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TOLAC trial of labor after Ceasean section

Trupangi Chaudhari

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I. Introduction :

Vaginal birth after cesarean section (VBAC) is one of the strategies developed to control the rising rate of cesarean sections (CS). It is a trial of vaginal delivery in selected cases of a previous CS in a well-equipped hospital. In 1916, Cragin popularized the dictum, "once a caesarean section, always a caesarean section". That was the era of the classical CS. In the present era of lower segment caesarean section (LSCS), cesarean-related morbidity and mortality are significantly reduced. The dictum now is "once a caesarean section, always an institutional delivery in a well-equipped hospital". The reasons which led to the reversal of the old dictum are based upon the newer concepts of the assessment of scar integrity, fetal well-being, and improved facilities of emergency CS.

Nevertheless, a previous CS does cast a shadow over the outcome of future pregnancies.With present techniques and skill, the incidence of cesarean scar rupture in subsequent pregnancies is very low. The strength of the uterine scar and its capacity to withstand the stress of subsequent pregnancy and labor cannot be completely assessed or guaranteed in advance.Trial of labor after CS (TOLAC) is a programmed attempt to deliver vaginally for a woman with previous CS. This approach enables the opportunity to achieve a vaginal birth after CS (VBAC), a realistic option for some women with history of CS, which should be encouraged with the view of containing the number of unnecessary CS.For decades women were discouraged from VBAC, due to the risk of rupture of the previously vertically incised large uterine muscle during contractions .This risk increases with number of previous CS. The introduction of the transverse lower incision diminished this risk and allowed more women to try TOLAC. TOLAC is now widely recommended in appropriately selected and supported pregnant women with up to two transverse low-segment CS

Hence, the present study was undertaken to assess the success and safety of VBAC in selected cases of one previous LSCS and to evaluate the maternal and fetal outcome in these cases.

II. Aims And Objectives:

1) To study maternal outcome in pt with previous ceasarian section.
2) To study complications in pt with vaginal delivery after cesarian section.

III. Methods And Materials

This prospective observational study was carried out at a tertiary care teaching hospital located in a rural area of central India from February 2022 to august 2022 This hospital gets referrals of high-risk cases from neighbouring villages and townships. A total of 50 cases of a previous CS were selected in emergency labour room . patients, who reported directly for labor, were then assessed for a trial of vaginal delivery. A study protocol was submitted to the institutional ethical committee of the Gujrat adani Institute of Medical Sciences, and approval was sought before start of the study.

Cases with a single previous transverse lower uterine segment scar with adequate size of pelvis were included in the study after informed consent. Cases with previous classical or inverted T-shaped incision on the uterus, previous two or more LSCSs, with other uterine scars, history of previous rupture of the uterus or scar dehiscence, contracted pelvis or cephalopelvic disproportion, and those having other medical or obstetrical complications associated with pregnancy were excluded from the study. A total of 50 cases that fulfilled the selection criteria were enrolled in the study. All cases and their close relatives were explained about the advantages of vaginal birth over elective CS. They were also explained about the risk of scar dehiscence and the need for emergency CS, if trial of vaginal delivery failed. Written informed consent was obtained at the time of enrolment in the study. The patients were asked to come for regular antenatal checkups and were advised to plan their delivery in the hospital where the study was conducted. Hematological and serological investigations and obstetric sonography were performed during antenatal visits. The cases selected for VBAC were monitored carefully during labour by continuous electronic fetal monitoring. All the cases were provisionally prepared for emergency CS. Intrapartum monitoring was done by using the standard partograph of the World Health

Organization (WHO). Four-hourly internal examinations were performed to assess the progress, and special attention was paid toward the evidence of scar dehiscence or rupture. The trial of vaginal delivery was continued till there was satisfactory progress. The trial was terminated by emergency repeat CS, when there was evidence of unsatisfactory progress, scar tenderness, or fetal distress. Cases with successful VBAC delivery were kept in the hospital for three days and those who required repeat CS were kept for five days after the operation. All cases received broad-spectrum antibiotics for either three or five days.

IV. Results:

PARITY		
2ND GRAVIDA	12	48%
3RD GRAVIDA	8	32%
4th GRAVIDA	5	20%
TOTAL	25	

INTER PREGNANCY INTERVAL		
2 YEAR	6	14%
3 YEAR	14	56%
4YEAR	5	20%

BABY WEIGHT		
2- 2.5 KG	17	68%
>2.5- 3 KG	8	32%

INDICATIONS		
BREECH	6	24%
NPOL	3	12%
MSL	16	64%

FAILURE	4	16%

COMPLICATION Pelvic abscess	1	4%

V. Results :

Successful vaginal delivery occur in 80% cases with failure of TOLAC in 16 % cases with complication in 4% cases .Complications includes uterine scar rupture , hemorrhage ,pelvic abscess ,perinatal and maternal mortality and morbidity . Successful vaginal delivery occur in patient with pregnancy interval of 2 or more years with good bishop score and adequate pelvis .out of 25 cases 12 cases of 2nd Gravida with pregnancy interval of 3 years had successful vaginal delivery with no complications . out of 25 cases only 1 case had complication of delayed rupture of cs scar with abscess formation .

VI. Conclusion :

After ceaserian section vaginal delivery occur with proper monitoring of pulse and fhs monitoring and proper partogram formation and per vaginal examination .

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