

Vaginal Birth after Caesarean Section (VBAC): A Case Report on V-Back in Saudi Arabia

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Abstract

Repeat caesarean sections increase the possibility of maternal morbidity. Worldwide, the need for a trial of labor after caesarean delivery is gaining more ground in selected cases. Here, we report a case of an unbooked 37-year-old multigravida, with a history of five (5) previous lower-segment caesarean sections who presented in spontaneous labor. A live male baby of 2900 grams was delivered following episiotomy. Post-partum, she was observed with normal findings and a serial follow-up ultrasound scan showed normal uterine contours and surrounding structures. As the evidence for the practice of vaginal delivery in women who underwent 2 or more previous LSCS are still fewer, this report intends to highlight the possibility of successful vaginal birth after multiple caesarean sections putting into consideration the optimal care of the parturient. The term "V-back" was coined from the Roman numeral 'v' meaning five (5), the case here has had five (5) previous lower segment caesarean sections come "back" for spontaneous vaginal delivery.

Keywords: Repeat caesarean sections, Lower segment caesarean sections, VBAC, Trial of labor, Saudi Arabia.

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INTRODUCTION

Caesarean delivery rates are increasing worldwide and are sometimes associated with adverse maternal and neonatal outcomes [1-4].

The commonly encountered counselling and clinical decision-making for women with multiple prior caesarean deliveries is complex. Although relatively, low complication rates including uterine rupture, have been demonstrated among women with two prior lowtransverse caesareans who attempt vaginal birth (VBAC).

Some of the high risks posed by caesarean section are: anesthesia risks, excess bleeding, blood transfusion, adjoining organ injury, neonatal respiratory distress syndrome, infections, repeated caesareans and related risks (placenta accreta spectrum (PAS), rupturing of the uterus, intra-abdominal adhesion) [3]. However, after the realization of risks behind repeated CS, some experts took the initiative of 'Trial of Labor After

caesarean, to put forward an alternative to reduce caesarean section rates [6-14].

In Saudi Arabia, the rate of CS was 19%–25% and more than 50% of the women with previous CS underwent a repeated Elective CS [15].

CASE REPORT

An unbooked 37-year-old (gravida 7 with parity 5 and 1 missed miscarriage) woman, at 35 weeks gestation who had a history of five (5) previous lower segment caesarean sections (4 live births and one (1) early neonatal death) presented to the delivery room in well-established labor (spontaneous rupture of membrane). On examination, her general condition was stable. Vitals were within normal range. Previous Pfannenstiel scar and appendectomy scar seen with no scar tenderness. The patient was immediately taken to the operating theatre examined further.

On vaginal examination, normal female external genitalia. The cervix was fully dilated, station

+2, fully effaced, with occipito-anterior position of the fetus and the pelvis was adequate. Detailed obstetrics

examinations and clinical investigations of the patient before delivery is as follows:

Table 1: Details of obstetrics examination and clinical investigation

Obstetrics examination	
Per abdominal examination	
Uterine size	35/40
Position/Lie	OccipitoAnterior/Longitudinal
Presentation	Cephalic
Fetal Heart Rate	140-150 bpm
3-4 contractions/ 40 sec/ 10 Contractions min	
Previous LSCS Present scars	
Scar tenderness	Absent
Per Vaginal Examination	
CX dilation	Fully dilated
Effacement	100%
Membranes	Absent, liquor clear
Station	+2
Pelvis	Adequate
Clinical Investigations	
Blood and Rh type	ORh (+)
Hb	10 gm/dl
Platelet count	190/mcl

After complete assessment of the patient in the theatre, while on continuous electronic fetal monitoring, she subsequently had the urge to bear down and progressed to have a spontaneous vaginal delivery. Outcome was a live female neonate of 2900 grams and APGAR score of 9 and 10 (at first and fifth minutes respectively) following a mediolateral episiotomy. Post-

delivery abdominal ultrasound scan showed no signs of scar dehiscence or uterine rupture. In the postpartum period, it was observed that the uterus was involuted on abdominal examination. There was no peculiarity on vaginal examination. Uterine contours were regular in ultrasonography and there was no free fluid in the abdomen.



Figure 1: Ultrasound Post Delivery

On postpartum day 5, having normal vital findings, the patient was discharged from the hospital. Women who have had two or more prior lower segment caesarean deliveries may be offered VBAC after counselling by a senior obstetrician. This should include the risk of uterine rupture and maternal morbidity, and

the individual likelihood of successful VBAC (e.g. given a history of prior vaginal delivery). Labor should be conducted in a Centre with suitable expertise and recourse to immediate surgical delivery [16].

Women should be informed that the success rate of planned VBAC is 72–75% and Women with one or more previous vaginal births should be informed that previous vaginal delivery, particularly previous VBAC, is the single best predictor of successful VBAC and is associated with a planned VBAC success rate of 85–90%. Previous vaginal delivery is also independently associated with a reduced risk of uterine rupture (0.5%) [16].

However, the Royal College of Obstetricians and Gynecologists (RCOG) and American College of Obstetricians and Gynecologists (ACOG) do not currently recommend planned VBAC attempts in women with three or more prior caesarean deliveries, the number of women with such a history are less frequently encountered than those with fewer prior caesareans [1, 16].

Cahill *et al.*, found no difference in the rates of success or of VBAC-associated morbidities in women who attempted VBAC having had three or more prior caesareans compared with those having had one or two prior caesareans [5].

In addition, maternal morbidity in women with three or more prior caesareans did not differ by mode of delivery [5].

However Wakode *et al.*, in their case report identified that difficulties may occur in patients who are undergoing VBAC depending on issues such as age, weight of mother and the baby, the week of the pregnancy and the position of the fetus. Hence, vaginal delivery can be encouraged after ruling out high risk factors, proper examination and patient's consent [6].

The above-mentioned case was chosen after a thorough evaluation of successful vaginal delivery after 5 previous lower-segment caesarean sections, opening new possibilities for us to explore the option of vaginal birth for such patients; therefore creating a platform for further studies on the subject.

CONCLUSION

Vaginal delivery for women with multiple previous caesarean sections is possible with or without previous vaginal delivery. However, care should be taken in patient selection especially in planned vaginal delivery. The risks associated with repeat caesarean sections can be avoided with good understanding of vaginal births after caesarean sections (VBAC).

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