Abnormal labour (cont.)

Labour with previous uterine surgery

By

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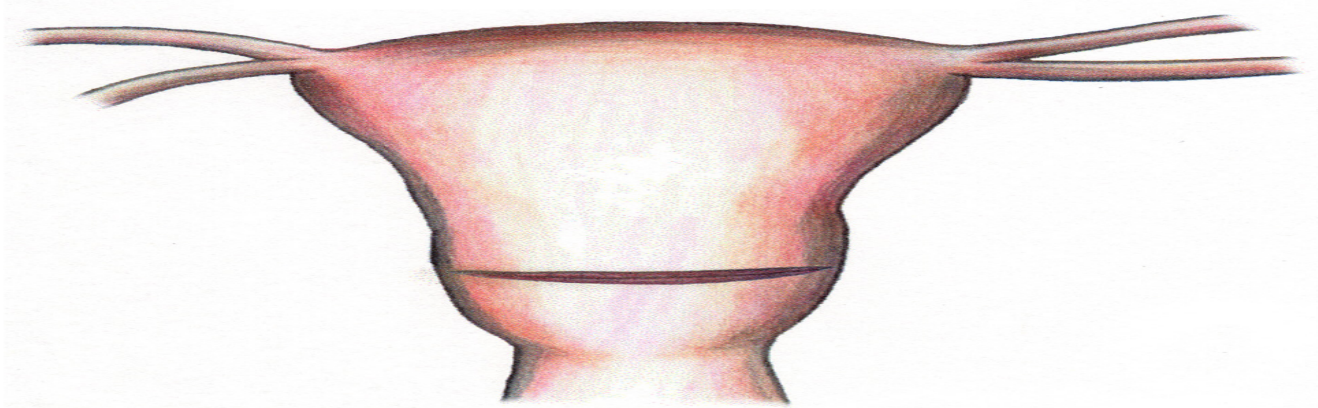
Uterine surgery could be

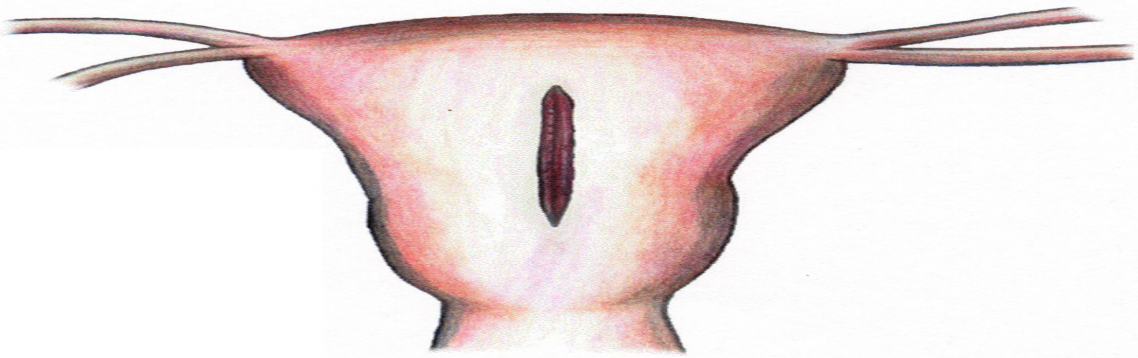
- Cesarean section (transverse. &. classical)
- Myomectomy. For uterine fibroid
- Metroplasty for correction of uterine anomaly

