Vaginal Birth After Three Previous Caesarean Sections: A Case Report

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Abstract

BACKGROUND
Caesarean delivery is the most common major obstetric operation carried out for maternal and/or fetal indications. While most obstetricians will permit vaginal birth after a prior caesarean, those with 2 or more previous caesarean sections are usually delivered abdominally because of increased risk of uterine rupture in labour.

AIM
To report a case of successful term vaginal delivery in a parturient with 3 previous caesarean sections.

CASE REPORT
A 28-year old housewife, gravida5 para4+0, 2 alive, with 3 previous caesarean sections, was verbally referred to Kendox Medical Services, Elelenwo, Port Harcourt, South-South Nigeria, from a private maternity home where she had laboured at term for over 12 hours. She was assessed to be in advanced labour, with good uterine contractions, moderately sized baby, fetal head descent of 2/5th, reassuring fetal heart tones, cervical os dilatation of 8cm, and cephalopelvic disproportion excluded. She eventually had a spontaneous vaginal delivery of a 3.7kg live male baby with good Apgar scores while arrangements were being made for emergency surgery.

CONCLUSION
Safe vaginal delivery is possible in carefully selected patients with 3 prior caesarean sections.

KEYWORDS:
Vaginal birth, three previous caesarean sections, term.

Introduction

Caesarean section is the most common major obstetric operation with a steadily increasing rate globally, and with repeat caesarean sections accounting for a significant proportion of this.\(^1\)\(^4\) Uterine rupture in subsequent labour is the most dreaded complication after 2 or more prior caesarean deliveries\(^4\), necessitating the policy of elective repeat caesarean section in patients with two or more prior caesarean births\(^5\). However, there have been several reports of successful vaginal birth in patients with 2 or more prior caesarean sections.\(^6\)\(^8\)

Case Report(s)

Mrs. S.W. was a 28-year old house wife with secondary education, gravida 5 para 4+0, 2 alive. Her last menstrual period was on the 12/12/08, her expected date of delivery was on 19/09/09 and her gestational age at presentation was 41 weeks.

Her first confinement was in 2001. She had antenatal care at Braithwaite Memorial Specialist Hospital (BMSH) Port Harcourt, South-South Nigeria, but had an assisted term vaginal breech delivery of a 2.5kg live male baby in a private hospital. Baby died 1 month later from complications of neonatal jaundice.

Her second delivery was in 2002 at a private hospital, by an emergency caesarean section for symptomatic placenta previa at 34 weeks gestation. She was delivered of a fresh male stillborn.

The third delivery was in 2004 by elective repeat caesarean section for transverse lie at term, in a private hospital. The birthweight of the male baby was 3.2kg, alive and well.

Her fourth confinement was in 2007, also by an elective repeat caesarean delivery at term for 2 previous caesarean births, in the same private hospital. The female baby weighed 3.8kg, alive and well.

She had normal puerperium and was discharged home on the seventh post-operative day with no evidence of wound sepsis in each of the abdominal deliveries.

She booked for antenatal care in her index pregnancy at a gestational age of 20 weeks in a private hospital in Port Harcourt. The antenatal period was uneventful apart from breech presentation noted at 26 weeks from a routine obstetric scan. She was scheduled for elective repeat caesarean section at 38 weeks, but defaulted, because ‘someone’ had spiritually focasted a spontaneous vaginal delivery for her and she believed firmly in that.
She therefore presented in a private maternity home where she was admitted with history of labour pains and passage of show of 4 hours duration. She was assessed to be in labour and was given analgesics and plain intravenous fluids. She was however verbally referred to the nearby Kendox Medical Services (a private hospital) 12 hours later, for emergency caesarean section for ‘poor’ progress in labour.

