LABOUR FOLLOWING PREVIOUS CAESAREAN SECTION

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SUMMARY:

A study of 350 cases of post-caesarean pregnancy was carried out. Incidence of post-caesarean pregnancy was 3.03% ; 48% of the cases delivered vaginally. L.S.C.S. was performed in 50.5% cases. Classical C.S. was performed in 0.57% cases. Scar rupture occured in 1.5% Maternal mortality rate was 0.28%.

INTRODUCTION :

The increasing awareness about the perinatal health has lead to the liberal use of primary caesarean for foetal indications. Consequently there is an increase in post caesarean pregnancies.

A detailed study was therefore considered worthwhile to find out the problems and risks involved with the post caesarean pregnancies.

MATERIAL AND METHOD :

In this study, 350 cases with post caesarean pregnancy who were admitted in Zanana Hospital, R.N.T. Medical College, Udaipur from 1st January, 1980 to 31st December, 1982, were included. A detailed history of previous caesarean section and post operative period was obtained. The patients were given trial of vaginal delivery when they had only one C.S. and there was no contra-indication to vaginal delivery in the current pregnancy. These patients were carefully observed during labour especially for maternal pulse, scar tenderness and foetal heart sounds or vaginal bleeding. Oxytocin if indicated was used for induction or augmentation of labour. Forceps were applied if indicated.

RESULTS :

During this period of 3 years, there were 11536 confinements out of which 596 cases were delivered by caesarean section giving an incidence of 5.1% 350 patients i.e. 3.03% of all confinements, were admitted with previous caesarean section. The indications of previous caesarean section are given in Table I, which also shows the mode of delivery in present preg-

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TABLE I

Mode of delivery in the present pregnancy with regard to indications for previous caesaren section.

Indications of Previous C.S.	Vaginal Delivery		Caesarean Section		Other	
	Sponta-neous	Forceps	Elective	After trial	Rupture Uterus	
CPD	12	2	17	60	3	
Malposition	30	7	7	9	1	
Fetal distress	26	14	1	16		
P.R.O.M.	10	5	1	5		
Cervical Dystocia	2	1	3	13		
APH	10	1	-	4		
Toxaemia	5	1	4	5		
Incordinate Uterine Action	6	5	-	2		
Diabetes	-	-	2	-		
VVF Repair	-	-	2	-		
Rh. Isoimmunisation	-	-	1	-		
Other indications	10	1	4	4		
Unknown	14	5	4	4		
Total	125	42	46	132	5	
Percentage	36%	12%	13%	37.5%	1.5%	

TABLE II

Indications for Elective CS in present pregnancy

	No.
Contracted Pelvis	13
Previous one C.S.	13
Previous two C.S.	12
Previous 1 C.S. + Rent Repair	2
Diabetes	2
VVF Repair	2
Rh Isoimmunisation	1
Transverse Lie	1
Total	46

TABLE III

Indications for Repeat C.S. after trial in present pregnancy.

	No.
Contracted Pelvis	54
Previous one C.S.	36
Cervical dystocia	11
Fetal distress	8
Threatened Rupture	7
Premature rupture of membrane	5
Incordinate uterine Action	4
Malpresentation	3
Placenta Previa type I	2
Cord Prolapse	1
PET	1
Total	132

nancy.

Mode of delivery : :

Out of 350 caeses, elective caesarean section was done in 46 (13%). 304 cases were given a trial for vaginal delivery, out of which 167 (48%) delivered successfully by the vaginal route but in 132 (37.5%) trial had to be discontinued and caesarean section (C.S.) was performed. 5 cases were admitted with rupture uterus.

Out of 167 vaginal deliveries, 125 were spontaneous vaginal deliveries and 42 were forceps delivery. Oxytocin drip was also given in 15 cases, who had inefficient uterine contraction.

