Non Bloody Caesarean Section in Granmultiparous Sudanese Woman with One Previous C/S: A Case Report

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Citation

Abstract
Introduction: Caesarean section is a common operation in obstetric practice, Puerperal sepsis remains an important cause of maternal morbidity and mortality, Burst abdomen is a serious postoperative complication. Patient and Method: 37 years obese Sudanese woman, running on her 8th pregnancy she had no Ante natal care (ANC) presented in the casualty of Khartoum North Teaching Hospital, Khartoum state Sudan on June 2014 in labour. Result: The patient had seven deliveries the first six deliveries were vaginal deliveries and the last one was emergency C/S due to placenta previa, in remote hospital in East Sudan, on the fifth post operative day the diagnosis of burse abdomen was made and secondary sutured was performed, the C/S wound was healed within one month time. Three years latter she was get pregnancy with no ANC visits, she presented in the casualty with abdominal discomfort, her menstrual gestational age was 41weeks, Emergency C/S was decided intra operative the uterine scar was gape and the featus with amniotic sac was found to be in the abdominal cavity, while the placenta was inserted in uterine fundus ie non bloody C/S the uterine scar edges were tripping and resutured 5 days latter the patient was discharged with her baby in a good condition. Discussion: The genital sepsis following CS may lead to poor healing of the uterine scar. The patient was 37 years, obese granmultiparous had no ANC presented with vaginal bleeding indicate emergency C/S and the patient developed primary PPH and wound infection with purse abdomen on fifth postoperatively day, of her previous pregnancy all these factors were predispose to wound infection. There was strong association between maternal age, body mass index, anaemia, unbooked status prolonged labour, and skill of the surgeon, and post caesarean wound infection. Conclusion: Caesarean wound infection is a major cause of prolonged hospital stay, as well as other morbidities and mortality.(cancelled). Caesarean Wound infection and purse abdomen in the previous delivery indicate severity of the infection and indicates termination of current pregnancy by elective C/S to guard against rupture uterus and PPH which is major cause of maternal mortality.

1. Introduction

Caesarean section is a common operation in obstetric practice. The incidence is rising worldwide and the reported incidence ranges from 5 to 25% depending on the nature and area of practice (1) Primary maternal mortality is 4 times that of vaginal delivery which may be due to early complications like shock anaesthetic complications Haemorrhage usually due to extension of the uterine incision to the uterine vessels, atony of the uterus or DIC. Injuries to the bladder or ureter, thrombosis and pulmonary embolism, acute
dilatation of the stomach, paralytic ileus. Wound infection, puerperal sepsis and burst abdomen, chest infection and foetal injuries. Surgical site infection (SSI) complicates up to 8.9% cesarean sections (CSs). [2] The late complications like Rupture of the uterine scar and Incision hernia. Caesarean wound infection is a major cause of prolonged hospital stay, high hospital bills, as well as other morbidities and mortality. Recovery from Caesarean section is more difficult for women who develop postoperative wound infection [3]. A wound is considered infected if there were indurations and swelling of the wound edges, discharge of pus or wound dehiscence.

Post-caesarean wound infection is a bacterial infection in the surgical incision. This infection can develop after an abdominal (cesarean or C-section) delivery. The infection occurs in about 3-6 percent of women who have a cesarean delivery. In high-risk cases and developing countries, surgical site infection rates can be much higher (15-75 percent) [4] Staphylococcus aureus is the most commonly isolated bacteria in wound infections following CS. [5] Women who develop a post-caesarean wound infection usually have a slight fever (100.5 to 103 °F), wound sensitivity, and lower abdominal pain. Overwhelming genital sepsis following CS may lead to poor healing of the uterine scar. Some patients are more likely than others to get a post-caesarean wound infection. High-risk patients include those who: are obese, have diabetes or an immunosuppressive disorder (like HIV), have chorioamnionitis (infection of the amniotic fluid and fetal membrane) during labor, are taking steroids (by mouth or intravenously), receive a staple suture wound closure, had fewer than 7 prenatal care visits, previously had a C-section delivery [6] experienced an emergency C-section and that did not receive cautionary antibiotics or pre-incision antimicrobial care(7), experienced a long labor or surgery, had excessive blood loss during labor, delivery, or surgery, do not follow proper steps for wound care after leaving the hospital There exist a direct correlation between increasing maternal weight and higher rate of wound infection[3]. The mean body mass index of the women with wound infection was significantly higher than the women without wound infection. Wound infection and purse abdomen point out the severity of the infection to the extent of rupture uterus in next pregnancy but surprising that the uterine scar is opened in this case from the severity of her previous infection and the amniotic sac was found to be in the abdominal cavity with the featus in, in her current pregnancy so we report this case, to highlight that wound infection is a serious and gives rise to rupture uterus which is one of the main causes of maternal mortality.

