"A CROSS SECTIONAL STUDY OF PRIMARY CESAREAN SECTION IN MULTIGRAVIDA AT A TERTIARY HEALTH CENTRE, BELAGAVI"

By

REG. NO. BJ0120010

Dissertation

Submitted to the KAHER, Belagavi, Karnataka
In partial fulfilment

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PG student in Obstetrics and Gynaecology,
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Sub: Institutional Ethical Clearance for the study.

With reference to the above, we wish to inform you that your proposed research project titled **"A CROSS SECTIONAL STUDY OF PRIMARY CESAREAN SECTION IN MULTIGRAVIDA AT A TERTIARY HEALTH CENTRE, BELAGAVI** is ethical and justifiable. The proposed research project has been cleared by the JNMC Institutional Ethics Committee on Human Subjects Research.

(Dr. Smita Sonoli)
Member Secretary
JNMC Institutional Ethics Committee
on Human Subjects Research,
J.N.Medical College, Belagavi.

(Dr. Harsha Hegde)
Chairman,
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LIST OF ABBREVIATION

APH	-	Antepartum hemorrhage
BMI	-	Body Mass Index
BOH	-	Bad obstetrics history
CTG	-	Cardiotocography
CPD	-	Cephalopelvic disproportion
CS	-	Cesarean section
CD	-	Cesarean delivery
CDMR	-	Cesarean delivery at maternal request
DCDA	-	Dichorionic diamniotic
DTA	-	Deep transverse arrest
FHR	-	Fetal heart rate
FGR	-	Fetal growth restriction
FFP	-	Fresh frozen plasma
GDM	-	Gestational diabetics mellitus
IVF	-	In vitro fertilization
LSCS	-	Lower segment cesarean section
MAS	-	Meconium aspiration syndrome
MCDA	-	Monochorionic diamniotic
MCMA	-	Monochorionic monoamniotic
NICU	-	Neonatal intensive care unit
NHFS	-	National health family survey

PE -Pre	-	eclampsia
PROM	-	Premature rupture of membrane.
PPH	-	Postpartum hemorrhage
PRBC	-	Packed red blood cells
RDP	-	Random donor platelets
SDP	-	Single donor platelets
SD	-	Standard deviation.
UTI	-	Urinary tract infection
URTI	-	Upper respiratory tract infection
WHO	-	World Health Organization

ABSTRACT

OBJECTIVE

To study indications and outcome of primary cesarean section in multigravida.

To study the incidence of primary cesarean section in multigravida.

MATERIALS AND METHODOLOGY

The present cross sectional observational study was conducted at, Dr Prabhakar Kore Hospital and MRC, Belagavi attached to KAHER'S Jawaharlal Nehru Medical College during period of January 2021 to June 2022. The Data was collected from the patients record of all multigravida women who had undergone cesarean section for the first time. The data obtained was coded and entered in Microsoft excel worksheet. The categorical data was expressed in terms of percentage and continuous data was expressed as mean ± standard deviation.

RESULT

Total number of deliveries conducted between January 2021 to June 2022 were 5181. Incidence of primary cesarean section in multigravida was 5.79%. Fetal distress was the most common indication followed by malpresentation, thick meconium-stained liquor with non-reassuring CTG, severe pre-eclampsia and eclampsia. Extension of uterine incision was the most common intraoperative complication. The most observed post operative complication in the present study were wound gape, fever, post spinal headache, abdominal distension. There were 320 live birth ,3 fresh still births,1 macerated still birth. Majority of the babies had a birth weight between 2.6 to 3.0 kg with an average APGAR score of 7. There were 59 perinatal deaths with prematurity and sepsis contributing the major part.

CONCLUSION

Our study has shown that multigravida is associated with unfavorable maternal and fetal outcome, hence multigravida should receive adequate obstetrics care. The most effective approach to reducing overall morbidities related to cesarean delivery is to avoid the first cesarean. This mandates the need of target driven restrictions on the primary cesarean delivery

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INTRODUCTION

Cesarean section is the delivery of an alive or dead fetus through an abdominal uterine incision after the period of viability excluding abdominal pregnancy and removal of the fetus following uterine rupture[1]. A cesarean section performed for the first time on woman is known as primary cesarean section . Women who have one or more than one viable birth are called multipara.

Cesarean section is one of the most common major operative procedure performed worldwide[2]. Cesarean section has become a global epidemic in recent decades, with approximately a third of women giving birth using cesarean section in the world today[2].

Globally, 29.7 million births 21.1% via cesarean section took place in 2015, about twice as many as the equivalent rate in 2000 12.1%[3]. According to Vital Statistics Rapid Release July 2022, the rate rose 1% in 2020 reaching 21.9% and 2% reaching 22.4% in 2021. [3]

According to NFHS-5 2019-21, the cesarean section rate in total was 21.5% comprising about 32.3% in urban and 17.6% in rural areas[4]. As compared to NFHS-4 an increase of 4% is seen.

The WHO recommends a cesarean section rate of 10-15% [2].However, WHO formally retracted its prior recommendation rate of 15% in June 2010, stating that it must on women's medical needs rather than aiming for a specific rate[2].Dr Bethel Solomon's 1934 paper “The Dangerous Multipara” mentions the need to remove the false notion that primigravida denotes difficult labour and multipara denotes easy labour [2]. Obstetricians generally believe that first pregnancies and pregnancies after

cesarean sections are high-risk pregnancies[2]. Although multiparous women who have previously delivered normally are seen as being in the low-risk group, in actuality we see unfavourable obstetric outcomes in these women as well[2].

In multigravida women who have previously experienced uneventful vaginal deliveries, a false sense of security often prevails, leading to neglect in attending routine antenatal check-ups increasing the risk factors[5]. Multigravida is more prone to anaemia, malpresentation, haemorrhage, and uterine rupture[5]. However if multigravida has previously given birth vaginally to a full-term child, she may still have cephalopelvic disproportion[5]. Malpresentations are favoured in multigravida patients by a pendulous abdomen and lumbar spine lordosis, and in many case, the fetus does not engage in the pelvis until labour begins.

The primary cesarean rate has become a major driver in the total cesarean rate. 50% of the increase in cesarean deliveries at their institution was attributed to an increase in primary cesarean deliveries[6].The number of primary cesarean deliveries is rising, in addition to the annual incidence rates of total cesarean deliveries[7].

The objectives of this study were to characterize the indications for primary cesarean delivery and to identify opportunities to lower the primary cesarean rate. The current study was carried out to determine the incidence of primary caesarean section in multigravida, to investigate the indications for a primary caesarean section in multigravida ,and to investigate the maternal and neonatal outcome. Understanding the factors leading to primary cesarean deliveries is essential to reducing the total cesarean rate.

AIMS AND OBJECTIVES

PRIMARY OBJECTIVE:

To study indications and outcomes of primary cesarean section in multigravida.

SECONDARY OBJECTIVE:

To study the incidence of primary cesarean section in multigravida.

REVIEW OF LITERATURE

HISTORY

Cesarean is derived from the Latin word " caedare" which means to cut[8]. The term cesarean has been debated throughout history[9]. It is believed to be derived from Julius Caesar's birth, it is highly improbable that his mother, Aurelia, might have survived the operation; her knowledge of her son's European invasion numerous years later indicates that she managed to live[9]. Surgical delivery was dedicated to instances when the woman was dying or dead all through Caesar's time[9].

Under Numa Pompilius I ("Lex Regia"), Roman law required surgical removal of the fetus before the actual funeral of the dead pregnant woman; religious edicts were subject of a special funeral for the mother and the infant. Before Guillimeau's 1598 publication, which introduced the term section, the preferred term was caesarean operation[9].

The first written account of a cesarean birth when both the mother and the baby survived comes from Switzerland in 1500[9]. Jacob Nufer performed this on his wife. Even after many days of labour and with the assistance of thirteen midwives, the woman was unable to deliver the fetus[9]. After receiving approval from the local authorities, the desperate husband Jacob Nufer tried a Caesarean[9]. The mother and child both lived and the woman survived and went on to have five more children[9].Although there have been isolated accounts of cesarean births saving heroic lives for hundreds of years, the procedure did not become a standard element of obstetric practice until the latter half of the 19th century[9].

This happened at the same time that birthing shifted from being primarily a midwifery event, in rural settings to an experience inside an urban motherhood hospital[11]. The development of maternity hospitals across Europe in the 18th and 19th

centuries established the groundwork for obstetrics to become a hospital-based specialty[10]. In contrast to destructive techniques like craniotomy or high forceps delivery, which were frequently linked to major foetal injury, deep maternal pelvic lacerations, and long-term damage to the maternal bladder and anal sphincter, with the use of laudanum syrup and chloroform anaesthesia cesarean section, became popular to treat obstructed labour[10].

CD mortality rates, on the other hand, remained exceedingly high, with infection and haemorrhage being the predominant causes of postoperative fatalities. Primitive surgical procedures and a lack of aseptic technique worsened morbidity[10]. Surgeons sought to finish the procedure without suturing the uterus because they were concerned that the suture material would create infection and that the uterus would recover better through secondary intention[10].

In 1769, Lebas proposed suturing the uterus[9]. Since they were believed to be impossible to remove after the cavity is closed, sutures were not used [9]. Eduardo Porro promoted the removal of both ovary and Fallopian tubes and subtotal hysterectomy in 1876 to stop bleeding and prevent postoperative infection[9].

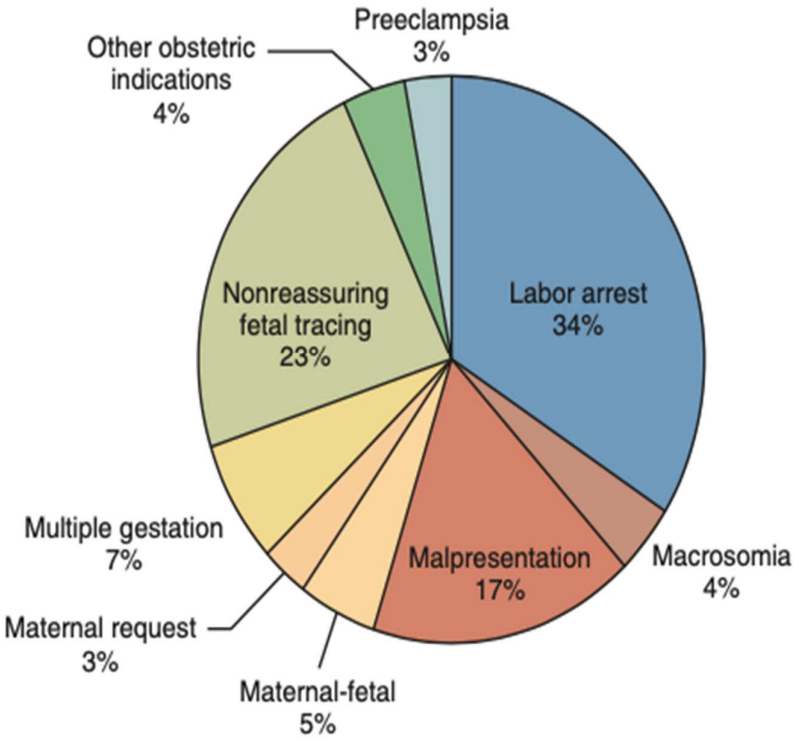
Shortly after the usage of internal suturing using silver-wire stitches developed by gynaecologist J. Marion Sims. Two German obstetricians, Ferdinand Adolf Kehrer and Max Sänger proposed a transverse incision of the lower uterine segment, just above the internal cervical os, and introduced double-layer closure methods in the early 1880s[10].

Hermann Johannes Pfannenstiel 1900, a German gynaecologist, described a curvilinear suprapubic incision, also known as a pelvic skin incision[10]. The location of the uterine incision was given more consideration. Many surgeons started employing horizontal uterine incisions between 1890 and 1925[10].

The lower segment uterine incision and Pfannenstiel skin incision were popularized by John Martin Munro Kerr, professor in midwifery at Glasgow university, who is regarded as the "father" of the modern cesarean delivery [10]. There was a decrease in the number of infections and incisional hernias and uterine ruptures as compared to vertical incision[9]. However, extraperitoneal cesarean was recommended by Frank, Veit and Fromme , Latzko , and Beck around 1900s. Even though it was known from the start of the 20th century that the vertical incision has a higher incidence of wound gape and incisional hernia, cosmetically inferior, it was the most commonly used in still 1970s[9].

The incidence of peripartum infections significantly decreased once penicillin was developed in the 1940s[9]. There was less of a necessity for extraperitoneal dissection as antibiotic therapy developed[1]. The use of CD in obstetrics increased as technology advanced, making use of uterotonics, better anaesthetic, and blood transfusions available[9]. Over the past 40 years, there has been a liberalisation of the use of cesarean delivery in developed nations because of its present safety and efficacy[11].

INDICATION OF PRIMARY CESAREAN SECTION[12]



Indications for Primary Cesarean Delivery. (Data from Barber EL, Lundsberg LS, Belanger K, et al. Indications contributing to the increasing cesarean delivery rate. *Obstet Gynecol.* 2011;118:29–38.)

Maternal-Fetal Indications

Most CDs are performed for conditions that might pose a threat to both mother and fetus if vaginal delivery occurred[13]. Complete placenta previa and placental abruption with the potential for haemorrhage are clear examples[13]. Dystocia presents a risk for both direct foetal and maternal trauma, and it may also compromise foetal oxygenation and metabolic status[14] .

Foetal Indications

Foetal indications are primarily recognized by non-reassuring FHR with the potential for long-term consequences of metabolic acidosis[15]. Continuous FHR monitoring is associated with a significant reduction in neonatal seizures and remains the most commonly used modality for foetal monitoring in labor. Scalp stimulation can be used to ameliorate the high false-positive rate of continuous FHR monitoring[16]. Other foetal indications for CD include malpresentation, such as a breech, and more than 90% of these fetuses in singleton gestations are delivered by cesarean[17]. Active maternal genital herpes infection is an indication for CD to reduce the risk for transmission of infection[13]. Suspected macrosomia or the potential for foetal trauma are indications for CD only in rare circumstances. Fetuses with certain birth defects, such as hydrocephalus with macrocephaly have traditionally undergone CD[17].

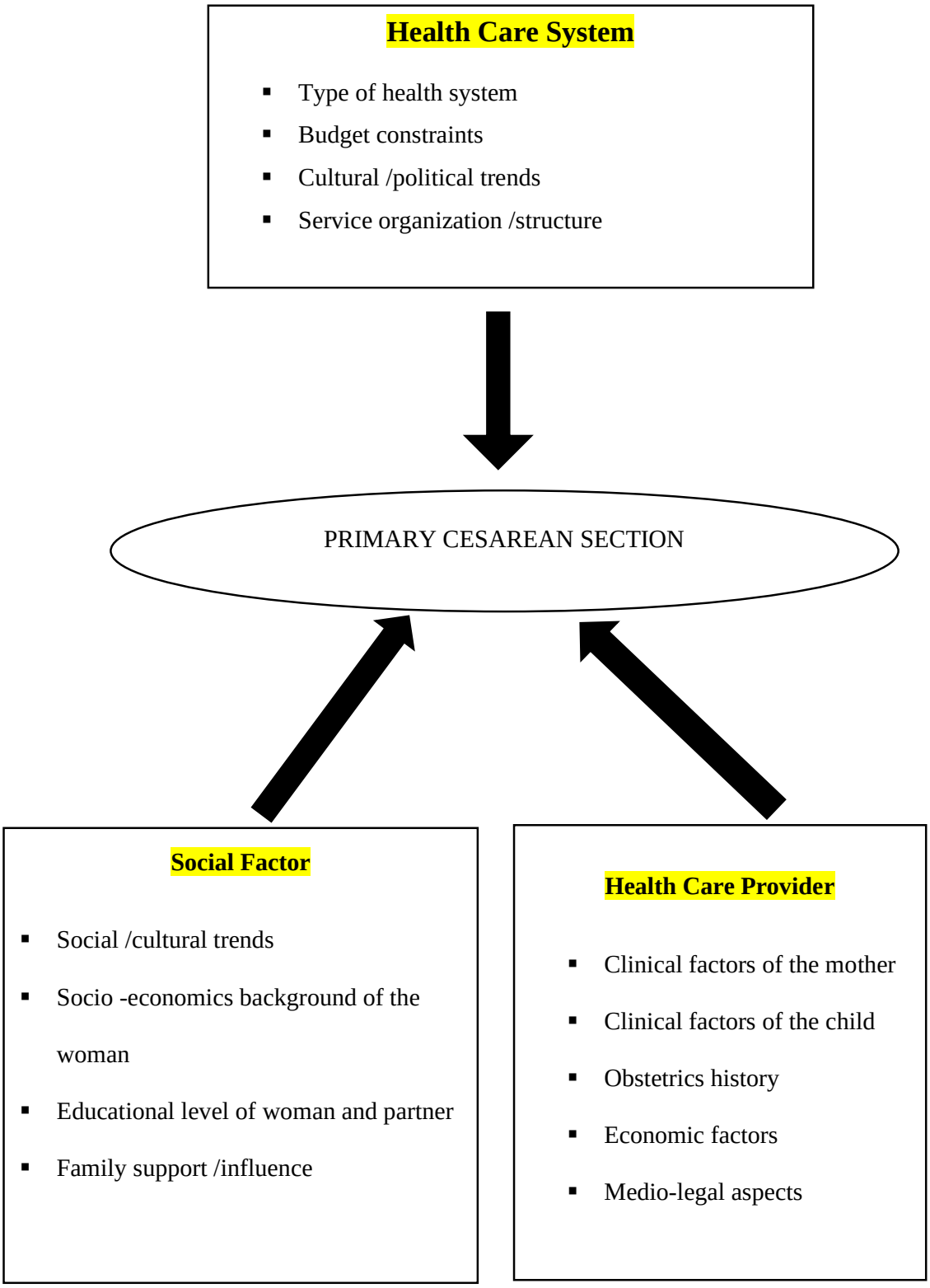
Maternal Indications

Maternal indications for CD are relatively few and can be considered medical or mechanical[1].Certain maternal cardiac conditions, such as a dilated aortic root (≥4 cm) with Marfan syndrome, are indications for CD. Maternal central nervous system abnormalities in which increased intracranial pressure would be undesirable, such as accompanying the second stage of labor, have also led to recommendations for CD[16]. Alterations in the capacity of the maternal pelvis can be indications for CD[19]. Mechanical vaginal obstruction as a result of pelvic masses such as lower segment myomata is examples[19]. Finally, women with massive condylomata and primary herpes infection at term may also require CD[20].

Cesarean Delivery on Maternal Request

As CD has become safer, women have occasionally expressed a desire for a cesarean without a medical indication[15]. This clinical scenario has been recently called "cesarean delivery on maternal request." The lack of specificity of the term "elective" suggests the most reasonable and prudent course of action is, rather than using that term, to document the specific indication—whether medical or nonmedical—for the intervention or procedure (i.e., CD on maternal request)[20]. Occasionally CD is performed on maternal request because of a fear of excessive pain and fear of damage to the vagina and perineum[21]. Fear of childbirth is present in about 3% to 8% of women, who should be reassured of adequate maternal pain relief in labor. Increased maternal risks attributed to vaginal delivery also include urinary and faecal incontinence, pelvic prolapse, and sexual dysfunction[22].

POSSIBLE FACTORS AFFECTING PRIMARY CESAREAN SECTION[22-27]



Savita Somalwar et[2] al conducted a cross-sectional Study of Primary Cesarean Section in Multiparous Women in Central India at the Department of Obstetrics and Gynaecology, N.K.P. Salve Institute of Medical Sciences, Nagpur, Maharashtra, India and the Department of Obstetrics and Gynaecology, Adesh Institute of Medical Sciences & Research, Bathinda, Punjab, India for 21 months from December 2014 to 30 November 2016. Non-reassuring foetal status (47%), malpresentation (13%) and thick meconium-stained liquor (13%) were the three most predominant reasons for primary caesarean delivery in the majority of multigravida women. The incidence of primary cesarean section in multiparous women was 5.73% of all deliveries and 10.89% of all cesarean sections. Postpartum haemorrhage (12%) was the most frequent intraoperative complication. fever (6%) and wound discharge (5%) were the most frequent postoperative problems3. Out of the 205 babies, 70 (34.14%) infants were admitted to the NICU, 60 (30.73%) had newborn morbidity and 7 (3.41%) experienced neonatal death. 35 (17.07%) Premature baby care was the newborn morbidity that was most prevalent[3] . The limitation of the study was small sample size and socioeconomic status were not studied.

Jyothi H Rao et[28] al performed a cross-sectional study of primary caesarean section in multiparous women at Basaveshwar teaching and general hospital and Sangameshwar hospital in Gulbarga for 18 months. The primary caesarean rate in multigravida was 10.28%. The most indication was malpresentation (33.5%), antepartum haemorrhage (23.5%) and CPD (18.5). 14% of women experienced postoperative morbidity wound infection (7.5%), UTI (2.0%), febrile morbidity (3.5%), respiratory infections tract infections, and secondary PPH (0.5%). 14 of 200 babies were stillborn due to cord prolapse, abruption, placenta previa, and obstructed labor[33]. There was 33 NICU admission due to septicemia, MAS, convulsion and

congenital anomaly. The limitation of the study was Intraoperative complications and demographic variables were not studied.

US Hangarga et al[29] conducted an observational study From January 2018 to December 2018 on a clinical trial on primary caesarean sections in multiparous women in District Hospital in Dharwad[34]. The incidence of primary cesarean section in multiparous women is 2.7%. The most common indication of primary cesarean section is severe oligohydramnios (22%), foetal distress (15.4%) and breech presentation (14%). 48 out of 84 patients required blood transfusions during or immediately after surgery. post-operative morbidity was seen in 6 cases i.e 1 paralytic ileus, 2 puerperal fever,1 urinary tract infection, and 2 wound gaping. 7 (8.4%) of 87 were stillbirths of which 2 (28.5%) placenta previa, 2 (28.5%) fetal distress, each one case of abruption placenta (14.2%), cord prolapse (14.2%) and obstructed labor (14.2%) .limitation of the study was small sample size and information regarding NICU admission is not mentioned.

Nidhi Meena et al[30] conducted a retrospective, record-based research of the indication of primary caesarean section in multigravida hospitalised at the Department of Obstetrics and Gynaecology, Jhalawar Medical College from January 2021 to march 2021. 208 patients in all were involved in the research. The most common three indications for primary LSCS in multigravida patients were fetal distress 46 (22.22%) cases followed by malpresentation in 38 (18.36%) cases, meconium-stained liquor with fetal distress in 23 (11.05%). The limitation of this study is that it was purely a record-based study, small sample size, and maternal and fetal outcomes were not studied.

Desai E. et al[31] conducted a randomised hospital-based study of primary caesarean sections in multipara in the Dhiraj General Hospital's Obstetrics and

Gynecology Department in Pipariya, Ta-Waghodia, Vadodara, Gujarat, India. The most common indication was fetal distress 22 (25.58%), APH 19 (22.09%), CPD 17 (19.77%) and abnormal presentation 15 (17.44%)[36]. Maternal morbidity was seen in 23 cases of which wound sepsis 9 (10.47%), abdominal distension 12 (13.95%), pyrexia 10 (11.63%), and UTI 2 (2.33%). The limitation of the study was small sample size, incidence of primary cesarean section and neonatal outcome were not studied.

P. Sree Sailaja et al[32] conducted a prospective Study of Primary Cesarean Section in Multigravida at the Obstetrics and Gynaecology Department at GIMSR Teaching Hospital From January 2017 to December 2018. The incidence of primary cesarean section in multigravida was 6.34%. The most common indication of primary cesarean section in multigravida was fetal distress (29.5%), Cephalopelvic disproportion occurred (17%), and malpresentation (10.5%). 15.8% of patients had intraoperative complication of which atonic PPH (11.57%), traumatic PPH (4.21%) .Puerperal pyrexia (23.10%) was the most common post-operative complication.20 (21.05%) infants were admitted to the NICU of which meconium aspiration 7 (7.37%) and birth asphyxia 4 (4.2%) were two most common causes. The limitation of the study was small sample size and socioeconomic status were not studied.

P Begum et al[33] conducted a study on the Indication and Outcome of Cesarean Section in Multigravida Women with a History of Vaginal Delivery in a Tertiary Care Hospital at the Department of Obstetrics and Gynaecology in Diabetic Association Medical College Hospital in Faridpur, Bangladesh between April 2016 and July 2017. The most common indication of primary cesarean section in multigravida is fetal distress 37 (33.6%), obstructed labor 12 (10.9%) and breech 12 (10.9%) .27 of 110 had the post-operative complication of which 12(10.9%) sepsis, URTI 9 (8.2%),

wound infection 3 (2.7%), postoperative ileus 2 (1.8%), and PPH 1 (0.9%). 105 (95.5%) of the new-borns survived the birth[38]. 3 (2.7%) stillbirths and 2 (1.8%) new-borns deaths were observed[38]. The limitation of the study was a small sample size, the socioeconomic status, incidence of primary cesarean section and intraoperative finding and complication were not studied.

Preeti Bajaj et al [34] conducted a prospective, randomised trial A Study of Primary Cesarean Section in Multipara Between August 2015 and August 2016 at Government Medical College, Bhavnagar. The incidence of primary caesarean section in multipara was 5.2%[39]. Foetal distress (25%) ,APH 33 (15.2%) and pre-eclampsia 26 (12%) were common indication for primary cesarean section. Abdominal distension 30 (13.8%) and wound sepsis 12 (5.5%) were the most common maternal morbidity. 44 (20.37%) babies were admitted to NICU. The limitation of the study was the small sample size and intraoperative finding and complication, information regarding NICU admission were not studied.

M. Mallika et al[35] conducted prospective research Clinical Study of Primary Cesarean Section in Multiparous Women at the Govt Medical Hospital in Ananthapuramu from January 1 to August 31, 2019. The incidence of primary cesarean section in multigravida is 4.9%. Fetal distress (25%), malpresentations (23.3%), placenta previa 13(10.9%) were the most common indication .35(29.16%) of 120 had maternal morbidity of which wound sepsis 8(6.7%), abdominal distension 5(4.2%) were most common causes. 37(30.83%) of 120 babies were admitted to NICU of which preterm care 14(37.8%), MAS 12(32.4%) and birth asphyxia 3(8.1%). The limitation of the study was small sample size and socioeconomic variables, intraoperative findings and complications, extended operative procedure were not studied.

Summary of review of literature of various studies:

Prevalence of primary cesarean section was about 5.2% [34] to 10.28%[28].

Indications of primary cesarean section were fetal distress, malpresentation , APH [28-34] .

Maternal complications of primary cesarean section abdominal distension , wound gaping [28-34].

Fetal complications of primary cesarean section were preterm delivery , meconium aspiration [28-34] .

Multiparous women who had previous vaginal deliveries may still require a cesarean section for safe outcome of mother and foetus. Though vaginal delivery is always safer than cesarean section, difficult vaginal delivery and obstructed labour carries more morbidity and perinatal mortality when compared to elective cesarean section, Previous vaginal delivery

gives the patient as well as her relatives a false sense of security. In many cases, a cesarean becomes mandatory. The fact that a multipara has had one or more vaginal deliveries should be regarded as an optimistic historical fact, not as a diagnostic criterion for spontaneous delivery of the pregnancy at hand.

MATERIALS AND METHODS

This study was conducted at Dr Prabhakar kore Hospital and MRC, Belagavi attached to KAHER'S Jawaharlal Nehru Medical College during the period of January 2021 to JUNE 2022.

STUDY DESIGN- A Cross Sectional study

STUDY PERIOD - 1 year 6 months (January 2021 to June 2022)

SOURCE OF DATA

The data was collected from the patient record of all multiparous women who have undergone cesarean section for the first time at Dr Prabhakar kore Hospital and MRC, Belagavi attached to KAHER'S Jawaharlal Nehru Medical College.

SAMPLE SIZE

The minimum sample size formula based on prevalence rate is

$$n=\frac{z_{\alpha}^{2}P(1-p)}{d^{2}}$$

where P is the percentage of prevalence and d is the percentage likely difference in the prevalence.

z_{α} is linked with the level of significance. For 5% level of the significance $z_{\alpha} = 1.96$.

Ref:

With P = 28.6% and d = 10% of P = 25%, the sample size is 280

To get confirmative result, sample size can be increased up to 300

OBJECTIVE

PRIMARY OBJECTIVE:

To study indications and outcomes of primary cesarean section in multigravida.

SECONDARY OBJECTIVE:

To study the incidence of primary cesarean section in multigravida.

SELECTION CRITERIA

Inclusion criteria-

Gestational age more than 28 weeks.

Multigravida who underwent primary cesarean section

Exclusion criteria-

Patient who had a previous cesarean section or hysterotomy

Patient not willing to participate in study

ETHICAL CLEARANCE

Before the commencement of study, the ethical clearance from the ethical and research committee, Jawaharlal Nehru medical college, Belagavi was obtained.

(Annexure 3 -Letter number MDC/DOME/180 dated 25/01/2021)

WAIVER OF CONSENT- waiver of consent was sought and obtained as all data was procured through the patient record, before the commencement of study

STATISTICAL ANALYSIS

The data obtained was coded and entered in Microsoft excel worksheet. The categorical data was expressed in terms of percentage and continuous data was expressed as mean ± standard deviation.

METHOD OF COLLECTION OF DATA

All the multigravida women who have previously delivered vaginally admitted in labor room or ward above 28 weeks of gestational age and underwent cesarean section for the first time were recruited in the study and data was collected using proforma.