Caesarean Section :

Repeat C.S. was performed in 176 cases (50.5%). Out of these 46 (13%) were chosen for elective C.S. for indications shown in Table II, and in 132 patients (37.5%) C.S. was performed after a period of trial. The indications for discontinuation of trial are shown in Table III.

Classical Caesarean Section:

3 patients had previous classical C.S. Out of these, 1 patient was delivered by repeat classical C.S. and 2 patients came with scar rupture. Subtotal hysterectomy was done in one of them, rent-repair with sterilization was done in the other two cases.

In the present pregnancy,rent-repair with sterilization was done in the two other cases.

In the present pregnancy, classical C.S. was done in 2 cases, because of presence of dense adhesions between the lower uterine segment and bladder; the lower segment was unapprochable.

Operative and Other Findings :

Adhesions between abdominal wall, omentum, intestines, bladder and uterus were found in 20 cases. Placenta was adherent to uterine wall in one case. Bladder was injured while operating in one patient as it was densely adherent to the uterus as well as to parietal peritoneum.

IIIrd Stage Complications :

In cases who had vaginal delivery, atonic postpartum haemorrhage occurred in 5 cases, MRP was done in 3 cases for adherent placenta. In cases who had repeat section, atonic postpartum haemorrhage occured in 5 cases. Haemorrhage was controlled by oxytocin drip

and uterine massage.

Maternal Morbidity and Mortality :

One patient of scar rupture was admitted as an emergency, died of haemorrhage and shock after subtotal hysterectomy. Maternal morbidity was higher in cases after repeat C.S. Sepsis was more in cases who had C.S. after trial.

Perinatal Outcome -

(1) Birth weight varied from 1.5 to 4 kg, and

(2) Perinatal mortality was 3%.

DISCUSSION :

Although the appropriate use of C.S. is associated with a significant decrease in perinatal mortality and morbidity it results in increase in the post-caesarean pregnancy. The incidence of post caesarean pregnancy was 3.03% in this institution. Goswami (1982) reported 2.4% incidence while Sagar and Goyal (1983) reported 4.53%.

The incidence of successful vaginal delivery following previous C.S. was 48% in the present series. It has been variously reported from 60% (Irani et al 1982) to 32.50% (Sagar and Goyal 1983) Table IV.

TABLE IV

Incidence of a successful vaginal delivery after a previous C.S.

Authors	Percentage
Irani et al. (1982)	60.00%
Goswami (1982)	34.55%
Sagar et al (1983)	32.50%
Present study	48.00%

Failed trial has been reported to be 10% by Irani et al (1982), 22.45% by Goswami (1982) and 42.5% by Sagar and Goyal (1983). In the present series it was 37.5%. Repeat C.S. was performed in 50.5% cases in present series Irani (1980) and Goswami (1982) reported 65.46%, while Sagar and Goyal (1983) reported 60%. Classical section was performed in 0.57% of cases in present series while in 0.7% cases of Irani (1982) and 1.41% of Sagar and Goyal (1983). Classical section is justifiable in cases with adherent bladder to avoid injuring it or in a case where previous section was already done by classical method.

Incidence of scar rupture was 1.5% in the present study of while 1.82% in Goswami (1982) and 2.12% in Sagar and Goyal (1983).

Maternal mortality was 3% in the present series while Irani (1982) reported 1.3% Goswami (1982) 4.5% and Sagar and Goyal (1983) 5.3%.

CONCLUSION :

This study shows that after one C.S. specially done for nonrecurrent indications, vaginal delivery is possible and therefore every patient in whom there is no contra-indication for vaginal delivery should be given a chance to deliver vaginally and "once a C.S., alway a C.S." does not stand true. All patients who have undergone C.S. should be given the following advice at the time of discharge - (1) She should not conceive for at least next 2-3 years.(2) When she conceives, she should have regular antenatal check up in hospital (3) She should be explained that successful vaginal delivery is also possible after C.S. (4) Delivery should be planned in institution and not at home or small hospitals like PHC. (5) Delivery should be supervised by well experienced obstetrician.

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