2. Patient and Method

A granmultiparous lady had no Ante natal care (ANC) presented in the casualty of Khartoum North Teaching Hospital, Khartoum state Sudan on June 2014 in labour. The patient was admitted, assessed, examined, then delivered by emergency caesarian section (C/S), the indication of C/S was her history of Caesarean Wound infection and purse abdomen in her last previous delivery the outcome was male baby alive and well, the patient was followed and discharged within 5 days in a good condition.

3. Results

37 years 'Sudanese woman, married for 17 years running on her 8th pregnancy, she had seven deliveries the first six deliveries were normal spontaneous vaginal deliveries and the last one was emergency C/S due to placenta previa, in remote hospital in East Sudan the outcome was male alive and well, the patient developed post partumhaemorrhage in her last previous delivery, the bleeding was controlled, she received antibiotics and followed on the fifth post operative day the diagnosis of burse abdomen was made and resutured, swab for cultured was taken and, then the antibiotics was described according to the sensitive antibiotics, the stayed in the hospital for dressing of infected wound for almost one month and then discharged in a good condition. Three years latter the patient get pregnancy with no ANC visits, she presented in the casualty of Khartoum North Teaching Hospital with abdominal discomfort for two days her gestational age was 41 weeks according to her last menstrual period she had no ultrasound through out her current pregnancy, on examination the patient was obese stable with normal vital signs, concerning abdominal examination the abdomen was distended with gravid uterus the scar of her previous c/s was dimple in the center due to her previous infection and it was par median vertical supra pubic incision. The fundal level was term,longudinal lie cephalic presentation and the fetal heart sound was 140 beats /minute. Pervaginal examination revealed that the vagina was normal but the cervix was not palpable this finding was confirmed by more than one examiners. Then the patient was prepared for emergency C/S, intra operatively, the abdominal layers were opened carefully the dimpling of the previous scar was released, there were no intra abdominal adhesions the amniotic sac with the baby in was found in the abdominal cavity, the sac was opened and the baby was delivered, the umbilical cord was clamped and the cord was followed, the previous c/s scar was opened with cleaned edges ie gape due to her previous wound infection & purse abdomen and there was no bleeding the placenta was followed and was found to be implanted on the uterine fundus. The placenta was removed smoothly, the edges of the uterine scar were removed and then resutured, the abdominal layers were closed. Then Per vaginal examination revealed this time the cervix was found in place ie absent cervix in the first assessment was due to open C/S scars and after sutured the cervix was in place. The outcome was male baby 3.0 Kg alive and well The patient received antibiotics, followed and discharged within five days in a good condition we asked the patient about her menstruation after her last delivery she was stated that she had normal menstruation and no abdominal pain or even discomfort, her current pregnancy was normal &she had no complains.
4. Discussion

Puerperal sepsis remains an important cause of maternal morbidity and mortality, especially in less-developed countries. [8] Burst abdomen is a serious postoperative complication that concerns every abdominal surgeon. Staphylococcus aureus is the most commonly isolated bacteria in wound infections following CS. This organism causes serious infections and has been shown to be resistant to commonly available, cheap antibiotics like the penicillins. The variation in the spectrum of causative organisms means that prophylactic antibiotic though effective may fail when the wrong agent is used or used inappropriately. [9] Other workers isolated more gram negative organisms like E. coli, Proteus mirabilis. The patient was 37 years, obese married for 17 years with 6 vaginal deliveries. There exist a direct correlation between increasing maternal weight and higher rate of wound infection. [3] The mean body mass index of the women with wound infection was significantly higher than the women without wound infection. Her 7th delivery was emergency C/S the indication was APH in labour confirmed to be placenta previa with no ANC, she had intra operative bleeding and postpartum haemorrhage so the patient was at high risk of all complication especially wound infection. Some investigators were able to demonstrate an association between maternal age, anaemia, prolonged labour, previous caesarean section, multiple vaginal examination and unbooked status, skill of the surgeon, and post caesarean wound infection. [10] The patient was developed wound infection and burst abdomen to which she received antibiotics according to sensitivity and secondary sutured was applied and then dressing and hospital stay for 6 weeks the patient incision was midline sub umbilical incision which was added factor for wound infection. Midline sub umbilical incision is a major contributor to post operative morbidity, except where it is practically impossible. The 8th pregnancy was 3 years after her c/s passed without complications, she presented to the hospital for the first time during her current pregnancy at 41 weeks by her date and is sure of her date. The c/s was decided according to her previous history been granmultiparous with infected previous c/s, intra operatively the c/s scar was also gape due to severity of her c/s infection. The genital sepsis following CS may lead to poor healing of the uterine scar and this has implication in women who often times would wish a vaginal delivery in subsequent pregnancy. [11].

5. Conclusion

Caesarean wound infection is a major cause of prolonged hospital stay, as well as other morbidities and mortality. Wound infection and burst abdomen indicate severity of the infection and indicate termination of current pregnancy by elective C/S to guard against rupture uterus and PPH which is major cause of maternal mortality. Strategies for prevention of this morbidity in CS patient must target prolonged labor from unbooked emergencies, reduce intraoperative blood loss and long operating time. Overall strategies that reduce CS rate will lower this morbidity and its sequelae.

References