Data regarding age, socioeconomic status, registration status, risk factor, period of gestation, stage of labor, indications of cesarean section, intraoperative findings, blood loss, extended operative procedure, neonatal outcome, APGAR score at 1 min and 5 min, birth weight, gender, NICU admission, blood transfusion, post operative complications, condition of neonate at discharge were collected from case record.

RESULTS

CONSORT DIAGRAM

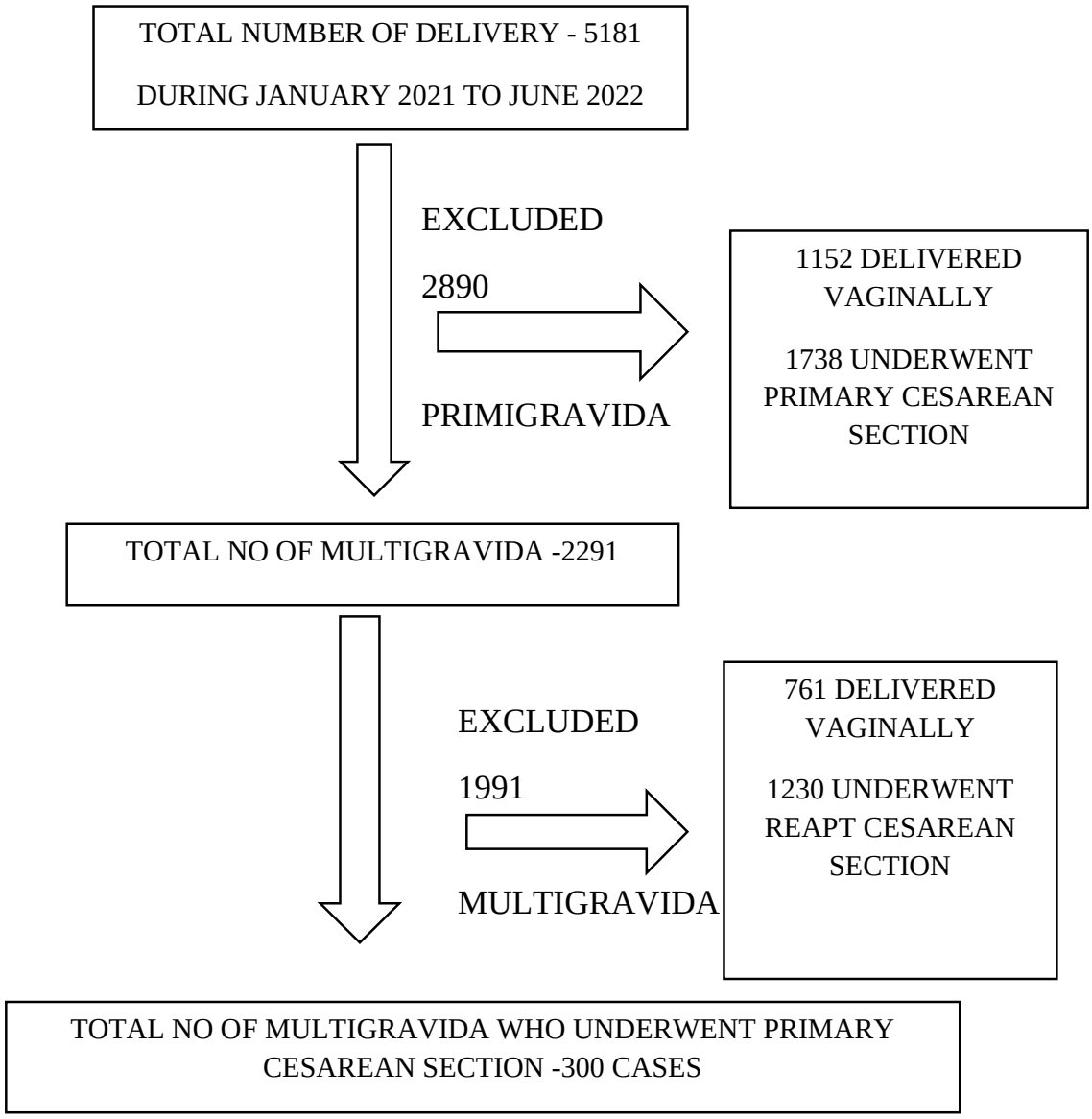


Table 1: Type of delivery(vaginal and LSCS)wise distribution

Type of delivery	**Number n=5181**	**Percentage (%)**
Total no of Primigravida who delivered vaginally	1152	22.24
Total no of Primigravida who underwent primary cesarean section	1738	33.55
Total no of multigravida who delivered vaginally	761	14.69
Total no of multigravida who underwent repeat cesarean section	1230	23.73
Total no of multigravida who underwent primary cesarean section	300	5.79
Total	5181	100

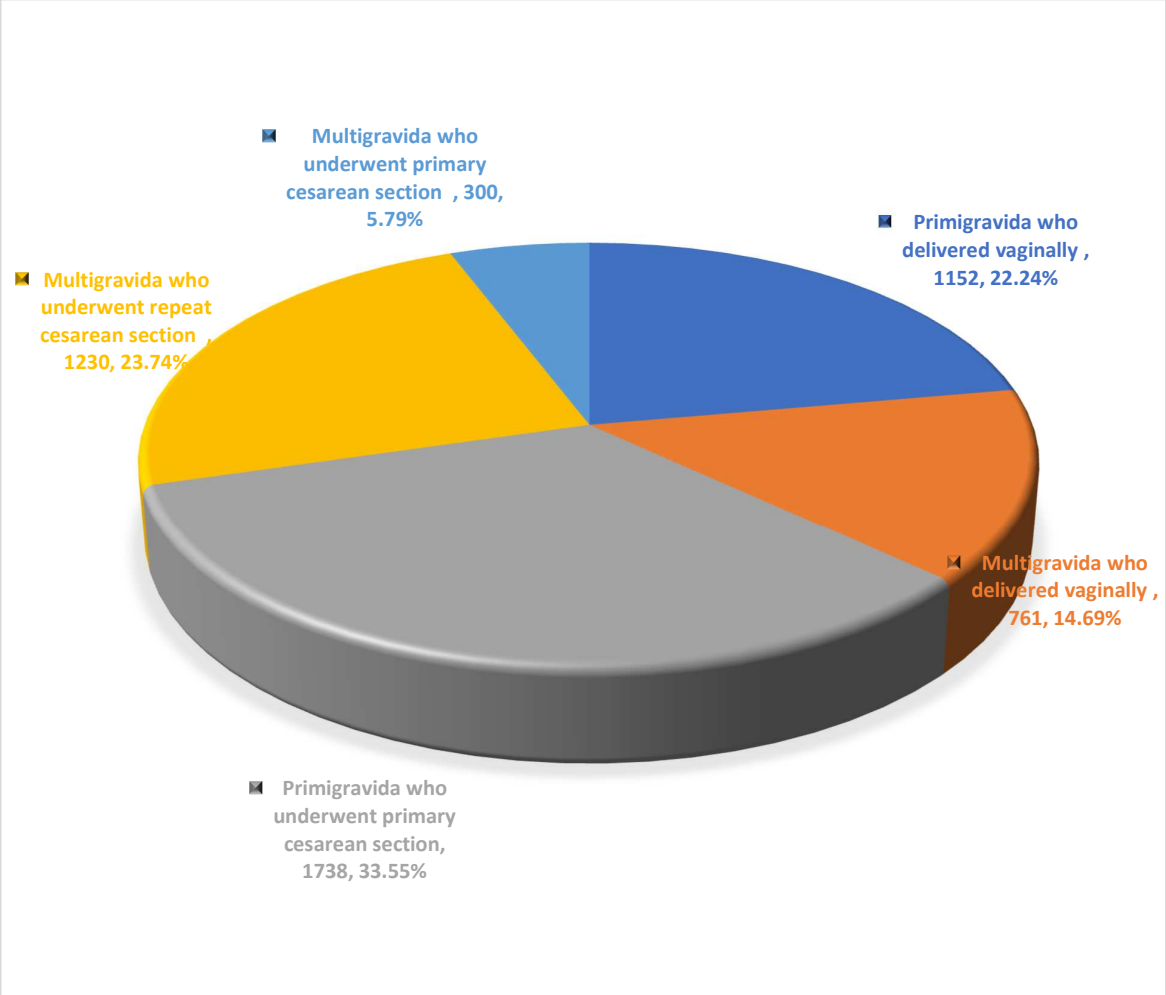

Multigravida who underwent primary cesarean section , 300, 5.79%
Primigravida who delivered vaginally , 1152, 22.24%
Multigravida who underwent repeat cesarean section , 1230, 23.74%
Multigravida who delivered vaginally , 761, 14.69%
Primigravida who underwent primary cesarean section, 1738, 33.55%

Table 2: Age wise distribution

Age in years	Number n=300	Percentage (%)
18-20 years	7	2.33
21-25 years	90	30
26-30 years	158	52.67
31-35 years	35	11.67
36-40 years	10	3.33
Total	300	100

Mean age of women was 25.6 years . In present study among 300 subjects,158 subjects (52.67%) were between age group of 26–30 years, 90 subjects (30%) were aged between 21–25 years of age, 35 subjects (11.67%) were aged between 31–35 years of age ,10 subjects (3.33%) were between 36–40 years of age, and 7 subjects (2.33%) were in the 18–20 years of age .

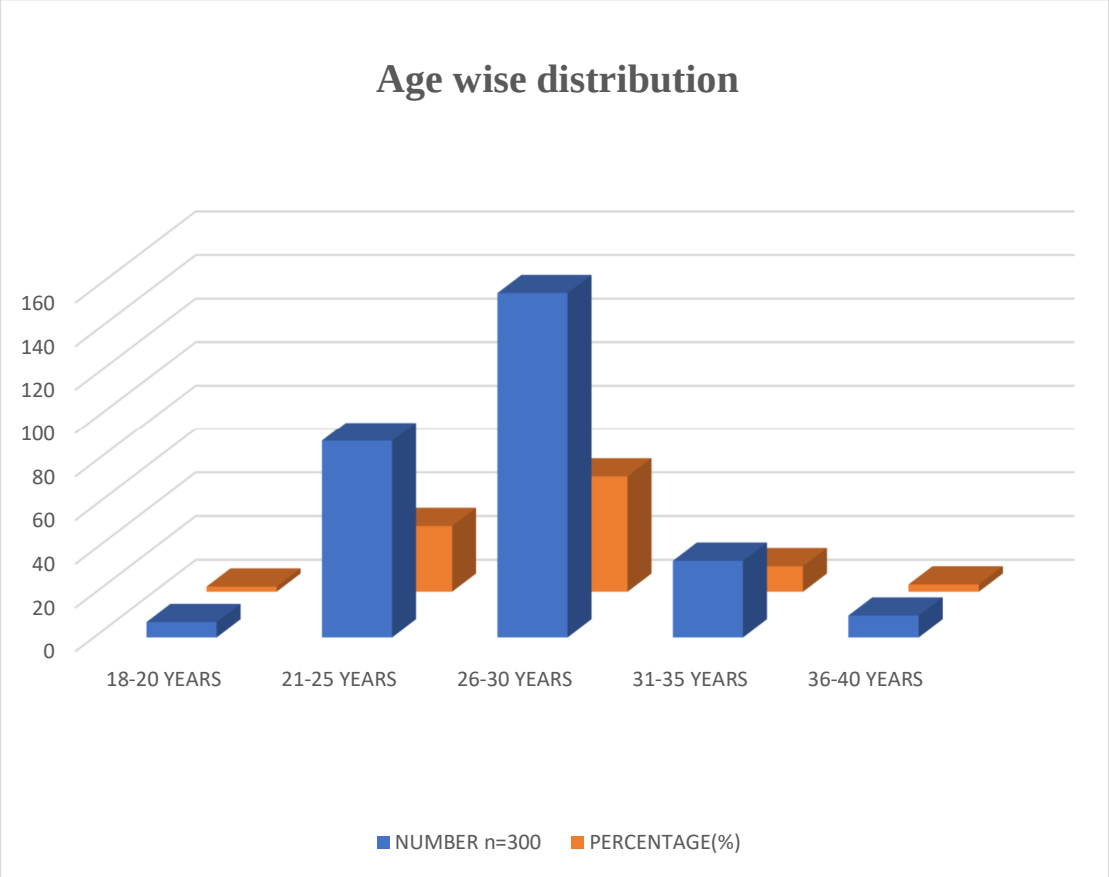

Age wise distribution
160
140
120
100
80
60
40
20
0
18-20 YEARS
21-25 YEARS
26-30 YEARS
31-35 YEARS
36-40 YEARS
NUMBER n=300
PERCENTAGE(%)

Table 3: Socioeconomic status distribution.

Socio-economic status	Number n=300	Percentage(%)
Class 1	88	29.33
Class 2	78	26
Class 3	52	17.34
Class 4	15	5
Class 5	67	22.33
TOTAL	300	100

According to modified B.G Prasad classification among 300 subjects,88 subjects(29.33%) belonged to class 1(upper class),78 subjects (26%) belonged to class 2(upper middle), 52 subjects (17.34%) belonged to class 3(middle class), 15 subjects(5%) belonged to class 4(lower middle class), 67 subjects (22.33%) belonged to class 5(lower class).

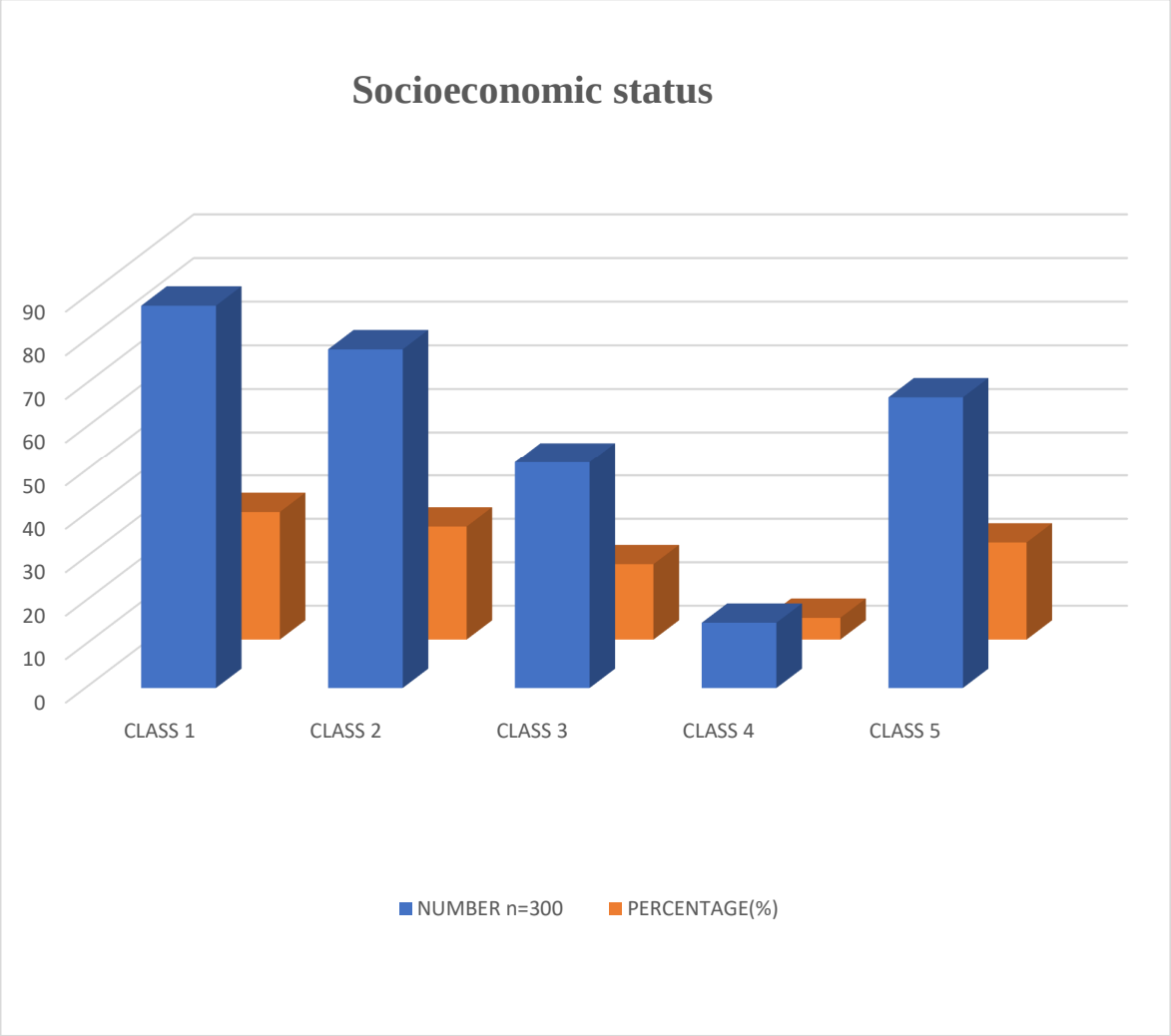

Socioeconomic status
90
80
70
60
50
40
30
20
10
0
CLASS 1
CLASS 2
CLASS 3
CLASS 4
CLASS 5
NUMBER n=300
PERCENTAGE(%)

Table 4: Antenatal registration

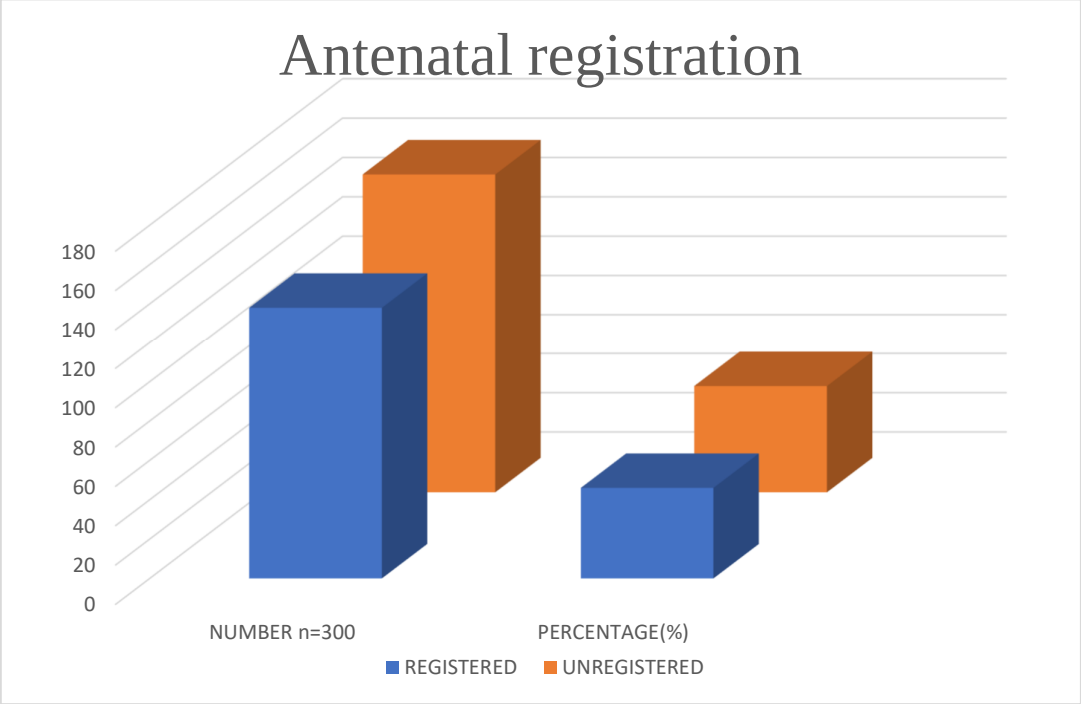
Registration	Number n=300	Percentage(%)
Registered	138	46
Unregistered	162	54
Total	300	100

Registered antenatal case meaning minimum of 4 antenatal visit. In present study among 300 subjects maximum number of women were unregistered 162(54%) and 138(46%) were registered.

Table 5: Risk wise distribution

Type of risk	Number n=300	Percentage(%)
Low risk	68	22.67
High risk	232	77.33
Total	300	100

In the present study, 232(77.33%) women were in high risk category


Antenatal registration
180
160
140
120
100
80
60
40
20
0
NUMBER n=300
PERCENTAGE(%)
REGISTERED
UNREGISTERED

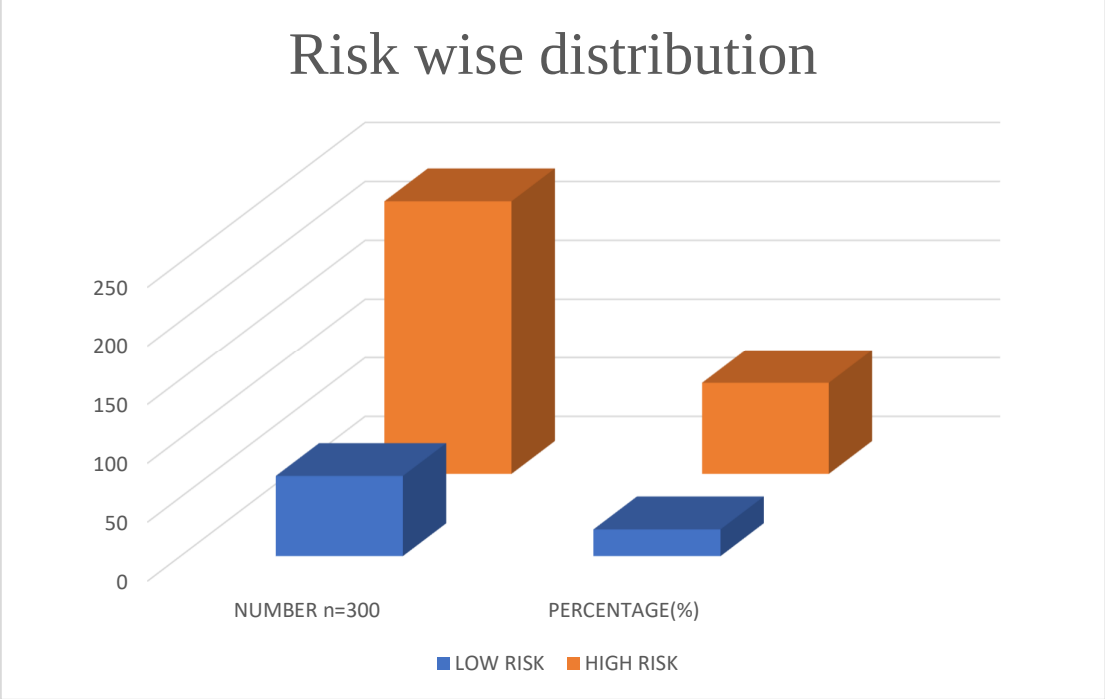

Risk wise distribution
250
200
150
100
50
0
NUMBER n=300
PERCENTAGE(%)
LOW RISK
HIGH RISK

Table 6: Gravida based distribution

Gravida	Number n=300	Percentage(%)
G2	204	68
G3	80	26.67
G4	14	4.66
G5	2	0.67
Total	300	100

In present study among 300 subjects 204 subjects (68%) had 1 prior vaginal delivery, 80 subjects (26.67%) had 2 prior vaginal delivery, 14 subjects (4.66%) had 3 prior vaginal delivery, and 2 subjects (0.67%) had 4 prior vaginal delivery.

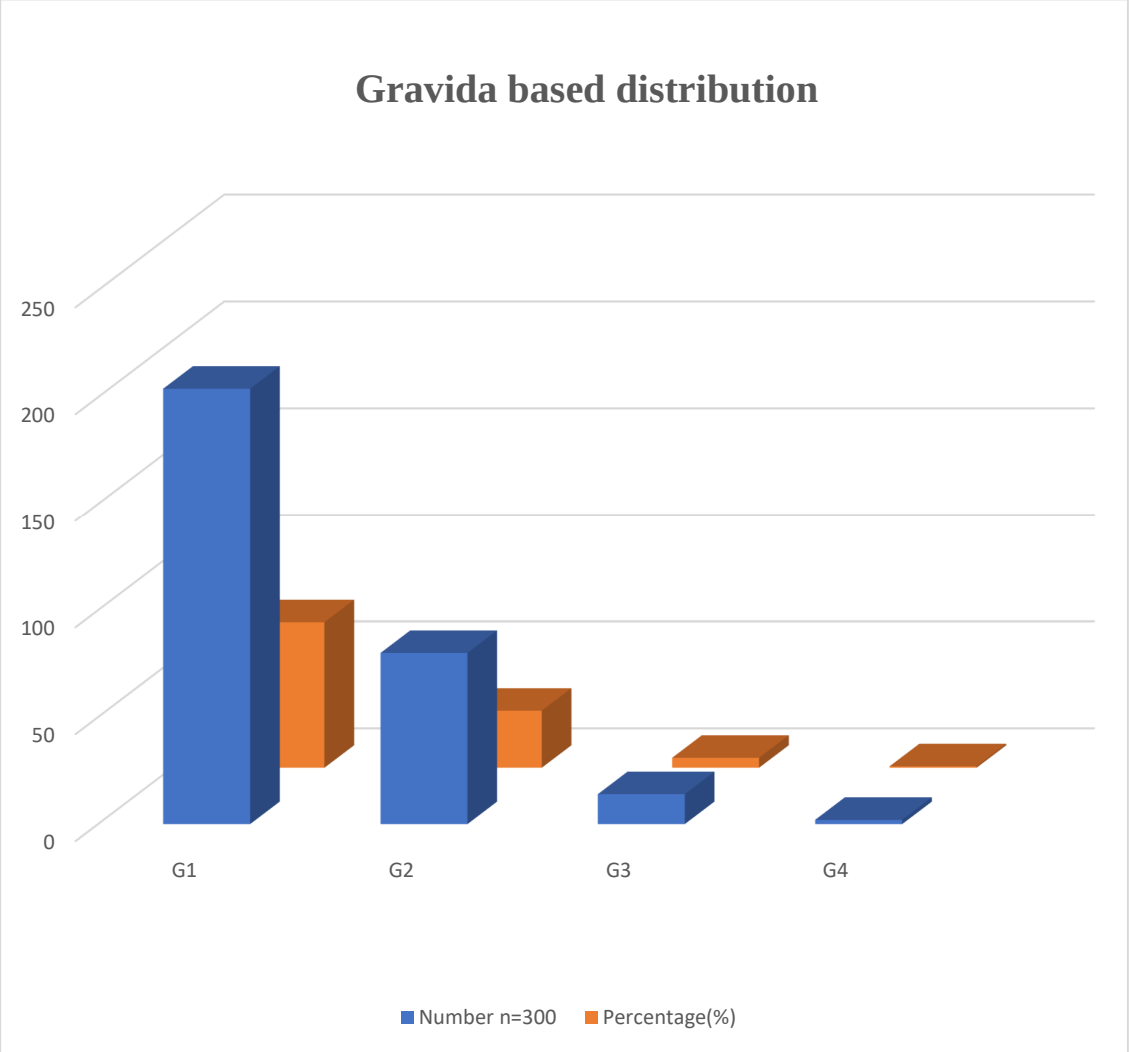

Gravida based distribution
250
200
150
100
50
0
G1
G2
G3
G4
Number n=300
Percentage(%)

Table 7: Period of gestation distribution

Period of gestation	Number n=300	Percentage(%)
28 to 31 weeks^{+6}	8	2.67
32 to 33 weeks^{+6}	7	2.33
34 to 36 weeks^{+6}	69	23
37 to 39 weeks^{+6}	160	53.33
40 to 41 weeks^{+6}	53	17.67
>42 weeks	3	1
Total	300	100

In present study among 300 subjects 160 subjects (53.33%) were between 37 weeks to 39 weeks $^{+6}$ POG, 69 subjects (23%) were between 37 weeks to 39 weeks days^{+6} POG , 53 subjects (17.67%) were between 40 weeks to 41weeks $^{+6}$ d POG, 8 subjects (2.67%) were between 28 weeks to 31 weeks $^{+6}$ POG, 7 subjects (2.33%) were between 32 weeks to 33 weeks $^{+6}$ POG and 3 subjects (1%) more than 42 weeks POG.

