

od sampling (FBS). FBS can reduce operative intervention but it requires additional expertise, is dependant on appropriate interpretation of CTG patterns, is time consuming and give only intermittent information and thereby it is not widely used.

The second is represented by pulse oximetry. This procedure allow the continuous evaluation of fetal O<sub>2</sub> saturation and can help in differentiating abnormal CTG patterns. Recent clinical studies have shown a reduction of 50% in the rate of caesarean section for suspected fetal distress. However the current literature holds somewhat diverging views on the information available from fetal pulse oximetry during labour in particular regarding the ability of CTG + pulse oximetry to provide diagnostic capacity on fetal metabolic acidosis.

The third is focused on evaluation of function of a high priority organ like the heart, based on the analysis of the ST waveform of the fetal electrocardiogram. ST waveform elevation reflects compensated myocardial stress and a switch to anaerobic metabolism. Persistent biphasic or negative waveform changes indicate myocardial decompensation as a result of direct myocardial ischemic hypoxia. Extensive experimental work indicate that analysis of changes in ST waveform provide continuous information on metabolic events occurring within myocardial cells which allow cardiac function to be maintained during hypoxia. This information is available from the same source from which we obtain the fetal heart rate. Large clinical studies have shown that ST analysis of the fetal ECG provide useful information on fetal reaction to labour and can safely reduce the number of obstetric operative intervention with a parallel improvement in fetal outcome.

Improvement of intrapartum fetal monitoring however require also the capacity of making the appropriate use of the information available.

## L23

### **ELECTIVE CESAREAN SECTION: IS IT ABUSED?**

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Cesarean section (CS) still remains the most common operation, being performed in the world. Although The World Health Organization suggested a limit of 15% for cesarean section rate, it has grown markedly in recent years. In Turkey, there are not healthy records regarding the rate of caesarean section but as far as we know in private hospitals it reaches 90%.

The reasons for this unacceptable rate are not understood exactly. Advanced maternal age, widely use of electronic fetal monitoring, breech presentation, concern for malpractice litigation, socioeconomic/cultural factors and "maternal request" might be the possible reasons.

In this presentation, the aspects of cesarean section mainly performed by maternal request and the following questions will be discussed.

What is the exact reason for a physician to perform CS in the case of advanced maternal age, poor obstetric history, infertility history, or a history of ovulation induction/ART?

Does CS really carry more morbidity than vaginal delivery? Or

Is it safer for the fetus/mother?

Is it more comfortable than a vaginal delivery?

Is CS cause less complications than vaginal delivery concerning pelvic floor disorders, stress incontinence and sexual disorders?

Who makes the decision to made CS? The physician? The patient? Or both of them?

Has the woman have a right to chose the mode of delivery? Is it a human right or not?

Should physicians perform an elective CS on request?

## L25

**THE MISGAV LADACH METHOD – METHOD OF CHOICE OF CESAREAN SECTION FOR DEVELOPING COUNTRIES**

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**Introduction**

Among obstetric techniques, cesarean section seemed to represent a well-defined procedures and significant advances in this intervention were considered to be unlikely. But during the last time obstetric surgery has undergone many improvements. In the 1970s Joel-Cohen presented a new method for opening the abdomen [1] This method is the result of critical assessment of each surgical step.

It is performed by a superfital transverse cut in the cutis, two to three cm below the line between the anterior and superior spinae illiacae; deepening the cut in midline with a scalpel to expose the fascia; dissecting fascia laterally below the fat tissue with scissors; then manual bilateral traction of the recti muscles and the subcutis at the same time. The parietal peritoneum is opened manual transversaly to avoid damage of the bladder. After the delivery, the abdomen is closed by a continuous suture of the fascia, and few, widely spaced stitches in the scin.

One of the most important step is the leaving non-sutured visceral and parietal peritoneum. Namely, peritoneal repair of surgical defects occurs simultaneously in multiple sites by migration of mesothelial cells into supportive matrix. Reestablishment of the peritoneal layer is observed within 72 h of surgery and complete repair occurs within 1 week where the peritoneum is leaving unsutured because of avoid ischaemia, necrosis, foreign body reaction [6]. In the case of sutured peritoneum normal fibrinolytic activity is suppressed under ischaemic conditions. Fibrin that is not resorbed becomes stabilised, infiltrated by fibroblasts, and ultimately organised into permanent adhesions [7]

Advantages of this metod are: less ferquency of fever and urinary tract infection as well as the administration of therapeutic antibiotics and narcotics, mean time to positive auscultation of bowel sounds, shorter maternal hospital stay and avoiding postoperative adhesion formation [5].

## L26

**DELIVERY CONSIDERATIONS OF MULTIPLE PREGNANCY**

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The overall incidence of spontaneous multiple gestations is approximately 1-2 %. About 95 % of multiple pregnancies are twin pregnancies. Multiple pregnancies are coming increasingly common after ART. This is true for especially for triplets and higher order pregnancies where antepartum and intrapartum complications are much more higher.

Approximately half of twins and 90 % of triplets have low birthweight and they are more likely to have complications immediately or later on.

Labour and delivery management is very important in multifetal pregnancies, because complication of labour and delivery such as preterm labour, uterine disfunction, abnormal presentations, and uterine laceration and atonia is much more common than sigleton pregnancies.

Special precautions and arrangements and close monitoring must be considered when delivery of two or more fetusus is expected.