ASSOCIATION OF APGAR SCORE WITH DELIVERY MODE IN THE NON DISTRESS NEWBORNS

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ABSTRACT

The Apgar score is the most commonly used measure of newborn infant well-being. Infants of women with caesarean section were at increased risk of low Apgar score and/or perinatal death. The aim of study was to determine the impact of the cesarean section on Apgar score. This is a case-control study, which compared 100 Elective Cesarean Section (ECS) cases, with 199 uncomplicated Normal Vaginal Deliveries (NVD). All newborns were product of first or second pregnancy and they are full term and singleton babies. Apgar score in the minute 5 was measured in both groups. The descriptive and analytical statistics (X² and T test) were used. Average of fifth Apgar score was 8.63±0.79 in NVD group and was 8.79±0.94 in ECS group, that there was no significant difference. About 76.5% of the NVD neonates in minute 5 had Apgar scores of 9 and 10. While in cesarean group, 59% of the neonates in minute 5 had Apgar scores of 9 and 10. There was no significant difference between minute five Apgar scores of the two groups. Therefore it is not acceptable that with ECS baby will have worse Apgar score.

Keywords: Apgar Score, Newborn, Cesarean, Delivery

1. INTRODUCTION

Newborn infants should assess immediately after delivery. The Apgar score is a simple and effective method for assessing of the neonatal health in the immediate period after birth (Apgar et al., 1958; Papile, 2001). The Apgar score includes five components: Appearance, pulse, grimace, activity and respiration, each of the five clinical findings is assessed a value of 0 to 2. This score is the sum of the five components (Apgar et al., 1958). A low 5 min Apgar score is a valid predictor of neonatal mortality, neurologic disability, central auditory impairment and lower intelligence quotient (Nelson and Ellenberg, 1981; Drage et al., 1964; Odd et al., 2008a; Moster et al., 2001; Lee et al., 2010; Jiang and Wilkinson, 2006; AAP, 2006). Also Casey et al. (2001) reported that the mortality risk was very higher for newborn with score ≤3 than newborn with score ≥7. Previous works showed that many factors such as social class, educational level, social factors, maternal diseases, fetal factors and others affected on newborn Apgar scores (Hemminki et al., 1990; Kalland et al., 2006; Odd et al., 2008b). Also, Suka et al. (2002) suggested that the preeclampsia was more frequently associated to low Apgar score.

Vaginal delivery causes lung clearance from secretions and fluids with pressure on neonate chest. This phenomena help to neonate for better respiration. Cesarean section is an alternative method of delivery in conditions that threatened fetal and maternal life (Levine et al., 2001; Zanardo et al., 2004; Villar et al., 2007; Robson, 2001). But today, some mothers select cesarean section for fear of vaginal delivery pain and offspring protection. Drugs used for anesthesia during cesarean section can decrease uterine and placental
circulation then it causes fetal hypoxemia (Miller et al., 2000). Near 32% of infants born by cesarean section during 2008 in Jahrom (Rahmanian et al., 2011), especially due to previous cesarean section (35%). Some of studies showed that the mean Apgar score of 5 min in vaginally delivered newborn was higher than in those delivered by cesarean section (Rafati et al., 2006; Garzoli et al., 2007). Also, in a study conducted by Carlsson-Wallin et al. (2010) infants of women with one previous cesarean section were at increased risk of low Apgar score compared with infants of women with one previous vaginal delivery (Carlsson-Wallin et al., 2010). But other researchers suggested that Apgar score was not associated to mode of delivery (Ziae and Fallah, 2008; Kalos et al., 2006; Kilsztajn et al., 2007; Burt et al., 1988; Islami and Fallah, 2008).

According to opposite results of these investigations, the aim of this study was to assess the relation of Apgar score at 5 min and delivery mode in elective cesarean section and normal vaginal delivery.

2. MATERIALS AND METHODS

The fifth minute Apgar score recorded on the birth documentation was used as a measure of infant health at birth. A case-control study of Apgar score was conducted in all full term (gestational age 37 weeks or higher) and singleton deliveries between March 21, 2008 and March 20, 2009 at two hospitals, which has situated in Jahrom, southern of Iran. We reviewed one year delivery records and record first and second uncomplicated deliveries. Among them, there were 100 cases of elective cesarean section (case group). For each of the cases, two newborns that delivered vaginally were randomly selected as control group. Data has been collected through a questionnaire included delivery route, 5 min Apgar score, birth weight, sex of neonate, gestational age at delivery, gravid, medical complications (hypertension, diabetes, asthma, cardiac disease, renal disease) and instrumental use at delivery. Apgar score divided to three groups, 5-6, 7-8 and score 9-10. Also birth weight divided to two groups, normal birth weight (≥2500 gm) and low birth weight (<2500 gm). Exclusion criteria included any medical complications of mother during pregnancy and delivery, fetal distress and disease and use of instrument for delivery.