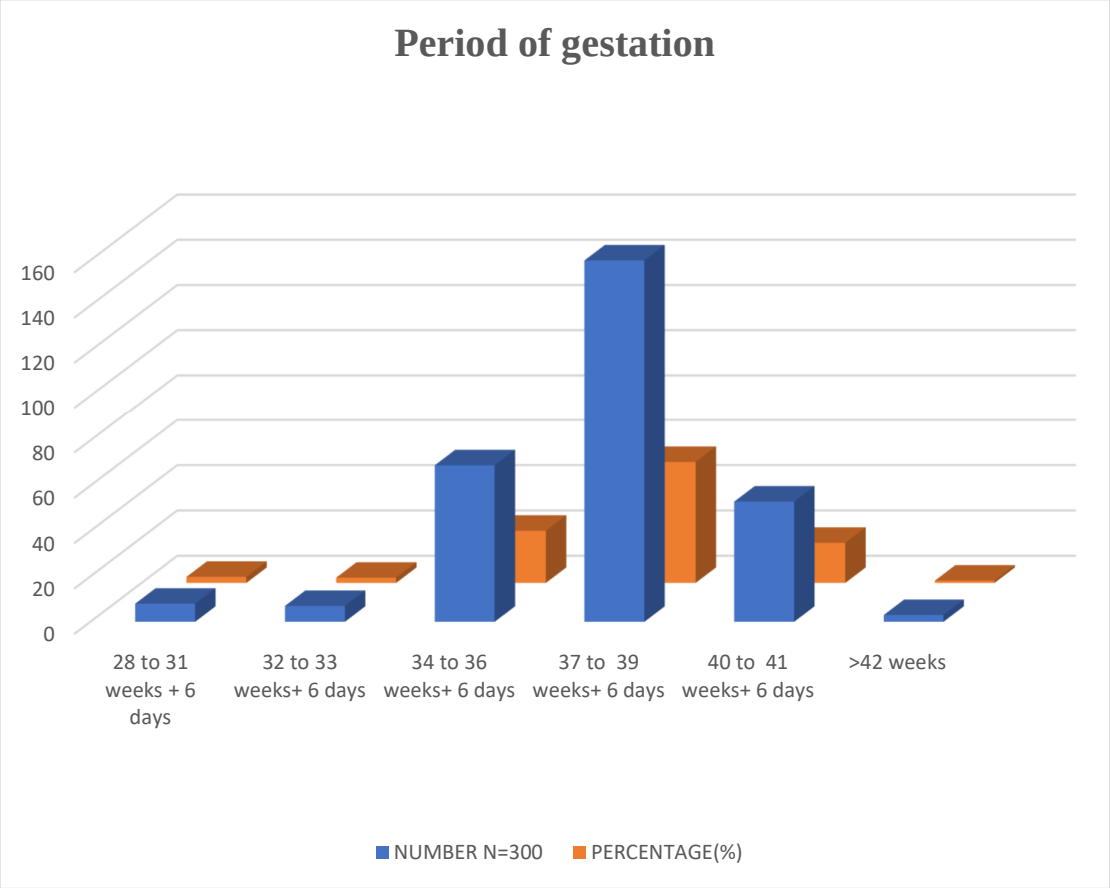

Period of gestation
160
140
120
100
80
60
40
20
0
28 to 31 weeks + 6 days
32 to 33 weeks+ 6 days
34 to 36 weeks+ 6 days
37 to 39 weeks+ 6 days
40 to 41 weeks+ 6 days
>42 weeks
NUMBER N=300
PERCENTAGE(%)

Table 8: Emergency v/s Elective

Type of cesarean section	Number n=300	Percentage(%)
Preterm emergency	64	21.33
Preterm elective	24	8
Full term emergency	185	61.67
Full term elective	27	9
Total	300	100

In present study among 300 subjects 185 subjects (61.67%) underwent full term emergency cesarean section , 64 subjects (21.33%) underwent preterm emergency cesarean section ,27 subjects (9%) underwent full term elective cesarean section and 24 subjects (8%) underwent preterm elective cesarean section.

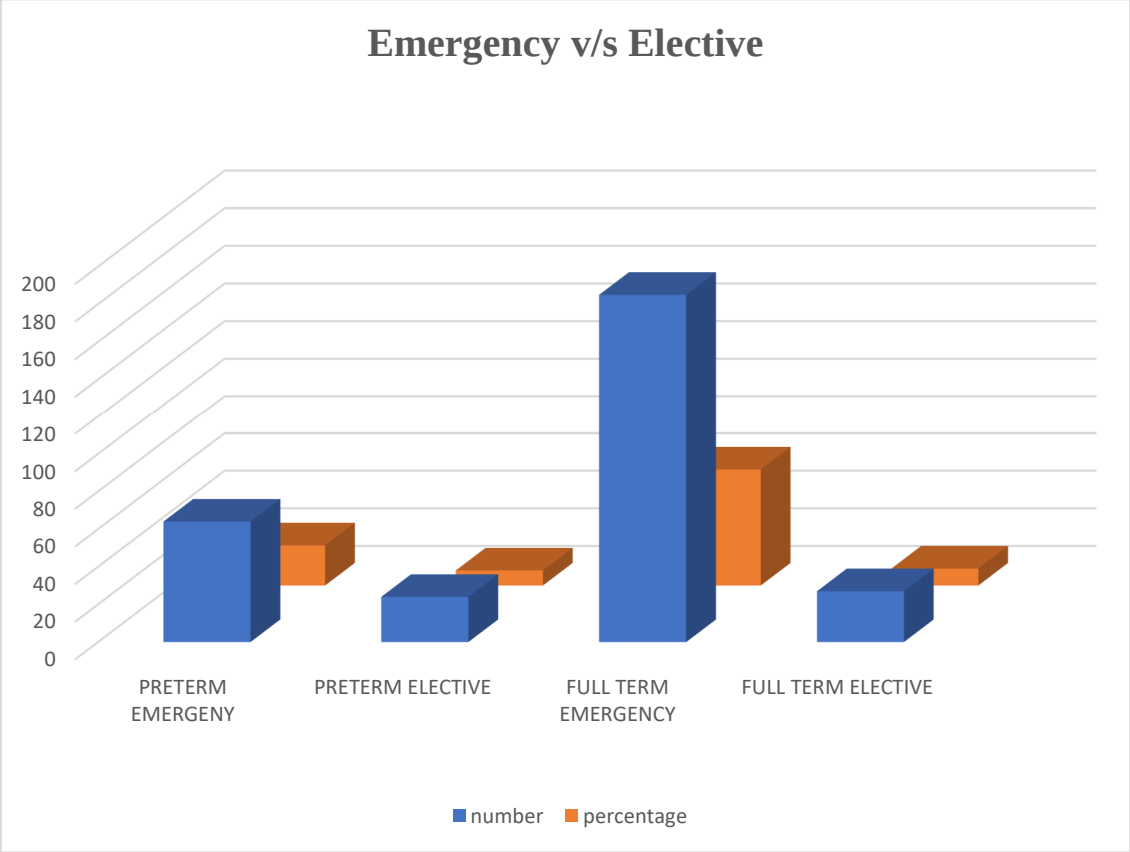

Emergency v/s Elective
200
180
160
140
120
100
80
60
40
20
0
PRETERM EMERGENY
PRETERM ELECTIVE
FULL TERM EMERGENCY
FULL TERM ELECTIVE
number
percentage

Table 9: Stage of labor

Stage of labor	Number n=300	Percentage(%)
Before onset of labor	51	17
First stage	245	81.67
Second stage	4	1.33
Total	300	100

In present study among 300 subjects primary cesarean section were done in 51 subjects (17%) before onset of labor , 245 subjects (81.67%) in first stage of labor and 4 subjects (1.33%) in second stage of labor.

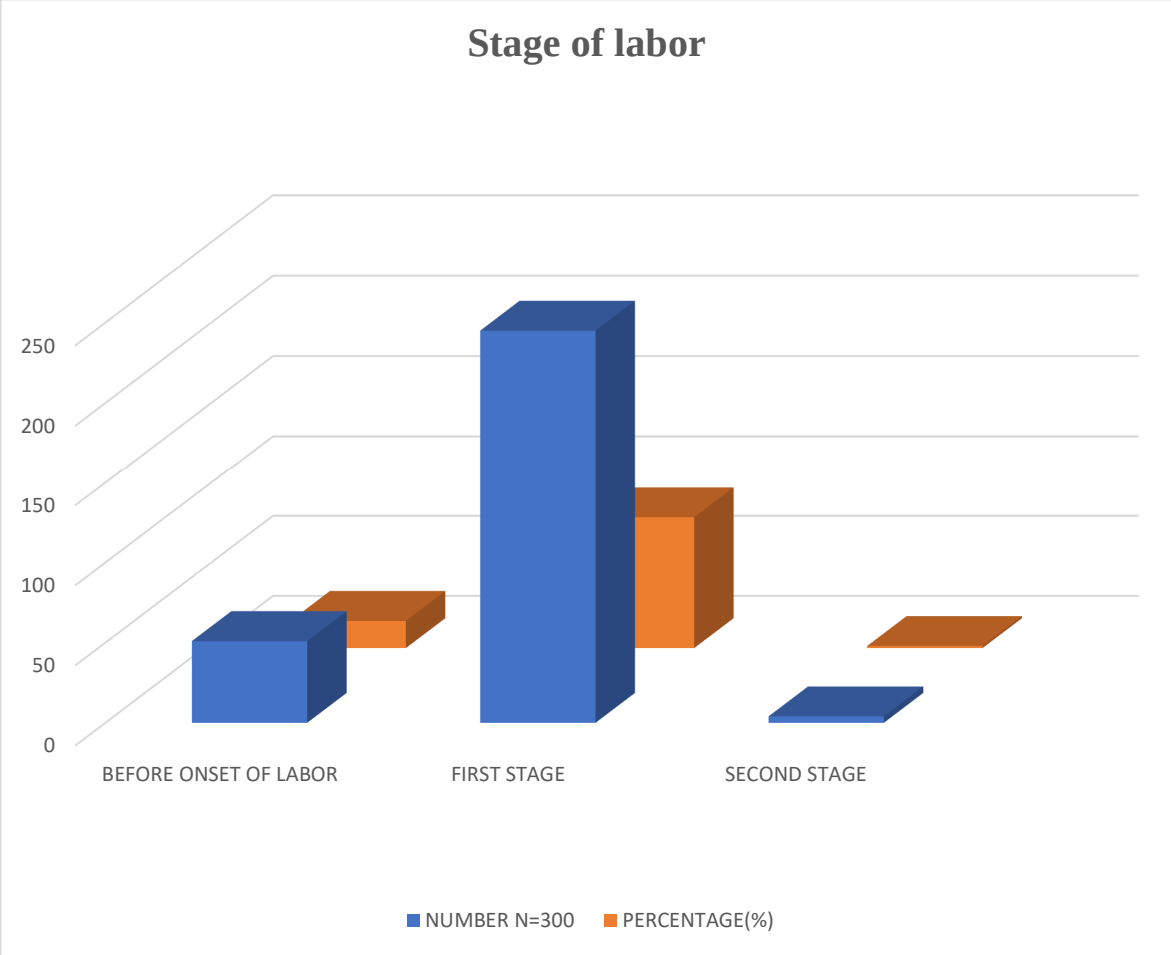

Stage of labor
250
200
150
100
50
0
BEFORE ONSET OF LABOR
FIRST STAGE
SECOND STAGE
NUMBER N=300
PERCENTAGE(%)

Table 9: Indications

Indications	Number n=300	Percentage(%)
Fetal distress	67	22.33
Malpresentation	42	14
Thick meconium stained liquor with non -reassuring NST	30	10
Severe pre-eclampsia and eclampsia	27	9
Twin gestation	24	8
Fetal growth restriction with doppler changes	23	7.67
Antepartum haemorrhage	16	5.34
oligamnios	16	5.34
CDMR	14	4.67
Cephalopelvic disproportion	10	3.33
Precious pregnancy	10	3.33
BOH	6	2
Deep transverse arrest	3	1
Failed induction	3	1
Cervical dystocia	1	0.33
Obstructed labor	1	0.33
Others	7	2.33
Total	300	100

The most common indication were fetal distress 67(22.33%), malpresentation 42(14%) ,thick meconium stained liquor with non -reassuring NST 30(10%), severe pre-eclampsia and eclampsia 27(9%).

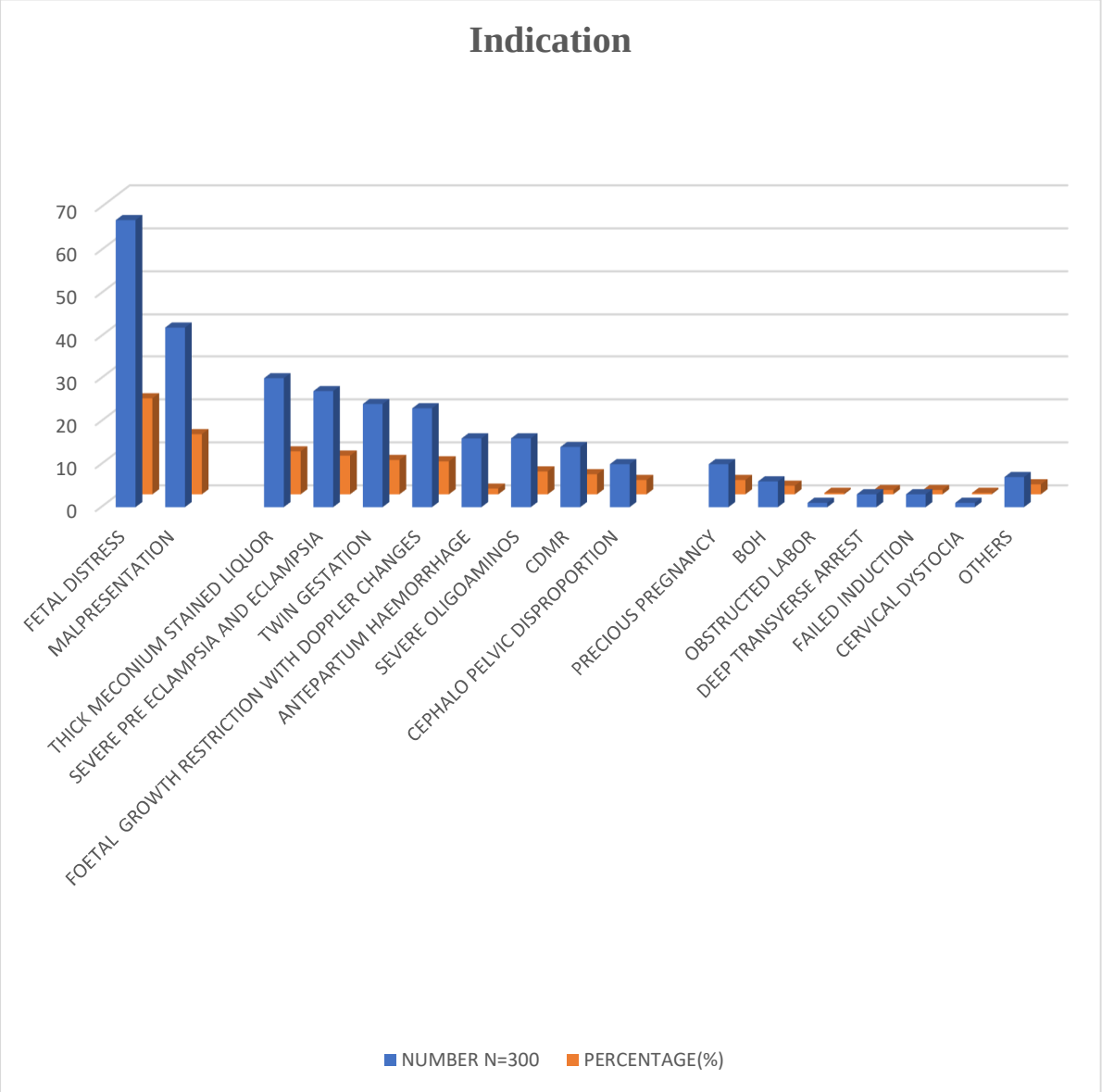

Indication
70
60
50
40
30
20
10
0
FETAL DISTRESS
MALPRESENTATION
THICK MECONIUM STAINED LIQUOR
SEVERE PRE ECLAMPSIA AND ECLAMPSIA
TWIN GESTATION
FOETAL GROWTH RESTRICTION WITH DOPPLER CHANGES
ANTEPARTUM HAEMORRHAGE
SEVERE OLIGOAMINOS
CDMR
CEPHALO PELVIC DISPROPORTION
PRECIOUS PREGNANCY
BOH
OBSTRUCTED LABOR
DEEP TRANSVERSE ARREST
FAILED INDUCTION
CERVICAL DYSTOCIA
OTHERS
NUMBER N=300
PERCENTAGE(%)

Table11: Intra operative findings

Intraoperative complication	Number n=208	Percentage=69.32 (%)
Thick msl	62	20.66
Cord around neck	42	14
Placenta previa	12	4
Extension of incision	30	10
Retroplacental clots	5	1.67
Blood stained liquor	4	1.33
PPH	4	1.33
Thinned out lower segment	32	10.67
Bladder injury	1	0.33
Couvelaires uterus	3	1
Fibroid	9	3
Ovarian cyst	4	1.33
Total	208	69.32

In present study among 300 subjects 208(69.32%) subjects had significant intra operative findings of which 62 subjects (20.66%) thick msl, 42 subjects (14%) cord around the neck, 32 subjects (10.67%) thinned out lower segment , 30 subjects (10%) extension of uterine incision , 12 subjects (4%) placenta previa, 5 subjects (1.67%) retroplacental clot , 4 subjects (1.33%) blood stained liquor , 3 subjects (1%) couvelaires uterus, 9 subjects (3%) fibroid , 4 subjects (1.33%) PPH,4 subjects (1.33%) ovarian cyst.

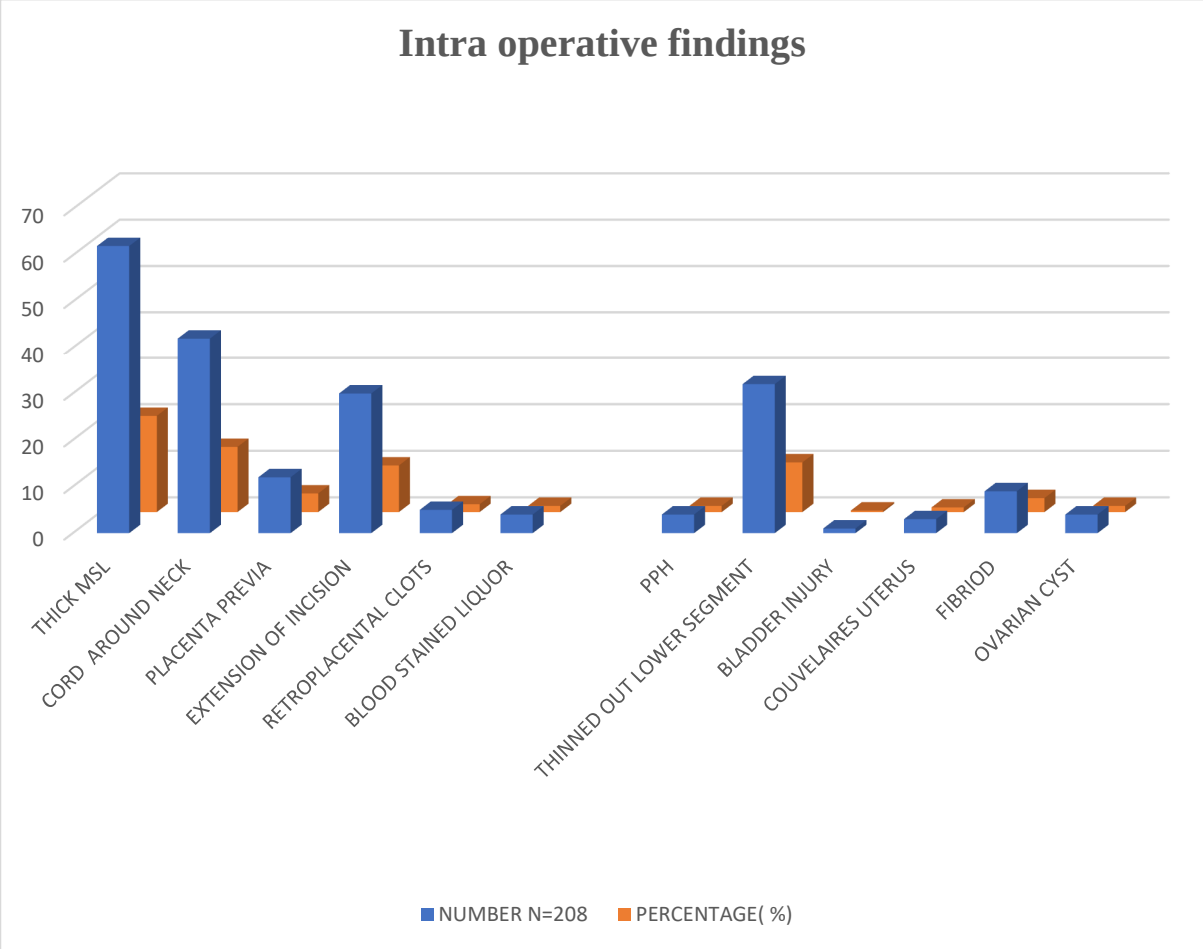

Intra operative findings
70
60
50
40
30
20
10
0
THICK MSL
CORD AROUND NECK
PLACENTA PREVIA
EXTENSION OF INCISION
RETROPLACENTAL CLOTS
BLOOD STAINED LIQUOR
PPH
THINNED OUT LOWER SEGMENT
BLADDER INJURY
COUVELAIRES UTERUS
FIBRIOD
OVARIAN CYST
NUMBER N=208
PERCENTAGE(%)

Table 12:Extended operative procedure

Extended operative procedure	Number n=50	Percentage=16.65 (%)
Repair of extension	30	10
Uterine artery ligation	10	3.33
B/L internal iliac artery ligation	2	0.66
Hayman suturing	6	2
Peripartum hysterectomy	1	0.33
Bladder repair	1	0.33
Total	50	16.65

In present study among 300 subjects 50 subjects (16.65%) underwent extended operative procedure of which 30 subjects (10%) repair of uterine extension, 10 subjects (3.33%) uterine artery ligation, 6 subjects (2%) Haymans suturing , 2 subjects (0.66%) B/L internal artery ligation, 1 subjects underwent both bladder repair and peripartum hysterectomy accounting to (0.66%).

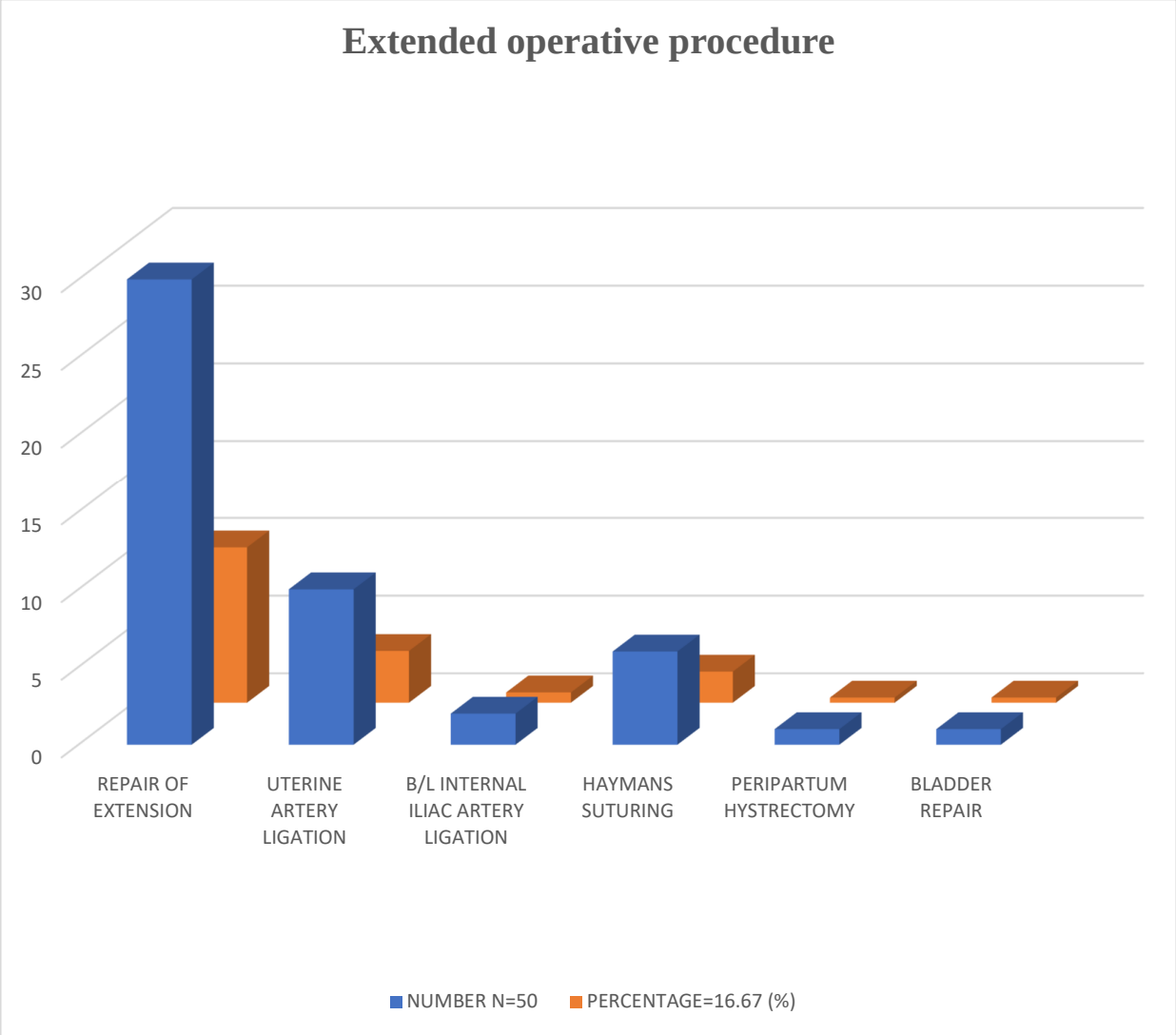

Extended operative procedure
30
25
20
15
10
5
0
REPAIR OF EXTENSION
UTERINE ARTERY LIGATION
B/L INTERNAL ILIAC ARTERY LIGATION
HAYMANS SUTURING
PERIPARTUM HYSTRECTOMY
BLADDER REPAIR
NUMBER N=50
PERCENTAGE=16.67 (%)

Table 13: Post operative complication

Post operative complication	Number n=87	Percentage=29 (%)
Abdominal distension	12	4
Wound gape	21	7
Paralytic ileus	3	1
Fever	16	5.33
Urinary tract infection	6	2
Upper respiratory tract infection	13	4.34
Post spinal headache	16	5.33
Total	87	29

In present study among 300 subjects 87(29%) had post operative complication 21 subjects (7 %) wound gape, 16 subjects (5.33%) fever , 16 subjects (5.33%) post spinal headache, 12 subjects (4%) abdominal distension, 13 subjects (4.34%) URTI ,6 subjects (2%) UTI and 3 subjects (1%) paralytic ileus.

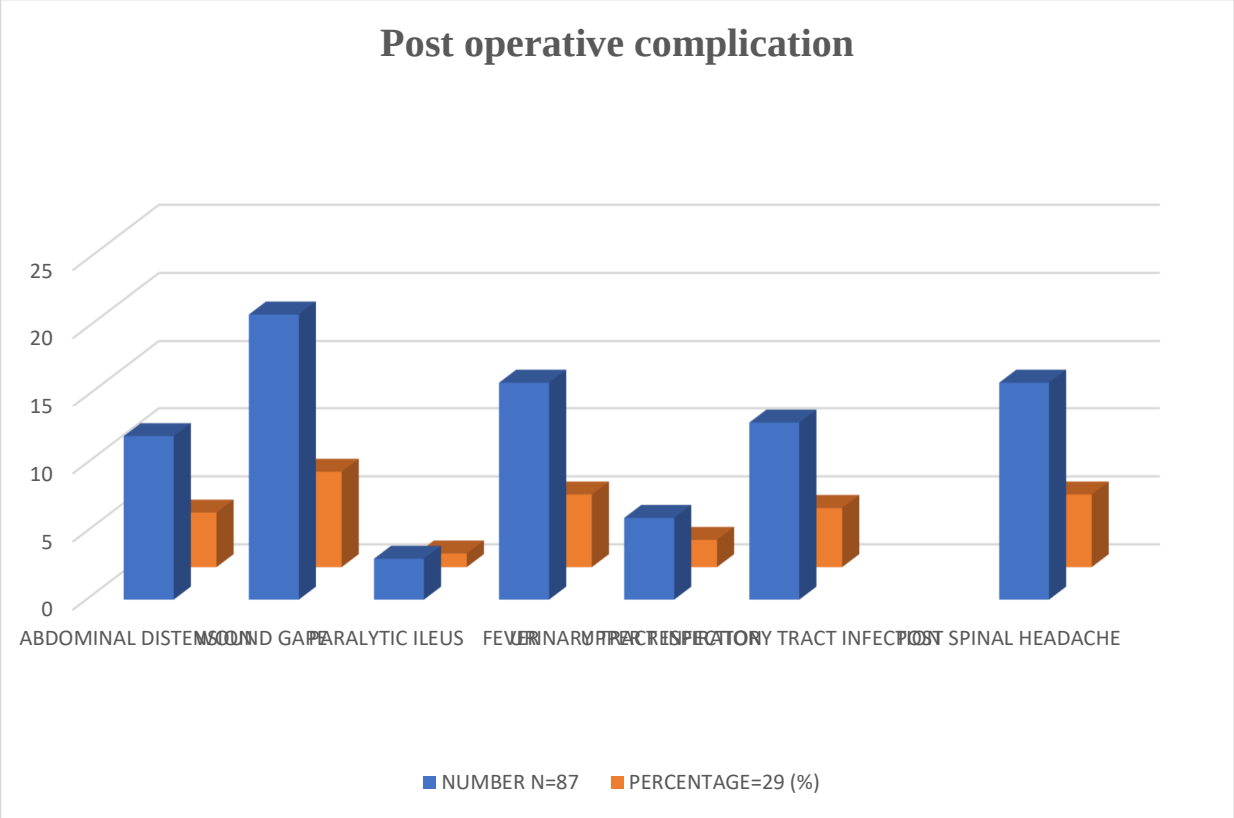

Post operative complication
25
20
15
10
5
0
ABDOMINAL DISTENSION
WOUND GAPE
PARALYTIC ILEUS
FEVER
URINARY TRACT INFECTION
POST SPINAL HEADACHE
NUMBER N=87
PERCENTAGE=29 (%)

Table14: Need for blood and blood products

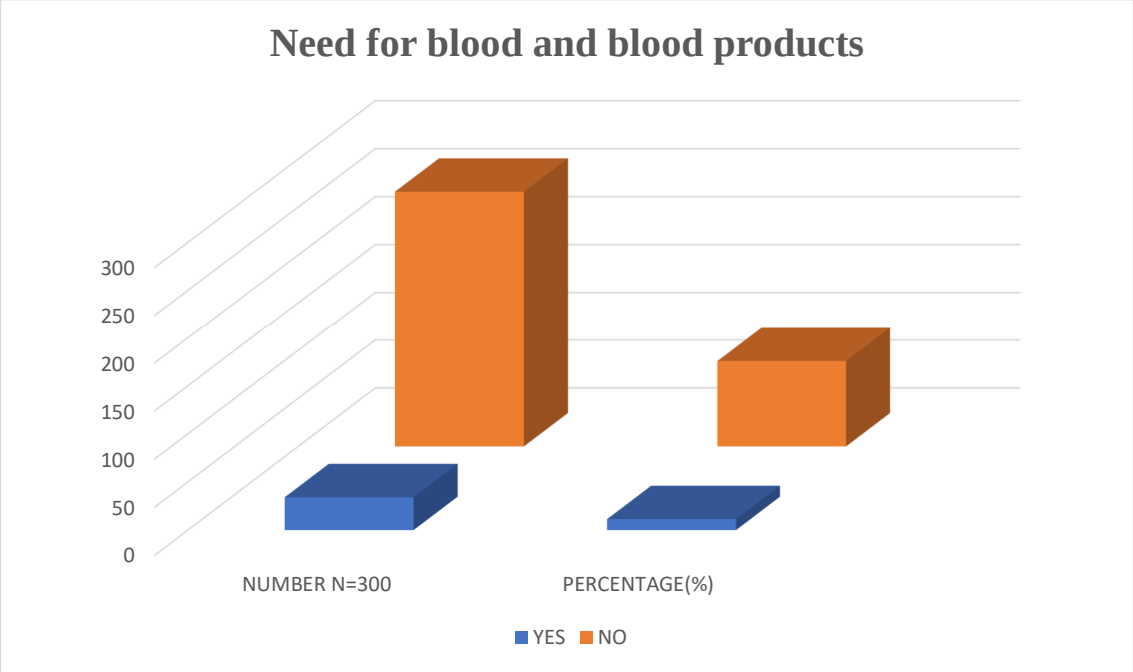
Blood transfusion	Number n=300	Percentage(%)
Yes	34	11.33
No	266	88.67
Total	300	100

In the present study 34 (11.33%) subject needed blood and blood products

Table 15: Outcome of birth

Condition of baby	Number n=324	Percentage(%)
Live birth	320	98.76
Fresh still birth	3	0.93
Macerated still birth	1	0.31
Total	324	100%

In the present study there were 320 (98.76%) live birth, 3 (0.93%) fresh still birth and 1 (0.31%) macerated still birth.


