DELIVERY AFTER PRIMARY CAESAREAN SECTION

Thesis

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By

DR. IBRAHIM ABDEL AZIM SARHAN
M.B.B.Ch.

Supervised by

Dr. **ALAA ELDIN MOHAMMED EL-ETRIBY**
Ass. Professor of Obstetrics and Gynecology
Ain-Shams University

Dr. **KHALED MOHAMMED AZIZ DIAB**
Lecturer of Obstetrics and Gynecology
Ain-Shams University

FACULTY OF MEDICINE
AIN-SHAMS UNIVERSITY

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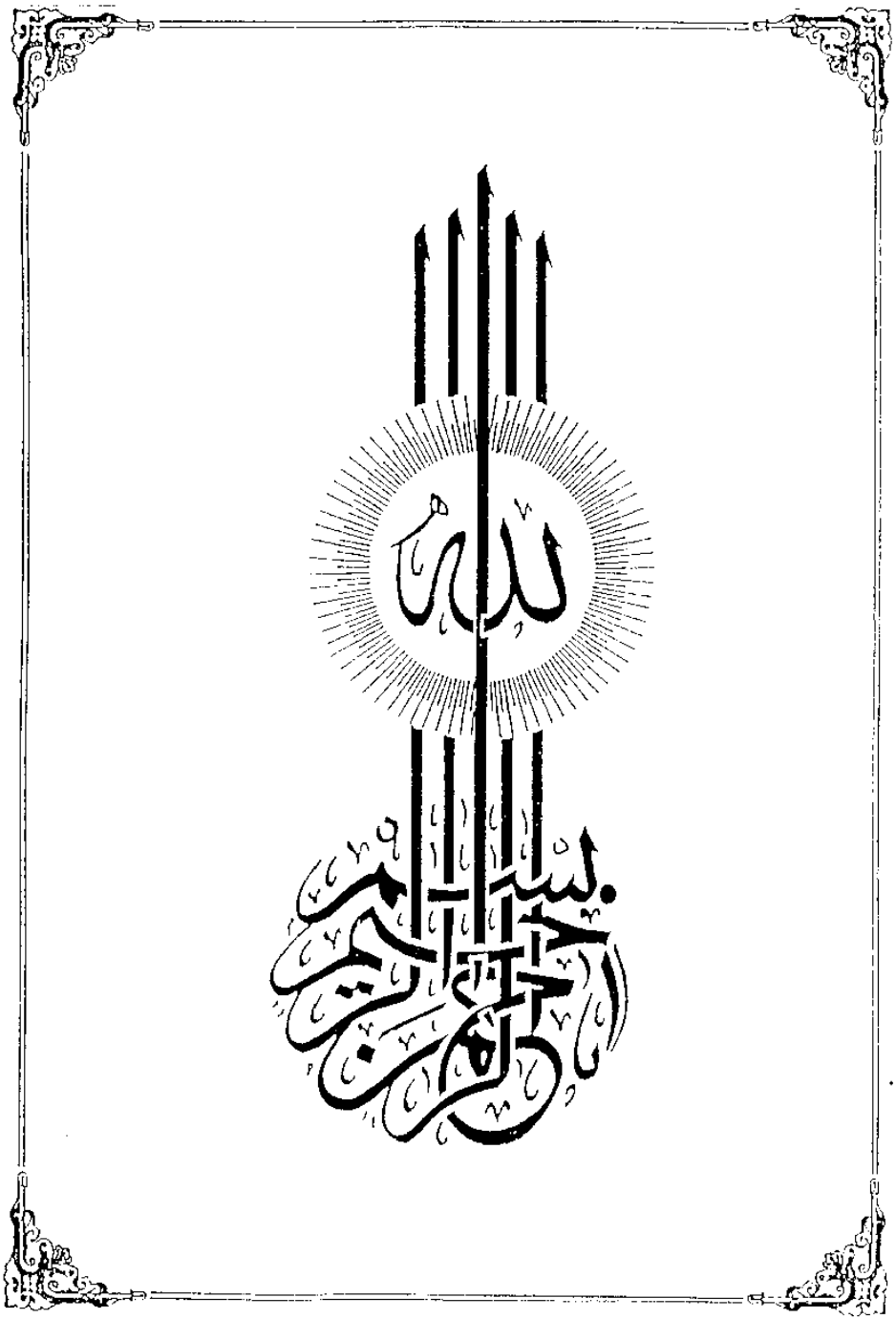
بسم الله الرحمن الرحيم



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INTRODUCTION

One of the oldest controversies in the field of obstetrics is the optimal management of the pregnant patient with a previous caesarean section. Why has this controversy become so heated in the past few years? The main reason is undoubtedly the sky-rocketing caesarean section rate which has increased by about 300% in the last decade (Flamm, 1985).

Once a caesarean section, always a caesarean section was first proposed as a clinical dictum by Craigin (1916). This dictum dates back to an era when most caesarean sections involved classical uterine incision and when antibiotics and transfusions were unknown (Saldana et al., 1979).

Now, due to changes in the type of uterine incision being mostly lower segment transverse, combined with advances in technology which allows continuous and accurate monitoring of the mother and the fetus, it is widely accepted that an attempt at vaginal delivery should be made unless there is other indication for abdominal delivery (Graham, 1984).

A recent American College of Obstetricians and Gynaecologists Committee recommended that the concept of routine repeat caesarean birth should be replaced by a specific indication for a subsequent abdominal delivery and in the absence of a contraindication, a woman with one previous

caesarean delivery with a low transverse incision should be counseled and encouraged to attempt labour in her current pregnancy (Kirk et al., 1990).

The greatest problem for the attendant is the integrity of the uterine scar. Uterine rupture has the potential for serious harm to the parturient and the fetus (Horowitz et al., 1981).

The risk of uterine rupture in patients who have previously undergone caesarean section and are allowed a trial of labour is low and not severe enough to deny the patients' vaginal delivery with its well-known advantages. Furthermore, a rupture of a lower segment scar is usually recognized and should not increase fetal risk, if appropriately managed (Nielson et al., 1989).

However, controversy remains as to which patients should be excluded from trial of labour based on previous repetitive indications, more than one uterine scar, type of previous uterine incision, or febrile morbidity during the healing of previous uterine scar (Jarrell et al., 1985).

II AIM OF THE WORK

AIM OF THE WORK

The aim of this work was to evaluate the prevalence of parturients with previous single caesarean section, seen at Ain Shams University Hospital. Also, to evaluate their method of delivery, factors which are related to the the success of the trial of labour, and the incidence and sequelae of gapped scar occurring in these women.

III REVIEW OF LITERATURE

CAESAREAN SECTION SCAR

TYPES OF CAESAREAN SECTION SCARS

Caesarean section (C.S) scars are differentiated according to the location and direction of the uterine incision, which are divided into two major types and other rare varieties:

1. UPPER UTERINE SEGMENT INCISION:

They include the following subtypes:

- *Vertical incision*: which is the classical incision.
- *Transverse incision*: which is rarely used nowadays and was originally known as (Kherer's incision).

2. LOWER UTERINE SEGMENT INCISION:

Where the bladder is displaced downwards to expose the appropriate area of the lower uterine segment. They include the following subtypes:

- *Transverse incision (Kerr)*: which is the most frequently used incision nowadays.