- Surgery may or may not include full uterine wall thickness

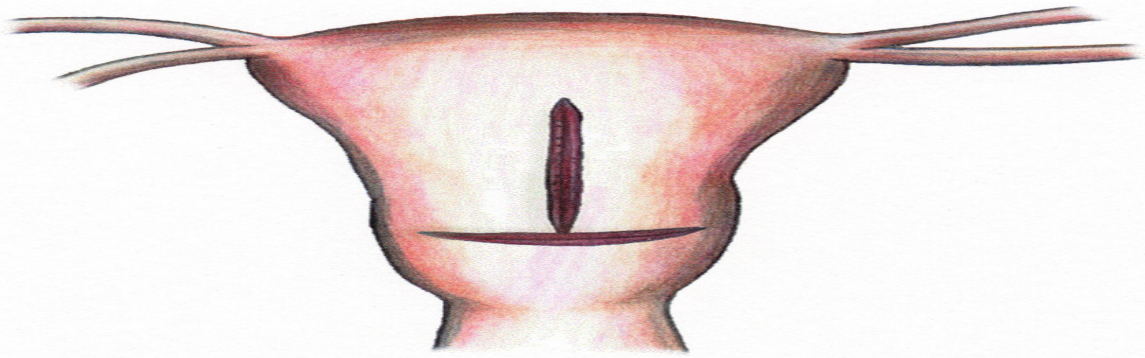
Cesarean section



Low transverse uterine incision



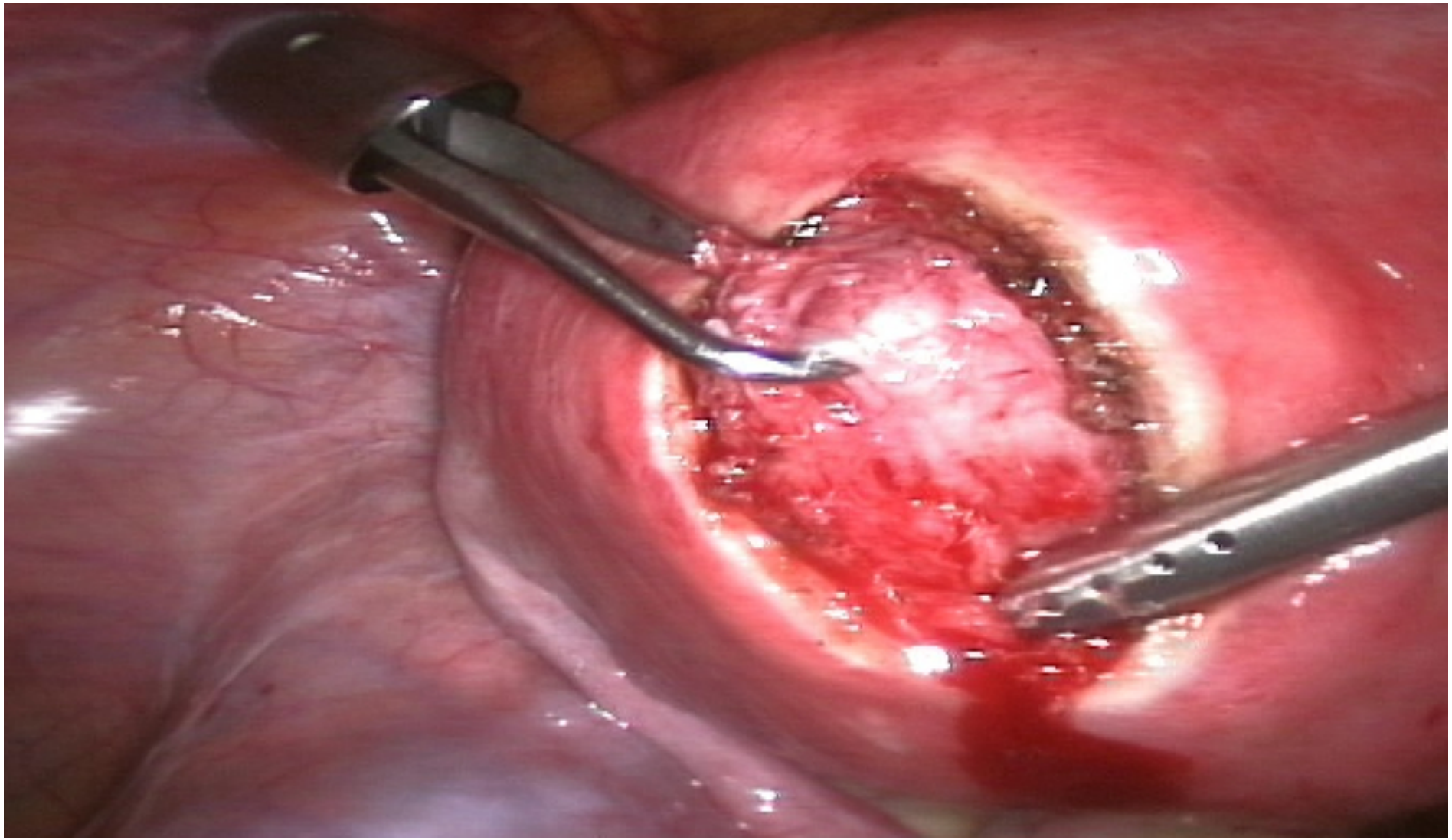
Classical uterine incision



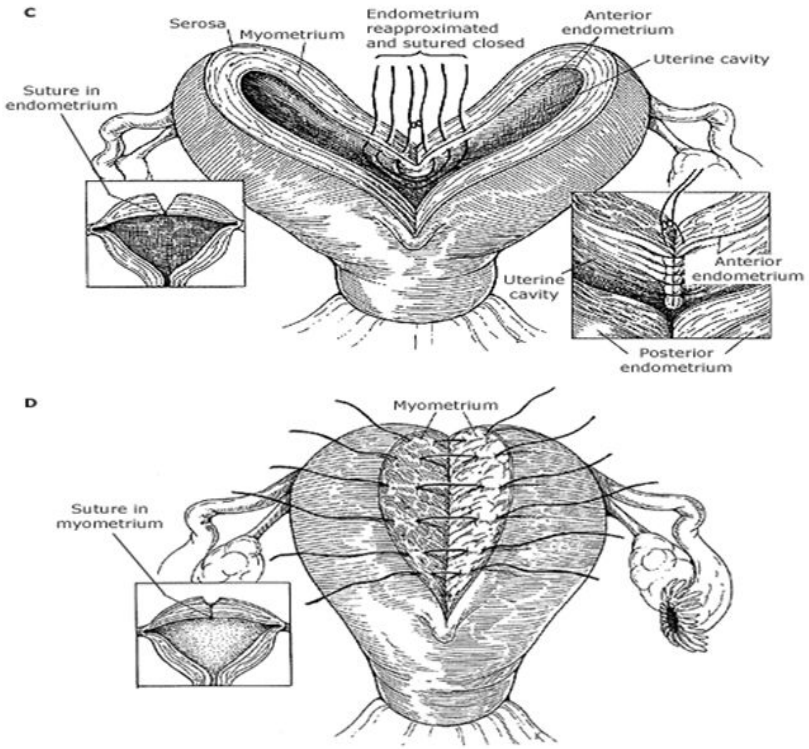
T-incision of uterus

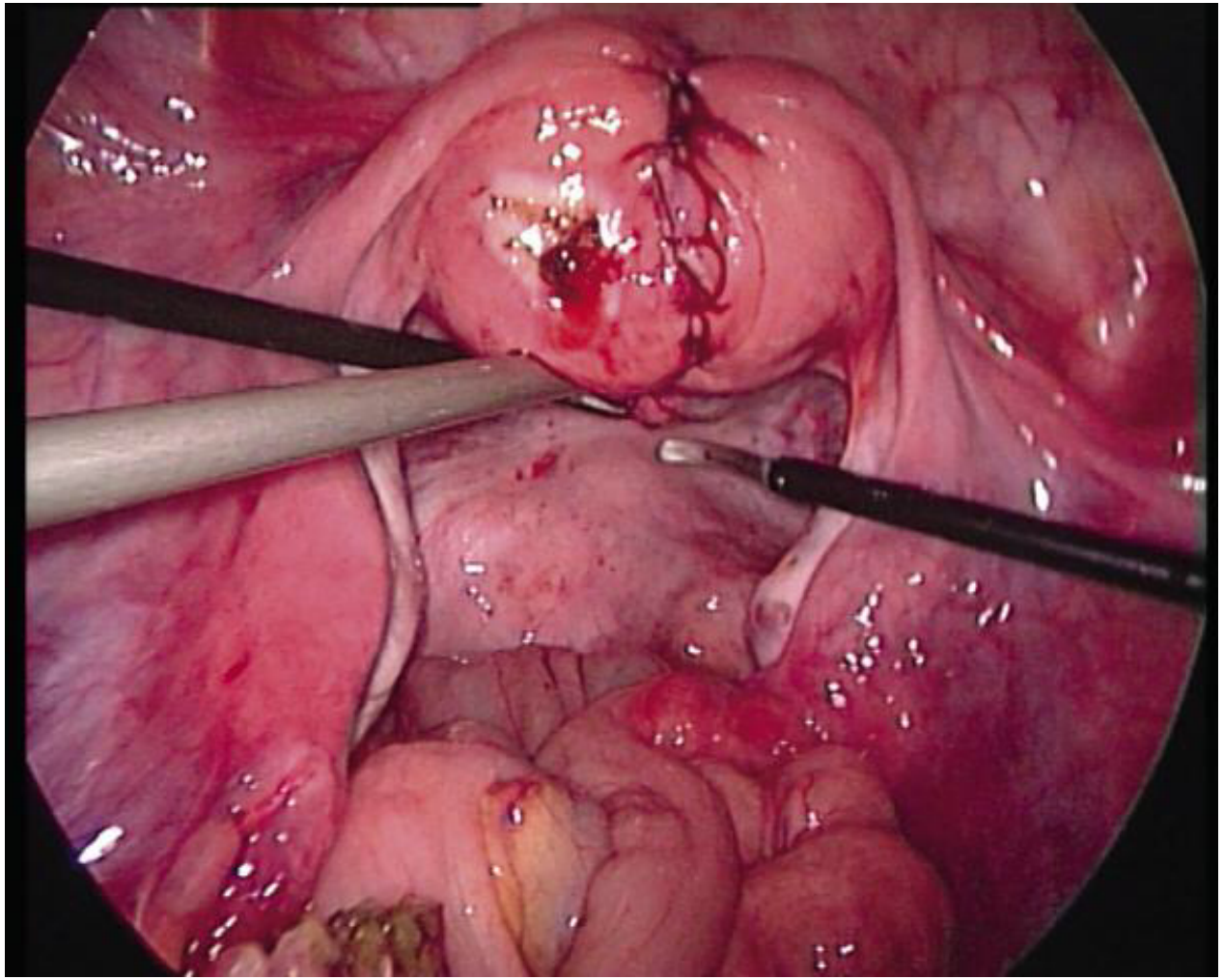
High risk uterine incisions (not VBAC candidates)

Myomectomy



Metroplasty





VAGINAL BIRTH AFTER CESAREAN

Options for a patient with previous cesarean

- **Elective repeat cesarean Delivery (ERCD)** – Also called ERCS (Elective Repeat Cesarean Section)
- **Trial of labor after cesarean (TOLAC)**

This can have 2 outcomes

- **Successful TOLAC** – Vaginal Birth After Cesarean Delivery (60 to 80%)
- **Failed TOLAC** – Emergency cesarean Delivery

Repeat elective caesarean section: risks and benefits

Maternal benefits

Caesarean section avoids labour with its risks of:

- perineal trauma (urinary and faecal problems),
- the need for emergency caesarean section,
- scar dehiscence or rupture with subsequent morbidity and mortality.

It also has the advantage of allowing a planned delivery.

Maternal risks

- Prolonged recovery.
- Future pregnancies would probably require caesarean section for delivery.
- Increased risks of placenta praevia and accreta in subsequent pregnancies.

Fetal benefit

- No risk from intrapartum scar rupture.

Fetal risk

- Increased risk of transient tachypnoea/respiratory distress syndrome (1–3 per cent at 39 weeks, 6 per cent at 38 weeks).

