THE INCIDENCE OF VBAC VERSUS REPEATED CS IN PATIENT WITH PREVIOUS ONE CS IN KASR ELAINI

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By

Emad Mohammed Salah El Din
(M.B.B.Ch.) Resident of Obstetrics and Gynecology Faculty of Medicine Cairo University

Supervisors

Prof. Dr. Shamel Mostafa Hefny
Professor of Obstetrics and Gynecology
Faculty of Medicine Cairo University

Dr. Hoda Mohamed Abd El Aal
Lecturer of Obstetrics and Gynecology
Faculty of Medicine Cairo University

Faculty of Medicine
Cairo University
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LIST OF ABBREVIATIONS

ACOG: American college of Obstetrician and Gynecologists.

CBC: complete blood picture.

CS : cesarean section.

CP: cerebral palsy.

CPD: cephalopelvic disproportion.

DIC: disseminated intravascular coagulopathy.

DM: diabetes mellitus.

EDD: expected delivery date.

FHR: fetal heart rate.

HIE: hypoxic ischemic encephalopathy.

PGE2: prostaglandins E2.

PIH: pregnancy induced hypertension.

PT & PC: prothrombin time and concentration.

RDS: respiratory distress syndrome.

TOL: trial of labour.

VV FISTULA: vesico-vaginal fistula.

VBAC: vaginal birth after cesarean section.

ABSTRACT

Previous cesarean section is the most common cause for the rising rate of cesarean section.

Vaginal delivery after cesarean section is considered the best method to decrease the rising rate of cesarean section. Proper selection of candidates is mandatory before giving trial of labour for patients with prior cesarean section.

It is also mandatory to follow strictly the guidelines for management of trial of labour in these patients to avoid development of maternal or fetal complications during trial of labour.

In our study 200 were selected using certain guidelines made them suitable candidate of trial of labour. The incidence of trial of labour, VBAC, relation between VBAC and history of vaginal delivery and complications of both VBAC and cesarean section all will be discussed.

If the prerequisites for trial of labour are not available, the obstetricians should choose elective repeat cesarean section for termination of pregnancy in these patients for the sake of mother and fetus .

KEY WORDS

Cesarean section, Vaginal birth after cesarean, trial of scar, Elective repeat cesarean section.

INTRODUCTION

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Caesarean section is a common surgical procedure performed on women worldwide. The rate of caesarean section in most developed countries around the world has continued to increase over recent years, and currently accounts for 21.3% of all births in the United Kingdom, and 26% in the United States .

Many reasons have been suggested to account for the increase in caesarean section observed over recent years, including:

1- The increasing use of electronic fetal heart rate monitoring during labour.

2-The reduction in the training available to obstetricians in both operative vaginal births and vaginal breech births.

3- Fears of litigation .

previous caesarean section is the most common primary indication for a woman undergoing a repeat caesarean section **(Dodd et al ,2007**).

The number of women attempting VBAC has declined markedly. This is highlighted by data from the United States, indicating a fall in the number of women attempting VBAC from 28.3% in 1996 to 12.7% in 2002 **(Hamilton et al, 2003**).

Vaginal birth after cesarean section (VBAC) is a safe and reasonable alternative. In 1994 and 1995 the American College of Obstetricians and Gynecologists (ACOG) stated, A woman with one previous cesarean delivery with a lower uterine segment incision should be counseled and encouraged to undergo a trial of labor in her current pregnancy **(Zweifler et al,2006**).

There is no increase in fetal or maternal morbidity or mortality associated with TOL as compared with elective CS ,and in fact the risk may be reduced in TOL**(Reid ,1986).**

Many complications are associated with CS like anesthesia complications ,bleeding ,infection ,thrombosis ,pain ,adhesions injury to internal organ like intestine and bladder and prolonged hospital stay.

A pregnant woman with a previously scarred uterus is at increased risk for complications whether she has a successful VBAC-TOL, unsuccessful VBAC-TOL or elective repeat cesarean birth. Neither elective repeat cesarean nor VBAC-TOL is risk-free. overall rate of uterine rupture in women attempting VBAC-TOL is quoted to be less than 1%, women who elect a repeat cesarean birth without labor still have a uterine rupture risk of 0.03% to 0.2. Among those women attempting VBAC-TOL, rates of uterine rupture vary significantly, depending on associated risk factors . Characteristics in a woman's obstetric history (type of uterine scar, single-layer versus double-layer uterine closure, number of prior cesarean births, number of prior vaginal births, interdelivery interval, maternal age, maternal fever following cesarean), in addition to factors related to current labor management (induction or augmentation with prostaglandins and/or oxytocin).(**O'Brien,2003)**

Recommendation was given by the ACOG useful for selection candidate for VBAC include:

1-No more than one low transverse CS

2-Clinically adequate pelvis

3-No other uterine scars or previous rupture

4-Physician immediately available throughout active labor who is capable of monitoring labor and performing an emergency CS

5-Availability of anesthesia and personnel for emergency CS

AIM OF THE WORK

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The aim of this work is to study the incidence of patients delivered vaginally following C.S versus those who delivered by repeated CS ,and try to find the effect of many factors such as history of VBAC ,previous vaginal delivery prior to CS, prematurity ,fetal weight ,indication of the previous CS in the mode of delivery and illuminating the complications associated with both repeated cs and VBAC.

REVIEW OF LITERATURE