Need for blood and blood products
300
250
200
150
100
50
0
NUMBER N=300
PERCENTAGE(%)
YES
NO

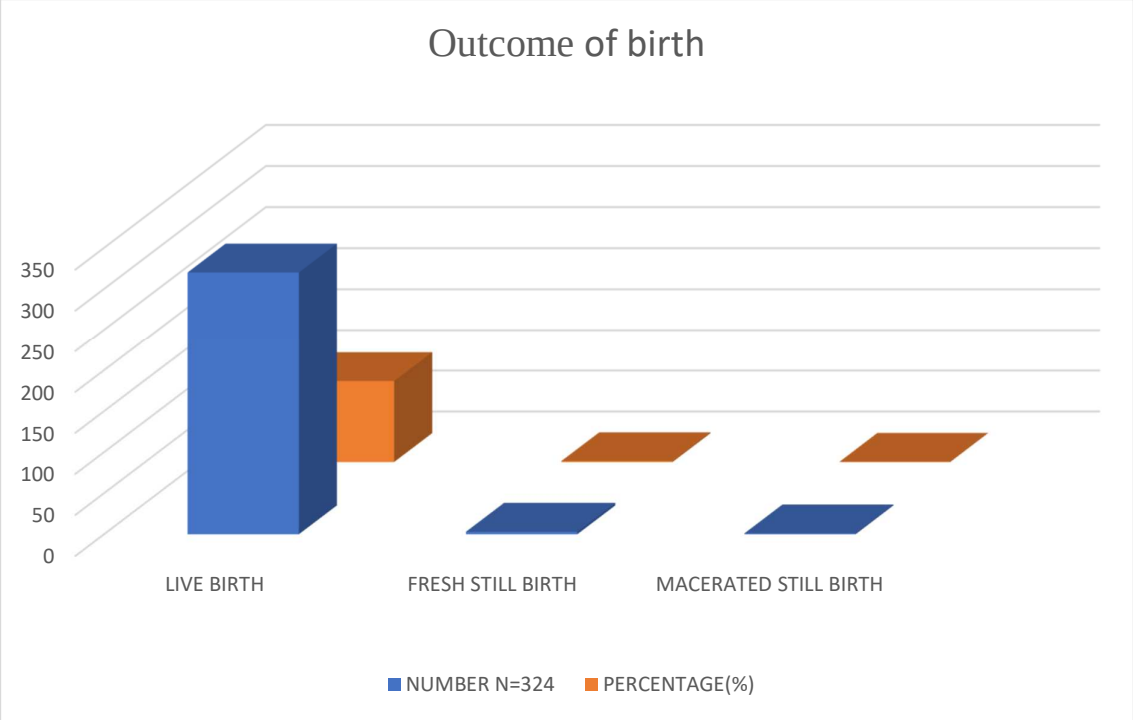

Outcome of birth
350
300
250
200
150
100
50
0
LIVE BIRTH
FRESH STILL BIRTH
MACERATED STILL BIRTH
NUMBER N=324
PERCENTAGE(%)

Table 16: Birth weight distribution

Birth weight	Number n= 324	Percentage(%)
0.7-1.0 kg	6	1.88
1.1-1.5 kg	24	7.40
1.6-2.0 kg	37	11.42
2.1-2.5 kg	63	19.45
2.6-3.0 kg	86	26.55
3.1-3.5 kg	83	25.60
3.6-4 kg	24	7.40
> 4.1 kg	1	0.30
Total	324	100

In present study among 300 deliveries in order of frequency 86 babies (26.55%) were between 2.6 -3.0 kg, 83 babies (25.60%) were between 3.1-3.5 kg, 63 babies (19.45%) were between 2.1-2.5 kg, 37 babies (11.42%) were between 1.6-2.0kg, 24 babies (7.40%) were between 3.6 kg-4 kg, 24 babies (7.40%) were between 1.1-1.5 kg, 6 babies (1.88%) were between 0.7-1.0 kg and 1 baby (0.30%) more than 4.1 kg .

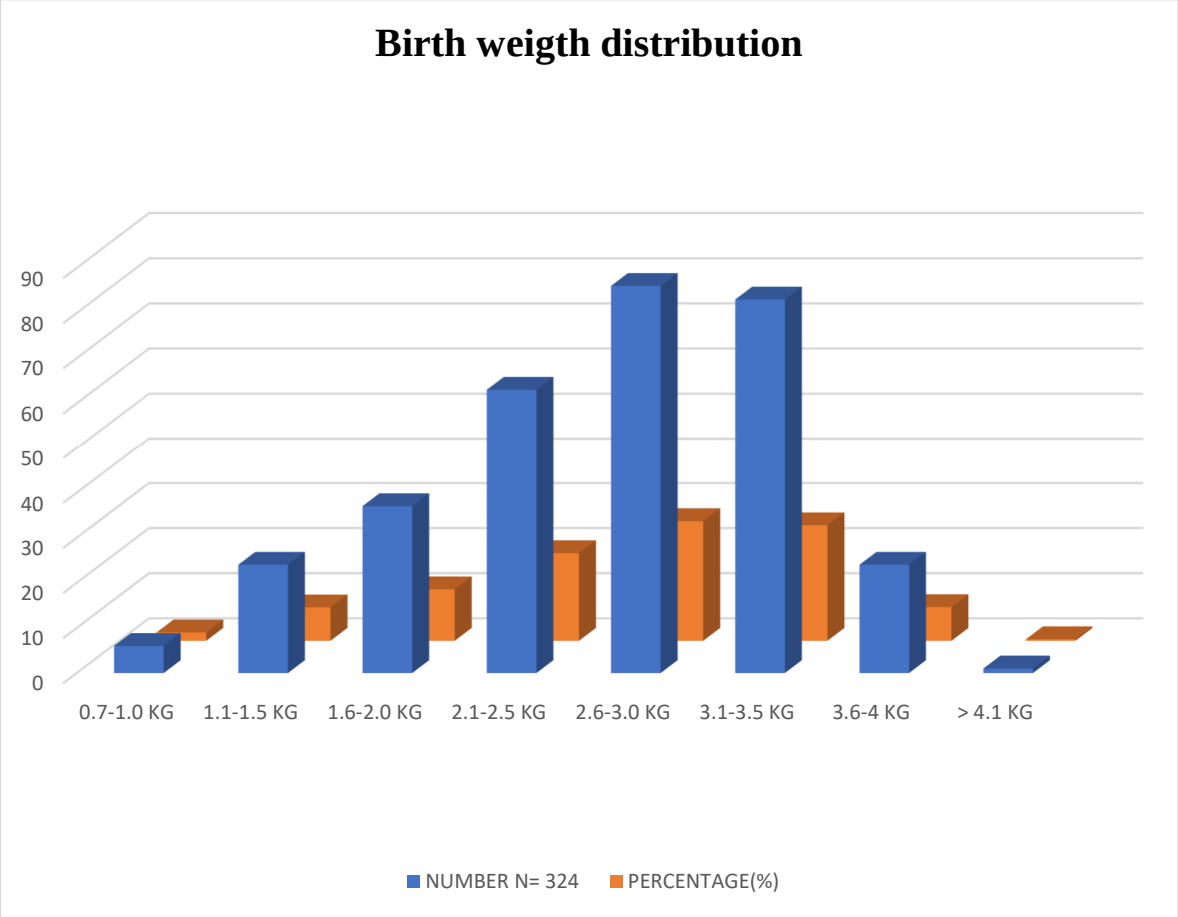

Birth weigth distribution
90
80
70
60
50
40
30
20
10
0
0.7-1.0 KG
1.1-1.5 KG
1.6-2.0 KG
2.1-2.5 KG
2.6-3.0 KG
3.1-3.5 KG
3.6-4 KG
> 4.1 KG
NUMBER N= 324
PERCENTAGE(%)

Table 17:APGAR score at 1 min

APGAR score at 1 min	Number n=324	Percentage(%)
0	4	1.23
1	1	0.30
2	1	0.31
3	1	0.31
4	54	16.67
5	21	6.48
6	36	11.11
7	110	33.95
8	54	16.67
9	42	12.97
Total	324	100

In present study mean APGAR score at 1 min is 7.17± 0.56.

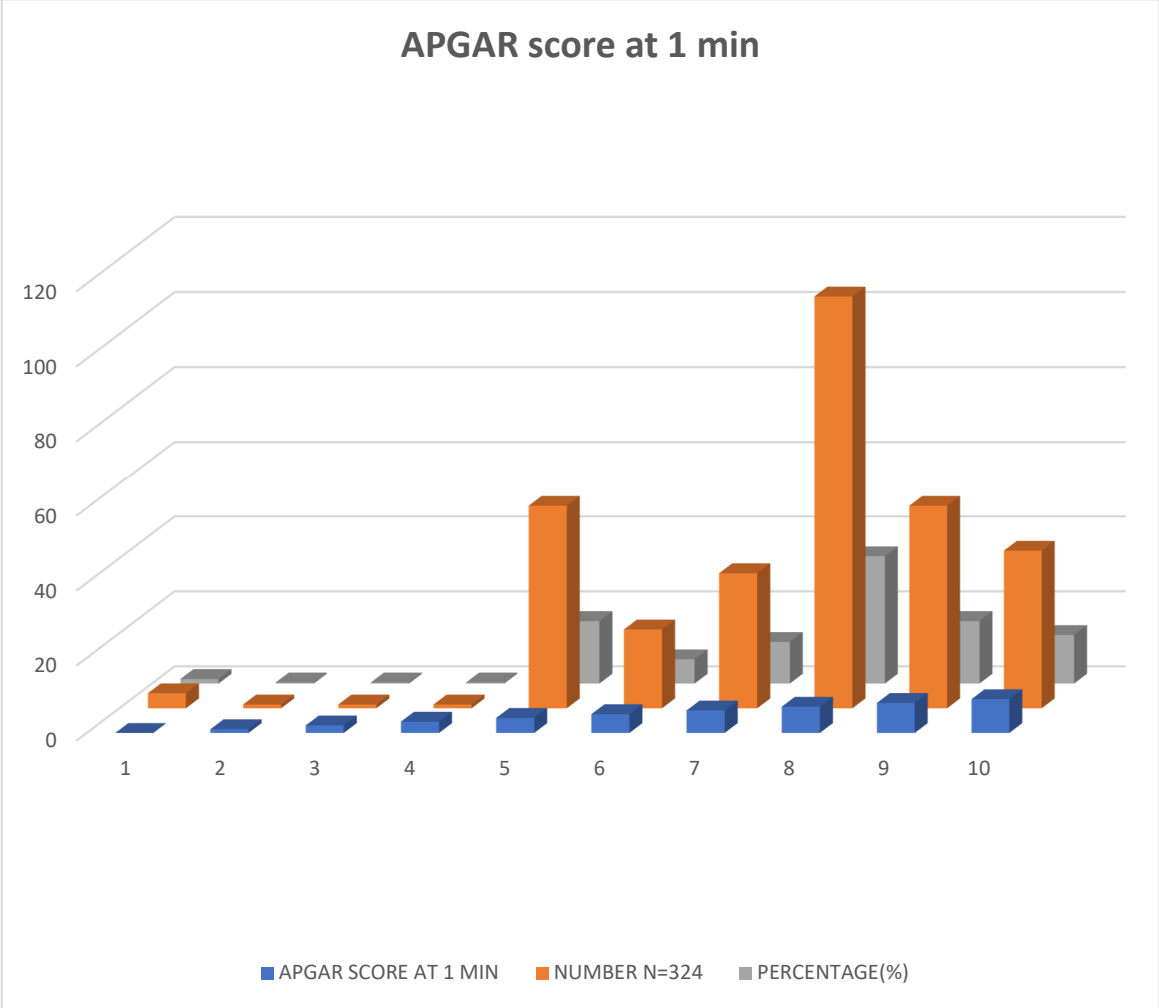

APGAR score at 1 min
120
100
80
60
40
20
0
1
2
3
4
5
6
7
8
9
10
APGAR SCORE AT 1 MIN
NUMBER N=324
PERCENTAGE(%)

Table 18:APGAR score at 5 min

Apgar score at 5 min	Number n=324	Percentage(%)
0	4	1.20
1	1	0.30
2	6	1.80
3	1	0.30
4	66	20.50
5	34	10.60
6	24	7.50
7	56	17.40
8	102	31.70
9	30	8.7
Total	324	100

In present study mean APGAR score at 5 min is 8.2 ± 0.50.

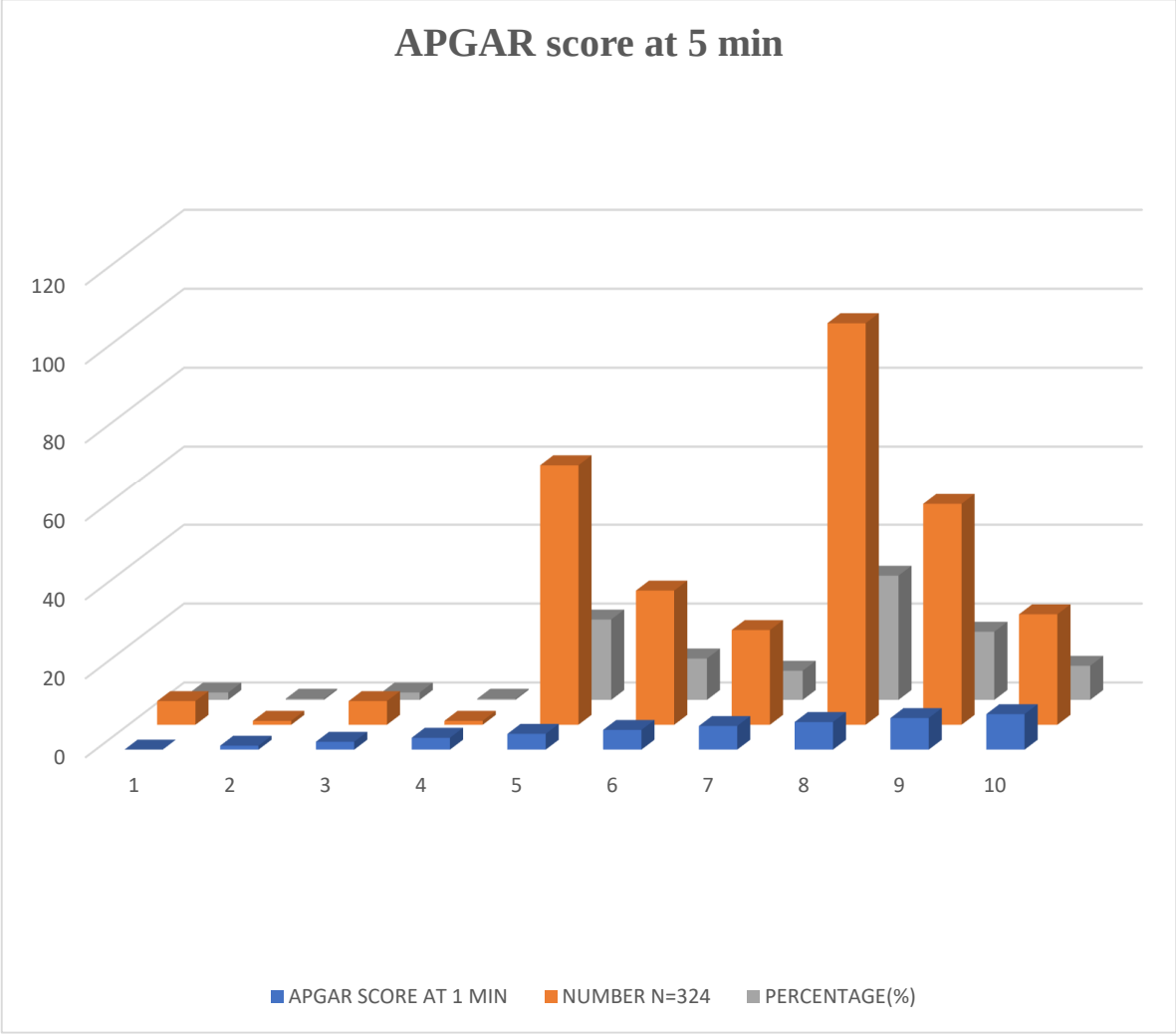

APGAR score at 5 min
120
100
80
60
40
20
0
1
2
3
4
5
6
7
8
9
10
APGAR SCORE AT 1 MIN
NUMBER N=324
PERCENTAGE(%)

Table19: Indication for NICU admission

Cause of NICU admission	Number n=184	Percentage=57.5 (%)
Low birth weight	45	14.06
Prematurity	40	12.5
Meconium aspiration	32	10
Respiratory distress	14	4.32
Hypoglycaemia	14	4.32
Jaundice	37	11.68
Birth asphyxia	2	0.62
Total	184	57.5

In present study among 300 deliveries 184 babies (57.5%) had NICU admission of which 45 babies (14.06%) low birth weight ,40(12.5%) prematurity ,32 babies (10%) meconium aspiration ,37 babies (11.68%) neonatal jaundice , 14 babies (4.32%) respiratory distress ,14 babies (4.32%) hypoglycaemia, 2 babies (0.62%)birth asphyxia.

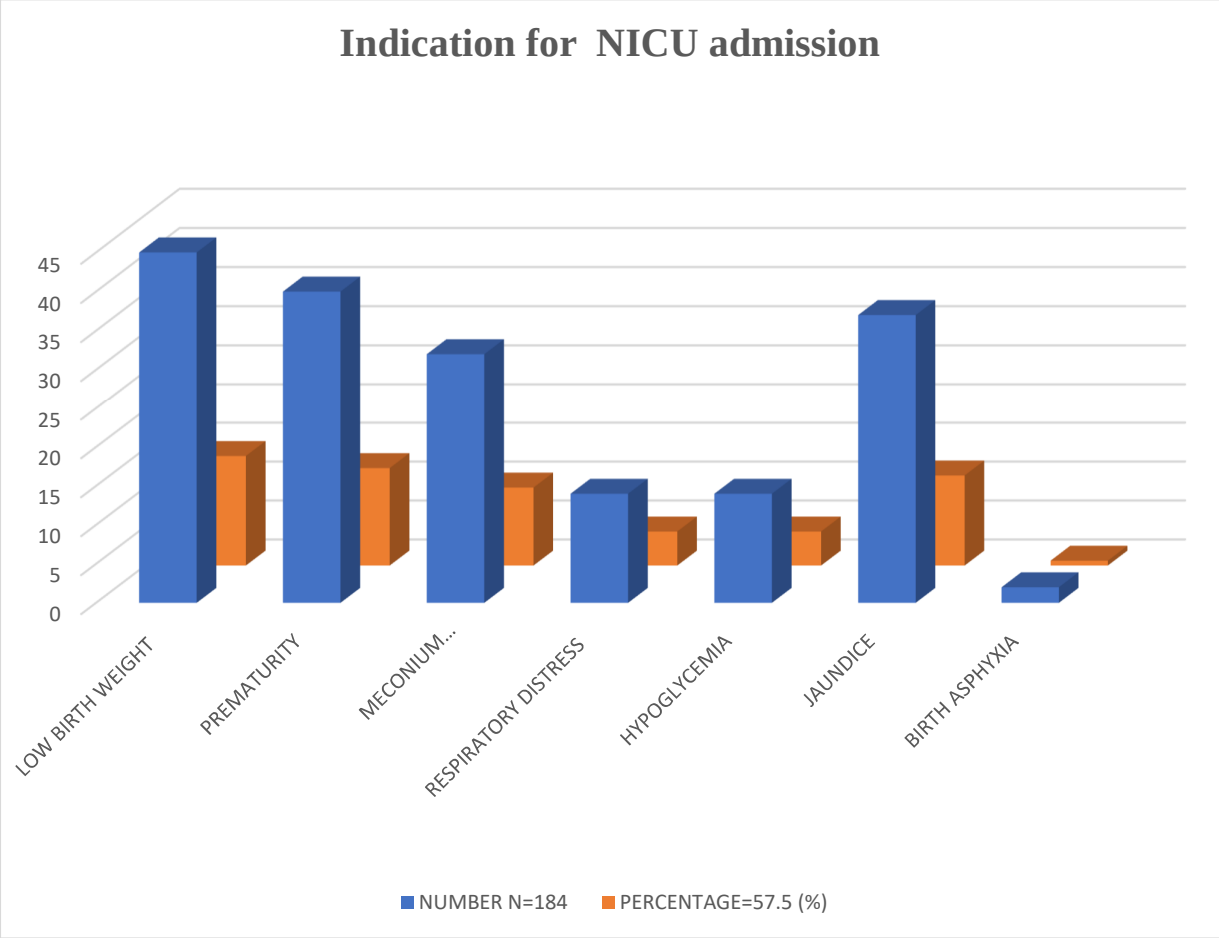
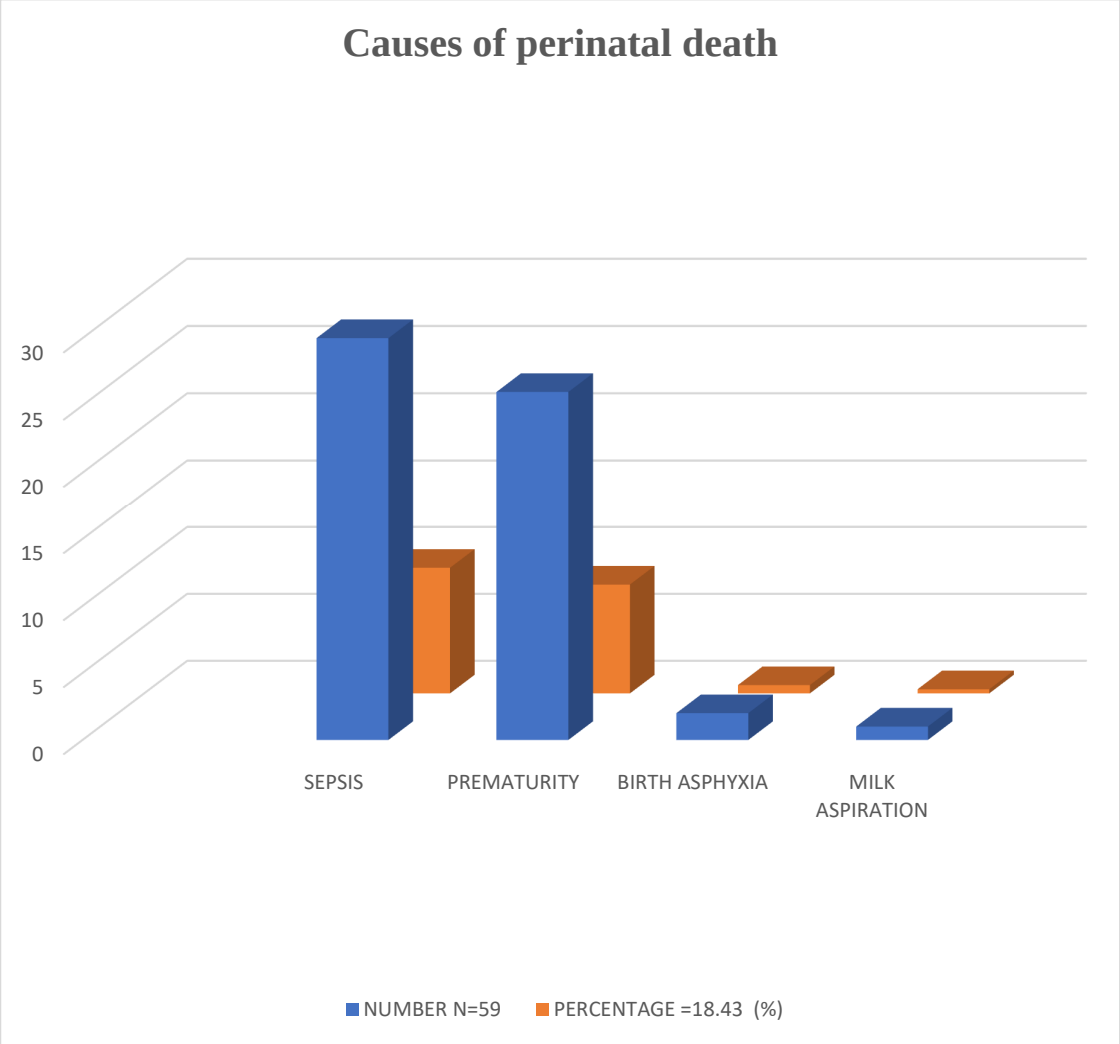

Indication for NICU admission
45
40
35
30
25
20
15
10
5
0
LOW BIRTH WEIGHT
PREMATURITY
MECONIUM...
RESPIRATORY DISTRESS
HYPOGLYCEMIA
JAUNDICE
BIRTH ASPHYXIA
NUMBER N=184
PERCENTAGE=57.5 (%)

Table 20:Causes of perinatal death

Causes of perinatal death	Number n=59	Percentage =18.43 (%)
Sepsis	30	9.37
Prematurity	26	8.12
Birth asphyxia	2	0.62
Milk aspiration	1	0.32
Total	59	18.43

In present study among 300 deliveries perinatal death is seen in 59 babies (18.68%) of which 30 babies (7.5%) sepsis ,26 babies (6.25%) prematurity , 2 babies (0.62%) birth asphyxia,1 baby (0.31%) milk aspiration.


Causes of perinatal death
30
25
20
15
10
5
0
SEPSIS
PREMATURITY
BIRTH ASPHYXIA
MILK ASPIRATION
NUMBER N=59
PERCENTAGE =18.43 (%)

DISCUSSION

The present cross sectional study was conducted during period of January 2021 to June 2022 in KAHER'S, Dr Prabhakar kore Charitable Hospital and MRC, Belagavi attached to Jawaharlal Nehru Medical College. A total of 300 women fulfilling the inclusion criteria were included in present study - A CROSS SECTIONAL STUDY OF PRIMARY CESAREAN SECTION IN MULTIGRAVIDA AT A TERTIARY HEALTH CENTRE, BELAGAVI.

DEMOGRAPHIC CHARACTERICS

INCIDENCE

According to the table no 1 in the present study, a total of 5181 were delivered from January 2021 to June 2022, of which 3268 underwent cesarean section and 1913 were delivered vaginally. Among the 3268 cesarean sections, 1230 repeated cesarean sections,1738 were primary cesarean sections in primigravida and 300 were primary cesarean sections in multigravida. The incidence of primary cesarean section in multigravida accounted for 5.79%. The incidence of primary cesarean section among multigravida is 66.7%. The incidence of primary cesarean section in multigravida among multigravida who previously delivered vaginally is 28.27%. The incidence of primary cesarean section among primigravida is 60.1%. The incidence of primary cesarean section in primigravida is 33.54%.In similar study conducted by spoorthy et al[5] incidence of primary cesarean section in multigravida is 3.007%. In similar another study conducted by Jyothi et al[28], the primary caesarean rate in multigravida is 10.28%.

