

International Journal of Clinical Obstetrics and Gynaecology

ISSN (P): 2522-6614
ISSN (E): 2522-6622
© Gynaecology Journal
www.gynaecologyjournal.com
2019; 3(4): 135-136
Received: 03-05-2019
Accepted: 06-06-2019

Dr. Tanya Agrawal
Assistant Professor, Department of
Obstetrician & Gynaecology, Index
Medical College Hospital &
Research Centre, Indore, Madhya
Pradesh, India

Dr. Ishita Ganguly
Consultant Obstetrician &
Gynaecologist and Infertility
Specialist, Department of
Obstetrician & Gynaecology,
Shalby hospital, Indore, Madhya
Pradesh, India

To determine the integrity of scare in all cases of previous cesarean section before VBAC is tried

Dr. Tanya Agrawal and Dr. Ishita Ganguly

DOI: <https://doi.org/10.33545/gynae.2019.v3.i4c.301>

Abstract

Background: A study carried out on 175 cases of VBAC. Record of all patients was retrieved, variables like age, gravidity, parity, indication of previous cesarean section, co-existing condition in the present admission and outcome of pregnancy, interdelivery, period were tabulated for all patients and whether the patient was in labour or not at the time of admission

Result: If scar tenderness is present than trial of labour for VBAC is risky.

In our study 95.46% patient having no scar tenderness and 4.53% patient came with scar tenderness.

Maximum patient had scar thickness >2 mm (94.96%) remaining patient had scar thickness <2mm (5.06)

Conclusion: The incidence of caesarean section as well as VBAC has increased over the years. So, an attempt for VBAC is well justified for the first cesarean pregnancies with non-recurrent indications. Proper selection, appropriate timing and close supervision by a competent staff are the key factors to achieve greater degree of success. [25] This can prevent the postoperative maternal mortality and morbidity.

Keywords: Integrity, Scare, Cesarean & VBAC

Introduction

Vaginal birth after caesarean (VBAC) refers to the practice of delivering a baby vaginally (naturally) after a previous baby has been delivered through caesarean section (surgically). A caesarian section leaves a scar in the wall of the uterus. This scar is weaker than the normal uterine wall, so if the woman goes in labor in a subsequent pregnancy there is a higher than normal risk of a ruptured uterus. Because of this risk an attempt at normal vaginal delivery was for most of the 20th century considered unacceptably risky. This opinion was challenged by many studies showing that many women with previous caesarian sections did have successful vaginal deliveries. [1]

The decision to have a trial of VBAC is made by the mother with the advice of her obstetrician. The decision is guided by an assessment of the known risk factors for complications. In general, an attempt at VBAC is safe if there are no other identified risk factors. [2]

Risks of cesarean section include a higher chance of re-hospitalization after birth, infertility, uterine rupture in the next pregnancy, injury to the baby, premature birth and respiratory problem & ill. The baby, as well as bonding and breastfeeding difficulties. [1] The risk of uterine rupture in a WAC is, 0.2% to 1.5%. Because of the risks involved, many health insurance companies will not support VBAC. Today only about 10% of eligible women in the United States try VBAC. [3]

Material & Method

A retrospective study of two years 2016-2017 carried out on 175 cases of VBAC. Record of all patients was retrieved, variables like age, gravidity, parity, indication of previous cesarean section, co-existing condition in the present admission and outcome of pregnancy, interdelivery, period were tabulated for all patients and whether the patient was in labour or not at the time of admission at People's College of Medical Sciences & Research Centre, Bhopal.

Prospective study of year 2018-2019 done for 200 cases in same way. Those patients who reached in hospital were already in established labour. Carefully examination done, patient prepare for cesarean section. Blood arranged.

Decision taken from higher authority for short trial in active labour.

• Intermittent auscultation of foetal heart every 15 minutes in first stage and every 5 minutes in second stage of labour.

Correspondence
Dr. Ishita Ganguly
Consultant Obstetrician &
Gynaecologist and Infertility
Specialist, Department of
Obstetrician & Gynaecology,
Shalby hospital, Indore, Madhya
Pradesh, India

• Maternal monitoring was done by hourly recording of maternal vital parameters, particularly pulse, blood pressure and urine output.

• A close watch for early recognition of scar dehiscence by identifying maternal tachycardia, vaginal bleeding, scar tenderness and foetal distress.

If uterine contractions were not efficient, intravenous oxytocin infusion was started after artificial rupture of membranes. Parenteral analgesics were administered as epidural was not administered routinely.

All patients undergoing trial of scar were prepared for a possible emergency Cesarean section with grouping and cross-matching.

