SUMMARY
GENERAL PART

The caesarian is the surgical operation which consists in the opening of the abdomen, in the severing of the uterine wall for the extraction of the fetus / foeti and fetal appendices. The intervention realizes an artificial extraction of the fetus and of his appendices after the surgical opening of the womb / hysterotomy. Usually, it is performed by the abdominal way, by celiotomy / laparotomy. The caesarian by vaginal way consists in the section of the cervix and of the inferior segment, without penetrating the big peritoneum cavity (cervico-segmental longitudinal hysterotomy up to the peritoneal vesico-uterine sac) (160 ( 161 )).

The term of caesarian was used for the first time by Francois Rousset (1581). The term of caesarian section was used by Jaques Guillemeau, the surgeon of Henri IV (1598). According to other authors, Chome (cited by 1). The term of caesarian was used at first by Theopilus Raynaldus (1637). The etymology of the word caesarian is not known. We have several hypotheses in discussion due rather to myths and legends than to the historic and etymologic realities (151) (182) (30) (31).

The equal respect of the materno-fetal interests, in the sense of keeping the maternal integrity and of not traumatizing the fetus represents the imperative of modern obstetrics. These are performed by directing the labor and more and more by the surgical solution for the difficult gestures in order to avoid the risky surgical operations for the mother and the fetus. In this arsenal, the segmental caesarian section occupies a special place, by marking the modern epoch of the obstetrics.

Except for the absolute indications, the other indications of caesarian section are hierarchized, depending on the local and general conditions, in the obstetrician’s final experience analysis. Two principles are the base of the decision: 1-the maternal risks shouldn’t be higher than the attempt of a natural birth and on no account bigger than the fetal ones; 2-the fetus should
deserve the risks of the operation. The extraction by caesarian has to put in the foreground the mother risks; the analysis of the accidents or of the potential complications shows that a useless operation was practiced when the case could have been solved by obstetrical operations (1).

The caesarian section constitutes a remarkable progress in the obstetrics. No other surgical procedure has influenced in such a manner the evolution of a surgical specialty.

*The obstetrical clinical conditions for performing the caesarian section are:*

- **Living or viable fetus**
- **Unengaged presentation** (on the engaged skull the fetus is extracted by forceps; there are also serious situations, it's true, when the engaged and/or even partially released fetus is reintroduced in the uterine cavity in order to be extracted by caesarian operation "the salvation method by abdominal way or the Zavanelli method."

- **The inferior formed segment** (some authors prefer the practice of the caesarian section at the beginning of the labor, on intact membranes due to the favorable fetal-segmental ampliation and to the uterine orifice presence/provides the easy drainage of blood and lochia).

- **The lack of infection for the amniotic cavity.**

The criteria for the classification of caesarian sections are the following: - according to the mother’s condition (living woman; post-mortem caesarian); - according to the initial approach way (abdominal caesarian, Dhurssen vaginal caesarian); - the abdominal caesarian can be: transperitoneal, extraperitoneal; - according to the pregnancy age: proper caesarian, for the extraction of a viable fetus; small caesarian, operation of necessity for extracting small slices, before the viability age - up to 6 months of amenorrhea; according to the level to which the hysterotomy is practiced: medio-corporeal longitudinal classic caesarian; segmental/longitudinal caesarian Kronig - Beck and transversal Fuchs-Doffleff.
SPECIAL PART

I performed this study for a retrospective research and at present for the indications of the caesarian section as compared to a natural birth. I analyzed the accidents and/or the potential complications that occurred and that may occur after a caesarian section fact that will demonstrate that a useless operation was practiced, when the case could have been solved by other obstetrical maneuvers.

I remain the adept of the natural birth and I try to sustain, by statistical data collected during the five years of study, 2005-2009, that the indication of the caesarian section is abusive, from various reasons that will be analyzed, and what happens if we do not comply strictly with its indications.

I performed the study in the maternity no. II of the Pitesti Arges Emergency County Hospital for a period of five years: 2005-2009.

I performed this study for the caesarian section by taking into consideration the theoretical frame and the present concept, the specialty literature and the medical practice experience from the maternity where I have the access to praxis, research and documentation. From these sources I extracted the independent or dependent variables used in the study.

