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Letter to the Editor

Morbid Obesity and Caesarean in a Low Resource Setting

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Dear Editor,

Drastically rising prevalence of obesity across each and every countries, nations, age groups and ethnicities has become a major health problem in the whole world. Doubling the prevalence of morbid obesity (BMI>40kg/m^2) between 2000 to 2005 highlights the gravity of the issue while 8% of women in reproductive age being morbid obese further enumerate the developing challenge to Obstetricians, especially when they need caesarean delivery[1]. Because caesarean rate among morbid obese women is high (47%) compare to normal women (20%)[2]. Emergency caesarean rate is 42-50% among them compare to normal women[3]. Other than antenatal complications, morbid obesity generates surgical, anesthetic and logistic challenges when they require caesarean delivery. The problem becomes worse when dealing in a low resource setting.

In order to overcome these problems, all obstetrics unit should maintain their own protocol to handle such patients which should start from the booking visit of a morbid obese woman. These units should have a mobile bed which can accommodate the weight of the patients and transport the patient to the theater. Bed should be placed closer to the wash rooms which have supporting accessory fittings to aid these women.

Assessment of the woman by a Consultant Anesthetist during antenatal period and before the surgery is very important and they should maintain their own policy regarding handling morbid obese women during caesarean delivery. Operating table should be stronger enough to tolerate the weight and maintain the left lateral tilt during the surgery. Using a spinal board will facilitate the shifting the woman to the table and taking back to the bed. Having a theater in the labour suit and closer to the antenatal ward will further reduce the logistical problems. Larger blood pressure cuffs should be available for intra operative monitoring. Even though combined spinal epidural analgesia is the first choice in these women, usage has limited due to unavailability of longer needles and trained personals. Hydrating the woman, applying anti embolic stockings and early post-operative mobilizing with optimum analgesia and pharmacological thrombo-prophylaxis will reduce the risk of deep vein thrombosis.

Women and her partner should have a proper counselling session regarding the all possible complications which might help to prevents conflicts between health care provider and the patients.

Patient should have a bath before the surgery with adequate cleaning on the incision site. Low transverse incision below the panniculus would be the best incision even though it has its own demerits. Cephalad retraction of the panniculus should be done with care as it may increase the intra-abdominal pressure. This can be easily done in a low resource setting by applying Little wood's tissue forceps to the panniculus and retract with the usage of sterile bandage over the operative bed rail. Surgery should be done by the experience most person available. Insertion of post-partum intrauterine contraceptive device at the time of surgery can be done after proper pre-operative counselling. Subcutaneous fat layer should be sutured to prevent serous fluid accumulation and subsequent wound infections. Even though controversial, application of subcutaneous closed suction drain can be considered with the use of feeding tube and a syringe. Using interrupted sutures with a monofilament material like Nylon to skin closure can be considered in a low resource setting.

Early mobilization with adequate analgesics, early removal of catheters and cannulas, usage of antibiotics and proper wound care should be done to improve the final outcome of the surgery. Proper plan should be implemented regarding post-operative weight reduction and contraception.

In conclusion, caesarean delivery in a morbid obese woman in a low resource setting is a growing challenge in Obstetrics which need proper management under strict management protocols to minimize the maternal morbidity and mortality.

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