A strict criteria for assistance of vaginal delivery was not followed but every effort was made to make the second stage as short as possible. [2] Assistance was provided in the form of either episiotomy and / or forceps / vacuum application.

For all procedure 'VBAC drill' makes. Fetal outcome recorded for vitals. Patients kept 4 hours in observation than shift to postnatal ward. Before discharge interview taken from patient of VBAC for its satisfaction.

Results

Table 1: Scar Tenderness

Scar Tenderness	VBAC									
	2016		2017		2018		2019		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Present	2	2.32	4	4.49	8	7.92	3	3.93	17	4.53
Not Present	84	97.67	85	95.50	93	92.07	96	99.96	358	95.46

If scar tenderness is present than trial of labour for VBAC is risky.

In our study 95.46% patient having no scar tenderness and 4.53% patient came with scar tenderness.

Table 2: Scar Thickness

Scar Integrity	VBAC									
	2016		2017		2018		2019		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
>2 mm	82	95.34	83	93.22	96	95.04	95	95.95	356	94.96
<2 mm	4	4.65	6	6.75	5	4.95	4	4.44	19	5.06

Maximum patient had scar thickness >2 mm (94.96%) remaining patient had scar thickness <2mm (5.06)

Discussion

Scar tenderness and scar integrity: If scar tenderness is present than trial of labour for VBAC is risky.

In our study 95.46% patient having no scar tenderness and 4.53% patient came with scar tenderness.

Maximum patient had scar thickness >2 mm (94.96%) remaining patient had scar thickness <2mm (5.06)

Cheung (Toronto). Sonographic measurement of the lower uterine segment thickness in women with previous CS JOG. Vol. 27pp. 674, 2005. [4]

US evaluation of the LUS in 102 patients with one or more PCS. The mean sonographic thickness was 1.8 mm Two women had uterine rupture, both of which had a lower uterine segment of < 1mm.

Successful VBAC rates are higher for those women with non-recurring causes (such as a breech presentation with the first baby, but the favorable head-down position with the second) and those who have previously delivered vaginally. [5, 6]

There are many reasons a woman might choose to deliver a baby vaginally after a cesarean. Some women feel a sense of

accomplishment with a vaginal birth, others have a medical condition which makes a repeat c-section riskier, while others do not want to repeat the lengthy and often painful recovery process associated with a c-section. Cesarean is also considered major surgery and, as such, is not without risks to mother and child, such as hemorrhage, infection and venous thromboembolism, and may place future pregnancies at increased risk for placenta previa, placenta accreta, uterine rupture, and peripartum hysterectomy. In addition, the process of labor and delivery helps prepare your baby for life outside the womb by helping him or her to expel much of the mucus and fluid from his lungs. There is also a decreased incidence of surgery-related fetal injuries (lacerations, broken bones) with a VBAC. [7, 8]

Conclusion

The incidence of caesarean section as well as VBAC has increased over the years. So, an attempt for VBAC is well justified for the first cesarean pregnancies with non-recurrent indications. Proper selection, appropriate timing and close supervision by a competent staff are the key factors to achieve greater degree of success. [25] This can prevent the postoperative maternal mortality and morbidity.

References

1. Meehan FP, Rafla NM. Bolagi II Delivery following previous cesarean section In: Studd J, ed. Prognosis in obstetrics and gynaecology vol 10. Edinburgh: Churchill Livingstone, 1993 pp. 213-28.
2. Mafatlal JS, Mehta MN, Gokhale AV. Vaginal birth after cesarean delivery. Obs & Gynaec Today. 2007; 12:6.
3. Brill Y, Kingdom J, Thomas J, Fraser W, Milne JK, Thomas M, Windrim R. The management of VBAC at term: a survey of Canadian obstetricians. J Obstet Gynecol Can. 2003; 25(4):300-10.
4. Cheung (Toronto) Sonographic measurement of the lower uterine segment thickness in women with previous CS JOG. 2005; 27:674.
5. O'brien-Abel N. Uterine rupture during VBAC trial of labor: risk factors and fetal response. J Midwifery Womens Health. 2003; 48(4):249-57.
6. Crawford (Eglin AFB). How safe is VBAC for the mother and fetus? J fam Pract. 2006; 55:149.
7. Yeh (U at Buffalo). Temporal trends in the rates of trial of labor in low risk pregnancies and their impact on the rates and success of VBAC, AJOG. 2006; 194:144.
8. Ibrahim Ayyad. Vaginal birth after cesarean section. The Middle East Journal of Family Medicine, January. 2006; 4(4):1.