The algorithm used for the caesarian operation indication – follows the anamnensis stages, the general clinical examination, the obstetrical examination and those of the paraclinical investigations.

The study performance plan - I elaborated it by correlating the practical aspects met with the theoretical ones. The research materials consisted in: the warding registries of the maternity and the specialty cabinet from the specialty ambulatory, the clinical observation sheets, (including the partogramas) the birth register, the operations register, the operation protocols, the computer system. I extracted the following data necessary for my study: age, domicile, profession, hospital admission reasons, the manner in which the hospital admission was performed, personal antecedents,
implied risk factors, associated pathology, general clinical examination, obstetrical examination, medical and non-medical fundaments of the operation indication, operation protocol (operation type, anesthesia type) immediate evolution, post-anesthesia complications, post-operative complications, prognosis and other data.

The lot and the sampling method – was represented by the pregnant women hospitalized for childbirth during the five years period. The study was based on the pregnant women lot for whom the birth was finalized by caesarian section.

The study inclusion criteria – consisted in the diagnosis criteria sufficient for each patient. I excluded from the study the insufficiently documented or insufficiently supervised cases.

The data analysis and the data analysis procedures were made both statistically and conceptually.

The ethic issues were strictly complied with. During the study I ensured the personal data protection, the pregnant patients being included in the study only numerically.

In the present work I proposed to analyze the casuistic of the caesarian operations within the maternity no. II of the Arges Pitesti Emergency County Hospital during the period 2005-2009. In this period, a number of 6067 births was recorded out of which 4349 were natural births (71,68 %) and 1718 births by caesarian section (28,32 %).

Analyzing the data and the percentages included in Table no. 1 in the diagrams 1.1; 1.2; 1.3 and 1.4 we observe the following: 1) – the reduction of the number of births progressively but surely from 1380 in 2005 to 1052 in 2009; 2) – the reduction of the number of natural births: 1070 (77,54 %) in 2005 as compared to 667 (63,4 %) in 2009; 3) – the continuous increase of the number of caesarian sections during each year on the studied period as follows: 2005 – 310 caesarian sections representing 22,46 % of the total of births respectively; 2006 – 325 (24,62 %) caesarian sections; 2007 – 348 (29,62 %) caesarian sections; 2008 – 350 (30,7 %) caesarian
sections and 2009 - 385 (36,6 %).

By placing in balance the two manners of the birth process approach (vaginally or by caesarian section) I can state that there is an obvious tendency for the reduction of the number of natural births with 14,14 % and an increase of the number of caesarian sections with the same percentage 14,14 %.

The World Health Organization declared that no region should exceed 10 -15 % of the proportion of caesarian sections from the total of births.

I applied the percentage of 15% of caesarian sections recommended by the World Health Organization to the total number of births and it came out that only 910 caesarian sections should have been performed, therefore 808 caesarian sections, representing 47,03 % of the total caesarian sections were not necessary or had no medical indication.

I also applied the minimum percentage of 10% recommended by the World Health Organization to the total number of births (6067 in the five years of study) and it came out that only 607 caesarian sections should have been performed, as a result 1111 operations, representing 64,02 % of the total caesarian operations were not necessary or had no medical indication.

Most of the pregnant women 979 (57%) were monitored by the family doctor. If we add to them also the unmonitored pregnant women (in the sense that during the pregnancy they did not address to any doctor) 137 pregnant women representing 8% we reach a percentage of 65% (1116 pregnant women), so, almost 2-3 the pregnant patients in the studied lot had no contact with an obstetrician during pregnancy (Table no. 9, Diagrams 9.1 and 9.2).

Through the private cabinets of obstetrics-gynecology 137 pregnant women (8%) were monitored; through the cabinets of obstetrics-gynecology 206 pregnant women (12%) were monitored; the doctors from the maternity no. II (through the guardroom or through the presentations service) monitored 259 pregnant women (15%).
At hospitalization 85% of the pregnant women, namely 1460 could make the proof of an initial screening, while 258 pregnant women, representing 15% did not perform any instigation from the category of those included in the initial screening during the entire pregnancy evolution.

