UNPLANNED VAGINAL BIRTH AFTER TWO PREVIOUS CESAREAN SECTION. THE CASE OF A BOOKED PATIENT.

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ABSTRACT

Caesarean Section is one of the most common operative procedures in Obstetrics. It is carried out for the benefit of both mother and baby. Most Obstetricians will permit vaginal birth after a previous Caesarean section.

We report the case of a 33-year old teacher, Gavida 3 Para 2^{+0}, both alive with two previous Caesarean Sections came in active phase of labor at term. She had an unplanned successful vaginal birth.

This case highlights the fact that vaginal delivery is possible after two previous Caesarean Sections if a careful selection of the patient is made.

INTRODUCTION

Uterine rupture is a catastrophic obstetric complication associated with a previous Caesarean section scar. However, a vaginal birth after a Cesarean section is considered safe in carefully selected population of women.[1]

Several studies suggest that vaginal birth after cesarean section is a safe and well accepted procedure in patients with two or more prior Cesarean Sections without any contraindication[2,3].

CASE REPORT

Mrs. O. C. was a 33-year old school teacher, Gravida3 para 2^{+0} both alive. She presented with labor pains at 37 weeks gestation. She booked her index pregnancy at a gestational age of 20 weeks and her general condition was satisfactory. Her antenatal care was uneventful. She had a total of six antenatal visits and had been planned for elective cesarean section at term.

Her first and second confinements in 2003 and 2005 were by lower segment cesarean section. The indication for surgery in 2003 was major degree placenta praevia and the baby, a female weighed 3.2kg. The post-operative period was uneventful and she was discharged home on the 5th day after surgery. In 2005, she had an elective cesarean section due to breech presentation and previous cesarean section and the baby, a male weighed 3.4kg. There was no post-operative complication and she was discharged on the 6th day after surgery. Both babies are alive and well.

On examination, she was healthy–looking, not pale and her vital signs were normal. Her respiratory and cardiovascular systems were also normal. The abdominal examination revealed she was having strong uterine contractions of 3 in 10 minutes each lasting 40seconds. There was a well -healed scar, fundal height was term, with a singleton fetus in longitudinal lie and cephalic presentation. The descent of the head was 2/5 palpable per abdomen. The fetal heart beat was heard and regular with a rate of 140 beats per minute.

The vulva and vagina were normal and there was no bleeding. The cervix was anterior, soft, 80% effaced and the cervical os was about 8cm dilated.

An intact membrane which ruptured in the course of vaginal examination with clear liquor was found. There was no cord prolapse, caput succedenum or molding. The presenting part was vertex at zero station.

She was booked for an emergency Cesarean Section after blood samples had been taken for investigations and grouping and cross matching of a pint of blood. She was rehydrated with intravenous fluids and informed consent obtained.

While preparations were going on for the surgery, she had the urge to bear down. She was examined and found to be in second stage of labor. She was taken to the second stage room and delivered of a live male baby weighing 2.8kg with an Apgar score of 7 and 9 in 1 and 5 minutes respectively. The estimated blood loss was 350mls. The abdomen was soft and the uterus was well contracted with no evidence of hemorrhage. Her vital signs were monitored for about one hour and were within normal limits. The baby did not require any special management but was breast -fed until discharged after 48hours of observation by the

Pediatrician in the hospital. She was seen at the postnatal clinic six weeks postpartum and referred to the family planning clinic for counseling on contraception.

DISCUSSION

The fear that the scarred uterus may rupture after a previous classical cesarean section led to the dictum by Craigin, ''once a caesarean section, always a caesarean section[4]''. Today a lot of reports show that vaginal delivery is possible after a previous Cesarean Section with good maternal and fetal outcome[5,6]. While ''once a caesarean section, always a cesarean'' may not stand true any more , twice a Cesarean Section always a caesarean section still stands because of high maternal and fetal complications following vaginal birth[7].

The criteria for selecting patients for trial of vaginal delivery after two previous cesarean sections will include non-recurrent indication for the previous cesarean Sections and well-healed scar assessed ultrasonographically where readily available or clinically. Others are the exclusion of cephalopelvic disproportion and more importantly the readiness to carry out an emergency cesarean section at short notice. Though Mrs. O. C had 2 previous cesarean sections; the third delivery would normally have been by elective cesarean section following our management protocol of ''twice a cesarean Section always an elective cesarean Section''. This patient presented late in labor and progressed rapidly to full dilatation and eventually had a normal delivery before arrangements could be concluded for emergency cesarean section. This is not unusual in this environment especially among unbooked patients[8] and defaulters who would have been booked for elective cesarean section.

For term pregnancies it is now a reasonable option to try labor in carefully selected patients after two previous cesarean sections[9.10], particularly where facilities and personnel are available to do emergency cesarean section within thirty minutes of taking such a decision.

This becomes relevant in our environment because it will encourage them to have hospital-supervised delivery and reduce cases of uterine rupture with the associated maternal/perinatal morbidity and/ or mortality. This occurs when such deliveries are unsupervised in spiritual homes, traditional birth attendants' place and poorly equipped private hospitals that lack facilities and personnel for abdominal delivery.

REFERENCES

1. **Mastrobattista JM**. Vaginal birth after Caesarean delivery. *Obstet.Gynaecol. Clin North Am* 1999; 26; 295-304

2. **Wang PH, Yuan CC, Chao HT, Yang MJ, Ng HT**. Posterior wall rupture during labour. *Hun Reprod* 2000; 15(5); 1198 -1199,

3. **Shimonovitz S, Botosneano A, Hochner–Ceinitkier D**. Successful first vaginal birth after Caesarean Section; a predictor of reduced risk for uterine rupture in subsequent deliveries *Isr. Med .Assoc. J* 2000 2(7); 526-528

4. **Craigin EB**. Conservatism in Obstetric *NY Med J* 1916; 104; 1-3

5. **Okpere EE, Oronsaye AU**. Pregnancy and delivery after Caesarean Section *Trop J Obstet Gynaecol* 1982; 1, 45 -48

6. **Brody CZ, Kosasa TS, Nakaryama RT, Hale RW**. Vaginal birth after Caesarean Section in Hawaii. Experience in Kapiolani Medical

centre for women and Children. *Honolulu Hawaii Med J* 1993; 52(2); 38 -42.

7. **Jamelle RN**. Outcome of unplanned Vaginal deliveries after two previous Caesarean Section *J. Obstet. Gynaecol Res* 1996; 22(5); 431-436.

8. **Uzoigwe SA, Ogu RN**. Unplanned Vaginal Birth After Two Previous Caesarean Sections: The Case Of an Unbooked Patient; *The Nig. Med. Pract.* 2005;48(2);43-44.

9 .**Bautrant E, Bouali L, Nadal F, et al**. Delivery after 2 previous Caesarean Section. A series of 41 uterine trials. *J Gynecol Obstet Biol (Paris)* 1993; 22(5); 543-7

10. **Chattopadhyay SK, Sherbeeni MM, Anokete CC**. Planned Vaginal delivery after two previous Caesarean Section. *Br. J. Obstet Gynaecol* 1995 102(3) 262-3