The data recorded by SPSS, version 11.5. The qualitative variables analyzed by descriptive and quantitative variables analyzed by mean±standard deviation. For relation of Apgar score with qualitative and quantitative variables used chi square, independent t-test and logistic regression. The p<0.05 considered as significant.

3. RESULTS

Of among newborns in control group, 48.7% were boys, compared to 46% of the newborns in case group (Table 1). About 95% of participants had normal birth weight in both studied groups.

According to Table 1, the mean Apgar score was no significant difference in both case and control groups (8.79±0.94 Vs. 8.63±0.79; p = 0.12). One hundred fifty two infants (76.4%) in the NVD group had Apgar score ≥9 at 5 min after birth and 59 (59.0%) infants had Apgar score ≥9 at 5 min after birth in the ECS group that was different statistically (p = 0.001). Although, birth weight was 67 gm higher in control group than in case group but there was no significant difference (p = 0.236).

<table>
<thead>
<tr>
<th>Variable</th>
<th>NVD (n = 199)</th>
<th>ECS (n = 100)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Boy</td>
<td>97.00</td>
<td>48.70</td>
<td>46.00</td>
</tr>
<tr>
<td>girl</td>
<td>102.00</td>
<td>51.30</td>
<td>54.00</td>
</tr>
<tr>
<td>Birth weight group (gram)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥2500</td>
<td>190.00</td>
<td>95.50</td>
<td>95.00</td>
</tr>
<tr>
<td>&lt;2500</td>
<td>9.00</td>
<td>4.50</td>
<td>5.00</td>
</tr>
<tr>
<td>Apgar score group, 5 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-6</td>
<td>8.00</td>
<td>4.00</td>
<td>2.00</td>
</tr>
<tr>
<td>7-8</td>
<td>39.00</td>
<td>19.60</td>
<td>39.00</td>
</tr>
<tr>
<td>9-10</td>
<td>152.00</td>
<td>76.40</td>
<td>59.00</td>
</tr>
<tr>
<td>Quantitative</td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Apgar score, 5 min</td>
<td>8.63</td>
<td>0.79</td>
<td>8.79</td>
</tr>
<tr>
<td>Birth weight; gram</td>
<td>3219.00</td>
<td>448.60</td>
<td>3152.00</td>
</tr>
</tbody>
</table>

Abbreviations: Elective Cesarean Section (ECS); Normal Vaginal Delivery (NVD)
Table 2 showed the relations of studied variables between the both case and control groups with logistic regression. There were no significant differences between Apgar score and delivery modes with sex and birth weight. Elective cesarean section increased about 1.55 fold risk of Apgar score 7-8 than Apgar score of 9-10 (p = 0.001).

4. DISCUSSION

Apgar score has been used to evaluate of newborn condition. The low Apgar score indicates the adverse state of newborn. The cesarean section seems affect and reduces the Apgar score during 5 min of life. Our result showed increased risk of Apgar 7-8 in ECS group in compare to no significant difference between the mean Apgar scores in newborns delivered by normal vaginal delivery (control group) and by elective cesarean section (case group). This result reported by Kalos et al. (2006); Burt et al. (1988); Kilsztajn et al. (2007) and Eberle et al. (2006) that delivery mode don’t affect on Apgar score. Also in Iran, Islami and Fallah (2008) and Sabzi et al. (2006) reported that Apgar score was no related to delivery modes. But other investigators reported that there was a relation between Apgar score and delivery modes (Garzoli et al., 2007; Murphy et al., 1984). In Iran, Rafati et al. (2006) reported that Apgar score was higher in neonates delivered vaginally than in neonates delivered by other modes. Also, Kaveh et al. (2004) suggested that acidemia associated to delivery modes and to Apgar score. Rafati et al. (2006) and Ratcliffe and Evan (1993) suggested that neonatal Apgar score in cesarean section by spinal anesthesia is higher than in the general anesthesia. The different result in studies may be due to type of study, selected infants, type of anesthesia and duration of surgery.

Our study showed that the mean Apgar score was no difference in two studied groups by gender. Also, Islami and Fallah (2008) suggested that Apgar score was no related to gender. But Kaveh et al. (2004) and Nagy et al. (2009) reported a significant relation between Apgar score and gender.

Our study had some limitations as following:

Some pregnant women maybe in early stage of disease that it can’t diagnose but it can affect on fetus. Another was that we used medical records. We don’t control for duration of labor.

5. CONCLUSION

It was not found any significantly different between the mean Apgar score at 5 min in infants after birth in women who underwent an elective cesarean section compared with those who delivered vaginally.

6. ACKNOWLEDGEMENT

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7. REFERENCES


