"TWICE A CESAREAN, ALWAYS A CESAREAN ???"

D.S. SHAH ● A.U. MEHTA ● RAJESH GONDALIA

SUMMARY

Dramaticaly rising the incidence of C.S. has become an increasing concern to obsterric profession and patients too.

Old days dictim of Craigin "once a C.S. always a C.S." has been replaced by "Once a C.S. always a hospital delivery".

But what about patient with previous 2 C.S. Is the trial of scar safe ?

To determine this, a prospective & retrospective study was done from Jan 1991 to Aug 95 in the Dept. of Obst. & Gyn., M.P. Shah Medical College, Jamnagar. 74 patients with previous two C.S. were admitted in this institute during 91 to 95. Out of 74 paients 28 were given trial of scar under strict supervision of senior consultant; among them 18 (i.e. 64.29%) delivered vaginally.

Oxytocin drip was used for induction / augmentation of labour in limited cases with no scar dehiscene or rupture.

INTRODUCTION

Today, in modern obstetrics C.S. delivery rate is continously rising since last 2 decades. This has brought a remarkable change in obstetric practice regarding management of a women with prior C.S. and many women with previous 2 C.S. are delivered by elective repeat C.S. and the common indication is previous C.S. The condition is equally worsening in developing countries as in developed countries.

We should not forget that in 1984, the C.S. was the most commonly performed operation in the United States. (Myres & Gleider (1988)). In 1985 the National C.S.

Dept. of Obs & Gyn. M.P. Shah Medical College, & Hosp. Jamnagar (Guj)

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rate in United States reached up to 23% and nearly every one women out of four had C.S. (Myres & Gleicher, 1988). In 1987 the increase in C.S. rate in United States has risen to 400%. (Flamm et al 1987)

In western countries, the increasing frequency of litigation (Tay et al 1992) may have lead to defensive medical practice and in developing countries more liberalization of indications of C.S. has increased the C.S. rate. The relative risk of C.S. compared to vaginal delivery is 2-11 times more for maternal mortality and morbidity (kirkinaen, 1988).

Our experience says that if there is no obstetric/medical contraindication the patient should be given trial of scar. If trial of scar is given and sufficient number of patients delivered vaginally (in the present series 64.29%) the medical risk, socio-financial burden and incidence of C.S. can be reduced.

Reviewing the literature, success rate for vaginal birth after one C.S. ranges from 40-70%. There is scarcity of literature in our country regarding trial of scar with previous 2 C.S. The objective of this study was to determine whether trial of scar can be accomplished safely in a patient with previous 2 C.S.

MATERIAL AND METHODS

This study was carried out in the Dept. of Obst. & Gyn. Itwin hospital, M.P. Shah Medical College, Jamnagar (GUJ) from Jan. 91 to Aug. 95.

During 1991 to 1993, trial of scar was not given in cases of previous 2 C.S. due to fear of maternal morbidity and mortality.

All patients with vertical scarred uterus were excluded from this study.

From 1993, all patients with previous 2 C.S. were registered and scrutinized for trial of scar. During intrapartum period, on admission all patients were examined thorougly and monitored with the help of WHO partograph by our senior consultant. Oxytocin infusions was used for induction/augmentatioin at required time in few patients. Informed and written consent was taken. Trial of scar in some cases was terminated with C.S. whenever required. Exploration of lower segment was done routinely to rule out dehiscence, fenestration or scar rupture.

OBSERVATIONS

Table I shows that during 1994-1995

Table I
INCIDENCE & OUTCOME

Yrs.	Pts.	Trial of Scar given	C.S.	Vaginal Delivery
1991	15	-	13 (86.60%)	02 (13.33%)
1992	12	-	11 (91.67%)	01 (08.33%)
1993	14	-	11 (78.57%)	03 (21.43%)
1994	21	19 (90.48%)	07 (36.84%)	12 (63.16%)
1995	12	09 (75.00%)	03 (33.33%)	06 (66.67%)

we gave a trial of scar in the cases of previous 2 C.S. During this period 33 patients. of previous 2 C.S. were admitted in labour room but only 28 were given trial of scar. Out of this 28 , 18 (64.29%) delivered vaginally & 10 (35.71%) had repeat C.S.

