SUCCESSFUL VAGINAL DELIVERY AFTER CAESAREAN SCAR RUPTURE: *A case report*

P. MAOURIS
Queen Charlotte's and Chelsea Hospital - London (G.B.)

Summary: A case of successful vaginal delivery following a previous lower segment caesarean scar rupture is presented.

INTRODUCTION

Craigin's dictum of "once a Caesaren section always a Caesarean section" ([1]), is now considered by most authorities to be outdated. In a comprehensive review of vaginal delivery following previous Caesarean section, Flamm ([2]) emphasizes the safety of a trial of labour. He also comments on the arbitrary nature of the decision to exclude patients with multiple sections from a trial of labour.

Once a uterine scar rupture has occurred, an elective Caesarean section is recommended in future pregnancies for fear of a repeat rupture of the scar. An interesting case of a successful vaginal delivery following a previous lower segment uterine scar rupture is presented.

CASE REPORT

Mrs. L. P. was 31 years old, and in her seventh pregnancy. In 1971 and 1976 she had two full term normal vaginal deliveries. The birth weights were 2.55 kg and 2.35 kg respectively.

In 1980 she was delivered by lower segment Caesarean section at term because of failure to progress in the first stage of labour. The baby weighed 2.9 kg. In 1981 and 1982 she aborted spontaneously in the first trimester.

In 1984 she was allowed a trial of labour but after five hours of good uterine contractions, an emergency lower segment Caesarean section was performed for fetal distress, when cervical dilatation was only 3 cm.

At laparotomy the uterine scar was found to have dehisced in its entire length. The umbilical cord was found lying outside the uterine cavity but still below the pelvic peritoneum which was intact but bulging. A live fetus weighing 3.12 kg was delivered. The right uterine artery was damaged during delivery and was ligated. The uterus was repaired in two layers using a continuous catgut suture.

In her next pregnancy, an elective Caesarean section and bilateral tubal ligation was planned at 39 weeks gestation. However, the day prior to her scheduled Caesarean section, she delivered vaginally, on arrival in the delivery ward, a healthy infant weighing 2.43 kg. Following the delivery she complained of supra-pubic pain and was tender to palpation over the previous Caesarean section scar. There was no active bleeding per vaginam.

Because of the possibility of repeat scar rupture and her continuing wish to be sterilised, a mini-laparotomy was performed a few hours later. The lower segment of the uterus was found to be intact and a sterilisation operation was performed. Her post operative recovery was uneventful.

DISCUSSION

The severity of rupture of the uterine scar reflects the degree of risk of a repeat scar rupture during a subsequent pregnancy and labour. When there is complete rupture of the scar, a repeat Caesarean is always planned for and, hence, data quantifying the extent of this risk are lacking. When an asymptomatic silent rupture is discovered following a vaginal delivery, it usually involves a small portion of the scar ("window") and it can often be left unrepaired without any apparent adverse consequences. Indeed, as long ago as 1963, Allahbadia ([3]) suggested that when a vaginal delivery follows a Caesarean section, post-partum digital examination of the scar should only be performed for speci-

fic indications such as haemorrhage or pain.

It is likely that a lot of cases of silent scar rupture escape detection and in a subsequent pregnancy proceed to have a successful vaginal delivery. The case described here, however, involved rupture of the entire length of the scar, with the umbilical cord bulging through the uterine defect warranting primary repair. The fact that is was followed by an unplanned but successful vaginal delivery, testifies to the strength of the repair.

It is however fortuitous that the size of the fetus delivered vaginally was smaller than the one involved in the scar rupture. This may well have been the crucial factor contributing towards the maintenance of the integrity of the previously ruptured scar.

For this reason and also due to the paucity of similar reports in medical literature, it would be unwise to recommend a trial of labour after a uterine scar rupture based on the experience of a single case. Unless more similar cases are reported, however, we will never be in a position to quantify the risk of such a trial of labour.

BIBLIOGRAPHY

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