In similar another study conducted by Savita somalwar et al[2] primary caesarean sections in multigravida is 5.73%. The present study's finding is consistent with other studies.

AGE DISTRIBUTION

Age is an important factor because it is associated with increased adverse maternal and perinatal outcomes. Childbirth at a young (i.e, ≤ 19 years old) or advanced maternal age (i.e, ≥ 35 years old) is associated with an increased risk of adverse maternal and perinatal outcomes such as postpartum haemorrhage, eclampsia and cephalopelvic disproportion as well as adverse neonatal outcome including preterm birth, poor fetal growth, low birth weight and neonatal mortality(78). The mean age of women was 25.6 years. According to the table no 2 in a present study among 300 subjects,158 subjects (52.67%) were between the age group of 26–30 years, 90 subjects (30%) were aged between 21–25 years of age, 35 subjects (11.67%) were aged between 31–35 years of age, 10 subjects (3.33%) were between 36–40 years of age, and 7 subjects (2.33%)were in the 18–20 years of age.

In a similar study done by Spoorthy et al[5] total number of subjects was 235 among those 111 subjects (47.8%) were between the age group 25-29 years, 55 subjects (23.7%) were between the age group 20-24 years, 38 subjects (16.37%) were between the age group 30-34 years,25 subjects (10.77%) were between the age group 35 to 39 years and only one subject(0.42%) was more than 40 years of age.

In a similar, study conducted by Savita Somalwar et al[2] among 200 subjects 105 subjects (52.5%) were in the age group 25-29 years, 41 subjects (20.5%) were less than 25 years and 54 subjects(27%) were more than 30 years.

In a similar, study conducted by Hangarga et al[29] the total number of subjects enrolled was 84 and 31% of subjects were in the age group 25–27 years, 34% of subjects were in the age group 22–24 years, 14% of subjects were in the age group 19–21 years and 7% were in the age group 28–31 years. The present study's finding is consistent with other studies.

SOCIO ECONOMIC STATUS DISTRIBUTION

According to the modified B.G. Prasad classification in table no 3 among 300 subjects,88 subjects(29.33%) belonged to class 1(upper class),78 subjects (26%) belonged to class 2(upper middle), 52 subjects (17.33%) belonged to class 3(middle class), 15 subjects (5%) belonged to class 4(lower middle class), 67 subjects (22.33%) belonged to class 5(lower class).

In a similar study conducted by Janani et al[36], the majority of patients belonged to class 4 socioeconomic status.

We can correlate in the present study that the majority of primary cesarean sections were observed in the upper class and lower class combined accounting for 155(51.66%) among 300 delivery even though the upper class has better education, insurance policy, and regular antenatal check-up. The reason is a lack of willingness to accept even a minor increased associated risks with medical and sociolegal expectations of perfect neonatal outcomes and operative vaginal delivery. In the lower class, there is a lack in availability of resources like nutrition, regular antenatal check-ups, formal education leading to malnutrition, anemia, cephalopelvic disproportion, FGR, eclampsia, oligohydramnios, post datism leading to higher primary cesarean section rate. The present study's findings are consistent with other studies.

REGISTERED CASE

According to table no 4, in the present study among 300 subjects 162 subjects (54%) were unregistered and 138 subjects (46%) were registered. Registered antenatal case means a minimum of 4 antenatal visits.

In a similar study conducted by Spoorthy et al[5] among 235 subjects 168 (72.8%) were the unregistered case. In a similar study done by Savita Somalwar et al [2], among 152 subjects 110(72.36%) were unregistered.

The lack of regular antenatal visits by the multiparous women contributed to complications such as anaemia, pregnancy-induced hypertension, fetal growth restriction, oligohydramnios, post datism, haemorrhage, cephalopelvic disproportion leading to higher primary cesarean section rate. The present study's finding is consistent with other studies.

RISK WISE DISTRIBUTION

According to table no 5, in the present study among 300 subjects 232(77.33%) women were in the high-risk category. High-risk factors such as 98 subjects (32.66%) were anaemic, 40 subjects (13.33%) PIH, 38 subjects (12.6.7%) breech, 12 subjects (4 %) GDM, 24 subjects (8%) twin gestation, 10 subjects (3.33%) precious pregnancy, 10 subjects (3.33%) early onset FGR.

Our hospital is a tertiary care setup and referral hospital to the surrounding district, availability of NICU care and a blood bank is the reason for a large number of high-risk cases.

GRAVIDA DISTRIBUTION

According to the table no 6 in present study 300 subjects 204 subjects (68%) had 1 prior vaginal delivery, 80 subjects (26.67%) had 2 prior vaginal delivery, 14 subjects (4.66%) had 3 prior vaginal delivery, and 2 subjects (0.66%) had 4 prior vaginal delivery.

In a similar study conducted by Spoorthy et al[5] among 235 subjects 149 subjects (64.22%) were para 2 and 69 subjects (29.74%) were para 3 and 5 subjects (1.72%) were para 4. In a similar study conducted by Hangarga et al a total of 84 subjects were enrolled of which 37 subjects (44%) were para 1, 20 subjects (23%) were para 2, 21 subjects (25%) were para 3 and 6 subjects (7%) were para 4.

We can correlate in the present study that the majority of primary cesarean sections were seen in para 1 and para 2 284 subjects (94.67%). This is because in present times concept of the nuclear family and knowledge of contraception as restricted to grand multigravida in our study. we should be more cautious in para 1 and 2 women to reduce primary cesarean section rates. The present study's finding is consistent with other studies.

PERIOD OF GESTATION

According to table no 7 in the present study among 300 subjects 160 subjects (53.33%) were between 37 weeks to 39 weeks +6 days POG, 69 subjects (23%) were between 37 weeks to 39 weeks days +6 POG, 53 subjects (17.67%) were between 40 weeks to 41weeks +6 days POG, 8 subjects (2.67%) were between 28 weeks to 31 weeks +6 days POG, 7 subjects (2.33%) were between 32 weeks to 33 weeks +6 days POG and 3 subjects (1%) more than 42 weeks POG.

In a similar study conducted by Janani et al[36] a total of 600 subjects were enrolled of which 455 subjects (75.8%) were between 37 to 40 weeks POG, 79 subjects (13.2%) were between 34 to 36 weeks POG and 66 subjects (11%) were less than 34 weeks POG. The present study's finding is consistent with other studies.

TYPE OF PRIMARY CESAREAN SECTION

According to table, no 8 in the present study among 300 subjects 185 subjects (61.66%) underwent full-term emergency cesarean section, 64 subjects (21.33%) underwent preterm emergency cesarean section,27 subjects (9%) underwent full-term elective cesarean section and 24 subjects (8%) underwent preterm elective cesarean section.

in a similar study conducted by spoorthy et al[5] among 235 subjects 222 subjects (94.46%) underwent emergency cesarean section and 13(5.54%) subjects underwent elective cesarean section.

In similar another study conducted by Jyothi et al[28], a total of 200 subjects were enrolled of which 192 subjects(96%) underwent emergency caesarean section.

In similar, another study done by Savita somalwar et al[2] a total of 200 subjects were enrolled of which 193 subjects (96.5%) underwent emergency cesarean section and 7 subjects (3.5%) underwent elective cesarean section. The present study's finding is consistent with other studies

STAGE OF LABOR

According to table no 8 in the present study among 300 subjects primary cesarean sections were done in 51 subjects (17%) before the onset of labor, 245 subjects (81.66%) in the first stage of labor and 4 subjects (1.33%) in the second stage of labor.

In a similar study conducted by Hariprasad et al[37] among 200 subjects 156(78%) patients were in labour and 44(22%) were not in labour. The present study's finding is consistent with other studies

INDICATIONS

According to table no 9 in present study among 300 subjects indication of primary cesarean section is 67 (22.33%) fetal distress, 42(14%) malpresentation of which 38(12.67%)breech presentation, 2(0.67%)brow presentation and 2(0.66%) face presntation , 30(10%) thick meconium stained liquor with non-reassuring NST, 27(9%) severe pre-eclampsia and eclampsia group of which 19(6.33%) were severe PE and eclampsia, 6(2%) were imminent 2(0.66%)were eclampsia were seen, 24 (8%) twin gestation of which 4 (1.33%) were MCMA, 10(3.33%) were MCDA with twin A

breech and 10 (3.33%) DCDA twin with twin A breech, 23(7.67%) FGR with doppler changes of which 19(6.33%) had absent end diastolic flow and 4(1.67%) had reversal end diastolic flow , 16(5.33%) oligamnios, 16(5.3%)antepartum haemorrhage of which 9 were placenta previa with PV bleeding and 7 revealed abruptio placenta ,14(4.67%) CDMR,10(3.33%) cephalopelvic disproportion, 10(3.33%) precious pregnancy of which 5 were conceived by ovulation induction ,4 had an history of more than 10 years of married life and 1 had conceived by IVF , 9(3%)placenta previa with no bleeding ,6(2%) bad obstetrics history,3(1%)deep transverse arrest, 3(1%) failed induction,1(0.33%) cervical dystocia,1(0.33%) obstructed labor and 7(2.33%)other indication of which 2(0.66%) cardiac cases in which one was pulmonary artery hypertension and one was RHD with severe MS and 5(1.67%) cases of cord presentation.

In a similar study conducted by spoorthy et al[5] among 235 subjects primary cesarean section was done in 114(49.13%) with fetal distress, 36(15.52%), malpresentation, 26(15.52%) failure to progress due to minor degree CPD,24(10.3%) placenta previa,8(3.4%) abruptio placenta, 8(3.4%)failed induction, 6(2.5%) failed induction, 6(2.5%) cord presentation, 5(2.1%) antepartum eclampsia with an unfavourable cervix, 5(2.1%) twin gestation, 2(0.86%) cord prolapse.

In a similar, study conducted by Savita somalwar et al[2] among 200 subjects, primary cesarean section was done in 94(47%) fetal distress, 26(13%) malpresentation, 26(13%) thick meconium-stained liquor 11(5.5%) cervical dystocia,10(5%) APH, 10(5%) maternal desire, 7(3.5%) failed induction, 4(2%) MCDA with twin A breech, 2(1%) DTA, 2(1%) abnormal doppler.

In similar another study conducted by Hangarga et al[29] a total of 87 subjects were enrolled of which primary cesarean section was done in 19 (22%) with severe

oligohydramnios,13 (15.4%) foetal distress,12 (14%)breech presentation,10 (11.49%) PROM, 7 (8.3%) APH, 5 (6%) CPD, 6 (7%) multiple pregnancies, 4 (4.7%) severe PE, 3 (3.5%) obstructed labour. The present study's finding is consistent with other studies.

INTRA OPERATIVE FINDINGS

According to table no 10 in the present study among 300 subjects 208(69.33%)subjects had significant intraoperative findings of which 62 subjects (20.66%) had thick MSL, 42 subjects (14%) had cord around the neck, 32 subjects (10.67%) thinned out the lower segment, 30 subjects (10%) extension of uterine incision, 12 subjects (4%) placenta previa, 5 subjects (1.67%) retroplacental clot, 4 subjects (1.33%) blood stained liquor, 3 subjects (1%) couvelaires uterus, 9 subjects (3%) fibroid, 4 subjects (1.33%) PPH,4 subjects (1.33%) ovarian cyst.

In similar study conducted by Satish et al[38] among 90 subjects 43 subjects (47.7%)of subjects had no significant intraoperative findings and the remaining 20 subjects (22.2%) had cord around the neck,13 subjects (14.4%) had MSL,10 subjects (11.1%) had PPH,4 subjects (4.4%) had angle extension.

In a similar, another conducted by Girija et al[39] among 160 subjects 112(70%) subjects had significant intraoperative findings and complications of which 46 subjects (28.8%) had meconium-stained liquor, 16 subjects (10%) had PPH, 10 subjects (28.8%) had placenta previa, 7 subjects (4.4%) had thinned out the segment, 7 subjects (4.4%) had scanty liquor,5 subjects (3.1%) had bladder wall edema, 3 subjects (1.9%) had retroplacental clots, 3 subjects (1.9%) had ascites, 3 subjects (1.9%) had excess liquor, 2 subjects (1.3%) had bandl’s ring, 2 subjects (1.3%) had a uterine anomaly , 1 subjects (0.6%) had couvelaire uterus. The present study's finding is consistent with other studies

EXTENDED OPERATIVE PROCEDURE

According to the table no 12 in the present study among 300 subjects 50 subjects (16.67%) underwent the extended operative procedure of which 30 subjects (10%) repaired of extension, 10 subjects (3.33%) uterine artery ligation, 6 subjects (2%) Haymans suturing, 2 subjects (0.66%) B/L internal artery ligation, 1 subjects underwent (0.66%) bladder repair and peripartum hysterectomy. There are no studies where extended operative procedure of primary cesarean section in multigravida is analysed.

POST OPERATIVE COMPLICATION

According to the table no 13 in the present study among 300 subjects 87(29%) had postoperative complications 21 subjects (7 %) wound gape, 16 subjects (5.33%) had fever, 16 subjects (5.33%) post spinal headache, 12 subjects (4%) abdominal distension, 13 subjects (8%) URTI,6 subjects (2%) fever and 3 subjects (1%) paralytic ileus.

In a similar study conducted by Savita et al2 among 200 subjects, 33 subjects (16.5%) had the post-operative complication of which 12 subjects (6%) had a fever, 10 subjects (5%) wound discharge, 6 subjects (3%) PPH, 4 subjects (2%) UTI and 1 subjects (0.5%) fever with wound discharge.

In similar, in another study conducted by Satish Kumar et al[38] among 90 subjects 14 subjects (15.5%) had the post-operative complication of which 3 subjects (3.33%) had a fever, 3 subjects (3.33%) had atonic PPH, 3 subjects (3.33%) wound discharge, 2 subjects (3.33%) UTI.

In similar, in another study conducted by Girija et al[39] among 160 subjects 31 subjects (19.4%) had the post-operative complication of which 12 subjects (7.5%) had UTI, 10 subjects (6.3%) had pyrexia,4 subjects (6.3%) paralytic ileus, 3 subjects

(1.9%) wound infection, 2 subjects (1.3%) respiratory tract infection. However in contrast to the current study similar finding is not seen because the majority of subjects belonged to lower socioeconomic status due to which lack of availability of resources like nutrition, regular antenatal check-ups, and formal education leading to malnutrition, and anemia leading to higher post-operative complication.

NEED FOR BLOOD AND BLOOD PRODUCTS

According to table no 14 in the present study among 300 subjects 34 subjects (11.33%) required transfusion of blood and blood products of which 28 pints of PRBC,31 pints of RDP,2 pints of SDP and 23 pints of FFP were used. The majority of patients were anaemic, the requirement of blood became necessary, especially in cases of antepartum haemorrhage and post-partum haemorrhage.

In a similar study conducted by Sherin et al[40] among 211 subjects 8 subjects (3.79%) required blood transfusions.

In similar another study conducted by Hariprasad et al[37] among 150 subjects 33 subjects (22%) out of 150 cases required blood transfusion either before or after the surgery. The present study's finding is consistent with other studies.

CONDITION OF BABY

According to table, no 15 in the present study there were 320 (98.76%) live birth, 3 (0.93%) fresh stillbirths due to abruptios placenta and 1 (0.31%) macerated stillbirth due to anaminos

In a similar study conducted by Hariprasad et al[37] among 150 deliveries 147(95.45%) live birth, and 7(4.55%) stillbirths.

In a similar study conducted by Jyothi et al[28] among 200 deliveries of which 186(93%) live birth and 14(7%) stillbirths were seen.

In similar another study conducted by Girija et al[39] studies among 160 deliveries of which 158 live birth (98.8%) and 2 stillbirths (1.2%) were seen. %. The present study's finding is consistent with other studies.

BIRTH WEIGHT DISTRIBUTION

According to table no 16 in the present study among 300 deliveries in order of frequency 86 babies (26.55%) were between 2.6 -3.0 kg, 83 babies (25.60%) were between 3.1-3.5 kg, 63 babies (19.45%) were between 2.1-2.5 kg, 37 babies (11.42%) were between 1.6-2.0kg, 24 babies (7.40%) were between 3.6 kg-4 kg, 24 babies (7.40%) were between 1.1-1.5 kg, 6 babies (1.88%) were between 0.7-1.0 kg and 1 baby (0.30%) more than 4.1 kg. Around 67(20.93%) babies were less than 2 kg because Our hospital is a tertiary care setup and referral hospital to the surrounding district, availability of NICU care and the blood bank is the reason for a large number of babies less than 2 kg.

In a similar study conducted by Savita et al[2] among 200 deliveries of which 133(64.9%) babies were in 2.1-3.0 kg,47(22.91%) babies were more than 3.1 kg, and 25(12.19% babies were)less than 2 kg.

In similar another study conducted by hangarga et al[29] among 87 deliveries babies were maximum in 2.6 - 3 kg 30 babies(35%) followed by 2.1 – 2.5 kg babies (29%), 1.6 – 2 11 babies (13%), 3.1- 3.5 10 babies (12 %), 3.6 and above 5 babies (6%) and less than 1.5 kg 3 babies (3.5%). The present study's finding is consistent with other studies.

APGAR SCORE AT 1 MIN AND 5 MINS

According to the table, no 17 and 18 in the present study among 300 deliveries mean APGAR score @ 1 min was 7.17± 0.56 and APGAR score @ 5 min was 8.2± 0.50.

In a similar study conducted by Satish Kumar et al[38] among 90 deliveries of which 82(91%) of the babies had an APGAR score of 7 or more at 5 minutes and 8(9%) of the babies had an APGAR score of less than 7.

In similar another study conducted by Savita et al[2] among 200 deliveries 186 babies (93%) had an APGAR score of more than 7, and 14 babies (6.8%) had an APGAR score of less than 7. %). The present study's finding is consistent with other studies.

NICU ADMISSION

According to table, no 19 in the present study among 300 deliveries 184 babies (57.5%) had NICU admission of which 45 babies (14.06%) had low birth weight,40(12.5%) prematurity,32 babies (10%) had meconium aspiration,37 babies (11.68%) neonatal jaundice, 14 babies (4.32%) respiratory distress,14 babies (4.32%) hypoglycaemia, 2 babies (0.62%)birth asphyxia.

In a similar study conducted by Savita et al[2] study among 200 deliveries 70 babies (34.14%)were admitted to the NICU, of which 62 babies (31%)had newborn morbidity and 8(4%)experienced neonatal death.

In similar another study conducted by Satish et al[38] among 90 deliveries 18 babies (20%) were admitted to NICU of which 8 babies (44.4%) had preterm care, 3 babies(16.7%) had respiratory distress, 2 babies(11.1%) birth asphyxia, which 5 babies (27.8%) had meconium aspiration syndrome. However in contrast to the current study similar finding is not seen because high-risk cases like eclampsia, early onset FGR with doppler changes, overt DM with uncontrolled sugar, and severe oligohydramnios are referred since our hospital is tertiary care setup and referral hospital to the surrounding district, availability of NICU care and blood bank.

CAUSES OF PERINATAL DEATH

According to the table no 20 in the present study among 300 deliveries perinatal death is seen in 59 babies (18.68%) of which 30 babies (7.5%) have sepsis,26 babies (6.25%) prematurity, 2 babies (0.62%) birth asphyxia,1 baby (0.31%) milk aspiration.

In a similar study conducted by Savita et al[2] study among 200 deliveries, Neonatal mortality affected 79 babies (39.5%), of which 35 babies (17.07%) died due to preterm care, 22 babies (10.73%) from respiratory distress, 6 babies (2.93%) from meconium aspiration syndrome, 4 babies (1.95%) from hypoglycaemia, 2 babies (0.98%) a from sepsis,5 babies (2.44%) from extremely low birth weight, and 3 babies(1.46%) from birth asphyxia. The perinatal mortality rate is comparatively less in the current study when compared to other studies, proving the factor that prompts treatment to the mother and timely delivery of the baby and proper NICU care in the current setup.

The strengths of the study are that it is a cross-sectional study and all details regarding the primary cesarean section of the study population are studied.

The major limitation of the current study is that it's a one-year study which has been conducted only in a single tertiary care centre and small sample size.

To conclude “the art of surgery may be necessary to perform difficult cesarean section but to decide whether this is necessary and to choose the ideal moment to deliver the baby is surely the art of obstetrics [41]

CONCLUSION

Our study has shown that multigravida is associated with high primary cesarean section rate, maternal complication and neonatal complication , although multigravida is considered as a low-risk group leading to a false sense of security.

Our study has shown that multigravida is associated with unfavorable maternal and fetal outcome, Hence same as high risk pregnancies multigravida should also receive adequate obstetrics care .

SUMMARY

In the present study, following are the significant finding:-

- Incidence of primary cesarean section in multigravida was 5.79%.
- Maximum number of cesarean section were done in age group of 26-30 years. Mean age of women was 25.6 years .
- Maximum number of study women belonged to class 1 88(29.33%), class 2 78(26%) and class 5 67(22.33%) of modified B.G prasad classification.
- Maximum number of women were unregistered 162(54%).
- 232(77.33%) women were in high risk category.
- Maximum number of women 204(68%) had 1 prior vaginal delivery.
- Most number of primary cesarean section were done between 37 to 39 $^{+6}$
- Maximum number of cesarean section done were full term emergency cesarean section 185(61.66%).
- Most number of women underwent primary cesarean section in first stage 245(81.66%).
- The most common indication were fetal distress 67(22.33%), malpresentation 42(14%) ,thick meconium stained liquor with non-reassuring CTG 30(10%),severe pre-eclampsia and eclampsia 27(9%).
- The most common intraoperative finding were thick MSL 62(20.66%) and extension of incision 30(10%).
- The most common extended procedure performed was repair of uterine extensions 30(10%).
- The most common post operative complication were wound gape 21(7%).
- Blood transfusion was needed in 34 (11.33%) women.

- There were 320 (98.76%) live birth, 3 (0.93%) fresh still birth and 1 (0.31%) macerated still birth.
- Maximum babies were between 2.6-3.0 kg group 86 (26.54%).
- Mean APGAR score at 1 min is 7.17± 0.56 and mean APGAR score at 5 min is 8.2± 0.50.
- NICU admission were given to 184(57.5%) neonates. 45 (14.06%) low birth weight ,40(12.5%) prematurity was the most common causes
- Perinatal death were seen in 59(18.43%) .Sepsis 30(9.37%) and prematurity 26(8.12%) were most common cause for perinatal death.

BIBLIOGRAPHY

1. American College of Obstetricians and Gynecologists: Scheduling planned cesarean delivery. Patient Safety Checklist No. 3, December 2011.
2. Somalwar S, Bansal R. Study of Primary Caesarean Section in Multiparous Women in Central India. Journal of Krishna Institute of Medical Sciences (JKIMSU). 2020 Oct 1;9(4).
3. Osterman MJ. Changes in primary and repeat cesarean delivery: United States 2016-2021.
4. NFHS-5). National Family Health Survey–5 (2019-21).
5. Parvathreddy S, Shetty S. Incidence Primary LSCS in Multigravida–A Prospective Study. European Journal of Molecular & Clinical Medicine. 2021 Jun 22;8(04):2021.
6. Barber EL, Lundsberg LS, Belanger K, Pettker CM, Funai EF, Illuzzi JL. Indications contributing to the increasing cesarean delivery rate. *Obstet Gynecol.* 2011;118:29–38.
7. Boyle A, Reddy UM, Landy HJ, Huang CC, Driggers RW, Laughon SK. Primary cesarean delivery in the United States. Obstetrics and gynecology. 2013 Jul;122(1):33.
8. Gondwe T. *Cesarean section delivery in India: an analysis of maternal factors and infant outcomes* (Doctoral dissertation, University of Pittsburgh).
9. Sterilization T. Vincenzo Berghella, A. Dhanya Mackeen, Eric RM Jauniaux. Obstetrics: Normal and Problem Pregnancies. 2020 Feb 17:374.
10. Caughey AB, Cahill AG, Guise JM, Rouse DJ, American College of Obstetricians and Gynecologists. Safe prevention of the primary cesarean delivery. American journal ofobstetrics and gynecology. 2014 Mar 1;210(3):179-93.

11. Cegolon L, Mastrangelo G, Maso G, Dal Pozzo G, Ronfani L, Cegolon A, Heymann WC, Barbone F. Understanding factors leading to primary cesarean section and vaginal birth after cesarean delivery in the Friuli-Venezia Giulia Region (North-Eastern Italy), 2005–2015. Scientific reports. 2020 Jan 15;10(1):1-8.
12. Barber EL, Lundsberg LS, Belanger K, et al. Indications contributing to the increasing cesarean delivery rate.*Obstet Gynecol.* 2011;118:29–38.)
13. Cegolon, L. *et al*. Length of Stay Following Cesarean Sections: A Population Based Study in the Friuli Venezia Giulia Region (North-Eastern Italy), 2005–2015. *PLoS One.* **14**(2), e021075 (2019).
14. Cegolon,L.*etal*ASystematicEvaluationofHospitalPerformanceofChildbirthDeliveryModesandAssociatedFactorsinthe FriuliVenezia-Giulia Region (North-Eastern Italy), 2005–2015. *Scientific Reports*. (under review) (2019).
15. Italian Ministry of Health. Ministerial Decree April 2, 2015, (G.U. June 4, 2015, n. 127). http://www.camera.it/temiap/2016/09/23/ OCD177-2353.pdf. (Last accessed 14 October 2019).
16. Barber EL, Lundsberg LS, Belanger K, et al. Indications contributing to the increasing cesarean delivery rate.*Obstet Gynecol.* 2011;118:29–38.)
17. Hannah ME, Hannah WJ, Hewson SA, Hodnett ED, Saigal S, Willan AR. Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial. term breech trial collaborative group. *Lancet*. 2000;356(9239):1375–1383.
18. Caughey AB, Cahill AG, Guise JM, Rouse DJ, American College of Obstetricians and Gynecologists. Safe prevention of the primary cesarean delivery. American journal ofobstetrics and gynecology. 2014 Mar 1;210(3):179-93.

19. Berghella V, Blackwell SC, Ramin SM, Sibai BM, Saade GR. Use and misuse of the term “elective” in obstetrics. *Obstet Gynecol*. 2011; 117(2 Pt 1):372–376.
20. Hofmeyr GJ, Barrett JF, Crowther CA. Planned caesarean section for women with a twin pregnancy. Cochrane Database of Systematic Reviews. 2015(12).
21. Liu S, Liston RM, Joseph KS, Heaman M, Sauve R, Kramer MS. Maternal mortality and severe morbidity associated with low-risk planned cesarean delivery versus planned vaginal delivery at term. Cmaj. 2007 Feb 13;176(4):455-60.
22. Berghella V, Blackwell SC, Ramin SM, Sibai BM, Saade GR. Use and misuse of the term “elective” in obstetrics. *Obstet Gynecol*. 2011; 117(2 Pt 1):372–376.
23. Hofmeyr GJ, Barrett JF, Crowther CA. Planned caesarean section for women with a twin pregnancy. Cochrane Database of Systematic Reviews. 2015(12).
24. Liu S, Liston RM, Joseph KS, Heaman M, Sauve R, Kramer MS. Maternal mortality and severe morbidity associated with low-risk planned cesarean delivery versus planned vaginal delivery at term. Cmaj. 2007 Feb 13;176(4):455-60.
25. Deneux C, Carmona E, Bouvier C, Breart G. Postpartum maternal mortality and cesarean delivery. Obstetrics and gynecology. 2006;108(3 Pt 1):541-8.
26. Abenhaim HA, Azoulay L, Kramer MS, Leduc L. Incidence and risk factors of amniotic fluid embolisms: a population-based study on 3 million births in the United States. American journal of obstetrics and gynecology. 2008 Jul 1;199(1):49-e1.
27. Hofmeyr GJ, Barrett JF, Crowther CA. Planned caesarean section for women with a twin pregnancy. Cochrane Database of Systematic Reviews. 2015(12)
28. Saluja JK, Roy PK, Mahadik K. Study of primary caesarean section in multiparous women. National Journal of Integrated Research in Medicine. 2014 Mar 1;5(2).

29. Hangarga US, Yattinamani B. Clinical study of primary cesarean section in multiparous women. Emergency. 2020;77:91-6.
30. Meena N, Parveen S, Nagar T, Meena NK. Study of indications of primary cesarean section in multigravida patients: A retrospective study. Asian Journal of Medical Sciences. 2022 Jul 1;13(7):145-8.
31. Desai E, Leuva H, Leuva B, Kanani M. A study of primary caesarean section in multipara. Int J Reprod Contracept Obstet Gynecol. 2013 Sep 1;2(3):320-4.
32. Sree Sailaja P, Kavitha G. Study of primary caesarean section in multigravida. J. Evid. Based Med. Healthc. 2019;6(45):2900-3.
33. Begum P, Saha DR, Zeba D. Indication and outcome of caesarean section in multigravid women with a history of vaginal delivery in a Tertiary Care Hospital. Faridpur Medical CollegeJournal. 2019;14(2):86-9.
34. Preeti B, G. Kadikar, Dipti P, Manoj B. A Study of Primary Cesarean Section in Multipara. Natl J Integr Res Med 2017; 8(2):161- 163
35. Kamath V, Patil V. A clinical study of primary caesarean section in multiparous women.
36. Priyadarsene P, Vilvapriya S, Kavitha S, Janani S. Primary cesarean section: A prospective cross sectional study.
37. Hariprasad, Himabindu, Sundari MT, Sireesha KV, Sairam MV. Primary cesarean section in multipara. IOSR-JDMS 2015;14(5):22-5.
38. Satish, Dr.G .Partha Saradhi Reddy, Dr.S.Venkata Ramana, Dr. Salma Bhanu, PG. Clinical Study of Primary Caesarean Section in Multiparous Women. Indian Journal of Research, 2015; 4(10): 112-114.

