

Research Article**A Case Study of Three Consecutive Vaginal Deliveries
after Three Caesarean Section****¹Nazish Butt, ²Shaista Ejaz,
and ³Syed Musarrat Hussain**¹Women Medical Officer, BHU Kotha Kalan, Rawalpindi, Pakistan.²Women Medical Officer, BHU Sargodha, Pakistan.³Abasyn Hospital Peshawar, Pakistan.**ABSTRACT**

Caesarean section involves the delivery of the fetus through a direct incision in the abdominal wall and the uterus. Women with scarred uterus are considered at risk of uterine rupture during subsequent pregnancies and labour. Although trial of labour is usually given to patients having past history of previous one lower segment caesarean section (LSCS) due to non-recurrent cause with a considerable success rate but most obstetricians opt an elective LSCS in women having past history of two or more LSCS. We report a case of three consecutive successful vaginal deliveries with an intact scar in a woman having history of previous 3 LSCS.

Keywords: LSCS, vaginal delivery, uterine scar.**INTRODUCTION**

Caesarean section is the most common major obstetric operation with a steadily increasing rate globally¹. The overall caesarean section rate for nulliparous women in UK is about 24% and for women who have had at least one prior caesarean delivery the rate has increased to about 67%¹. Uterine rupture is very rare but is the most dreaded complication in the subsequent labour after 2 or more previous caesarean deliveries [2]. The risk of uterine rupture is 50:10000 with VBAC (vaginal birth after caesarean delivery). Therefore, most obstetricians opt for elective caesarean delivery if there is a past history of previous 2 LSCS. We also follow the same policy at our institute (Abbasi Shaheed Hospital) due to risk of uterine rupture; hence, a trial of vaginal delivery is prohibited in women with a past history of previous 2 or more LSCS. However, several studies have been published

regarding successful vaginal births in patients with 2 or more prior LSCS but to the best of our knowledge no study has been published yet that has shown three consecutive successful vaginal deliveries in a woman having history of previous 3 LSCS^{4,5} [3]. We observed in Abbasi Shaheed Hospital an unusual case of such a woman. This patient reminds us that vaginal delivery is still possible after 2 or 3 LSCS, therefore a criterion has to be established for trial of labour in women having 2 or 3 prior LSCS in well selected cases. Mrs. XXX was a 33 years old housewife with secondary education, married since 12 years, G7P6+0, all alive. Her Last Menstrual Period (LMP) was on 10-09-2013 and her gestational age was 35 weeks. Her first confinement was 11 years back. She had antenatal care at Abbasi Shaheed Hospital (ASH), Karachi and she had an emergency LSCS

at 38 weeks gestation due to breech presentation and had delivered an alive female baby of 3 kg. Her second delivery was 10 years back at Civil Hospital Karachi (CHK) by an emergency LSCS due to prolonged leaking, previous 1 LSCS and NPOL (Non progress of labour) at 38 weeks' gestation. She had delivered an alive female baby of 3.2kg. Her third delivery was 8 years back which was also at CHK by emergency LSCS at 37 weeks' gestation due to previous 2 LSCS and scar tenderness. She had delivered an alive male baby of 3.2 kg.

Her fourth confinement was 6 years back, she had antenatal care at a private hospital and her obstetrician had planned an elective LSCS at 37 completed weeks for a past history of previous 3 LSCS however because of lack of financial means she did not come for follow-up consultation. Patient developed complain of labour pains at 36+ weeks gestation and delivered an alive female baby of wt 3kg at home through spontaneous vaginal delivery. She had normal puerperium and remained well thereafter. Her fifth confinement was 5 years back, she got booked for antenatal care at a private hospital, and the antenatal period was uneventful. She was scheduled for elective LSCS but as patient already had successful VBAC at home, she wanted a vaginal delivery this time also, she discussed with her obstetrician and planned for a short trial of labor with full preparation of emergency LSCS. She therefore presented to hospital at 37 weeks' gestation with complain of labour pains for 4 hrs, she was assessed to be in labour and was given IV fluids and IV analgesia and she has delivered an alive healthy male baby of 3.4kg through Vacuum Vaginal Delivery (VVD) due to poor maternal effort.