In order to be able to make a more precise analysis of the caesarian section ratio evolution, at a world level, a few common and well standardized directives are imposed, such as the following: caesarian sections indications classification, the same method of data collection and especially the unitary computer processing. Only in this way we can conclude concerning the place of the caesarian section in the modern obstetrics.

The continuously increasing caesarian sections ratios constituted and will continue to constitute intense reason of debate in the entire obstetrical medical world.

The researched caesarian operations that were performed during the study for absolute maternal indications were in number of 655 interventions representing 38,05 % of the total studied interventions represented as follows: surgical basin (useful diameter below the limits - below 8 cm) 343 indications (20,85%), negative labor test 300 indications (17 %) and praevia obstacles of the genital ways (voluminous uterine fibroma 2 cases and voluminous ovary cyst l case) 3 indications (0,2%).

The relative maternal indications that lead to the decision of caesarian section were in number of 605 representing 35.31. These indications were granted for the following: fetal-pelvic disproportion 171 indications (10%); scar uterus with imminence of uterine rupture 326 (19 %); eclampsia and pre-eclampsia 9 (0.52%); severe myopathy and myopic choroidopathy 21 indications (1.24%); aged primiparous (more than 35 years old); precious baby by fertilization in vitro 5 indications (0.3%).

The fetal indications that imposed the decision of birth finalization by caesarian section were in number of 458 indications representing 26.64 % of the total operations studied during the research. Thus, for the acute fetal sufferance 278 (16.04%); cord prolapse 17 (1%); pelvic presentation with a
large fetus 70 (4.07%); pelvic presentation for aged primiparous patients 25 indications (1.45%); pelvic presentation with broken membranes on a long cervix 8 indications (1.46%); transversal presentation 9 indications (0.52%); deflected skull presentation 10 indications (0.6%); twin presentation with interception risk 13 indications (0.8%); group and rh isoimmunization 13 cases (0.8%); and chronologically extended pregnancy 15 indications (0.9%).

During the study period I performed 333 caesarian sections representing 19.38% of the total researched interventions, (Table no. 28, Diagrams 28.1 and 28.2).

The absolute maternal indications represented 38.3% of the total number of indications and concretized in a number of 127 interventions that I performed. These indications were represented by: surgical basin (useful diameter below the limits - below 8 cm) 66 indications (20%); negative labor tests 60 indications (18%) and praevia obstacles of the genital ways (voluminous uterine fibroma) 1 indication (0.3%).

I performed a number of 117 caesarian sections (34.9% of those that I performed) for the following relative maternal indications: fetal-pelvic disproportion with or without labor assay 33 (10%); scar uterus 60 (18%); eclampsia and pre-eclampsia 2 (0.65); severe myopathy and myopic choroidopathy 5 (1.5%) and aged primiparous 17 (4.8%).

The fetal indications for which I performed 89 caesarian sections represented 26.8% of the caesarian sections that I performed and I recorded for acute fetal sufferance 55 indications (16.5%) cord prolapse 3 indications (0.9%); pelvic presentation with a large fetus 13 indications (4%); pelvic presentation for aged primiparous (more than 35 years old) 5 indications (1.5%); transversal presentation 3 indications (0.9%); deflected skull presentation 3 indications (0.9%); twin presentation with interception risk 2 indications (0.6%) group and Rh isoimmunization 2 indications (0.6%) and biologically extended pregnancy (more than 42 weeks) 3 indications (0.9%).
I performed 60 interventions on scared uterus (18.4% of the 326 operations on scared uterus) distributed as follows: 53 operations performed on scared uterus for a caesarian section in antecedents; 2 interventions on scared uterus with 2 caesarian operations in antecedents (1 operation in 2005 and 1 operation in 2009); 1 intervention in 2006 on scared uterus after the small caesarian section and 4 operations on scared uterus for another operated uterine pathology (myomectomy 2 interventions and 2 operations after hysteroraphy after instrumental perforation).

During this period I performed 328 segmental-transversal interventions (98.5% of the total number of operations that I performed) and 5 segmental-longitudinal operations.