39. Girija, Samal R, Palai P, Ghose S. Clinical study of primary caesarean section in multiparous women in a tertiary care hospital. Int J Reprod Contracept Obstet Gynecol 2016; 5:1506-9.
40. Dr Sherin Sams et al JMSCR Volume 05 Issue 04 April 2017 Page 20720
41. Purandare CN. The over roofing rates of cesarean sections. The General of Obstetrics and Gynecology India 2011;61:501-2.

WAIVER OF CONSENT

K.L.E. ACADEMY OF HIGHER EDUCATION AND RESEARCH
(Deemed – to- be- University)
Accredited 'A' Grade by NAAC (2nd Cycle) Placed in Category 'A' by MHRD (GoI)
JAWAHARLAL NEHRU MEDICAL COLLEGE,
NEHRU NAGAR, BELAGAVI-590010 (KARNATAKA-INDIA)
Website: http//www.jnmc.edu
E-Mail : dome@jnmc.edu
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Principal: 2471701
Fax No. +91 (0)831 – 2470759

Ref: MDC/DOME/ 290 **Date: 22/12/2021**

To

REG. NO. BJ0120010
P G Student in Obstetrics & Gynaecology,
J. N. Medical College,
BELAGAVI.

With reference to the above, we wish to inform you that your proposed research project titled

"A CROSS SECTIONAL STUDY OF PRIMARY CESAREAN SECTION IN MULTIGRAVIDA AT A TERTIARY HEALTH CENTRE, BELAGAVI" I records and the study does not involve any interaction with cases and no identifiable information will be collected. The waiver of consent has been approved for the proposed research project and has been cleared by the JNMC Institutional Ethics Committee on Human Subjects Research.

(Dr. Smita Sonoli)
Member Secretary
JNMC Institutional Ethics Committee
on Human Subjects Research,
J.N.Medical College, Belagavi.

(Dr. Harsha Hegde)
Chairman,
JNMC Institutional Ethics Committee
on Human Subjects Research,
J.N.Medical College, Belagavi

PROFORMA

TITLE : " A CROSS SECTIONAL STUDY OF PRIMARY CESAREAN SECTION IN MULTIGRAVIDA AT A TERTIARY HEALTH CENTRE, BELAGAVI

NAME: AGE: IP NO: DOA: DOD:

OCCUPATION: ADDRESS:

SOCIO-ECONOMICS

LOW: ☐

MIDDLE: ☐

HIGH: ☐

EDUCATION: DURATION OF HOSPITAL STAY

REASON FOR SEEKING CARE:

a)LABOR PAIN

b)PROLONGED LABOR:

c)RUPTURED MEMBRANES:

d)ECLAMPSIA WARNING SYMPTOMS:

1)HEADACHE

2)VISUAL DISTRUBANCE

3)CHEST PAIN

4)SHORTNESS OF BREATH

5)HIGH BLOOD PRESURE

e)ANY OTHER MATERNAL HEALTH PROBELMS:YES/NO

f)REDUCED FETAL MOVEMENTS:YES/NO

OBSTETRIC HISTORY:

MARRIED LIFE : CONSANGUINEOUS/ NON-CONSANGUINEOUS

PREVIOUS PREGNANCY DETAILS

PRESENT PREGNANCY DETAILS :

TIME OF DIAGNOSIS

INFERTILITY TREATMENT

MODE OF CONCEPTION

NUMBER AND LENGTH OF HOSPITALISATION

PRENATAL CARE ULITIZATION :ADEQUATE /INADEQUATE

OBSTETRICS SCORE:	**G**		**P**		**L**		**A**
LMP (DD/MM/YY):							
EDD:							
C. EDD:							

PERIOD OF GESTATION(WEEKS+DAYS) | | |

HISTORY OF HYPERTENSION Y N

HISTORY OF DIABETICS MELLITUS Y N

HISTORY OF PRE-EXISTING RENAL /CARDIAC DISORDERS Y N

HISTORY OF THYROID ABNORMALITY Y N

HISTORY OF ALOCHOL CONSUMPTION Y N

HISTORY OF ABRUPTIO PLACENTA Y N

GENERAL PHYSICAL EXAMINATION

HEIGTH:

WEIGHT:

BMI:

VITALS:

PULSE:

BLOOD PRESURE:

TEMPERATURE:

RESPIRATORY RATE:

PALLOR

ICTERUS

EDEMA

BREAST

THYROID

SPINE

SYSTEMIC EXAMINATION:

RESPIRATORY SYSTEM:

CARDIOVASCULAR EXAMINATION:

PER ABDOMEN:

UTERUS SIZE

PRESENTATION

FHR

PER SPECULAM:

PER VAGINA:

DETAILS OF DELIVERY:

INDICATION FOR CESAREAN SECTION

FETAL DISTRESS

CEPHALOPELVIC DISPROPORTION

BREECH:

PLACENTA PREVIA

FAILED PROGRESS

SEVERE PIH

OBSTRUCTED LABOR

OLIGOHYDRAMINOS

IUGR

FAILED INDUCTION

MECONIUM STAINED IN

THE FIRST STAGE OF LABOR

ANTEPARTUM ECLAMPSIA

PROM

ABRUPTIO PLACENTA

UTEROPLACENTAL INSUFFICENCY

PRECIOUS PREGNANCY

DEEP TRANVERSE ARREST

TRANVERSE LIE

BROW PRESENTATION

CORD PROLAPSE

FACE PRESENTATION

SEVERE ECLAMPSIA

MULTIPLE GESTATION

VASA PREVIA

IMPENDING RUPTURE

MEDICAL CONDITION

ANY OTHER,SPECIFY:

OUT COME OF PREGNANCY

CONDITION OF MOTHER:

LIVE BIRTH

FRESH STILL BIRTH

MACERATED STILL BIRTH

BABY WEIGTH AT BIRTH:

BABY GENDER :MALE/FEMALE

DID THE BABY HAVE ANY CONGENTIAL ANOMALY:
IF YES SPECIFY

Y N

DID THE BABY HAVE BIRTH INJURY: Y N

IF YES SPECIFY

WAS THE BABY ADMIITTED TO NICU FOR COMPLICATION:
IF YES CAUSE OF ADMISSION

Y N

INFECTION/SEPSIS:

BREATHING DIFFICULITIES:

ASPHYSIA:

RESPIRATORY DISTRESS:

JAUNDICE :

CONVULSION:

CONDITION OF BABY AT DISCHARGE: STABLE UNSTABLE

IF BABY DIED ,CAUSE OF DEATH:

PREMATURITY:

LOW BIRTH WEIGHT:

SEPSIS:

BIRTH ASPHYXIA

SIGNATURE AND NAME OF INVESTIGATOR

IP NO	AGE	EDUCATION	OCCUPATION	SOCIOECONOMICS STATUS	ANC VISIT	DURATION OF STAY	REASON FOR SEEKING CARE	MARRIED LIFE	CONSANGUINITY	RISK FACTOR	OBSTETRICS SCORE	PREVIOUS BABY WEIGTH	POG	ELE V/S EMER	STAGE OF LABOR	INDICATION	INTRA OPERATIVE COMPLICATION	BLOOD LOSS	CONCURRENT TUBECTOMECY	BLOOD TRANSFUSION	POST OPERATIVE COMPLICATION	CONDITION OF BABY	BIRTH WEIGTH	BABY GENDER	ANY ANOMALY	ANY BIRTH INJURY	NICU ADMISSON	CONDITION OF BABY AT DISCHARGE	REASON FOR BABY DEATH
1033402	24	5	6	2	REG	5	1	2	2	ANEMIA	G2P1L1	3.5	38.6	PT EMER	FIRST STAGE	PATHOLOGICAL TRACE	-	600	NO	2 PINT PCV	POST SPINAL HEADACHE	1	3.2	1	0	0	0	1	-
1033408	24	5	6	1	REG	4	1	3	2	ANEMIA	G2P1L1	3	40	FT EMER	FIRST STAGE	PATHOLOGICAL TRACE	2 TIGTH LOOP OF CORD	410	NO	-	-	1	2.7	1	0	0	0	1	-
1033719	24	7	6	2	REG	3	7	3	2	MCDA,FGR WITH NORMAL DOPPLER	G4P3L3	2,2.5,2.5	36.5	PT ELEC	PRE LABOR	MCDA WITH TWIN A BREECH	-	330	YES	-	-	1	2.1 2.1	1 1	0	0	0	1	-
1033705	30	5	6	1	UNREG	6	5	4	2	GDM,MACROSOMIA	G3P2L2	3,3	36.1	PT ELEC	PRE LABOR	NPL WITH SUSPICOUS TRACE	-	310	NO	-	-	1	3	1	0	0	1(RESPIRATORY DISTRSS)	1	-
1034106	32	4	6	1	UNREG	4	7	3	2	SEVERE PE,HYPOTHYROIDISM	G2P1L1	3	40	FT EMER	FIRST STAGE	MSL	MSL	250	NO	-	-	1	3.1	2	0	0	0	1	-
1034557	25	4	6	1	REG	1	1	2	2	-	G2P1L1	2.5	39.1	FT EMER	FIRST STAGE	MSL	MSL	360	NO	-	-	1	2.3	2	0	0	1(RESPIRATORY DISTRSS)	1	-
1034259	30	5	6	3	REG	3	5	4	2	GDM,MACROSOMIA,POLYHYDRAMINOS	G2P1L1	2.7	36.2	PT ELEC	PRE LABOR	GDM	UTERINE ATONY	700	NO	-		1	3.8	2	0	0	0	1	-
1036070	25	2	6	1	REG	2	1	6	2	-	G4P2L1A1	2.5,2.5	39.2	FT EMER	FIRST STAGE	SECONDARY ARREST OF CERVICAL DILATATION	-	440	NO	-	-	1	2.8	2	0	0	0	1	-
1036068	37	7	5	3	UNREG	6	7	14	2	HYPOTHYROIDISM	G4P2L1A1	2.7,UNKNOWN	35.1	PT ELEC	PRE LABOR	MACROSOMIA	-	490	YES	-	-	1	3.1	2	0	0	0	1	-
1036220	25	5	6	1	UNREG	4	1	2	2	-	G3P2L1	2.5.2	39.6	FT EMER	FIRST STAGE	IUGR WITH SUSPICOUS TRACE	2 TIGTH LOOP OF CORD	300	NO	-	-	1	2.5	1	0	0	0	1	-
1037017	25	5	6	1	REG	2	1	3	2	DCDA	G2P1L1	2.2	36.6	PT EMER	FIRST STAGE	DCDA WITH TWIN A BREECH	PPH,Hayman suturing	1100	NO	-	-	1	2 1.8	2	0	0	1(LBW)	1	-
1037057	29	5	6	2	REG	2	7	2	2	POST DATISM,POLYHYDRAMINOS,HYPOTHYROIDISM	G2P1L1	3	40.1	FT EMER	FIRST STAGE	FETAL DISTRESS	EXTENSION,U/L UTERINE ARTERY LIGATION	440	NO	-	-	1	3.2	1	0	0	0	1	-
1037366	36	3	6	1	REG	6	7	16	2	GDM	G4P2L2A1	2.5	37.6	FT EMER	FIRST STAGE	FETAL DISTRESS	1 TIGTH LOOP OF CORD	390	NO	-	-	1	3	1	0	0	0	1	-
1037637	32	7	3	3	REG	2	7	3	2	HYPOTHYROIDISM	G3P1L1A1	3.7	39	FT ELEC	PRE LABOR	CDMR	-	400	YES	-	-	1	3.1	1	0	0	0	1	-
1038329	22	5	6	1	UNREG	2	3	2	2	-	G2P1L1	3	37.2	FT EMER	FIRST STAGE	MSL	-	380	NO	-	-	1	2.3	1	0	0	0	1	-
1038085	24	7	6	1	REG	6	7	2	2	OLIGO	G2P1L1	3	36.2	PT EMER	PRE LABOR	FETAL DISTRES	EXTENSION,U/L UTERINE ARTERY LIGATION ,ATONY	550	NO	-	-	1	2.5	1	0	0	0	1	-
1039082	32	8	5	3	REG	1	3	3	2	-	G2P1L1	3	37.5	FT EMER	PRE LABOR	OLIGO	-	300	NO	-	-	1	3.5	2	0	0	0	1	-
1039188	24	5	6	2	REG	1	1	2	2	-	G2P1L1	3.4	40.4	FT EMER	FIRST STAGE	NON REACTIVE NST	MSL,EXTENSION,U/L UTER LIGATION	370	NO	-	-	1	3.3	1	0	0	0	1	-
1039450	25	5	6	2	REG	3	2	2	2	-	G2P1L1	2.6	38.4	FT EMER	FIRST STAGE	MSL	U/L UTERINE LIGATION	560	NO	-	-	1	2.8	1	0	0	0	1	-
1039518	26	5	6	2	UNREG	3	2	2	2	-	G3PL1A1	2.3	39	FT EMER	FIRST STAGE	MSL	-	330	NO	-	-	1	2.6	2	0	0	0	1	-
1039476	25	5	6	2	REG	2	7	1	2	PRECIOUS PREGNANCY	G3P1L1A1	3.3	40	FT EMER	PRE LABOR	PERSISTERNT FETAL TACYCARDIA	-	330	NO	-	-	1	3.3	1	0	0	0	1	-
1039742	30	5	6	1	REG	1	1	4	2	GDM,MACROSOMIA	G4P1L1A2	3	35.3	PT EMER	FIRST STAGE	CORD PRESENTATION	UTERINE ATONY	490	NO	-	-	1	2.8	2	0	0	0	1	-
1039567	29	8	5	1	REG	1	7	4	2	-	G2P1L1	2.5,2.6	40.1	FT EMER	FIRST STAGE	FAILED INDUCTION	2 TIGTH LOOP OF CORD,EXTENSION,UTERINE ATONY	390	NO	-	-	1	3.25	1	0	0	0	1	-
1039713	27	5	6	1	REG	1	3	3	2	-	G3P2L2	2.5,2.3	39.1	FT EMER	FIRST STAGE	MSL	2 TIGTH LOOP OF CORD,EXTENSION,UTERINE ATONY	390	N0	-	-	1	2.8	2	0	0	0	1	-
1039772	28	7	3	3	UNREG	1	7	3	2	-	G2P1L1A1	2.4	38.2	FT ELEC	PRE LABOR	CDMR	-	220	NO	-	-	1	3.08	2	0	0	0	1	-
1040167	32	5	6	1	REG	2	1	2	2	-	G2P1L1	2.9	38.2	FT EMER	FIRST STAGE	CPD	EXTENSION,ATONY	660	NO	-	-	1	3.3	1	0	0	0	1	-
1040293	34	5	6	1	REG	2	1	2	2	OLIGO	G2P1L1	2.7	38.5	FT EMER	FIRST STAGE	FETAL DISTRESS	EXTENSION,U/L UTERINE LIGATION	460	NO	-	-	1	3.5	2	0	0	0	1	-
1040454	31	8	4	3	REG	2	7	2	2		G4P1L1A2	2.2	39.2	FT ELEC	PRE LABOR	OLIGO	-	390	NO	-	-	1	2.9	2	0	0	0	1	-
1040667	31	7	6	3	UNREG	1	4.1	1	2	GEST HTN,PRECIOUS PREGNANGY	G3P1L0A1	2.5	36.6	PT ELEC	PRE LABOR	PRECIOUS PREGNANCY	-	440	NO	-	-	1	2.9	1	0	0	0	1	-
1042078	28	5	6	3	REG	5	1	3	2	-	G4P2L2A1	3,3.5	39.1	FT EMER	FIRST STAGE	CPD	2 TIGTH LOOP OF CORD,EXTENSION,UTERINE ATONY,B/L UTERINE LIGATION	550	NO	-	-	1	3.5	1	0	0	1(RDS)	1	-
1042074	26	7	6	3	REG	3	1	1	2	APH	G2P1L1	3	36.6	PT EMER	FIRST STAGE	PLACENTA PREVIA	B LYNCH, UTERINE ATONY	440	NO	4 RDP	-	1	3.2	1	0	0	0	1	-
1041684	26	6	6	3	UNREG	6	1	2	2	FGR,OLIGO	G3P2L2	3.1,2.5	35.1	PT EMER	PRE LABOR	FETAL DISTRESS	-	300	NO	-	-	1	2.2	2	0	0	1(RDS)	1	-
1041787	30	7	3	2	REG	2	2	3	2	GDM	G4P2L2A1	2.5	37.4	FT EMER	FIRST STAGE	MSL	MSL	250	NO	-	-	1	3.1	2	0	0	0	1	-
1042838	33	7	5	3	REG	4	3	2	2	-	G3P1L1A1	3.25	40	FT EMER	FIRST STAGE	FETAL DISTRESS	-	340	NO	-	-	1	3.5	1	0	0	0	1	-
1042929	23	4	3	2	REG	3	4	1	2	IGT,HYPOTHYROIDISM	G2P1L1	2.5	38.4	FT EMER	FIRST STAGE	MSL	MSL	400	NO	-	-	1	3.2	2	0	0	0	1	-
1043615	22	6	5	2	REG	1	9	6	2	PRECIOUS PREGNANCY,HYPOTHYROIDISM	G3P1L0	3.3	38.1	FT EMER	FIRST STAGE	PRECIOUS PREGNANCY	-	250	NO	-	-	1	2.8	2	0	0	0	1	-
1043884	30	5	4	1	REG	3	5	3	2	IGT	G3P2L2	3,3.5	40	FT EMER	FIRST STAGE	BROW	-	390	NO	-	-	1	3.9	2	0	0	0	1	-
1043947	35	7	2	1	UNREG	5	4	12	2	CHR HTN WITH SUPERIMPOSED PE,FGR,AEDF	G4P2L2A1	2.6	30.1	PT EMER	PRE LABOR	REVERSAL OF END DIASTOLIC FLOW	-	390	NO	-	-	1	917 G	1	0	0	1	EXPIRED AT D 24	SEPTICEMIA
1046380	35	5	2	1	REG	7	4	17	2	-	G5P2L1A2	3.4,3.9	36.1	PT EMER	FIRST STAGE	BREECH	-	300	NO	-	-	1	3.9	1	0	0	0	1	-
1046841	35	5	6	2	UNREG	5	4	6	2	SEVERE PE,FGR	G2P1L1	2.8	30.4	PT EMER	PRE LABOR	SEV PE WITH AEDF	-	400	NO	-	-	1	1.02	2	0	0	1(LBW)	EXPIRED AT D 15	PNEUMOTHORAX
1047312	32	5	6	1	REG	2	1	5	2	HYPOTHYROIDISM,ANAMINOS	G5P2L2A2	2.5,3.5	40	FT EMER	PRE LABOR	ANAMINOS	-	400	NO	-	-	1	3.1	2	0	0	0	1	-
1047604	29	5	6	1	UNREG	3	4	4	2	MILD PE	G3P2L1	unknown	35.6	PT EMER	FIRST STAGE	IUGR WITH PATHOLOGICAL TRACE	-	400	NO	-	WOUND GAPE	1	1.4	1	0	0	1(LBW,RDS)	1	-
1048360	21	5	6	1	REG	2	1	2	2	-	G3P2L2	3.5,2.5	36.4	PT EMER	FIRST STAGE	NON REASSURING NST	-	430	NO	-	-	1	2.6	2	0	0	0	1	-
1048537	32	5	6	1	REG	2	3	4	2	-	G2P1L1	1.5	37.4	FT EMER	FIRST STAGE	BREECH	-	310	NO	-	-	1	2.5	1	0	0	0	1	-
1049040	30	7	6	3	REG	4	1	4	2	SEVERE PE,TORCH +	G2P1L1	3.2	39.3	FT EMER	FIRST STAGE	SEVERE PE	-	300	NO	-	-	1	2.5	2	0	0	0	1	-
1049188	28	8	6	3	REG	1	1	3	2	COVID POSITIVE	G2P1L1	3	38.3	FT EMER	FIRST STAGE	NPL	-	440	NO	-	-	1	2.9	2	0	0	0	1	-
1049593	36	7	6	3	REG	5	4.5	4	2	PARTIAL HELLP,PE,HYPOTHYROIDISM	G3P1L1A1	2.4	34.1	PT EMER	PRE LABOR	PARTIAL HELLP	MSL	470	NO	-	-	1	1.3	1	0	0	1(LBW,RDS)	1	-
1049770	26	5	6	1	REG	2	1	1	2	-	G2P1L0	2.1	39.1	FT EMER	FIRST STAGE	DTA	UTERINE ATONY,HAYMANS SUTURE	500	NO	-	-	1	3.4	2	0	0	1	1	-
1050027	24	5	6	1	REG	3	7	3	2	HYPOTHYROIDISM,MACROSOMIOA,INCRESED RESISTANCE ON DOPPLER	G4P2L2A1	2.5,3	38	FT EMER	FIRST STAGE	BREECH	-	360	YES	-	-	1	2.6	2	0	0	0	1	-
1050304	25	7	6	3	UNREG	1	7	2	2	-	G2P1L1	2.7	37.3	FT ELEC	PRE LABOR	BREECH	-	200	N0	-	-	1	3.17	1	0	0	0	1	-
1050544	40	5	6	1	UNREG	4	7	18	2	HYPOTHYROIDISM,SCHIZOPHRENIA	G2P1L1	3	40.1	FT EMER	PRE LABOR	BREECH	-	350	NO	-	-	1	3.4	2	0	0	0	1	-
1050602	26	5	6	2	UNREG	4	7	3	2	HYPOTHYROIDISM	G2P1L0		35.6	PT ELEC	PRE LABOR	GDM WITH UNCONTROLLED SUGAR	-	410	NO	-	-	1	2.6	1	0	0	1	1	-
1051071	30	5	6	1	UNREG	5	4	8	2	GEST HTN	G2P1L1	2.5	38.5	FT EMER	FIRST STAGE	THICK MSL	-	200	NO	-	-	1	3.4	1	0	0	0	1	-
1051194	30	7	4	2	UNREG	2	2	2	2	TYPE 4 PLACENTA PREVIA	G2P1L1	2.5	33.2	PT EMER	PRE LABOR	PLACENTA PREVIA	B/L uterine artery ligation	560	NO	-	-	1	1.44	2	0	0	1	0	-
1051364	36	7	5	2	REG	3	2	1	2	CHR HTN WITH SUPERIMPOSED PE	G2P1L1	2.6	36.5	PT EMER	PRE LABOR	CHRONIC HTN WITH SUPERIMPOSED PE	-	410	NO	-	-	1	2.5	2	0	0	0	1	-
1051411	22	5	6	2	UNREG	3	3	3	2	CLINICAL FGR,OLIGOHYDRAMNIOS,PPROM	G2P1L1		37.6	FT EMER	PRE LABOR	OLIGOHYDROMINOS	-	350	NO	-	-	1	2.4	2	0	0	0	1	-
1052148	24	5	6	3	UNREG	3	1	1	2	HBSAG+	G3P2L1	1.5,2.5	39.2	FT EMER	FIRST STAGE	PATHOLOGICAL TRACE	-	700	NO	-	-	1	0.8	1	0	0	0	1	-
1052318	30	4	6	2	UNREG	2	1	1	2	THREATENED PRETERM LABOR,ANEMIA	G4P3L3	3,2.7,2	34.6	PT EMER	FIRST STAGE	MCDA	-	900	NO	1 SDP,1PCV	-	1	1.9 2	2 2	0	0	0	1	-
1052434	30	5	6	2	REG	7	1	6	2	-	G3P2L1	NOT KNOWN	37.1	FT EMER	FIRST STAGE	ABRUPTIO PLACENTA	Couvalaries uterus					1	1.8	1	0	0	1	1	-
1053461	30	8	6	2	UNREG	2	1	1	2	POST DATISM,OLIGOHYDRAMNIOS	G4P2L1D1A1	3.5,3	40.2	FT EMER	PRE LABOR	OLIGO	-	380	NO	-	-	1	3.5	2	0	0	0	1	-
1053584	40	5	5	2	UNREG	7	1	16	2	RH NEGATIVE,TORCH+,FETAL LEFT RENAL PELVIECTASIS,HYPOTHYROIDISM,MOD	G3P2L1	NOT KNOWN	40.2	FT EMER	PRE LABOR	THICK MSL	-	350	NO	-	-	1	3.2	1	0	0	0	1	-
1053703	20	5	5	2	UNREG	3	1	3	2	PROM	G3P1L1A1	3	39.5	FT EMER	FIRST STAGE	FETAL DISTRESS	-	700	NO	-		1	2.5	1	0	0	0	1	-
1054401	34	5	6	2	UNREG	3	1	16	2	-	G5P3L3A1	3,2.5	40.5	FT EMER	FIRST STAGE	FETAL DISTRES	RIGHT UTERINE ARTERY LIGATION	400	NO	-	-	1	3.4	2	0	0	0	1	-
1054260	32	5	6	2	REG	4	1	14	2	-	G3P2L2	2.3,2.5	40.6	FT EMER	FIRST STAGE	MSL	-	310	NO	-	-	1	3	2	0	0	0	1	-
1053677	20	5	6	2	UNREG	7	7	15	2	RH NEGATIVE	G3P2L2	-,3.5	39.2	FT EMER	PRE LABOR	FAILED PROGRESS	-	460	YES	-	-	2	3.7	2	0	0	0	1	-
1054267	27	5	6	2	UNREG	3	7	5	2	-	G3P1L1A1		37.1	FT EMER	PRE LABOR	AEDF	-	300				1	1.46	2	0	0	0	1	-
1054063	29	6	5	2	UNREG	4	1	8	2	-	G5P2L2A2	2.5,3	40.3	FT EMER	FIRST STAGE	MSL	-	360	NO	-	-	1	3.2	1	0	0	1	1	-
1054575	32	5	6	2	REG	5	7	10	2	LOW LYING PLACENTA	G2P1L1	3.5	37.1	FT ELEC	PRE LABOR	PLACENTA PREVIA	B/L uterine ligation	700	NO	-	-	1	3.3	1	0	0	0	1	-
1055052	30	5	6	2	UNREG	4	4	12	2	MILD PE,MSL	G5P3L3A1	2.5,2,2.2	39.3	FT EMER	FIRST STAGE	MSL	-	500	NO	-	-	1	3.1	1	0	0	0	1	-
1054789	23	5	6	2	UNREG	6	7	6	2	OVERT DM	G3P1L1A1	3.5	36.5	PT EMER	PRE LABOR	MCMA	-	200	NO	-	-	1	2.7/2.6	1,1	0	0	0	1	-
1055505	33	5	6	2	REG	8	4	5	2	HYPOTHYROIDISM,CHRONIC HTN,GDM	G4P2L1A1	0.5,1.2,	36.4	PT ELEC	PRE LABOR	TRANSVERSE LIE	-	350	NO	-	-	1	2.6	2	0	0	0	1	-
1056144	28	5	6	2	REG	8	3	5	2	BREECH,PROM	G2P1L1	2.5	38.1	FT EMER	PRE LABOR	BREECH	-	350	NO	-	-	1	2.5	1	0	0	0	1	-
1055647	30	8	6	2	UNREG	7	3	14	2	SECOND STAGE ARREST,SEVERE	G4P3L3	2.5,3,3.5	40.1	FT EMER	FIRST STAGE	DTA	-	500	NO	1 PCV	-	1	3.1	1	0	0	0	1	-
1056449	29	5	6	2	UNREG	4	1	11	2	EARLY PRETERM LABOUR	G3P2L1A1	2.5	34.1	PT EMER	PRE LABOR	MCMA	-	360	NO	-	-	1,1	1.8,1.96	1,1	0	0	1,1	1,1	-
1056554	24	5	6	2	REG	3	1	7	2	-	G3P2L2	3.2,2.5	39.3	FT EMER	FIRST STAGE	MSL	-	350	NO	-	-	1	3.2	1	0	0	0	1	-
1056805	25	5	6	2	UNREG	5	4	8	2	ANTEPARTUM ECLAMPSIA,CLINICAL FETAL GROWTH RETARDATION,SEVERE OLIGOHYDRAMNIOS	G3P2L2	2.5,2.2	35.5	PT EMER	PRE LABOR	ANTEPARTUM ECLAMPSIA	Hayman suturing	250	NO	-	-	1	2.2	2	0	0	1	1	-
1056702	25	5	6	2	UNREG	5	1	7	2	POST DATISM	G3P2L1	2.5	41	FT EMER	PRE LABOR	FETAL DISTRESS	-	410	NO	-	-	1	3	1	0	0	0	1	-
1056871	24	5	6	2	UNREG	1	1	5	2	FGR,SEVERE PE,THROMBOCYTOPENIA	G2P1L1	2.5	39.6	FT EMER	PRE LABOR	FETAL DISTRESS	-	360	NO	-	-	1	1.7	1	0	0	1	1	-
1056652	21	5	6	2	UNREG	7	1	4	2	THREATENED PRETERM,MILD ANEMIA	G2P1L1	1.5	34	PT EMER	FIRST STAGE	FETAL DISTRESS		350	NO	-	-	1	2	1	0	0	1	1	-
1057161	33	5	6	2	UNREG	4	7	10	1	GESTATIONAL HTN,INCREASED RESISTANCE ON DOPPLER	G4P2L1D1A1	2.5	36W3D	PT EMER	PRE LABOR	Breech in labour	-	390	YES	-	-	1	2.1	2	0	0	0	0	1
1057474	23	5	6	2	UNREG	3	7	1	2	BREECH	G2P1L0	2.5	37W5D	FT ELEC	PRE LABOR	BREECH	-	200	NO	-	-	1	2.4	1	0	0	0	0	1
1058990	31	7	5	2	UNREG	3	7	8	2	-	G2P1L1		30W4D	PT EMER	PRE LABOR	Oligohydramnios	-	3O00				1	2.4	1	0	0	0	0	1
1058011	24	5	6	2	UNREG	2	3	6	2	PROM,THICK MSL	G3P2L2	2.5,2.8	41W1D	FT EMER	FIRST STAGE	MSL	-	290	YES	-	-	1	2.6	1	0	0	0	0	1
1058236	32	5	6	2	UNREG	1	3	7	2	PROM	G3P1L1A1	2.5	38W2D	FT EMER	FIRST STAGE	Anamnios	-	450	NO	-	-	1	2.4kg	2	0	0	0	0	1
1583348	35	5	4	2	REG	4	7	1	2	-	G2P1LO	1.5	34W5D	PT EMER	PRE LABOR	Severe PE with HELLP	-	450	NO			1	1.5	2	0	0	0	1	1
1058429	25	5	6	2	REG	3	7	3	2	-	G4P1L1A2	2.4	40W	FT EMER	FIRST STAGE	Fetal distress	-		NO			1	3.1kg	1	0	0	0	0	1
1057890	27	5	6	2	REG	2	1	13	2	-	G2P1L1	2.2	39W2D	FT EMER	FIRST STAGE	Fetal distress	-		NO			1	2.6kg	1	0	0	0	0	1
1058345	22	6	5	2	REG	2	1	4	2	-	G3P1L1A1	2.5	38W2D	FT EMER	FIRST STAGE	Pathological trace	-		NO			1	1.7	1	0	0	0	1	1
1059062	24	6	5	2	UNREG	2	1	2	1	PROM,THICK MSL,MCDA	G2P1L1	2.5	39W5D	FT EMER	FIRST STAGE	MSL	-	240	NO	-	-	1	2.5,2.1	1,1	0	0	0	1	1
1059585	32	6	5	2	REG	3	1	4	2	GDM,THROMBOCYTOPENIA,FETAL MACROSMIA	G4P1L1A2	2.5	38W1D	FT EMER	PRE LABOR	MSL	-	410	YES	-	-	1	3.6	1	0	0	0	0	1
1059876	36	6	5	2	REG	2	1	11	1	-	G3P2L2A1	2.4	39W2D	FT EMER	PRE LABOR	BREECH	-		YES			1	2.8	2	0	0	0	0	1
1057899	26	6	5	2	REG	2	7	4	1	-	G2P1L1	3	38W4D	FT EMER	FIRST STAGE	Fetal distress	-		NO			1	2.6	2	0	0	0	0	1
1060125	24	6	5	2	UNREG	2	7	2	2	CHR HTN,POST DATISM	G2P1L0	3.2	40W3D	FT EMER	FIRST STAGE	MSL	-	350	NO	-	-	1	3.4	1	0	0	0	0	1
1060110	30	6	5	2	UNREG	2	7	10	2	PLACENTA PREVIA,PLACENTA ACCRETA	G2P1L1	2.9,3	36W1D	PT ELEC	PRE LABOR	Placenta increta-peripartum hysterectomy	B/L INTERNAL ARTERY LIGATION	310	NO	-	-	1	2.4	1	0	0	0	0	1
1060901	26	6	5	2	REG	2	7	5	2	GDM,SHORT STATURE,EARLY ONSET IUGR,INCREASED ESISTANCE ON	G2P1L1	1.5,	36W4D	PT EMER	FIRST STAGE	Fetal distress	-	320	NO	-	-	1	1.4	2	0	0	0	1	1
1060898	24	7	6	2	UNREG	2	7	7	2	LESS LIQUOR,MACROSMIA	G2P1L1	3.5	37W6D	FT EMER	PRE LABOR	NPL	-	450	NO	-	-	1	2.9	1	0	0	0	0	1
1061168	39	6	5	2	UNREG	2	1	17	2	BREECH	G3P2L2	2.7,3,2.8	39W	FT EMER	PRE LABOR	BREECH	RIGHT UTERINE ARTERY LIGATION	690	YES	-	-	1	3.6	1	0	0	0	0	1
1060895	24	6	5	2	REG	3	5	7	2	SEVERE PRE ECLAMPSIA,RH NEGATIVE PREGNANCY	G3P2L2	UNKNOWN WEIGHT	35W	PT EMER	PRE LABOR	Severe PE with uncontrolled hypertension	Hayman suturing	440	NO	-	-	1	1.4	1	0	0	0	1	1
1061332	24	6	5	2	UNREG	2	7	3	2		G2P1L0	3.5	37W6D	FT ELEC	PRE LABOR	CDMR	-	350	NO	-	-	1	2.9	1	0	0	0	0	1
1061306	29	6	5	2	REG	2	1	6	1	RH NEGATIVE WITH FGR	G3P1L1A1	2.5	37W6D	FT EMER	FIRST STAGE	Fetal distress	-	450	NO	-		1	1.8	2	0	0	0	0	1
1061326	26	5	8	2	UNREG	2	1	7	2	PROM	G3P1L1A1	3	37W1D	FT EMER	FIRST STAGE	Fetal distress	-	350	NO	-		1	2.7	2	0	0	0	0	1
1061426	27	6	5	2	UNREG	3	7	11	2	OLIGO WITH INCREASED REISITANCE	G4P1L1A2	1KG	33W1D	PT ELEC	PRE LABOR	Breech	-	350	NO	-		1	1.5	2	0	0	0	1	1
1061573	33	6	5	2	REG	2	7	15	2	BREECH	G3P2L2	3.5,2.5	38W4D	FT ELEC	PRE LABOR	Breech	-	390ML	YES			1	2.5	2	0	0	0	0	1
1062640	28	6	5	2	UNREG	2	7	3	2	CENTRAL PLACENTA PREVIA	G4P3L3	2KG,1.5,1.5	34W6D	PT EMER	PRE LABOR	CPD with APH-B/L Uterine artery ligation		590ML	NO	4 PINT PCV		1	1.9	1	0	0	0	0	3
1062626	38	6	5	2	REG	2	7	4	1	HYPOTHYROIDIM	G4P1L1A2	3.1	36W6D	PT ELEC	PRE LABOR	BOH	-	340	YES	-		1	3	2	0	0	0	0	1
1063282	37	7	5	2	UNREG	2	4	4	2	SEVERE PE	G5P2L1E2	UNKNOWN	36W2D	PT EMER	PRE LABOR	Severe PE with uncontrolled hypertension	-	480		-		1	2.8	2	0	0	0	0	1
1063523	23	6	5	2	REG	2	7	3	2	OLIGO WITH FGR WITH INCREASED RESISTANCE	G2P1L1	2.3	36W2D	PT EMER	PRE LABOR	Fetal distress	LEFT UTERINE ARTERY LIGATION	440ML	NO	-		1	2.1	2	0	0	0	1	1

