CAESAREAN SECTION
PATIENT INFORMATION SHEET
DR ADAM GUBBAY

BACKGROUND

The reasons for caesarean section are many and varied. Caesarean sections may be either performed as an emergency or elective procedure. The commonest reasons for an emergency caesarean section are failure to progress in labour and concern about the baby's condition ("fetal distress"). Caesarean sections may also be performed electively. Some common reasons for elective caesarean sections are:- previous caesarean section, breech presentation (i.e. bottom first), placenta praevia (i.e. placenta covering the lower part of your womb and thus physically preventing a normal vaginal delivery) and concern that the baby is just "too big". Rates of caesarean section vary throughout the world. In Australia and most of the developed world, caesarean section rates have continued to steadily increase. The reasons for this are many and varied and beyond the scope of this handout. However, in part this is due to the aging pregnant population, increasing birth weight of babies and the improved safety of elective caesarean sections.

MY ROUTINE

You will either see your anaesthetist before the day of your caesarean section or just prior to your caesarean. This depends on your circumstances and your anaesthetist's routine. The most common anaesthetic is either spinal, epidural or mostly a combination of both. These anaesthetics usually have the advantage of being safer than a general anaesthetic. In addition, they allow you to be awake and aware during the delivery of your baby and for your husband or partner to be with you.

The actual caesarean takes about 30 minutes; 5 minutes to deliver your baby and about 25 minutes to sew up. At delivery, I will hold up your baby and show you what you have! A paediatrician will then examine your baby and then hand the baby back to you and your husband. There is an approximate 20% chance that your baby will need to go to the nursery. The common reason for this is "fluid on the lung". This is due to the fluid not being "squeezed" out of the lungs as in a vaginal delivery. This is a completely benign condition and will get better in a few hours usually.

I am happy for you to drink and even eat a few hours after the surgery if you are well. The next day, the catheter in your bladder will be removed as will the automatic calf compression machine ("Flowtrons"). We like you to "walk around" and mobilise as this reduces the risk of blood clots in your legs. My policy is to keep you in full length leg stockings for a few days. I mostly use 'staples' on the skin. The alternative is a nylon stitch. Both are removed on Day 5.

Discharge is generally on day 5, although this is a little variable. By discharge your pain should be considerably less with only the need for milder pain medication. In addition, you should have picked up, from the midwives, much of the breastfeeding advice you'll need (should this be relevant). After discharge I will generally catch up with you in my rooms at about 6 weeks.

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COMPLICATIONS

As with any operation there is always a small risk of a complication. The combined risk of the serious complications listed below is about two percent. In other words these complications are rare.

These risks are;

1. Infection of a serious nature involving the wound, pelvic region, or inside the womb requiring intravenous antibiotics or surgical drainage.

2. Bleeding requiring a blood transfusion.

3. Organ damage such as injury to the bowel, bladder or ureter ("kidney tubes"). The most important thing is that if one of these injuries occurs, then it is picked up during the caesarean and repaired. In this situation it almost always has no other long term consequences. However, in the event that an injury is not picked then this can be more serious. For example, a bowel injury could lead to bowel leakage which is a very serious complication but also a very rare complication. This would obviously require further surgery.

4. Blood clots: operations are associated with an increased risk of blood clots developing in the legs which could travel to your lungs which is serious and life threatening. However, we minimise this risk by the various measures stated earlier.

In addition, there are a number of other minor complications that can result from surgery. The most common of which is a minor wound infection. This is usually sorted out with just oral antibiotics. The cosmetic appearance of the wound may occasionally be suboptimal. This can either be as a result of infection or keloid scarring. Usually the scarring will improve with time.

Generally, once you have had one caesarean, you are much more likely to have another caesarean section either electively or as an emergency. Certainly, after about three caesarean sections (i.e. the 4th caesarean section), the risk from the operation does increase. Not only is there higher rates of inadvertent organ injury due to scarring but there is also a greater chance of the placenta being scarred and very stuck down to the inside of the womb. Multiple caesarean sections are also associated with the placenta being situated on the lower part of the womb i.e. placenta praevia. This is associated with serious bleeding on occasions. In very rare instances hysterectomy (removal of womb) will need to be performed at the time of a caesarean section.

It must be stressed that many of these outcomes are extremely rare. These risks need to be weighed up against the alternative of not having a caesarean section. In some situations there is literally "no choice". However in other situations a vaginal delivery may be possible.

It is not possible to cover every single complication in this pamphlet. If you have any concerns please discuss these with me.

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