

# Correlation between Cesarean Delivery and Neonatal Morbidity

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**Abstract:** *This study shall include all births concluded in the intensive care unit during 2013-14, carried out at “Mbretëresha Geraldinë” University Hospital Center of Obstetrics and Gynecology, Tirana. The study is retrospective. The number of babies involved is 629, of which 154 (24.5%) were normal deliveries and 475 (75.5%) were C-section ones. According to the results, it is clearly noticed a considerable growth of the number of C-section deliveries which have been transferred at the intensive care unit. The prevalence of serious conditions (problematic diagnosis) is much higher among C-section delivery (44.4%) versus vaginal delivery (18.8 %) and this difference is statistically highly significant. (P<0.001).*

**Keywords:** caesarean section, vaginal delivery, neonatal morbidity.

## 1. Introduction

Caesarean section delivery is defined as delivery of the fetus through incision of abdominal wall (laparotomy) and uterine wall (hysterectomy). This definition does not include the extraction of fetus from the abdominal cavity in case of uterus rupture or in case of an abdominal pregnancy. In some cases and more often as a result of urgent complications like uncontrolled bleeding, abdominal hysterectomy is indicated after birth. In the event that hysterectomy is done after birth by caesarean section, it is called cesarean hysterectomy. If done right after vaginal delivery, it is called postpartum hysterectomy. (Fig 1)



**Figure 1:** Baby born by caesarean section

The origin of the term “caesarean section” is dark and three main possible explanations have been suggested. First, according to the legend, Julius Cesar was born that way and consequently the procedure has become known as caesarean section. However there are some circumstances that do not support the explanation in question. Caesar's mother lived for many years after his birth in 100 BC, while until the 17<sup>th</sup> century this type of surgery was invariably fatal. Secondly, the operation, conducted both in living and dead people, is

not mentioned by any medical document before the Middle Ages.

Caesarean section is the most common surgical procedure used by women in the US (Trimble 2009). The optimal rate of caesarean section recommended by the World Health Organization (WHO) is 10 to 15%, while in the USA since 2010 it is 32.8% (Gibbons 2010) (Fig 2). This number has minimally changed in the recent years, despite the increased awareness about cesarean statistics. Certified professional midwives who take care of women are trying to avoid this high figure of cesarean incisions making women choose themselves natural delivery at hospital. Thus, their chances to undergo a caesarean section have dramatically decreased, although it is impossible to be eliminated.



**Figure 2:** Cesarean Incision

Opinions differ on the benefits of achieving an empowering birth experience. For many women, giving birth is a transforming life event, one that is anticipated for months or even years. Unexpected events can cause postpartum depression or posttraumatic stress disorder ( el Alcorn et al 2010. Allen 1998; Griebenoë 2006; Smith et al 2000).

Evidence shows that the majority of women who have a cesarean have a less-than-satisfactory childbirth experience (Smith, Plaat and his colleagues).

Patient choice for cesarean delivery

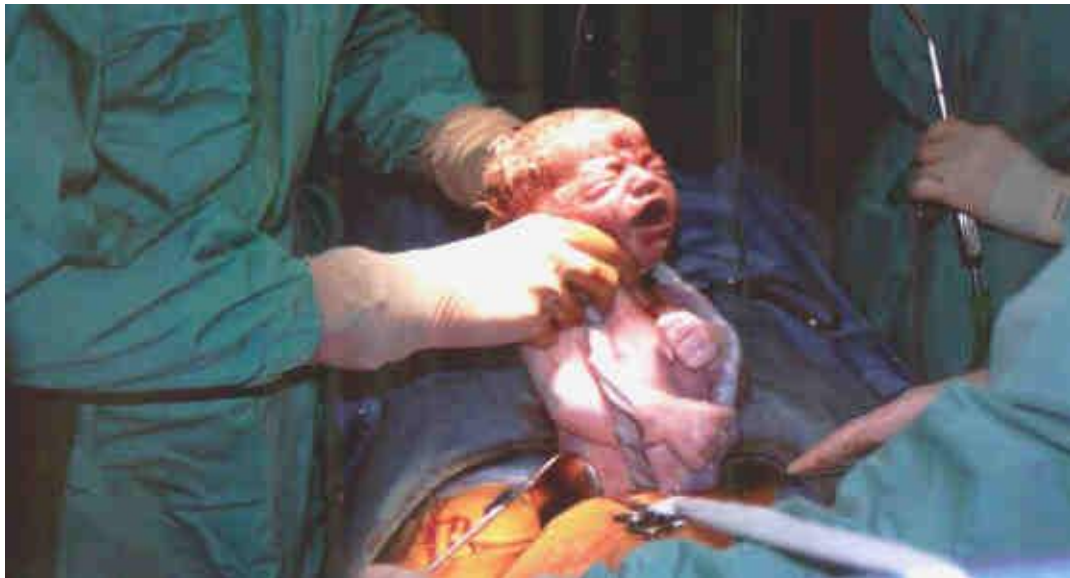


Figure 3: Cutting the umbilical cord

Here are some of the reasons why C-section birth rate has increased. The reasons why the birth rate by cesarean incision quadrupled between 1965 and 1988 and its continued growth is not very clear, but we have provided some explanations as follows:

- 1) Women who wish to have fewer children. In this way, a greater percentage of mothers are nulliparous and it has been observed a growing tendency in them to give birth by caesarean section.
- 2) The average age of pregnant mothers is growing, even at women of not very young age, especially nulliparous; it has been observed a growing tendency to give birth by caesarean section.
- 3) The use of electronic fetal monitoring has increased. This technique is associated with such events as the fall of fetal heartbeat rhythm and its overestimation may be followed by a growth of caesarean section.
- 4) The vast majority is related to abnormal fetal presentation and therefore subject to caesarean section.
- 5) Complaints on malpractice and consequently judicial cases have significantly contributed to the growth of the actual number of births by caesarean section.
- 6) More than a decade ago, it was reported that the failure of birth by caesarean section may lead to neonatal neurological problems or cerebral paralysis. This was the dominant obstetrical demand in the United States (Independent Practice Association, 1992).
- 7) Specifically, in 2001, neonate brain damage was the claim holding responsible the obstetrician-gynecologist in 40% of all forensic indemnity. (Independent Practice Association, 2002).
- 8) Some reasons that enable the choice of cesarean birth are related to the concerns about the damage of pelvis associated with vaginal delivery (Nygaard and Cruikshank, 2003).
- 9) Also caesarean section is usually performed even by a large part of women who willfully choose to undergo

the caesarean section (Harer, 2000). They play a key role in taking this decision, which is about giving birth and receiving obstetric care. The reason of their decision for caesarean section delivery is that in this way they feel safer both for themselves and their baby. Currently it is assumed that the issue is highly controversial.

- 10) The reasons for this choice include avoiding pelvis damage compared to vaginal delivery, risk reduction with regards to the damage of fetus and the comfort (Al - myftiu and colleagues, 1997)

#### Purpose

The purpose of this study is to identify the impact of caesarean section delivery versus vaginal delivery, the risks and benefits, and neonate morbidity.

#### Objectives

- Birth impact by caesarean section in neonatal morbidity.
- Birth impact by caesarean section in increasing the number of hospital days.

## 2. Material and Methods

### Population under study

To achieve the objectives, a retrospective study has been conducted observing and studying the growing number of births by caesarean section in years. Information for the study has been obtained from the patient card database at "Mbretëresha Geraldinë" Obstetric and Gynecological University Hospital, Tirana, which is responsible for all admissions at the institution.

The time period covers the data of births over a 1 year period, 2014. The study started in September 2012 until June 2015. The study included women who came to this institution for the birth procedure and for receiving proper assistance and care.

**Data Collection**

Files of this institution were studied and they include women who had given birth at “Mbretëresha Geraldinë” Obstetric and Gynecological University Hospital. It also included babies transferred at the intensive care unit by mothers who had given caesarean section and vaginal deliveries. Their data included pregnancy age, entry diagnosis, oxygen therapy, duration of stay, method of delivery. The study is a cross-sectional one and its population is patients after giving birth at our hospital. The samples of patients under the study are of non probability nature.

**Statistical Analysis of Data**

The study is of retrospective type, with two components:

- a) **Descriptive:** This component refers to the description and evaluation of the situation and the division by delivery method, clinical classification and babies that show various problems.
- b) **Analytical:** This component refers to the evaluation of the connection (association) of the risk factors related to babies born by caesarean section.

The calculation is based on standard indicator. There are used descriptive statistical methods,  $\chi^2$  tests and Binary Logistic Regression tests. The OR probability ratio is used to assess the association among variables. Point ratings have been associated with 95% confidence interval on the analysis of cards data conducted to meet the proper objectives of our study. Tables and graphs have been used for data visualization. The value of  $p < 0.05$  was considered statistically significant.

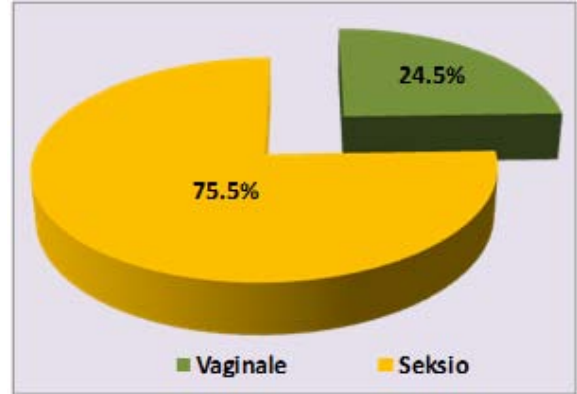
**3. Results**

In our paper it is noticed that in total there are 629 records, of which 154 (24.5%) were normal delivery (vaginal), 475 (75.5%) were caesarean section, as shown in the graph below:

Presented in tab. no. 1 and fig. 3

**Table 1:** The number of neonates depending on the delivery method

		Sexio_Cesarea			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Jo	154	24.5	24.5	24.5
	Po	475	75.5	75.5	100
	Total	629	100	100	