Planned VBAC: risks and benefits

Maternal benefits

- Shorter hospital stay and convalescence.
- Potentially easier future deliveries.

Maternal risks

- Increased risk of transfusion (relative risk 1.7, due to increased need in women with failed VBAC).
- Increased risk of endometritis (relative risk 1.6, due to increased risk in women with failed VBAC).
- Risk of uterine rupture (0.22–0.74 per cent which is stratified by need for intervention, i.e. highest risk with prostaglandin induction of labour, lowest risk for spontaneous delivery) [D].

Fetal benefit

- Reduced risk of transient respiratory morbidity.

Fetal risks

- 0.08 per cent risk of hypoxic ischaemic encephalopathy (similar to risk for nulliparous women).
- 0.04 per cent risk delivery-related death.

Contraindication to VBAC

- Prior classic,T shaped incision or other trans mural uterine surgery.
- Contracted pelvis.
- Medical/obstetric complication that preclude vaginal delivery.
- Previous rupture or scar dehiscence
- Previous two LSCS
- Lack of resource to perfom emergency CS round the clock.

Predictors of VBAC Success or Failure

Increased Chance of Success	Decreased Chance of Success
Prior vaginal delivery	Maternal obesity
Prior VBAC	Short maternal stature
Spontaneous labor	Macrosomia
Favorable cervix	Increased maternal age (>40 y)
Nonrecurring indication (breech presentation, placenta previa, herpes)	Induction of labor
Preterm delivery	Recurring indication (cephalopelvic disproportion, failed second stage)
	Increased interpregnancy weight gain
	Latina or African American race/ethnicity
	Gestational age ≥41 wk
	Preconceptional or gestational diabetes mellitus

Intrapartum management

- Take detailed informed written consent
- To be conducted in a suitably staffed & equipped setting with the facility for emergency cesarean delivery 24x7 & neonatal resuscitation
- An Obstetrician, Anesthesiologist & pediatrician should be immediately available
- PGE 2 may be used to induce labor with caution.
- IV access, adequate blood cross matched
- Monitor maternal BP, PR & ST every 15 min

- Continuous fetal monitoring by CTG (II A)
- Intrauterine pressure catheters – not routinely useful
- Oxytocin should be used with caution (In AIIMS – low dose, starting from 1mIU/min is being used for augmentation)
- No contraindication for epidural analgesia – does not reduce success or mask signs of rupture
- Regular review of partogram by senior obstetrician
- Routine postpartum exploration of scar – not needed

Signs and symptoms of scar rupture

The cardinal signs of imminent uterine rupture are:

- worsening cardiotocography (CTG) changes (especially prolonged variable or late decelerations),
- haematuria,
- secondary arrest,
- small amounts of vaginal bleeding,
- pain over the scar which persists between contractions.

Signs of uterine rupture are:

- fetal bradycardia,
- upward displacement of the presenting part,
- sudden loss of contractions,
- maternal hypotension,
- heavy vaginal bleeding.
- abdominal or shoulder pain.

MANAGEMENT OF THE THIRD STAGE

Postpartum haemorrhage is more common in women who have a scarred uterus, probably because of the inability of the scar tissue to contract and increased placental adherence. Therefore, a low threshold for very active management of the third stage should be implemented.

This should include:

- oxytocics at delivery of the shoulders,
- prompt delivery of the placenta after separation,
- consideration of continued Syntocinon infusion for 4 hours after delivery.

If the placenta is retained, the possibility of a placenta accreta must be borne in mind. Therefore, before proceeding to a manual removal, important steps must be taken.

- Establish the probable placental site from the previous scan reports. Accreta is much more likely if the placenta was noted to be anterior.
- Cross-match 4 units of blood.
- Obtain the woman's consent and note that the possibility of accreta has been discussed, with its potential problems and management options.
- Ensure that senior staff are aware and, if you are inexperienced, ask for help before you go to theatre.

If at the time of manual removal a clear plane of cleavage cannot be defined, placenta accreta is likely. Different management options have been tried with variable success.


Thank
you