Table II shows the various indications of C.S. after failed trial of scar. Fifteen patients were terminated by C.S. in which 5 pts. were not given trial of scar due to fear of rupture.

C.P.D. was the commonest indication for repeat C.S. i.e. 60%. One patient (i.e. 10%) had threatened rupture of the uterus.

The single most common cause for elective repeat C.S. was fear of catastrophic uterine rupture and litigations.

Table III shows that out of 33 patients 28 were given trial of scar and 5 underwent elective repeat C.S. Out of 28 patients, 18 delivered vaginally among which 3 required forceps delivery & 3 required vacuum extraction.

Table II
CAUSES OF FAILED TRIAL OF SCAR

Indication for Repeat C.S.	Pts.	%
C.P.D.	06	(60%)
Threatened Rupture	01	(10%)
Foetal Distress	02	(20%)
Persistant Malposition	01	(10%)
Elective Repeat	05	
Total	15	

Table III
MODE OF VAGINAL DELIVERY

Mode of Vaginal delivery	Pts.	%
Normal delivery	12	(66.66%)
Forcepts delivery	03	(16.67%)
Vacuum delivery	03	(16.67%)
Total	18	

Table IV
CONDITION OF PREVIOUS SCAR

Condition of Scar	Vaginal Deliveries	C.S.
Normal	18	13 (86.60%)
Thinned out Scar	00	02 (13.33%)
Dehiscence / Fenestration	00	-
Rupture	00	-

Table V
BIRTH - WEIGHT.

Gms.	Vaginal deliveries	C.S.
1500 - 2000	2 (11.11%)	-
2001 - 2500	5 (27.77%)	5 (33.33%)
2501 - 3000	9 (50.00%)	4 (26.66%)
> 3000	2 (11.11%)	6 (40.00%)
	18	15

The uterine scar was evaluated in all 28 cases who were given trial of scar, by the senior consultant (Table IV). Eighteen patients who delivered vaginally, the uterine scar was normal. The remaining 15 patients, underwent C.S. only 2 had thinned out scar which was noted at the time of C.S., while remaining 13 had normal scar, with no dehiscence / fenestration / rupture. Thus scar rupture is not so common.

Table V shows that if expected baby weight is more than 3000 gms. then we have to remain on our guard while giving the trial of scar.

There was no maternal morbidity or mortality and only 0.18 perinatal mortality due to respiratory distress syndrome on 4th day.

DISCUSSION AND CONCLUSION

Our study suggests that if a patient with previous two C.S. is to be given trial of scar neither the decision for trial of scar, nor the management during that labour should be carried out in a superficial manner. One should keep in mind that she requires planned management and close observation and the obstetrician should be ready to terminate the labour any moment.

The commonest indications of C.S. are C.P.D., foetal distress and cervical dystocia,

which are diagnosed subjectively by individual experience, hence patients must be evaluated properly.

The relative risk of C.S. compared to vaginal delivery is 2-11 times more for maternal mortaity and morbidity. If trial of scar is given and sufficient number of paients with previous 2 C.S. are delivered vaginally (in present series 64.29%) the medical risk, socio-financial burden and incidence of C.S. can be reduced.

Thus we suggest following guidelines for trial of scar after 2 C.S.

GUIDELINES

1. It should be a planned management.
2. Opinion/decision should be formed by two obstetricians caring for the mother to enhance safety.
3. No medical / Obstetric (vertical scarred uterus) contraindication.
4. Facilities to monitor mother and foetus should be available.
5. Obstetrician and expert anaesthetists with all facilities must be available to terminate the labour at any moment.
6. Readiness/willingness to change to abdominal delivery on appearance of warning signals. (alert obstetricians)

In conclusion we have made the new dictim for previous 2 C.S.

"TWICE A C.S. ALWAYS A PLANNED MANAGEMENT"

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