Case Report

An Example of Non-Co-operative Patient Attitude and Legal Implications

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Previous two Cesarean Section is a clear indication for C/section at term for safe mode of delivery .In earlier gestation if labour sets in and it fails to respond to tocolytics or in situations where tocolysis is contraindicated, even then operative delivery is safe mode .This is a case report of a patient with history of laparotomy for repair of uterine rupture followed by four cesarean section .In her last pregnancy she presented with premature preterm established labour obstetrician decided about cesarean section on failure of primary management with tocolytics and dexamethasone .But she refused to give consent for cesarean section .Although she went safe and sound along her baby after three days of delivery but exposed her self , her baby and the obstetrician to multiple hazards .

Key words: Patient attitude, legal implications

The trial of scar can be given in previous one cesarean section in the absence of any additional indication for operative delivery. Previous two cesarean sections are indication for cesarean section in subsequent pregnancy. The rule for cesarean section after previous two cesarean sections is in consideration for feto-maternal morbidity. There are multiple known complications of attempting vaginal delivery in these cases. These include scar dehiscence, uterine rupture, peripartum haemorrhage and maternal death .Fetal complications reported are asphyxia or demise

Case Report

A 43 years old , grand-multipara ($G^{13}P^{11}A^{1}$) , was admitted through emergency on 27th January 2003 at 31 weeks of gestation by her LMP on 18.06.02 .She had amniorhhexis (leakage of liquor due to rupture of membranes) since last 4 hours. She was not having labour pains and fetal movements were normal .In current pregnancy she was on Aldomet therapy 250 mg TDS per oral for pregnancy induced hypertension. Additional risk factor was past history of laparotomy. Laparotomy was done for ruptured uterus with intrauterine fetal death in her 7th pregnancy. Uterus was repaired. This was followed by 4 cesarean sections in subsequent pregnancies.

Her blood pressure at admission was 180/100 mm of Hg and urinary protein were +++. On examination pubosymphysial height was 31 cm, matching with dates and early USG which was conducted at 11 weeks gestation (on 31-8-2002). There were no palpable uterine contractions .Fetal heart rate was 140 beats/minute regular .CTG was showing reactive pattern with occasional low intensity uterine contractions .Single sterile speculum examination was done , confirming rupture of membranes by positive Nitrizine test .All the routine investigations and blood work up was found to be normal including platelet count and 24 hours urinary protein. In liver function test Alkaline-phosphatase was 149 u/l and Alkaline-amino-transferase 31u/l both slightly high .On the basis of protein-uric hypertension and premature preterm rupture of membranes she received Dexamethasone and Magnesium sulphate therapy .Inj. Dexamethasone was given I/M 12.5 mg two doses at 12 hours interval. Magnesium Sulphate 4gm I/V bolus in 30 minutes followed by 20 gm per 1000 ml of R/Lactate at a rate of 1 gm /hr .Respiratory rate ,reflexes ,urine output and serum magnesium levels were monitored during this therapy .This is her 13th pregnancy having 11 alive issues and one abortion as details are shown in obstetrical calendar below

On 29th of January (2 days after admission) she complained of labour pains at 17:20 hrs. She had palpable regular uterine contractions of 40 seconds duration at interval of 3 minutes .CTG was reactive with base line heart rate 143 beat/minute showing regular uterine contractions. On vaginal examination cervix was 3cm dilated, 1 cm long and centrally placed .Presenting part was at 2 station, membranes were absent and liquor was clear.

On the basis of her previous history , cesarean section was planned, which was refused by the patient despite of explaining the risks involved to mother and baby by vaginal delivery. During this time strict monitoring was done for vital signs, vaginal bleeding, urine out put and it's colour (with foleys catheter). .She progressed very quickly while counseling her for Cesarean section .An hour later findings at vaginal examination were 7cm dilated, fully effaced cervix, presenting part at zero and clear liquor. CTG during this time remained reactive with out any deceleration.

At this moment patient was shifted to operation theatre for delivery (by cesarean section) in case consent is granted by husband who was not available in the hospital till that time. In operation theatre with in 10 minutes of last examination cervix was fully dilated (as she was gravida 13) and she started pushing .

Sr. No	Year	Ante-Natal Complications	Gestational age.	Mode of delivery.	Sex	Wt In kg	Post-partum Complication
1	1975	Nil	Full term	SVD	M	3.0	Nil
2	1977	Abortion	8 Weeks	Spont. Complete Abortion	-	-	Nil
3	1978	Nil	Full term	SVD	F	3.0	Nil
4	1980	Nil	Full term	SVD	M	3.0	Nil
5	1982	Nil	Full term	SVD	M	3.0	Nil
6	1984	Nil	Full term	SVD	M	3.0	Nil
7	1986	IUFD	Full term	Laparotomy for repair of uterine Rupture	F	3.0	Patient remained in ICU for 5 days .
8	1989	Nil	Full term	C/ Section	F	3.0	Nil
9	1990	Nil	Full term	C/ Section	M	3.0	Nil
10	1992	Nil	Full term	C/ Section	M	3.0	Nil
11	1993	Nil	36 weeks	C/ Section	M	2.5	Nil
12	1999	Herpes Gestationalis Treated by prednisolone	31 weeks	SVD	F	1.8	Baby was sent to Neonatal ICU
13	2003		Current pregnancy				

Out come was a male baby having Apgar Score 6/10 at 1 minute and 9/10 at 5 minutes. Total duration of labour was 2 hours and 05 minutes in current pregnancy. First stage lasted 1 hr 50 minutes, 2nd stage 5 minutes and 3rd stage was 10 minutes.