On examination at presentation, her general condition was satisfactory. She was neither febrile nor pale. Her cardiovascular system was normal. Her abdomen was enlarged. There was a midline sub-umbilical scar which healed by primary intention. There was no undue abdominal tenderness. The baby was moderately sized. The fundal height was 36 weeks size. There was a singleton fetus lying longitudinally, and presenting cephalic. The fetal head was 2/5th palpable per abdomen. She had 4 strong uterine contractions in 10 minutes, each lasting 50 seconds. The fetal heart rate was 146 beats per minute, strong and regular. Her vulva and vagina were normal. The cervical os was 8cm dilated. The fetal vertex was presenting at station +1, and the membranes bulging. There was no cord presentation. Artificial rupture of the membranes yielded about 40ml of clear liquor. Cephalopelvic disproportion was excluded.

She was catheterized and an intravenous line immediately sited and blood taking at the same time for investigations. She was placed on 1L of intravenous 5% dextrose saline. Her urinalysis was normal. The haemoglobin concentration was 10.6g/dl, 2 units of compatible blood cross-matched. The anaesthetist was invited.

However, within one hour of presentation, and while arrangements were being made for an emergency repeat caesarean delivery, she expressed an irresistible strong desire to bear down. She was re-assessed. Findings were essentially as noted above except that the cervical os was now fully dilated. She eventually bore down during subsequent uterine contraction, and had a spontaneous vaginal delivery of a 3.7kg live male baby with good Apgar scores. She was given 0.2mg of intravenous ergometrine immediately after delivery of the baby. The placenta was delivered complete by controlled cord traction 5 minutes later. The estimated blood loss was 250ml.

Her general condition postpartum was satisfactory. Her vital signs remained normal and stable. The uterus was well contracted and there was no undue abdominal tenderness.

She was discharged home 24 hours later in good clinical condition and on haematinics. She was seen with her baby 6 weeks later on appointment. They had no complaints. Findings on general and systemic examinations were essentially normal. She was counselled jointly with her spouse on contraception and discharged home.

Discussion

Some decades ago, pregnant women with prior caesarean section scar were electively delivered by repeat caesarean section, in keeping with Craigin’s dictum, once caesarean, always caesarean section. This was as a result of fear of a potentially catastrophic uterine rupture in labour.

Later, with passage of time and refinements in obstetric practice, people felt bolder to attempt vaginal birth after caesarean (VBAC). This was found to be relatively safe in carefully selected patients and now an accepted standard obstetric practice.

While Craigin’s dictum may no longer stand the test of time, twice caesarean always caesarean still stands, because of relatively high maternal and fetal complications following vaginal delivery. This has necessitated the policy of repeat caesarean delivery for women with 2 or more prior caesarean births.

However, few years back there were reports of successful vaginal birth in women with 2 previous caesarean scars, and more recently there was a report of a planned vaginal birth after three previous caesarean sections with good feto-maternal outcome. Mrs. S.W. with three previous caesarean sections had uneventful vaginal delivery at term.

Though, her subsequent delivery would normally have been by elective repeat caesarean section following the standard management protocol as was done for her in her last confinement and as appropriately offered her in the index pregnancy, this patient instead presented in private maternity home to avert a fourth caesarean delivery, as ‘someone’ had earlier strongly focasted that she would have a safe vaginal birth. She however laboured for over 12 hours, before referral to Kendox Medical Services where she eventually had uncomplicated vaginal delivery within minutes of presentation even when she had already consented to, and arrangements were being made for abdominal delivery.

Vaginal delivery was possible in this patient, because at presentation at the private hospital, she was having good uterine contractions with no evidence of scar.
dehiscence or disruption, favourable head descent, moderately sized baby, reassuring fetal heart beats and cervical os dilatation of over 8cm, with no evidence of cephalopelvic disproportion. In addition, the three previous operations were for non-recurrent indications and healed primarily with no evidence of clinical infections.

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 along way in reducing the rising caesarean section rate.

Conclusion

Safe vaginal delivery may be possible in carefully selected patients with 3 prior caesarean sections.

Authors contribution(s)

Dr. J.D. mooted the idea of reporting this case, took the delivery and was supposed to have performed the 4th caesarean section on the patient. he wrote the introduction and the case report and the discussion.

DR. Ken Anyawuocha did extensive literature search on the subject matter and wrote the preliminary discussion on, and made valuable contributions and suggestions on the report.

References

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