age of inductions requiring termination by Caesarean section. The percentage of inductions accompanied by foetal loss is also shown. The indications for induction are also tabulated, and the main indication in 1965 was postmaturity. The second largest group is signified by the word "other". All of these were done for well established indications such as toxaemia, borderline disproportion, etc. The remainder are self explanatory. The enormous numbers done for postmaturity constitute a very disturbing group. These inductions were done in good faith, grounded in the belief that postmaturity has its hazards, and that induction is preferable to inaction. Our inability to detect the condition of the foetus in utero has led to much haphazard intervention, much of which is undoubtedly unnecessary, and possibly even risky for the foetus. Until means of detecting the foetal condition in utero can be successfully applied in clinical practice, this induction pattern is unlikely to change.

There was one maternal death associated with Table 28, Case No. 70714, details of which are reported under Maternal Mortality Page 46. Induction of labour was carried out in order to expedite delivery and to relieve pain arising from a massive and inoperable tumour of the liver. This was metastatic in origin and the primary growth was not ascertained. The maternal death was not related to the obstetrical management in this case.

Case No. 72530 was associated with rupture of the old section scar following induction by P.O.M. and syntocinon drip. The drip was started shortly after puncture of the membranes, and 4 hours after it had been started, the patient was having strong contractions. Marked tenderness was detected over the site of the former section incision, and the foetal heart was noted to be very slow. Immediate laparotomy was performed, and incomplete rupture of the uterus involving a 2 inch dehiscence of the old scar was discovered. The baby was alive and thrived, and the uterine scar was repaired in two layers.

CAESAREAN SECTION (R.C.G.O. TABLE 29)

THE MASTER and DR. IAN J. DALRYMPLE

Summary:

(a) Total number of cases ... ... ... ... 376 \ Booked = 304
\ Unbooked = 72
Incidence against total deliveries 28 weeks maturity and over (3,272) ... ... ... ... 7.1 per cent.
(b) Maternal mortality ... ... ... ... Nil
(c) Gross foetal loss ... ... ... ... 21 \ 1st week NND's = 13
\ Late NND's = 2
Perinatal mortality rate ... ... ... ... 50
(d) Multiple pregnancies ... ... ... ... 4 sets of twins
(e) Primary Caesarean sections ... ... ... ... 265 \ L.S.S. = 261
\ Classical = 4
(f) Repeat Caesarean sections ... ... ... ... 111 \ L.S.S. = 110
\ Classical = 1
## Indications for Caesarean Sections:

<table>
<thead>
<tr>
<th>Primary operations:</th>
<th>Total</th>
<th>D/B.</th>
<th>NND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foetal distress</td>
<td>55</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Placenta praevia</td>
<td>35</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Transverse/oblique lie</td>
<td>28</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Disproportion</td>
<td>26</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Obstetrical history and other factors</td>
<td>25</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Prolapse/presentation of cord</td>
<td>22</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Accidental haemorrhage</td>
<td>19</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Eclampsia/toxaemia</td>
<td>19</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Breech and other factors</td>
<td>15</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Inertia/prolonged labour</td>
<td>14</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rhesus incompatibility</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Previous repair operation</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Diabetes/toxaemia</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**TOTALS** | 265 | 5 | 12 |

<table>
<thead>
<tr>
<th>Repeat operations:</th>
<th>Total</th>
<th>D/B.</th>
<th>NND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disproportion</td>
<td>65</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Obstetrical history and other factors</td>
<td>10</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transverse/oblique lie in labour</td>
<td>8</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Foetal distress</td>
<td>8</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Failed induction</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Placenta praevia</td>
<td>4</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Toxaemia</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Nephrotic syndrome</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prolapsed cord</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rhesus incompatibility</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>? rupture of old scar</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**TOTALS** | 111 | 1 | 3 |

## Foetal loss associated with Caesarean section delivery:

**Deadborn = 6**

<table>
<thead>
<tr>
<th>Causes of death</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ruptured uterus</td>
<td>1</td>
</tr>
<tr>
<td>Prolapsed cord and A.P.H.</td>
<td>1</td>
</tr>
<tr>
<td>Rh. antibodies—hydrops foetalis</td>
<td>1</td>
</tr>
<tr>
<td>Prolapsed hand and cord</td>
<td>1</td>
</tr>
<tr>
<td>Presentation of cord. Sub-pleural and sub-pericardial petechiae</td>
<td>1</td>
</tr>
<tr>
<td>No F/H. on admission—macerated</td>
<td>1</td>
</tr>
</tbody>
</table>

## Comment

There were 6 stillbirths associated with Caesarean section which are summarised below. Avoidable factors were thought to be present in 3 instances.

1. Case No. 70024. This patient was a primigravida who was admitted with antepartum haemorrhage and severe pre-eclamptic toxaemia at 35 weeks gestation. She remained 4 weeks in hospital, and at 39 weeks gestation an unsuccessful attempt was made to induce labour by medicinal means. This was repeated on 2 occasions. This was followed by surgical induction which was successful. Foetal distress however developed after 14 hours labour when the cervix was 2 fingers dilated. It was therefore decided to perform Caesarean section. At operation a cord presentation was incidentally discovered. The foetus was dead on delivery. Earlier elective Caesarean section might have resulted in a living child. Insufficient note was taken of early signs of foetal distress as gauged by a rapid foetal heart rate.

2. Case No. 71776. Severe antepartum haemorrhage developed at 28 weeks gestation in a patient with severe haemolytic disease and an intrauterine death. The haemorrhage