Delivery of placenta was also spontaneous and with out delay but it was followed by primary post partum haemorrhage , despite of the active management of third stage of labour .Estimated blood loss was around 1200cc.She was given stat dose of Inj. Syntocinon 10 units I/V followed by maintenance dose of infusion Syntocinon 40units /500ml Ringer lactate at 40 ml /hour ,along with 4 units of fresh frozen plasma .Uterine massage was done bimanually .20 minutes later uterus was well contracted but patient still continuing to have per-vaginal bleeding. Blood sent for coagulation profile and patient examined under general anaesthesia with suspicion of scar dehiscence .Examination revealed two cervical lacerations at 3'o and 9'o clock position. These were sutured with Vicryl No.0 but still slight oozing persisted so uterus and vagina were packed with 4 packings. Placenta was sent for histopathology. She received I/V antibiotics for 48 hours in post-partum period. Placental tissue on histopathology later showed maturing placenta, normal umbilical cord containing three vessels and there was no evidence of chorioamnionitis and villitis.

At recovery after 12 hours of the delivery her pulse was 111 beats /min ,blood pressure 149/89mm of Hg , uterus was well contracted and urine output was satisfactory. Vaginal pad was slightly soaked ensuring controlled active bleeding .Uterine and vaginal packings were removed after 24 hours of delivery. An ultrasound was conducted after 6 hours of delivery which ruled out any collection in pouch of Douglas or hematoma in upper genital tract.

As shown in the obstetrical table there is history of vaginal delivery 4 years back in that pregnancy patient was admitted with preterm labour at 31 weeks of gestation. Tocolysis was done along with Inj. Dexamethasone, but despite of that she had strong uterine contractions. On examination she was in established labour. While the arrangements were being made for the Cesarean section she progressed to full dilatation and started pushing in operation theatre and delivered female baby of 1.8 kg with Apgar score 8/10 at 1 minute and 9/10 at 5 minutes .So it is repetition of the same attitude second time. She is known case of bronchial asthma since last 10 years treated by ventoline therapy.

Discussion

The most common indication for delivery by cesarean section is a previous cesarean section[1] .Commonest reason for cesarean section was previous C/Section as depicted by Notzon FC in that is as under[1]

Country	Abdominal delivery after one C/Section
United states	36 %
Sweden	29 %
Scotland	22 %

Currently there is supporting evidence for attempting vaginal delivery following previous one lower uterine segment C/Section, Flamm BL has reported figure of 60-80 % success which is very encouraging[2].

Due to known complications of vaginal delivery after uterine surgery, (classical cesarean section, myomectomy involving uterine enedometrium, and cesarean section followed by endometritis), majority of the patients were undergoing repeat cesarean section both as option by obstetrician and preference of patient. But later studies proved that trial of scar is a safe option under vigilant monitoring .In late 1980's the concept of trial of labour after previous one C/section started gaining popularity[3].

However in 1990's the catastrophic complications reported for giving trial of labour halted this practice[4]. This is the reason that only 9% of the females received trial of labour in 1981[5]. However during the period between 1988 and 1993 in America the number of females having vaginal delivery after previous C/section got doubled from 12.6% to 25.4 %[5]. The report by Flamm et al about adverse out come in previous C/ Section were compared in both modalities.

Complications	Trial of Labour	Elective repeat c/section	P value
Uterine rupture	0.8%	0	
Hysterectomy	0.27%	0.12%	0.205
Hospitalization	84.9hours	57.2hours	0.0001
Increased blood transfusion	1.72%	0.72%	0.0001
Apgar less than 7 at 5 minutes	0.68%	1.48%	0.004

In another study by Farmer et al uterine rupture rate is 0.8%[6]. But as mentioned before in previous 2 or more C/section elective C/section at term is safe mode of delivery. In view of multiple risks mentioned in trial of labour after one cesarean section and fairly increased feto-maternal morbidity and mortality, decision is easy to make for elective cesarean section or emergency cesarean section in established labour cases.

Here the patient response and attitude is under consideration. This depends upon the education level confidence upon the obstetrician, exact under standing of the degree of risk involved, and faith on the management offered, which is the best in favour of baby and mother. This issue high lights the health education during her antenatal visits. This includes informing her about the risks and their management options, planning mode and time of delivery. With these much number of cesarean sections, history of laparotomy and expected non co-operative attitude of this patient in subsequent pregnancy she is also candidate for tubal ligation .

Conclusion

This case is not reported for promoting hercularian in the obstetrical practice. Rather it is showing the bound hands of the competent health providers by the legal implications in the absence of consent. Of course building confidence and achieving the faith is the essence of obstetrical practice to exercise the best in favour of mother and baby .Co-operation of patient is important to perform legal and moral duties .

Experience

1. Notzon FC, Cnattingius S, Bergsjo P et al. Cesarean section delivery in the 1980's international comparison by indication .American Journal of Obstetrics & Gynaecology 1994; 170: 495-504.
2. Flamm BL, Goings JR, Liu Y, Wolde-tsadik G. Elective repeat cesarean delivery versus trial of labour: a prospective multicenter study. Obststrics and Gynaecology 1994; 83: 927-932.
3. Clarke SC, Taffel S (1995) Changes in cesarean section delivery in the United States, 1988 and 1993.Birth 22, June 63-67.
4. Novas J, Myers SA, Gleicher N. Obstetrics out come of patients with more than one previous cesarean section. American Journal of Obstetrics & Gynaecology 1989; 160: 364-376.
5. Jones RO, Nagashima AW, Hartnett-Goodman MM et al. Rupture of low transverse cesarean scar during trial of labour . Obststrics and Gynaecology 1991; 77: 815-817.
6. Farmer R, Kirschbaum T, Potter D, Strong T. Medearis A. Uterine rupture during trial of labor after previous cesarean section . American Journal of Obstetrics & Gynaecology 1991; 165: 996-1001.