Her sixth delivery was also at the same private hospital, her antenatal period was unremarkable and she presented to hospital at term pregnancy with complain of labour pains, according to discharge card. On examination at presentation to hospital she was vitally stable, on per abdominal exam there was no scar tenderness, and she was

having 4 strong uterine contractions in 10 minutes each lasting about 40 sec. The fetal heart rate was 146b/ min; she delivered an alive healthy female baby of wt 3.3kg within 2 hrs of presentation through spontaneous vaginal delivery. Her general condition post-delivery was satisfactory, she was discharged from hospital 24 hrs later in good clinical condition on haematinics. Currently she is 35 weeks pregnant, this is her seventh conception, she got booked at Abbasi Shaheed Hospital in her index pregnancy at a gestational age of 20 weeks. Her anomaly scan done at 22 weeks was unremarkable except for anterior low lying placenta. Her ultrasound growth scan and placental doppler to rule out morbidly adherent placenta but no evidence of MAP was found. She was given steroid cover at 34 weeks, she was offered elective LSCS and bilateral tubal ligation at 37 weeks but patient wants another vaginal delivery after 3 successful VBACS. Currently she is on weekly antenatal visits, she and her spouse have been counselled regarding risk of uterine rupture but they are willing for trial of labour with full preparation of emergency laprotomy. They have also been counselled for tubal ligation after this delivery.

DISCUSSION

Some decades ago, pregnant women having history of prior caesarean section were delivered electively through LSCS in keeping with Craigin's dictum¹ "once caesarean always a caesarean" which was published in New York in 1916. This was as a result of fear of a potentially catastrophic uterine rupture in labour which occurs 0.5 to 1% of the time during trial of labour after caesarean. Later with the passage of time and advancement in obstetrics, vaginal birth after caesarean section VBAC have become popular and now according to NHS guideline women who had one uncomplicated LSCS and have an otherwise uncomplicated pregnancy should be encouraged to attempt a VBAC, the success rate is 72 to 76% if the women never had a vaginal delivery and 87 to 90% if she had a history prior

vaginal delivery⁶. However VBAC should only be attempted in a level 2 or 3 hospital where an in house obstetrician, anaesthetist, neonatologist and Operation Theatre staff is available.

While Craigin's dictum may no longer stand the test of time, twice caesarean is always caesarean still stands because of relatively high maternal and fetal complication following vaginal delivery⁷. According to ACOG guidelines 2010 patients with more than 1 prior caesarean section are at increased risk of uterine rupture ranging from 1.8% to 3.7%⁷. This has necessitated the policy of elective repeat caesarean section for women with 2 or more prior caesarean sections. However over the past few years several studies have been published which showed that successful vaginal birth is also possible in women having previous 2 or 3 caesarean section. Our patient Mrs. Asma had a past history of previous three caesarean sections followed by three consecutive successful vaginal births without any complication. Although her first vaginal delivery after 3 LSCS was at home without any monitoring which was quite risky but after that she had 2 more vaginal births at hospital, which became possible because at the time of presentation she was having adequate uterine contractions with no evidence of scar dehiscence or disruption, favourable head descent, average wt baby, reassuring fetal heart rate and favorable bishop score. In addition her previous 3 sections were for non-recurrent indications.

This goes to show that, it may be possible, in carefully selected patients, to have safe vaginal delivery after 3 previous caesarean sections. The criteria for this should include non-recurrent indications, estimated size of the baby, integrity of the scar, desire of the patient and readiness for emergency surgery should the need arise. This would go a long way in reducing the rising caesarean section rate.

CONCLUSION

This case report confirms the fact that safe vaginal delivery is possible in some well selected

women with past history of two or more caesarean sections although trial of scar may be risky in women with multiple scarred uterus. Hence, obstetricians should establish criteria for trial of labour in multiple scarred uterus in well selected women given that the risk of morbidity and mortality increases with the increasing number of caesarean sections.

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