- The caesarian operations of segmental-transversal type that I performed according to indications and contraindications are classified as follows:
  - Absolute maternal indications 126 interventions (38.6%);
  - Relative maternal indications 114 interventions (34.9%);
  - Fetal indications 88 interventions (26.5%)

During the five years of study I placed under surgery 5 pregnant women for whom I indicated segmental-longitudinal caesarian section. These represent 1.5% from the caesarian sections that I performed. Analyzing the indications and the contraindications, I performed these segmental-longitudinal interventions due to the following reasons:

- 3 operations for multiple scared uterus
- 1 operation for transversal presentation
- 1 segmental-longitudinal caesarian section for a low inserted placenta.

The caesarian section on the pregnant women’s demand in the absence of medical indications is a reality. For now, the research of the medical records from the observation files of the pregnant patients hospitalized for birth finalization will not reveal the indication of caesarian on demand, because this is not distinctly provided under any classification of the
intervention medical indications registered by the obstetrician. The caesarian operation indication on demand is masked under „various and plausible medical indications" which after the successful surgical intervention cannot be verified any longer. In this case we find ourselves in the following situation: the express request of the pregnant woman and the obstetrician’s professional probity of making a decision outside the medical conduct for birth finalization, and the pregnant woman’s express wish (without any medical culture) for the birth by caesarian section.

The obstetrical medical guides require the doctor to act in mother’s and fetus interest. The doctrine of the informed consent imposes the obligation for the doctor to talk to his pregnant patient: to explain to her the diagnosis, the available therapeutic possibilities (vaginal childbirth or caesarian section), to present the relevant risks and benefits for both situations and to perform the objective recommendations that are imperative from a medical point of view. (66).

The execution of a caesarian section in the absence of certain medical indications cannot be considered an alternative to the vaginal childbirth, which is considered a standard for any pregnancy finalization. In case of disagreement between the obstetrician’s professional integrity on the one hand and the pregnant women option for caesarian on demand, on the other hand, allows the doctor to reject the patient’s demand on condition that the pregnancy obstetrical evolution be not put in danger and the transfer to another doctor’s supervision be made in due time. (62)

At the present medical knowledge moment we cannot even place the problem of changing the birth finalization standard by surgical intervention on the patient’s demand because there are no justifiable proofs concerning the benefits and risks as compared to the vaginal childbirth.

The bleeding by uterine hypotony, noticed during the interventions of the caesarian sections that I performed (Table no. 36 and Diagrams 36.1 and 36.2) occurred in a number of 4 cases that represented 1.18% of my
caesarian sections. I noticed in 2005 - 1 case (0.32%); 2 cases (0.57%) in 2007 and one case in 2008 (0.29%).

Hemorrhages by injuring the vascular pedicel on the uterus borders at the caesarian sections that I performed (Table no. 38 and Diagrams 38.1 and 38.2) occurred in a number of 11 cases and represented 3.30% of the total caesarian sections that I performed during the study, in 2005 I noticed 2 cases (0.65%); in 2006 - 3 cases (0.92%); in 2007 – 1 case (0.29%); in 2008 - 4 cases (1.14%) and in 2009 – 1 case (0.26%).

The frequency of urinary bladder lesions during the studied caesarian interventions was of 0.17% from the researched cases being represented by 3 cases: 1 case (0.32%) in 2005 and 2 cases in 2007 (0.57%).

In the study that I performed I observed the following morbidities: adherent complications discovered during intervention, hemorrhagic complications, septic, thrombo-embolic, psychic complications, and those related to the administrated anesthesia.

During the study I did not record any sign of maternal death.

If at first the caesarian section was rarely practiced because of the excessive mortality, it represents a frequent intervention and a progressively increasing one, being the safest procedure able to save both the mother and the child when certain factors which complicate the act of birth interfere.

The caesarian intervention represents the most remarkable progress in obstetrics. No other surgical procedure ever influenced that much the evolution of a surgical specialty.

The caesarian operation remains a mankind revolutionary intervention, a mediation of life, a pact between “medical” and “surgical”, a bridge between necessity and wish, a conciliation between thought and fact, an identification of the God from each one of us.