

POST-CAESAREAN PREGNANCY—A STUDY

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SUMMARY

Two hundred and forty-eight patients of post-caesarean pregnancy were selected for trial of labour, after excluding those patients who had caesarean for recurrent causes. Two hundred and forty-one (81%) could be delivered vaginally with no maternal mortality and perinatal mortality within normal range.

Introduction

Until a decade ago, the caesarean section rate used to be around 4-5%. But since in last decade caesarean rate has gone up many folds for indications, which are questionable or invalid at times. It is agreed that with modern operative technique, blood transfusion and antibiotics this route of delivery has become very safe and quick. It also relieves the anxiety of patient's relation and is more comfortable for the obstetrician.

Craigin (1916) suggested a repeat caesarean section should be done prior to onset of labour to avoid the risk of rupture of uterine scar in all post-caesarean pregnancies. Eames (1953) reviewed cases of uterine scar rupture and found 24 percent ruptures occurred before 37 weeks of pregnancy (before an elective repeat caesarean could be done) and 76% after 37 weeks. During trial of labour, incidence of rupture of uterine scar was 2.6%

in classical scar and 1.3% in lower segment scar. Maternal mortality after classical scar rupture was 2.3%, whereas after lower segment scar rupture was 0.0%. Foetal mortality was 72% in the former group and 7% in the later group. He also found that expected maternal mortality in cases given trial of labour where sections were done previously for non-recurrent causes was 0.01% for lower segment scar rupture. Foetal mortality was 1.4% in the former group and 0.7% in later group.

If classical scar ruptures, it is more likely to be complete, whereas lower segment scar rupture may be incomplete, at times only discovered after delivery on a routine exploration of lower uterine segment. The scar most likely to undergo rupture, is the inverted T shaped incision where a weak point exists at the junction of transverse and vertical incision.

Material and Methods

The authors have been following a uniform policy from January 1975 to December 1984 and allowed the trial of

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labour for selected patient of post-caesarean pregnancy.

Patient once reported in early months of pregnancy was booked, history taken to find out the indication of previous caesarean and post-operative recovery. Regular antenatal checkups were carried out and each case was seen by the authors weekly especially after 36 weeks of pregnancy. Pelvis assessment was done around 37-38 weeks to rule out CPD; wherever required, an X-Ray pelvis was taken (True lateral view in standing position). Patients were not selected for trial of labour when two or more sections were done or recurrent cause like cephalopelvic disproportion was present. When patient started labour, one bottle of blood was cross-matched and kept ready, patient was supervised closely and frequently seen by the obstetrician until delivery.

Observations

During this period (1975-1984), 11860 deliveries were conducted, out of which 248 cases of post-caesarean pregnancy were managed by the authors and selected for trial of labour. Two hundred and one (81%) delivered vaginally, while 47 (19%) required repeat caesarean section.

TABLE I

Duration of Labour in Repeat C.S.

Duration of Labour (Duration in hours)	Vaginal	No. of patients repeat (CS)
	%	%
1. 0-5	93 (46)	21 (45)
2. 5-10	78 (39)	15 (32)
3. 10-15	24 (12)	07 (15)
4. 15 & above	6 (3)	04 (8)
	201	47

Duration of labour in most cases was within 5 hours, 5-10 in 71 cases, 10-15 hours in 31 cases, more than 15 hours in 10 cases only. Most of the patients with the previous caesarean section were given a trial of labour, could be delivered by the end of 10 hours. Two hundred and one cases delivered vaginally, out of them 97% were below the age of 35 years. It appears that patients below 35 years of age especially between 25-30 years do fairly well in trial of labour following previous section.

Table II shows the mode of delivery in these selected patients. One hundred and twelve (45%) delivered vaginally without any assistance, 77 (31%) required assistance, 8 (4.8%) were breech and 47 (19%) required repeat caesarean section.

TABLE II
Mode of Delivery

Type of delivery	No. of cases	%
1. Spontaneous vertex	112	45.00
2. Assisted breech	8	3.2
3. Breech extraction	4	1.6
4. Forceps	45	18.1
5. Ventouse	32	12.1
6. Repeat C S	47	19.00
	248	

The indications for repeat section are given in Table III. In majority of cases foetal distress, impending scar rupture of uterus were the causes for repeat section. There was no obvious cause detected for foetal distress except in 5 cases, when the cord was found around the neck and in 2 cases there were placental infarcts. Eight cases had ante partum haemorrhage and in 5 cases maternal exhaustion was the indication. There was no maternal mortality in this series, and no case of caesarean

hysterectomy while perinatal mortality was within normal range.

TABLE III
Indication for Repeat C S

Indications	No. of patients	%
Foetal distress	19	40
Signs of impending rupture of scar	15	31
A P H	08	17
Maternal distress (Uterine inertia and cervical dystocia)	05	10

Discussion

A comparative incidence of vaginal delivery following previous caesarean operation is given in Table IV. In present series we had vaginal deliveries in 81% of cases which is very encouraging. It is because all our cases were booked, seen during whole antenatal period and cases of two

TABLE IV
Vaginal Delivery Following Caesarean Section

Sl. No.	Authors	Year	Percentage of incidences
1.	Chossan	1970	54.0
1.	Chakrabarthy	1971	33.3
3.	Upreti <i>et al</i>	1977	54.3
4.	Present series	1985	81

TABLE V
Incidence of Scar Rupture

Sl. No.	Authors	Year	Percentage of incidences
1.	Lawrence	1953	0.47
2.	Parikh	1964	1.29
3.	Upreti <i>et al</i>	1976	0.53
4.	Ganguly <i>et al</i>	1977	2.3
5.	Present Series	1985	Nil

and more caesarean and cases of CPD were excluded. This could also be a reason that there was no case of scar rupture in our series (Table V).

Table VI shows the incidence of repeat caesarean ranges between 15-27% as quoted by various authors.

TABLE VI
Incidence of Repeat Caesarean

Authors	Year	Percentage of incidence
Menon	1962	27.4
Upreti <i>et al</i>	1976	15.8
Present <i>et al</i>	1985	19.0

We observe that selected cases, given a chance of trial of labour do fairly well and come out successfully after undergoing a process of labour.

Trial of labour, does put a strain on the nursing staff, obstetrician and does cause anxiety to patient's relative. But it reduces the maternal morbidity, number of days of hospitalization and very reassuring for the patients for future pregnancies.

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