**Figure 3:** Percentage no of the two birth methods

**2. Comparison of average birth weight between the two groups (vaginal delivery vs. caesarean section)**

**During the analysis in study groups of neonate average weight was observed that:**

The average weight at birth is much higher in vaginal births (average value: 2866±730) compared to babies born by caesarean section (average value: 2567±898), and this difference is highly statistically significant ( $P < 0.001$ ), as expressed in the following table (student’s t-test): (tab 2, graph 2)

**Table 2:** Average weight of babies and delivery method

Group Statistics					
	Sexio_Cesarea	N	Mean	Std. Deviation	Std. Error Mean
Pesha_lindjes	Jo	154	2866.17	729.911	58.818
	Po	475	2566.66	897.659	41.187

**Table 2.1:** Comparison of average birth weight between the two groups (vaginal delivery vs. caesarean section)

**Independent Samples Test**

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Pesha_lindjes	Equal variances assumed	8.878	.003	3.757	627	.000	299.506	79.724	142.947	456.064
	Equal variances not assumed			4.171	315.361	.000	299.506	71.805	158.228	440.783

**Analysis of the two groups, vaginal vs. caesarean section, about the duration of hospital stay is comparatively very significant.** Average stay is much higher among caesarean section deliveries (8.0±8.2) compared to vaginal delivery (5.3±3.9) and this difference is highly statistically significant

( $P < 0.001$ ), as expressed in the following table (student’s t-test). This is reflected in Table 4

**Table 4:** Comparison of average stay between the two groups (vaginal delivery vs. caesarean section)

		Group Statistics			
Sexio_Cesarea		N	Mean	Std. Deviation	Std. Error Mean
Dite_qendrimi	Jo	154	5.31	3.938	.317
	Po	475	8.02	8.231	.378

Average stay is much higher among caesarean section delivery (8.0±8.2) compared to vaginal delivery (5.3±3.9) and this difference is highly statistically significant (P<0.001) as expressed in the following table (student's t-test).

**Table 5:** Student's t-test in the calculation of average stay of babies in the intensive care unit

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Dite_qendrimi	Equal variances assumed	27.869	.000	-3.933	627	.000	-2.705	.688	-4.056	-1.355
	Equal variances not assumed			-5.484	542.218	.000	-2.705	.493	-3.674	-1.736

**Comparison of the average pregnancy age between the two groups (vaginal delivery vs. caesarean section)**

section births (37.3±2.6) and this difference is highly statistically significant (P<0.001), as expressed in the following table (student's t-test):

As shown in Table no 6, the average pregnancy age is much higher in vaginal delivery (35.9±3.7) compared to caesarean

**Table 6:** Comparison of the average pregnancy age between the two groups (vaginal delivery vs. caesarean section)

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Mosh_barres	Equal variances assumed	17.147	.000	4.308	627	.000	1.389	.322	.756	2.022
	Equal variances not assumed			5.124	367.359	.000	1.389	.271	.856	1.922

**Comparison of entry diagnosis between the two groups (vaginal delivery vs. caesarean section)**

The prevalence of serious conditions (problematic diagnosis) is much higher among caesarean section delivery (44.4%) compared to vaginal delivery (18.8%) and this difference is highly statistically significant (P<0.001), as expressed in the following table (chi-squared test and/or Fisher's exact test):

**Table 7:** Comparison of entry diagnosis between the two groups (vaginal delivery vs. caesarean section)

		Sexio_Cesarea		Total
		Jo	Po	
Diagnoza	Gjendje jo e rende	125	264	389
		81.2%	55.6%	61.8%
	Gjendje e rende	29	211	240
		18.8%	44.4%	38.2%
Total		154	475	629
		100.0%	100.0%	100.0%

**Chi-Square Tests**

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	32.273 <sup>b</sup>	1	.000		
Continuity Correction <sup>a</sup>	31.198	1	.000		
Likelihood Ratio	34.782	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	32.222	1	.000		
N of Valid Cases	629				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 58.76.

#### 4. Discussions

As seen from the above results, caesarean section delivery involves a greater risk in neonate morbidity compared to vaginal delivery (%). This conclusion is clearly described at (Merc Manual)<sup>[3,5]</sup>

The risk for the presence of various diagnoses, such as neonatal respiratory distress, leads to its treatment in an intensive care unit.<sup>[1,3,5,8]</sup>

Caesarean section delivery increases the duration of hospital stay, and as a consequence there is a longer care and observation from the medical personnel, including here physicians and nurses in podalic presentations where the risk on neonatal morbidity is higher<sup>[1,4,7]</sup>.

Women that undergo caesarean section, despite of its their choice or it is predetermined by the medical staff which is independent from the demographic or clinical data, display twice as much risk for morbidity or death, including (death, hysterectomy, blood transfusion, admission to the intensive therapy<sup>[19,20,21]</sup> and display five times more the risk of postpartum infections than those with vaginal delivery<sup>[1,7,9,15]</sup>.

#### 5. Conclusions

Caesarean section neonates display a higher morbidity, which is a statistically significant value. They have a higher staying period, a lower weight although in accordance with the pregnancy age. Intensive care in this group requires attention from the medical staff

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