1063703	30	6	5	2	REG	2	1	3	2	RH NEGATIVE WITH HBS AG POSITIVE STATUS	G2P1L1	3.1	40W	FT EMER	FIRST STAGE	Fetal distress	-	430	NO	-		1	3.1	1	0	0	0	0	1
1063255	27	6	5	2	REG	2	7	3	2	APH	G3P2L2	3,2.5	36W3D	PT EMER	PRE LABOR	Pathological trace	-	370	NO	-		1	2.8	1	0	0	0	0	1
1063962	27	6	5	2	REG	2	7	2	2	FETAL MACROSOMIA	G3P2L1D1	3.5,2.5,	36W6D	PT EMER	PRE LABOR	Fetal distress	-	350	NO	-		1	3.3	2	0	0	0	0	1
1064010	26	6	5	2	UNREG	1	1	2	1	LATE ONSET FGR	G2P1L1	2.5	38W4D	FT EMER	PRE LABOR	Oligohydramnios	-	350ML	NO	-		1	2.4	2	0	0	0	0	1
1064128	28	6	5	2	UNREG	1	1	2	1	NO	G2P1L1	2.7	36W3D	PT EMER	FIRST STAGE	Transverse lie	-	340	NO	-		1	2.4	1	0	0	0	0	1
1064123	23	6	5	2	UNREG	2	1	8	2		G3P2L2		41W2D	FT EMER	FIRST STAGE	Fetal distress	-			-		1	3.7	1	0	0	0	0	1
1064677	24	6	5	2	REG	2	7	4	2	FETAL MACROSOMIA	G3P1L1A1	2.9	38W4D	FT ELEC	PRE LABOR	Fetal Macrosomia	-	330ML	NO	-		1	2.4	1	0	0	0	0	1
1064680	28	6	5	2	REG	2	1	7	1	SHORT STATURE	G3P2L2	1	38W	FT EMER	FIRST STAGE	CPD	LEFT UTERINE ARTERY LIGATION	490	YES	-		1	3	1	0	0	0	0	1
1065090	30	6	5	2	REG	2	1	10	1	FETAL MACROSOMIA	G3P2L2	2.5,3	39W5D	FT EMER	FIRST STAGE	MSL	B/L UTERINE ARTERY LIGATION	540	YES	-		1	3.7	2	0	0	0	0	1
1065081	30	8	5	2	REG	2	7	4	2	POSTDATISM	G3P1L1A1	2.5,	40W1D	FT EMER	PRE LABOR	Fetal distress	-	400	YES	-		1	3	1	0	0	0	0	1
1064971	32	5	6	2	REG	2	7	16	2	HOGKIN LYHPHOMA	G3P2L1D1	3,UNKNOWN	39W4D	PT ELEC	PRE LABOR	Hodgkin Lymphoma	-	700	YES	-		1	3.6	1	0	0	0	0	1
1065365	29	5	6	2	UNREG	2	3	11	2	PROM WITH EPILEPSY	G2P1L1	2.5	38W1D	FT EMER	PRE LABOR	Failed Induction	-	780	NO	-		1	2.3	2	0	0	0	0	1
1065627	24	7	4	2	REG	3	7	5	1	BREECH	G2P1L1	3	30W3D	PT EMER	PRE LABOR	Breech with PPROM	-	450	NO	-		1	1.5	2	0	0	0	0	1
1066539	24	5	6	2	UNREG	1	1	7	2	NO	G2P1L1	2.3	37W6D	FT EMER	FIRST STAGE	Perineal fistula	-	550	NO	-		1	2.8	1	0	0	0	0	1
1066098	31	5	6	2	UNREG	2	1	7	2		G3P2L2		42W3d	PT ELEC	PRE LABIR	Oblique lie	-			-		1	3.8	2	0	0	0	0	1
1066558	31	5	7	2	UNREG	2	1	10	2	HYPOTHRYOIDISM	G3P1L1A1	2.1	40W1D	FTEMER	FIRST STAGE	CDMR	-	450	NO	-		1	3.3	1	0	0	0	0	1
1067238	28	5	6	2	UNREG	2	7	6	2	CENTERAL PLACENTA PREVIA	G3P1L1A1	2.5	35W4D	PT EMER	PRE LABOR	Central Placenta previa	B/l internal iliac artery ligation	650	NO	3 PINT		1	2.53	2	0	0	0	0	2
1067299	30	5	6	2	REG	4	7	5	2	FGR WITH AEDF	G2P1L1	2.5	38W	FT EMER	PRE LABOR	FGRwith absent end diastolic flow	-	450	NO	-		1	2	1	0	0	0	1	1
1067356	36	8	5	2	UNREG	2	3	10	2	LOW LYING PLACENTA	G3P1L1A1	2.7	28W	PT EMER	PRE LABOR	anamnios with PPROM	-	390ML	NO	-		1	1.3	1	0	0	0	1	1
1067806	25	5	6	2	UNREG	1	1	5	2	NO	G2P1L1	2.5	39W3D	FT EMER	FIRST STAGE	CPD	B/L uterine artery ligation	550	NO	-		1	3.6	1	0	0	0	0	1
1067888	26	5	6	2	UNREG	2	1	6	2	NO	G2P1L1	2.1	39W2D	FT EMER	FIRST STAGE	Brow presentatin	-	230	NO	-		1	3.2	2	0	0	0	0	1
1068021	29	5	6	2	REG	2	7	9	2	POSTDATISM	G2P1L1	2.5	40W2D	FT EMER	FIRST STAGE	CPD	-	280	YES	-		1	3.3	2	0	0	0	0	1
1068068	32	5	6	2	REG	2	1	6	2		G2P1L1		39W1D	FT EMER	FIRST STAGE	MSL	-			-		1	2.7	2	0	0	0	1	1
1068240	21	5	6	2	REG	2	1	16	2	GHT WITH DCDA TWIN	G5P4L4	UNKNIWN	37W3D	FT EMER	FIRST STAGE	DCDAwith twin A breech	-	540	YES			1	2.6,2.4	1,1	0	0	0	0	1
1068229	26	5	6	2	REG	2	1	8	2	HYPOTHRYOIDISM	G3P2L2	2.3,3	38W4D	FT EMER	PRE LABOR	MSL	-	300	NO			1	3.4	1	0	0	0	0	1
1068234	30	5	6	2	UNREG	2	7	7	2	GHTN	G3P2L2	2.5,2.7	40W	FT EMER	PRE LABOR	FETAL DISTRESS	-	440ML	YES			1	3.2	2	0	0	0	0	0
1068436	27	5	6	2	REG	1	7	5	2	CENTRAL PLACENTA PREVIA	G2P1L1	3	37w2d	FT EMER	PRE LABOR	entral placenta previa	LEFT UTERINE ARETRY LIGATION	870	NO			1	2.6	2	0	0	0	0	1
1068589	28	3	6	2	UNREG	2	1	6	2	GHTN	G2P1L1	3.1	39W	FT EMER	SECOND STAGE	CPD	-	480	NO			1	4.4	1	0	0	0	0	1
1068556	24	5	6	2	UNREG	2	7	5	1	BREECH	G3P1L1A1	3	37W5D	FT ELEC	PRE LABOR	Breech with left uterine artery ligation	LEFT UTERINE ARTERY LIGATION	450	NO			1	3.1	2	0	0	0	0	1
1065756	30	5	6	2	UNREG	4	7	10	2	CHRONIC HTN EITH GDM WITH TWIN	G3P2L2	2.6,3.5	37W2D	FT ELEC	PRE LABIR	DCDA Twin with FGRwith AEDF	-	550	NO			1	1.7,1.2	2,1	0	0	0	0	1
1069084	35	5	6	2	REG	2	7	17	2	SEVERE PE WITH TWIN	G4P3L2	UNKNOWN	38W6D	FT EMER	PRE LABOR	DCDA twins with severe PE	-	450	NO			1	2.6,2.8	1,2	0	0	0	0	1
1069125	25	5	6	2	UBREG	1	1	6	2	NO	G2P1L1	2.7	41W	FT EMER	FIRST STAGE	CDMR		430	NO			1	3	1	0	0	0	0	1
1069747	26	5	6	2	UNREG	4	7	6	2	CHRONIC HTN	G2P1L1	2	39W3D	FT EMER	PRE LABOR	ncontrolled HTN with FGR	-	330ML	NO			1	3.4	2	0	0	0	0	1
1069724	22	5	6	2	REG	1	1	4	2	NO	G2P1L1	3	38W3D	FT EMER	FIRST STAGE	Fetal distress	-	300ML	NO			1	2.8	1	0	0	0	0	1
1070228	28	5	6	2	REG	2	7	9	2	DCDA TWIN	G2P1L1	UNKNIWN	37W	FT ELECT	PRE LABOR	DCDA twins	-	600ML	NO			1	2.6,2.5	2,2	0	0	0	0	1
1070518	24	5	6	2	REG	2	1	3	2	BREECH	G2P1L1	2.5	36w	FT EMER	FIRST STAGE	Breech	-	450	NO			1	2.9	1	0	0	0	0	1
1071421	23	5	6	2	UNREG	1	1	5	2	PROM	G2P1L1	3	38W1D	FT EMER	FIRST STAGE	MSL	-	459	NO			1	2.7	1	0	0	0	0	1
1071651	33	5	6	2	UNREG	2	7	7	2	BREECH	G2P1L1	2.8	40W3D	FT ELEC	PRE LABOR	Breech	-	230	NO			1	3.4	1	0	0	0	0	1
1071844	23	5	6	2	UNREG	2	1	7	2	BOH WITH DCDA	G3P2L1D1	UNKNOWN,1.6	37W	FT EMER	FIRST STAGE	DCDtwins	-	480	NO			1	2.4,1.8	1,2	0	0	0	1	1
1071830	27	5	6	2	REG	2	1	9	2	NO	G4P23L3	8,2.6,2.8	39W 2D	FT EMER	FIRST STAGE	NPL	-	450	YES			1	4	1	0	0	0	0	1
1072062	34	8	5	2	UNREG	3	7	12	2	GHTN WITH INCREASED RESISTANCE	G2P1L1	2.7	38W	FT EMER	PRE LABOR	NPL	-	450	YES			1	2.6	1	0	0	0	0	1
1075585	26	5	6	2	REG	4	7	5	2	MCDA ,GEST HTN	G2P1L1	3.1	34W	PT ELEC	PRE LABOR	MCDA Twin with GHTN	U/L UTERINE LIGATION		NO			1	2,1.7	1,2	0	0	0	0	1
1075902	29	8	5	2	REG	4	3	5	1	PPROM,HYPOTHYROIDISM	G2P1L1		33W4D	PT EMER	FIRST STAGE	Anamnios	-	350	NO	-	-	1	2.1	1	0	0	0	0	1
1072519	22	8	5	2	REG	2	1	5	1	GEST HTN,RH NEGATIVE PREGNANCY,CERVICAL STITCH IN SITU	G3P1L0A1	UNKNOWN WEIGHT	39W4D	FT EMER	FIRST STAGE	Fetal Macrosomia	-	440	NO	-	-	1	3.75	1	0	0	0	0	1
1073992	26	5	6	2	REG	2	7	4	2	IGT,HYPOTHYROIDISM	G2P1L1	2.4	37W5D	FT EMER	FIRST STAGE	MSL	UTERINE ATONY	440	NO	-	-	1	2.6	1	0	0	0	0	1
1073944	22	5	6	2	REG	2	7	3	2	OLIGO,IUGR WITH INCREASED RESISTANCE ,RH NEGATIVE PREGNANCY	G2P1L1	2.3	39W4D	FT EMER	FIRST STAGE	Fetal distress	-	420	NO	-	-	1	2	1	0	0	0	1	1
1074002	25	5	6	2	UNREG	2	7	5	2	ANAMINOS,ANEMIA	G2P1L1	3	35W	PT EMER	PRE LABOR	Breech with anamnios	-	380	NO	-	-	1	2.2	2	0	0	1(LBW)	1	1
1073025	25	5	6	2	REG	2	7	7	2	DCDA,EARLY ONSET FGR WITH NORMAL DELIVERY	G3P2L2	2.5,1.6	36W3D	PT ELEC	PRE LABOR	DCDA WITH TWIN B- TRANSVERSE	-	400	YES	1 PINT PCV	-	1	2.2,1.7	1,1	0	0	1(LBW)	1	1
1074525	22	5	6	2	UNREG	2	1	4	1	DCDA ,IUD	G2P1L1	3	39W6D	FT EMER	FIRST STAGE	DCDA Twins twin a in breech	-	380	NO	-	-	1	2,1.7	2,1	0	0	1(LBW)	0	1,3
1075706	25	5	6	2	REG	4	1	4	1	-	G2P1L1	3	40W1D	FT EMER	FIRST STAGE	Fetal Distress	Bladder serosa sutured	490	NO	-	-	1	3.5	2	0	0	0	0	1
1071851	25	5	6	2	REG	4	7	5	2	ANEMIA ,PLACENTA PREVIA	G2P1L1	3	34W5D	PT EMER	FIRST STAGE	PLACENTA PREVIA	B/L UTERINE ARTERY LIGATION	770	NO	2 PINT PCV,1 FFP	WOUND GAPE	1	2.5	2	0	0	1(LBW)	0	1
1073089	26	5	6	2	UNREG	3	7	6	2	CENTRAL PLACENTA PREVIA,GESTATINAL HYPERTENSIN,	G2P1L1	2.5	30W2D	PT EMER	FIRST STAGE	Placenta previa	B/L uterine artery ligation ,UTERINE ATONY	600	NO	1 PINT PCV	-	1	1.3	2	0	0	0	1	1
1072773	26	5	6	2	REG	2	1	7	2	-	G2P1L1	2.75	39W6D	FT EMER	FIRST STAGE	MSL	-	300	NO	-	-	1	3	2	0	0	1(RDS)	0	1
1072521	29	5	6	2	UNREG	2	1	9	1	ANEMIA	G4P3L2D1	2.5,2.8,4.1	39W	FT EMER	FIRST STAGE	MSL	MSL	490	NO	-	-	1	3.7	2	0	0	0	0	1
1070664	25	5	6	2	REG	4	7	9	1	IUGR WITH INCREASED RESISTANCE ON DOPPLER	G5P2L1A2	UK,2.4,2.4	38W4D	FT EMER	PRE LABOR	IUGR WITH AEDF	-	380	NO	-	-	1	1.8	2	0	0	0	0	1
1075375	32	8	5	2	UNREG	2	7	11	2	POST DATISM	G5P3L3A1	3	40W	FT EMER	PRE LABOR	CDMR	-	240	NO	-	-	1	3.7	1	0	0	1(LBW)	0	1
1077690	25	8	5	2	REG	2	7	2.5	2	PLACENTA PREVIA	G2P1L0	900	34W2D	PT EMER	PRE LABOR	Placenta previa	B/L uterine ligation	670	NO	1 PINT PCV	-	1	1.6	2	0	0	0	0	1
1078847	32	7	6	2	REG	4	1	12	2	IGT	G2P1L1	2	39	FT EMER	FIRST STAGE	THICK MSL	ONE LOOP OF CORD AROUND NECK	400	NO	-	-	1	2.8	2	0	0	0	1	-
1082165	32	7	6	2	UNREG	6	4	12	2	TRANSVERSE LIE,POLYHYRAMINOS,SEVERE PE	G3P2L2	3.5,3	38.6	FT EMER	PRE LABOR	SEVERE PE	-	450	YES	-	SPINAL HEADACHE	1	3.5	2	0	0	0	1	-
1081975	25	7	6	1	UNREG	4	1	5	2	TRANSVERSE LIE	G2P2L1	2	38.6	FT EMER	FIRST STAGE	TRANSVERSE LIE	-	420	YES	-	-	1	2.7	1	0	0	0	1	-
1079960	37	5	6	1	REG	8	7	10	2	DCDA,SHORT CERVIX	G3P1L1A1	2.5	37.6	FT EMER	PRE LABOR	CDMR	-	320	YES	-	-	1,1	2.1,2	1,2	0	0	0	1,1	-
1082036	26	4	6	1	UNREG	4	1	4	2	-	G2P1L1	3	40.4	FT EMER	FIRST STAGE	FETAL DISTRESS	-	400	NO	-	-	1	2.8	1	0	0	0	1	
1082391	27	7	5	2	REG	5	7	2.5	2	POST DATISM	G2P1L1	2	41.4	FT EMER	FIRST STAGE	THICK MSL	-	370	NO	-	-	1	3.8	1	0	0	0	1	-
1080006	34	5	6	2	UNREG	16	4	6	2	SEVERE PE,FGR	G2P1L1	2	33.4	PT EMER	PRE LABOR	SEVERE PE	-	410	NO	-	-	1	1.1	2	0	0	1(LBW,RDS)	1	-
1078812	25	7	5	2	REG	3	3	5	2	GDM	G2P1L1	2.5	40.4	FT EMER	FIRST STAGE	THICK MSL	-	450	NO	-	-	1	2.8	2	0	0	1	1	-
1078133	25	5	6	2	REG	6	7	6	2	-	G2P1L1	2	39.5	FT EMER	FIRST STAGE	FETAL DISTRESS	2 TIGTH LOOP OF CORD	240	NO	-	-	1	2.96	1	0	0	1(RDS)	1	-
1079624	23	5	6	2	UNREG	6	4	6	2	BOH ,GEST HTN	G5P2L0A2	Unknown	37.1	FT EMER	PRE LABOR	SEVERE PE	-	300	NO	-	-	1	2.7	1	0	0	0	1	-
1078756	28	7	6	2	UNREG	5	7	5	2	THROMBOCYTOPENIA	G3P2L1	unknown	36.4	PT EMER	PRE LABOR	BREECH	-	450	NO	6 RDP	-	1	1.8	1	0	0	1(LBW)	1	-
1081068	27	5	6	2	REG	4	3	6	2	-	G3P1L1A1	3.2	39.6	FT EMER	FIRST STAGE	THICK MSL	-	510	NO	-	-	1	3	1	0	0	1(RDS)	1	-
1083505	28	6	6	2	UNREG	5	1	10	2	RH NEGATIVE,GDM, POST	G3P2L2	2.7,2.7	40.6	FT EMER	FIRST STAGE	CORD PRESENTATION	-	540	NO	-	-	1	4	1	0	0	0	1	
1083095	21	5	6	2	UNREG	7	3	3	2	MCDA	G2P1L1	2.6	34.3	FT EMER	PRE LABOR	TWIN B WITH FGR WITH AEDF	-	560	NO	-	-	1,1	1.8,1.3	1,1	0	0	1,1(LBW,RDS)	1,1	-
1033330	34	5	6	2	REG	6	7	8	2	-	G3P1L1A1	2.7	38	FT ELEC	PRE LABOR	BREECH	-	400	NO	-	-	1	3	1	0	0	0	1	-
1083480	23	5	6	2	UNREG	7	1	6	2	MCDA,THRETENED PRETERM LABOR	G2P1L1	2.5	33.4	PT EMER	FIRST STAGE	MCMA	Hayman suturing	300	NO	2 PINT PCV	-	1,1	1.8,1.4	1,1	0	0	1,1(LBW,RDS)	1,1	-
1084432	30	6	6	2	REG	4	7	10	2	BOH,PRECIOUS PREGNANCY	G3P2L0	1.7,3.2	37.4	FT ELEC	PRE LABOR	PRECIOUS PREGNANCY	EXTENSION,U/L UTERINE ARTERY LIGATION	440	NO	-	-	1	2.96	1	0	0	0	1	-
1084358	27	8	5	2	REG	5	2	5	2	HYPOTHYROIDISM, FETAL ANOMALY	G4P1L1A2	2.75	38	FT EMER	FIRST STAGE	FETUS HAVING CYSTIC HYGROMA	-	300	NO	-	-	1	2.6	1	1	0	1(OBSERVATION)	1	-
1084746	23	5	6	1	REG	4	1	4	2	POST DATISM	G2P1L1		40.6	FT EMER	PRE LABOR	ANAMNIOS	-	520	NO	-	-	1	2.3	1	0	0	0	1	
1084963	20	8	5	2	UNREG	5	7	5	2	EPILEPSY,HYPOTHYROIODISM,THROMBOCYTOPENIA	G2P1L1	3	41	FT EMER	PRE LABOR	THICK MSL	MSL,EXTENSION,U/L UTER LIGATION	450	NO	SDP	-	1	2.6	1	0	0	0	1	-
1084984	29	5	6	2	UNREG	5	7	7	2	GEST HTN	G3P2L2	2.1,3.2	37.5	FT EMER	PRE LABOR	PATHOLOGICAL TRACE	-	400	YES	-	-	1	2.3	1	0	0	0	1	-
1085222	28	5	6	2	UNREG	7	1	9	2	-	G5P2L2A2	2.1,3.2,	39.3	FT EMER	FIRST STAGE	THICK MSL	-	380	YES	-	-	1	3.2	2	0	0	0	1	-
1085443	24	5	6	1	UNREG	5	1	4	1	-	G2P1L1	3	37.1	FT EMER	FIRST STAGE	BREECH	-	450	NO	-	-	1	3.8	2	0	0	0	1	-
1083708	34	8	5	2	REG	6	1	13	2	CARDIAC DISEASE	G3P1L1A1	3	35.3	PT ELEC	PRE LABOR	RHD WITH POST MVR	-	320	NO	-	-	1	3.2	1	0	0	1(LBW,RDS)	1	-
1085635	23	5	6	1	REG	4	1	3	2	-	G2P1L1	2.4	40.6	FT EMER	FIRST STAGE	FETAL DISTRESS	-	550	NO	-	-	1	3.4	1	0	0	0	1	-
1085809	25	5	6	2	UNREG	4	1	7	2	-	G2P1L1	3	40	FT EMER	FIRST STAGE	THICK MSL	-	450	N0	-	-	1	2.7	1	0	0	0	1	-
1086077	30	5	6	2	REG	5	7	2	2	-	G2P1L1	2.4	34.1	PT EMER	FIRST STAGE	ANAMNIOS	-	350	NO	-		1	1.1	1	0	0	1(RDS)	1	-
1086079	31	6	6	2	REG	5	1	5	2	SEVERE PE,BOH,PRECIOUS PREGNANCY	G4P3L0	Unknown	37	FT EMER	FIRST STAGE	BOH	-	300	NO	-	-	1	2.5	2	0	0	0	1	-
1086062	29	8	5	2	REG	6	7	3	2	FGR,IGT,HYPOTHYROIDISM,	G3P1L0A1	1.1	36.4	PT ELEC	PRE LABOR	PRECIOUS PREGNANCY	-	380	NO	-	-	1	2.05	1	0	0	1(RDS)	1	-
1087661	32	5	6	2	REG	8	5	10	2	-	G3P1L1A1	3.5	38.2	FT EMER	FIRST STAGE	FETAL DISTRESS	-	390	NO	-	-	1	1.8	1	0	0	1(LBW)	1	-
1087111	23	7	6	2	REG	7	5	5	2	-	G2P1L1	2.4	38.1	FT ELEC	PRE LABOR	BREECH	-	350	NO	-	-	1	3.1	1	0	0	0	1	-
1088176	28	5	6	2	REG	7	1	9	2		G3P2L2	3,3.2	41.1	FT EMER	FIRST STAGE	FETAL DISTRESS	-	300	YES	-	-	1	3.2	1	0	0	0	1	-
1088886	26	5	6	2	REG	1	3	1.5	2		G2P1L1	2.2	38	FT EMER	FIRST STAGE	FETAL DISTRESS	-	400	NO	-	-	1	2.5	2	0	0	0	1	-
1089744	24	5	6	2	UNREG	1	3	3	2	-	G2P1L1	3	40	FT EMER	FIRST STAGE	THICK MSL	EXTENSION,ATONY	600	NO	-	-	1	3	1	0	0	0	1	-
1088764	28	5	6	2	REG	1	3	3	2	-	G2P1L1	2.5	38.5	FT EMER	FIRST STAGE	FETAL DISTRES-		400	NO	-	-	1	3	1	0	0	0	1	-
1089792	27	5	6	2	REG	1	7	2	2	-	G3P2L2	3.1	38.2	FT EMER	SECOND STAGE	DTA	2 TIGTH LOOP OF CORD	500	NO	-	-	1	3.1	1	0	0	0	1	-
1089529	24	5	6	2	REG	1	7	2	2	HYPOTHRYOIDISM	G2P1L0	3.5	37W6D	PT EMER	FIRST STAGE	CORD PROLAPSE	-	500	NO	2 PINT PCV	POST SPINAL HEADACHE	1	3.2	1	0	0	0	1	-
1090011	23	5	6	2	REG	3	3	3	2	CENTERAL PLACENTA PREVIA	G3P1L1A1	2.5	37W6D	PT EMER	PRE LABOR	FETAL DISTRES-	-	200	NO	-	-	1	2.7	1	0	0	0	1	-
1099489	24	5	6	2	REG	2	1	2	2	FGR WITH AEDF	G3P1L1A1	3	37W1D	FT ELEC	PRE LABOR	FETAL DISTRES-	MSL	350	YES	-	-	1	2.1 2.1	1 1	0	0	0	1	-
1090204	23	5	6	2	REG	3	1	16	2	LOW LYING PLACENTA	G4P1L1A2	1KG	33W1D	PT EMER	PRE LABOR	ANAMINOS	MSL	350	NO	-	-	1	3	1	0	0	1(RESPIRATORY DISTRSS)	1	-
1089317	27	7	6	2	REG	2	1	3	2	NO	G3P2L2	3.5,2.5	38W4D	FT EMER	FIRST STAGE	PRECIOUS PREGNANCY	UTERINE ATONY	500	NO	-	-	1	3.1	2	0	0	0	1	-
1086579	23	6	6	2	REG	2	7	2	2	NO	G4P3L3	2KG,1.5,1.5	34W6D	FT EMER	FIRST STAGE	PRECIOUS PREGNANCY	-	360	NO	-	-	1	2.3	2	0	0	1(RESPIRATORY DISTRSS)	1	-
1090642	23	7	6	2	REG	4	7	2	2	POSTDATISM	G4P1L1A2	3.1	36W6D	PT EMER	PRE LABOR	PRECIOUS PREGNANCY	-	350	NO	-		1	3.8	2	0	0	0	1	-
1090596	34	7	6	2	REG	5	3	3	2		G5P2L1E2	UNKNOWN	36W2D	FT EMER	FIRST STAGE	Oblique lie	2 TIGTH LOOP OF CORD	250	NO	-	-	1	2.8	2	0	0	0	1	-
1091404	23	4	6	2	REG	3	7	2	2	GHT WITH DCDA TWIN	G2P1L1	2.3	36W2D	FT EMER	FIRST STAGE	PLACENTA PREVIA	PPH,Hayman suturing	410	YES	-	-	1	3.1	2	0	0	0	1	-
1093276	21	5	6	1	REG	3	1	2	2	HYPOTHRYOIDISM	G2P1L1	3.1	40W	FT EMER	FIRST STAGE	DCDA Twins twin a in breech	EXTENSION,U/L UTERINE ARTERY LIGATION	360	NO	-	-	1	2.5	1	0	0	0	1	-
1093789	23	6	6	1	REG	3	1	2	2	GHTN	G3P2L2	3,2.5	36W3D	FT EMER	FIRST STAGE	4 TH DEGREE PERINEAL TEAR	1 TIGTH LOOP OF CORD	350	NO	-	-	1	2 1.8	2	0	0	1(LBW)	1	-
1093881	34	7	6	2	REG	3	1	1	2	CENTRAL PLACENTA PREVIA	G3P2L1D1	3.5,2.5,	36W6D	FT EMER	PRE LABOR	ECLAMPSIA	-	390	NO	-	-	1	3.2	1	0	0	0	1	-
1094185	32	7	3	2	REG	3	7	4	2	GHTN	G2P1L1	2.5	38W4D	FT EMER	PRE LABOR	IMMENENT ECLAMPSIA	-	200	NO	-	-	1	3	1	0	0	0	EXPIRED AT D12	SEPTICEMI A
1094355	32	6	6	2	UNREG	3	7	4	2	BREECH	G2P1L1	2.7	36W3D	FT EMER	FIRST STAGE	ANAMINOS	EXTENSION,U/L UTERINE ARTERY LIGATION ,ATONY	3O00	YES	-	-	1	3.1	1	0	0	0	1	-
1094567	34	6	6	2	UNREG	3	3	3	2	CHRONIC HTN EITH GDM WITH TWIN	G3P2L2		41W2D	FT EMER	FIRST STAGE	ANAMINOS	-	290	NO	-	-	1	2.3	1	0	0	0	EXPIRED AT D 21	SEPTICEMI A
1123496	23	5	6	2	UNREG	3	1	3	2	SEVERE PE WITH TWIN	G3P1L1A1	2.9	38W4D	PT ELEC	PRE LABOR	THICK MSL	MSL,EXTENSION,U/L UTER LIGATION	450	NO	-	-	1	2.5	1	0	0	0	1	-
1116948	21	5	3	1	UNREG	3	1	2	2	NO	G3P2L2	1	38W	PT EMER	FIRST STAGE	CPD	U/L UTERINE LIGATION	450	NO	-	-	1	3.5	2	0	0	0	1	-
1117312	24	5	6	1	UNREG	3	7	2	2	CHRONIC HTN	G3P2L2	2.5,3	39W5D	FT EMER	PRE LABOR	THICK MSL	-		NO	-	-	1	3.3	1	0	0	0	1	-
1119166	25	5	6	1	UNREG	3	1	2	2	NO	G3P1L1A1	2.5,	40W1D	FT EMER	PRE LABOR	ABRUPTIO PLACENTA	-		NO	-	-	1	2.8	1	0	0	0	1	-
1119438	25	5	3	2	UNREG	3	1	1	2	DCDA TWIN	G3P2L1D1	3,UNKNOWN	39W4D	PT EMER	PRE LABOR	ANAMINOS	UTERINE ATONY		NO	-	-	1	2.6	2	0	0	0	1	-
1119582	25	5	3	2	UNREG	2	1	3	1	BREECH	G2P1L1	2.5	38W1D	FT ELEC	PRE LABOR	CDMR	2 TIGTH LOOP OF CORD,EXTENSION,UTERINE ATONY	240	NO	-	-	1	3.3	1	0	0	0	1	-
1119943	26	5	3	2	REG	2	7	1	1	PROM	G2P1L1	3	30W3D	FT EMER	FIRST STAGE	FGRwith absent end diastolic flow	2 TIGTH LOOP OF CORD,EXTENSION,UTERINE ATONY	410	NO	-	-	1	2.8	2	0	0	0	1	-
1120142	28	6	3	2	REG	2	7	2	1	BREECH	G2P1L1	2.3	37W6D	FT EMER	FIRSTSTAGE	FETAL DISTRES	-		NO	-	-	1	3.25	1	0	0	0	1	-
1120192	21	5	4	2	EREG	2	1	3	1	BOH WITH DCDA	G3P2L2		42W3d	PT ELEC	PRE LABOR	Breech	EXTENSION,ATONY		N0	-	-	1	2.8	2	0	0	0	1	-
1120936	21	5	6	2	REG	2	7	2	1	NO	G3P1L1A1	2.1	40W1D	FT ELEC	PRE LABOR	Placenta previa	EXTENSION,U/L UTERINE LIGATION	350	NO	-	-	1	3.08	2	0	0	0	1	-
1121068	23	7	6	2	REG	2	7	1	2	GHTN WITH INCREASED RESISTANCE	G3P1L1A1	2.5	35W4D	PT EMER	PRE LABOR	CDMR	-	310	NO	-	-	1	3.3	1	0	0	0	1	-
1120503	23	7	6	2	UNREG	1	7	6	2	MCDA ,GEST HTN	G2P1L1	2.5	38W	PT ELEC	PRE LABOR	MCDA WITH TWIN A BREECH	-	320	NO	-	-	1	3.5	2	0	0	0	1	-
1120560	23	8	6	1	UNREG	1	1	3	2	PPROM,HYPOTHYROIDISM	G3P1L1A1	2.7	28W	PT EMER	PRE LABOR	Placenta previa	2 TIGTH LOOP OF CORD,EXTENSION,UTERINE ATONY,B/L UTERINE LIGATION	450	NO	-	-	1	2.9	2	0	0	0	1	-
1121826	21	8	6	1	REG	1	7	12	2	GEST HTN,RH NEGATIVE PREGNANCY,CERVICAL STITCH IN SITU	G2P1L1	2.5	39W3D	PT EMER	PRE LABOR	DCDA Twins twin a TRANVERSE	B LYNCH, UTERINE ATONY	690	NO	-	-	1	2.9	1	0	0	0	0	-
1121726	23	8	5	1	REG	1	1	17	2	IGT,HYPOTHYROIDISM	G2P1L1	2.1	39W2D	FT EMER	FIRST STAGE	CDMR	UTERINE ATONY,HAYMANS SUTURE	440	NO	-	-	1	3.5	1	0	0	1(RDS)	1	-

