

LABOUR FOLLOWING CAESAREAN SECTION

by

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One of the outstanding features of modern obstetrics is increasing number of caesarean sections as a method of delivery. As caesarean section has become safer with the advent of the lower segment operation with all its advantages, greater number of these women are coming under observation for management of labour after previous caesarean section.

A proportion of these women have to be sectioned in subsequent pregnancies if the indication for the previous section was gross cephalopelvic disproportion or contracted pelvis.

Even if the indication for previous section is a non-recurring one like placenta praevia and the type of previous caesarean section performed was a classical one, a repeat section should be performed in all subsequent pregnancies. On the other hand, if a lower segment caesarean section was performed in a previous pregnancy the great majority are however capable of achieving vaginal delivery if an opportunity is offered.

To support this view 101 cases of previous caesarean section who were allowed to go in labour are reviewed here.

In the William Smellie Memorial Hospital, Scotland, (U.K.), there were 101 women between the year 1969-73 who were allowed to attempt vaginal delivery after previous caesarean section.

The indication of previous caesarean section are given in Table I. The total number of previous caesarean sections was 101, of these, 15 women required repeat caesarean section after giving a trial for vaginal delivery, labour was ultimately terminated by caesarean section either due to foetal distress, maternal distress or scar tenderness. Eighty-six women delivered vaginally.

Type of previous Caesarean Section

Lower segment Caesarean section was performed in 93 patients. The type of Caesarean section performed was not known in 8 patients as these patients were delivered in other hospitals and details given were inadequate to indicate the type of operation performed (Table I).

TABLE I

Indication for Previous Caesarean Section

Fetal distress	29
Prolonged labour	15
Placenta praevia	9
Malpresentation of fetus	6
Incoordinate uterine action	6
Pre-eclampsia	6
Cord Prolapse	4
Intra-uterine Infection	2
Rhesus iso-immunisation (severely affected baby)	3
Failed forceps	3
Failed Induction	1
Cephalopelvic disproportion	2
Placental insufficiency	3
Eclampsia	1
Accidental haemorrhage	2
Unknown	8

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Induction of Labour

It is a routine procedure in the William Smellie Memorial Hospital to induce every case of previous caesarean section, at the 38th week of pregnancy in the hope that the head will be small and soft. As a matter of routine the induction of labour was started in the form of castor oil, bath and enema on the previous evening. The following morning a low rupture of the membranes was performed followed by an intravenous infusion of syntocinon. The syntocinon infusion was started with a low dosage but the concentration was increased or decreased according to the uterine response, irrespective of a scar in the uterus. The strength of syntocinon as high as 32 units in one bottle of 5% Dextrose was infused. The drip rate was regulated from 15 drops per minute to 60 drops per minute.

Surgical induction followed by intravenous infusion of syntocinon was carried out in 64 patients at 38th week of pregnancy. In 37 patients labour commenced spontaneously either at term or before term.

It was supposed that if uterus with previous scar can stand the stress and strain of normal labour then it can stand the contractions induced by syntocinon as well. Surgical induction was performed only with a ripe cervix and fixed head.

The induction delivery interval was shortened by oxytocin drip and the average duration of labour in patients delivered vaginally was 6 hours.

The Method of Delivery is given in Part—II

Vaginal delivery			
Spontaneous vertex delivery	..	82	
Forceps delivery	2	
Breech delivery	2	
Repeat caesarean section	15	
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Total (including 2 sets of twins)	..	103	

Incidence of scar rupture: In this series no rupture of the uterus occurred and no evidence of scar weakness was noticed during repeat section among these patients.

Fetal result: In the present series out of 103 infants there were 4 stillbirths and one neonatal death. Stillbirths were intrauterine deaths. One was associated with twins, 1 with antepartum haemorrhage and prematurity and 2 were associated with Rhesus incompatibility.

Discussion

Brown and McGrath (1965), Donnelly and Frauzoni (1967), Kuah (1970) all consider that carefully selected patients may be allowed to undergo a trial of vaginal delivery after one previous caesarean section.

Jhaveri (1969) allowed 64 patients with previous lower segment caesarean section to go in labour in subsequent pregnancy. Out of 64 patients, 19 had previous caesarean section for recurrent causes out of which only 26 per cent had vaginal delivery, 45 had lower segment caesarean section for non-recurrent indication and 73 per cent delivered vaginally.

McGarry (1969) reported on 334 patients who were allowed vaginal delivery. Non-elective repeat section was required in 27.5 per cent of the cases and vaginal delivery was achieved in 72.5 per cent. One scar ruptured and there was perinatal loss of 11 babies.

Greenhill (1971) performs repeat caesarean section in most of the patients unless the conditions are conducive to vaginal delivery viz. a soft, partially effaced cervix, and a low-lying head.

The incidence of forceps delivery was less than half for the whole hospital.

The perinatal mortality was 48.5 per 1000 births as against 28.9 per 1000 births

for hospital as a whole but among these there were 3 macerated stillbirths.

In conclusion it should be stated that vaginal delivery in patients previously delivered by Caesarean section needs to be justified in each particular instance. Good results, however, depend on careful selection of cases and proper management of labour in a well equipped specialist Obstetric Unit.

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References

1. Browne, A. D. H. and McGrath, J.: J. Obst. & Gynec. Brit. Cwlth. 72: 557, 1965.
2. Donnelly, J. P. and Frauzoni, K. T.: Obst. & Gynec. 29: 871, 1967.
3. Greenhill, J. P.: Year book of Obst. & Gynaecology, 1971, 123.
4. Jhaveri, A. A.: J. Obst. & Gynec. of India, 19: 561, 1969.
5. Kuah (1970): Year book of Obst. & Gynec. 1971, 123.
6. McGarry, J. A.: J. Obst. Gynec. Brit. Cwlth. 76: 137, 1969.