	N	N	N	N	F	2	YES	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.7	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.7	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	1.2	YES-VENTILATOR	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.4	NO	NO	NO
NO	NO	10	NO	N	N	N	N	M	2	NO	NO	NO
NO	NO	5	NO	N	N	N	N	M	2.9	NO	NO	NO
NO	NO	5	NO	N	N	N	N	F	2.9	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.9	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	1.9	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.7	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.7	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	3.2	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.3	YES-CPAP	NO	NO
NO	NO	6	NO	N	N	N	N	M	3.2	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	1.8	YES-CPAP	NO	NO
NO	NO	5	NO	N	N	N	N	M	3.2	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	3.2	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.7	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.8	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.9	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.4	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.8	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.5	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	2	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	3.2	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.8	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	2.8	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	3	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.7	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	3.3	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	3.4	YES PHOTOTHERAPY	NO	NO
NO	NO	13	NO	N	N	N	N	M	2.9	NO	NO	NO
NO	NO	4	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	12	NO	N	N	N	N	F	1.8	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	3.4	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	3.2	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.4	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	2.7	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2	YES-CPAP	NO	NO
NO	NO	7	NO	N	N	N	N	M	3.3	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.6	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3.4	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.9	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	2.6	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3.23	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.5	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	1.9	YES-CPAP	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.6	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	2.4	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.4	NO	NO	NO
YES	YES	7	NO	N	ABNORMAL	ABNORMAL	N	M	2.5	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3.4	YES-NASAL PRONGS	NO	NO
NO	NO	7	NO	N	N	N	N	M	3.1	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	2.6	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.8	NO	NO	NO
YES	YES	7	NO	N	ABNORMAL	N	N	M	2.8	NO	NO	YES
NO	NO	6	NO	N	N	N	N	M	1.4	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	2.6	NO	NO	NO
NO	NO	9	NO	N	N	N	N	M	2.5	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	3.1	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	2.1	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	3.1	YES-O2 HOOD	NO	NO
NO	NO	9	NO	N	N	N	N	F	2.9	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	3.5	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	3.5	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.6	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.4	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	2.9	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.4	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	3.6	NO	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.9	NO	NO	NO
YES	NO	14	NO	N	ABNORMAL	GAPING	N	M	2.3	NO	NO	YES
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NO	NO	8	NO	N	N	N	N	M	1.9	YES-CPAP	NO	NO
NO	NO	7	NO	N	N	N	N	F	2.3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.9	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.4	NO	NO	NO
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NO	NO	9	NO	N	N	N	N	F	2.8	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	2.8	NO	NO	NO

NO	NO	7	NO	N	N	N	N	M	3.5	NO	NO	NO
NO	NO	8	NO	N	N	N	N	F	2.45	NO	NO	NO
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NO	NO	6	NO	N	N	N	N	F	2.5	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2	YES	NO	NO
NO	NO	6	NO	N	N	N	N	M	2.5	NO	NO	NO
NO	NO	7	NO	N	N	N	N	M	3	NO	NO	NO
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NO	NO	5	NO	N	N	N	N	F	3.5	NO	NO	NO
NO	NO	6	NO	N	N	N	N	F	1.6	YES-CPAP	NO	NO
NO	NO	7	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	9	NO	N	N	N	N	F	3.1	NO	NO	NO
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NO	NO	8	NO	N	N	N	N	M	2.9	NO	NO	NO
NO	NO	6	NO	N	N	N	N	M	1.4	YES-CPAP	NO	NO
NO	NO	6	NO	N	N	N	N	M	3	NO	NO	NO
NO	NO	8	NO	N	N	N	N	M	2.7	NO	NO	NO
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NO	NO	8	NO	N	N	N	N	M	3	NO	NO	NO

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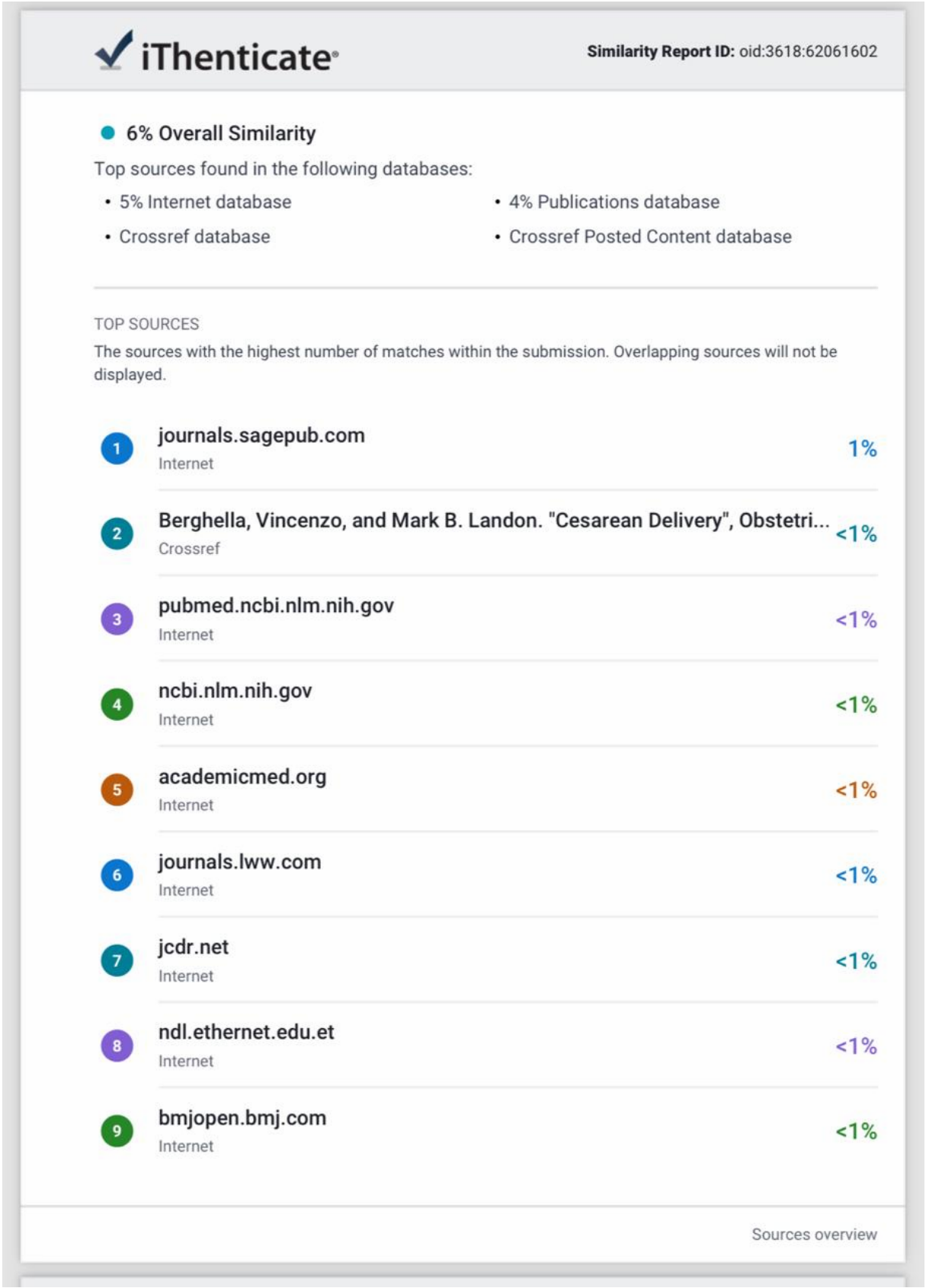

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