1121867	25	8	5	1	REG	1	7	6	2	OLIGO,IUGR WITH INCREASED RESISTANCE ,RH NEGATIVE PREGNANCY	G2P1L1	2.5	40W2D	PT EMER	PRE LABOR	CORD PROLAPSE	-	350	NO	4 RDP	-	1	3.2	1	0	0	0	1	-
1094331	25	8	5	2	UNREG	1	1	5	2	ANAMINOS,ANEMIA	G2P1L1		39W1D	PT EMER	PRE LABOR	FETAL DISTRES-	-	450	NO	-	-	1	2.2	2	0	0	1(RDS)	1	-
1095086	25	4	5	2	UNREG	1	1	4	2	DCDA,EARLY ONSET FGR WITH NORMAL DELIVERY	G5P4L4	UNKNIWN	37W3D	FT EMER	PRE LABOR	PPROM WITH BOH	-	350	NO	-	-	1	3.1	2	0	0	0	1	-
1095337	26	5	5	2	UNREG	1	7	10	2	DCDA ,IUD	G3P2L2	2.3,3	38W4D	PT EMER	FIRSTSTAGE	ANAMINOS	-	350	NO	-	-	1	3.5	1	0	0	0	1	-
1095518	25	5	5	2	REG	1	1	17	2	DCDA ,IUD	G3P2L2	2.5,2.7	40W	FT EMER	FIRST STAGE	FETAL DISTRESS	-	390ML	NO	-	-	1	3.2	2	0	0	0	1	-
1096492	24	8	6	2	UNREG	1	1	6	2	-	G2P1L1	3	37w2d	FT ELEC	PRE LABOR	ANAMINOS	B/L uterine artery ligation	590ML	NO	-	-	1	2.8	2	0	0	0	1	-
1097146	23	6	5	2	REG	1	7	6	2	ANEMIA ,PLACENTA PREVIA	G2P1L1	3.1	39W	FT EMER	FIRSTSTAGE	Severe PE with uncontrolled hypertension	-	340	NO	-	-	1	3.9	2	0	0	0	1	-
1098520	21	6	6	2	REG	1	5	4	2	CENTRAL PLACENTA PREVIA,GESTATINAL HYPERTENSIN,	G3P1L1A1	3	37W5D	FT EMER	FIRST STAGE	CPD	-	480	NO	-	-	1	917 G	1	0	0	1	1	-
1098602	21	6	6	2	REG	2	7	9	2	-	G3P2L2	2.6,3.5	37W2D	FT EMER	PRE LABOR	Severe PE with uncontrolled hypertension	-	440ML	NO	-	-	1	3.9	1	0	0	0	1	-
1098456	22	5	6	2	REG	2	1	3	2	ANEMIA	G4P3L2	UNKNOWN	38W6D	PT ELEC	PRE LABOR	POST MYOMECTOMY	-	430	NO	-	-	1	1.02	2	0	0	1(LBW)	1	-
1098381	23	5	6	2	REG	2	5	5	2	IUGR WITH INCREASED RESISTANCE ON DOPPLER	G2P1L1	2.7	41W	FT EMER	PRE LABOR	THICK MSL	Couvalaries uterus	370	NO	-	-	1	3.1	2	0	0	0	1	-
1100182	22	5	6	2	REG	2	1	7	2	POST DATISM	G2P1L1	2	39W3D	PT EMER	PRE LABOR	THICK MSL	-	350	NO	-	WOUND GAPE	1	1.4	1	0	0	1(LBW,RDS)	1	-
1100032	21	5	6	2	REG	2	7	7	2	PLACENTA PREVIA	G2P1L1	3	38W3D	FT EMER	FIRST STAGE	NPL	-	350ML	NO	-	-	1	2.6	2	0	0	0	1	-
1100460	22	5	6	1	REG	2	1	9	2	IGT	G2P1L1	UNKNIWN	37W	PT ELEC	PRE LABOR	FETAL DISTRES-	-	340	NO	-	-	1	2.5	1	0	0	0	1	-
1100801	24	5	6	1	UNREG	3	1	12	2	TRANSVERSE LIE,POLYHYRAMINOS,SEVERE PE	G2P1L1	2.5	36w	FTEMER	FIRST STAGE	COMPLETE PLACENTA PREVIA	RIGHT UTERINE ARTERY LIGATION		NO	-	-	1	2.5	2	0	0	0	1	-
1100905	25	5	6	1	UNREG	3	7	5	2	TRANSVERSE LIE	G2P1L1	3	38W1D	PT EMER	PRE LABOR	FETAL DISTRESS	-	330ML	NO	-	-	1	2.9	2	0	0	0	1	-
1101069	26	5	6	1	UNREG	3	7	5	2	DCDA,SHORT CERVIX	G2P1L1	2.8	40W3D	FT EMER	PRE LABOR	CPD	-	490	NO	-	-	1	1.3	1	0	0	1(LBW,RDS)	1	-
1101363	27	5	6	2	UNREG	2	7	5	2	-	G3P2L1D1	UNKNOWN,1.6	37W	PT EMER	PRE LABOR	IMMENENT ECLAMPSIA	-	540	NO	-	-	1	3.4	2	0	0	1	1	-
1101448	28	5	5	2	UNREG	2	3	4	2	POST DATISM	G4P2L3	8,2.6,2.8	39W 2D	FT EMER	FIRST STAGE	FETAL DISTRESS	-	400	YES	-	-	1	2.6	2	0	0	0	1,1	-
1100699	29	5	5	2	UNREG	2	7	3	2	SEVERE PE,FGR	G2P1L1	2.7	38W	FT EMER	FIRST STAGE	RHD WITH MS WITH PAH	B/L uterine ligation	700	N0	-	-	1	3.17	1	0	0	0	1	-
1101524	30	5	5	1	UNREG	1	3	5	2	GDM	G2P1L1	3.1	34W	FT EMER	FIRST STAGE	Severe PE with uncontrolled hypertension	-	780	NO	-	-	1	3.4	2	0	0	0	1	-
1101763	20	5	5	1	UNREG	1	1	7	2	-	G2P1L1	-	33W4D	FT EMER	FIRST STAGE	FETAL DISTRESS	-	450	NO	-	-	1	2.6	1	0	0	1	1	-
1101723	20	5	5	1	REG	2	2	4	2	BOH ,GEST HTN	G3P1L0A1	UNKNOWN WEIGHT	39W4D	FT EMER	FIRST STAGE	MACROSOMIA	-	550	NO	-	-	1	3.4	1	0	0	0	1	-
1101745	28	6	5	1	REG	2	2	4	2	THROMBOCYTOPENIA	G2P1L1	2.4	37W5D	FT EMER	PRE LABOR	CERVICAL DYSTOCIA	-		NO	-	-	1	1.44	2	0	0	1	1	-
1102277	27	6	5	1	REG	1	7	5	2	-	G2P1L1	2.3	39W4D	FT EMER	PRE LABOR	THICK MSL	-	450	NO	-	-	1	2.5	2	0	0	0	1	-
1102513	23	6	5	1	UNREG	1	1	6	2	-	G2P1L1	3	35W	PT EMER	PRE LABOR	PLACENTA PREVIA	-	650	NO	-	-	1	2.4	2	0	0	0	1	-
1102780	25	6	3	1	UNREG	2	7	7	1	GDM,MACROSOMIA,POLYHYDRAMINOS	G3P2L2	2.5,1.6	36W3D	PT EMER	PRE LABOR	OBSTRUCTED LABOR	-	450	NO	-	-	1	0.8	1	0	0	0	0	-
1102790	26	7	5	1	REG	1	3	9	2	-	G2P1L1	3	39W6D	FT EMER	PRE LABOR	THICK MSL	Hayman suturing	390ML	NO	1 SDP,1PCV	-	1	1.9	2 2	0	0	0	1	-
1103232	27	7	4	1	REG	2	7	9	2	HYPOTHYROIDISM	G2P1L1	3	40W1D	PT EMER	FIRSTSTAGE	THICK MSL	-	550				1	1.8	1	0	0	1	1	-
1103404	28	7	6	1	REG	2	1	11	2	-	G2P1L1	3	34W5D	FT EMER	FIRST STAGE	CORD ENTANGLEMENT	-	230	NO	-	-	1	3.5	2	0	0	0	1	-
1103546	23	6	6	1	REG	1	1	2.5	2	DCDA	G2P1L1	2.5	30W2D	FT ELEC	PRE LABOR	CDMR	-	280	NO	-	-	1	3.2	1	0	0	0	1	-
1103634	22	6	6	1	REG	1	7	12	2	POST DATISM,POLYHYDRAMINOS,HYPOTHYROIDISM				FT EMER	FIRST STAGE	LOW LYING PLACENTA	-		NO	-		1	2.5	1	0	0	0	1	-
1103742	22	5	6	2	REG	1	4.1	12	2	GDM	G4P2L2A1	2.5,3	38	FT EMER	FIRST STAGE	FAILED INDUCTION	-	540	NO	-	-	1	3.4	2	0	0	0	1	-
1103814	23	6	6	2	REG	2	1	5	2	HYPOTHYROIDISM	G2P1L1	2.7	37.3	FT EMER	PRE LABOR	POP	-	300	NO	-	-	1	3	2	0	0	0	1	-
1104978	24	7	6	2	REG	2	1	10	2	-	G2P1L1	3	40.1	PT ELEC	PRE LABOR	FETAL DISTRESS	-	440ML	YES	-	-	2	3.7	2	0	0	0	1	-
1104964	25	6	6	2	REG	2	1	4	1	OLIGO	G2P1L0	-	35.6	FT EMER	PRE LABOR	MACROSOMIA	-	870				1	1.46	2	0	0	0	1	-
1105387	26	6	7	2	REG	1	2	2.5	2	-	G2P1L1	2.5	38.5	PT EMER	PRE LABOR	FETAL DISTRESS	-	480	NO	-	-	1	3.2	1	0	0	1	1	-
1155669	27	6	5	2	REG	1	3	6	2	-	G2P1L1	2.5	33.2	FT EMER	FIRST STAGE	BREECH	-	450	NO	-	-	1	3.3	1	0	0	0	1	-
1105352	28	6	7	2	UNREG	1	4	5	2	-	G2P1L1	2.6	36.5	PT ELEC	PRE LABIR	ANAMINOS	-	550	NO	-	-	1	3.1	1	0	0	0	1	-
1105931	29	6	6	2	UNREG	3	9	6	2	-	G2P1L1		37.6	FTEMER	FIRST STAGE	POP	PPH,Hayman suturing		NO	-	-	1	2.7/2.6	1,1	0	0	0	1	-
1106096	30	6	7	2	UNREG	3	5	9	2	PRECIOUS PREGNANCY	G3P2L1	1.5,2.5	39.2	PT EMER	PRE LABOR	Severe PE with uncontrolled hypertension	EXTENSION,U/L UTERINE ARTERY LIGATION	430	NO	-	-	1	2.6	2	0	0	0	1	-
1105412	31	6	5	2	UNREG	4	4	6	2	GDM,MACROSOMIA	G4P3L3	3,2.7,2	34.6	FT EMER	PRE LABOR	PERSISTENT LOP	1 TIGTH LOOP OF CORD	330ML	NO	-	-	1	2.5	1	0	0	0	1	-
1106580	32	6	7	2	UNREG	4	4	16	1	-	G3P2L1	NOT KNOWN	37.1	PT EMER	PRE LABOR	FETAL DISTRESS	-	300ML	NO	1 PCV	-	1	3.1	1	0	0	0	1	-
1107479	24	7	7	2	UNREG	2	4	8	1	-	G4P2L1D1A1	3.5,3	40.2	FT EMER	FIRSTSTAGE	PRECIOUS PREGNANCY	-	600ML	NO	-	-	1,1	1.8,1.96	1,1	0	0	1,1	1	-
1108083	26	7	7	2	UNREG	2	1	7	2	-	G3P2L1	NOT KNOWN	40.2	FT EMER	FIRST STAGE	BREECH IN LABOR	EXTENSION,U/L UTERINE ARTERY LIGATION ,ATONY	450	NO	-	-	1	3.2	1	0	0	0	1	-
1107682	27	7	4	2	UNREG	1	7	5	2	-	G3P1L1A1	3	39.5	FT EMER	FIRST STAGE	PRECIOUS PREGNANCY	-	450	NO	-	-	1	2.2	2	0	0	1	1	-
1108413	29	6	3	2	UNREG	1	7	6	1	OLIGO	G5P3L3A1	3,2.5	40.5	FT EMER	FIRST STAGE	Severe PE with uncontrolled hypertension	MSL,EXTENSION,U/L UTER LIGATION	230	NO	-	-	1	3	1	0	0	0	1	-
1109402	20	6	3	2	UNREG	1	7	5	1		G3P2L2	2.3,2.5	40.6	FT EMER	FIRST STAGE	FETAL DISTRESS	U/L UTERINE LIGATION	480	NO	-	-	1	1.7	1	0	0	1	1	-
1109573	20	6	3	2	UNREG	1	3	10	2	GEST HTN,PRECIOUS PREGNANGY	G3P2L2	-,3.5	39.2	FT EMER	PRE LABOR	TRANSVERSE LIE	-	450	NO	-	-	1	2	1	0	0	1	1	-
1109583	21	6	5	2	REG	1	3	17	2		G3P1L1A1		37.1	FT EMER	PRE LABOR	BOH	-	450	YES	-	-	1	2.1	2	0	0	0	1	-
1110604	22	5	7	2	REG	2	7	6	2	APH	G5P2L2A2	2.5,3	40.3	FT EMER	PRE LABOR	CDMR	UTERINE ATONY		NO	-	-	1	2.4	1	0	0	0	1	-
1111020	24	5	5	2	UNREG	2	7	6	1	FGR,OLIGO	G2P1L1	3.5	37.1	FT EMER	SECOND STAGE	MSL	2 TIGTH LOOP OF CORD,EXTENSION,UTERINE ATONY	350				1	2.4	1	0	0	0	1	-
1109528	25	6	3	2	UNREG	1	1	4	2	GDM	G5P3L3A1	2.5,2,2.2	39.3	FT ELEC	PRE LABOR	Severe PE with uncontrolled hypertension	2 TIGTH LOOP OF CORD,EXTENSION,UTERINE ATONY	440	YES	-	-	1	2.6	1	0	0	0	1	-
111162	25	5	4	2	REG	1	1	9	2		G3P1L1A1	3.5	36.5	FT ELEC	PRE LABOR	FETAL DISTRESS	-	440	NO	-	-	1	2.4kg	2	0	0	0	1	-
1111589	25	5	4	1	UNREG	3	1	3	2	IGT,HYPOTHYROIDISM	G4P2L1A1	0.5,1.2,	36.4	FT EMER	PRE LABOR	PLACENTA PREVIA	EXTENSION,ATONY	420	NO			1	1.5	2	0	0	0	1	-
1112743	26	5	5	1	UNREG	3	1	5	2	PRECIOUS PREGNANCY,HYPOTHYROIDISM	G2P1L1	2.5	38.1	FT EMER	FIRST STAGE	Severe PE with HELLP	EXTENSION,U/L UTERINE LIGATION	380	NO			1	3.1kg	1	0	0	0	1	-
1113527	23	5	6	1	UNREG	4	1	7	2	IGT	G4P3L3	2.5,3,3.5	40.1	FT EMER	PRE LABOR	FETAL DISTRESS	-	400	NO			1	2.6kg	1	0	0	0	1	-
1113466	23	5	6	1	REG	4	7	7	2	CHR HTN WITH SUPERIMPOSED PE,FGR,AEDF	G3P2L1A1	2.5	34.1	FT EMER	FIRST STAGE	MSL	-	380	NO			1	1.7	1	0	0	0	1	-
1113560	32	5	6	1	REG	4	7	9	2	-	G3P2L2	3,2,2.5	39.3	FT ELECT	PRE LABOR	COMPLETE PLACENTA PREVIA	2 TIGTH LOOP OF CORD,EXTENSION,UTERINE ATONY,B/L UTERINE LIGATION	490	NO	-	-	1	2.5,2.1	1,1	0	0	0	1	-
1113541	32	5	6	1	UNREG	4	7	12	2	SEVERE PE,FGR	G4P2L1A1	2.7,UNKNOWN	35.1	FT EMER	FIRSTSTAGE	FETAL DISTRESS	B LYNCH, UTERINE ATONY	770	YES	-	-	1	3.6	1	0	0	0	1	-
1114273	32	5	6	1	UNREG	4	7	5	2	HYPOTHYROIDISM,ANAMINOS	G3P2L1	2.5,2	39.6	FT EMER	FIRST STAGE	BREECH IN LABOR	-	600	YES			1	2.8	2	0	0	0	1	-
1114151	30	5	7	1	UNREG	4	7	5	2	MILD PE	G2P1L1	2.2	36.6	FT ELEC	PRE LABOR	ANAMINOS	MSL	300	NO			1	2.6	2	0	0	0	1	-
1114780	32	5	5	1	REG	4	1	5	2	OLIGO WITH INCREASED REISITANCE	G2P1L1	3	40.1	FT EMER	FIRST STAGE	THICK MSL	-	490	NO	-	-	1	3.4	1	0	0	0	1	-
1114603	22	6	5	1	UNREG	1	5	4	2	BREECH	G4P2L2A1	2.5	37.6	FT EMER	FIRST STAGE	ANAMINOS	MSL	380	NO	-	-	1	2.4	1	0	0	0	1	-
1112727	28	5	6	1	REG	2	7	3	2	CENTRAL PLACENTA PREVIA	G3P1L1A1	3.7	39	FT EMER	PRE LABOR	MCMA	-	240	NO	-	-	1	1.4	2	0	0	0	1	-
1115513	27	6	6	1	UNREG	1	1	5	2	HYPOTHYROIDM	G2P1L1	3	37.2	FT EMER	PRE LABIR	BOH	-	670	NO	-	-	1	2.9	1	0	0	0	1	-
1114469	26	7	6	1	REG	1	1	7	2	SEVERE PE	G2P1L1	3	36.2	PT EMER	FIRST STAGE	CDMR	-	400	YES	-	-	1	3.6	1	0	0	0	1	-
1114567	23	6	6	1	UNREG	1	7	4	1	OLIGO WITH FGR WITH INCREASED RESISTANCE	G2P1L1	3	37.5	FT EMER	PRE LABOR	BOH	-	450	NO	-	-	1	1.4	1	0	0	0	1	-
1112356	23	6	6	1	REG	2	7	4	2	RH NEGATIVE WITH HBS AG POSITIVE STATUS	G2P1L1	3.4	40.4	FT EMER	PRE LABOR	CDMR	-	420	NO	-	-	1	2.9	1	0	0	0		
1113425	23	7	6	1	REG	3	7	5	2	APH	G2P1L1	2.6	38.4	FT EMER	PRE LABOR	BREECH	-	320	YES										