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# THE MISGAV LADACH LOWER SEGMENT: CAESAREAN SECTION: EXPERIENCE AT A TERTIARY HOSPITAL

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## INTRODUCTION

Lower segment caesarean section is most frequently performed surgery by obstetricians today. From the days of julius cesar, there have been countless efforts to improve the technique. One such innovative breakthrough technique is Misgav Ladach method of LSCS. Originally developed in the Misgav Ladach hospital, Israel, devised by Dr Michael stark has minimalist approach as compared to conventional method of caesarean section. Various studies conducted across the globe have shown that the technique of properly used could change the way LSCS being performed.

## MATERIALS AND METHODS

Retrospective analysis of 100 cases of primary LSCS done at KIMS Hubli chosen for the study.

The patients were divided into 2 groups. The 1st group composed the study group for 50 patients. This category included the patients who had undergone Misgav Ladach lower segment caesarean section with:

1. Joel cohens incision
2. Minimum use of instruments
3. Manual separations of layers of abdomen and uterus
4. Single layer uterine closure
5. Non closure of visceral and parietal peritoneal layers
6. Closure of abdomen with minimal mattress suture.

The control group included 50 patients who had undergone conventional method of caesarean section with

1. Pfannenstiel incision
2. Use of instruments/sharp dissection
3. Double layer uterine closure
4. Abdominal wall closure in layers.

Type of anaesthesia was decided by anaesthetist. Post operatively broad spectrum antibiotics and analgesics and i v fluids were administered.

During hospitalization following parameters were carefully assessed

1. Mean operating time (from incision to skin closure)
2. Post operative pain (subjective)
3. Febrile morbidity
4. Wound behaviour:

A: Indurations
B: Approximation
C: Wound discharge
D: keliod formation

5. Blood loss.

## RESULTS

**Table 1**

**Indications**

| Sl.no | | Study group(n=50) | Control group (n=50) |
|---|---|---|---|
| 1 | Fetal distress | 60% | 65% |
| 2 | CPD | 20% | 15% |
| 3 | Vb presentation | 05% | 03% |
| 4 | BOH | 05% | 04% |
| 5 | Failed induction | 04% | 06% |
| 6 | APH | 02% | 03% |
| 7 | Cord prolapsed | 02% | 03% |
| 8 | Twins | 02% | 01% |

Table 1: shows various indications for performance of LSCS. Main was fetal distress. Others were CPD, BOH etc.

**Table 2**
**Operating time**

| Sl.no | Group | Study | Control |
|---|---|---|---|
| 1 | Duration | 18-25 min | 35-50 min |
| 2 | Mean | 20 min | 43min |

The duration of surgery was almost half of the control group this led to reduced duration of anaesthesia. Baby delivery from the time of skin incision was 50 sec -2min, faster than study group. This proves valuable in cord proalpse, fetal distress where time is essence.

**Table 3**
**Wound behaviour**

| Sl.no | | Study | Control |
|---|---|---|---|
| 1 | Induration | 10 % | 15% |
| 2 | Pain | 35% | 40% |
| 3 | Febrile morbidity | 7% | 8% |
| 4 | Wound dehiscence | - | 2% |
| 5 | Discharge/sepsis | 7% | 14% |
| 6 | Keloid formation | - | 1% |
| 7 | Visceral injury | Nil | Nil |

Patients in control group showed a slight increase in pain, wound induration, discharge and keloid formation**.**

## DISCUSSION

1. Abdomen can be opened with blunt dissection reducing the vessel injury and blood loss.
2. Peritoneum heals by 24-48 hrs by transmigration of mesothelium. Study have revealed reduced need of post operative analgesia and quicker return of bowel function, when both parietal and visceral peritoneum left unsutured which is unnecessary step(1&2).
3. Rectus muscle need not be separated as in pfannenstiel incision.
4. Placenta removed manually after extraction of the baby and i.v. Methergine injection given which shortens the third stage.
5. Single layer of uterine closure with no.1 /2chrome catgut or no.1 vicryl which reduces the suture material used.
6. Giving less used number of suture for the skin.

However the technique has its own limitations. Generally not recommended for obese women, previous LSCS/scar on abdomen, obstructed labour, and hand prolapse.

In our study, we found Misgav Ladach technique to be advantageous with reduced operative time. Anaesthasia, suture material, tissue handling, blood loss, hospital stay, post operative adhesions and morbidity. There was better wound healing and less post operative pain.

## CONCLUSION

Our study showed the Misgav Ladach technique is the faster and minimalist approach offers promising results. The technique is easy to learn and perform. After carefull selection, it is safe method in practice of modern obstetrics.

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